Don Meichenbaum: I'm Don Meichenbaum and I want to welcome you to this two-hour presentation. I need to just begin with one caveat or apology and that is at 5:00, I have to exit quickly in order to catch a plane home so that means I won't be able to linger afterwards for questions so I'm going to encourage you to raise any questions or comments prior to the 5:00 exit. I'm sorry. I usually hang around but my grandchildren are coming tomorrow and I can't miss it. I got to get to Florida.

So let me tell you about the work that I do. I was a professor at the University of Waterloo in Ontario, Canada as I mentioned this morning and I retired some 17 years ago and Waterloo is about an hour west of Toronto and like about 20 percent of Canadians, I spend winters from October to May in Florida and one of the things that takes me to Florida is that I'm the research director of the Melissa Institute. Melissa was a young lady who grew up in Miami and she was going to school in Washington University in St. Louis and she was carjacked and brutally murdered. When such a tragedy like that befalls an individual family, friends, communities at large and so forth, people transform their pain into something good that will come of it.

So one of the things that the Melissa Institute does besides supporting scholarships or the kinds of consultations that I do is we do ongoing training such as this and I would like to encourage you very much to visit that Melissa Institute website. The Melissa Institute website, we have an annual conference every year. This is our 17th year coming up and all of the material that we have online is available to you for free so if you go to the homepage and then hit author index and then scroll down to Meichenbaum, you see a dozen papers, a 90-page handout on adolescent suicide and depression, ways to involve trauma, spirituality, and therapy, how to do domestic violence from a cross-cultural perspective.

So it's a very, very rich website and there's a separate website for educators called Teach Safe Schools and as I've mentioned, I'm really proud in the fact that this year, the Melissa Institute website has had two million hits worldwide and if you're into education, we have 300 movies for free that you could download on teaching young kids to read because if you can't get them to read by grade three, they really get in trouble with the law. I can go on and on.

As I've mentioned, I'm in the generativity phase in my life and whenever I write a paper and put it in a chapter of a book and so

forth, maybe 200 people read that paper, half of whom are my relatives. So when my kids call for money, I ask them what they thought of my last article and they go what? I said call back after you visit the website. So a lot of what I have to offer, I actually do five-day workshops and when I do workshops, I provide people with 100 to 200-page handouts of all the kinds of core tasks. So while you're going to get the bullet point here, please visit that as well.

The other thing that I'm really quite proud of as well is I have, I mentioned this morning, have been working with returning soldiers from Iraq and Afghanistan and with a whole variety of populations who have been victimized by trauma and just a few weeks ago, I came out with a book called *Roadmap to Resilience* which is downstairs at the self-esteem workshop bookstore. I think that's what they call it and as I noted this morning, there are several ways to read this book.

You can go and read it from cover to cover. That will explain how to improve fitness in a physical interpersonal motional cognitive behavior or you can go into the appendix and look up any problem that you're having with nightmares or anger control or forgiveness or spirituality or relating to your spouse or what have you and it'll go to the how to page so it's like a mini computer and if you go to the second website which is *Roadmap to Resilience*, you will see that people who are reading the book are submitting their own examples of ways in which they could enhance resilience.

Then there's a second piece that I'll make reference to as we go along which is a handbook on treating individuals who have anger control problems and aggressive behavior which is consistent with the Melissa Institute. So let me tell you what I do that frames this presentation. I do a lot of consultation in training commissions so I have been involved in training the DPH staff. These are the people who are working with national guardsmen when they're returning from Iraq and Afghanistan in terms of looking at the kinds of core task.

I trained all of the addiction counselors in the province of Nova Scotia to talking about how to do integrative treatment with individuals who have PTSD and a whole variety of comorbid disorders and I've trained mental health workers who deal with native populations, torture victims. I consulted a head injury center so I'm actually in the business of trying to teach people and one of

the kind of issues is what is it that I should teach? What do you think we know about the field of psychotherapy that should guide and influence the content? Because I'm an honest broker, I don't have any soapbox to say that this is the way, I'm really looking at what are the common tasks of psychotherapy whereby therapists get better results.

I'm going to share my answer with you during the course of his presentation and then what I'm going to do is play for you some clinical interviews with clients I've seen over the years. I absolutely love doing psychotherapy and counseling. I absolutely love it and the reason I love it is I'm enamored with the way I think about cases. I love my head. Now you may not like it but I am having one hell of a field day, okay? So when I show you these cases, I'm going to tell you everything that's going on in my head and moreover, I'm going to try and stop it along the way in saying if you were me, what would you do next?

I come out of sessions really tired because not only am I actively listening to the client, I'm doing this whole kind of internal search. That's covertly. I don't want you to get the wrong impression, okay? As you'll see, there are even, sometimes I talk to the patient. So one of the things that I'm going to do is to try and make sure you come away with from these two hours with a more informed internal dialogue on what are the kinds of core tasks, what are the barriers that get in the way of that process.

So I'm going to walk you through what I consider are the core tasks of psychotherapy. To begin with, let me ask you to think of who is the best counselor, psychotherapist, shrink that you know besides yourself? Just a moment of humility here, okay? So I want you to conjure up that if you had a problem or a family member had a problem, or someone else, who would you refer them to? Who do you think is the hotshot in your area and what is it that makes them so good? What is it that characterize expert therapist from your perspective?

What I want to do is before I give you my answer to the question based on the research and our own clinical experience and training, I would like to glean from you sort of your notion of what do you think are the characteristics that lead to positive outcomes, rich and rewarding lives, and that makes these people so good. So let's just open it up to get a sampling from you on what do you think are the characteristics that make someone an expert therapist.

Unknown Speaker: Good connection.

Don Meichenbaum: Good connection. What do you mean by –**?**

Unknown Speaker: Good connection with the client, being able to stay present, being able to stay present with them, being able to listen, show empathy, you know –

Don Meichenbaum: Okay, that whole thing, right. Rogers Lives, right, you may be authentic and genuine, all those kinds. Okay, I just want to, yes, ma'am, please.

Unknown Speaker: I've seen two things, two ways of approaching therapy that are very interesting. It's true you have to have a relationship with your client or not. I've seen people who are very kind and very warm and that can bring out things that you didn't know that were in there and I've also seen therapists that were amazing that were kind of brutal, tough.

Don Meichenbaum: Albert Ein. Ellis, I mean, others. But you know, Albert Ellis' therapy only works for people from New York? Cognitive therapy works if you come from Philadelphia. I mean you just got to find the right kind of, okay, I actually, I've worked with Ellis a long time and I had a funny kind of thing that I told him. I said Al, you all know Albert Ellis in terms of rational emotive therapy. I said Al, when do you think therapy ends for people who are seeing you?

The vision I had was that a woman gets into a taxi cab on 42nd Street; you got to get me up to 86th Street to get to his office. I can't be late and the taxi driver turns and says lady, what's this rush, huh? So you're going to be late. You think your whole worth depends on whether he accepts you or not? And for 20 blocks, this guy talks to her like that and she walks into Dr. Ellis' office and says, Dr. Ellis, you would not believe what I've been through and she transcribes, tells him about this taxi driver and he says I don't understand. You think your whole self-worth depends on what that taxi driver thinks? It dawns on her that it's cheaper to ride taxis in New York than it is to pay him for his sessions.

It's interesting. Your point is really an interesting one about the style and the manner, and gender differences and the like because I've worked with native populations and that raises some really

interesting issues about being culturally sensitive. What else do you think characterizes expert therapists? What else do you think you need to do? Yes, ma'am, please.

Unknown Speaker: A genuine curiosity.

Don Meichenbaum: A genuine curiosity and that's conveyed to the client. Okay, let's just, yes, sir, keep going. Healthy, do you see anyone here at this conference? Okay. I mean by healthy you mean that they're – okay, right, I mean it's interesting because I can sell to a lot of treatment centers where half the staff are ex-addicts, so it becomes really interesting whether health is something or is a transition in journey and the degree to which they're a coping model. Yes, ma'am, yeah, shout it out.

You mean soliciting feedback from the client? Okay, I'm willing to buy that. Yeah, please. What? Insight? Integrity, oh, on the part of the therapist, okay, anything else? Anyone have anything else they want to – please go ahead, ma'am. Right, so they got to be an expert, they got to have some knowledge and we'll talk about different kinds of knowledge. Yes, sir, you got the last one.

Unknown Speaker: Yeah, willing to make a mistake.

Don Meichenbaum: Right, okay. Assessment, conducting assessments, right, and giving feedback, okay. So, okay, I got a hand back there.

Unknown Speaker: Willing to not just stick with their agenda but work with the client.

Don Meichenbaum: Follow the lead of the client or let the client lead, right, okay, that's kind of interesting. You know, I've lectured all over the world and I've asked this question often and it's interesting what comes up and what doesn't come up because one of the things that I would have expected from your answer is that – I'll tell you what expert therapists do. They actually get better results. What they do leads to better outcomes so God forbid you had some kind of medical condition like breast cancer and so forth. One of the things you do is you go and do med lit search to look at the relative merits of chemotherapy versus radiation versus surgery, a combination on which clients, what stage and so forth. I don't go to see a doctor or a dentist without doing med lit search.

These guys don't read the literature so one of the things that becomes interesting is what are the kind of characteristics that

would lead to this? So if you look at the literature and you say of all the variable that are out there, what is the most important skill that the therapist needs in order to have favorable outcomes from their therapeutic interventions? What is the most critical thing you could do in order to have a rich and rewarding life? It turns out that the most important you need as a therapist is the ability to choose your patients carefully.

If you could choose who you see, this will go a long way in order, so it turns out that patient variance accounts for the largest proportion of outcome in terms of, so as I mentioned this morning, you wanted to limit your practices to what I call YAVISes. These are young attractive verbal intelligent and successful people. You want to essentially treat yourself because these people could get better with or without you so you might as well take credit for it. You know, oh, this is good, I should charge more. You have no idea.

So one of the things that becomes very interesting is that most of us do not have a clientele who fits YAVISes so we have clients who have a long history of victimization, high incidents of comorbidity, who come from often distressing or poverty restricted environments and who have limited access and so forth. So the key kind of question is if in fact you cannot choose who you're going to see, what is it that characterizes expertise? So I'm going to do is walk you through what I think are the other key ingredients that predict outcome.

An apropos of the comment about not being made in failures, it turns out that if you look at the data, one of the things expert therapists do is to constantly convey to their clients that they're not experts, that they're constantly in the midst of learning that we're going to work together and we'll talk about this therapeutic alliance that was highlighted in a number of your answers. So let me move you through a couple of the slides. One of the questions that was one of the answers that was offered here which I thought was interesting had to do with the nature of expertise and this is sort of straight out of Ericsson and we had been using this for some time and one of the things that happens is that people have knowledge.

There are different kinds of knowledge that we try to train commissions on so there's knowledge about facts, declarative knowledge so that in fact, you know something about the prognosis, the diagnosis, the assessment, the evidence-based

interventions, you know something about cultural sensitivity so that's one kind of knowledge that we want to make sure that clients and therapists have and we're talking about how you do psycho education to make sure that it's changed.

The other kind of knowledge that's important is conditional knowledge. So one of the things that becomes really important is the kind of if then rules so for instance, if you have a woman who comes in who is depressed, clinically depressed then one of the key things for you to do is to assess for marital distress because marital distress and depression go hand in hand. In fact it's very hard for a woman to be depressed without the help of a male. It's not a requirement but it really, really helps, okay? And I don't want to be accused of any kind of gender bias here because it turns out that the incidence of domestic violence is comparable in gay and lesbian couples as it is in heterosexual.

But if you get someone who's depressed, that means you need to have an if then rule about the nature of the marital distress. Knowing that, it would be valuable to know if the depression came before the marital distress or after the marital distress and if in fact you get the marital distress, then one of the other if then rules that you should have in your head is that you should go for the possibility of some kind of abuse so you can start to look at the conflict tactic scale where other kinds of issues and that leads to the kind of immediacy.

So if I tell you, for instance, apropos of our work on adolescent depression, you know, what are the key elements that you should go through in assessing risk? What should you document? So one of the things we do and you'll see this online is that we have spelled out in some very detailed manner what are the specific questions you should ask children, adolescents, and adults with regard to prediction of violence and that's what you'll find in the anger book or online with regard to depression.

So one of the things that we want to do is to make sure that people have that kind of working knowledge that becomes important and moreover that they have these kinds of flexible strategies in their repertoire so they can pick out and choose in a certain kind of fashion. So the Melissa Institute did a whole conference on how to alter evidence-based interventions if you're working with Hispanic populations. Keep in mind that the Melissa Institute is in Miami so

you got a lot of groups there who are Haitian, Cuban, Puerto Rican, and so forth.

One of the things that become really interesting is how to tailor these interventions. In fact, my colleagues on this have talked about how to alter battering intervention programs for Hispanic men as compared to other kinds of groups and moreover, as I've mentioned this morning, the major way that people cope with trauma is to use some form of spirituality. So we have included there a lot of things about how you incorporate spirituality, how to find co-therapist, how to do these kinds of process. So that's part of what we think is important in helping people become more expert.

The other thing that was highlighted by Dr. Ericsson this morning has to do with the cold concept of deliberate practice. So what I'm going to do is essentially give you a to do list on the various kinds of things that we contribute to psychotherapeutic expertise. So this is going to be a therapeutic alliance. It's going to be how to do relapse prevention, how to get people to follow through on homework, how to do self-monitoring so in all of our work, we have now spelled out the subroutines in accomplishing this.

It seems to us that it would be really important to not only do this and saying I'm going to improve everything but to pick out a target behavior that you and a colleague would do together. So on the DPH, this is really kind of interesting. This is the group for the military. We just submitted to the military a program that spells out all the core tasks of the psychotherapy. Not only does it spell out the core task, it also gives you the how to feature with the manual, with the modeling fill and the like so that you could actually access this.

But you cannot access it alone so one of the things that you have to do is find a colleague who you're going to work with and you're going to have to specify a specific set of goals that you're going to work on. So I'll read the manual. I'll try it with a client. I'll listen to the tape and so forth. So one of the things that we have done is you and your colleagues have to sign in. See, essentially I have built guilt into the training program. I was raised on guilt; I figured it would work on the field of psychotherapy.

My mother would say I know you're very busy, okay? You know your sisters call every Sunday. So I was trained on that so the whole notion is that you cannot access this training material

because then your partner's going to say I can't get to next step unless you do that other step, okay? But the key thing is what are the core tasks that are going to be incorporated in that process and how can we evaluate that in some productive way?

The largest percentage of outcome in any of these aspects has to do with the quality and nature of the therapeutic alliance. So a lot of what you described being supportive, non-judgmental, empathic, respectful, all of that is the glue so that when I present it to all the people doing treatment in Nova Scotia, I had all these people who were experts in treating substance abuse so I went through all the literature in my conscientious way to sort of ascertain what is the best way to proceed so you had 12-step, you have motivational interview, you had cognitive behavior, you had family-based and so forth.

It turns out that if you put all of those together and do the meta analysis like Andel and others, they're all comparable in their effectiveness, same thing on the PTSD with one acronym next to another. What you find out is that the quality and nature of the relationship by the third session is the best predictive outcome because the quality and nature of the relationship by the third session is predictive of how long people are going to go through and the willingness that Burns was talking about to follow through.

So there is a need not only to develop, monitor, and maintain that therapeutic alliance, I'm going to try and highlight that for you. I think your most valuable tool as a coalition is the art of questioning. The art of Socratic questioning is your most valuable tool and as I've mentioned earlier this morning, one of the things that happens is we try to train coalitions to emulate that fine inquisitor of the TV personage Peter Falk playing the character Columbo. So we try to teach people how to use their bemusement, their befuddlement and the like.

As I noted, one of the things we tried to do is to train clinicians to play dumb. For some this is not a difficult nor challenging role. The key question is how to play dumb without giving up your placebo value because if you know nothing, why should I come, let alone pay for this, okay? So one of the things that become interesting is how do you monitor the effectiveness of this and if you go to some of the work of Duncan and others, they have these scales that you could use.

Burn has the helping alliance scale or you could just do this informally. I do this on a regular basis in every session; I'm saying before we break up, I was wondering if I could ask you something a bit different, a bit unusual. Is there anything I did or failed to do, anything I said or failed to say that you found particularly helpful or unhelpful with regard to this session? What is it that we've been dealing with and how are we going to apply it? So all of the concerns that I'm going to raise is how to monitor the quality and nature of this relationship? That's really important if you're doing work with adolescents.

A lot of people don't know why they're there. Why are you here? My mother brought me. Any other reason? My father's a Neanderthal. Fix him, okay? So one of the things that happens is if people don't see that they have a problem, why in any way should they work? So the name of the game is how do you do this in a culturally, developmentally, and gender sensitive fashion? This becomes really important because in our work on treating men versus women both with regard to substance abuse, PTSD and even developmentally, there's a very different kind of developmental trajectory so we are really big advocates that men and women should be seen separately in many of these kinds of treatment programs so that you could have gender sensitive kinds of interventions and then there's a whole issue of how to do this in a developmentally sensitive way.

How to use cognitive behavior play therapy with kids as compared to adolescents versus adults and there's a lot more that I can say on that score. The key thing is how do you get people to see that they have a problem? If they don't see that they have a problem, why should they work? So people come in and they have a story to tell us and what we're going to do is try and get people to change the nature of the story that they give and motivational interviewing, you know, apropos of Burns's talk, this thing calling emotive, these guys are on the target so they use express the empathy, they use this developing discrepancy, avoid argumentation, and in fact, how to support self-efficacy.

If you're really interested, I just wrote an article about how to change the mind of the NRA using motivational interviewing. No, seriously, I mean it's a very interesting instead of being argumentative and leading to what I call the hardening of the categories on their part. You could read about all this online. Indeed, apropos of that, I also wrote a chapter recently on what the

world would be like if various members, presidential members in their cabinet had someone who knows cognitive behavior therapy and decision making.

So after you invade Iraq, do you think we should have any follow-up plan? Yeah, can we look at the pros and cons of these kinds of things? So one of the things that become really interesting is that we wait for disasters to occur, Bay of Pigs, gulf **[inaudible]**, Iraqi War, and afterwards historians come in and find decision making errors that people make. So my sense is why wait? Why not you have someone right there so if you go to that paper, it's me interviewing Obama and George Bush as if he were a client and developing a therapeutic alliance that would permit him to explore the dirty dozen errors that people make in these kinds of decision making processes.

Okay, psycho education, not only do you want to develop therapeutic alliance with clients and monitor it, you want to also help them understand their presenting problem and in a moment I'm going to talk to you about what is called a case conceptualization model. So I am not about to reduce your entire professional career to one page. There's nothing that you do for a living that I have not accounted for in this next slide. So what you have here is a generic case conceptualization that may be small to read from the back so I'll tell you about it.

So what happens is imagine that this is something that pops up in your screen and you have these nine boxes and moreover, that you could have break out on each of those boxes, one A, one B, two A, two B, and two C and if you get to the anger book, you'll see that breakout. Now we have developed this kind of model not only generically but we've also done this for returning service members. We've done this for people who have head injury. We've done this for people who have all kinds of other clinical problems.

So let's say that a client comes into you and I'm sure that every one of you in your clinical practice have some kind of background information that you accrue from the client, that you know their gender, their age, their living circumstances, their sexual orientation and so forth and that you have an intake form that gets you at one A. You may also ascertain one B. One B is why are they here now? That is are they being mandated and sent here by the courts or to keep their job or keep their family or do they come in and see that they have a particular problem?

I am going to convey to clients what I do for a living. See, what I do for a living, what I say to clients is not that complicated. Let me tell you right from the outset what's going to go on here. See, I work with folks just like yourself to see how things are right now in your life and then what I want to do is to find out how would you like them to be and what could we, therapeutic alliance, do to help you get there? Moreover, what have you tried in the past?

What has worked? What hasn't worked? What is it that you're having difficulty following through with? If we work together and I hope we can, how would we know if we're making progress? What would we see change? What would other people notice? Could I ask one last question? Can you foresee, can you envision anything that might get in the way of it? Every single question that I just asked is what and how question. I do not ask why questions. Why questions are not preferred, how are things now, how it's likely to be. What could we do to help you get there? What are we trying to pass? What's worked? What hasn't worked?

What do you have difficulty following through with? Have we worked together? How do we know if we're making progress? What would other people see? Let me ask one last question. So what you're going to see, is that kind of social discourse covers these boxes. So the interesting question is what kinds of two-way are they coming in with? What is that that's getting in the door? Are they depressed and suicidal? Are they having substance abuse problems? Are they having anger control kinds of issues? Are they having difficulty sleeping? Do they have physical pain?

I need to ascertain them box two A, and now that I need two A, I need to know the developmental history of this and moreover, what makes it better and along the way I'm also willing to do risk assessment well towards the self and others. Once again, you're going to the Melissa Institute and see all the key questions that we ask about, lethality, intention and so forth that get at that kind of risk assessment and moreover, we're also looking at the level of functioning.

So it's not just symptomatology. So we need quality of life indicated so one of the things that's interesting about PTSD studies at the VA is that if they use pharmacological interventions, especially with positive symptoms, they get favorable results but people's quality of life does not improve. So, either in terms of

interpersonal relationships or life satisfaction and the like, so therefore some of your interventions may be at the level of two C. What am I doing?

I am inviting you to join me. See, I go around from center to center, VA hospitals, traumatic brain injury, developmental centers and what they do is they pick out the most difficult, challenging patient family group that they have and then they're going to put me in the room with that person and they're all going behind the mirror to watch, okay? I serve two functions. One is entertaining value and the other is reassurance because these people are going to wipe me out just like they wipe out the clients and they they go look at that, we're one of the top ten guys. How much do you think they're paying him? I should be in that room.

So one of the things that becomes kind of interesting is I need some way to understand that client and group before I go in. So not only do I have box two, but 80 percent of the cases you have comorbid disorders. You have axis one, axis two, axis three and you can start to think about what is the quality of life. You also have stressors that people have and there are four kinds of stressors that people have in their lives. So the day to day hassle kind of things with the economy or with interpersonal relationships that may be past or present in terms of four A and maybe ecological stressors, they live in a high risk area, there's lots of crime and violence, unemployment. Maybe the mishap after Hurricane Sandy.

They also have developmental stressors. They may have a history of victimization in terms of four C, in terms of child sexual abuse or invalidating environment or neglect or there may be familial stressors like they're the offspring of a depressed mother. There's substance abuse in the house. There's an inter-generationally transmitted aggression. So what's happening is we have everyone around. You have the social worker, the psychologist, the psychiatrist, you got front lines and everybody's dumping information and I needed some way to organize that and moreover, I need to ascertain what treatments have they received in the past for this? How effective were they?

Were they in 12-step programs? Were they on antidepressant medications? Did they get cognitive therapy? Then they got that, did they stick with it? How many sessions did they go to? Did they take their meds and moreover, how effective was it? Now I would

suggest that all of you in some sense do boxes one to five in some kind of fashion. But from my perspective, given the kind of constructive narrative perspective and strength-based, your job is not done because you need box six. Box six is what Paul Harvey, the radio commentator called the rest of the story.

The rest of the story is the nature of the strains that people have. So this is what do people bring to this? What contributed to their resilience in the *Roadmap to Resilience*? How did they survive in spite of? So what are the individual social and systemic kinds of strengths? Moreover, I need to explore with them of these different areas, where do you think we should begin? This is all going to be collaborative. You're going to see my therapeutic best when the clients I see are one step ahead of me offering a suggestion or the advice I would otherwise offer.

The whole name of the game is to get people to convince me that what they need is cognitive behavior therapy to which I go I'm not too sure. Help me understand how that would help. Moreover, I need to go collaborative goal setting in terms of what would be the short term intermediate and long term signs that we were making improvement and then finally box nine, and box nine, the nature of the barriers so there may be individual barriers like level of psychopathology, neuropsychological involvement, belief systems and maybe social systemic. You meet my husband, now you know why I'm depressed. How long would you live with that guy?

Maybe systemic, there may be long waiting lines. There are no one culturally sensitive, no one who looks like me at that clinic. There may be no child care and in fact one of the things that's emerging in the literature is how important it is to get these barriers analysis. So what have I done? I have just suggested to you that this is a framework that you could use not only for yourself but you could also use it with the client. So, let's walk this through. So let me see if I understand on what brings you here is and it's particularly bad when, oh, look at that, he just did box two, nicely done and you came of your own volition?

Box one, in terms of one B and this has been going on for how long? Oh, look at that, he's doing two A with regard to this and moreover in addition, and every time you hear me say in addition, you now know nicely done, Don, you're going for box three. Okay, so in addition, you're also struggling with and the impact of that on a day to day basis is, and this seems to be maintained and made

worse by, oh look at that, he nicely slid down to box four. Go for it, Don.

So some of the day to day stressors you're having are and you're living where and the impact of that is? And it's not only now. This has been going on, oh, look at that, he's doing four C, developmental stressors. Go for it, Don. Okay? And more of this runs in the family? So some of the inherent, what lingers from that childhood experience was? And for this you received what kinds of treatment?

Look at that. He's doing box five, nicely done. My wife's a dancer. She thinks I'm the Balanchine of psychotherapy, okay? I'm just moving from box – so if you watch me doing therapy, you know exactly what I'm doing and we're ongoing and how I'm conveying that to the patient, so in addition, you received what kinds of treatments? Seem to be most effective. You have difficulty following through but you were satisfied with and in spite of and every time you hear me say to a client in spite of, you now know I'm working box six.

No one, no one leaves my office without box six material. You need the rest of the story. You need nuggets so you need individual systemic and social kinds of strains that people evidence in spite of and I'm going to give you writing strategies on how to use timelines, how to use the art of questioning in order to get at box six and moreover, you need to do have I captured what you're saying? This is the Columbo routine, right? Have I picked up on it? Am I in tune with, am I missing anything?

Of these different areas, where do you think we should begin? So instead of therapists being what we call a surrogate frontal lobe for their clients, of telling them what to do, this is where they old collaborative, and why is it collaborative goal setting? Because collaborative goal setting is one of the core tasks of nurturing hope and moreover we need to ascertain what might get in the way of it. The best laid plans of mice and men go often awry. Robbie Burns, one of the first cognitive behavior therapists, Scottish poet. So one of the things that happens; you got to figure out all the reasons why this is not going to work and how do you build that in.

We wrote a whole book on treatment non-adherence. So we wrote down all the reasons why people fail to comply and what are the things you could do and you can use clever strategies. So we wrote

the treatment non-adherence book. It was interesting. I had recently gone for some kind of surgery, gum surgery. I don't know if I need it and so forth so I go in to see my dentist. Now he wants me to floss. That's his client strategy. Now this guy has a range of repertoire to get me to floss. He could use guilt. I was raised on guilt, you know, how much we put our effort and so forth, what's your mother's number, let me call her and say if she can –

You could say pain. You think the last surgery was bad? You don't floss, you know how much you're paid? The next one is not covered by insurance. So this guy has fear, guilt, anger. You know what this guy says to me? He says Don; I know you're a very busy person so I'll tell you what I'll want you to do. Just floss those teeth you want to keep. The rest of them, forget about them. I know how busy you are going around the world doing all your shtick and stuff. Now that is clever. In fact I jumped out of the chair and I went to my, I called up my publisher. Have we gone to press? He said no. I said you got to put my dentist in this.

That's interesting, right? Think about the variety of strategies that are available. So I consulted a VA hospital, right? So what happens? They pick out the most challenging group of patients, all these guys. I walk in, I sit down, they're all behind the mirror and these guys verbally assault me. They said the system sucks. They're out to screw you. No one gives a god damn and you can hear the people behind the mirror go ha ha ha, look at that.

So if you're in my shoes, what would you do? Now I'm a cognitive behavior therapist. So the question is why does cognitive behavior therapy work with difficult challenging patients and I've been doing this for over 30 years. My answer to this is that what cognitive behavior therapy does is that it helps to prevent depression in psychotherapists. So if you are getting depressed on your job, it is because you have embraced the wrong theoretical perspective.

You know, your psychodynamic, your somatic, your family solution oriented, whatever it is, okay? Cognitive behavior therapists do not get depressed so these guys verbally assault me. So what do I do? I go what a relief. For me in therapy, everything is a relief so I go what a relief. Before I walked in this room, they told me that each and every one of you guys were emotional dead wood. The fact that you could attack a stranger out of nowhere is

indeed impressive. You hang on to that indignation. You give that up, you, nothing.

So they're not going to give up the indignation anyway so now you're bringing them under instructional control. Okay so that's like Burns saying to the guy. You could walk or you could sit, either one, okay? So what you do is you assume their behavior. Knowing that, I say to them are you ready for this? I'm not sure you're ready for this. It turns out that the system is much worse than you're making out. You just hit the tip of the iceberg. So one of the things that becomes really kind of interesting is how can you anticipate the barriers.

Now let's go back and see the significance of this. So one of the things that becomes interesting is how do you spend your time? One of the things that characterize expert therapists are they take good progress notes. So imagine that you were willing to play this game with the boxes and I wanted to know what did you do in therapy. So all I have is your progress notes. You're out of town, I can't get in touch with you, all I have is your progress notes and on your progress notes it says I'm a two A five B six B guy.

Wait a – I'm a two A, five B, six B guy. See, I'm working on managing the presenting symptoms but I'm first doing an adherence history to see the kinds of difficulty in terms of five B and I realize I can't do it alone. I need social support from others. There is nothing that you do for a living that I cannot code. Okay? There is nothing that you do that is not code-able on this page. So the interesting thing that becomes a value is that you have therapists as I go around to these treatment centers, if you go to these fancy treatment centers, you know, all these kinds of things where people pay tons of money, one thing that becomes interesting is you go to this board which is the program for the week.

I'm really glad you came to our center because when you wake up in the morning, you'd be able to ease into the day with meditation and yoga that you'll find particularly helpful and then after that, you'll be able to come for breakfast and then we'll do the med check. This morning, we have the 12-step program. The bus will be coming at 10:30 – staff love it, they get people off campus – right? 10:30 and you'll be able to go to the 12-step program and relinquish to a higher power and deal with the disease of substance abuse.

You'll come back in the afternoon and we'll do trauma focus cognitive behavior therapy when you'll be able to take charge and boss your PTSD. The client looks at you and says I'm screwing it all up. In the morning, I tried the Borscht card. In the afternoon, I relinquish the PTSD. Not only that, we have the ropes course on Wednesday, the relaxation and breathing on Thursday afternoon. Your parents are coming on the weekend so we'll get into conflict. We do not get into relapse prevention until you're about to leave because we want to increase the likelihood that you will return so we have more heads on beds.

Now one of the things that becomes really interesting is that there's no integration about this, okay? Each person doing each of these things think they have the answer. We draw a picture of your life. We'll do, I mean we got the horses. You'll be able to go see the crocodiles. So one of the things that become kind of interesting is that there's no communication between people as to how they spend their time or how they're coordinating in the same language.

Most importantly, how do you then use this with a follow-up therapist who's going to come in so they know exactly how you spend your time? So I could tell you look, you really need to go for okay, four C because the development and that's what's lingering. But in spite of, I want you to identify the following strains. One last element to this that I'd like to take you through before I show you, so, another core task is psycho education and that case conceptualization is not only something i do with my colleagues, it's something I'm willing to share with the clients and that's really valuable. It's not that they're really crazy, they're stuck using something that worked in another setting whether it's the association or aggressive behavior or emotional control and what have you.

The other thing that we do a lot of is we try to educate people of the interconnection between the appraisal events, feelings, thoughts and behaviors. In order to accomplish that, we use what is called a clock metaphor. So I get paid as you do to listen to people's stories but the key question is what distinguishes us from a beautician, bar tender, and the mother earth figure? I mean what is it what we bring that makes them worth paying us as compared to just self-disclosing their story to other people?

My answer to that is not only are they able to listen to the story but you have this particular way to retell the story and one way that we have found particularly helpful is to use what we call a clock metaphor. So everybody's events can be broken down into what I call 12:00. 12:00 are triggers. These are either external or internally based triggers. It's what someone said, or did, or failed to say or do or the trigger might be internal. It might be a flashback. It might be a craving. It might be some kind of affective experience but 12:00 gets you going and then I slowly say see if I picked up one.

So what happened was I put my hand at 12:00 and then try to solicit from them examples that they could offer of what got them going, what was the trigger in that particular situation then I slowly move my hand to 3:00 and what's 3:00? 3:00 on the nature and the primary and secondary emotions that people have. So I felt sad. I felt angry. Now interesting, anger may be a secondary emotion so people may feel angry because they've been neglected, abandoned, disrespected. I felt anxious and one of the things because it's very interesting in this model is not only to have people tell you about their affective experience but ask people what they do with those emotions.

It's very interesting to treat emotions like a commodity. So what did you do with all those emotions? I stuff them away. I hit the bitch. I went out. I withdraw. I went for a drink. So treating emotions like a commodity becomes very interesting because you could say so you did that? Then how did you feel? Then I move my hand down to 6:00 and 6:00 are the nature of the thoughts that people have. This might be the automatic thoughts or images and maybe the thinking styles that people engage in. It might be developmental schemas that they've experienced and again acknowledgement and embellishment and then 9:00is what do they do?

So I stuff the feeling and what were the consequences? How do other people respond? So what am I doing? I'm encouraging you to be an exquisite listener to your clients' stories and then to repackage the story so it could be broken into these four quadrants. 12:00 is the external and internal trigger. 3:00 are primary and secondary emotions and people often have theories about emotions. Once it blows, it goes. If I start to tell that, I'm going to lose control. So we need to ascertain what is the theory about those emotions?

When you have those emotions, what do you do with them? If you do that, what is the impact? What is the toll? What is the price you and others pay? I ask that question all the time, impact, toll, price you pay. So it's the clients who're going to say I don't know. To which you should say I don't know either. Remember, you don't have to be a surrogate frontal lobe. So the key question is how could we find out? Now there's a beautiful aspect to asking questions and the aspect of the question is that behind every question you ask is a supposition that there's an answer.

So when you ask what is the impact, toll, and price, there's a supposition that there's an impact or the price and if they can't find it, we'll go and create it. So you get triggers, emotions, and then I put emotions always before thoughts because it's not a matter of thinking changing emotions. Emotions can change thoughts as much so it's a two-way street and then what I do is I say to the client it sounds to me Columbo, and correct me if I'm wrong, see if I've picked up on, see if I'm in tune with, it's just a vicious and on the word vicious, I put my hand at 9:00 and I slowly move it around this imaginary circle without finish the sentence.

I go it's just a vicious, now no I just don't go vicious, I go vicious, now if you try this with your clients, I could assure you that there's a remarkably high probability that they will answer the question by saying vicious cycle or circle. Now if you try this, and you get to 6:00 and they have not said it, you say it. You do not sit there going sounds like, small word, come on, work with me, we can get this, two syllables. Come on, vicious, come on, tip of the tongue.

This is not charades. This is psychotherapy and they're going to go vicious cycle to which you and your best Columbo style go vicious cycle. In what way is this a vicious cycle? I mean are you telling me, are you saying to yourself, are you saying to the group that when that occurs, you do what? So you go from 12:00 to 9:00 and then when you do that, it makes you feel how? The three and then you have the thought of and then that even makes you more vigilant about?

So one of the things you're going to do is take whatever story you get. There's no story that you encounter in your life that cannot be broken up in this fashion. Look, don't change anything. Let's see if this vicious cycle as you describe it actually occurs. That's where we're going to get people to do the self-monitoring and then there's

a lot I could say about how to get people to self-monitor and so forth in terms of the core task. So they're going to comment and say I do it.

You do what? I do the vicious cycle. Tell me about it. Tell the group about it. And if you do the vicious cycle as you described, what's the impact? What's the toll? What's the price you and others pay? Is that the way you want it to be? What could we do about it? Now your client does not have to be a rocket scientist to say that maybe one of the things he or she should do is break the cycle to which you go break the cycle. That's kind of interesting. What do you have in mind?

Knowing that, how are you currently trying to break the cycle? So all of the present psychopathology of substance abuse, dissociative behavior, withdrawal, acting out, is there a way to break the cycle? Fortunately they're in the presence of a therapist who could teach them other ways to perhaps break the cycle. So one of things that's interesting is that this is a very strong format in terms of being an expert and getting the client engaged in the process.

Now I supervise a lot of people who run groups. They don't do groups. They actually do one on one therapy while everyone else is watching. Your turn's coming, you shape up. So one of the things that happens is if you play the game of the clock, you could say so what got you going was and what set you off was and the trigger for you was, so now I'm doing 12:00 of course the whole group and I could say what's common among each of these that got you going.

When that happens, how'd that make you feel? Have others, have you had those kinds of feelings? When you get those feelings, what do you do with them? If you do that, what is the impact? What's the toll? What's the price? Any other thought of? Then you did what and how did they respond? So the whole notion is how are you going to get the people to view their – I do this everywhere. My wife takes me to the opera to see *Madame Butterfly*. I say you didn't have to kill yourself. There were alternatives.

I mean it's a nice gesture and everything, don't get so excited. There are other people out there, okay? If you don't want to try this with your clients, try it on your significant other. When you take that tone of voice, I knew how to drive before we got married and I'll know how to drive when this is over. You did this in front of

everybody and this is not the first time so there is absolutely no story in your life that cannot be broken up into the clock.

The key question is how are you going to get the client to see their presenting problem in that particular mode? I want to show you a client in a moment but I'm going to just take you through examples. So one of the things is there's a lot of business on you'll see in the *Roadmap to Resilience* book on how to nurture hope, how to do collaborative goal setting and it turns out that they do collaborative goal setting as an expert therapist as a real good trick. It turns out that to get people away from, so New Year's Eve resolutions have smart goals that specific measurable achievable relevant and time limited is really an important skill and that would be a good example of where your deliberate practice might come into play.

So I want you to audiotape you doing goal setting with your clients and have your colleague look at that. We also use timelines as I'll describe in the next case. We use help in generating models and mentors a lot of the programs that I've been involved with the military and so forth is we've made modeling films and they can now hear other people going for help. There's a whole program for adolescents called reachout.com where adolescents who are having specific problems with body image or parent thing or academic or bullying could go and hear coping stories.

So we really embrace the constructive narrative perspective and if you go on the Melissa Institute website, you could read a paper I wrote about the future of psychotherapy and computers. It becomes really kind of interesting in terms of nurturing hope so for example, in our work with substance abuse they now have it up where if people have multiple trials of lapsing so they can come to me or someone on our team and say doc, I really need help with regards to these lapses, I've been on and off many times and I say to you can you please tell me where it is your favorite watering hole, where do you go for your drinks, where do you shoot up and then what happens is you give the person a cell phone and in the cell phone is a GPS system and every time they get to that bar, the phone rings and on there can be the picture of their sponsor, their AA sponsor, you can do videotaping of refusal skills in your session using your cell phone and that can be played out.

So, the goal is to have them take your voice with them and their modeling the computer technology of the future is going to be

substantial as supplemental tools for you to achieve generalization. There's a lot of talk about how to build in generalization, how to get people to do homework, how to do relapse prevention and then how to address the issue of PTSD that we talked about this morning, how to integrate treatments, how to do memory work, how to help people find meaning, as i described how to avoid re-victimization and then how to help the helpers. Okay, so what do expert therapists do?

From my perspective they do all of these component skills, they develop, maintain, and monitor the quality and nature of the therapeutic alliance. They do so in a culturally, gender, and developmentally sensitive fashion. They conduct psycho education in a way that's going to nurture hope and that's going to lead to collaborative goal setting. They are going to do psycho education in a collaborative fashion whereby the client is going to be one step ahead of the therapist in following that lead and that we're going to find strains, my box six material in that particular perspective.

They also try and teach skills but they don't just teach skills. They have to build in generalization and if you get to the anger book, you'll see that we have a checklist of what you need to do before, during, and after to increase the likelihood that people are going to imply anything you taught them. How well people do in residential programs whether it's children, adolescents and adults is in no way predictive of what's going to happen once they leave. So there's a whole area that you need to address about how to put people in a consultative mode where they have to generate reasons, where there's a patient checklist to fill in.

Then moreover, there's a whole issue of about 50 percent of the clients we see having a history of victimization and how to provide integrative treatment. Rather than just talk about it, let me see if I could show you a client who I've seen over the course of five years and the client I'm about to show you is a real client so please treat the material you're about to see with the same privacy and dignity you would me.

Recording: I'm really pleased that you came in and perhaps we could start by just having you tell me a little bit about –

Don Meichenbaum: You hear it in the back?

Recording: How, they're okay. They're up and down. Mostly the –

Don Meichenbaum: Now, as she goes through this, I want you to think of the boxes. Okay? I want you to think what is her presenting problem, what's the evidence of the comorbidity that she's evidencing, what treatments has she been receiving? Now I don't take notes during the course of seeing clients but the entire time that the client is giving me information, I'm actually sliding into boxes. So when she leaves, I could immediately generate that case conceptualization.

So you're going to see that I'm working boxes and she's going to start to tell you box two and then she's going to tell you about box three and how big box three is and what is the treatment she got for box three in terms of comorbidity and then what she's going to do is start to tell you about some of the developmental history of victimization in terms of four C and then the key question is remember, no one leaves my office without box six which is the in spite of story.

So you can actually see that I'm working the boxes.

Recording: Tell me what you've been through from recently and may I get some picture, I mean I've heard it from other people; I'd like to hear it in your own words.

Like what time frame?

Well, let's start with how things are, any time frame what you think would be most helpful for me to understand, I mean, once we –

Gosh, I don't know. I did pretty well. I was out of the hospital for about a year and a half and then started having trouble with the eating disorder again and the depression. I mean the depression's always there but it started to be more and more and more of a problem, got more suicidal then lost more and more weight and I can't seem to interrupt the cycling and the coming to the hospital. I'm okay while I'm in here then I go home and I don't do very well when I get home.

You said there's a cycle. Can you give me a sense of what, how do you see the cycle that, between –

Well, I don't know. So much of the cycle is just when I get to a low and I ended up back in the hospital which was kind of discouraging

because I've done well, I thought pretty well for a while and then there are some stressors in my, in some things that went on. If there were anything worse that I've been through before but for some reason the eating disorder just started and once it starts then, and I've been battling the depression ever since I went off the Nardil when I had surgery two years ago. So I have the ECTs and the Nardil, until I had my hysterectomy and we haven't been able to find anything really.

So there's a lot. I mean there's the depression, there's the eating, there's the hysterectomy. There's stressors. I mean is that sort of a –

Well, there are a lot of physical illnesses, too.

What is –**?**

I have rheumatoid arthritis and hypoglycemia and fibromyalgia and hypertension and hypothyroidism and just a bunch of stuff all together. So I have a lot of medications that I take for those things.

And in spite of all of these medical conditions, and the depression, you mentioned something at the time that you felt things were going fairly well or I mean you mentioned something about that there was a period back there that –

It was a time between when I have the ECTs and I was on the Nardil. It was about four months for the time I had the hysterectomy and I had a different scenario for that.

What was happening in there? What was going well then? Give me a sense of when you said things were –

I don't know. All I remember is telling Joe on my birthday it was the first time I've ever been glad I was alive even though I had pneumonia and Joe's mom had a stroke and he almost lost his job and I had to have my surgery. We still needed **[inaudible]**.

And what was it that led you feeling that you were glad that you were alive? What was it that –

I don't remember exactly. It was just –

But you remember saying that.

Uh-hum.

And how did that feel?

It felt nice. I've been depressed for as long as I can remember.

Don Meichenbaum: Okay so let's see what we have. We have a woman coming in who is suicidal and depressed and you're sitting there and you're the expert therapist so you're trying to understand in your head what are all the possible hypothesis, factors that contribute to her depression? So she's already giving you some clues. I mean this is, I mean I love doing therapy because it's like detective work. So one of the things that she told you is that she's anorexic and one of the things that becomes interesting is that her depression could be a byproduct of that anorexia because anorexia changes the potassium balance of the cell and that they're physiological sequelae of that.

The second thing that she'd tell you is that she is a walking medical report, right? She's the whole desk reference, doctor's desk reference and she has all these neurohormonal kinds of things that can contribute to the depression as well. Not only that, she's also undergone ECT and Nardil and then hospitalized so some of the depression may be a result that's orthogenically generated. What else do we know about adult women who are suicidal and depressed? That is they have a high possibility of having a history of victimization, of sexual abuse and in fact she's saying to me Dr. Meichenbaum, would you please to join me to explore four C?

She says I've been depressed as long as I could remember. Remember I'm a plucker. I think therapists talk too much, they don't get paid enough. So when you say as long as you could remember; what else do we know about women who are depressed? As I mention, there's a high likelihood of marital distress. There's got to be a man in her life. What else do we know about women who are adults and depressed is that they tend to have perfectionistic standards. Now this is cool. You got a woman who comes in, sits down for four minutes 26 seconds and I have a possible hypothesis in my head that's contributing to her depression.

Now you know what's neat about this lady? She has all of them. Managed care is going to pay for a portion of it, right? So, one of the things that become interesting is you playing the game of the boxes. I mean you're sitting there and oh my God, I got the

depression, so forth, let's go for as long as I could remember. Let's see where four C goes and test out that hypothesis. So if in fact I supervise you and I supervise a lot of clinicians, I'm going to stop the tape at various points and say to you tell me what's in your head? What are all the hypotheses that you were testing? What are the things you're excluding, where are you going to go and moreover, how are you going to engage the client to go on this journey with you?

Now that's the fun. If you don't do this, you go find another job. Drive a cab or something. New York, you can do therapy for free.

Recording: Since I was a child so –

Don Meichenbaum: Ever since she's been a child.

Recording: Back then, how far back can you go when you remember that you –

Oh, I tried to commit suicide when I was 16, the first time so I could go back to 13, 12, 13 at least that I could remember.

And there was –

Younger than that.

Younger than that, you felt depressed?

Um-hum.

Don Meichenbaum: Keep in mind that there are very few forms of adult psychopathology that did not begin in adolescence, one of which is depression. So if in fact while you're doing the risk assessment there, if you have suicide, you got to know whether this is a multiple suicide attempt or whether it's the first time kind of event and why would she choose anorexia of all the types to do it? I mean this is just detective work and the key question is you're watching this unfold over the course of the session that's going to influence your interventions.

Recording: And then there was a suicide attempt when you were 16?

Um-hum.

Just to give me the overview, what happened then? I mean did you, was the first suicide attempt? Have there been others?

Yeah, that one was after some sexual abuse and then there was another one when I was 19.

What, I know this suicide attempt, do you have any recollection of what triggered that, what's going on then?

More sexual abuse by the same guy. I didn't learn fast. Then there was in between neither was a date rape, too.

That was after the 19?

No, that was in between the 16 and the 19.

You've been through quite a bit. After, just to give me sense of the history of what you talked about, this depression, were there more suicide attempts after 19?

No, not until I was at **Lasset**.

Don Meichenbaum: It's a psychiatric hospital. She tried to hang herself.

Recording: There weren't any others.

Do you see any of that experience that happened back then having an impact on how, on what's going on now? I mean is there, you said something about the abuse at 16 and then with the same guy at 19 and there was a date rape. Do you see some kind of –

Well, there was more before that.

Don Meichenbaum: Now I don't know what your clientele is like but this is my clientele because I am sitting there saying you know lady, we actually have enough material. With your present suicidal behavior, the history of victimization, all the other kinds of illnesses here, you know what this lady's going to say? You haven't heard anything. What happens is it just keeps coming and coming, and coming. You can't believe that so many bad things could happen to one person and what happens is it is depressing for her and it could be depressing for you the therapist and then you have to remind yourself that you're a cognitive behavior therapist and you do not get depressed.

Because the story you're hearing from her is the depressogenic channel. She is channel-y selective into all of her story which you have to listen to in a compassionate, respectful, validating fashion but if you only delimit your assessment to that top timeline, you're not going to be therapeutic. Remember, you got to get box six. You cannot come to the conference without box six materials. We refuse as a case conference to get depressed. So if you cannot find some redeeming feature, some strength, don't even bother to show up because the way assessments are done at hospitals, in order to get a DSM diagnosis, they only go for the timeline of the whole sequence that's going to give them a DSM diagnosis and as a constructive therapist, I want to get timeline, too, which is box six, what is the story in spite of?

But you can't go for the in spite of. You can't go for the miracle question until you've heard the pain otherwise they think you don't understand the depth of their distress. So keep in mind that I am encouraging you to be an exquisite listener of all box six materials. I'll stop and say what have you heard that's box six? That's in spite of. That's a sign of resilience.

Recording: I don't know if I actually wanted to go there with the physical and emotional abuse when I was little from – I was adopted and there was abuse there and some abandonment issues and stuff and it's, you know, some physical emotional abuse, too, from a sibling.

As part of the adopted, is this part of the, you said something about being adopted and abandonment issues.

Well, my parents decided to give me up for adoption because they were fighting so they just decided to get rid of me because I was the issue and so I went to live with relatives but then they wouldn't let me adopt. They wouldn't let the adoption occur for five years, and so I just sort of lived in limbo for five years with this family and finally they gave permission for the adoption. But in the meantime I had one sister who was real physically, verbally abusive, told me I didn't belong in the family, they weren't my parents and she used to choke me, totally went hysterical, tried to drown me even and several other things. She was not very kind. It wasn't a big thing but it just seemed like at the time.

And you said that contribute to what you, would you call it an abandonment issue? Would you give me a sense of what you meant by that.

Well, because I always felt like my parents, first of all, they just used me as a pawn you know, my father said you got pregnant just to keep me and my mother said no, I didn't and to give it up, to prove it, I'll give the baby away. Then my father beat up my mother and I was born early and so she gave me to a relative and then when my mom found out they thought I was going to die, she told me that she never would have taken me because she didn't know the doctor said I was going to die. It was kind of – but then I had a different name for five years. I didn't belong in one family or the other. I was just sort of; I guess she wouldn't let the adoption go through, my birth mother. Until then my sister played on that.

Don Meichenbaum: Now watch her face.

Recording: They're my parents. They just got stuck with you and she was real physically abusive to me, you know. She did all kinds of things. When I got old enough to get better, I got –

Don Meichenbaum: Now, you cannot see it very well here because it's a fuzzy tape but she says she gets back at her sister and she smiles and I clinically pounced or you prefer strategically intervene on that smile because that smile is going to take me to box six and she's already told you something. They didn't think she would survive. She survived. She got back at her sister. Come on, lady. Prevent me from getting depressed here, okay? So how does this woman get back at her sister?

Recording: You got to get back at her you –

Yeah, I used to get back. I was always smaller than she was – until I got bigger but then I'd get back at her by throwing worms and things on her.

Don Meichenbaum: How does she get back at her sister? She gets back at her sister by throwing worms at her. Not only that, she waits for the sister to be in the tub to throw the worms. This is very good behavior. This is a frontal lobe I could relate to. I mean if my boys did this to each other, I would be terribly impressed. I'd just say don't tell mom where you hid the worms but this is really good stuff. This is constructive narrative. The key question for you is who else is she

getting back at and what form does it take? Where does the anorexia, where does the suicide attempt fit in?

But she started to fill in box six. She survived. She threw the worms. Come on lady, get it out. See, I am like a lawyer who's going to present a good brief and what I'm doing is I'm collecting data and I wait, I wait and then I'm going to put box six material before her and see what she makes of it.

Recording: She hated worms.

Don Meichenbaum: She hated worms.

Recording: I wasn't physically abusive with her, though.

And given that line of story of the adoption and question of what you call abandonment and the thing that you went on with your sister and then they, what is the impact of all of that? What lingers from all that that now –

Don Meichenbaum: Now, that is a critically important question from my perspective that makes you an expert. If you get a history of victimization, you should not assume automatically that that history of victimization is the cause and the fact to contributing to present distress. As I highlighted this morning, there's a lot of question about whether criterion A causes PTSD. So, one of the kinds of issues is not only that bad things happen, bad things happen to 68 million women in the United States. It's what is the story you fashion as a result of that?

What are the conclusions you draw about yourself and others as a result of having that kind of experience? So I got to hear the story about what lingers from that kind of cumulative victimization experience that she had of the abandonment and neglect, the depression at 13, the sexual abuse at 16, 19 by the same guy, the date rape in between. I have all of these kinds of events; I want to know what lingers from that. Is it those kinds of things that causing difficulty, are there more approximate events that we should consider?

Recording: Well, I don't know that it's all of that. It's just that when I got there, the arthritis and I had to quit working and I didn't expect to have to quit working under this condition and we had a daughter that went

through drug and alcohol. She went off the deep end and everything just kind of built up you know.

Were you working at – what did you, what kind of job did you have?

I'm a licensed clinical social worker.

Don Meichenbaum: You think I would pass that up in a conference like this? So, she is a licensed clinical social worker. So now Columbo comes into play, right? I have a box six material and every time I get that kind of thing, are you saying to me, are you saying to yourself that in spite of all of these things you've been through, with the rape, the neglect and so forth, in spite of that, you became a social worker?

How'd you do it? So isn't that hard? Therapy is developed, therapeutic relationship with a client that is compassionate, respectful, that developed a therapeutic alliance that fills in boxes one to five and then what happens is you wait, you wait, you wait and then you start to collect box six strains and when you get box six strains, you ask in spite of, how, and what. That is therapy. It isn't that complex. How did she become a social worker? Columbo needs to know how in spite of repeated victimizations, multiple sexual abuses, she became a social worker.

Recording: I still have my life. I'm not practicing right now but I have my license.

So in spite of having all of those kinds of events happened to you, you were able to continue your education and get a job and so forth? I mean you –

Um-hum.

How did you do that? How did you not allow those –

Because when people told me I couldn't do something and then I proved that I could.

If people say –

Don Meichenbaum: So one of the things you're going to see is that as the interview unfolds, I use more and more sentence incompletion. People would say in spite of. Before managed care, I used to use whole sentences

and if things keep going, I'm just going for hmms. You want to make sure that your interview with the client doesn't sound like an excerpt of the old drag net just the facts, ma'am. You want people to talk to you in paragraphs. So people would say in spite of, how did you become a social worker? I need to know that. This is straight box material.

Recording: I always told I wasn't smart enough to go to college so I went to college and graduated in the top 10 percent of my class.

Wow.

Don Meichenbaum: Well, how do you like those apples? Every time people tell her she can't do something, she proves them wrong.

Recording: Back at them.

Yeah, I proved that I could do it.

And you got back at your sister, too.

As a kid, yeah.

No, but I mean there's a kind of strong fiber here it sounds like –

Don Meichenbaum: Now what the hell does that mean? There's a kind of strong fiber here. We're talking about rope or cereal, okay? There's a kind of strong fiber here. Watch what she says next.

Recording: Am I picking up on that?

Yeah. I'm stubborn.

Tell me a little bit about that –

Don Meichenbaum: She's stubborn. What's her presenting problem? Anorexia nervosa, of the 300 plus categories of DSM, that is the most stubborn disorder that exists. People are going to say just eat a lot, you're not eating, you want to eat by yourself? Do not become the next Karen Carpenter, okay? Don't get to that tipping point, and she's going to say no way. So the interesting question from a constructive narrative perspective is she a stubborn victim or is she a tenacious survivor? See, which CD she plays in her head is going to be really critical as to where you go.

You can't say you're really a tenacious survivor. You threw the worm. You survived. You became yourself. They told you, you weren't smart enough to go to school and you got in the top 10 percent in the case? So you need data and you are presenting to her who's the jury the data for which side are you on. So it's all collaborative storytelling.

Recording: Give me; tell me how that stubborn-ess shows up.

It doesn't anymore, I just give up.

Don Meichenbaum: Okay, so let me show you this woman one year later because she's now an outpatient. I have five years with this woman so I want you to now take cognizance of her appearance and most importantly become an exquisite listener to her language and I want you to count the number of times she uses what I call metacognitive active transitive verbs to tell her story, the way in which it's bathed with R-E verbs, because the goal of therapy is to have the client take your voice with them. And as I mentioned this morning, one of my favorite questions is to ask clients the question do you ever find yourself out there in your day to day experience asking yourself the questions that we ask each other right here?

So the whole idea is for them to take my voice with them. Do you ever find yourself out there just in your everyday experience, asking yourself the kinds of questions that we ask each other right here? So the whole point is that you're saying you know what therapy is? It's a style of cognitive modeling and I need you to take that voice with you.

Recording: Oh, it's good seeing you again and I want to thank you for coming in. Okay again, maybe you can sort of fill me in on how things are going since I've seen you last, how things are right now. It's been a while.

I **[inaudible]** much of last time.

Well, fill me in on how things are going now.

Well, up and down but a lot better than it was. At least I can function.

Don Meichenbaum: Function, listen to her verbs.

Recording: In some areas anyway.

Well, fill me in on the areas you're able to, as you say, function.

Well, before when you were here, I was on a downhill slide and so with the information, I think seeing from the last tape when we came up with a different game plan.

Don Meichenbaum: Game plan, listen to the verbs.

Recording: I like to refer to it as tenacity.

Don Meichenbaum: Tenacity.

Recording: And I'm stubborn and hardheaded so I decided to turn that around and use that to be beneficial instead of –

So you're tenacious.

Yes.

Tell me a little bit about.

I'm a survivor.

You're a survivor.

Don Meichenbaum: So now she is a tenacious survivor. Now if you see me in therapy, there are no freebies. You cannot come in and say I am a tenacious survivor. I mean where do you get that? Is that the theme of Oprah's program this week? We're going to wheel in a number of tenacious survivors, watching you to become one. You operationally define that term and give me multiple examples of the degree to which you are one tenacious survivor.

Now without using any of that jargon, I go tenacious survivor? What am I asking? I say please operationally define that term and give me multiple exemplars and who is she convincing? Not me but herself so the key question is if you are an expert therapist, you got to make sure that the client takes credit for the changes. They need to see the interaction between their efforts and the resulting consequences so it's not the medication, it's not you, it's that she

threw the worms. She got in the top 10 percent of the class. She became the social worker.

So in fact, the portion, I want to get, make sure we have the time for questions and the like, is that she now goes on to describe examples of her tenacity and it's pretty impressive as to what she's doing. So one of the things that's happened is she's actually stabilized her weight so she and her husband for the first time have gone out to dinner at a restaurant. She's not overeating but she's able to maintain her weight. She's now taking a class on social work and religion. She has a sister who is being assessed for breast cancer and given her social work background, she rises to the occasion.

Her son got into a burn situation in a fire and she helps the brother – it is really impressive. So she goes on to demonstrate the variety of factors that are contributing to this process. Moreover, one of the things that becomes really fascinating is that this woman decides with the help of a therapist that she should go out and try and find her biological mother who she had not seen for many years and one of the things she decides to do is to visit Las Vegas where this mother is located, to sort of sort out those roots.

Now in terms of tenacity, this provided a very unique opportunity because I participate in the evolution of psychotherapy conference for **[Inaudible]**. Has anyone ever been into the evolution of psychotherapy conference? It's kind of interesting. They're going to have it again next December and they invite all these senior domos of the field. I've actually characterized the conference I'll see them before they die. I don't want to be morbid but there was an element of this and since it's late in the day, I'll give you one quick example.

[Inaudible] has this practice of putting, it attracts like 6,000 7,000 people, okay? It's really kind of a happening and over the registration desk, they have silhouettes of people who have presented at previous conferences but who have died. You know, Viktor Frankl and all these people from the past so I was walking through the lobby with Albert Ellis and Aaron Beck and myself, the triumvirate in cognitive therapy and Ellis, in light of his memory, he recently died, looked at Tim Beck and I and said in his own inimical style what the fuck is that? And Beck told the two of us not to look because it was bad luck. Keep your head down. Just keep going, okay?

So one of the things that's interesting is that this woman, Cathy, was going to be in Las Vegas when I was going to present her tape. I have a lot more. I do a whole week on expert therapists in Cape Cod so one of the things is I invited her to be a guest of mine at the presentation when I was going to talk about her. So she was in a room with 3,000 people and we talked about how she got from point A of being a stubborn victim to becoming a tenacious survivor and moreover, I had a lot of trepidation about this but given that she was a social worker and sat in the front, if she felt comfortable, would she be willing to come up on stage?

So she came up on stage and she answered questions from the audience of the 3,000 people in terms of how she got from point A to point B. Now one of the things is really interesting is I work with native populations and they have a very interesting ceremony for wounded warriors. So what they do is they put the wounded warrior through a cold set of ceremonial procedures with sweat lodges and the chanting and the pipe and so forth and then they have a circle where they take members of the community and put them around the edge of the circle and they put the wounded warrior in the middle so that he or she can share the lessons that they've learned that the rest of the group can benefit from.

So what was I doing in Las Vegas? I'm doing the exact same thing. Instead of a sweat lodge, she's been through therapy and then what happens is she is now going to make a gift of her experience to the rest. Now you don't have to go to that extent but I often asked my clients, let me ask you something a bit unusual and a bit different and feel free to say no. Do I have your permission? Do I have your permission to share how you got from being a stubborn victim to a tenacious survivor with my colleagues and with other clients?

I will not in any way self-disclose your name or violate your privacy. So the notion here is one of the tasks of an expert therapist is to help people find meaning. to transform their experience into something good. The case example I gave this morning about Vicky's mother accidentally killing her daughter and then translating that into her gift of trying to educate parents about the dangers of guns, the Melissa Institute trying to transform their loss of Melissa into an institute that will help save other people and try to work towards gun control.

So it doesn't have to be a major social event but an expert therapist in dealing with trauma gets the person to tell their story and to help incorporate that event into an autobiographical account that's coherent, that has redemptive features. So when you get to the *Roadmap to Resilience* book, I included an algorithm of exactly what people need to do to have chronic PTSD. So if something bad happens to you and you seem to be making it, just go to page 84. They'll tell you exactly how to screw up your life. If there's any merit to it, it also has implications of how you could help other people get unstuck and has what is a healing story.

So what you're seeing in Cathy is a co-authoring with her of the kind of healing story and also ensuring that she has the skills to implement that. What characterizes expert therapist? A, the development, monitoring of a therapeutic alliance in a culturally gender sensitive way. Moreover, to conduct psycho education in a way that leads to collaboration and that nurtures hope. So in the case of Cathy, one of the things that we do is we actually draw a timeline with a client from when she was born and all of the victimization that she experienced, the abandonment and the abuse and the attempted drowning of the sister and then what goes on at 13, what goes on at 16, 19, the date rape and so forth but my job would be incomplete if I did not draw a second timeline right underneath that with the client.

The second timeline with that client has to do with the box six in spite of. So in spite of it, let me see if I got this, you survived. Oh, by the wa, how old were you when you first threw the worms? Were you one of these precocious worm throwers who do it well before the developmental norm? They told you, you weren't smart enough to go to school, you got in the top 10 percent so one of the things that becomes really interesting is people do not take data from timeline to as evidence to unfreeze their beliefs especially if they have a therapist who never ask about the in spite of.

Remember, if I am your man at that case conference, you cannot come to the table without box six materials so I have a lot of other kinds of videos that I show them. I'm running out of time obviously, of bipolars, of schizo, of other people about how you could build on strengths and resilience. You could address the symptomatology that they have in terms of sleep disturbance or pain or anger control and the like but from my perspective, if you cannot boast the resilience in terms of having the three positive emotions, these negative emotions of getting the social supports of

having a more optimistic life to having some kind of hope of finding some kind of meaning whether it's spiritual or other, then these people are going to lapse down the road.

We have about 15 minutes left. I know you've been very patient. Why don't I just pause and see if there are any comments, questions, reactions to what I've been presenting on the nature of expertise. Maybe you'll try the clock with your clients or the in spite of followed by how and what or look at some of these other kinds of component skills. If you go to the Melissa Institute, a lot of this materials, they're in a lot of detail and you could actually see the boxes and all the other questions. Just don't call me for money.

Unknown Speaker: Did you introduce the notion of tenacious survivor?

Don Meichenbaum: No, she came up with that. She came up with it but it was, there was a lead into the tenacious survivor, right? Because you're laying this out. Wait a sec, are you telling me that in spite of, so they told you, you weren't smart enough to go to school? What'd you do? I got in the top 10 percent. How did you pull it off? Well, every time people tell me to do something, I prove them wrong and then you get into the whole issue about the anorexia which is really an interesting aspect.

One of the things that become interesting on the anorexia is that given that this one was repeatedly sexually abused, she had the mistaken belief that if she deludes herself by becoming anorexic, this would be a protective device against future victimization. So you find a very high incidence in eating disorders especially among women about a history of victimization and that kind of belief is my 6:00 material.

Yes, sir, please.

Unknown Speaker: Trivialize your beautiful case here but, I don't know, I met your colleague, your legendary colleague, Albert Ellis, it was like in some demonstration while he was still working in ADA but do you do this same annoying thing in constantly challenging people's beliefs?

Don Meichenbaum: No, first of all I never characterize a belief as irrational. I would never do that and I would never adopt his style. I really was only being partly facetious in saying that that works in New York and

nowhere else. That kind of abrasive challenging kind of manner so I would not do the Ellis thing, that's –

Unknown Speaker: Would you challenge somebody's beliefs in a gentler manner or not?

Don Meichenbaum: No, I need them to challenge their beliefs, okay? I'm going to play Columbo. I'm a little bit confused, okay? Because on the one hand you say you're a victim. On the other hand, you took charge of X, Y, and Z. Help me understand that. This is a very rabbinical approach. On one hand and on the other hand, okay? I feel that if nature had given me a third hand, I would've been a phenomenal therapist. I'm biologically limited.

It's just like Burns did, the advantages disadvantages in cost benefit analysis and then what happens is a very powerful technique to use the art of questioning and it's really valued to be under the business of being confused and having clients help you understand how to get out of this. So if you were just that Burns' presentation on motivation, he's essentially doing this exact same thing. On the one hand let's look at all the advantage. Why give it up? Help me understand that, right?

One last one, yes, ma'am, please.

Unknown Speaker: I've talked to you earlier that I heard 30 years ago and you were doing your presentation –

Don Meichenbaum: You were 18 then, right?

Unknown Speaker: And I remembered you doing a presentation and you said that is irreversible difference. I think you were showing a –

Don Meichenbaum: Yeah, right. You remember that?

Unknown Speaker: I do and I have taped this over and over again when that –

Don Meichenbaum: Okay, all right. This woman is having intrusive traumatic memories of me 30 years ago and in order to consolidate this – so there's a film I showed all the way through my teaching at Waterloo, and it was called *Journey Into Self* and it was a film of Cole Rogers doing therapy and it underscored for me the magic of language so he says to the groups I want each and every one of you in this room who spent these two hours with me, I want you to

know that what we've been through is just irreversible. It's just irreversible.

Now the problem is everything's irreversible. It's absolutely bullshit. It's like my saying strong fiber. Okay, so what happens is everyone in the group goes I'm telling you this is good, pay him. Not only that, you should see me every 30 years because it will be just, you take the words right out of my mouth. Enjoy your conference.

[End of Audio]

Duration: 105 Minutes