

**CORE TASKS OF PSYCHOTHERAPY/COUNSELING:
WHAT “EXPERT” THERAPISTS DO
And
HOW TO USE EVIDENCE-BASED PRINCIPLES AND INTERVENTIONS
TO GUIDE CLINICAL PRACTICE**

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Presentation at the 12th Annual Melissa Institute Conference May, 2008

**Reducing Violence by Nurturing Emotional and Behavioral Well-being: Application
to Schools, Communities and Social Agencies**

THE NATURE OF THE CHALLENGE

Clinicians and health care providers who work with troubled and troubling children, adolescents and their families are confronted by a conundrum. On the one hand, they are “pressured” by agencies, third party payers and State legislatures to use evidence-based treatments. There is increasing debate as to what treatments are appropriate to conduct in practice, what treatment procedures will be reimbursed, and what training programs will be accredited for Continuing Education. Clinicians are encouraged to check websites of current evidence-based interventions such as <http://ucoll.fdu.edu/apa/lmksinter.html>, Substance Abuse and Mental Health Services Administration SAMHSA website <http://www.nationalregistry.samhsa.gov>; Center for the Study and Prevention of Violence www.colorado.edu/cspv/blueprints/; and National Network Stress www.nctsn.net. Similar calls have been made by Lilienfeld et al. (2003) who have cautioned against the use of unfounded, pseudoscientific interventions.

An examination of these websites indicates that a number of promising approaches have been developed to treat aggressive children and adolescents. For example, these treatment programs include multisystemic therapy, multidimensional treatment foster care model, parent management training, and functional family therapy. But these are only a few of the more than 550 different treatments that are available for children and adolescents, as Kazdin (2000) has noted.

How should the practicing clinician choose from this burgeoning array of possible interventions for children, adolescents and their families? Kazdin (2008) has raised questions about just how applicable and generalizable are the results of research studies on evidence-based treatment (EBTs) to everyday general clinical practice. Clinicians in social agencies are often confronted with clients who evidence more severe disorders, more co-morbid disorders and whose life experiences are more complex. Such stressful life circumstances often undermine treatment participation and contribute to treatment non-adherence.

In addition, there is a line of research that highlights that the most critical feature of these EBT interventions are not the specific treatment features of the proposed interventions, but rather the key proposed mechanism of change is the quality of the therapeutic alliance between the therapist and the client. Norcross (2002), Norcross et al. (2005) and Wampold (2001) highlight the finding that the therapeutic relationship accounts for a large proportion (approximately 30%) of the outcome variance in psychotherapy. The role of the therapeutic alliance is further underscored when culturally adapted mental health interventions are conducted with diverse ethnic and racial groups (see Comas-Diaz, 2006; Griner and Smith, 2006).

With this debate in mind, consider the following questions:

1. How should clinicians choose from the array of 550 treatment approaches?
2. Which treatments, and in which combinations, and with which clients, should be implemented and evaluated?
3. Should clinicians only be allowed or encouraged to use evidence-based treatments (EBT's)?
4. How much confidence should clinicians have in applying EBT's that were developed and tested with quite different populations than the populations they are working with?
5. How should these treatment interventions be individually tailored to the client's needs, strengths and preferences?

In my two presentations I will address these questions. More specifically, I intend to:

- (1) enumerate the Core Tasks of Psychotherapy/Counseling that provide evidence-based treatment guidelines and principles for clinicians and health care providers who work in social agencies;
- (2) provide a Case Conceptualization Model that informs assessment and treatment decision-making;
- (3) demonstrate how to implement these guidelines with children and adolescents and their families (parent training procedures); referred for treatment with externalizing (acting out) and/or internalizing (anxiety, depression) clinical problems.
- (4) discuss how to conduct risk assessment and how to assess for the presence of suicidality that often co-occurs with childhood acting out and depressive disorders.
- (5) consider how to conduct interventions with suicidal clients.

I have included a detailed discussion of these interventions as an accompanying handout that has been posted on the Melissa Institute Website (www.melissainstitute.org).

I will begin with a consideration of the **Core Tasks of Psychotherapy/Counseling**. Think of the best psychotherapist you have ever known. Or consider if you had a clinical problem, or a family member, or a dear friend had a clinical problem and he/she was experiencing marked distress, who would you recommend as a psychotherapist or counselor? Now consider what you think this “expert” therapist does that makes him or her so “effective”?

Here is my list of **Core Tasks of Psychotherapy**.

CORE TASKS OF PSYCHOTHERAPY: WHAT “EXPERT” THERAPISTS DO

1. Develop a collaborative **therapeutic relationship/alliance** and help the patient "tell" his/her story. After listening attentively and compassionately to the patient's distress and "emotional pain," help the patient identify "strengths" and signs of resilience. *"What did he/she accomplish in spite of ...?" "How was this achieved?"* Obtain the "rest of the story." Use Socratic Questioning.
 - i. Be culturally-sensitive in formulating interventions at the Universal, Selective and Indicated levels.
 - ii. Foster bonding and a therapeutic alliance. Address any ruptures or strains in the therapeutic alliance and address any therapy-interfering behaviors.
 - iii. Collaborate with the patient in establishing treatment goals and the means to achieve these goals. Encourage the patient's motivation to change and promote the patient's belief that therapy can help. Use Motivational Interviewing and treatment engagement procedures.
 - iv. Monitor the patient's participation and progress in therapy and use this information to guide ongoing treatment.

2. On an ongoing basis **educate** the patient about his/her problems and possible solutions. Also include an ongoing discussion of the treatment model. Include various ways to educate and nurture a sense of curiosity and discovery.
 - i. Conduct a Risk and Protective factors assessment and a Barriers analysis. Assess for culturally specific symptomatology and provide culturally sensitive feedback and interventions. Probe about the patient's problems and theory about what it will take to maintain any changes.
 - ii. Use a Case Conceptualization Model and share therapy rationale
 - iii. Have the patient engage in self-monitoring and conduct situational and developmental analyses
 - iv. Use videotape modeling films and other educational materials (simple handouts with acronyms)

- v. Use a “Clock Metaphor” – “Vicious Cycle” Model

| | |
|-------------------|--|
| 12 o’clock | external and internal triggers |
| 3 o’clock | primary and secondary emotions |
| 6 o’clock | automatic thoughts and images, thinking patterns and underlying beliefs and developmental schemas |
| 9 o’clock | behaviors and resultant consequences |

The psychotherapist can use his/her hand to convey the **Clock Metaphor** by moving his/her hand slowly from 9 o'clock around to 6 o'clock. The therapist can say:

“ It sounds like this is just a vicious... without finishing the sentence allowing the patient to interject “cycle or circle.” To which the therapist can say, “In what ways is this a vicious cycle?” “Are you suggesting...?”

The therapist can also ask questions that probe what the patient does with his/her emotions. View emotion as a “commodity” or as a set of feelings that one does something with such as stuff their feelings, explode and act out, withdraw and avoid.

The therapist can then ask:

“If you handle emotions in such a fashion, then what is the impact, what is the toll and what is the emotional and behavioral price that you are paying? Is that the way you want things to be? If not, then what can you do about it?”

This line of questioning sets the stage for the patient to recognize the need to break the “vicious cycle.” “How is he or she presently trying to break the cycle? What are better ways to break the cycle?”

- vi. The therapist models thinking: The psychotherapist can ask the client: *“In your day-to-day experience, do you ever find that you ask yourself the kind of questions that we ask each other right here?”*
- vii. Educate about relapse prevention strategies

3. Help the patient **reconceptualize** his/her "problem" in a more **hopeful** fashion.

- i. Conduct a life-review (time-lines). Help the patient identify "strengths."

Timeline 1- Birth to present Note the experience of any marked stressors (victimization experiences) and the nature and effectiveness of treatments

Timeline 2- Birth to present Note “strengths” and any *“In spite of” behaviors*. Use *“How”* and *“What”* questions to probe about signs of resilience and ways the patient can apply those skills to the present situation.

Timeline 3- Present into the future The objective is to have the patient adopt a problem-solving set. The psychotherapist can ask:

“How are things now in your life and how would you like them to be in the future?”

“What can we do to help you achieve your treatment goals of...? What have you tried in the past? What has worked and what has not worked as evidenced by...?”

“If we work together, and I hope we will, then how would we know you were making progress? What changes would someone else notice in your behaviors and in you?”

“Let me ask one final question, if I may. Can you foresee or envision anything that might get in the way, or act as a barrier or obstacle to your achieving your treatment goals of ...? What do you think could be done to anticipate and address such potential barriers so you do not get blind-sided down the road?”

- ii. Use collaborative goal-setting (short-term, intermediate, long-term goals)
 - iii. Use videotape modeling films
 - iv. Use letter-writing, journaling
 - v. Use group processes – open-ended groups
 - vi. Alumni clubs of successful patients (Coping models)
 - vii. Use helpful mentors and pro-social peers
4. Ensure that the patient has intra- and interpersonal **coping skills**.
- i. Highlight the discrepancies between valued goals, current behaviors and consequences. Consider what can be done to close this gap.

- ii. Train and nurture specific skills to the point of mastery
 - iii. Build in generalization guidelines – do not merely “train and hope” for transfer (Follow the specific steps of what you need to do to achieve generalization and ensure maintenance. *See Meichenbaum, 2004, pp. 334-341 and also the accompanying handout which is online at www.melissainstitute.org*)
 - iv. Put the patient in a consultative mode. The patient needs to explore, teach and demonstrate the acquired skills.
5. Encourage the patient to **perform "personal experiments"**
- i. Solicit commitment statements and self-explanations – reasons for change
 - ii. Involve significant others
 - iii. Ensure that the patient takes the "data" from his/her personal experiments as "evidence" to unfreeze his/her beliefs about self, the world and the future.
6. Ensure that the patient **takes credit** for change
- i. Use attribution training -- use metacognitive statements ("notice," "catch," "interrupt," "game plan").
 - ii. Nurture a sense of mastery and efficacy (*"In spite of ... How ..."*). Use the language of “becoming.”
 - iii. Monitor the degree to which the patient ascribes personal agency for change. Note the number of unprompted examples of where the patient has taken on the psychotherapist’s voice with him/her, especially the patient's use of active transitive verbs that reflect a sense of personal efficacy and mastery.
 - iv. Help the patient change his/her personal narrative or the “stories” he/she tells oneself and others.
7. Conduct **relapse prevention** – follow treatment guidelines on how to conduct relapse prevention (*See Meichenbaum, 2004, pp. 355-361*)
- i. Be sensitive to beliefs, interpersonal conflicts and barriers that may block improvement
 - ii. Consider the episodic nature of the patient's psychiatric disorder and anniversary effects
 - iii. Help the patient identify and learn to anticipate any high risk situations or external and internal triggers and help the patient develop coping strategies and back-up plans.

- iv. Consider family and peer factors that can both undermine and support change
- v. Consider the sequelae of ongoing stressors that need to be addressed

Additional Psychotherapeutic Tasks for Treating Psychiatric Patients With a History of Victimization

(Note that approximately 50% of psychiatric patients have a history of victimization.)

- 8) Address **basic needs** and **safety issues** and help the patient develop the tools for **symptom regulation** including treating symptoms of **comorbidity**
 - i. Treat the sequelae of PTSD and Complex PTSD
 - ii. Conduct an **integrated treatment** program, rather than sequential or parallel treatment programs
 - iii. Normalize, validate and reframe symptoms as a means of coping and as a form of survival processes, “Stuckiness” issue
- 9) Address **“memory work”** and help with changes in the patient's **after trauma belief system**
 - i. Consider various forms of “retelling” his/her trauma story -- A “restorying” process
 - ii. Relive by means of exposure-based and cognitive restructuring procedures trauma experiences. Help the patient contextualize his/her memories and learn to discriminate between “then and there” and “here and now” events. Help the patient integrate memories into an autobiographical account and develop coping procedures to deal with current stressors.
 - iii. Consider what implications (beliefs) the patient has drawn as a result of victimization experiences (*“What lingers from ...”; “What conclusions do you draw about yourself and others as a result of ...”*)
 - iv. Consider the impact of “shattered assumptions” and how to rescript narrative. Listen for

and employ the patient's metaphors

10) Help the patient **construct "meaning"** and take on this task as a personal "mission." (See Schok et al. 2008). Adopt a Constructive Narrative Perspective

- i. Consider what the patient did to "survive" and help the patient construct a positive meaning from the traumatic events. (See Park and Folkman, 1997).
- ii. What evidence of strengths and benefits to self and others
- iii. What "lessons" were learned that the patient can share with others – What can be salvaged from survivorship that the patient can make a "gift" to offer others? (Use Timeline 2 data and "In spite of" discussion)
- iv. What is the role of the client's faith (spirituality)

11) Help the patient **reengage life and reconnect with others**: Address the impact of trauma on family members and of significant others

- i. How to move beyond viewing oneself as a "victim" and becoming a "survivor," or even a "thrifer"
- ii. How to take on a proactive "helper" role
- iii. How to connect with **adaptive/supportive** peers and community resources

12) Address issues of possible "**revictimization**"

- i. Address issue of trust and forgiveness. Consider the nature of the lessons learned.
- ii. Help the patient develop safe and effective boundaries and healthy and safe relationships.
- iii. Ensure that the therapist monitors and addresses the impact of "vicarious traumatization" (VT), by means of using individual, social and systemic resources.

(See www.melissainstitute.org for discussion of ways to cope with VT)

One of the Core Tasks of Psychotherapy is the ability to formulate a **Case Conceptualization Model** that individually guides assessment and treatment decision-making. One of the things that the “expert” psychotherapist is likely to do is collaboratively co-construct an individualized treatment plan that matches the client's needs, situation, preference and treatment goals, thus maximizing the probability of therapeutic gain. This intervention plan needs to be culturally and racially sensitive.

The Case formulation is a descriptive and an explanatory summary of the client’s most important issues/problems, as well as risk and protective factors. In addition, the Case Conceptualization needs to consider any possible individual, social and systemic barriers that might undermine treatment. A well-formulated Case Conceptualization helps to give direction to the treatment plan. Without a Case formulation, the therapist is proceeding like a ship without a rudder, drifting aimlessly through the morass of 550 treatment options (see Persons, 1989).

The essential components of the present Case Conceptualization include:

1. Relevant background information and referral information.
2. Current presenting problems and current symptoms and their sequelae. These symptoms/problems are considered from a life-span perspective.
3. Co-morbid disorders (present/past) and their sequelae.
4. Current and past stressors for the client and family members.
5. Current and past treatments received with information as to treatment efficacy, adherence and patient satisfaction.
6. Evidence of client and family strengths and signs of resilience.
7. Consideration of treatment options and specifiable treatment objections (short-term, intermediate and long-term goals).
8. Possible individual, social and systemic barriers.

GENERIC CASE CONCEPTUALIZATION MODEL

One of my major clinical activities is to consult at various psychiatric hospitals, residential settings for adolescents, VA hospitals, and rehabilitation centers for individuals with Traumatic Brain Injuries (TBI). In each of these settings I am going to be asked to interview the most difficult and challenging patients, who often have a history of suicidal behavior. First, however a Case presentation is conducted where all the Health Care Providers will come together and share relevant clinical information and then they adjourn to watch the interview from behind a one-way mirror.

I needed some way to summarize the plethora of information and to ensure that the staff presented the “full story” of risk and protective factors and information that can guide clinical decision-making. The following multi-component Case Conceptualization Model (CCM) is one that I have found helpful. The CCM provides a means for me to share, not only with the staff, but also with the patient (see Feedback sheet) the results of the assessment interview.

The staff can keep Progress Notes indicating how they intend to develop a treatment plan. For example, using the CCM of Boxes described below, the therapist can code the sequence of clinical interventions, namely, 2A (Focus on presenting problem) and reducing risk with the help of the family (6B), while anticipating possible treatment delays (9C). In fact, I often point out to the staff that the CCM reduces their entire professional activities to one page. There is nothing that they do that is not codable. See Meichenbaum (2004) for a fuller description of the CCM and also the accompanying piece on the website www.melissainstitute.org for an example of how the CCM can be employed with juvenile offenders.

FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see **if I understand:**

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

“What brings you here is...? (distress, symptoms, present and in the past)
 “And it is particularly bad when...” “But it tends to improve when you...”
 “And how is it affecting you (...in terms of relationships, work, etc)”

BOX 3: COMORBIDITY

“In addition, you are also experiencing (struggling with)...”
 “And the impact of this in terms of your day-to-day experiences is...”

BOX 4: STRESSORS

“Some of the factors (stressors) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... consider Current ecological stressors
 “And it's not only now, but this has been going on for some time, as evidenced by...” (Developmental stressors)
 “And it's not only something you have experienced, but your family members have also been experiencing (struggling with)...” “And the impact on you has been...” (consider Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

“For these problems the treatments that you received were...”-note type, time, by whom
 “And what was most effective (worked best) was... as evident by...”
 “But you had difficulty following through with the treatment as evident by...” (Obtain an adherence history)
 “And some of the difficulties (barriers) in following the treatment were...”
 “But you were specifically satisfied with...and would recommend or consider...”

BOX 6: STRENGTHS

“But in spite of...you have been able to...”
 “Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are...”
 “Moreover, some of the people (resources) you can call upon (access)are...” “And they can be helpful by doing...” (consider Social supports)
 “And some of the services you can access are...” (Systemic resources)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

“Have I captured what you are saying?”
 (Summarize risk and protective factors)
 “Of these different areas, where do you think we should begin?” (Collaborate and negotiate with the patient about a possible treatment plan.
 Do not become a “surrogate frontal lobe” for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

“Let's consider the following. What are your expectations about the treatment? As a result of our working together, what would you like to see change (in the short- term)?” The therapist can ask the following questions.
 “How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?”
 “What has worked for you in the past?”
 “How can our current efforts be informed by your past experience?”
 “Moreover, if you achieve your goals, what would you see changed ?”
 “Who else would notice these changes?”

BOX 9: POSSIBLE BARRIERS

“Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way- any possible obstacles or barriers to your achieving your treatment goals?”
 (Consider with the patient possible individual, social and systemic barriers
 Do not address the potential barriers until some hope and resources have been addressed and documented.)
 “Let's consider how we can anticipate, plan for, and address these potential barriers.”
 “Let us review once again...” (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words.
 Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback.
 Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc) Maintain progress notes and share these with the patient and with other members of the treatment team.

As discussed in my accompanying handout that appears on the www.melissainstitute.org Website, a key aspect of the **Case Conceptualization Model** is the need for **Risk Assessment** toward others, as well as toward oneself (suicidal potential). The accompanying handout is a paper I will be giving at the Suicidology Conference. It summarizes the lessons I have learned over 35 years of clinical practice working with suicidal adolescents and adults. It focuses on both assessment and intervention strategies and highlights how clinics and social agencies need to be vigilant and responsible in screening for suicidal potential in their clients.

See Accompanying Handout

35 Years of Working with Suicidal Patients: Lessons Learned

Contents Include:

- 1. Incidence of suicide (Adults, Adolescents, College Students)**
- 2. A Constructive Narrative Perspective of Suicide**
- 3. Assessment of Suicidal Ideation and Suicidal Behavior**
- 4. Clinical Interventions with Suicidal Patients**

A second accompanying handout to be found on www.melissainstitute.org is entitled **Treatment of Children and Adolescents with Behavioral (Externalizing) and Emotional (Internalizing) and Co-morbid Disorders.**

Contents covered in the Handout include:

- 1. Cognitive-behavioral model of treatment**
- 2. Case Conceptualization Models**
- 3. Assessment of aggressive behavior in children and adolescents**
- 4. Cognitive-behavioral treatment with aggressive children and adolescents**
- 5. Guidelines for achieving Treatment Generalization**
- 6. Parent training and interventions for parent-adolescent conflict**
- 7. Assessment and treatment of childhood and adolescent depression**
- 8. Assessment and treatment of victimized children**

COGNITIVE-BEHAVIORAL APPROACH TOWARD UNDERSTANDING PARENT-CHILD INTERACTIONS

A way to analyze the parents' reports of their child's or adolescent's distressing misbehaviors.

The psychotherapist needs to listen in a nonjudgmental and empathetic fashion to the parents' account of their family situation. But at the same time, the therapist needs to have a theoretical framework in mind of the component features of their account. The following description provides a useful heuristic framework for such an analysis.

I. An analysis of an anecdote: Toward a conceptual model for assessment and intervention

The analysis begins with a consideration of the Parents' **Behavioral Repertoire**

- Personal and family goals
- Behavioral competence to meet their goals. Do the parents evidence a skills deficit or a performance deficit (skills in their repertoire, but factors get in the way of implementation)?
- Role of parental expectancies
- Knowledge-base (declarative, strategic, conditional – if-then rules)
“What advice can you give to other parents to achieve such goals?”
- Role of potential barriers to achieve goals (intra, interpersonal, familial, societal barriers). Use Barrier Scales in assessment.

II. Consider bi-directionality of behavioral incident (Not only do parents affect children, but children affect parents – two-way street)

1. Ask circular questions to tap the interactive systemic behavioral chain of events. *“You did what and then what happened and then ...?”*
2. Listen for descriptions of coercive interpersonal cycles and potential barriers to change
3. Watch for triggers and for sequence patterns. Behavioral interpersonal “scripts”

III. Consider the role of the thoughts and feelings that precede, accompany and follow prototypic stressful family encounters. Attend to the role of cognitive events, cognitive processes and cognitive structures.

1. **Cognitive Events** – automatic thoughts and images that precede, accompany and follow events. Dripping with affect and are “hot cognitions.” Characteristic of cognitive events – appear to occur automatically, emotionally-charged, may reflect immediate reactions or convey “old

anger” and response to previous triggers. Such thoughts are rarely questioned. Taken as truthful, God-given assertions! The Primary Appraisal process is one of a personal provocation, threat, personal slight, and this behavior by their child was done “on purpose” – attribution of intentionality. See one’s responses as justified and see self as a “victim.”

Use a phenomenological approach to tap the role of “hot cognitions,” namely use the Art of Questioning (Socratic questioning, play “Columbo-like character --ask a lot of “What” and “How” questions. Stay away from “Why” questions. Use imagery reconstruction procedures (use videotalk). Use direct observation in home or in clinic.

2. **Cognitive Processes** -- styles of thinking, ruminative processes of not letting go, attributions of intentionality (“He did it on purpose”) and mental habits or “mental heuristics” that are emotionally-driven. Emotions act like a “channel selector” for present and past – availability and salient heuristics and confirmatory bias. Attend to the role of cognitive distortions – such as dichotomous thinking, over generalization, selective abstraction. Thoughts become “commandments” -- “Tyranny of shoulds and musts.” Role of personal beliefs that reflect cognitive structures and schemas.

Attend to the role of meta-emotions and meta-cognitions. Personal theory about child’s behaviors and what it will take to change behaviors. Also, attend to meta-cognitions or thoughts about one’s thinking processes. Problem-solving capacity to view perceived threats as problems-to-be-solved. Evidence of executive and emotional regulation skills – empathy, perspective-taking, decentering perceptions, compassion and the like. Revisit issue of parent goals and where these goals come from. (Developmental history and family-of-origin issues.)

3. **Cognitive Structures** – nature of the personal, familial and cultural schemas and beliefs that “drive” their behaviors. These are the Core Organizing Principles (COPS) and accompanying behavioral, cognitive and emotional “**scripts**” and “**if ... then**” rules.

How to tap cognitive structures?

1. Pick a prototypic stressful interpersonal event and elicit the “story.”
2. Reflect key affective features and then conduct situational analysis – “*Where else did the individual or family experience similar feelings and have similar reactions? How long has this been going on?*” Conduct a developmental analysis. Ask clients, “*What is common, if anything, across these many situations?*” To which the client is likely going to answer, “*I don’t know!*” The therapist can respond: “*I don’t know either. How can we go about finding out? And moreover, how will finding out help you achieve your goals of X?*”

This line of Socratic questioning lays the groundwork for clients to collect data and self-monitor. (See Meichenbaum's Handbook on Anger-control for a discussion of how to help parents self-monitor.)

Review common themes that characterize cognitive structures that parallel dominant emotions. These may include:

Anger/Aggressive – issues of fairness, equity, justice, “respect,” entitlement, and interpersonal control. Ruminates about “getting even”

Depression/Sadness/Withdrawal – issues of hopelessness, helplessness, fear of possible rejection, preoccupation and rumination about perceived losses, and moreover, things that are not likely to improve nor change. Too many obstacles!

Anxiety/Avoidance – issues of loss of personal control and perception of threat – triggers or reminders from the past and fear of future possible threats, low sense of efficacy. Hypervigilant and sense of “looming vulnerability.” Role of cognitions in perpetuating chronic difficulties

Note: Client may have mixed emotions and some emotions such as anger may be a secondary emotion, where the primary emotions are feeling humiliated, guilty, embarrassed and disrespected (dissed). Or the client may become depressed about being anxious.

IV. Putting It All Together

The therapist can reflect to the client or family (“recast their story”) using a **Clock Metaphor** that highlights the interconnections between perceived triggers, primary and secondary emotions and accompanying thoughts, behavioral acts and resultant consequences.

Use a Clock metaphor – “Vicious circle” or “Vicious cycle”

12 o’clock – External and Internal Triggers

3 o’clock – Primary and Secondary Emotions

6 o’clock – Cognitive Events (automatic thoughts, “hot cognitions”); Cognitive processes – (thinking habits and styles of thinking with accompanying meta theories); Cognitive structures (core beliefs, schemas with accompanying if-then rules)

9 o’clock – Behaviors and reciprocal bi-directional consequences from others

Vicious Cycle or Vicious Circle

Use the Clock Metaphor to reframe the client's (families’, groups’) reactions as consisting of the four interdependent elements of triggers, emotions, cognitions and behaviors. Encourage clients to collect data that this clock process indeed occurs and then collaboratively consider implications for change efforts. See if you can have clients come up with the need to **“Break the cycle.”** *You are at your “therapeutic best” when your clients are one-step ahead of you offering the observations or suggestions that you, the helper, would otherwise offer. Nurture self-efficacy and client participation in treatment.*

In order to assist the client in coming up with the suggestion to **“Break the cycle”**, the psychotherapist can demonstrate the concept of the **Clock Metaphor** by specifying with hand motions the components of 12 o'clock (triggers), 3 o'clock (primary and secondary emotions), 6 o'clock (thinking process), and 9 o'clock (behaviors and resultant consequences). Once the psychotherapist has obtained examples and elaborations from the client (or family members) of each of these component processes, the psychotherapist can place his/her hand at 9 o'clock (on his imaginary clock) and then slowly move his/her hand around to 6 o'clock and say, ***“It sounds to me, and correct me if I am wrong, it is just a vicious...”*** (and the psychotherapist should not finish the sentence. There is a high likelihood that the client will finish the sentence and say “vicious circle” or “vicious cycle.” If the psychotherapist's hand reaches 6 o'clock and the client has not answered, then the psychotherapist can say “vicious cycle.”

This **Clock Metaphor** can be used with families, highlighting for them, how they often get caught up in similar bi-directional cycles. ***“If they do so, as they describe, then what can be done?”*** The implicit assumption is that they need to learn better ways to break such cycles; they need to learn to anticipate when these cycles are likely to occur; notice warning signs and nip the cycle in the bud; consider how they now go about breaking such cycles and whether this is the best way to proceed. Thus, the use of the **Clock Metaphor** lays the ground work for psychotherapeutic interventions.

In addition, the therapist can ask the client ***“What he or she does with all of their feelings?”*** View the 3 o'clock primary and secondary emotions as “commodities” that one does something with (for example, stuff his/her feelings, let the feelings blow, avoid situations, drink them away). The therapist can then ask the client: ***“If he/she does X with his or her feelings, then what is the impact, what is the toll, what is the price he or she (or others) is paying for handling his/her emotions in such a fashion?”*** If the client answers, ***“I don't know”***, then the psychotherapist can answer, ***“I don't know either, and how can we go about finding out? Moreover, how will finding out help us better figure out how to help you achieve your treatment goals of X, Y, and Z (be specific)?”***

Behind each question is a supposition that there is an answer, namely, an impact, a toll, a price that is being paid. The therapist and client can work to discover and/or co-construct such answers.

After having collected such data that supports the **Clock Metaphor** with multiple examples, the psychotherapist can ask, ***“If you (the client) are engaging in a vicious cycle, as you describe, then what can be done?”*** The client may answer, ***“I need to break the cycle,”*** to which the therapist can reply ***“Break the cycle? What did you have in mind? How are you now going about breaking the cycle?”*** ***Psychotherapy consists of learning and practicing better ways to break the “cycle” that you describe and experience.***

V. Consider Different Ways to Help Clients Break the “Vicious Cycle”

1. Ask the clients how they have tried to “break the cycle” in the past in order to achieve their goals. How has it worked? Check out the data.
2. Also, the psychotherapist and the clients can use the **Clock Metaphor** to address examples of positive behaviors that reflect “signs of resilience.” Together the psychotherapist and clients can consider the implications for change.

Ask the client(s):

“What are the goals of treatment?” “In other words, what do I (the therapist) exactly do for a living? The answer is really quite straightforward. I work with clients like yourself, to find out how things are right now in their lives and how they would like them to be.”

“In order that our current efforts can be informed, I ask clients what have they tried in the past to get what they want; to achieve their goals.”

“What has worked? What has not worked?”

“How could you tell if it was working?”

“How did that make you feel?”

“What things, if any, got in the way of your doing Y?” (Consider intra and interpersonal barriers.)

“If we work together and I hope we do, how would we know if you were making progress? What would change? Who else would notice these changes?” (Nurture collaborative “We” goal-setting.)

“Can you foresee or envision any barriers, obstacles that might get in the way of your working on achieving Y? What can we do to anticipate and to plan for such potential barriers so you do not get blindsided?”

Don’t rush through these questions. They evolve. Note the widespread use of “what” and “how” questions and the use of we. You can also pose to clients the following questions to nurture “internalization” or increase the likelihood that the client(s) will “take your voice with them.” As therapy progresses, the therapist can ask:

“Let me ask you a different 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?”

Note the therapist is modeling and having clients take on a style of thinking.

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