What “Expert” Therapists Do:
A Constructive Narrative Perspective

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We each spend a great deal of time, money and effort in search of excellence. We attend concerts, dance recitals, and athletic events in the hope of catching a stellar performance. We have favorite restaurants where the chef has a “perfect touch”. We delight in our favorite novelist, singer, or actor. We try to hire experts to help us with our computers, our taxes, our cars, and our health, and when in distress we may seek the assistance of an expert therapist.

Psychologists have studied many types of experts and compared them to their less accomplished and novice colleagues (See Meichenbaum and Biemiller, 1998 Chapter 2 for a review of this literature.).

This paper is designed to consider the factors that contribute to an “expert” therapist. For a moment, consider who is the best psychotherapist in your community, besides “yourself”. If you, or a family member, or a friend, needed counseling, to whom would you go for help? Moreover, if you had an opportunity to watch this nominated therapist conduct therapy, exactly what would you see him or her do? Before reading on, take a moment and generate a list of the attributes and activities that you think an “expert” therapist would evidence and engage in.

The literature on expertise is fascinating as it highlights that experts differ from both novices and experienced non-experts in three areas, namely:

a) knowledge differences which include declarative (“knowing about things” or “knowing that”), and conditional or strategic knowledge (“knowing when, where, why, if-then rules”);

b) strategy differences (plans for solving problems and achieving goals) and the ability to monitor implementation and adjust accordingly;

c) motivational differences that contribute to commitment and persistence.

We can now turn to how these concepts apply to expert psychotherapists.

In your list of features that characterize the best therapist in your town, you might have included that the expert therapist should achieve favorable outcomes. In the same way that you may wish to know the results of a surgeon you choose, hopefully one with a good track record, you would expect the expert therapist to also have a deservedly favorable reputation for the positive outcomes he or she helped to nurture.

The literature on psychotherapy provides some guidance on what we should look for in the expert therapist’s repertoire. First, and foremost, if you wish to become an expert therapist who achieves favorable treatment outcomes on a regular basis, then the most important skill you need in your therapeutic repertoire is the ability to choose your patients carefully. If you wish a rich and rewarding career as a therapist with favorable treatment outcomes, then the most important skill is the ability to select your patients carefully (same thing twice?). You want to delimit your practice to the proverbial YAVIS patient (young, attractive, verbal, intelligent and successful) who has a circumscribed nonpsychotic Axis I Disorder from both novices and experienced non-experts in three areas, namely:

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social supports. In short, the literature indicates that patient characteristics account for most of the variance outcome. But for many therapists, they do not have the option or penchant to only work with YAVIS-like patients. Then what are the other sources of variance that contribute to treatment outcomes? These include:

1) relationship factors;
2) therapist characteristics;
3) specific intervention procedures.

How do these features show up as you watch your nominated expert therapist go about the business of healing? The following core tasks of psychotherapy are designed to capture the complex processes of therapy. Because of space limitations, these are enumerated in point form. Elsewhere, I have discussed in detail how to implement each of these core tasks of psychotherapy (Meichenbaum, 1994, 2002).

Core Tasks of Psychotherapy

1) Develop a therapeutic alliance that is nonjudgmental, empathic and supportive (The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment, Norcross, 2001; Ahn & Wampold, 2001; Wampold, 2001).

2) Educate patients about the nature of their presenting problems (e.g., symptom features and course of their disorder, relapse symptoms, etc.). This educational process is not a didactic lecture, but arises from a Socratic dialogue and from various discovery procedures such as patient self-monitoring, feedback, and a collaborative case conceptualization that is individually tailored to the patient.

3) Nurture the patient’s hope by engaging in collaborative goal-setting and by ascertaining both past and present examples of strengths and resilience. Adopt a strengths-based perspective.

4) Help patients develop and implement a flexible coping repertoire, bolstering intra- and interpersonal coping skills. Build in generalization procedures. Do not train and hope for transfer. Follow specific generalization training guidelines (See Meichenbaum, 2002).

5) Ensure that patients take credit and make self-attributions concerning the changes that they have brought about. Ensure that patients view the “data” that results from performing in vivo personal experiments as “evidence” that unfreezes their beliefs about themselves, the world, and the future.

6) Address issues of relapse prevention (i.e., warning signs, high-risk situations like anniversary events, coping with lapses).

7) Employ a flexible repertoire in customizing both relationship stances and specific intervention methods to the individual patient and condition. In approximately the one-half of clinical cases where there is a documented history of victimization, the expert therapist also needs to:

8) Ensure patient’s safety and address the clinical sequelae of trauma exposure and comorbid problems.

9) Help patients do memory work of trauma resolution and reintegration. The focus is not on merely retelling the details of the traumatic event, but instead examining what patients did to survive (focus on the “rest of the story”), and also focus on the conclusions and implications they draw as a result of having experienced the trauma. As described below, help patients engage in activities that assist them in constructing new more adaptive stories.

10) Help patients find and construct meaning (salvaging something positive from the
trauma) that gives a sense of purpose, mastery, control and acceptance. Use patients’ already existing belief systems (e.g., religion, communal rituals).

11) Ensure that the patients reconnect with others who encourage them to adopt active roles in multiple domains. (Not delimit special contacts to only other victims.)

12) Ensure that victimized patients develop skills and a sense of efficacy on learning ways to avoid revictimization.

A Search for Change Mechanisms

The “expert” therapist is also curious in searching for the nature of the mediators and moderators that contribute to change. How do the implementation of these core tasks of psychotherapy foster and nurture change? A constructive narrative perspective provides an heuristically valuable framework to answer this question. A beginning point is the recognition that people are story-tellers. They offer accounts that are designed to make sense of their world and their place in it. They construct narratives that include descriptions of events and of their and others’ reactions to those events.

As Howard (1999, p. 190) observed, “We are lived by the stories we tell. Beware of the stories you tell yourself, for you will surely be lived by them.”

The observation that people tell stories, or actively construct personal realities, is not new. From the philosophical musings of Immanuel Kant to those of Jean-Paul Satre, from the psychological writings of Wilhelm Wundt to those of George Kelley, there is a long tradition of the importance of story-telling or the creation of personal meaning. Common to this tradition is the view that individuals do not merely respond to events, but that they respond to their interpretations of events.

Perhaps it is possible that the core tasks of psychotherapy operate by changing the nature of the stories or narratives that individuals offer themselves and others. The change in the stories that individuals offer may represent a “final common pathway” of behavioural change.

As an example, consider the stories individuals who have been victimized might offer themselves and others. Epidemiological studies indicate that while three-quarters of individuals will experience traumatic events during the course of their lives, only approximately 10% to 25% will evidence a lifetime instance of PTSD. While the nature of the traumatic stimulus, the response to victimization, vulnerability, and recovery factors have each been implicated in influencing the post-trauma adjustment process, the present focus is on whether these variables are mediated through the narratives that individuals offer themselves and others.

Meichenbaum and Fitzpatrick (1993) and Meichenbaum and Fong (1993) compared the nature of the narratives of those individuals who continued to have difficulties following experiencing a traumatic event versus those who were able to continue functioning, in spite of the trauma exposure. Those individuals with lingering distress tend to:

1) evidence more intrusive ideation and are less likely to resolve their stories and integrate their traumas;
2) dwell on injuries and death and continue to search for an explanation and fail to find satisfactory resolution (i.e., they continually try to answer “why” questions for which there are no acceptable answers);
3) engage in “undoing” activities or what has been called contrafactual thinking (“what if” or “only-if” thinking);
4) continually make comparisons between life as it is, compared to what it might have been or what it was;
5) see themselves or others as blameworthy and get caught up with preoccupying thoughts of revenge;
6) see themselves as “victims” and as being “at risk” with little expectations or hope that things will improve or change.

Moreover, mere words or descriptive accounts of the traumatic event often feel inadequate to describe the horror of what they have experienced and the perceived negative implications for the future. In order to capture and convey the “emotional pain”, the traumatized individual becomes a poet (of sorts) and uses metaphorical descriptions such as:
“I am a prisoner of the past.”
“I am soiled goods.”
“I am on sentry-duty all of the time.”
“I stuff my feelings.”

See Meichenbaum (1994) for a collation of the variety of metaphors that patients offer to describe their PTSD symptomatology of hypersensitivity, psychic numbing, intrusive ideation, sense of personal loss, and the implications for their life.

Consider the impact of individuals telling others and themselves that they are “prisoners of the past”, or that they are “soiled goods”. The use of such metaphorical descriptors, either by individuals, families, communities, or even nations, can readily influence how they appraise events, the world and their future. As Janoff-Bulman (1992) and McCann and Pearlman (1991) highlight, traumatic events, such as those of September 11, 2001 can affect an individual’s (as well as a nation’s) core beliefs concerning safety and trust and the resultant stories they tell. These stories, in turn, can influence the adjustment process, which, in turn, can confirm one’s beliefs that strengthens the story-line, and thus, the process continues.

What can be done to break this cycle? What naturally occurring socially supportive activities (religious or communal); what therapeutic procedures can help traumatized individuals alter their stories so they come to find benefits, co-construct meaning and marshal their strengths? That these are important tasks is underscored by calls in the treatment literature for traumatized individuals to:
• Assimilate their traumatic experiences (Janet)
• Fabricate a new meaning (McCann & Pearlman)
• Develop a healing theory (Figley)
• Re-story their lives (Epston & White)
• Restructure and conclude the trauma story (Herman)
• Come to terms with or resolve their hurt (Thompson)
• Rebuild shattered assumptions (Janoff-Bulman)
• Develop a new mental schema and seek completion (Horowitz)
• Acknowledge and work through memories (Courtois)
• Reconstruct the self and provide new perspectives about the past (Harvey)
• Develop their own voice and not repeat the voice of the perpetrator (Meichenbaum)

Whatever the particular coin of phrase, each of these authors are calling for victimized patients to tell their stories differently. Patients often enter treatment with an account that reflects a sense of victimization, demoralization, helplessness and hopelessness. They feel victimized by their circumstances, by their feelings and thoughts, and by the absence of support from others. This is especially true if they have a prior history of victimization. (Note that 35% of female victims have such a prior history of repeated victimization.)

Research indicates that therapy can help individuals both alter their narratives by distinguishing threatening and nonthreatening features of trauma and lead
to fewer disorganized thoughts (see Foa et al., 1995; van Minnen et al., 2002). As Harvey and Bryant (1999) and Pennebaker (1993) and Pennebaker and Francis (1996) highlight, engaging in more coherent, insightful causal thinking can lead to more positive outcomes and improved health changes.

The various core psychotherapeutic tasks are designed to foster these narrative and behavioral changes as patients alter their accounts from one in which they view themselves as being “victims” to becoming “survivors”, if not people who can even “thrive”. For example, in one case the patient initially viewed herself as a “stubborn victim” and over the course of treatment she began to view herself as a “tenacious survivor” based on her past history of coping efforts and the variety of personal experiments she was able to perform successfully. In another case a patient was able to transform her emotional pain that she felt at the death of her daughter into a “gift” that she was able to share with others (see Meichenbaum, 2001). The Melissa Institute for Prevention of Violence and Treatment of Victims that I direct, grew out of the tragic murder of Melissa. Her parents, relatives and friends, came together to transform their pain into hopefully some good that would come from this tragic loss. If they could help prevent one more such death, then perhaps Melissa did not die in vain. As Viktor Frankl observed (as cited by Mahoney, 1997, p. 32):

The meaning is always there, like barns full of valuable experiences. It may be the deeds we have done, or the things we have learned, the love we have had for someone else, or the suffering we have overcome with courage and resolution. Each of these brings meaning to life. Indeed, to bear a terrible fate with dignity is something extraordinary. To master your fate and use your suffering to help others is for me the height of all meaning.

Such gifts to others are the basis for new “stories”. Expert therapists help individuals engage in meaning-finding activities that transform pain and bolster coping. How expert therapists go about implementing the core tasks of psychotherapy to achieve these objectives of resilience is a story yet to be fully told.

References


