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## Community Resiliency Model Treatment Manual for Loma Linda University Healthcare

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LOMA LINDA UNIVERSITY  
School of Behavioral Health  
in conjunction with the  
Department of Psychology

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Community Resiliency Model Treatment Manual for Loma Linda University Healthcare

by

Ann White

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A Project submitted in partial satisfaction of  
the requirements for the degree  
Doctor of Psychology

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September 2022

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Each person whose signature appears below certifies that this doctoral project in his/ her opinion is adequate, in scope and quality, as a doctoral project for the degree Doctor of Psychology.

\_\_\_\_\_, Chairperson  
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\_\_\_\_\_  
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## ABBREVIATIONS

CRM	Community Resiliency Model
CBT	Cognitive Behavioral Therapy
PFA	Psychological First Aid

## ABSTRACT OF THE DOCTORAL PROJECT

Community Resiliency Model Treatment Manual for Loma Linda University Healthcare

by

Ann White

Doctor of Psychology, Department of Psychology  
Loma Linda University, September 2022  
Dr. Susanne Montgomery, Chairperson

Burnout is a national phenomenon on the United States, effecting between 60% and 78% of healthcare professionals (21) across a variety of settings. Burnout results in increased cost to the healthcare industry, significantly decreased quality of patient care, and increased malpractice claims. At the same time, healthcare providers are increasingly under demands to their time that limit their ability to access wellness resources to mitigate the effects of burnout, such as outpatient psychotherapy. In order to address this growing crisis and respond to the specific needs of healthcare providers, we have utilized the biological basis and six skills comprising the Community Resiliency Model (CRM) to create a brief, three-session, in service training to provide wellness skills to these providers. We shortened the CRM training from its current five-day training, into a three hour training would allow for the skills to be transmitted to healthcare providers in order to decrease their levels of burnout and improve their wellness and coping skills.

# **CHAPTER ONE**

## **LITERATURE REVIEW**

### **Defining Burnout**

Among healthcare professionals in the United States, over one-half of physicians and one-third of nurses report experiencing burnout (NCBI, 2018). The effects of care-provider burnout impacts patient care, as well as contributing to shortages and turnover of care providers. Burnout is defined as a combination of exhaustion, negativism, and self-perception of inefficacy. This cluster of symptoms occurs after extended periods of occupational stress. Herbert Freudenberger, a clinical psychologist, introduced the idea of burnout in 1974 after working with drug-addicted populations at a clinic in New York City. Freudenberger noted psychosomatic symptoms and emotional exhaustion among the staff working at the clinic. He termed his observations “burnout,” and defined it as depletion resulting from “excessive demands on energy, strength, or resources” in the workplace, and noted associated symptoms included cynicism, fatigue, frustration, inefficacy, and malaise (Freudenberger, 1974). Finally, he observed that the phenomenon of burnout was often found in settings that demands a high degree of personal involvement and empathy—particularly characteristic of healthcare providers.

Christina Maslach, a social psychologist at the University of California, Berkeley, built upon this early work on the phenomenon of burnout. A social psychologist, Maslach organized a model of burnout based on three dimensions: emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment (Maslach, 1981). The Maslach Burnout Inventory (MBI) was created in 1981 to measure individual

symptoms within each dimension of burnout.

### **Impact of Burnout**

Burnout remains a critical issue almost forty years after the early work on burnout by Freudenberger and Maslach. Not only is burnout associated with detrimental effects to care providers, but also has an adverse impact on patient care. Studies show that surgeons likelihood of making major medical errors is correlated with their level of burnout (Shanafelt et. al, 2010), and being implicated in a malpractice suit (Balch et. at., 2011). Higher levels of burnout have been found among nursing populations that are exposed to high rates of patient mortality (Welp, Meier, & Manser, 2015), and dissemination of infections due to hospital transmission (Cimiotti, Aiken, Sloane, & Wu, 2012). Burnout has been associated with dishonest care practices among medical students, as well as lowered levels of altruism (Dyrebye, Massie, Eacker, et al, 2010) and increased levels of alcohol abuse (Jackson, et al., 2016). Finally, high rates of provider burnout are consistently associated with patients rating their satisfaction about care they receive lower (Halbesleben, 2008).

Institutions are effected by burnout due to increased job turnover and elevated considerations of quitting in physicians (Shanafelt, Sloan, Satele, & Balch, 2011), and nursing staff (Leiter & Maslach, 2009). The current rate of burnout and resulting loss of productivity is comparable to the loss of seven entire medical school graduating classes, a recent study at the Mayo Clinic found (Shanafelt, Dyrbye, West, & Sinsky, 2016). This suggests that workplace burnout not only effects the care providers themselves, but also their patients and their workplaces. This suggests that burnout is an additional

exacerbating factor to the national shortage of medical care providers.

### ***Burnout in Medical Doctors and Students***

Research suggests that the phenomena of burnout is widespread. Over 50% of American physicians report symptoms of burnout, which is notable for the fact that that is almost double burnout reported by individuals in other careers, even when controlling for hours worked, age, gender, and other factors (14). Current trends suggest that the rate of burnout among physicians is likely to increase. A 2013 survey of over 20,000 physicians by the Medscape Lifestyle Report indicated that burnout rates nationwide are at 40% (15), and in 2017 the rates are greater than 51% (16), which indicates that burnout has increased by just 25% in only four years. Physicians working in the fields of emergency medicine, family medicine, internal medicine, and obstetrics/gynecology have been found to be fields particularly at risk for burnout, and women within the field have been found to be more likely to experience this than men (16).

Physicians in training are particularly susceptible to burnout—a 2016 physician resident study surveying all specialties found rates of burnout of about 70%. Non-surgical residents experience burnout at rates of 66%, and their surgical counterparts at 78% (21). Earlier reports from 2009 support these findings, suggest that general rates of burnout hover around 75% (22). Even prior to residency, medical students experience high rates of burnout—in 2013, research suggested that about 50% of American medical students experience significant burnout (23), and a sample of 16,000 medical students across the world were found to experience burnout at rates of about 44% (24).

## ***Burnout in Nurses***

While well-studied among physicians, burnout has also been found to be prevalent in American nurses at rate of 43%, according to one 2001 study (18). These nurses reported experiencing emotional exhaustion, and it was found in 2011 that 37% of nurses working with nursing home residents, and 33% of hospital nurses also experienced these facets of burnout. Other providers, such as physician's assistants, are yet to be studied in depth in regards to their levels of burnout, but early research suggests that these providers may experience burnout at rates comparable to others (20).

### **Impact of Patient Populations on Burnout**

These challenges only increase in complexity when medical care providers work with chronically ill and non-compliant patient populations, (such as those with Sickle cell disease or Type 1 Diabetes). These chronically ill populations are uniquely challenging for several reasons: their high utilization of resources, the complexity of the health management strategies necessitated, and their low or inconsistent rates of compliance with treatment plans. In fact, medical nonadherence is such a widespread problem among those with chronic diseases, that it costs the United States about \$290 billion every year in avoidable healthcare costs; among Canadian populations, medical nonadherence accounts for 5.4% of all hospitalizations (Lemstra, Nwankwo, Bird & Moraros, 2018). The American Diabetes Association, for example, found in one study that only 7% of patients surveyed 6-12 months after diabetes education class were in compliance with all 45 points considered to be "necessary" for "good control of their disease" (Cerkoney & Hart, 1980). Understandably, this crisis contributes to care provider burnout. A 2017

study of 1554 primary care clinicians found that burnout is associated with low satisfaction regarding resources to treat complex patients (Whitebird, et al, 2017). The provider populations working with these non-compliant populations are found to experience compassion fatigue “commonly and episodically,” suggesting a persistent toll on care-providers (Maytum, Heiman & Garwick, 2004). This 2004 study also found that it is critical for care providers to be able to first identify signs of compassion fatigue and develop a myriad of coping strategies to decrease their risk of burnout.

### **Treatments for Burnout**

These combined current crises in our country of care provider burnout and patient non-compliance seem to interact in a bidirectional relationship (25). The current body of research on these issues suggests that interventions to improve coping for providers and chronically ill patients alike are critical. Due to the increasingly prominent role of psychology in the treatment of provider burnout, research on biopsychosocial models of intervention are beginning to expand (Veehof, et al, 2011). Current research suggests that body-based and somatic therapies are uniquely appropriate to treat the effects of chronic stress and traumatic experiences (van der Kolk, 2014). However, neuroscientific evidence presents a strong argument for the importance of these body-based interventions (Haase et al., 2016), and their effectiveness at developing individual resiliency.

The scope of the current problem of care provider burnout is one that is far too large for the standard one-on-one, therapist and patient model as it currently exists. Problems with this model of care include issues of accessibility; while tele-psychology works to address issues such as this, it is still limited by availability of technology and

necessity of the individual to realize their own need for care. Two of the primary models currently used to address burnout and chronic stress include psychotherapeutic interventions such as cognitive-behavioral therapy (CBT) and Psychological First Aid (PFA).

### *CBT and PFA for burnout*

CBT-based interventions work with the individual's thoughts or cognitions as the individual's way of understanding their experience, which is believed to in turn determine how they will act in future events. This is the basis for behavioral change within CBT, as these behavioral changes are believed to lead to altered cognitions and new understandings (U.S. Department of Health and Human Services, 2016). CBT models have shown to produce improved coping—interestingly, even when they are delivered by health workers without specialized training (Weiss et al., 2015). This suggests that while we currently have treatment models that have been shown to be effective, they are handicapped by issues of patient's insight into need for treatment and accessibility of care. They are also further handicapped by the conceptualization of sources of stress as singular events, rather than the ongoing exposure that care providers experience. PFA is a peer-driven, evidence-informed model of care that addresses some of these issues of identification and accessibility. However, this model also has limitations as well, namely its design as a time-limited, supported intervention, that does not provide future skills.

This emerging field of modalities is particularly critical as our understanding of the biological roots of disease and psychological wellbeing are expanding. Chronic stress



and trauma impacts almost every physiological system, and results in lasting biological alterations in neuroendocrine and neurotransmitter systems, proinflammatory cytokines, and alterations in mood regulation systems (Nemeroff, 2016). Adversity alters the structure of the protective coverings at the tips of chromosomes known as telomeres, which has been shown to mediate cell aging and early disease (Puterman et al., 2016; Shalev et al., 2013). Furthermore, DNA methylation alters genes in the brain and peripheral tissues, which is associated with adverse gene expression, resulting in health disorders that are otherwise preventable and reversible (Szyf, Tany, Hill, & Musci, 2016). Unsurprisingly, then, the human response to stress and threat is not only biological and primitive, but innately physiological and subcortical (Levine, 2003).

### ***CRM for Burnout***

The Community Resiliency Model (CRM), are a set of novel wellness skills that have been shown to significantly improve the posttraumatic resiliency and mitigate the effects of long-term exposure to stress (Habimana & Montgomery, 2016). CRM has been studied as an intervention for community-level dissemination in the use of health promotion and wellbeing (Kulig, 2008), but remains in the early stages of development for more specific application among healthcare populations. The model most often taught in a 4-5 day training session, focuses on providing brief, easily understandable interventions that individuals can use to reregulate their parasympathetic nervous systems. The goal of the skills included in this model are to expand access to parasympathetic-based interventions to frontline service providers, community leaders, and clinicians. The model seeks to achieve this by providing brief coping strategies and

guiding participants to generate self-soothing skills specific to themselves, rather than traditional psychological models that include processing, reframing, and other tools that can only be utilized by trained therapists or psychologists. The model places the individual receiving the intervention as the expert on their own experience, rather than in a traditional care provider model, where the care provider is placed in the “expert” role. The CRM model is also devoid of any requirement for the individual receiving treatment to explicitly state their stressor, which builds on contemporary psychotherapeutic research that finds that narrative therapies may be less effective than previously thought (Schmidt, et al., 2011). Furthermore, the CRM intervention allows for brief implementation for both care providers and patients, and as it is currently utilized, requires only a one to three day training for the care provider to be able to teach the CRM skills to their patients and use the CRM skills for themselves.

The CRM model is composed of six basic skills: Tracking, Resourcing, Grounding, Gesturing and Movement, Help Now!, and Shift and Stay. Each skill is a brief intervention that the individual can then later practice on their own, when they experience psychological dysregulation via the parasympathetic nervous system, without props or external feedback.

According to Tracy, Ioannou, Baker, and Gibson (2016), findings suggest that there is decreased parasympathetic nervous system activation when an individual experiences burnout-related stress. Therefore, this suggests that interventions that target stress via the parasympathetic nervous system may have efficacy in treatment.

## **CHAPTER TWO**

### **GOALS AND SPECIFIC AIMS**

#### **Goals**

As the Community Resiliency Model (CRM) currently relies primarily upon a four-five-day training dissemination model, it is important to develop a method of delivering this training in a shorter format—as is particularly necessary when working with care providers, who often have little available free time. The first goal is then to establish the elements of the four-five-day-training that are particularly critical to retain in a shorter format. While the shortening of the training is necessitated by the demands of primary care settings, the basic philosophy and six skills of the training must still be disseminated in an effective manner. Therefore, it becomes important not only to identify the elements of the longer training that must be retained, but also to develop a format in which the philosophy and skills of the shorter training may be taught. Finally, possible barriers and challenges to retention of the CRM skills when taught in the shorter, four session format, must be identified.

#### **Specific Aims**

Specific Aim 1: To identify which core elements of the full training need to be included in a low dose brief version of CRM (4-5 sessions) used for health care provider self-care and burnout.

Specific Aim 2: to identify the best teaching/learning modality to make the brief CRM intervention effective.

## **CHAPTER THREE**

### **METHODS**

This brief format of the CRM model teaching was developed by Loma Linda University faculty and students who had been trained in the CRM model. The method of dissemination of this brief model for care providers is through in-service staff trainings, which are limited to one to one-and-a-half hour blocks of time. These parameters lend themselves to multiple teaching sessions spread over several days.

To facilitate the dissemination of the CRM model in a brief format, the five-day training was shortened to a five session model. The first three sessions comprise the trainings, with the following two sessions acting as booster sessions to support participant retention and use of skills. This five session model is expected to occur over the course of five hours in total, with three hours devoted to sessions one, two, and three, and an hour for each follow up booster session at a later date.

In order to maintain the dissemination of the core philosophy and skills of the model, the main objectives of the model were distilled down for the training sessions.

#### **Session Objectives**

In session one, the objectives identified are: 1. Briefly explain the CRM approach, including the biological bases of the model. 2. To learn the skill of tracking: being able to tell the difference between sensations of distress and sensations of wellness within your body; 3. To learn the skill of resourcing: how identifying and intensifying your resource can promote greater resiliency and improve your wellness (the skill Resourcing).

For session two, the objectives are: 1. To learn to bring our attention to the present moment by having our body make contact with a supportive surface (the skill Grounding); 2. To learn to bring attention to the different ways to guide the nervous system back into the Resilient Zone (the skill Shift and stay); 3. To learn strategies to help a person get back to the Resilient Zone if they are stuck in the High Zone or Low Zone (the skill Help Now/Deactivate Now); 4. To identify gestures that are self-soothing that can be brought into the present-moment awareness to return the nervous system back into balance (the skill Gesturing).

In session three, the objectives are: 1. Observe full length CRM demonstration with the incorporation of skills; 2. Practice CRM skills in order to ensure fidelity.

### **Format Abbreviation**

To support the understanding and retention of the skills and to address specific aim 2, within this new format, a new training protocol was created. Qualitative data from care provider staff who had experienced early trainings reported environmental challenges including staff exhaustion from having worked a 12-hour shift prior to the in-service trainings. Staff also reported difficulty concentrating in the trainings due to the lecture-style format of the CRM training. In consideration of this feedback, the brief format of the CRM training was modified to be more activity-based, rather than more lecture-based.

### **Session Delivery**

Qualitative data provided by staff following brief-format CRM training was surprising.

While the initial goal of the study was to decrease care provider burnout by offering a set of self-help skills, providers reported that a large source of their burnout was feeling as if they could not help their patients. They reported that the stress they experience with their high-utilizing patients was a feeling of a lack of success in patient care. The qualitative data also showed that the staff who reported the most benefit from the CRM trainings were not just using the skills for themselves, but rather using the skills to increase patient wellbeing also. These study participants reported that the way in which they utilized the skills indirectly with their patients, rather than for themselves, actually improved their feelings of wellbeing and decreased their stress. This suggests that the effectiveness of the brief CRM skills trainings for care providers may lie in their ability to improve their patient's coping with the skills, rather than directly using the skills for themselves.

### **Training Materials**

Key to the delivery of the CRM training was the development and integration of vignettes and prompts. A series of vignettes were developed by psychology graduate students in the CRM lab, designed to target the specific patient populations and healthcare settings that CRM trainees would likely encounter. These vignettes were designed to be brief examples of patient or provider distress, with the goal of challenging the participants to consider how they can apply the CRM skills to their daily workplace challenges. These vignettes were designed to be applied frequently throughout the CRM training, in order to maximize participant buy-in and engagement. After the teaching of the first CRM skill, vignettes can and should be integrated into the training.

“Huddle prompts” were also developed to support and maximize continued engagement after the culmination of the CRM training. These prompts were designed to be implemented by CRM trainers during brief staff meetings and the beginning of shifts, in order to challenge the now-trained participants to continue to apply the CRM skills. Early qualitative data suggested that it was necessary to provide additional applied support in this way, in order to ensure the continued use of the skills. Because of the brief nature of these staff meetings, the “huddle prompts” were created as only one- or two sentences each, including questions such as “What is your gesture of calm or joy?,” and “Do you have a patient today who could benefit from shift and stay?” When necessary, the CRM trainer could also assist the providers in generating answers to these prompts and thus provide a highly abbreviated refresher post-CRM training.

## CHAPTER FOUR

### REVISED BRIEF CRM INTERVENTION MANUAL

#### *Introduction to the CRM training sessions*

The goal of each CRM training has three treatment objectives for participants, as follows: to learn simple, biologically based skills, based upon current science, to help individuals and communities get back into balance in body, mind, and spirit; to learn the six wellness skills of the Community Resiliency Model; to train individuals to be Community Resiliency Model Teachers so that they can teach the Community Resiliency Model Wellness Skills to their communities.

When introducing the model, the CRM teacher conveys several points:

- As a patient or care provider interacting with a complex illness, it is easy to struggle with one's own wellbeing. CRM is a set of wellness skills that will assist you in seeking balance and managing your stress.
- It is hoped that if you find these skills useful, you can use them with yourselves and others.

#### *3.2 CRM training session one*

Objectives of session one for participants are as follows: to learn to tell the difference between sensations of distress and sensations of wellbeing within the nervous system (Tracking); to learn the significance of building a resource to promote greater resiliency (Trounding). It may be expected that the first session can take about 60 minutes, and time allotted should include an ice breaker.

- Introduction of CRM teachers (names and roles).



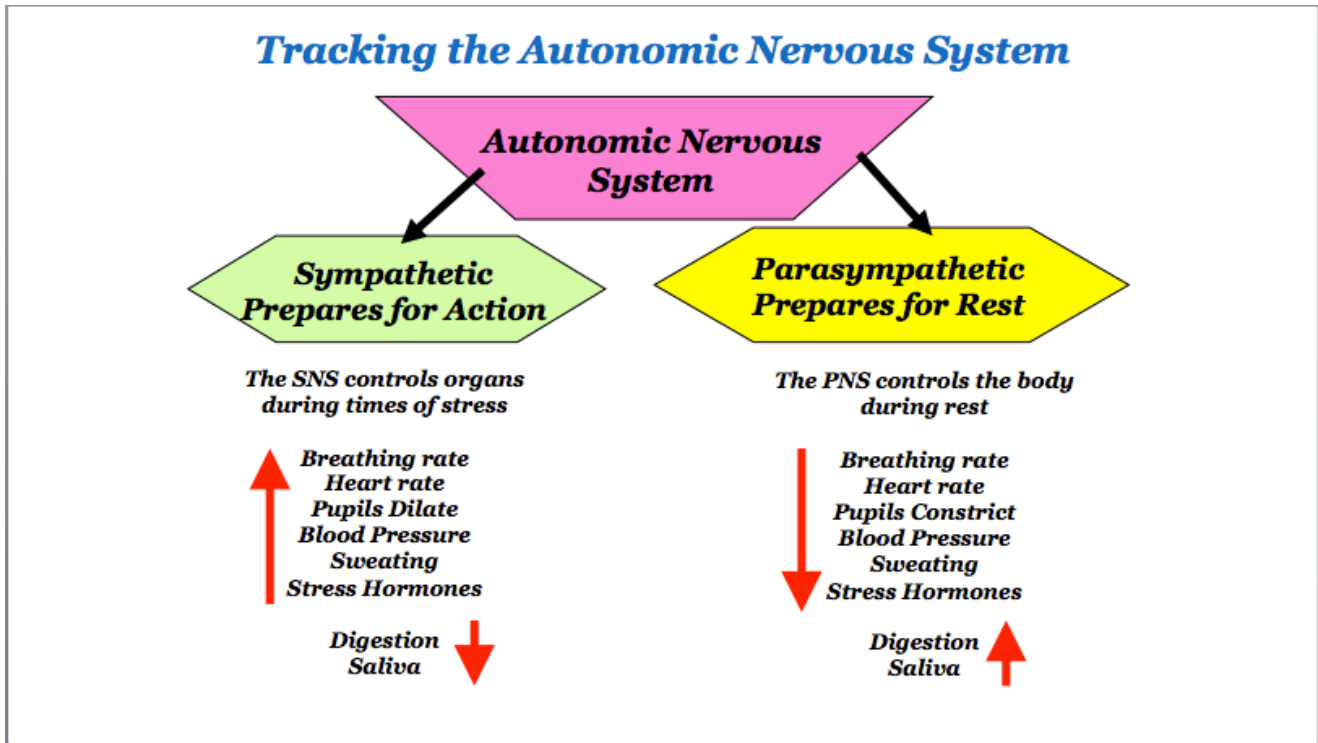
- Ice breaker (to participants): “Pull up your favorite photo on your phone, one that puts a smile on your face. Turn to the person next to you and show them the photo. Tell them a little bit about it.”
- Introduce *Key Concept 1: The neurobiology of the nervous system.*
  - No matter who we are, we all share the same biology of the stress response. There are two sides of our autonomic nervous systems: the sympathetic and parasympathetic nervous systems. The sympathetic nervous system revs us up for the fight-or-flight response in the face of a threat or perceived threat. Then there is the parasympathetic side, which acts like a parachute and calms the nervous system back down – we call it the rest-and-relax response. In the face of a threat – and that threat could be a complicated health decision, the hospital setting, or a difficult patient – our sympathetic nervous system gets activated. When it becomes too activated, we begin the fight-or-flight response, which unfortunately changes the way our brain processes information.

At this time, you may introduce and demonstrate Daniel Siegel’s “hand model” of the brain, which may be found in the appendix. Explain the spinal cord (arm), limbic system (thumb folded across palm), and cortex (four fingers folded over thumb).

- What the model shows us is that once you have enough activation (due to a current or triggered stressor or trauma) you “pop” or “flip your lid” and your brain shifts to that fight-or-flight response taking your pre-frontal cortex (the reasoning part of your brain) offline. When we think about our patients, who have diabetes or other chronic health conditions, they need all of their

faculties in-place when they are making difficult decisions. In fact, the number one reason why people stop health behavioral change programs is emotional distress. This is where CRM can help.

- At its heart the CRM model is a nervous system hack. We teach simple and straight-forward techniques that help engage the parasympathetic or calming response, which is a way to self-regulate and calm the sympathetic or fight-or-flight system.
- Because this is a biological model, we talk less about feelings and emotions. Instead, we focus on physical sensations, which become the window into the activation of the nervous system. CRM is a non-therapeutic approach that can be taught to anyone. It is also a practical model of self-regulation that anyone can learn and use.

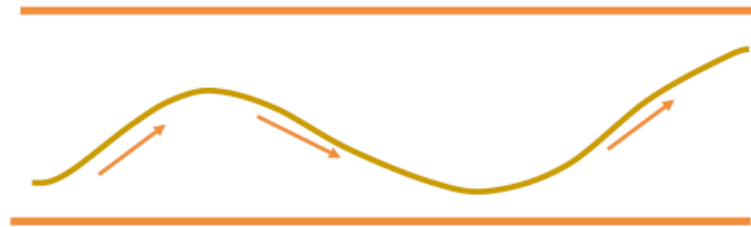


**Figure 1.** Tracking the Autonomic Nervous System

Note: This slide gives an overview of the autonomic nervous system. At this time, review the physiological components of the sympathetic nervous system, and the parasympathetic nervous system.

- Introduce *Key Concept 2: The Resilient Zone and High/Low Zones.*
  - The Resilient Zone is an abstract representation of the nervous system. When we are in our Resilient Zone and are in homeostatic balance, we are our best self and can experience all emotions including being sad and mad. However, you are in control and can manage these emotions. Our thoughts and feelings move around in the Resilient Zone throughout the day. In our daily life, things happen than can stress us. The most important part of being in the zone is we can make the best decisions for ourselves, our patients, and our family.

## *Resilient Zone-OK Zone State of Well Being*



- ❖ A state of well-being in mind, body and spirit
- ❖ When in the Resilient Zone one is able to handle the stresses of life

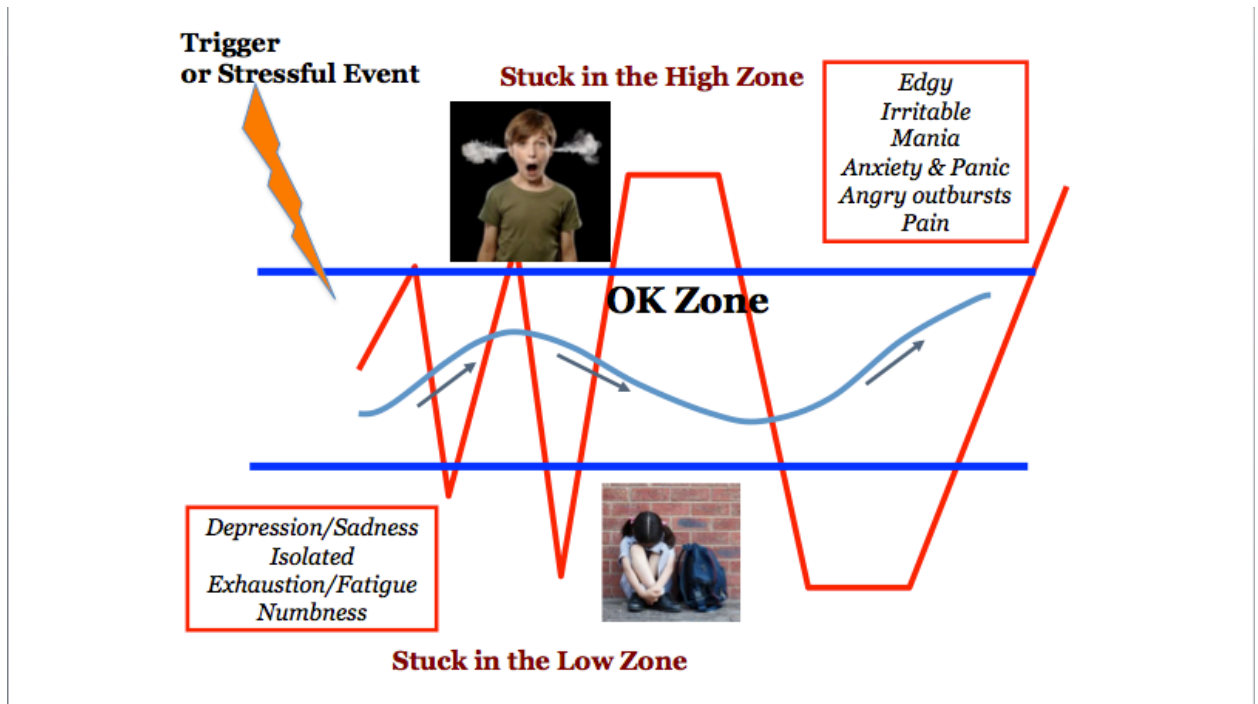
**Figure 2.** Resilient Zone/OK Zone

Note: The resilient zone and fluctuations within the resilient zone as an abstract representation of autonomic nervous system.

- The High Zone and the Low Zone. Sometimes, it can be challenging to stay in our Resilient Zone. Everyone at times get bumped out of their RZ and knocked into their High Zone or Low Zone. If you are bumped into the High Zone you tend to be more irritable, anxious, and angry. When bumped into the Low Zone you may be depressed, feel helpless or withdrawn. and it can become hard to find the energy to even get out of bed or go to work. Regardless of which zone you are in, you may say and do things that you end up regretting, and you are no longer in control of your thoughts and feelings.
- When we are in our High or Low Zones it can be difficult to be the person we want to be. It is common for anyone to get bumped into their High/Low

Zones, it is a problem if we get stuck there. Your body naturally does this when life becomes too hard. However, when we learn to read our body to better know when we are out of our Resilient Zone, we can use the wellness skills of CRM to change our behavior so that we can be our best selves.

- The good news is, the more we practice and use the CRM skills, the wider or deeper our Resilient Zone can become. The wider the Resilient Zone, the better we can handle daily stressors.
- Provide example of being in the high or low zone.
- Invite participants to share examples of minor triggers that can bump them out of their resilient zone.



**Figure 3.** Trigger Impact on Resilient Zone

Note: When a trigger occurs, our nervous system reacts and we find that we are no longer in our resilient zone. Instead of our day feeling like it's going along nicely like the pale blue line (gesture to line with arrows), our day may begin to feel like the red line.

- Introduce *Key Concept 3: Skill 1 – Tracking, the Foundational Skill*
  - The goal of teaching Key Concept 3 is to describe the skill of tracking, and the importance of sensation in activating the parasympathetic nervous system.
  - Caution: do not invite participants to utilize tracking formally until they have been taught Skill 2, Resourcing. Utilizing tracking prior to learning any other regulatory skills may be activating and/or triggering for the participant, and at this stage in the training they do not yet have the skills to activate their parasympathetic nervous system and reregulate themselves.
  - Tracking is a method of reading your nervous system, based on interoception, which is the awareness of internal sensations (e.g., how do you know you are hungry?). Tracking means paying attention to the sensations in the body. Tracking helps individuals learn to tell when they are in their Resilient Zone, High Zone, or Low Zone. Basically, it means learning to tell the difference between sensations of distress and sensations of wellness within the nervous system. Exploring sensations connected to well-being is key to helping one feel better in mind, body and spirit. That is why Tracking is used with all the skills you will be learning from this training.
  - Tracking exercise: Palm Rubbing is a quick way to begin to track your nervous system. CRM Trainer demonstrates: Place palms together and rub your palms together quickly for 5-10 seconds, then stop. Ask, “Do you notice any sensations in your hands?” Prompt – is there is a temperature change?

Are your palms cooling down now that you have stopped? Are your hands smooth, rough? Does the color of the palm change? Are there any other changes you notice on the inside?]- The problem with this is this example is external sensation. Let's find an example of internal sensations so that it does not confuse people.

- Learning to tracking is important because it is the foundation of nervous system regulation. If you are going to learn skills that help you get back into your Resilient Zone, then you need to know about sensations in your body that are more pleasant and neutral. When you pay attention to sensations that are more pleasant and are connected to a sense of “well-being” it helps to bring your nervous system back into balance and helps you return to your resilient zone.
- Tracking example: “How does your body react to stress?” “When you are stressed how do you know it physically?” Ask participants for examples. “Now, when you are happy how do you know it physically?” Ask participants for examples.
- Tracking is a foundational skill and is used in conjunction with all the other techniques. The better you are at tracking, the earlier in the activation process you can intervene with CRM skills.
- Teaching point: Learning to track will help you be aware of pleasant and neutral sensations that may affect where you are in your Resiliency Zone.

## ***Skill 1: Tracking***

***Tracking refers to  
paying attention to sensations***

- ❖ Tracking is the foundation for helping stabilize the nervous system.
- ❖ Tracking helps children and adults learn to tell the difference between sensations of distress and upset and sensations of balance and well-being within the nervous system.
- ❖ Exploring sensations connected to well-being is key to helping one feel better in mind, body and spirit.
- ❖ Tracking is used with all the skills.



***Figure 4.*** Skill 1: Tracking

Note: Tracking is the “save button” that hardwires the effect of your use of each of the skills in the model. With tracking, using the skills to achieve parasympathetic nervous system activation becomes a well-worn path in your brain.

- Introduce *Key Concept 4: Skill 2 – Resourcing and Resource Intensification*.
  - Goals of this section should be to explain what a resource is and resource intensification; demonstrate resourcing and tracking together; explain the multiple natures of a resource.
  - One way we can get back into the Resilient Zone is through resourcing. When we build resources, it can be helpful to think of memories that are special or powerful to us. These memories often can be pleasant or joyful but can also be moments of strength or faith. Ask questions like: “What uplifts you?”, “What calms you?”, “What brings you peace?”, “What brings you joy?”,



“What gives you strength?” These questions can help you identify your resources.

- Once we have a resource, we want to add as many sensory details as possible (what do you see, hear, smell, etc.). This is what we call resource intensification.
- Lastly, we pay attention to pleasant and/or neutral sensations connected to the resource. We may notice our breathing and heart rate slowing, our muscles relaxing, temperature changing, tearing up, or even tingling in our bodies.
- It is important to note that sometimes a resource can flip from being something that brings us peace and joy to something that makes us sad (e.g. a favorite pet that is no longer living). If this happens ask yourself (or the patient) to try and shift the thoughts back to the pleasant memories but if this is too hard it is okay to pick another resource.
- At this point, the trainer should provide a brief demonstration of how to help someone develop a resource, intensify the resource; and track sensations. We also want to stress the point that we never develop a resource for someone; also explain the concept of staying a step-behind.
- Pair participants off and using the resourcing handout, (see appendix), guide participants to identify and intensify their own resources with each other.
- Following this activity, prompt participants to utilize the skill of Tracking, but asking what they noticed in themselves and each other.
- Prompt participants to generate ideas of how and when they could use their resource for self-care.

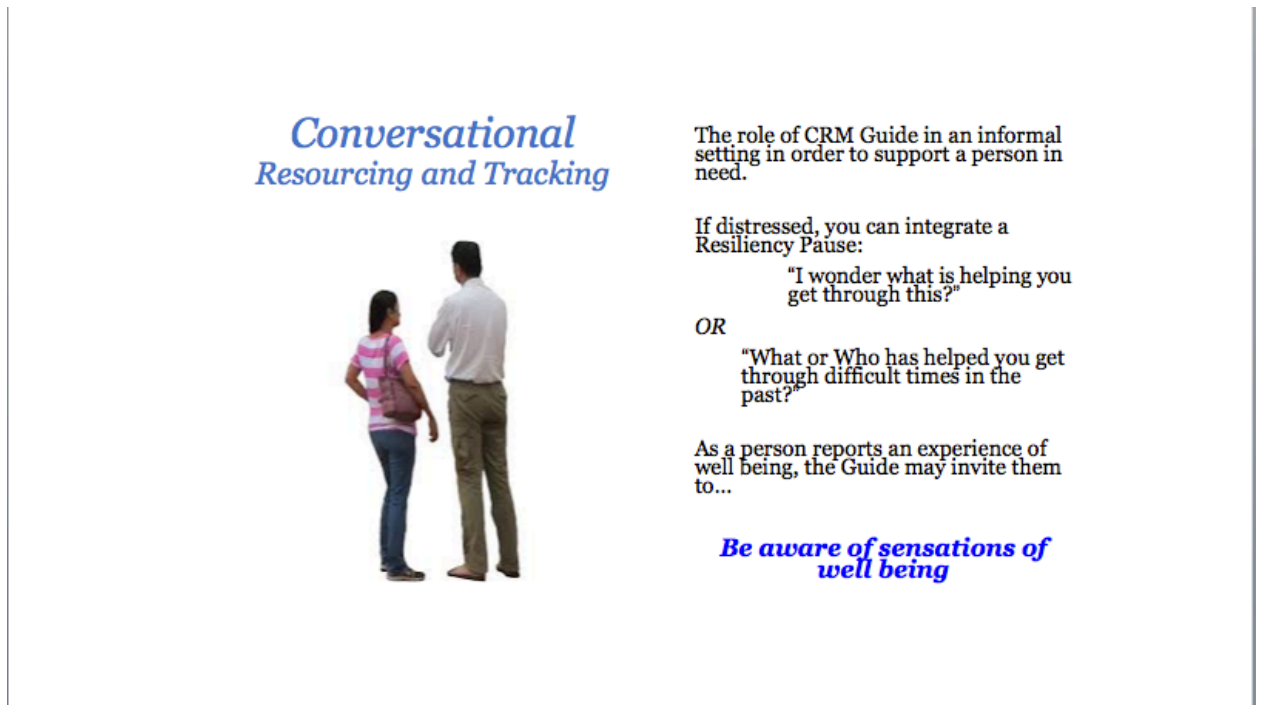
## ***Skill 2: Resourcing***

- ❖ Person
- ❖ Place
- ❖ Activity
- ❖ Faith
- ❖ Strengths



***Figure 5.*** Skill 2: Resourcing

Note: Your resource is personal to you, that's what makes it so powerful! We all have many resources—even if we may not think we do at first. And the beauty of a resource is that, much like a turtle always carries his home on his back, your resource is something you can always carry with you as well.



**Figure 6.** Conversational Resourcing and Tracking

Note: Sometimes, it isn't appropriate to teach the CRM skills to another individual. Sometimes, we just need to use them to help someone else get regulated! In these instances, we can use something called "conversational CRM," to help the individual reregulate their nervous system. For example, someone who is terribly upset may not be interested in learning the skill of Resourcing, but we can still ask them questions such as "Who or what has helped you get through difficult times in the past?" Questions such as this invite someone to identify their resource in a more conversational way. Remember the importance of tracking, following up these questions by asking the person to notice any sensations of well-being.

### 3.2. CRM Training Session Two

Objectives for the second training session are to: 1. learn to bring one's attention to the present moment by having the body make contact with a supportive surface (Grounding); 2. learn to bring attention to the different ways to guide the nervous system back into the Resilient Zone (Shift and stay); 3. learn strategies to help a person get back to the Resilient Zone if they are stuck in the High Zone or Low Zone (Help Now/Deactivate Now); 4. To identify gestures that are self-soothing that can be brought

into the present-moment awareness to return the nervous system back into balance (Gesturing). The second training session should require 60 minutes and should be interspersed by small group work of no more than 3-4 person who will practice the newly learned skills with one another while instructors at a coverage of 5-10 trainees per instructor circulate and engage the participants.

In the second session, it is important to welcome back the trainees and assess their retention of the skills from Session One.

Prompt them:

- Can you name the first two skills? Have any of you been using the techniques? How have they been helpful? Any questions that came up when using the skills? Has anyone used the iChill app?

Review skills of Tracking and Resourcing at this time, if needed. Group retention of the skills will determine how detailed your review will need to be. Ensure they recall the skills in full before moving on.

- Introduce *Key Concept 5, Skills 3 and 4—Grounding and Shift and Stay*

Note, it is helpful to have the iChill app accessible, and a small speaker for the grounding exercise

- Often times when we are stressed we are not focused on the present moment. Our attention is either focused on worrying about something in the past or in the future. For example, have you ever experienced a time when someone has been talking to you and you realize that you have not heard a word of what they said? This can happen when we are not grounded.

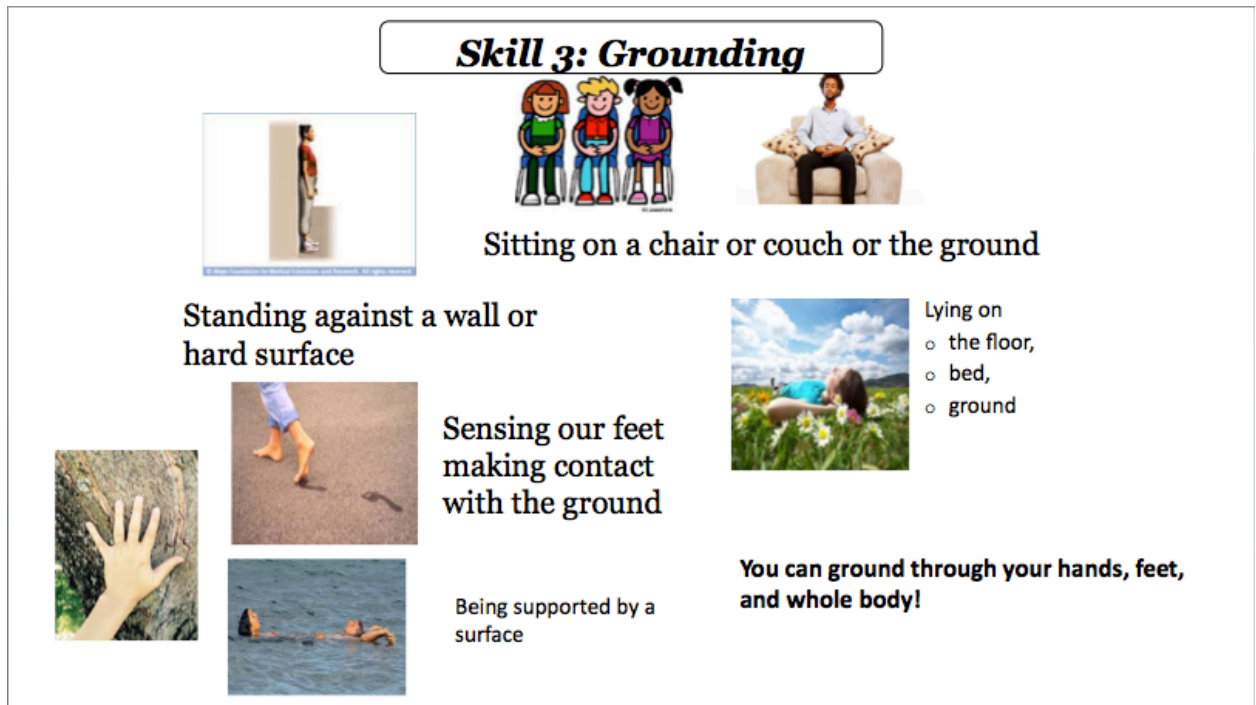
- Grounding is the direct contact of the body with something that provides support. You can ground by sitting in a chair, standing against a wall, laying on a bed, or even walking and paying attention to how your feet make contact with the ground.
- Do a grounding exercise. This is a good time to introduce the iChill App and play the grounding exercise. After the exercise ask the participants what they notice. Some key points that you may want to consider:

(1) Avoid feeling attributions when describing the body, such as “relaxed.” When this happens ask where it is in their body that they experience the feeling.

(2) Invitational language: incorporating invitations and options rather than imperative commands can allow more openness from others

(3) Never focus on an unpleasant sensation, as it will likely enhance distress

(4) Usage of the skills without tracking hinders the beneficial impact on the nervous system



**Figure 7.** Skill 3: Grounding

Note: Grounding is a skill that can be used in any environment, either briefly or more deliberately in a guided way, as is demonstrated on the iChill app. Grounding simply involves bringing awareness to how your body is meeting and making contact with a surface—floating in a pool, sitting on a couch, or your feet landing on the floor as you walk. Grounding can be done standing, sitting, lying down, or moving, and you can ground through your hands, feet, back, or any other part of your body!

- o Point out how shift-and-stay is skill that was used within the grounding exercise and used as a technique to shift away from unpleasant and/or painful sensations to a place in the body that is more pleasant or neutral. We then stay there while noticing what happens in the body. We can also choose to shift to a resource - stay there – and then notice what happens.
- o Trainer note: It can be helpful to use the assessment of pain as an example of how shift-and-stay works as this is a common practice within the hospital. For example, nurses often assess pain level and then leave the patient. By having the

patient shift his/her attention to a place in the body that is more pleasant or natural and having them notice the change can leave the patient feeling better.

### ***Skill 4: Shift and Stay***

**“Shift and Stay” means shifting your attention from sensations that are unpleasant to sensations that are neutral or pleasant and staying there.**



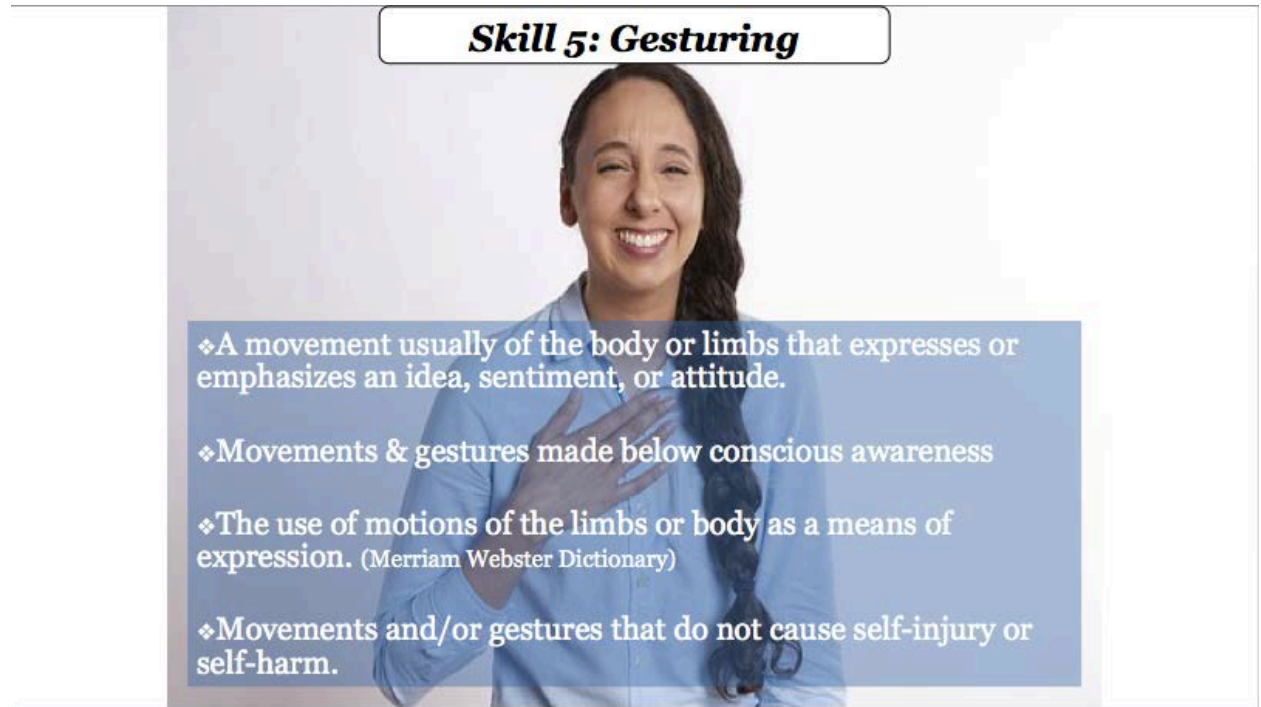
**Figure 8.** Skill 4: Shift and Stay

Note: The skill of Shift and Stay gives you the ability to notice not just the unpleasant sensations, but the pleasant ones as well. This attunement allows the body to notice sensations of wellbeing that might not have otherwise been ignored, and allows you to come back into your resilient zone.

- At this time, participants have now learned the first four skills. This is a good opportunity to pause and break into small groups to work through a vignette. Select a vignette that best applies to your group from the Appendix, and encourage the participants to begin to think about how they would specifically apply the skills they have learned so far.
- Introduce *Key Concepts 6: Skill 5—Gesturing*.

- The goal of this is to explain the importance of different types of gestures and how these are used in CRM.
- Gesturing refers to the use of motions of the body or limbs as a means of expression, and the practice of focusing on those that are self-soothing. Typically, these are not formally taught to someone but are reinforced as they occur when working with someone.
- If you start paying attention to gestures that are self-calming, your gestures can help you stay within or return to your Resilient Zone.
- Let's practice some self-calming gesturing.
  - Take 3 seconds to think about a self-soothing gesture... count down from 3 and then make the gesture, ready?... 3, 2, 1, *gesture*
  - Take 3 seconds to think about a gesture of joy or confidence... count down from 3 and then make the gesture, ready?... 3, 2, 1, *gesture*
  - As you perform your gesture, notice what happens on the inside
- Trainer Note: Provide an example of how you would use gesturing in your work with a patient. For example, noticing that a patient puts her hand over her heart when talking about her child. You can notice this gesture and say, "I noticed that you put your hand over your heart. What do you notice as you do this?"





**Figure 9.** Skill 5: Gesturing

Note: Gesturing is a way in which we use our bodies to communicate and self-soothe, often without even realizing it. By identifying these gestures that we make, we are able to use them deliberately, even slowing them down and using the skill of Tracking to notice what happens on the inside when we use a gesture. If you're not sure of what gestures you use, ask those around you and they will likely have noticed some.

- Introduce *Key Concept 7: Skill 6—Deactivate/Help Now*.
  - The goal of this skill is to introduce and demonstrate the 10 Deactivate Now techniques.
  - “Deactivate Now” techniques can be used when you get very bumped out of your Resilient Zone and find it too difficult to use one of the other techniques.
  - These techniques can be used quickly to help bring calm to the nervous system and help you return to your Resilient Zone.

- Trainer Note: Provide an example of when you have used a Deactivate Now skill. For example, one nurse has distressed family members walk to the other end of the hall and gives them water when she observes that they are upset.
- Use the iChill app to review the ten techniques.



**Figure 10.** Deactivate Now!

Note: Deactivate Now is made up of 10 techniques to reregulate someone who is too bumped out of their resilient zone to be able to use the other CRM skills we have learned. We can use the natural environment around us to help someone getting reregulated when they are extremely bumped out of their resilient zone, or just get them reregulated enough that they can then use the other CRM skills.

- This is a good time to break out into groups to work through another vignette (see Appendix for sample vignettes). By now, the participants have learned all six skills,

so encourage them to use these skills creatively as they work through the vignette together.

- As you wrap up the training, encourage the participants to practice their Tracking and Resourcing skills. Remember, Tracking is the “save button” that hardwires the impact of the skills into our nervous systems.
- Encourage participants to identify CRM in their own words as homework, and help them identify family members or patient populations that they can practice using the skills with.

### *3.3. CRM Training Session Three*

Objectives for session three are twofold: 1. Observe full length CRM demonstration with the incorporation of skills; 2. Practice CRM skills in order to ensure fidelity.

- Begin by checking in with participants, and recapping the previous two training sessions teaching the six CRM skills. In comparison to our past two sessions, session three will be more concentrated on the application of the skills of CRM with an individual. We want to briefly review what was learned in the prior session and see if there are any questions so far.
- Invite the group to go around the room and share one positive thing that happened to them over the past few weeks.
- Prompt the group: “What are some of the skills we learned so far?” Encourage participants to identify and define the six skills.
  - Tracking: Gauging your body’s current experience

- Resourcing: Tapping into a chosen memory or experience that helps regulate current stress
- Grounding: Direct contact of the body with the ground or using something to support the body
- Shift & Stay: Moving away from an unpleasant/painful stimulus to a more pleasant/less painful stimulus and staying there
- Gesturing: Body or limb movement that expresses/emphasizes an idea, sentiment, or attitude
- Deactivate Now: Exercises to help an individual track in the moment
- Allow time for questions about the skills before moving on.
- Conduct a participant demo for about approximately 15 minutes. We have talked a lot about the different skills of the model, but what does CRM look like in a real setting? To begin our experiential component for today, I'll ask for a volunteer from the group to help demonstrate [or play demo]. We understand that this demo might be a stressor so if you volunteer or find yourself getting dysregulated, please let us know. We will have a short session and then check-in afterwards.
  - If no volunteers are present, a co-facilitator can fill this role.
  - [*When volunteer is chosen and in front of CRM presenter*] You are allowed to talk about whatever you like. [*Upon hearing consent to exercise present may proceed. Check with participant at end of session to determine if it is okay to end demonstration*]
  - At the end of the demonstration, open discussion up to the group. Any thoughts or things that you noticed during the session?

- CRM breakout practice groups: divide participants into groups with a CRM guide or teacher in each one. The participants will now be asked to demonstrate the skills. Activity should require about 30 minutes.
  - “Now it is your turn to try. We will be spitting up into groups to practice. Each group will be overseen by one of our staff members to assist in the practice. We also want to remind everyone that using these skills takes practice, just like building a muscle. IF you’re not sure what to do or say next, the CRM guide will be there to assist. Or you can ask your partner what they’re sensing and where they notice it in their body.”
  - Trainers can also use the iChill app to provide a visual depiction of the resiliency zone or to assist in teaching grounding.
  - Trainees will practice skills with one another for majority of this session. Instructors will observe and assist when required.
- This is a time when a vignette can also be used (see Appendix for list of vignettes).
- Debrief with participants about the experience working through the vignettes. What are participants reaction to the practice?
- End the third session by making two final points:
  - We want you to practice CRM on three other people between now and the next session. This can be done in the moment or can be something you set time aside for, like asking a friend to practice with them. Regardless we ask you practice the skills because using these skills requires repetition, just like building a muscle. The more you practice, the more comfortable you will be in using the skills.

- We will be performing a check-in during the next session to see how the skills have been working for you. Understandably this handout may bring anxiety to some, but it is mostly a reminder of the skills. The purpose of the next session is primarily to continue practice with others and our staff. These handouts can help you work on different aspects and apply them continuously.
- Hand out the Skills Rubric (see Appendix) at this time.

### *3.4 CRM Booster Session*

There are two objectives for the booster sessions: 1. Review CRM skills; 2. Participants will be able to demonstrate sufficient knowledge in teaching CRM skills. The focus of these sessions is a chance to further practice CRM, while supported by CRM teachers and guides.

- Check in with participants at this time and see if they have any questions or experiences that they would like to share.
- Break the participants up into groups, with one CRM guide in each group. Groups should take about 40 minutes.
  - Offer each group a vignette (see Appendix) and invite participants to integrate CRM skills into their response plan for the vignette. Invite participants to think of specific things they could say to introduce CRM skills and develop their own “script” for transmitting the skills.
  - Be sure to wrap up by inviting everyone to share their thoughts and suggestions, and debrief as a group.
  - Invite participants to share the solutions they generated with the larger group.

## **CHAPTER FIVE**

### **DISCUSSION**

Part of the novelty of this work has been the process of adapting the original four day training format of the Community Resiliency Model (CRM) to a shorter, three-to-five hour format. Loma University faculty and psychology graduate students who had completed CRM guide and CRM teacher training programs met on a weekly basis beginning in the Spring of 2018. The purpose of these meetings was threefold: 1. To identify the elements of the CRM model that needed to be retained for an abbreviated training; 2. To identify how to teach these identified elements in a way that was clinically pertinent to medical care-providers; and 3. To gather data on the outcomes of the training.

The process of identifying the elements of the longer training that need to be retained was focused on the six skills of the model. As those are the core elements of the CRM model, it was immediately apparent that they were critical to any training. The Loma Linda University research team also identified that as their target population was medical care-providers, it was important to retain and emphasize the biological information included on trainings. The biological basis of the model was deemed to be particularly relevant for staff who are trained in medical models of care.

It was anticipated that it would be critical to receive buy-in from care providers quickly in process of administering the training, in order to ensure that would practice the CRM skills, thereby ensuring their retention and providing the opportunity to investigate effect of the CRM skills trainings. To this end, it was decided that the model's interaction with sympathetic and parasympathetic nervous system was to be highlighted. To further

increase buy-in from care providers, it was also decided that throughout the training, the relationship between patient dysregulation and patient demands would be emphasized. CRM trainers decided to be mindful of communicating specific ways in which the CRM skills could improve coping for the staff and reduce demands made by patients.

### **Strengths**

Strengths of the CRM in-staff trainings reinforced the novelty and applicability of the CRM model. Participants in trainings voiced resistance to psychotherapeutic interventions due to the presence of their coworkers and superiors in the trainings. The biological basis and lack of disclosure unique to the CRM model allowed for participants to feel safe engaging in these wellness skills despite this unique setting, allowing them to experience sensations of wellness and reregulation without cathartic disclosure. The simplicity of the CRM model also allowed for a wide variety of staff to be trained at one time—participants in trainings often included front-desk staff, nurses, physicians, and social workers. A lack of jargon or need for medical literacy made the model an equalizer among staff—unskilled employees could remind highly trained staff of the CRM skills and support them in their utilization, and vice versa.

The delivery method of the model was an additional strength as well. The newly shortened, three to five hour training, enabled staff to be trained during their previously established in-service trainings in one hour blocks of time. This negated the threat of strain that an additional training could place on already busy care providers. It also allowed staff to engage with CRM trainers across multiple trainings, giving them time to practice the skills and receive feedback from CRM trainers between sessions. Over time,



qualitative data also suggested that this format of delivering one, one-hour training session at a time allowed care providers the flexibility to experiment with using the skills with their patients, and provide valuable feedback to the CRM team about how the skills worked in their varied settings.

### **Limitations**

Qualitative data received from healthcare providers that participated in early CRM trainings revealed some of the initial weakness of the abbreviated training program. As the trainings were delivered to in-service staff, staff reported unique limitations to the very setting of the training itself. Particularly with nursing staff, it became clear that these in-service trainings were sometimes delivered at the end of their 12-hour shifts, when they were experiencing exhaustion and mental fatigue that made it difficult to concentrate on the training material. This early qualitative data, as well as subjective reports from CRM trainers, suggested that staff were unengaged with training materials, particularly as they were then being presented in a lecture-style format. Adjustments were made to deliver the material in a manner that maximized participant engagement, with break-out groups, vignettes, and activities (see Appendix), rather than simply providing them with a lecture style training.

CRM trainer feedback from booster sessions suggested the need for follow-up engagement to ensure retention of skills. As the time constraints of care providers limited the future engagement that could occur, it was suggested that posters for the medical settings be developed to could serve as easy reminders of the CRM skills. Staff engagement with the skills also appeared to vary across trainings, and it became clear that

follow-up support from CRM trainers was needed to support retention and integration of CRM skills for care-providers. To this end, CRM trainers attended regular staff “huddles,” and provided brief prompts and support to continue to apply CRM skills (see Appendix for brief prompts).

Staff also reported limited success using the skills with their most critically ill patients, and qualitative data suggested that teaching the skills to patients currently admitted to the intensive care unit resulted in staff frustration and little patient engagement.

### **Future directions**

Perhaps one of the most surprising take away messages uncovered during the first year and a half of implementing the brief CRM model was that staff reported that they were less interested in using the CRM skills for themselves, rather, they were more concerned with how the skills could assist their patients. Research supports improved patient wellbeing as a factor in reducing symptoms of burnout (27). This supports the importance of delivering the CRM skills as not just a self-help tool, but rather as a brief and easily accessible tool that care-providers can use to help others. The importance of support in retaining these skills was also found to be critical. An array of environmental supports were created by the CRM team to support the care providers in using and retaining their skills, including posters, brief ongoing check-ins with staff, and the ability to continually engage with other trained CRM guides and trainers. Perhaps the most rewarding outcome was seeing a “culture of CRM” arise among staff who valued the

skills and supported each other in using them. It became clear that this culture was necessary for maximized effectiveness of the skills.

The application for other care providers is an open field that requires further exploration. Currently, CRM has been taught to medical staff, religious leaders, community leaders, police officers, trauma survivors, behavioral health staff, the elderly, and children. The ability of the model to be taught to those with little medical literacy—as well as its ability to obtain buy-in from those with very high medical literacy—allow for it to be taught to other care providers in a multitude of driplines. Critical to its multi-disciplinary dissemination is the need for identification of the unique needs of each community. Among religious leaders, the “divine design” of the nervous system can be stressed, while among medical providers, the biology of the stress response can become the focus.

Specifically, for primary care settings, it is important to engage effectively with staff in the trainings. CRM trainers quickly reported that without achieving buy-in, the skills rarely left the room the training occurred in. For application in these settings, it is important to recognize the physical and psychological stress these staff are often experiencing, and to relay the information in a brief, engaging manner. As these settings are also workplace environments, it also important to stress the lack of disclosure required for utilization of the model. Future application for CRM in these settings is widespread. The skills can be taught to patients who are well-regulated enough to engage with the skills, but the skills are more easily disseminated among staff. This suggests that investing in teaching primary care staff CRM skills is an investment not only in patient care, but also against provider burnout.

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## APPENDIX A

### CRM PROMPTS FOR HUDDLES

- 1) What is one clinical responsibility you have today during which you can ground yourself (through feet, desk, etc.)?  
*During grand rounds, I can ground through my feet.*  
*While using the bathroom, I can ground while washing my hands.*
- 2) Who is one coworker that you can commit to reminding about their resource today?
- 3) What are 3 Help Now! skills that might help your patients today?  
*Getting my patient a cup of coffee.*  
*Giving my patient a warm blanket.*  
*Encouraging my patient to play a game on their phone.*
- 4) What is your gesture of calm or joy?
- 5) Do you have a patient today who could benefit from shift and stay?
- 6) What did you notice last time you used tracking?  
*Breathing, muscle tension, mental clarity, etc.*
- 7) Have you identified any resources that one of your patients might have?  
*A TV show they're always watching.*  
*A family member who makes them smile.*  
*A sport they used to play.*  
*Military service/career.*
- 8) What is YOUR resource for today?  
*My kids laughing this morning.*  
*My dog laying on my bed.*  
*My favorite vacation.*
- 9) How can you guide one of your patients to ground themselves today?  
*When holding a walker (grounding through hands).*  
*When walking to the restroom.*  
*When laying in bed (back supported by pillows, etc.)*
- 10) What resources do your well-regulated patients use?  
*Strong family support.*  
*Faith/spirituality.*  
*Happy memories.*

11) Is there a place on the unit where you feel most comfortable grounding?

*In the garden/outside.*

*At the nurse's station.*

12) Who do you plan on using Conversational CRM with today?

*Who might not need to learn the model, but might benefit from you offering them a few skills in an informal way?*