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A CONVERSATION WITH DONALD MEICHENBAUM

Following is a condensation of a conversation between Donald Meichenbaum and Michael F. Hoyt which took place in San Francisco on May 4, 1994, where Meichenbaum was conducting a two-day workshop on "Treating Patients with Post-Traumatic Stress Disorder" for the Institute for Behavioral Healthcare. The full conversation will appear in *Constructive Therapies 2*, edited by Hoyt and forthcoming from Guilford.

Hoyt: *How did you come to think of treating PTSD as a narrative constructive endeavor?*

Meichenbaum: I became fascinated with how people describe their experience and how their accounts changed over time. When something bad happens to you, when some natural or man-made disaster occurs, when some form of victimization experience occurs to you or to your family, ordinary language and everyday vocabulary seem inadequate to describe your experience and reactions. In their own ways, these "victimized" individuals became "poets," using metaphors to describe their experiences. They conveyed their experiences by using phrases such as, "this is like..."; "I feel like a..."; and so forth. The "victimized" individual may describe herself as a "prisoner of the past," as a "doormat," a "whore," as a "time-bomb ready too explode," and the like. Just imagine the impact on yourself and on others if you go about describing your experiences in such metaphoric terms? As a result of these initial clinical impressions, I undertook the task of analyzing the nature of the metaphors and the narrative accounts that clients offered over the course of their therapeutic sessions. Based upon both clinical analysis and a literature review, I came to appreciate the heuristic value of a constructive narrative perspective.

Hoyt: *When someone becomes a victim, has a horrible trauma, how does that affect them? What changes, especially in terms of their world view?*

Meichenbaum: That depends on which piece of the puzzle you look at. Clearly there is increasing evidence that something changes physiologically. This is especially true of chronic, prolonged exposure or what are called Type II stressors (e.g., abuse, domestic violence, holocaust victim). Such exposure leads too what are called Disorders of Extreme Stress that affect one's sense of trust in family and beliefs about self and the world. Traumatic events can "shatter" your basic assumptions about the world and can violate and invalidate your core beliefs. Another thing that trauma does is overly sensitize you to trauma-related cues and this hypervigilance feeds into, and is in turn, affected by the ruminations, flashbacks, and avoidance behaviors that characterize PTSD.

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Hoyt: *Is this primarily a protective mechanism: "I need to be on alert so it won't happen again"?*

Meichenbaum: I think there are functional and adaptive values in such behavior. To become vigilant and to

over-respond after exposure to a trauma can be adaptive initially. But, what happens to the people who have difficulty recovering is that they continue to behave in ways that may be no longer "necessary." People get "stuck" using techniques such as dissociation that were at one time effective in order to deal with trauma such as incest, or rape, or combat. It is my task, as a therapist, to help clients understand and appreciate the adaptive value of how they responded. But, I also help them appreciate the "price" of continuing to respond in this fashion, when it is no longer needed. This approach helps clients reframe their reactions as adaptive strengths, rather than as signs of mental illness. We work together to help them not only change their behavior, but also to tell their "stories" differently.

I go beyond understanding, to nurturing the client's discovery process by using Socratic questioning. I encourage clinicians to use strategically their bemusement, their befuddlement; I want them to be collaborators. The goal is to help the client in the initial phase of stress inoculation to better understand what they have been through, how are things now, how would they like them to be, and what can *we* do, working together, to help them achieve their goals? The educational phase of SIT lays the groundwork whereby the client can come to say, "You know, I'm stuck." A related objective of this initial phase is to help clients move from global metaphorical accounts of their experience and reactions to behaviorally prescriptive descriptions that lead to change and nurture the "sense of hope" to undertake this change.

Hoyt: *In essence, I think you're saying that as clinicians, we're trying to help clients reauthor their narratives, rather than undertake the role of correcting their accounts.*

Meichenbaum: Correct. The metaphors that describe my therapeutic approach include rescripting, reauthoring, helping clients generate a new narrative, being a coach. I don't just record the clients' accounts; rather I help them alter their personal stories. A second way is to help them engage in "personal experiments" in the present that provide them with "data" that they can take as "evidence" to "unfreeze" the beliefs they hold about themselves and the world. The results of such ongoing experiments that occur both within and outside of the therapeutic setting provide the basis for the client to develop a new narrative. This co-constructive process is one that emerges out of experientially meaningful efforts by the client. In terms of "strengths" and coping efforts, I help people who have post-traumatic stress disorder to appreciate that their intrusive thoughts, hypervigilance, denial, dissociation, dichotomous thinking, moments of rage, each represent coping efforts, and metaphorically reflect the "body's wisdom." For example, intrusive thoughts may reflect ways of making sense of what happened, as attempts to "finish the story," to answer "why questions." Denial may be an attempt to "dose oneself" dealing with limited amounts of stress at a given time, a way to take a "time out." Hypervigilance may be seen as being on continual "sentry duty" when it is no longer needed. In other words, it is not that people get anxious, angry, or depressed per se; those are natural human emotions. Rather, it is what people say to themselves about those conditions that is critical.

The collaborative process of therapy is designed to help the client "say" different things to herself, as well as, to others. A key element of cognitive behavioral interventions is that an effective way of having people to talk to themselves differently is to have them *behave* differently. Thus, a critical feature of cognitive behavioral interventions, such as stress inoculation training, is to encourage and even challenge clients to perform personal experiments, in vivo so, as I mentioned, they can collect data that will "unfreeze" their beliefs about themselves and about the world. Cognitive behavioral therapy is not just a "talking cure," it is a proactive, enabling form of intervention, that fits an "evidential" theory of behavior change. But such change is *not* enough. It is critical for clients to take credit for the changes that they have brought about. There is a need for the therapist to ensure that the clients take "data" resulting from "personal experiments" as "evidence," and thus, assume a greater sense of responsibility for the changes that they have brought about. This process of "ownership" is evident in the new narratives that clients relate. I listen careful to the clients' stories. I listen for their spontaneous use of metacognitive self-regulatory verbs as part of their new accounts. Improvement is evident when clients use such verbs as "I noticed...caught myself...interrupted...used my plan...felt I had options...patted myself on the back...became my own coach...anticipated high risk situations...tried my other options." When clients incorporate these expressions into their narratives, then they have become their own therapists, and truly have taken (appropriated) the clinician's "voice" with them.

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Hoyt: *This is the power of new experience, not just explanation of what's wrong, but disconfirming the expectations with a new experience.*

Meichenbaum: But for meaningful change to occur it has to be "affectively-charged." I am referring to the time-honored concept of "corrective emotional experience." People can readily dismiss, discount, dissuade themselves of the "data." They don't really accept data as "evidence," and it is critical therapeutically to work with clients in order to ensure that they take the "data" they have collected as evidence to unfreeze their beliefs, to get into the nature of the clients' belief system and to nurture an internal dialogue that they would find most adaptive, as compared to being "stuck" in maladaptive patterns of thinking and behaving.

Hoyt: *Watching you work, I'm always impressed by how much caring and effort goes into developing a therapeutic alliance and a collaborative relationship with the client. It appears to be the vehicle that carries the rest of your work.*

Meichenbaum: I agree. I think the therapeutic relationship is the *glue* that makes the various therapeutic procedures work. Some of the things that I try to highlight for a clinical audience watching my video tapes is how often I "pluck" and reflect the client's key words, use Socratic questioning, and often over the course of the session, I let the client finish my sentences. You need to encourage clients to tell their stories, at their own pace and to be in charge. But out of the telling of their stories, out of the narrative sharing--and there's a lot of therapeutic value in sharing one's story--new stories emerge that also reveal strengths and resources. Clients' stories are filled with expressions of hopelessness and helplessness. They often convey a tale of having been "victimized" and it is my job, as the therapist, to not only hear their stories and empathize with them, but also to help them appreciate what they have done to survive and to cope with their feelings, namely, help them attend to "the rest of the story." For "the rest of the story" is often the tale of remarkable strengths. Keep in mind that the story of how people cope with stressful events is inherently the story of resilience and courage. Even in the worst scenarios people evidence remarkable strengths. As a therapist, I need clients to attend to that part of their stories. Thus, the "bad things" that happened to people are only one chapter in their life stories.

Hoyt: *Often times therapists rush past the painful material, trying to reframe or restructure so quickly that the person doesn't feel heard of validated. Do you think there's also--maybe following from Aristotle--a need for catharsis and abreaction?*

Meichenbaum: The questions about differential forms of treatment is complex. How one should proceed therapeutically is dependent upon the target group. If you are treating people who have experienced traumas that are brief, sudden, yet life-threatening, such as automobile accidents, robberies, rape, and sudden disasters, or what have been characterized as Type I stressors. Yes. The data suggest that having clients go through re-experiencing procedures as a means of "coming to terms" with what happened, is therapeutic and beneficial. Indeed, there are a variety of very creative clinical techniques, including direct therapy exposure, guided imagery procedures, graded in vivo procedures, and the like, that are helpful. They fit your Aristotelian catharsis model and provide a means of "index.html"working through" that can prove valuable.

Hoyt: *What about people with more prolonged trauma?*

Meichenbaum: When, however, you are treating post-traumatic stress disorders that are chronic--and the traumatic events occurred many years ago--the treatment decision to undertake "memory work" of having clients "go back" may not be the most effective treatment strategy. Having clients recount and re-experience traumatic events, even in the area of incest, may not be the most therapeutic approach. Because in the attempt to conduct so-called "memory work," there is the danger that the therapist can inadvertently, unwittingly, and, perhaps, even unknowingly, help clients co-create memories. With such prolonged traumas that have a number of secondary sequelae it is important to address the secondary consequences such as depression, interpersonal distrust, sexual difficulties, addictive behaviors, and the like that may accompany PTSD. The full cognitive-behavioral therapeutic armamentarium needs to be employed to address these signs of co-morbidity. A "here-and-now" therapeutic focus as compared to a "there-and-then" approach, may prove most helpful. But keep in mind that from a constructive narrative perspective, even when clients are doing so-called "memory work," they are not relating, nor "uncovering" history, but rather, they are co-constructing history in a mood-congruent fashion. As Donald Spence observes, it is the "narrative truthfulness," not the "historical truthfulness," of clients'

account that needs to be the focus of therapeutic interventions.

Hoyt: *You have worked clinically with many diverse groups, and you have taught and given workshops internationally. How do these guidelines vary across these diverse settings?*

Meichenbaum: That question raises the important issue of how important it is to be culturally sensitive in formulating a treatment plan. Let me give you an example. There are "testimony" procedures in treating people who have been victims of torture. These procedures have individuals "go public" with what traumas they have experienced and what retribution should occur. For instance, one group of torture victims for whom this testimony procedure has been used came from Argentina, Chile, and other South American countries. On the other hand, there is another group of victims of torture who come from Southeast Asia-- Cambodia and other countries--who have also received treatment. Therapists such as Mollica and Kinzie have indicated that a somewhat different therapeutic approach, one that is designed to deal with their "here-and-now" problems, their practical employment and living situation, rather than do "memory work" is more effective. The torture victims' cultural orientation suggested that treatment should not encourage clients to go back and relive their victimization experiences, per se. When I am in doubt, I spell out the treatment options and collaborate with the client in formulating, implementing, and evaluating the therapeutic options. This is especially important when the database for alternative treatments is so limited. We are at such a preliminary stage in the area of PTSD treatment that anyone who gets on a soap box and say that, "Memory work interventions are essential," or who claims that, "This is the way to conduct intervention," should be received with a great deal of skepticism and caution; no matter what the therapeutic approach they advocate. I also think, however, that straightforward empiricism is not going to advance the field. We need a theoretical framework to explain therapeutic approaches. One such theoretical framework is that of a constructive narrative perspective.

Hoyt: *How would you distinguish the constructive narrative perspective from the other wing of cognitive therapy that sometimes is called "rationalist"?*

Meichenbaum: I really take issue with the so-called "rationalist" perspective. It is not that people distort reality, nor make cognitive errors, that contribute to their difficulties. Instead of one reality that is distorted, as some "rationalists" would advocate, I believe that there are multiple potential "realities." Instead, the focus of therapy is to help the client appreciate how he/she has constructed his/her realities, and what is the price of such constructions. Most importantly, what are the alternative constructions?

Hoyt: *How does this apply in the case of individuals who have been traumatized or victimized?*

Meichenbaum: For instance, consider the client who has been victimized sexually. Envision the clinical impact of this individual characterizing herself as being "damaged goods" or as "soiled property." Such labels, such metaphors, may be culturally reinforced. Whatever the origins and influences, the consequences of such narrative constructions are likely to lead to dysphoric feelings and distressing behavior. In therapy, I would help the client share her story either in individual or group therapy, "validate" her feelings, but at the same time help the client appreciate the price she pays if she goes around telling herself that she is "soiled goods"; that she is "useless." In this way, she can come to also appreciate that she speaks to herself in the same manner that the perpetrator spoke to her. She may inadvertently reproduce the "voice" of the perpetrator, as in the case of the victims of domestic violence. She needs to develop her own voice. One goal of treatment is to no longer let the perpetrator continue to victimize her when he is no longer present. Instead, what is the best revenge?

Hoyt: *Living well.*

Meichenbaum: To live life well. In therapy, we need to explore with clients operationally what it means to live life well. Moreover, given the cognitive behavioral approach, therapists also consider with clients what are the barriers, the obstacles, the potential reasons why clients may *not* do anything that they said they are going to do. This, when clients say, "I need to live well," there is a need to help clients translate such general admonitions into behaviorally prescriptive statements such as, "Between now and next time, how will that show up? What will you do differently?" There is also a need to build relapse prevention procedures into the treatment regimen,

anticipating "high-risk" situations, as well as ways of handling possible setbacks, so lapses don't escalate into full-blown relapses.

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Hoyt: *Some clients will get stuck in what I call a "persistent negative narrative." How do we then get the person to move out of that belief about herself? Do we go back through the earlier assumptions?*

Meichenbaum: I don't know the answer to your question, and I don't think the field knows either, but let me offer a clinical strategy. When the client