CHAPTER

14

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The Three Steps of Stage II

In many ways Stages II and III together with the action arrow are the most important parts of the helping model because they are about "solutions." It is here that counselors help clients develop and implement programs for constructive change. The payoff for identifying and clarifying both problem situations and unused opportunities lies in doing something about them. The skills needed to help clients do precisely that—engage in constructive change—are reviewed and illustrated in Stages II and III. In these stages, counselors help clients answer the following two commonsense but critical questions:

What do you want?
and
What do you have to do to get what you want?

Problems can make clients feel hemmed in and closed off. To a greater or lesser extent, they have no future, or the future they have looks troubled. But, as Gelatt (1989) notes, "The future does not exist and cannot be predicted. It must be imagined and invented" (p. 255). The steps of Stage II outline three ways in which helpers can partner with their clients in exploring and developing this better future.

Step II-A: Possibilities. "What possibilities do I have for a better future?" "What are some of the things I think I want?" "What about my needs?" Counselors, in helping clients ask themselves these questions, help them develop a sense of hope.

Step II-B: Choices. "What do I really want and need?" Here clients craft a viable change agenda from among the possible choices. Helping them design and shape the right goals is the central task of helping.

Step II-C: Commitment. "What am I willing to pay for what I want?" Help clients discover incentives for commitment to their change agenda. It is a further look at the economics of personal change.

Figure 14-1 highlights these three steps of the helping process. Without minimizing in any way what counselors can help their clients accomplish through Stage I skills and interventions—that is, problem and opportunity clarification; the development of new, more constructive perspectives of self, others, and the world; and the choice of high-leverage issues to work on—the real power of helping lies in helping clients set goals and move to accomplish them.

Solution-Focused Helping

O'Hanlon and Weiner-Davis (1989) claimed that a trend "away from explanations, problems, and pathology, and toward solutions, competence, and capabilities" (p. 6) was emerging in the helping professions. An earlier study showed that clients were interested in solutions to their problems and feeling better, whereas many helpers were concerned about the origin of problems and transforming them through insight (Llewelyn, 1988). Solution-focused therapies (Berg, 1994; de

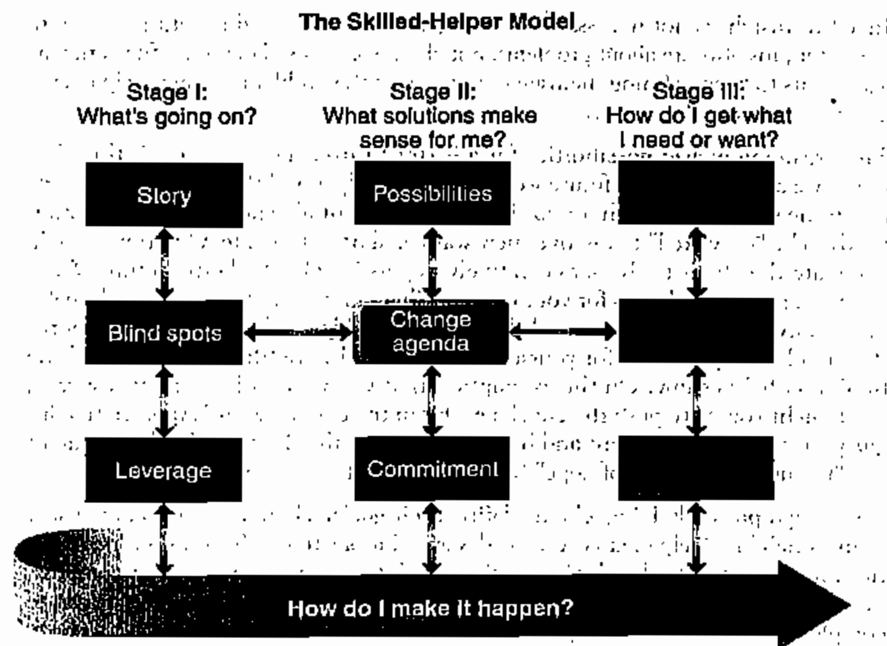

FIGURE 14-1
The Helping Model—Stage II

Shazer, 1985; Fish, 1995, 1997; Manthei, 1998; Metcalf, 1998; Miller, Hubble, & Duncan, 1996; Murphy, 1997; O'Connell, 1998; Walter & Peller, 1992; Zimmerman, Prest, & Wetzel, 1997) tackle this disconnect. Even today too many approaches to helping still focus on Stage I activities. Too many helper training programs still emphasize—or overemphasize—the exploration methods of Stage I. Communication skills are required in every approach to helping, but limiting their use to Stage I endeavors is a waste. Intensive discussion of problem situations is often based on a "working through" mentality, whereas action or "solution" approaches are based on the assumption that many problems need to be dealt with or even "transcended" rather than worked through. At any rate, the goal of helping, as stated in Chapter 1, is "problems managed," not just "problems explored and understood," and "opportunities developed," not just "opportunities identified and discussed."

Solution-Focused Therapies, Brief Therapy, and Appreciative Inquiry

Solution-focused therapies, brief therapy (Bloom, 1997; Cade & O'Hanlon, 1993; Cooper, 1995; Matthews & Edgette, 1999; Frieman, 1997; Hoyt, 1995; Preston, 1998; Ratner, 1998), and an approach to problem management and opportunity development called "appreciative inquiry" (Cooperrider & Srivasta, 1987; Zemke,

1999) have a common philosophy and approach to helping that is similar to the approach taken in this book. Each in its own way is a problem-management and, especially, opportunity-development approach. For instance, appreciative inquiry (Zemke, 1999) has the following four stages or steps:

- Discovery: What gives life? Help the clients identify past and current successes, strengths, and resources.
- Dreaming: What might be? Help the client identify possibilities for a better future.
- Design: What's the ideal? Help the client design outcomes, mapping out how the client's life will look in the areas of concern.
- Delivery: How do I move forward? Help the client find and implement the best way to realize the future he or she has designed. Some now call this stage "destiny," meaning that the client who finds his or her own power is now in charge of his or her own destiny.

The words are different but the process is more or less the same as the problem-management and opportunity-development model.

Here is a quick overview of what these approaches have in common. You have already seen and will see more of the philosophy, spirit, and methods outlined here. The following is a bit staccato-ish. It is meant to give you the flavor of a philosophy and approach that is common to these three positive-psychology approaches to helping.

Philosophy. In relating with clients, focus on resources rather than deficits, on success rather than failure, on credit rather than blame, on solutions rather than problems. Use common sense. Don't let theory get in the way of helping clients.

View of clients. Clients are people like the rest of us. See them as people with complaints about life, not symptoms. Don't assume that they will arrive ambivalent about change and resistant to therapy. Clients have a reservoir of wisdom, learned and forgotten but still available. Clients have resources and strengths to resolve complaints. Clients will have their own view of life just as everyone else. Respect the reality they construct, even though they might have to move beyond it. In a way, clients are experts in their own lives. Help them feel competent to solve their own problems. When helpers see clients as problems to be solved, they impoverish them and take away their power.

Dealing with the past. There is no escape from past trauma. It did happen. However, if you help clients dwell on it, they will become captives of it. If fact, many will arrive as captives. They need to liberate themselves from the past. That said, clients should get an organized or integrated view of past bad experiences, but they should not go into origins and causation. Looking for deep, underlying causes for symptoms is a mistake. Focus on the client's ability to survive a problem situation. Getting at causes does not usually resolve a complaint. Resolving the complaint resolves it. Nonetheless, clients have more confidence and comfort in their journey to the future when they carry forward parts of the past. The best things they can bring forward are past successes, what they have done that works. If clients carry

part of the past forward, it should be what is best about the past. As Bushe (1995) sees appreciative inquiry (and by extension, brief therapy and solution-focused therapy), as an attempt to generate a collective image of a new and better future by exploring the best of what is and has been.

The role of the helper. Helpers are consultants, catalysts, guides, facilitators, assistants. By adopting the client's world view, at least temporarily, helpers can lessen reluctance and resistance. Sharing highlights helps demonstrate your understanding of the client's world. Your job is to notice and amplify life-giving forces within the client and any sign of constructive change. Become a detective for good things. Develop an "appreciative ear." Listen to the problem, but listen even more to the opportunity buried within the problem. Use questions that inspire and encourage the client to give positive examples. Questions should stimulate dialogue. Remember that questions are not just questions, they are interventions.

The discovery phase: helping clients explore and exploit competencies, successes, and "normal times." Help them identify ways of thinking, behaving, and interacting that have worked in the past. And, since clients are not continually manifesting problem behavior, help them explore the times when they are free of such behavior. The "free" times point toward solutions. Help them identify what has been working during these misery-free periods and capitalize on it. How can they amplify what has been working? Have them recall successes from the past—for instance, when they have handled disagreements more creatively. When your marriage was good, what was it like? What did you do when you successfully resisted the urge to drink? Catch clients being competent and resourceful and help them take a good look at themselves at such times. Notice competencies revealed in a client's story and behavior. There are things that work in every client. Recognize and discuss these competencies because they are strengths that clients can build on. What is the client like when performing well?

The nature of problems and how we talk about things. Clients, like the rest of us, become what they talk about. If you always encourage them to talk about problems, they run the risk of becoming "problem people." Then helping turns into remedying pathology and deficits. What clients focus on becomes their chronic reality. Help them see their problems as "complaints." We all have complaints. In other words, help them "normalize" their problems—they are the ordinary difficulties of life. For instance, overeating is showing too much enthusiasm for the wonderful texture, taste, and comfort of food. Hyperactivity is energy that at times gets the better of us and interferes with rest, relaxation, and relationships. A perfectionist is a person who loves quality but who goes too far. Help clients see problems as external to themselves, not things that define and control their lives. Problems are intruders that get the best of us at times. Problems are complaints that bother us rather than define us. Ordinarily, you don't need to know a great deal about complaints to resolve them. So be careful about the questions you ask. They should not keep clients mired in problem talk, because problem talk can keep clients immersed in frustration, impotence, and even despair.

Insight. Insight is not necessary for change. Therefore, avoid insight generation. Too often, insights are about problems, not about solutions. Therefore, they encourage clients to keep defining themselves in terms of the problem. Rather, help clients generate "outcome" scenarios.

The dreaming phase: possibilities for a better future. The principle is this: The future we anticipate is the future we create. The helper and the client should partner in the systematic search for possibilities and potential. The client's imagination needs to be "provoked" to discover new ways of approaching life. Questions should stimulate the client to think as creatively as possible about a better future: What images capture your hopes for your future? What can you do to keep these hopeful images alive? If you no longer needed help, how would that show up in your actions? If you did the right thing for yourself this week and were filmed, what would the film's highlights show? On the assumption that you would like to move forward, what might you do to push the envelope a bit in the coming week? Appreciative inquiry aims at engaging client and helper in dialogue that leads to the development of a "textured vocabulary of hope" (Ludema, Wilmot, & Srivasta, 1997).

The design phase: helping clients define their goals. There is no one correct way to live one's life. Help clients actively design solutions that will turn their possibilities into opportunity-developing realities. Solutions do not have to be complex, even if the problem is complex. Rather, help clients to look for simple solutions to complex problems. Often only small changes are necessary. Nor do solutions have to take care of everything. Troubles don't have to be totally solved. Help clients find systemic solutions. A change in one part of the system can produce good results in another part of the system. Look for interventions that break up patterns of self-limiting behavior. Don't hesitate to design solutions that get rid of symptoms. Getting rid of symptoms is not shallow, useless, or dangerous. Solutions should include clients' ability to grapple with future problems on their own. Clients should leave therapy with identified tools to do so.

The delivery phase: implementation is everything. The pace of change will be different for each client. Some need help to ease themselves into solutions gradually. The smallest action is a step forward. On the other hand, rapid change is possible. Don't shortchange clients. Solutions often require that clients develop new ways of relating to their social environment. Where will support come from? Who needs to be engaged to make things work?

Recall that the helping model outlined in this book can be used as a browser to identify and integrate frameworks, methods, and skills in other approaches to helping. Simple Internet searches in solution-focused therapies, brief therapy, and appreciative inquiry will reveal a world of insights, frameworks, methods, and skills that you can integrate into the overall problem-management and opportunity-development framework.

Criticisms. There have been some criticisms of this positive-psychology approach to helping (see Zemke, 1999, and the excellent Comment section of the *American Psychologist*, January, 2001, pp. 75–90). For instance, some say that it runs the risk of being a "don't worry, just be happy" approach. That it's too pie-in-the-sky. Others

say, let's get real. Change comes from dealing with problems. People are used to dealing with problems, so this approach might be too new for some practitioners and some clients.

On the other hand, traditional problem-solving approaches to helping also come in for their knocks (Zemke, 1999). Critics say that traditional approaches are painfully slow, asks the client to look back at yesterday's failures, looks for the causes of problems, rarely results in a new vision, assumes that either the helper or the client knows what should be in place and therefore leads to talk about closing gaps, places blame and therefore promotes defensiveness, and uses deficit-focused language.

However, wedding the positive-psychology approach of solution-focused therapies to a problem-management and opportunity-development approach to problem solving faces down all these criticisms. There is no question of either/or. The interplay of the two philosophies provides the most robust system. The problem-management and opportunity-development approach provides the backbone of helping. But the use of its stages and steps are dictated by client need. The solution-focused philosophy gives direction to *how* clients and helpers partner in using these stages and steps. Flexibility is the key. The arbiter is common sense and social intelligence. Do what is best for the client.

Solutions Versus Solutions

This book offers a solution-focused approach to helping. There is, however, a semantic problem with the word *solution*. It means two distinct things. First and foremost, it means an end state—results, accomplishments. Take Pinta. Her eating was out of control. She was killing herself with food. But now she is eating moderately and has lost a lot of weight. A new approach to eating is in place. This is a solution in the end-state sense. *Solution* also means a strategy a client uses to get to the end state. For instance, Pinta joined a 12-step program for overeaters and faithfully attends the meetings. "My eating is out of control," she said at the first meeting. In the group, she learned a variety of ways to get back in control of her eating. Joining the group and using the strategies she learned in the group were solutions in the second, instrumental sense. They are activities or strategies that helped her get to the end state she now enjoys. Stage II of the helping process deals with solutions in the primary sense—end states, accomplishments, goals, outcomes. Stage III focuses on solutions in the secondary sense—means, actions, strategies.

The distinction is not inconsequential. Many approaches to problem solving confuse the two. Or they pay little attention to solutions as end states—what clients really want and need—and talk mostly about solutions in terms of the strategies clients must use to "solve" problems. They leap from problem or unused opportunity to action without linking action to outcome. The correct logic is this: Link solutions-as-goals to problem situations or unused opportunities. Pinta's problem is overeating. Her solution-as-goal is "a fitness program consisting of healthy exercise and nutritional habits consistently in place." Her solution-as-means is the 12-step group together with the self-regulation strategies it sponsors. Goals, not problems, should drive action.

The Beneficial Effects of Brief Therapy

Brief therapies are of their very essence solution focused. If there is little time, most of it had better be spent focusing on a better future. In fact, many books and articles on brief therapy have "solution-focused" in their titles and vice versa. Research has demonstrated that brief interventions can produce substantive changes that last. And solution-focused therapists like to work with fairly well-defined goals that are realizable within a reasonable amount of time. Brief therapy can be brief but still comprehensive (Lazarus, 1997). Asay and Lambert (1999), after reviewing the research on brief therapy, drew the following conclusions:

> The beneficial effects of therapy can be achieved in short periods (5 to 10 sessions) with at least 50% of clients seen in routine clinical practice. For most clients, therapy will be brief. . . . In consequence, therapists need to organize their work to optimize outcomes within a few sessions. Therapists also need to develop and practice interventions methods that assume clients will be in therapy for fewer than 10 sessions. (p. 42)

They also found that there are three categories of clients who do poorly in brief therapy. First, poorly motivated and hostile clients: Therapists who have the skills of handling resistance and know something about "motivational interviewing" have a better chance of success with such clients. Second, clients who come with a history of poor relationships: The helper's ability to establish a collaborative working alliance that is a "just society" is very important with this type of client. Third, clients who expect to be passive recipients of a medical procedure: Helping such a client quickly find a sense of self-responsibility and agency, however deeply buried, is the helper's challenge. Strategies for doing all of this are found in the pages of this book. Of course, not all helping should be brief. Some 20% to 30% of clients require treatment lasting more than 25 sessions.

Helping Clients Discover and Use Their Power Through Goal Setting

Goal setting, whether it is called that or not, is part of everyday life. We all do it all the time.

> Why do we formulate goals? Well, if we didn't have goals, we wouldn't do anything. No one cooks a meal, reads a book, or writes a letter without having a reason, or several reasons, for doing so. We want to get something we want through our actions or we want to prevent or avoid something we don't want. *These desires are beacons for our actions;* they tell us which way to go. When formalized into goals, they play an important role in problem solving. [emphasis added] (Dorner, 1996, p. 49)

Even not setting goals is a form of goal setting. If we don't name our goals, that does not mean that we don't have any. Instead of overt goals, we have a set of covert goals. These are our default goals. They may be enhancing or limiting. We don't

like the sagging muscles and flab we see in the mirror. But not deciding to get into better shape is a decision to continue to allow fitness to drift. Since life is filled with goals—chosen goals or goals by default—it makes sense to make them work for us rather than against us.

At their best, goals mobilize our resources; they get us moving. They are a critical part of the self-regulation system. If they are the right goals for us, they get us headed in the right direction. According to Locke and Latham (1984), helping clients set goals empowers them in the following four ways.

Goals help clients focus their attention and action. A counselor at a refugee center in London described Simon, a victim of torture in a Middle Eastern country, to her supervisor as aimless and minimally cooperative in exploring the meaning of his brutal experience. Her supervisor suggested that she help Simon explore possibilities for a better future. The counselor started one session by asking, "Simon, if you could have one thing you don't have, what would it be?" Simon came back immediately, "A friend." During the rest of the session, he was totally focused. What was uppermost in his mind was not the torture but the fact that he was so lonely in a foreign country. When he did talk about the torture, it was to express his fear that torture had "disfigured" him, if not physically, then psychologically, thus making him unattractive to others.

Goals help clients mobilize their energy and effort. Clients who seem lethargic during the problem-exploration phase often come to life when asked to discuss possibilities for a better future. A patient in a long-term rehabilitation program who had been listless and uncooperative said to her counselor after a visit from her minister, "I've decided that God and God's creation and not pain will be the center of my life. This is what I want." That was the beginning of a new commitment to the arduous program. She collaborated more fully in exercises that helped her manage her pain. Clients with goals are less likely to engage in aimless behavior. Goal setting is not just a "head" exercise. Many clients begin engaging in constructive change after setting even broad or rudimentary goals.

Goals provide incentives for clients to search for strategies to accomplish them. Setting goals, a Stage II task, leads naturally into a search for means to accomplish them, a Stage III task. Lonnie, a woman in her seventies who had been described by her friends as "going downhill fast," decided, after a heart-problem scare that proved to be a false alarm, that she wanted to live as fully as possible until she died. She searched out ingenious ways of redeveloping her social life, including remodeling her house and taking in two young women from a local college as boarders.

Clear and specific goals help clients increase persistence. Not only are clients with clear and specific goals energized to do something, but they also tend to work harder and longer. An AIDS patient who said that he wanted to be reintegrated into his extended family managed, against all odds, to recover from five hospitalizations to achieve what he wanted. He did everything he could to buy the time he needed. Clients with clear and realistic goals don't give up as easily as clients with vague goals or with no goals at all.

One study (Payne, Robbins, & Dougherty, 1991) showed that high-goal-directed retirees were more outgoing, involved, resourceful, and persistent in their social settings than low-goal-directed retirees. The latter were more self-critical, dissatisfied, sulky, and self-centered. People with a sense of direction don't waste time in wishful thinking. Rather, they translate wishes into specific outcomes toward which they can work. Picture a continuum. At one end is the aimless person; at the other, a person with a keen sense of direction. Your clients may come from any point on the continuum. Taz knows that he wants to become a better supervisor but needs help in developing a program to do just that. On the other hand, Lolita, one of Taz's colleagues, doesn't even know whether this is the right job for her and does little to explore other possibilities. One client can be at different points on the continuum with respect to different issues—mature in seizing opportunities for education, for instance, but aimless in developing sexual maturity. Most of us have had directionless periods at one time or another in life.

Setting goals, whether formally or informally, provides clients with a sense of direction. People who have a sense of direction

- have a sense of purpose;
- live lives that are going somewhere;
- have self-enhancing patterns of behavior in place;
- focus on results, outcomes, and accomplishments;
- don't mistake aimless action for accomplishments;
- have a defined rather than an aimless lifestyle.

Locke and Latham (1990) pulled together years of research on the motivational value of setting goals. Although the motivational value of goal setting is incontrovertible, the number of people who disregard problem-managing and opportunity-developing goal setting and its advantages are legion. The challenge for counselors is to help clients do it well.

There is a massive amount of sophisticated theory and research on goals and goal setting (Karoly, 1999; Locke & Latham, 1990, 1994) As you can well understand, not all theory and research is easily translated into practical advice for helpers. There is also an extensive self-help literature dealing with goal setting and implementation in everyday life (for instance, D. Ellis, 1999; K. Ellis, 1998; Secunda, 1999). There is a great deal of practical wisdom to be mined from the self-help literature, and helpers-to-be would be doing themselves a disservice if they were to turn their noses up at it. Once more, balance is the answer. The best in theory and research should be used to spot the best practical advice for both helpers and clients in the popular literature.

Helping Clients Become More Effective Decision Makers

The second overall goal for helping—outlined in Chapter 1—is to help clients, either directly or indirectly, become better problem solvers and opportunity developers in their everyday lives. Since the encouragement of client self-responsibility is a

key helping value, helping clients not only make good decisions but also become better decision makers is not an amenity but a necessity. Consider this case:

> Alice's third marriage has just ended. A counselor is helping her explore the decisions she has made in developing and dissolving intimate relationships. Alice discovers that she makes poor decisions about people in general—for instance, by being too trusting too soon. Although she is horrified by all the mistakes she has made, she realizes that without these sessions, she might well make the same mistakes all over again. She must become a more aware and savvy decision maker.

Though we make decisions of greater or less magnitude every day of our lives, society has not made education in decision making a priority.

Rational Decision Making

Decision making pervades problem management and opportunity development. One of the reasons clients get into trouble in the first place is that they make poor decisions. We need only review our own experiences to see how often the decisions we make or our failure to make decisions gets us into trouble. There are many decision points in the helping process. We have already seen a number of them. Clients must decide to come to a counseling interview in the first place; to talk about themselves; to return for a second session; to respond to the helper's empathic highlights, probes, and challenges; and to choose issues to work on. We are about to see that clients must also decide what they want, to set goals, to develop strategies, to make plans, and to implement those plans. Deciding—or letting the world decide for you—is at the heart of helping, as it is at the heart of living.

Decision making in its broadest sense is the same as problem solving. Indeed, this book could be called a decision-making approach to helping. In this chapter, however, the focus is on decision making in a narrower sense—the internal (mental) action of identifying alternatives or options and choosing from them. It is a commitment to do or to refrain from doing something:

- "I have decided to discuss my career problems but not my sexual concerns."
- "I have decided to start a new business."
- "I have decided to ask the courts to remove artificial life support from my comatose wife."
- "I have decided to get a better balance between work and home life."
- "I have decided not to undergo chemotherapy."
- "I have decided to stop putting myself down."
- "I have decided to move into a retirement home."

The commitment can be to an internal action—"I have decided to get rid of my preoccupation with my ex-wife"—or to an external action—"I have decided to confront my son about his drinking." Decision making, in the fullest sense, includes the implementation of the decision: "I made a resolution to give up smoking, and I haven't smoked for three years." "I decided that I was being too hard on myself, so I took a week off work and just enjoyed myself."

Traditionally, decision making has been presented as a rational, linear process involving information gathering, analysis, and making a choice. Here are the bare essentials of the decision-making process.

Information gathering. The first rational task is to gather information related to the particular issue or concern. A patient who must decide whether to have a series of chemotherapy treatments needs some essential information: What are the treatments like? What will they accomplish? What are the side effects? What are the consequences of not having them? What would another doctor say? And so forth. There is a whole range of ways in which she might gather this information: from the Internet, reading books, talking to doctors, talking to patients who have undergone treatment or who have refused treatment. Patients today routinely mount extensive Internet searches on their medical conditions to make better informed decisions.

Analysis. The next rational step is processing the information. This includes analyzing, thinking about, working with, discussing, meditating on, and immersing oneself in the information. Just as there are many ways of gathering information, so there are many ways of processing it. Effective information processing leads to a clarification and an understanding of the range of possible choices. "Now, let's see, what are the advantages and disadvantages of each of these choices?" is one way of analyzing information. Effective analysis assumes that decision makers have criteria, whether objective or subjective, for comparing alternatives. For instance, a patient wants to determine whether the weeks or months of life she will gain through a series of chemotherapy treatments will be worth the effort and discomfort.

Making a choice. Finally, decision makers need to make a choice—that is, commit themselves to some internal or external action that is based on the analysis: "After thinking about it, I have decided to sue for custody of the children." As indicated earlier, the fullness of the choice includes an action: "I had my lawyer file the custody papers this morning." There are also rational "rules" that can be used to make a decision. For instance, one rule, stated as a question, deals with the consequences of the decision: "Will it get me everything I want or just part?" Values also enter the picture because, from one point of view, values are criteria for making decisions: "Should I do X or Y? Well, what are my values?" The woman suing for the custody of the children says to herself, "I value fairness. I'm not going to try to extort a lot of money for child care. I'll make reasonable demands."

Counselors help clients engage in rational decision making; that is, they help clients gather information, analyze what they find, and then base action decisions on the analysis. Although this indeed does happen, it is not the full story.

The Shadow Side of Decision Making: Choices in Everyday Life

Thinking and reasoning are not always what they are supposed to be or seem to be in everyday life. And, when people get into trouble, thinking and reasoning can go even "further south." This means that decision making in everyday life, and in counseling, is not the straightforward, rational process just outlined. Rather, it is an ambiguous, highly complicated process with a deep shadow side (Cosier &

Schwenk, 1990; Etzioni, 1989; Gilovich, 1991; Heppner, 1989; Kaye, 1992; March, 1994; Schoemaker & Russo, 1990; Stroh & Miller, 1993; Whyte, 1991). For instance, Gati, Krausz, and Osipow (1996) discuss the messiness associated with making career decisions and list ten ways in which such decisions can be flawed. There is no such thing as the perfect career decision.

Headlee and Kalogjera (1988) found evidence that some of the roots of the shadow side of decision making begin in childhood. Some children are allowed too many choices, while others are given too few. Moreover, in the early years, distortions of choice evolve because of racial, ethnic, sexual, religious, and other prejudices. By the time the child becomes an adult, these distortions are ingrained in the decision-making process and nobody thinks about them. The sources of possible distortion are myriad. In everyday life, decision making is often confused, covert, difficult to describe, unsystematic, and, at times, quite irrational. A shadow-side analysis of decision making as it is actually practiced reveals a less-than-rational application of the three dimensions outlined in the previous section.

Information gathering. Information gathering should lead to a clear definition of the issues to be decided. A client trying to decide whether to pursue a divorce needs information about that entire process. However, information gathering is practically never straightforward. Decision makers, for whatever reason, are often complacent and engage in perfunctory searches. They get too much or too little information; the information they gather is inaccurate or misleading; or they cloud their search for information with emotion. In counseling, the client trying to decide whether to proceed with therapy may have already made up his or her mind and therefore may not be open to confirming or disconfirming information. Since full, unambiguous information is never available, all decisions are at risk. In fact, there is no such thing as completely objective information. All information, received by the decision maker takes on a subjective cast. A patient with prostate cancer who goes to the Internet to get some idea of what to do faces a bewildering range of opinions and options. In view of all this, Ackoff (1974) calls human problem solving "mess management" (p. 21).

> Eloise wanted to make a decision about whether to marry her partner or not. One obstacle was their conflicting careers. She didn't know whether she'd be in the same career five years from now; neither did he. Another obstacle lay in the fact that she knew little about his past. She thought it didn't matter. She liked him now. He knew that she was a nonpracticing Catholic but knew little about how her Catholicism affected her or how it would affect them in the future, especially if they had children. Since religion was not currently an issue, he did not explore it. There were many other things they did not know about themselves and each other. They eventually did marry, but the marriage lasted less than a year.

Granted, clients' stories are never complete, and information will always be partial and open to distortion. Though counselors cannot help clients make information gathering perfect, they can help them make it at least "good enough" for problem management and opportunity development.

Processing the information. Since it is impossible to separate the decision from the decision maker, the processing of information is as complex as the person making the decision. Factors affecting the analyzing of information include clients' feelings and emotions, their values-in-use, which often differ from their espoused values, their assumptions about "the way things work," and their level of motivation. There is no such thing as full, objective processing of gathered information. Poorly gathered information is often subjected to further mistreatment. Clients, because of their biases, focus on bits and pieces of the information they have gathered rather than seeing the full picture. Furthermore, few clients have the time or the patience to spell out all possible choices related to the issue at hand, together with the pros and cons of each. Therefore, some say that most decisions are based not on evidence but on taste: "I like it. It sounds good."

> Jamie was in a high-risk category for AIDS because of occasional drug use and sexual promiscuity. Once, when he was busted for drug use, he had to attend a couple of sessions on AIDS awareness. He listened to all the information, but he processed it poorly. These were problems for "other people." He engaged in risky sexual behavior "only occasionally." He was sure that his sexual partners were "clean." One or two "mistakes" were not going to do him in. He knew others who engaged in much riskier behavior than he and "nothing had happened to them." He'd be "more careful," though it was not clear what that meant as far as his behavior was concerned. He was in good health and "healthy people can take a lot."

Jamie distorted information and rationalized away most of the risk of his current lifestyle. He was living not on the edge but on a precipice.

Up to a point, counselors can help clients overcome inertia and biases and tackle the work of analysis. For instance, a client who says his values have "matured" but still automatically makes decisions based on his former values can be challenged to get these more mature values into his decision making. One client, trying to make a decision about a career change, kept moving toward options in the helping professions even though she had become quite interested in business. There was something in her that kept saying, "You have to choose a helping profession. Otherwise you will be a traitor." The counselor helped her see her bias. In the end, the client became a consultant, then a manager, then a senior manager. But she still had to salve her conscience by noting both to herself and to others that "running a successful business is an important contribution to society."

Choice and execution. A host of strange things can happen on the way to executing a decision. Here are some of the things decision makers do:

- Skip the analysis stage and move quickly to choice. "Let's get married. Love will conquer all."
- Ignore the analysis and base the decision on something else entirely. The analysis was nothing but a sham, because the decision criteria, however covert, were already in place. Reiner goes through an extended analysis of the reasons for becoming an entrepreneur and starting his own business, but then he accepts an offer from a large firm. He ignored the fact that security was his main driver.
- Engage in what Janis and Mann (1977) called "defensive avoidance." That is, they procrastinate, attempt to shift responsibility, or rationalize delaying a choice. An elderly man says, "I know that it makes sense to sell this big house and move into a retirement village, but what do the kids want? And what if we don't like it? We might run into people we don't like. We'd better take a closer look at this."

- Confuse confidence in decision making with competence. "I know what I want. If it's prostate cancer, I'm going for surgery and get it over with."
- Panic and seize on a hastily contrived solution that gives promise of immediate relief. The choice may work in the short term but have negative long-term consequences. Tess and Lars panic and get married quickly because she is pregnant. The next two years are very rocky.
- Are swayed by a course of action that is most salient at the time or by one that comes highly recommended, even though it is not right for them. Imogene, single, gives up her child for adoption. Later she bitterly regrets her decision.
- Let enthusiasm and other emotions govern their choices. Ben is so elated to be offered a promotion that he says yes right away. Only later does he realize that he was not cut out to be a manager.
- Announce a choice to themselves or to others but then do nothing about it. Bert and Linda tell their teenage children that they want to involve them more in household decision making but plan a summer vacation without their input. The kids become even more resentful.
- Translate the decision into action only halfheartedly. Sandra, grieving over the loss of her husband, decides to renew her social life. But she often fails to return phone calls, cancels engagements, and leaves get-togethers shortly after arriving, offering what seem to others as rather lame excuses.
- Decide one thing but do another. Ted decides to turn down a job offer because it's "not for me" but ends up taking it anyway.

The fact that choices do not necessarily make life easier for oneself and others explains a great deal of the shadow side of decision making. It is clear that counselors cannot help clients avoid all the pitfalls involved in making decisions, but they can help clients minimize them.

In summary, rational, linear decision making, in its pure form, has probably never been the norm in human affairs. Decision making goes on at more than one level. There is, as it were, the rational decision-making process in the foreground and an emotional or impulsive decision-making process in the background. Gelatt (1989) called for an approach to decision making that factors in these shadow-side realities: "What is appropriate now is a decision and counseling framework that helps clients deal with change and ambiguity, accept uncertainty and inconsistency, and utilize the nonrational and intuitive side of thinking and choosing" (p. 252). Positive uncertainty means, paradoxically, being positive (comfortable and confident) in the face of uncertainty (ambiguity and doubt)—feeling both uncertain about the future and positive about the uncertainty. Stages II and III, together with an understanding of the shadow side of these two stages, provide methodologies clients can use to make decisions, explore their consequences, and act on them.

Making Smarter Decisions

Learning how to make "good" decisions is left to chance in society. As with other skills—interpersonal communication, problem solving, parenting, and managing—

everyone thinks that decision-making skills are very important. But when asked in what forum these critical skills are to be learned, the usual reaction is a shrug of the shoulders. Once more, life itself is to be the teacher. James March (1994) discusses how decisions are actually made. In the last chapter on "decision engineering," March moves toward making suggestions on how to make "quality" or "intelligent" decisions. Hammond, Keeney, and Raiffa (1998, 1999), offer a guide to making better decisions, taking into account, of course, the shadow side of decision making. In one article (1998), they focus on hidden traps in decision making and how to handle them. Here are some of them.

The status quo bias. Clients often have a bias toward alternatives that perpetuate the status quo. The status quo is seen as the "safe" option even when it is not. Jeff, who has prostate cancer, is trying to make a decision about treatment. One option is "do nothing," because prostate cancer is usually slow growing, and older men who take a watch-and-wait approach often die of something else. Jeff, however, ignores the fact that he is not a good candidate for this approach. How could you help Jeff deal with his bias?

- Help him determine what his real objective is: comfort? living longer? living disease free? What do you want, Jeff?
- Help him review the alternatives in the light of what he wants. He might want a combination of things.
- Help him see whether he is choosing the status quo approach precisely because it is the status quo.
- Help him determine whether he wants to avoid the risk, pain, or trouble of choosing a non–status quo alternative. This is a different problem.
- Help him look further into the future. In Jeff's case, that might not be very far. Depending on the nature of his cancer and the likelihood of its spreading, the status quo situation might not last that long. "It's two years from now. You're looking back at this time in your life. Which decision would you have rather made?"
- Help him determine whether he is defaulting to the status quo option because it is difficult to choose from among the other alternatives. If this is the case, help him cope with the agony of making such a choice.

Amidst all this, aim your challenges at the "self-healing person" inside Jeff. Your job is not to choose for him, nor is it to talk him into anything. You can do any or all the above without robbing Jeff of any self-responsibility.

The confirming-evidence trap. If I have secretly—hidden more or less even from myself—decided to do or avoid doing something, I can begin looking for evidence that will confirm my choice or avoid evidence that will challenge it. Sheila, a college junior, was seeing a counselor because she was both shy and perfectionistic. She grew tired of counseling quickly because the counselor seemed to be trying to determine whether she was shy because she was perfectionistic—staying away from people gave her time to "get things done right"—or whether she was perfectionistic

because she was shy—her "high standards" meant that she had very few friends. Or maybe it was something else.

A second counselor, after hearing her recapitulate her experience with the first counselor, said during their second session, "Which do you want: to be perfect or to be alone?" She remained totally self-possessed, paused, and then said, "I want to leave school. My mother is dying. She needs me. She might have six months. She might have two years. No matter. My place is at her side." It was something else. When the counselor asked, "Is this what your mother wants," Sheila replied, "That's not the issue." In a later session, the counselor, after finding out that Sheila's decision was not seconded by her mother, her father, or any of her three younger brothers, tried to come at it from various angles. Sheila was very bright. She amassed evidence supporting her decision from every source: psychology, sociology, the Bible, theology, and her commitment "to my family and myself." This sounds as if she was being battered on all sides, but this was not the case. Her family and the counselor knew that the decision was hers. No one badgered her. But everyone wanted her to make the decision for the "right" reasons. According to Hammond, Keeney, and Raiffa, what could the counselor do? Here are a few suggestions:

- Help Sheila examine all the evidence with equal vigor. She was being very intellectual about it all. She did a great job with the evidence from the human and godly sciences but attended very little to what the significant people in her life were saying.
- Get someone Sheila respects to act as devil's advocate. Sheila had friends, and there were family friends, her doctor, her minister, and so forth. Or better yet, get Sheila herself to play her own devil's advocate. Reverse roles. The helper becomes Sheila, and Sheila becomes the helper.
- Have Sheila take a closer look at her motives. What does she really want? Is there something behind her leaving school besides her mother's illness? Is it her way of being both "alone" in some sense and "perfect"? If her mother were not sick, would she still be leaving school? These questions are not meant to be probes into her "deeper" internal dynamics. Rather, it would be helpful for Sheila to know what she is doing and what is moving her to do it.
- If Sheila seeks advice from others, help her frame her questions so they don't merely invite confirmation of what she has already decided. Sheila could say, "Here's what I'm thinking of doing. Grill me on it, will you?"

It might well be that Sheila wants to leave school because she wants to be at her mother's side during these difficult times. It may have nothing to do with either isolation or perfectionism. And, even if others think that it's a lousy decision, Sheila thinks it's right for herself. After all, it is her life. There are, of course, other decision traps.

In their book, *Smart Choices: A Practical Guide to Making Better Decisions* (1999), Hammond, Keeney, and Raiffa lay out a *system* for making smart choices. The eight elements of the system highlight the eight most common and most serious errors in decision making (p. 189):

- Working on the wrong problem
- Failing to identify your key objectives
- Failing to develop a range of good, creative alternatives
- Overlooking crucial consequences of your alternatives
- Giving inadequate thought to tradeoffs
- Disregarding uncertainty
- Failing to account for your risk tolerance
- Failing to plan ahead when decisions are linked over time

As you can see, when put positively ("Working on the right problem" and so forth), these are also elements of the problem-management process, most of which are addressed in Stages II and III.

Finally, since helpers themselves are human, they do not escape the shadow side of decision making. Helpers, as you can see, make decisions throughout the helping process. Pfeiffer, Whelan, and Martin (2000), after reviewing the decision-making research, comment:

> When examined as a whole, this research suggests that people tend to preferentially attend to information, gather information, and interpret information in a manner that supports, rather than tests, their decisions about another person. Therapists may not be exempt from this tendency, particularly given the often complex and ambiguous nature of clients' problems (p. 429).

No matter how empathic you are, as a helper you will still make hypotheses about your clients throughout the helping process and base some of your decisions on these hypotheses. Your challenge is to continually test these hypotheses against the reality of your clients in the context of their lives. Theories are theories. Clients are clients.

CHAPTER 15

Step II-A: "What Do I Need and Want?" Possibilities for a Better Future

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Possibilities for a Better Future

The goal of Step II-A is to help clients develop a sense of direction by exploring possibilities for a better future. I once was sitting at the counter of a late-night diner when a young man sat down next to me. The conversation drifted to the problems he was having with a friend of his. I listened for a while and then asked, "Well, if your relationship was just what you wanted it to be, what would it look like?" It took him a bit to get started, but eventually he drew a picture of the kind of relationship he could live with. Then he stopped, looked at me, and said, "You must be a professional." I believe he thought that because this was the first time in his life that anyone had ever asked him to describe some possibilities for a better future.

Too often the exploration and clarification of problem situations are followed, almost immediately, by the search for solutions in the secondary sense—actions that will help deal with the problem or develop the opportunity. But in many ways, outcomes are more important than actions. *What will be in place* once those actions are completed? As we saw in the last chapter, failure to specify outcomes is one of the major decision-making traps. The outcome is a Solution with a big S; while the actions leading to this outcome constitute a solution with a small s. There is great power in visualizing outcomes, just as there is a danger in formulating action strategies before getting a clear idea of desired outcomes. Stage II is about identifying or visualizing desired results, outcomes, or accomplishments. Step II-A is about envisioning possibilities. Stage III is about strategies, actions, and plans for delivering those outcomes. From another point of view, Stages II and III are about hope.

The Psychology of Hope

Hope as part of human experience is as old as humanity. Who of us has not started sentences with "I hope . . ."? Who of us has not experienced hope or lost hope? Hope also has a long history as a religious concept. St. Paul said, "Hope that centers around things you can see is not really hope," thus highlighting the element of uncertainty. If you know that tomorrow you will receive the Oscar, you can no longer hope for it. You know it's a sure thing. Hope plays a key role in both developing and implementing possibilities for a better future. An Internet search reveals that scientific psychology is more interested in hope than one might initially believe (Erickson, Post & Page, 1975; Stotland, 1969). As mentioned earlier, Rick Snyder has written extensively about the positive and negative uses of excuses in everyday life (Snyder, 1988; Snyder, Higgins, & Stucky, 1983) and has become a kind of champion for hope (McDermott & Snyder, 1999; Snyder, McDermott, Cook, & Rapoff, 1997; Snyder, 1994a, 1994b, 1995, 1998; Snyder, Michael, & Cheavens, 1999). Indeed, he linked excuses and hope in an article entitled "Reality negotiation: From excuses to hope and beyond" (1988). He has also developed scales for measuring both dispositional hope (Snyder et al., 1991) and state hope (Snyder et al., 1996). For a full bibliography for Snyder's work on hope, go to http://www.psych.ukans.edu/faculty/rsnyder/hoperesearch.htm.

The nature of hope. Snyder starts with the premise that human beings are goal directed. Hope, according to Snyder, is the process of thinking about one's goals—

Serena is determined that she will give up smoking, drinking, and soft drugs now that she is pregnant—of having the will, desire, or motivation to move toward these goals—*Serena is serious about her goal because she has seen the damaged children of mothers on drugs and she is also, at heart, a decent, caring person*—and of thinking about the strategies for accomplishing one's goals—*Serena knows that two or three of her friends will give her the support she needs, and she is willing to join an arduous 12-step program to achieve her goal.* Serena is hopeful. If we say that Serena has "high hopes," we mean that her goal is clear, her sense of agency (or urgency) is high, and that she is realistic in planning the pathways to her goal. Both a sense of agency and some clarity around pathways are required. Hope, of course, has emotional connotations. It is not a free-floating emotion. Rather it is the byproduct or outcome of the work of setting goals, developing a sense of agency, and devising pathways to the goal. Serena feels a mixture of positive emotions—elation, determination, satisfaction—knowing that "the will" (agency) and "the way" (pathways) have come together. Success is in sight even though she knows that there will be barriers—for instance, the ongoing lure of tobacco, wine, and soft drugs.

The benefits of hope. Snyder (1995) has combed the research literature to discover the benefits of hope as he defines it. Here is what he has found:

> The advantages of elevated hope are many. Higher as compared with lower hope people have a greater number of goals, have more difficult goals, have success at achieving their goals, perceive their goals as challenges, have greater happiness and less distress, have superior coping skills, recover better from physical injury, and report less burnout at work, to name but a few advantages (pp. 357–358).

Counselors who do not spend a significant part of their time with clients helping them develop possibilities, clarify goals, devise strategies or pathways, and develop the sense of agency needed to bring all this to fruition are certainly shortchanging their clients. Because Stages II and III deal with possibilities, goals, commitment, pathways, and overcoming barriers, they could be named "ways of nurturing hope."

Possible Selves

One of the characters in Gail Godwin's 1985 novel *The Finishing School* warns against getting involved with people who have "congealed into their final selves." Clients come to helpers not necessarily because they have congealed into their final selves—if this is the case, why come at all?—but because they are stuck in their current selves. Counseling is a process of helping clients get "unstuck" and develop a sense of direction. Consider the case of Ernesto. He was very young but very stuck for a variety of sociocultural and emotional reasons.

A counselor first met Ernesto in the emergency room of a large urban hospital. He was throwing up blood into a pan. He was a member of a street gang, and this was the third time he had been beaten up in the last year. He had been so severely beaten this time that it was likely that he would suffer permanent physical damage. Ernesto's style of life was doing him in, but it was the only one he knew. He was in need of a new way of living, a new scenario, a new way of participating in city life. This time he was hurting enough to consider the possibility of some kind of change.

Markus and Nurius (1986) use the term *possible selves* to represent "individuals' ideas of what they might become, what they would like to become, and what they are afraid of becoming" (p. 954). The counselor worked with Ernesto not by helping him explore the complex sociocultural and emotional reasons he was in this fix but principally by helping him explore his "possible selves" to discover a different purpose in life, a different direction, a different lifestyle. Step II-A is about possible selves. The notion of possible selves has captured the imagination of many helpers and of those interested in human development such as teachers (Cameron, 1999; Cross & Marcus, 1994; Hooker, Fiese, Jenkins, Morfei, & Schwagler, 1996; Strauss & Goldberg, 1999). Enter the term *possible selves* into an Internet search engine and you will find all sorts of examples of how helpers and teachers have been using this concept. In Step II-A, your job is to help clients discover their possible selves.

Skills for Identifying Possibilities for a Better Future

At its best, counseling helps clients move from problem-centered mode to discovery mode. Discovery mode involves creativity and divergent thinking. However, according to Sternberg and Lubart (1996), creativity is one of those topics in which psychology has underinvested. They present six reasons why they think this is so. Dean Simonton (2000) reviews advances in our understanding and use of creativity as part of positive psychology. However, according to Taylor, Pham, Rivkin, and Armor (1998), not just any kind of mental stimulation will do. Mental stimulation is help to the degree that it "provides a window on the future by enabling people to envision possibilities and develop plans for bringing those possibilities about. In moving oneself from a current situation toward an envisioned future one, the anticipation and management of emotions and the initiation and maintenance of problem-solving activities are fundamental tasks" (p. 429). This kind of thinking moves in the same direction as Snyder's. Not just fantasy. Not just rumination. The full problem-management and opportunity-development framework helps clients, to use Simonton's phrase, "harness the imagination."

Creativity and Helping

One of the myths of creativity is that some people are creative and others are not. Clients, like the rest of us, can be more creative than they are. It is a question of finding ways to help them be so. Stages II and III help clients tap into their dormant creativity. A review of the requirements for creativity shows, by implication, that people in trouble often fail to use whatever creative resources they might have (see Cole & Sarnoff, 1980; Robertshaw, Mecca, & Rerick, 1978, pp. 118–120). These are the characteristics of the creative person:

- Optimism and confidence—whereas clients are often depressed and feel powerless.
- Acceptance of ambiguity and uncertainty—whereas clients may feel tortured by ambiguity and uncertainty and want to escape from them as quickly as possible.

- A wide range of interests—whereas clients may be people with a narrow range of interests or whose normal interests have been severely narrowed by anxiety and pain.
- Flexibility—whereas clients may have become rigid in their approach to themselves, others, and the social settings of life.
- Tolerance of complexity—whereas clients are often confused and looking for simplicity and simple solutions.
- Verbal fluency—whereas clients are often unable to articulate their problems, much less their goals and ways of accomplishing them.
- Curiosity—whereas clients may not have developed a searching approach to life or may have been hurt by being too venturesome.
- Drive and persistence—whereas clients may be all too ready to give up.
- Independence—whereas clients may be quite dependent or counterdependent.
- Nonconformity or reasonable risk taking—whereas clients may have a history of being very conservative and conformist, or they may get into trouble with others and with society precisely because of their particular brand of nonconformity.

A review of some of the principal obstacles or barriers to creativity (see Azar, 1995) brings further problems to the surface. Here are some of the things that can hinder innovation:

- Fear—clients are often quite fearful and anxious.
- Fixed habits—clients may have self-defeating habits or patterns of behavior that may be deeply ingrained.
- Dependence on authority—clients may come to helpers looking for the "right answers" or be quite counterdependent (the other side of the dependence coin) and fight efforts to be helped with a variety of games.
- Perfectionism—clients may come to helpers precisely because they are hounded by this problem and can accept only ideal or perfect solutions.
- Social networks—being "different" sets clients apart when they want to belong.

It is easy to say that imagination and creativity are most useful in Stages II and III, but it is another thing to help clients stimulate their own, perhaps dormant creative potential.

Divergent Thinking

Many people habitually take a convergent-thinking approach to problem solving; that is, they look for the "one right answer." Such thinking has its uses, of course. However, many of the problem situations of life are too complex to be handled by convergent thinking. Such thinking limits the ways in which people use their own and environmental resources.

On the other hand, divergent thinking—thinking "outside the box"—assumes that there is always more than one answer. De Bono (1992) calls it "lateral thinking." In helping, that means more than one way to manage a problem or develop an opportunity. Unfortunately, divergent thinking, as helpful as it can be, is not always rewarded in our culture and sometimes is even punished. For instance, students who think divergently can be thorns in the sides of teachers. Some teachers feel comfortable only when they ask questions in such a way as to elicit the "one right answer." When students who think divergently give answers that are different from the ones expected, even though their responses might be quite useful (perhaps more useful than the expected responses), they may be ignored, corrected, or punished. Students too often learn that divergent thinking is not rewarded, at least not in school, and they may generalize their experience and end up thinking that it is simply not a useful form of behavior. Consider the following case:

> Quentin wanted to be a doctor, so he enrolled in the pre-med program at school. He did well but not well enough to get into medical school. When he received the last notice of refusal, he said to himself, "Well, that's it for me and the world of medicine. Now what will I do?" When he graduated, he took a job in his brother-in-law's business. He became a manager and did fairly well financially, but he never experienced much career satisfaction. He was glad that his marriage was good and his home life rewarding, because he derived little satisfaction from his work.

Not much divergent thinking went into handling this problem situation. No one asked Quentin what he really wanted. For Quentin, becoming a doctor was the "one right career." He didn't give serious thought to any other career related to the field of medicine, even though there are dozens and dozens of interesting and challenging jobs in the field of health care.

The case of Caroline, who also wanted to become a doctor but failed to get into medical school, is quite different from that of Quentin.

> Caroline thought to herself, "Medicine still interests me; I'd like to do something in the health field." With the help of a medical career counselor, she reviewed the possibilities. Even though she was in pre-med, she had never realized that there were so many careers in the field of medicine. She decided to take whatever courses and practicum experiences she needed to become a nurse. Then, while working in a clinic in the hills of Appalachia—an invaluable experience for her—she managed to get an MA in family-practice nursing by attending a nearby state university part time. She chose this specialty because she thought that it would enable her not only to be closely associated with delivery of a broad range of services to patients but also to have more responsibility for the delivery of these services.
>
> When Caroline graduated, she entered private practice with a doctor as a nurse practitioner in a small Midwestern town. Because the doctor divided his time among three small clinics, Caroline had a great deal of responsibility in the clinic where she practiced. She also taught a course in family-practice nursing at a nearby state school and conducted workshops in holistic approaches to preventive medical self-care. Still not satisfied, she began and finished a doctoral program in practical nursing. She taught at a state university and continued her practice. Needless to say, her persistence paid off with an extremely high degree of career satisfaction.

A successful professional career in health care always remained Caroline's aim. Using a great deal of divergent thinking and creativity, Caroline elaborated that aim into specific goals and came up with the courses of action to accomplish them. But for every success story, there are many more failures. Quentin's case is probably the norm, not Caroline's. For many, divergent thinking is either uncomfortable or too much work.

Brainstorming: A Tool for Divergent Thinking

One excellent way of helping clients think divergently and more creatively is brainstorming. Brainstorming is a simple idea-stimulation technique for exploring the elements of complex situations. Brainstorming in Stages II and III is a tool for helping clients develop both possibilities for a better future and ways of accomplishing goals.

There are certain rules that help make this technique work: suspend judgment, produce as many ideas as possible, use one idea as a takeoff point for others, get rid of normal constraints to thinking, and produce even more ideas by clarifying items on the list. Here, then, are the rules.

Suspend your own judgment, and help clients suspend theirs. When brainstorming, do not let clients criticize the ideas they are generating and, of course, do not criticize them yourself. There is some evidence that this rule is especially effective when the problem situation has been clarified and defined and goals have not yet been set. In the following example, a woman whose children are grown and married is looking for ways of putting meaning into her life.

CLIENT: One possibility is that I could become a volunteer, but the very word makes me sound a bit pathetic.

HELPER: Add it to the list. Remember, we'll discuss and critique them later.

Having clients suspend judgment is one way of handling the tendency on the part of some to play a "Yes, but" game with themselves. That is, they come up with a good idea and then immediately show why it isn't really a good idea, as in the preceding example. By the same token, avoid saying such things as "I like that idea," "This one is useful," "I'm not sure about that idea," or "How would that work?" Premature approval and criticism cut down on creativity. A marriage counselor was helping a couple brainstorm possibilities for a better future. When Nina said, "We will stop bringing up past hurts," Tip, her husband, replied, "That's your major weapon when we fight. You'll never be able to give that up." The helper said, "Add it to the list. We'll look at the realism of these possibilities later on."

Encourage clients to come up with as many possibilities as possible. The principle is that quantity ultimately breeds quality. Some of the best ideas come along later in the brainstorming process. Cutting the process short can be self-defeating. In the following example, a man in a sex-addiction program has been brainstorming activities that might replace his preoccupation with sex.

CLIENT: Maybe that's enough. We can start putting it all together.

HELPER: It doesn't sound like you were running out of ideas.

CLIENT: I'm not. It's actually fun. It's almost liberating.

HELPER: Well, let's keep on having fun for a while.

CLIENT (pausing): Ha! I could become a monk.

Later on, the counselor, focusing on this "possibility," asked, "What would a modern-day monk who's not even a Catholic look like?" This helped the client explore the concept of sexual responsibility from a completely different perspective and to rethink the place of religion and service to others in his life. And so, within reason, the more ideas the better. Helping clients identify many possibilities for a better future increases the quality of the possibilities that are eventually chosen and turned into goals. In the end, however, do not invoke this rule for its own sake. Possibility generation is not an end in itself. Use your clinical judgment, your social intelligence, to determine when enough is enough. If a client wants to stop, often it's best to stop.

Help clients use one idea to stimulate others. This is called piggybacking. Without criticizing the client's productivity, encourage him or her both to develop strategies already generated and to combine different ideas to form new possibilities. In the following example, a client suffering from chronic pain is trying to come up with possibilities for a better future.

CLIENT: Well, if there is no way to get rid of all the pain, then I picture myself living a full life without pain at its center.

HELPER: Expand that a bit for me.

CLIENT: The papers are filled with stories of people who have been living with pain for years. When they're interviewed, they always look miserable. They're like me. But every once in a while there is a story about someone who has learned how to live creatively with pain. Very often they are involved in some sort of cause which takes up their energies. They don't have time to be preoccupied with pain.

A client with multiple sclerosis brought up this possibility: "I'll have a friend or two with whom I can share my frustrations as they build up." When the helper asked, "What would that look like?" the client replied, "Not just a complaining session or just a poor-me thing. It would be a normal part of a give-and-take relationship. We'd be sharing both joys and pain of our lives like other people do."

Help clients let themselves go and develop some "wild" possibilities. When clients seem to be "drying up" or when the possibilities being generated are quite pedestrian, you might say, "Okay, now draw a line under the items on your list and write the word 'Wild' under the line. Now let's see if you can come up with some really wild possibilities." Later, it is easier to cut suggested possibilities down to size than to expand them. The wildest possibilities often have within them at least a kernel of an idea that will work. In the following example, an older single man who is lonely is exploring possibilities for a better future.

CLIENT: I can't think of anything else. And what I've come up with isn't very exciting.

HELPER: How about getting a bit wild? You know, some crazy possibilities.

CLIENT: Well, let me think. . . . I'd start a commune and would be living in it. . . . And . . .

Clients often need permission to let themselves go, even in harmless ways. They repress good ideas because they might sound foolish. Helpers need to create an atmosphere where such apparently foolish ideas will be not only accepted but also encouraged. Help clients come up with conservative possibilities, liberal possibilities, radical possibilities, and even outrageous possibilities.

It's not always necessary to use brainstorming explicitly. As a helper, you can keep these rules in mind and then, by sharing highlights and using probes, get clients to brainstorm even though they don't know that's what they're doing. A brainstorming mentality is useful throughout the helping process.

Future-Oriented Probes

One way of helping clients invent the future is to ask them, or get them to ask themselves, future-oriented questions related to their current unmanaged problems or undeveloped opportunities. By asking any of the following questions, helpers can encourage clients to find answers to the broader questions "What do I want?" and "What do I need?" These questions focus on outcomes—that is, on what will be in place after the clients act.

• ***What would this problem situation look like if you were managing it better?*** Ken, a college student who has been a "loner," has been talking about his general dissatisfaction with his life. In answer to this question, he said, "I'd be having fewer anxiety attacks. And I'd be spending more time with people rather than by myself."

• ***What changes in your present lifestyle would make sense?*** Cindy, who described herself as a "bored homemaker," replied, "I would not be drinking as much. I'd be getting more exercise. I would not sit around and watch the soaps all day. I'd have something meaningful to do."

• ***What would you be doing differently with the people in your life?*** Lon, a graduate student at a university near his parents' home, realized that he had not yet developed the kind of autonomy suited to his age. He mentioned these possibilities: "I would not be letting my mother make my decisions for me. I'd be sharing an apartment with one or two friends."

• ***What patterns of behavior would make life better?*** Bridget, a depressed resident in a nursing home, had this suggestion: "I'd be engaging in more of the activities offered here in the nursing home." Rick, who is suffering from lymphoma, says, "Instead of seeing myself as a victim, I'd be on the Web finding out every last thing I can about this disease and how to deal with it. I know there are new treatment options. And I'd also be getting a second or third opinion. You know, I'd be managing my lymphoma instead of just suffering from it."

• ***What current patterns of behavior would you eliminate?*** Bridget, a resident in a nursing home, adds these to her list: "I would not be putting myself down for incontinence I cannot control. I would not be complaining all the time. It gets me and everyone else down!"

• ***What would you have that you don't have now?*** Sissy, a single woman who has lived in a housing project for 11 years, said, "I'd have a place to live that's not rat infested. I'd have some friends. I wouldn't be so miserable all the time." Drew, a man tortured by perfectionism, muses, "I'd be wearing sloppy clothes, at least at times, and like it. More than that, I'd have a more realistic sense of the world and my place in it. The world is messy, it's chaotic much of the time. I'd find the beauty in the chaos."

• ***What accomplishments would you have that you don't have now?*** Ryan, a divorced man in his mid-thirties, said, "I'd have my degree in practical nursing. I'd be doing some part-time teaching. I'd be close to someone that I'd like to marry."

• ***What would this opportunity look like if you developed it?*** Enid, a woman with a great deal of talent who has been given one modest promotion in her company but who feels like a second-class citizen, had this to say: "In two years I'll be an officer of this company or have a very good job in another firm."

It is a mistake to suppose that clients will automatically gush with answers. Ask the kinds of questions just listed, or encourage them to ask themselves the questions, but then help them answer them. Create the therapeutic dialogue around possibilities for a better future. Many clients don't know how to use their innate creativity. Thinking divergently is not part of their mental lifestyle. You have to work with clients to help them produce some creative output. Some clients are reluctant to name possibilities for a better future because they sense that this will bring more responsibility. They will have to move into action mode.

Exemplars and Models as Sources of Possibilities

Some clients can see future possibilities better when they see them embodied in others. You can help clients brainstorm possibilities for a better future by helping them identify exemplars or models. By models I don't mean superstars or people who do things perfectly. That would be self-defeating. In the next example, a marriage counselor is talking with a middle-aged, childless couple. They are bored with their marriage. When he asked them, "What would your marriage look like if it looked a little better?" he could see that they were stuck.

COUNSELOR: Maybe the question would be easier to answer if you reviewed some of your married relatives, friends, or acquaintances.

WIFE: None of them have super marriages. [Husband nods in agreement.]

COUNSELOR: No, I don't mean super marriages. I'm looking for things you could put in your marriage that would make it a little better.

WIFE: Well, Fred and Lisa are not like us. They don't always have to be doing everything together.

HUSBAND: Who says we have to be doing everything together? I thought that was your idea.

WIFE: Well, we always are together. If we weren't always together, we wouldn't be in each other's hair all the time.

COUNSELOR: All right, who else do you know who are doing things in their marriage that appeal to you. Anyone.

HUSBAND: You know Ron and Carol do some volunteer work together. Ron was saying that it gets them out of themselves. I bet they have better conversations because of it.

COUNSELOR: Now we're cooking. . . . What else? What couple do you find the most interesting?

Even though it was a somewhat torturous process, these two people were able to come up with a range of possibilities for a better marriage. The counselor had them write them down so they wouldn't lose them. At that point, the purpose was not to get the clients to commit themselves to the possibilities but to identify them.

In the following case, the client finds herself making discoveries by observing people she had not identified as models at all:

Fran, a somewhat withdrawn college junior, realizes that when it comes to interpersonal competence, she is not ready for the business world she intends to enter when she graduates. She

wants to do something about her interpersonal style and a few nagging personal problems. She sees a counselor in the Office of Student Services. After a couple of discussions with him, she joins a "lifestyle" group on campus that includes some training in interpersonal skills. Even though she expands her horizons a bit from what the members of the group say about their experiences, behaviors, and feelings, she tells her counselor that she learns even more by watching her fellow group members in action. She sees behaviors that she would like to incorporate in her own style. A number of times she says to herself in the group, "Ah, there's something I never thought of." Without becoming a slavish imitator, she begins to weave some of the patterns she sees in others into her own style.

Models or exemplars can help clients name what they want more specifically. Models can be found anywhere: among the client's relatives, friends, and associates, in books, on television, in history, in movies. Counselors can help clients identify models, choose those dimensions of others that are relevant, and translate what they see into realistic possibilities for themselves.

Lockwood and Kunda (1999) have shown that, under normal circumstances, individuals can be inspired by role models so that their motivation and self-evaluations are enhanced. But not always. Bringing up role models with people who have been reviewing "best past selves" has a way of deflating people. Their best can pale in comparison with the model. Their best is none too good. This is important because in solution-focused therapies, reviewing past successes is an important part of the process. In addition, if people are asked to come up with ideas about their "best possible selves" and then are asked to review what they like about a role model, their ability to draw inspiration from the role model is impaired. In sum, using role models as sources of inspiration certainly works, but it can be tricky.

Cases Featuring Possibilities for a Better Future

Here are a couple of cases that illustrate how helping clients develop possibilities for a better future had a substantial impact.

The Case of Brendan: Dying Well

Brendan, a heavy drinker, had extensive and irreversible liver damage and it was clear that he was getting sicker. But he wanted to "get some things done" before he died. Brendan's action orientation helped a great deal. Over the course of a few months, a counselor helped him to name some of the things he wanted before he died or on his journey toward death. Brendan came up with the following possibilities:

- "I'd like to have some talks with someone who has a religious orientation, like a minister. I want to discuss some of the 'bigger' issues of life and death."
- "I don't want to die hopeless. I want to die with a sense of meaning."
- "I want to belong. You know, to some kind of community, people who know what I'm going through but are not sentimental about it. People not disgusted with me because of the way I've done myself in."
- "I'd like to get rid of some of my financial worries."
- "I'd like a couple of close friends with whom I could share the ups and downs of daily life. With no apologies."

Box 15-1 Questions for Exploring Possibilities

Help clients ask themselves these kinds of questions:

- What are my most critical needs and wants?
- What are some possibilities for a better future?
- What outcomes or accomplishments would take care of my most pressing problems?
- What would my life look like if I were to develop a couple of key opportunities?
- What should my life look like a year from now?
- What should I put in place that is currently not in place?
- What are some wild possibilities for making my life better?

- "As long as possible, I'd like to be doing some kind of productive work, whether paid or not. I've been a flake. I want to contribute, even if in just an ordinary way."
- "I need a decent place to live, maybe with others."
- "I need decent medical attention. I'd like a doctor who has some compassion. One who could challenge me to live until I die."
- "I need to manage these bouts of anxiety and depression better."
- "I want to be get back with my family again. I want to hug my dad. I want him to hug me."
- "I'd like to make peace with one or two of my closest friends. They more or less dropped me when I got sick. But at heart, they're good guys."
- "I want to die in my home town."

Of course, Brendan didn't name all these possibilities at once. Through understanding and probes, the counselor helped name what he needed and wanted and then helped him stitch together a set of goals from these possibilities (Stage II) and ways of accomplishing them (Stage III). Box 15-1 outlines the kinds of questions you can help clients ask themselves to discover possibilities for a better future.

The Washington Family Case

This case is more complex because it involves a family. Not only does the family as a unit have its wants and needs, but also each individual member has his or her own. Therefore, it is even more imperative to review possibilities for a better future so that competing needs can be reconciled.

Lane, the 15-year-old son of Troy and Rhonda Washington, was hospitalized with what was diagnosed as an acute schizophrenic attack. He had two older brothers, both teenagers, and two

younger sisters, one 10 and one 12, all living at home. The Washingtons lived in a large city. Although both parents worked, their combined income still left them pinching pennies. They also ran into a host of problems associated with their son's hospitalization: the need to arrange ongoing help and care for Lane, financial burdens, behavioral problems among the other siblings, marital conflict, and stigma in the community ("They're a funny family with a crazy son"; "What kind of parents are they?"). To make things worse, Troy and Rhonda did not think the psychiatrist and the psychologist they met at the hospital took the time to understand their concerns. They felt that the helpers were trying to push Lane back out into the community; in their eyes, the hospital was "trying to get rid of him." Their complaint was, "They give him some pills and then give him back to you." No one explained to them that short-term hospitalization was meant to guard the civil rights of patients and avoid the negative effects of longer-term institutionalization.

When Lane was discharged, his parents were told that he might have a relapse, but they were not told what to do about it. They faced the prospect of caring for Lane in a climate of stigma without adequate information, services, or relief. Feeling abandoned, they were very angry with the mental-health establishment. They had no idea what they should do to respond to Lane's illness or to the range of family problems that had been precipitated by the episode. By chance, the Washingtons met someone who had worked for the National Alliance for the Mentally Ill (NAMI), an advocacy and education organization. This person referred them to an agency that provided support and help.

What does the future hold for such a family? With help, what kind of future can be fashioned? Social workers at the agency helped the Washingtons identify both needs and wants in seven areas (see Bernheim, 1989).

- ***The home environment.*** The Washingtons needed an environment in which the needs of all the family members were balanced. They didn't want their home to be an extension of the hospital. They wanted Lane taken care of, but they wanted to attend to the needs of the other children and to their own needs as well.
- ***Care outside the home.*** They wanted a comprehensive therapeutic program for Lane. They needed to review possible services, identify relevant services, and arrange access to those services. They needed to find a way of paying for all this.
- ***Care inside the home.*** They wanted all family members to know how to cope with Lane's residual symptoms. He might be withdrawn or aggressive, but they needed to know how to relate to him and help him handle behavioral problems.
- ***Prevention.*** Family members needed to be able to spot early warning symptoms of impending relapse. They also needed to know what to do when they saw those signs, including such things as contacting the clinic or, in the case of more severe problems, arranging for an ambulance or getting help from the police.
- ***Family stress.*** They needed to know how to cope with the increased stress that all this would entail. They needed forums for working out their problems. They wanted to avoid family blowups, and when blowups occurred, they wanted to manage them without damaging the social fabric of the family.
- ***Stigma.*** They wanted to understand and be able to cope with whatever stigma might be attached to Lane's illness. For instance, when taunted for having a "crazy brother," the children needed to know what to do and what not to do. Family members needed to know whom to tell, what to say, how to respond to inquiries, and how to deal with blame and insults.

- ***Limitation of grief.*** They needed to know how to manage the normal guilt, anger, frustration, fear, and grief that go with problem situations like this.

Bernheim's schema constituted a useful checklist for stimulating thinking about possibilities for a better future. The Washingtons first needed help in developing these possibilities. Then they needed help in setting priorities and establishing goals to be accomplished. This is the work of Step II-B. For positive-psychology advances in the treatment of serious mental illness, see Coursey, Alford, and Safarjan (1997).

When it comes to serious mental illness in a family, Marsh and Johnson (1997) focus not just on family burden but also on family resilience and the internal and external resources that support such resilience. This is, of course, a positive-psychology approach. They list the ways in which a helper can assist the family (p. 233):

1. Understanding and normalizing the family experience of mental illness.
2. Focusing on the strengths and competencies of their family and relatives.
3. Learning about mental illness, the mental health system, and community resources.
4. Developing skills in stress management, problem solving, and communication.
5. Resolving their feelings of grief and loss.
6. Coping with the symptoms of mental illness and its repercussions for their family.
7. Identifying and responding to the signs of impending relapse.
8. Creating a supportive family environment.
9. Developing realistic expectations for all members of the family.
10. Playing a meaningful role in their relative's treatment, rehabilitation, and recovery.
11. Maintaining a balance that meets the needs of all members of the family.

Johnson and Marsh also outline a number of intervention strategies that can help families meet these objectives:

- ***Family interventions*** that stress the role of the family as a support system rather than the cause of mental illness.
- ***Family support and advocacy groups*** such as the NAMI. These groups provide support and education, and encourage advocacy for improved services.
- ***Family consultation,*** which can aid in helping families determine their own goals and make informed choices regarding their use of available services.
- ***Family education,*** with respect to information about mental illness, caregiving, the mental-health system, community resources, and the like.
- ***Family psychoeducation,*** which focuses on such things as coping strategies and stress management.

In all this, you can see the outline of the solution-focused philosophy discussed in Chapter 14.

Evaluation Questions for Step II-A

- To what degree am I an imaginative person?
- In what ways can I apply the concept of "possible selves" to myself?
- What problems do I experience as I try to help clients use their imaginations?
- Against the background of problem situations and unused opportunities, how well do I help clients focus on what they want?
- To what degree do I prize divergent thinking and creativity in myself and others?
- How effectively do I use empathic highlights, a variety of probes, and challenging to help clients brainstorm what they want?
- Besides direct questions and other probes, what kinds of strategies do I use to help clients brainstorm what they want?
- How effectively do I help clients identify models and exemplars that can help them clarify what they want?
- How easily do I move back and forth in the helping model, especially in establishing a "dialogue" between Stages I and II?
- How well do I help clients act on what they are learning?

CHAPTER 16

Step II-B: "What Do I Really Want?" Moving from Possibilities to Choices

From Possibilities to Choices
Helping Clients Shape Their Goals
Help Clients State What They Need and Want as Outcomes or Accomplishments
Help Clients Move from Broad Aims to Clear and Specific Goals
Good intentions
Broad aims
Specific goals
Help Clients Establish Goals That Make a Difference
Help Clients Set Goals That Are Prudent
Help Clients Formulate Realistic Goals
Resources: Help clients choose goals for which the resources are available
Control: Help clients choose goals that are under their control
Help Clients Set Goals That Can Be Sustained
Help Clients Choose Goals That Have Some Flexibility
Help Clients Choose Goals Consistent with Their Values
Help Clients Establish Realistic Time Frames for the Accomplishment of Goals
Needs Versus Wants
Emerging Goals
Adaptive Goals
Satisfactory alternatives
Coping
Strategic self-limitation
The "Real-Options" Approach
A Bias for Action as a Metagoal
Evaluation Questions for Step II-B

From Possibilities to Choices

Once clients have developed possibilities for a better future, they need to make some choices; that is, they need to choose one or more of those possibilities and turn them into a program for constructive change. Step II-A is, in many ways, about *creativity*—getting rid of boundaries, thinking beyond one's limited horizon, moving outside the box. Step II-B is about *innovation*—turning possibilities into a practical program for change. If implemented, a goal constitutes the Solution, with a big S, for the client's problem or opportunity. Consider the following case:

Bea, an African American woman, was arrested when she went on a rampage in a bank and broke several windows. She had exploded with anger because she felt that she had been denied a loan mainly because she was black and a single mother. In discussing the incident with her minister, she comes to see that she has become very prone to anger. Almost anything can get her going. She also realizes that venting her anger as she had done in the bank led to a range of negative consequences. But she is constantly "steamed up" about the "system." To complicate the picture, she tends to take her anger out on those around her, including her friends and her two children. The minister helps her look at four possible ways of dealing with her anger: venting it, repressing it, channeling it, or simply giving up and ignoring the things she gets angry at, including the injustices around her. Giving up is not in her makeup. Merely venting her anger seems to do little but make her more angry. Repressing her anger, she reasons, is just another way of giving up, and that is demeaning. And she's not very good at repressing anyway. The "channeling" option needs to be explored. In the end, Bea takes a positive-psychology approach to dealing with her frustrations. She joins a political action group involved in community organizing. She learns that she can channel her anger without giving up her values or her intensity. She also discovers that she is good at influencing others and getting things done. She begins to feel better about herself. The system doesn't seem to be such a fortress any more.

Since goals can be highly motivational, helping clients set realistic goals is one of the most important steps in the helping process.

Helping Clients Shape Their Goals

Practical goals do not usually leap out fully formed. They need to be shaped or "designed," a term we saw in Chapter 14. Effective counselors add value by engaging clients in the kind of dialogue that will help them design, choose, craft, shape, and develop their goals. Goals are specific statements about what clients want and need.

The goals that emerge through this client-helper dialogue are more likely to be workable if they have certain characteristics. They need to be

- stated as *outcomes* rather than activities;
- *specific* enough to be verifiable and to drive action;
- *substantive* and challenging;
- both *venturesome* and *prudent*;
- *realistic* in regard to resources needed to accomplish them;
- *sustainable* over a reasonable time period;
- *flexible* without being wishy-washy;

- ***congruent*** with the client's ***values***;
- set in a reasonable ***time frame.***

Just how this package of goal characteristics will look in practice will differ from client to client. There is no one formula. From a practical point of view, these characteristics can be seen as tools that counselors can use to help clients design and shape or reshape their goals. Ineffective helpers will get lost in the details of these characteristics. Effective helpers will keep them in the backs of their minds and, in a second-nature manner, turn them into helpful "sculpting" probes at the right time. These characteristics, then, take on life through the following flexible principles.

Help Clients State What They Need and Want as Outcomes or Accomplishments

The goal of counseling, as emphasized again and again, is neither discussing nor planning nor engaging in activities. Helping is about Solutions with a big S. "I want to start doing some exercise" is an activity rather than an outcome. "Within six months I will be running three miles in less than 30 minutes at least four times a week" is an outcome, a pattern of behavior that will be in place by a certain time. If a client says, "My goal is to get some training in interpersonal communication skills," then she is stating her goal as a set of activities—a solution with a small s—rather than as an accomplishment. But if she says that she wants to become a better listener as a wife and mother, then she is stating her goal as an accomplishment, even though "better listener" needs further clarification. Goals stated as outcomes provide direction for clients.

You can help clients describe what they need and want by using this "past-participle approach"—drinking stopped, number of marital fights decreased, anger habitually controlled. Stating goals as outcomes or accomplishments is not just a question of language. Helping clients state goals as accomplishments rather than activities helps them avoid directionless and imprudent action. If a woman with breast cancer says that she thinks she should join a self-help group, she should be helped to see what she wants to get out of such a group. Joining a group and participating in it are activities. She wants support. She wants to feel supported. Goals, at their best, are expressions of what clients need and want. Clients who know what they want are more likely to work not just harder but also smarter.

Consider the case of Chester, a former Marine suffering from post-traumatic stress disorder:

Chester was involved in the Kosovo peacekeeping effort. During a patrol, he and three of his buddies shot and killed four civilians who were out to kill their neighbors. Afterward he began acting in strange ways, wandering around at times in a daze. He was given a medical discharge and sent home. Although he seemed to recover, he lived an aimless life. He went to college but dropped out during the first semester. He became rather reclusive but never really engaged in odd behavior. Rather he was sinking into the landscape. He moved in and out of a number of low-paying jobs. He also became less careful about his person. He said to a counselor, "You know, I used to be very careful about the way I dressed. Kind of proud of myself in the Marine tradition. Don't get me wrong; I'm not a bum and don't smell or anything, but I'm not myself." The whole direction of Chester's life was wrong; he was headed for serious trouble. He was bothered by thoughts about the war and had taken to sleeping whenever he felt like it, day or night, "just to make it all stop."

Ed, Chester's counselor, had a good relationship with Chester. He helped Chester tell his story and challenged some of his self-defeating thinking. He went on to help Chester focus on what he wanted from life. They moved back and forth between Stage I and Stage II, between problems and possibilities for a better future. Eventually, Chester began talking about his real needs and wants—that is, what he needed to accomplish to "get back to his old self." Here is an excerpt from their dialogue:

CHESTER: I've got to stop hiding in my hole. I'm going to get out and see people more. I'm going to stop feeling so damn sorry for myself. Who wants to be with a nothing!

COUNSELOR: What will Chester's life look like a year or two from now?

CHESTER: One thing for sure, he will be seeing women again. He might not be married, but he will probably have a special girlfriend. And she will see him as an ordinary guy.

Here Chester talks about changes as patterns of behavior that will be in place. He is painting a picture of what he wants to be. He is designing some goals. The counselor's probe reinforces this outcome approach.

Help Clients Move from Broad Aims to Clear and Specific Goals

Specific rather than general goals tend to drive behavior. Therefore, broad goals need to be translated into more specific goals and tailored to the needs and abilities of each client. Skilled helpers use probes to help clients move from the general to the specific.

Chester said that he wanted to become "more disciplined." His counselor helped him make that more specific.

COUNSELOR: What areas do you want to focus on?

CHESTER: Well, if I'm going to put more order in my life, I need to look at the times I sleep. I've been going to bed whenever I feel like it and getting up whenever I feel like it. It was the only way I could get rid of those thoughts and the anxiety. But I'm not nearly as anxious as I used to be. Things are calming down.

COUNSELOR: So more disciplined means a more regular sleep schedule because there's no particular reason now for not having one.

CHESTER: Yeah, sleeping whenever I want is just a bad habit. And I can't get things done if I'm asleep.

Chester goes on to translate "more disciplined" into other problem-managing needs and wants related to school, work, and care of his person. Greater discipline, once translated into specific patterns of behavior, will have a decidedly positive impact on his life.

Counselors often add value by helping clients move from good intentions and vague desires to broad aims and then on to quite specific goals.

Good intentions. "I need to do something about this" is a statement of intent. However, even though good intentions are a good start, they need to be translated into aims and goals. In the following example, the client, Jon, has been discussing his relationship with his wife and children. The counselor has been helping him see that his "commitment to work" is perceived negatively by his family. Jon is open to challenge and is a fast learner.

JON: Boy, this session has been an eye-opener for me. I've really been blind. My wife and kids don't see my investment—rather, my overinvestment—in work as something I'm doing for them. I've been fooling myself, telling myself that I'm working hard to get them the good things in life. In fact, I'm spending most of my time at work because I like it. My work is mainly for me. It's time for me to realign some of my priorities.

The last statement is a good intention, an indication on Jon's part that he wants to do something about a problem now that he sees it more clearly. It may be that Jon will now go out and put a different pattern of behavior in place without further help from the counselor. Or he may benefit from some help in realigning his priorities.

Broad aims. A broad aim is more than a good intention. It has content; that is, it identifies the area in which the client wants to work and makes some general statement about that area. Let's return to the example of Jon and his overinvestment in work:

JON: I don't think I'm spending so much time at work in order to run away from family life. But family life is deteriorating because I'm just not around enough. I must spend more time with my wife and kids. Actually, it's not just a case of must. I want to.

Jon moves from a declaration of intent to an aim or a broad goal, spending more time at home. But he still has not created a picture of what that would look like.

Specific goals. To help Jon move toward greater specificity, the counselor uses such probes as "Tell me what 'spending more time at home' will look like."

JON: I'm going to consistently spend three out of four weekends a month at home. During the week, I'll work no more than two evenings.

COUNSELOR: So you'll be at home a lot more. Tell me what you'll be doing with all this time.

Notice how much more specific Jon's statement is than "I'm going to spend more time with my family." He sets a goal as a specific pattern of behavior he wants to put in place. But his goal as stated deals with quantity, not quality. The counselor's probe is really a challenge. It's not just the amount of time Jon is going to spend with his family but also the kinds of things he will be doing—quality time, some call it. But a client trying to come to grips with work-life balance once said to me, "My family, especially my kids, don't make the distinction between quantity and quality. For them quantity is quality. Or there's no quality without a chunk of quantity." This warrants further discussion because maybe the family wants a relaxed rather than an intense Jon at home.

This example brings up the difference between *instrumental* goals and *higher-order* or *ultimate* goals. Jon's ultimate goal is "a good family life." Such a goal, once spelled out, will differ from family to family and from culture to culture. Think of your own definition. When Jon says that one of his goals is spending more time at home, he is talking about an instrumental goal. Unless he's there, he can't do things with his wife and kids. Although just "being there" is a goal because it is a pattern of behavior *in place*, it is certainly not Jon's ultimate goal. But Jon is not worried about the ultimate goal. When he is there, they have a rich family life together; that's not the problem. However, instrumental goals are *strategies* for achieving higher-order goals, so it's important to make sure that the client has clarity about the higher-order goal. If Jon were spending a lot of time at the office

because he didn't like being with his wife and kids or because there was a great deal of conflict at home, then his higher-order goal would be something like "experiencing the stimulation of an exciting workplace" (if home life was dull) or "peace of mind" (if home life was full of conflict). When you are helping clients design and shape instrumental goals, make sure they can answer the instrumental-for-what question.

Helping clients move from good intentions to more and more specific goals is a shaping process. Consider the example of a couple whose marriage has degenerated into constant bickering, especially about finances.

- *Good intention*: "We want to straighten out our marriage."
- *Broad aim*: "We want to handle our decisions about finances in a much more constructive way."
- *Specific goal*: "We try to solve our problems about family finances by fighting and arguing. We'd like to reduce the number of fights we have and begin making mutual decisions about money. We yell instead of talking things out. We need to set up a month-by-month budget. Otherwise, we'll be arguing about money we don't even have. We'll have a trial budget ready the next time we meet with you."

Having sound household finances is a fine goal—a goal in itself. Reducing unproductive conflict is also a fine goal. In this case, however, installing a sound, fair, and flexible household budget system is also instrumental to establishing peace at home. Declarations of intent, broad goals, and specific goals can all drive constructive behavior, but specific goals have the best chance. Is it possible to get clients to be too specific about their goals? Yes, if they get lost in the planning details and crafting the goal becomes more important than the goal itself.

If the goal is clear enough, the client will be able to determine progress toward the goal. For many clients, being able to measure progress is an important incentive. If goals are stated too broadly, it is difficult to determine both progress and accomplishment. "I want to have a better relationship with my wife" is a very broad goal, difficult to verify. "I want to socialize more, you know, with couples we both enjoy" comes closer, but "socialize more" needs more clarity.

It is not always necessary to count things to determine whether a goal has been reached, though sometimes counting is helpful. Helping is about living more fully, not about accounting activities. At a minimum, however, desired outcomes need to be capable of being verified in some way. For instance, a couple might say something like "Our relationship is better, not because we've stop squabbling. In fact, we've discovered that we like to squabble. But life is better because the meanness has gone out of our squabbling. We accept each other more. We listen more carefully, we talk about more personal concerns, we are more relaxed, and we make more mutual decisions about issues that affect us both." This couple does not need a scientific experiment to verify that they have improved their relationship.

Help Clients Establish Goals That Make a Difference

Outcomes and accomplishments are meaningless if they do not have the required impact on the client's life. The goals clients choose should have substance to

them—that is, some significant contribution toward managing the original problem situation or developing some opportunity.

> Vitorio ran the family business. His son, Anthony, worked in sales. After spending a few years learning the business and getting an MBA part time at a local university, Anthony wanted more responsibility and authority. His father never thought that he was "ready." They began arguing quite a bit, and their relationship suffered from it. Finally, a friend of the family persuaded them to spend time with a consultant-counselor who worked with small family businesses. He spent relatively little time listening to their problems. After all, he had seen this same problem over and over again—the reluctance and conservatism of the father, the pushiness of the son.
>
> Vitorio wanted the business to stay on a tried-and-true course. Anthony wanted to be the company's marketer, to move it into new territory. After a number of discussions with the consultant-counselor, they settled on this scenario: A "marketing department" headed by Anthony would be created. He could divide his time between sales and marketing as he saw fit, provided that he maintained the current level of sales. Vitorio agreed not to interfere. They would meet once a month with the consultant-counselor to discuss problems and progress. Vitorio insisted that the consultant's fee come from increased sales. After some initial turmoil, the bickering decreased dramatically. Anthony easily found new customers, although they demanded modifications in the product line, which Vitorio reluctantly approved. Both sales and margins increased to the point that another person was needed in sales.

Not all issues in family businesses are handled as easily. In fact, a few years later, Anthony left the business and founded his own. But the goal package they worked out—the deal they cut—made quite a difference both in the father-son relationship and in the business.

Second, goals have substance to the degree that they help clients stretch themselves. As Locke and Latham (1984) note: "Extensive research . . . has established that, within reasonable limits, the . . . more challenging the goal, the better the resulting performance. . . . People try harder to attain the hard goal. They exert more effort. . . . In short, people become motivated in proportion to the level of challenge with which they are faced. . . . Even goals that cannot be fully reached will lead to high effort levels, provided that partial success can be achieved and is rewarded" (pp. 21–26). Consider the following case:

> A young woman was a quadriplegic as a result of an auto accident. In the beginning, she was full of self-loathing: "The accident was all my fault; I was just stupid." She was close to despair. Over time, however, with the help of a counselor, she came to see herself, not as a victim of her own "stupidity" but as someone who could bring hope to young people with life-changing afflictions. In her spare time, she visited young patients in hospitals and rehabilitation centers, got some to join self-help groups, and generally helped people like herself to manage an impossible situation in a more humane way. One day, she said to her counselor, "The best thing I ever did was to stop being a victim and become a fellow traveler with people like myself. The last two years, though bitter at times, have been the best years of my life." She had set her goal quite high—becoming an outgoing helper instead of remaining a self-centered victim—but it proved to be quite realistic.

Of course, when it comes to goals, challenging should not mean impossible. There seems to be a curvilinear relationship between goal difficulty and goal performance. If the goal is too easy, people see it as trivial and ignore it. If the goal is too difficult, it is not accepted. However, this difficulty-performance ratio differs from person to person. What is small for some is big for others (see the later section titled "Adaptive Goals.")

Help Clients Set Goals That Are Prudent

Although the helping model described in this book encourages a bias toward action on the part of clients, action needs to be both directional and wise. Discussing and setting goals should contribute to both direction and wisdom. The following case begins poorly but ends well:

> Harry was a sophomore in college who was admitted to a state mental hospital because of some bizarre behavior at the university. He was one of the disc jockeys for the university radio station. He came to the notice of college officials one day when he put on an attention-getting performance that included rather lengthy dramatizations of grandiose religious themes. In the hospital, it was soon discovered that this quite pleasant, likable young man was actually a loner. Everyone who knew him at the university thought that he had many friends, but in fact he did not. The campus was large, and his lack of friends went unnoticed.
>
> Harry was soon released from the hospital but returned weekly for therapy. At one point, he talked about his relationships with women. Once it became clear to him that his meetings with women were perfunctory and almost always took place in groups—he had imagined that he had a rather full social life with women—Harry launched a full program of getting involved with the opposite sex. His efforts ended in disaster, however, because Harry had some basic sexual and communication problems. He also had serious doubts about his own worth and therefore found it difficult to make a gift of himself to others. He ended up in the hospital again.
>
> The counselor helped Harry get over his sense of failure by emphasizing what Harry could learn from the "disaster." With the therapist's help, Harry returned to the problem-clarification and new-perspectives part of the helping process and then established more realistic short-term goals regarding getting back "into community." The direction was the same—establishing a realistic social life—but the goals were now more prudent because they were "bite-size." Harry attended socials at a local church where a church volunteer provided support and guidance.

Harry's leaping from problem clarification to action without taking time to discuss possibilities and set reasonable goals was part of the problem rather than part of the solution. His lack of success in establishing solid relationships with women actually helped him see his problem with women more clearly. There are two kinds of prudence: playing it safe is one, doing the wise thing is the other. Problem management and opportunity development should be venturesome. They are about making wise choices rather than playing it safe.

Help Clients Formulate Realistic Goals

Setting goals that demand clients stretch can help clients energize themselves. They rise to the challenge. On the other hand, goals set too high can do more harm than good. Locke and Latham (1984) put it succinctly:

> Nothing breeds success like success. Conversely, nothing causes feelings of despair like perpetual failure. A primary purpose of goal setting is to increase the motivation level of the individual. But goal setting can have precisely the opposite effect if it produces a yardstick that constantly makes the individual feel inadequate (p. 39).

A goal is realistic if the client has access to the resources needed to accomplish it and the goal is under the client's control, not hampered by external circumstances.

Resources: Help clients choose goals for which the resources are available. It does little good to help clients develop specific, substantive, and verifiable goals if

the resources needed for their accomplishment are not available. Consider the case of Rory, who, because of a merger and extensive restructuring, has had to take a demotion. He now wants to leave the company and become a consultant.

> INSUFFICIENT RESOURCES: Rory does not have the assertiveness, marketing savvy, industry expertise, and interpersonal style needed to become an effective consultant. Even if he did, he does not have the financial resources needed to tide him over while he develops a business.
>
> SUFFICIENT RESOURCES: Challenged by the outplacement counselor, Rory changes his focus. Graphic design is an avocation of his. He is not good enough to take a technical position in the company's design department, but he does apply for a supervisory role in that department. He is good with people, very good at scheduling and planning, and knows enough about graphic design to discuss issues meaningfully with the members of the department.

Rory combines his managerial skills with his interest in graphic design to move in a more realistic direction. The move is challenging, but it can have a substantial impact on his work life. For instance, the opportunity to hone his graphic design skills will open up further career possibilities.

Control: Help clients choose goals that are under their control. Sometimes clients defeat their own purposes by setting goals that are not under their control. For instance, it is common for people to believe that their problems would be solved if only other people would not act the way they do. In most cases, however, we do not have any direct control over the ways others act. Consider the following example:

> Tony, a 16-year-old boy, felt that he was the victim of his parents' inability to relate to each other. Each tried to use him in the struggle, and at times he felt like a Ping-Pong ball. A counselor helped him see that he could probably do little to control his parents' behavior but that he might be able to do quite a bit to control his *reactions* to his parents' attempts to use him. For instance, when his parents started to fight, he could simply leave instead of trying to "help." If either tried to enlist him as an ally, he could say that he had no way of knowing who was right. Tony also worked at creating a good social life outside the home. That helped him weather the tensions he experienced when at home.

Tony needed a new way of managing his interactions with his parents to minimize their attempts to use him as a pawn in their own interpersonal game.

Goals are not under clients' control if they are blocked by external forces that they cannot influence. "To live in a free country" may be an unrealistic goal for a person living in a totalitarian state because one cannot change internal politics, nor can one change emigration laws in one's own country or immigration laws in other countries. "To live as freely as possible in a totalitarian state," however, might well be an aim that could be translated into realistic goals.

Help Clients Set Goals That Can Be Sustained

Clients need to commit themselves to goals that have staying power. One separated couple said that they wanted to get back together again. They did so only to get divorced again within six months. Their goal of getting back together again was achievable but not sustainable. Perhaps they should have asked themselves, "What do we need to do not only to get back together but also to stay together? What would our marriage have to look like to become and remain workable?" In discretionary-change situations, the issue of sustainability needs to be visited early on.

Many Alcoholics Anonymous-like programs work because of their "one day at a time" approach. The goal of being, let us say, drug free has to be sustained only over a single day. The next day is a new era. In a previous example, Vitorio and Anthony's arrangement had enough staying power to produce good results in the short term. It also allowed them to reset their relationship and to improve the business. The goal was not designed to produce a lasting business arrangement because, in the end, Anthony's aspirations were bigger than the family business.

Help Clients Choose Goals That Have Some Flexibility

In many cases, goals have to be adapted to changing realities. Therefore, there might be some trade-offs between goal specificity and goal flexibility in uncertain situations. Napoleon noted this when he said, "He will not go far who knows from the first where he is going." Sometimes making goals too specific or too rigid does not allow clients to take advantage of emerging opportunities.

Even though he liked the work and even the company he worked for, Jessie felt like a second-class citizen. He thought that his supervisor gave him most of the dirty work and that there was an undercurrent of prejudice against Hispanics in his department. Jessie wanted to quit and get another job, one that would pay the same relatively good wages he was now earning. A counselor helped Jessie challenge his choice. Even though the economy was booming, the industry in which Jessie was working was in recession. There were few jobs available for workers with Jessie's skills. The counselor helped Jessie choose an interim goal that was more flexible and more directly related to coping with his present situation. The interim goal was to use his time preparing himself for a better job outside his current industry. In six months to a year, he could be better prepared for a career in the "new economy." Jessie began volunteering for special assignments that helped him learn some new skills and took some crash courses dealing with computers and the Internet. He felt good about what he was learning and more easily ignored the prejudice.

Counseling is a living, organic process. Just as organisms adapt to their changing environments, the choices clients make need to be adapted to their changing circumstances.

Help Clients Choose Goals Consistent with Their Values

Although helping is a process of social influence, it remains ethical only if it respects, within reason, the values of the client. Values are criteria we use to make decisions. Helpers can challenge clients to reexamine their values, but they should not encourage clients to perform actions that are not in keeping with their values.

The son of Vincente and Consuela Garza is in a coma in the hospital after an automobile accident. He needs a life-support system to remain alive. His parents are experiencing a great deal of uncertainty, pain, and anxiety. They have been told that there is practically no chance that their son will ever come out of the coma. One possibility is to terminate the life-support system. The counselor should not urge them to terminate the life-support system if that is counter to their values. But she can help them explore and clarify the values involved. In this case, the counselor suggests that they discuss their decision with their clergyman. In doing so, they find out that the termination of the life-support system would not be against the tenets of their religion. Now they are free to explore other values that relate to their decision.

Some problems involve a client's trying to pursue contradictory goals or values. Chester, the ex-Marine, wants to get an education, but he also wants to make a decent living as soon as possible. Going to school full time would put him in debt, but failing to get a college education would lessen his chances of securing the kind of job he wants. The counselor helps him identify and use his values to consider some trade-offs. Chester chooses to work part time and go to school part time. He chooses a job in an office instead of a job in construction. Even though the latter pays better, it would be much more exhausting and would leave him with little energy for school.

Help Clients Establish Realistic Time Frames for the Accomplishment of Goals

Goals that are to be accomplished "sometime or other" probably won't be accomplished at all. Therefore, helping clients put some time frames in their goals can add value. Greenberg (1986) talks about immediate, intermediate, and final outcomes. Here's what they look like when applied to Janette's problem situation. She suffers in a variety of ways because she lets others take advantage of her. She needs to become more assertive. She needs to stand up for her own rights.

- *Immediate outcomes* are changes in attitudes and behaviors evident in the helping sessions themselves. For Janette, the helping sessions constitute a safe forum for her to become more assertive. In her dialogues with her counselor, she learns and practices the skills of being more assertive.
- *Intermediate outcomes* are changes in attitudes and behaviors that lead to further change. It takes Janette a while to transfer her assertiveness skills both to the workplace and to her social life. She chooses relatively safe situations to practice being more assertive. For instance, she stands up to her mother more often.
- *Final outcomes* refer to the completion of the overall program for constructive change through which problems are managed and opportunities developed. It takes more than two years for Janette to become assertive in a consistent day-to-day way.

The next example deals with a young man who has been caught shoplifting. Here, too, there are immediate, intermediate, and final outcomes.

Jensen, a 22-year-old on probation for shoplifting, was seeing a counselor as part of a court-mandated program. An immediate need in his case was overcoming his resistance to his court-appointed counselor and developing a working alliance with her. Because of the counselor's skill and her unapologetic caring attitude that had some toughness in it, he quickly came to see her as "on his side." Their relationship became a platform for establishing further goals. An intermediate outcome was attitudinal in nature. Brainwashed by what he saw on television, Jensen thought that America owed him some of its affluence and that personal effort had little to do with it. The counselor helped him see that his entitlement attitude was unrealistic and that hard work played a key role in most payoffs. There were two significant final outcomes in Jensen's case. First, he made it through the probation period free of any further shoplifting attempts. Second, he acquired and kept a job that helped him pay his debt to the retailer.

Taussig (1987) talks about the usefulness of setting and executing minigoals early in the helping process. Consider the case of Gaston:

Gaston, a 16-year-old school dropout and loner, was arrested for arson. Though he lived in the inner city and came from a single-parent household, it was difficult to discover just why he had

turned to arson. He had torched a few structures that seemed relatively safe to burn. No one was injured. Was his behavior a cry for help? Social rage expressed in vandalism? Just a way of getting some kicks? The social worker assigned to the case found these questions too speculative to be of much help. Instead of looking for the root causes of Gaston's malaise, she tried to help him set some simple goals that appealed to him and that could be accomplished relatively quickly. One goal was social support. The counselor helped Gaston join a social club at a local youth center. A second goal was having a role model. Gaston struck up a friendship with one of the more active members of the center, a dropout who had gotten a high school equivalency degree. He also received some special attention from one of the adult monitors of the center. This was the first time he had experienced the presence of a strong adult male in his life. A third goal was broadening his view of the world. A group of college students who did volunteer work in both the black and the white communities invited Gaston and a couple of the other boys to help them in a housing facility for the elderly located in a white neighborhood. This was the first time he had been engaged in any kind of work outside the black community. The experience helped him push back the walls a bit. He saw white people with real needs. The accomplishment of these minigoals helped Gaston become a bit more realistic about the world around him. He enjoyed the camaraderie of the volunteer group and began experiencing himself in a new, more constructive way.

It is not suggested here that goal setting is a facile answer to intractable social problems. But the achievement of sequenced minigoals can go a long way toward making a dent in intractable problems.

There is no such thing as a set time frame for every client. Some goals need to be accomplished now, some soon; others are short-term goals; still others are long term. Consider the case of a priest who had been unjustly accused of child molestation.

- A *"now" goal*: some immediate relief from debilitating anxiety attacks and keeping his equilibrium during the investigation and court procedings.
- A *"soon" goal*: obtaining the right kind of legal aid.
- A *short-term goal*: winning the court case.
- A *long-term goal*: reestablishing his credibility in the community and learning how to live with those who would continue to suspect him.

There is no particular formula for helping all clients choose the right mix of goals at the right time in the right sequence. Although helping is based on problem-management principles, it remains an art.

It is not always necessary, then, to make sure that each goal in a client's program for constructive change has all the characteristics outlined in this chapter. For some clients, identifying broad goals is enough to kick start the entire problem-management and opportunity-development process. They shape the goals themselves. For others, some help in formulating more specific goals is called for. The principle is clear: Help clients develop goals that have some sort of agency—if not urgency—built in. In one case, this may mean helping a client deal with clarity; in another, with substance; in still another, with realism, values, or time frame. Box 16-1 outlines some questions that you can help clients ask themselves to choose goals from among possibilities.

Needs Versus Wants

In some cases, what clients want and what they need coincide. The lonely person wants a better social life and needs some kind of community to be more engaged in

Box 16-1 Questions for Shaping Goals

- Is the goal stated in outcome or results language?
- Is the goal specific enough to drive behavior? How will I know when I have accomplished it?
- If I accomplish this goal, will it make a difference? Will it really help manage the problems and opportunities I have identified?
- Does this goal have "bite" while remaining prudent?
- Is it doable?
- Can I sustain this goal over the long haul?
- Does this goal have some flexibility?
- Is this goal in keeping with my values?
- Have I set a realistic time frame for the accomplishment of the goal?

life. In other cases, clients might not want what they need. The alcoholic may need a life of total abstention but wants to drink moderately. Brainstorming possibilities for a better future should focus on the package of needs and wants that makes sense for this particular client. Consider the case of Irv:

Irv, a 41-year-old entrepreneur, collapsed one day at work. He had not had a physical in years. He was shocked to learn that he had both a mild heart condition and multiple sclerosis. His future was uncertain. The father of one of his wife's friends had multiple sclerosis but had lived and worked well into his seventies. But no one knew what the course of the disease would be. Irv had made his living by developing and then selling small businesses. He loved his work and wanted to continue to do it. But what he needed was a less physically demanding work schedule. Working 60 to 70 hours per week was no longer in the cards. Furthermore, he had always plowed the money he received from selling one business into starting up another. But now he needed to think of the future financial well-being of his wife and three children. Up to this point, his philosophy had been that the future would take care of itself. It was very wrenching for him to move from a lifestyle he wanted to one he needed.

Irv was a voluntary client who had to look at needs instead of wants. Involuntary clients often need to be challenged to look beyond their wants to their needs. One woman who voluntarily led a homeless life was attacked and severely beaten on the street. But she still wanted the freedom that came with her lifestyle. When a court-appointed counselor challenged her to consider the kinds of freedom she wanted, she admitted that freedom from responsibility was at the core. "I want to do what I want to do when I want to do it." It was her choice to live the way she did. The counselor helped her explore the consequences of her choices and tried to help her look at other options. How could she be "free" and not at risk? Was there some kind of trade-off between what she wanted and what she needed? In the end, of course, the decision was hers.

In the following case, the client, dogged by depression, was ultimately able to integrate what he wanted with what he needed:

Milos had come to the United States as a political refugee. The last few months in his native land had been terrifying. He had been jailed and beaten. He got out just before another crackdown. Once the initial euphoria of having escaped had subsided, he spent months feeling confused and disorganized. He tried to live as he had in his own country, but the North American culture was too invasive. He thought he should feel grateful, and yet he felt hostile. After two years of misery, he began seeing a counselor. He had resisted getting help because "back home" he had been "his own man."

In discussing these issues with a counselor, it gradually dawned on him that he *wanted* to reestablish links with his native land but that he *needed* to integrate himself into the life of his host country. He saw that the accomplishment of both these broad aims would be very freeing. He began finding out how other immigrants who had been here longer than he had accomplished this goal. He spent time in the immigrant community, which differed from the refugee community. In the immigrant community, there was a long history of keeping links to the homeland culture alive. But the immigrants had also adapted to their adopted country in practical ways that made sense to them. The friends he made became role models for him. The more active he became in the immigrant community, the more his depression lifted.

In this case goals responded to a mixture of needs and wants. If Milos had focused only on one or the other, he would have remained unhappy.

Emerging Goals

It is not always a question of *designing* and *setting* goals in an explicit way. Rather, goals can naturally emerge through the client-helper dialogue. Often when clients talk about problems and unused opportunities, possible goals and action strategies bubble up. Clients, once they are helped to clarify a problem situation through a combination of probing, empathic highlights, and challenge, begin to see more clearly what they want and what they have to do to manage the problem. Indeed, some clients must first act in some way before they find out just what they want to do. Once goals begin to emerge, counselors can help clients clarify them and find ways of implementing them. However, "emerge" should not mean that clients wait around until "something comes up." Nor should it mean that clients try many different solutions in the hope that one of them will work. These kinds of "emergence" tend to be self-defeating.

Though goals do often emerge, explicit goal setting is not to be underrated. Taussig (1987) showed that clients respond positively to goal setting even when goals are set very early in the counseling process. A client-centered, "no one right formula" approach seems to be best. Although all clients need focus and direction in managing problems and developing opportunities, what focus and direction will look like will differ from client to client.

Adaptive Goals

Collins and Porras (1994) coined the term "big, hairy, audacious goals" (BHAGs) for "superstretch" goals. The term, however, fits better into the hype of business than the practicalities of helping. It is true that some clients are looking for big goals. They believe, and perhaps rightly so, that without big goals their lives will not be substantially different. But even for clients who choose goals that can be called "big" in one way or another, a bit-by-bit approach to achieving these goals is needed. It is usually better to take a big goal and divide it into smaller pieces lest the big goal on its own seem too daunting. The meaning of the phrase "within reasonable limits" will differ from client to client.

Satisfactory alternatives. While difficult or "stretch" goals are often the most motivational, this is not true in every case. Some clients choose to make very substantive changes in their lives, but others take a more modest approach. Wheeler and Janis (1980) caution against the search for the "absolute best" goal all the time: "Sometimes it is more reasonable to choose a satisfactory alternative than to continue searching for the absolute best. The time, energy, and expense of finding the best possible choice may outweigh the improvement in the choice" (p. 98). Consider the following case:

Joyce, a buyer for a large retail chain, is nearing middle age. She has centered most of her nonworking life on her aging mother. Joyce had even turned down promotions because the new positions would have demanded more travel and longer hours. Her mother had been pampered by her now-deceased husband and her three children and allowed to have her way all her life. She now played the role of the tyrannical old woman who constantly feels neglected and who can never be satisfied. Though Joyce knew that she could live much more independently without abandoning her mother, she found it very difficult to move in that direction. Guilt stood in the way of any change in her relationship with her mother. She even said that being a virtual slave to her mother's whims was not as bad as the guilt she experienced when she stood up to her mother or "neglected" her.

The counselor helped Joyce experiment with a few new ways of dealing with her mother. For instance, Joyce went on a two-week trip with friends even though her mother objected, saying that it was ill timed. Although the experiments were successful in that no harm was done to Joyce's mother and Joyce did not experience excessive guilt, counseling did not help her restructure her relationship with her mother in any substantial way. The experiments, however, did give her a sense of greater freedom. For instance, she felt freer to say no to this or that demand of her mother. This provided enough slack, it seems, to make Joyce's life more livable.

In this case, counseling helped the client fashion a life that was "a little bit better," though not as good as the counselor thought it could be. When asked, "What do you want?" Joyce had in effect replied, "I want a bit more slack and freedom, but I do not want to abandon my mother." Joyce's "new" lifestyle did not differ dramatically from the old. But perhaps it was enough for her. It was a case of choosing a satisfactory alternative rather than the best.

Leahey and Wallace (1988) offer the following example of another client in adaptive mode:

> "For the last five years, I've thought of myself as a person with low self-esteem and have read self-help books, gone to therapists, and put things off until I felt I had good self-esteem. I just need to get on with my life, and I can do that with excellent self-esteem or poor self-esteem. Treatment isn't really necessary. Being a person with enough self-esteem to handle situations is good enough for me." (p. 216)

The following client, putting a more positive spin on the problem situation itself, takes a more adaptive route:

> "I would say that I am completely cured. . . . I can still pinpoint these conditions which I had thought to be symptoms. . . . These worries and anxieties make me prepare thoroughly for the daily work I have to do. They prevent

me from being careless. They are expressions of the desire to grow and to develop." (Weisz, Rothbaum, & Blackburn, 1984, p. 964)

In some cases, clients will be satisfied with "surface" solutions such as the elimination of symptoms. For instance, a couple is satisfied with reducing and managing the petty annoyances they both experience in their relationship. Although the very structure of the relationship may be problematic because some fundamental inequalities or inequities are built into the relationship, this couple doesn't want to do much about restructuring the relationship to avoid the annoyances they experience.

Some helpers, reviewing these examples, would be disappointed. Others would see them as legitimate examples of adapting to rather than changing reality. However, all these clients did act to achieve some kind of goal, however minimal. They did *something* about the way they thought and behaved. And they felt that their lives were better because of it.

Coping. Choosing an adaptive rather than a stretch goal has been associated with *coping* (Coyne & Racioppo, 2000; Folkman & Moskowitz, 2000; Lazarus, 2000; Snyder, 1999). All human beings cope rather than conquer at times. In fact, in human affairs as a whole, coping probably outstrips conquering. And sometimes people have no other choice. It's cope or succumb. For some, coping has a bad reputation because it seems to be associated with mediocrity. But in many difficult situations, helping clients cope is one of the best things helpers can do. Coping often has an enormous upside. A young mother with three children has just lost her husband. When someone asks, "How's she doing?" the response is, "She's coping quite well." She's not letting her grief get the better of her. She is taking care of the children and helping them deal with their sense of loss. She's moving along on all the tasks that a death in a family entails. At this stage, what could be more positive than that?

Folkman and Moskowitz (2000), from a positive-psychology point of view, see positive affect as playing an important role in coping. And so they ask how positive affect is generated and sustained in the face of chronic stress. They suggest three ways:

- ***Positive reappraisal:*** Help clients reframe situations to see them in a positive light. For instance, Victor, recovering from multiple injuries received when he fell off his bicycle, sees the entire rehabilitation process as "one big daunting glob." Taken as a whole, it looks undoable. However, the rehabilitation counselor first helps Victor picture himself once more engaging in the ordinary task of everyday life, even riding a bicycle. That is, she helps him separate the very desirable end state from the arduous set of activities that will get him there. Victor does not ever have to cope with the "big glob." He needs to cope with each day. Victor is rebuilding his body. Every day he is doing something to forge a link in the recovery chain. Each week he is helped to see that there is something he can now do that he was not able to do the previous week. Victor has low moments. Of course. But he also has moments of positive affect that keep him going.
- ***Problem-focused coping:*** Help clients deal with problems one at a time as they come up. For instance, Agnes is caring for her husband who has multiple sclerosis. There is a certain unpredictability and uncontrollability associated with her husband's disease. However, she does not have to cope with his multiple sclerosis. Rather, each day or each week or each stage brings its own set of problems. Her counselor can help her "pursue realistic, attainable goals by focusing on specific proximal tasks or problems related to caregiving" (Folkman and Moskowitz, p. 650). Agnes is heartened by the very fact that she faces and deals with each problem as it arises. The sense of mastery and control she experiences is accompanied by positive affect. Even in the face of great stress, she is buoyed up enough to move on to the next step or stage with grace.
- ***Infusing ordinary events with positive meaning:*** In one study, Folkman and Moskowitz asked the participants, all caregivers for people with AIDS, to describe something they did or something they experienced that made them feel good and helped them get through the day. More than 99% of the caregivers interviewed talked about some such event. The point is that, even at times of great stress, people note and remember positive events. The events were not "big deals." Rather they were "ordinary events," such as having dinner with a friend or seeing some flowers in a hospital room or receiving a compliment from someone. But these events together with the positive affect they produced helped them get through the day.

Lazarus (2000) adds a note of caution to all of this. He notes that so-called positively valenced emotions such as love and hope are often mixed with negative feelings and are therefore experienced as distressing. It is painful for caregivers to see those they love in pain. And so-called negatively valenced emotions such as anger are not unequivocally negative. Anger can be experienced as positive or is often mixed with positive feelings. While counselors can help clients under great stress do things that will increase the kind of positive affect that makes their lives more livable, there are limits. In other words, Lazarus is cautioning us to use but be careful with positive-psychology approaches.

Strategic self-limitation. Robert Leahy (1999) relates the kinds of reluctance and resistance reviewed in Chapter 9 to goal setting under the rubric of "strategic self-limitation." Reluctant and resistant behaviors serve the purpose of setting limits on change. All change carries some risk and uncertainty, and these can be distressing in themselves. Putting up barriers to change limits both risk and uncertainty. It is the client's way of saying, "Enough is enough. I don't want to engage in a change program that will lead to further effort, stress, failure, and regret." The strategies such clients use are the ordinary ones: attacking the therapist, failing to do homework assignments, being emotionally volatile, getting mired down in a "this won't work" mentality, and so forth. Helpers, even though they can point out to clients the ways they are engaging in what Leahy calls "self-handicapping," don't choose goals for clients. There is a huge difference between best possible goals and goals that are possible for this client in this set of circumstances.

The main point, however, is that helping clients cope with the adversities of life does not mean that you are shortchanging them. When you are helping them adapt rather than conquer, you are not failing. Neither are they. When it comes to outcomes, there is no one universal rule of success.

THE "REAL-OPTIONS" APPROACH

How can you help clients set goals if the future is uncertain—as it always is to one degree or another? One way is through the "real-options" approach. Borrowed from business settings (Trigeorgis, 1999), it has applications to personal life. The trick is flexibility. If the future is uncertain, it pays to have a broad range of options open. There is no use investing a great deal of time and energy designing a goal that will have to be changed because the client's world changes. The economics are poor. Therefore, help clients choose one or more backup goals to take care of such eventualities. If a client comes up with three viable possibilities, he or she may pursue one while holding the other two in reserve. In this way, the client has not only direction but also a contingency plan. If the world changes, the client can choose the best goals—that is, the one that best fits the circumstances at the time. Consider this example:

Linda is a young woman working for a computer firm in Mexico. Born and raised in Iraq (Linda is not her real name), she has made a tortuous journey through South and Central America as an illegal immigrant. Her journey included prostitution and a range of harrowing, even life-threatening experiences. The upside of all this is that she has learned to live by her wits. After returning from an illegal trip to the United States, she has one goal: to live there permanently. She takes counsel with a friend of hers, a lawyer in Mexico, telling him of her plan to live as an illegal in the United States. Both intelligent and socially savvy, she feels that she can pull it off.

Her lawyer friend, knowing that her ultimate goal is to live permanently in the United States, helps her review a range of instrumental goals—goals in themselves but also steps toward helping her achieve her ultimate goal. They dialogue about possibilities. Options other than living by her wits as an illegal immigrant include political refugee status, obtaining a green card, marrying a U.S. citizen, marrying a foreigner who is most likely to get a green card, and being included in the quota of immigrants allowed permanent resident status because they have essential skills such as those needed in booming technology industries. A set of strategies would be needed to pursue each of these. Linda's future is certainly filled with risk and uncertainty. She now has to choose an instrumental goal that she thinks offers the best possibility for success. But now she also has fallback options.

While clients can identify and develop further goal options as the risky and uncertain world changes, doing so upfront has advantages. We have already seen how the real-options approach applies to clients fashioning a career in medicine. If the ultimate goal is to have a satisfying career in health care, the first goal might be to become a doctor. However, if there is risk and uncertainty in the pursuit of this goal, then a cluster of other career possibilities in health care can be reviewed and chosen as standby positions. The economics are better.

So choosing need not be a once-and-forever decision. The client thinks, "I'll go this route until another of my real options seems better." Furthermore, having real options helps the client kill an option that is no longer working. Or an option that is not working at this time can be put on the back burner. The real-options approach provides freedom and flexibility. This approach keeps clients from falling into the status quo decision-making trap outlined earlier.

A BIAS FOR ACTION AS A METAGOAL

Although clients set goals that are directly related to their problem situations, there are also metagoals or superordinate goals that would make them more effective in

pursuing the goals they set and in leading fuller lives. The overall goal of helping clients become more effective in problem management and opportunity development was mentioned in Chapter 1. Another metagoal is to help clients become more effective "agents" in life—doers rather than mere reactors, preventers rather than fixers, initiators rather than followers.

Lawrence was liked by his superiors for two reasons. First, he was competent—he got things done. Second, he did whatever they wanted him to do. They moved him from job to job when it suited them. He never complained. However, as he matured and began to think more of his future, he realized that there was a great deal of truth in the adage "If you're not in charge of your own career, no one is." After a session with a career counselor, he outlined the kind of career he wanted and presented it to his superiors. He pointed out to them how this would serve both the company's interests and his own. At first they were taken aback by Lawrence's assertiveness, but then they agreed. Later, when they seemed to be sidetracking him, he stood up for his rights. Assertiveness was his bias for action.

The doer is more likely to pursue stretch goals rather than adaptive goals in managing problems. The doer is also more likely to move beyond problem management to opportunity development.

Evaluation Questions for Step II-B

- To what degree am I helping clients choose specific goals from among a number of possibilities?
- How well do I challenge clients to translate good intentions into broad goals and broad goals into specific, actionable goals?
- To what extent do I help clients shape goals that have the characteristics outlined in Box 16-1?
- How effectively do I help clients establish goals that take into consideration both needs and wants?
- To what degree do I help clients become aware of goals that are naturally emerging from the helping process?
- How well do I help clients identify real-option goals when the future is both risky and uncertain?
- How effectively do I help clients choose the right mix of adaptive and stretch goals?
- How well do I help clients explore the consequences of the goals they are setting?
- How do I help clients make a bias toward action one of their metagoals?

CHAPTER

17

Step II-C: "What Am I Willing to Pay for What I Want?" Commitment

Helping Clients Commit Themselves to a Better Future
Help Clients Set Goals That Are Worth More Than They Cost
Help Clients Set Appealing Goals
Help Clients Own the Goals They Set
Help Clients Deal with Competing Agendas
Great Expectations: Client Self-Efficacy
The Nature of Self-Efficacy
Help Clients Develop Self-Efficacy
Skills
Corrective feedback
Positive feedback
Using success as a reinforcer
Models
Providing encouragement
Reducing fear and anxiety
Stage II and Action
The Shadow Side of Goal Setting
Evaluation Questions for Step II-C

As mentioned earlier, Step II-C is not really a step in the true sense of the term but a dimension of the goal-setting process. Clients may formulate goals, but that does not mean that they are willing to pay for them. Once clients state what they want and set goals, the battle is joined, as it were. It is as if clients' "old selves" or old lifestyles begin vying for resources with their potential "new selves" or new lifestyles. On a more positive note, history is full of examples of people whose strength of will to accomplish some goal has enabled them to do seemingly impossible things.

> A woman with two sons in their twenties was dying of cancer. The doctors thought she could go at any time. However, one day she told the doctor that she wanted to live to see her older son get married in six months. The doctor talked vaguely about "trusting in God" and "playing the cards she had been dealt." Against all odds, the woman lived to see her son get married. Her doctor was at the wedding. During the reception, he went up to her and said, "Well, you got what you wanted. Despite the way things are going, you must be deeply satisfied." She looked at him wryly and said, "But Doctor, my second son will get married someday."

Although the job of counselors is not to encourage clients to heroic efforts, counselors should not undersell clients, either.

In Step II-C, which is usually intermingled with the other two steps of Stage II, counselors help their clients pose and answer such questions as these:

- Why should I pursue this goal?
- Is it worth it?
- Is this where I want to invest my limited resources of time, money, and energy?
- What competes for my attention?
- What are the incentives for pursuing this agenda?
- How strong are competing agendas?

Again, there is no formula. Some clients, once they establish goals, race to accomplish them. At the other end of the spectrum are clients who, once they decide on goals, stop dead in the water. Furthermore, the same client might speed toward the accomplishment of one goal and crawl toward another. Or start out fast and then slow to a crawl. The job of the counselor is to help clients face up to their commitments.

Helping Clients Commit Themselves to a Better Future

There is a difference between initial commitment to a goal and an ongoing commitment to a strategy or plan to accomplish the goal. The proof of initial commitment lies in goal-accomplishing action. For instance, one client who chose as a goal a less abrasive interpersonal style began to engage in an "examination of conscience" each evening to review what his interactions with people had been like that day. In doing so, he discovered, somewhat painfully, that in some of his interactions he actually moved beyond abrasiveness to contempt. That forced him back to a deeper analysis of the problem situation and the blind spots associated with it. Being dismissive of people he did not like or who were "not important" had become ingrained in his interpersonal lifestyle.

There are several things you can do to help clients in their initial commitment to goals and the kind of action that is a sign of that commitment: You can help clients set goals that are "cost-effective," help them make goals appealing, help them enhance their sense of ownership, and help them deal with competing agendas.

Help Clients Set Goals That Are Worth More Than They Cost

Here we revisit the economics of helping. Cost-effectiveness could have been included in the characteristics of workable goals outlined in the previous chapter, but it is considered here instead because of its close relationship to commitment. Some goals that can be accomplished carry too high a cost in relation to their payoff. It may sound overly technical to ask whether any given goal is "cost-effective," but the principle remains important. Skilled counselors help clients budget rather than squander their resources—work, time, emotional energy.

Eunice discovered that she had a terminal illness. In talking with several doctors, she found out that she would be able to prolong her life a bit through a combination of surgery, radiation treatment, and chemotherapy. However, no one suggested that these would lead to a cure. She also found out what each form of treatment and each combination would cost, not so much in monetary terms, but in added anxiety and pain. Ultimately, she decided against all three, since no combination of them promised much for the quality of the life that was being prolonged. Instead, with the help of a doctor who was an expert in hospice care, she developed a scenario that would ease both her anxiety and her physical pain as much as possible.

It goes without saying that another patient might have made a different decision. Costs and payoffs are relative. Some clients might value an extra month of life no matter what the cost.

Since it is often impossible to determine the cost-benefit ratio of any particular goal, counselors can add value by helping clients understand the consequences of choosing a particular goal. For instance, a client who sets her sights on a routine job with minimally adequate pay might find that this outcome takes care of some of her immediate needs but proves to be a poor choice in the long run. Helping clients foresee the consequences of their choices may not be easy. Another woman with cancer felt that she was no longer able to cope with the sickness and depression that came with her chemotherapy treatments. She decided abruptly one day to end the treatment, saying that she didn't care what happened. No one helped her explore the consequences of her decision. Eventually, when her health deteriorated, she had second thoughts about the treatments, saying, "There are still a number of things I must do before I die." But it was too late. Some reasonable challenge on the part of a helper might have helped her make a better decision.

The balance-sheet methodology outlined in Chapter 19 is a tool you can use selectively to help clients weigh costs against benefits in choosing both goals and the programs to implement goals. The balance sheet, as used in Chapter 19, also helps clients choose best-fit strategies for accomplishing their goals.

Help Clients Set Appealing Goals

Just because goals will help in managing a problem situation or developing an opportunity and are cost-effective does not mean that they will automatically appeal

to the client. Setting appealing goals is common sense, but it is not always easy to do. For instance, for many if not most addicts, a drug-free life is not immediately appealing, to say the least.

A counselor tries to help Chester work through his resistance to giving up prescription drugs. While he listens and is empathic, the counselor also challenges the way Chester has come to think about drugs and his dependency on them. One day the counselor says something about "giving up the crutch and walking straight." In a flash Chester sees himself not as a drug addict but as a "cripple." A friend of his had lost a leg in a land-mine explosion in Kosovo. He remembered how his friend had longed for the day when he could be fitted with a prosthesis and throw his crutches away. The image of "throwing away the crutch" and "walking straight" proved to be very appealing to Chester.

An incentive is a promise of a reward. As such, incentives can contribute to developing a climate of hope around problem management and opportunity development. A goal is appealing if there are incentives for pursuing it. Counselors need to help clients in their search for incentives throughout the helping process. Ordinarily, negative goals—giving up something that is harmful—need to be translated into positive goals—getting something that is helpful. It was much easier for Chester to commit himself to returning to school than to giving up prescription drugs, because school represented something he was getting. Images of himself with a degree and of holding some kind of professional job were solid incentives. The picture of him "throwing away the crutch" proved to be an important incentive in cutting down on drug use.

Help Clients Own the Goals They Set

In Chapters 10–12 we discussed how important it is for clients to "own" the problems and unused opportunities they talk about. It is also important for them to own the goals they set. It is essential that the goals clients choose be the clients' rather than the helpers' or someone else's goals. Various kinds of probes can be used to help clients discover what they want to do to manage some dimension of their problem situations more effectively. For instance, Carl Rogers, in a film of a counseling session (Rogers, Perls, & Ellis, 1965), is asked by a woman what she should do about her relationship with her daughter. He says to her, "I think you've been telling me all along what you want to do." She knew what she wanted the relationship to look like, but she was asking for his approval. If he had given it, the goal would have become, to some degree, his goal instead of hers. At another time, Rogers asks, "What is it that you want me to tell you to do?" This question puts the responsibility for goal setting where it belongs—on the shoulders of the client.

Cynthia was dealing with a lawyer because of an impending divorce. Discussions about what would happen to the children had taken place, but no decision had been reached. One day she came in and said that she had decided on mutual custody. She wanted to work out such details as which residence, hers or her husband's, would be the children's principal one and so forth. The lawyer asked her how she had reached her decision. She said that she had been talking to her husband's parents (she was still on good terms with them) and that they had suggested this arrangement. The lawyer challenged Cynthia to take a closer look at her decision. "Let's start from zero," he said, "and you tell me what kind of living arrangements *you* want and why." He did not think that it was wise to help her carry out a decision that was not her own.

Choosing goals suggested by others enables clients to blame others if they fail to reach the goals. Also, if they simply follow other people's advice, they often fail to explore the down-the-road consequences.

Commitment to goals can take different forms: compliance, buy-in, and ownership. The least useful is mere compliance. "Well, I guess I'll have to change some of my habits if I want to keep my marriage afloat" does not augur well for sustaining changes in behavior. But it may be better than nothing. Buy-in is a level up from compliance: "Yes, these changes are essential if we are to have a marriage that makes sense for both of us. We say we want to preserve our marriage, but now we have to prove it to ourselves." This client has moved beyond mere compliance. But like mere compliance, sometimes buy-in alone does not provide enough staying power because it depends too much on reason. "This is logical" is far different from "This is what I really want!" Ownership is a higher form of commitment. It means that the client can say, "This goal is not someone else's, it's not just a good idea; it is mine, it is what I want to do." Consider the following case:

A counselor worked with a manager whose superiors had intimated that he would not be moving much further in his career unless he changed his style in dealing with the members of his team and other key people with whom he worked within the organization. At first the manager resisted setting any goals. "What they want me to do is a lot of hogwash. It won't do anything to make the business better," was his initial response. One day, when asked whether accomplishing what "they" wanted him to do would cost him that much, he pondered a few moments and then said, "No, not really." That got him started. He moved beyond resistance.

With a bit of help from the counselor, he identified a few areas of his managerial style that could well be "polished up." Within a few months he got much more into the swing of things. Given the favorable responses to his changed behavior that he had gotten from the people who reported to him, he was able to say, "Well, I now see that this makes sense. But I'm doing it because it has a positive effect on the people in the department. It's the right thing to do." Buy-in had arrived. A year later, he moved up another notch. He became much more proactive in finding ways to improve his style. He delegated more, gave people feedback, asked for feedback, held a couple of managerial retreats, joined a human-resource task force, and routinely rewarded his direct reports for their successes. Now he began to say such things as "This is actually fun." Ownership had arrived. The people in his department began to see him as one of the best executives in the company. This process took over two years.

The manager did not have a personality transformation. He did not change his opinion of some of his superiors and was right in pointing out that they didn't follow their own rules. But he did change his behavior because he gradually discovered meaningful incentives to do so.

The use of contracts to structure the helping process itself was discussed in Chapter 3. Self-contracts—that is, contracts that clients make with themselves—can also help clients commit themselves to new courses of action. Although contracts are promises clients make to themselves to behave in certain ways and to attain certain goals, they are also ways of making goals more focused. It is not only the expressed or implied promise that helps but also the explicitness of the commitment. Consider the following example in which one of Dora's sons disappears without a trace.

About a month after one of Dora's two young sons disappeared, she began to grow listless and depressed. She was separated from her husband at the time the boy disappeared. By the time she saw a counselor a few months later, a pattern of depressed behavior was quite pronounced. Although her conversations with the counselor helped ease her feelings of guilt—for instance, she stopped engaging in self-blaming rituals—she remained listless. She shunned relatives and friends, kept to herself at work, and even distanced herself emotionally from her other son. She resisted developing images of a better future, because the only better future she would allow herself to imagine was one in which her son had returned.

Some strong challenging from Dora's sister-in-law, who visited her from time to time, helped jar her loose from her preoccupation with her own misery. "You're trying to solve one hurt, the loss of Bobby, by hurting Timmy and hurting yourself. I can't imagine in a thousand years that this is what Bobby would want!" her sister-in-law screamed at her one night. Afterward Dora and the counselor discussed a "recommitment" to Timmy, to herself, to the extended family, and to their home. Through a series of contracts, she began to reintroduce patterns of behavior that had been characteristic of her before the tragedy. For instance, she contracted to opening her life up to relatives and friends once more, to creating a much more positive atmosphere at home, to encouraging Timmy to have his friends over, and so forth. Contracts worked for Dora because, as she said to the counselor, "I'm a person of my word."

When Dora first began implementing these goals, she felt she was just going through the motions. However, what she was really doing was acting herself into a new mode of thinking. Contracts helped Dora in both her initial commitment to a goal and her movement to action. In counseling, contracts are not legal documents but human instruments to be used if they are helpful. They often provide both the structure and the incentives some clients need.

Help Clients Deal with Competing Agendas

Clients often set goals and formulate programs for constructive change without taking into account competing agendas—other things in their lives that soak up time and energy, such as job, family, and leisure pursuits. The world is filled with distractions. For instance, one manager wanted to begin developing computer and Internet-related skills, but the daily push of business and a divorce set up competing agendas and sapped his resources. Not one of the goals of his self-development agenda was accomplished. Programs for constructive change often involve a rearrangement of priorities. If a client is to be a full partner in the reinvention of his marriage, he cannot spend as much time "with the boys." Or the underemployed blue-collar worker might have to put aside some parts of her social life if she wants a more fulfilling job. She eventually discovers a compromise. A friend introduces her to the job search possibilities on the Internet. She discovers that she can work full time to support herself, do a better job looking for new employment on the Internet than by using traditional methods, and still have some time for a reasonable social life.

This is not to suggest that all competing agendas are frivolous. Sometimes clients have to choose between right and right. The woman who wants to expand her horizons by getting involved in social settings outside the home still has to figure out how to handle the tasks at home. This is a question of balance, not frivolity. The single parent who wants a promotion at work needs to balance her new responsibilities with involvement with her children. A counselor who had worked with a two-career couple as they made a decision to have a child helped them think of competing agendas once the pregnancy started. A year after the baby was born, they saw the counselor again for a couple of sessions to work on some issues that had come up. However, they started the session by saying, "Are we glad that you talked about competing agendas when we were struggling with the decision to become

Box 17-1 Questions on Client Commitment

You can help clients ask themselves these kinds of questions as they struggle with committing themselves to a program of constructive change:

- What is my state of readiness for change in this area at this time?
- How badly do I want what I say I want?
- How hard am I willing to work?
- To what degree am I choosing this goal freely?
- How highly do I rate the personal appeal of this goal?
- How do I know I have the courage to work on this?
- What's pushing me to choose this goal?
- What incentives do I have for pursuing this change agenda?
- What rewards can I expect if I work on this agenda?
- If this goal is in any way being imposed by others, what am I doing to make it my own?
- What difficulties am I experiencing in committing myself to this goal?
- In what way is it possible that my commitment is not a true commitment?
- What can I do to get rid of the disincentives and overcome the obstacles?
- What can I do to increase my commitment?
- In what ways can the goal be reformulated to make it more appealing?
- To what degree is the timing for pursuing this goal poor?
- What do I have to do to stay committed?
- What resources can help me?

parents! After the baby was born, we went back time and time again to review what we said about managing competing and conflicting priorities. It helped stabilize us for the last two years."

Even self-contracts have a shadow side. There is no such thing as a perfect contract. Most people don't think through the consequences of all the provisions of a contract, whether it be marriage, employment, or self-contracts designed to enhance a client's commitment to goals. And even people of goodwill unknowingly add covert codicils to contracts they make with themselves and others: "I'll pursue this goal—until it begins to hurt," or "I won't be abusive—unless she pushes me to the wall." The codicils are buried deep in the decision-making process and only gradually make their way to the surface.

Box 17-1 indicates the kinds of questions you can help clients ask themselves about their commitment to their change agendas.

Great Expectations: Client Self-Efficacy

The role of expectations in life is being explored more broadly, more deeply, and more practically (Kirsch, 1999). Clients need to find the motivation to seize their goals and run with them. The more they find their motivation within themselves, the better. "Self-regulation" is the ideal. Helping clients choose goals, commit to them, and develop a sense of agency and assertiveness (Galassi & Bruch, 1992) are part of the self-regulation picture. Expectations, whether "great" or not, are also part of the self-regulation picture. Here we look at client expectations through the lens of "self-efficacy" (Bandura, 1986, 1989, 1991, 1995, 1997; Cervone, 2000; Cervone & Scott, 1995; Lightsey, 1996; Locke & Latham, 1990; Maddux, 1995; Schwarzer, 1992). Self-efficacy is an extremely useful concept when it comes to constructive change. It is impossible to do justice to it here. What follows will, hopefully, pique your interest and help you relate self-efficacy to helping. You can feast on the vast self-efficacy literature later.

The Nature of Self-Efficacy

As Bandura (1995) notes, "Perceived self-efficacy refers to beliefs in one's capabilities to organize and execute the courses of action required to manage prospective situations. Efficacy beliefs influence how people think, feel, motivate themselves, and act" (p. 2). People's expectations of themselves and can-do beliefs have a great deal to do with their willingness to put forth effort to cope with difficulties, the amount of effort they will expend, and their persistence in the face of obstacles. Clients with higher self-efficacy will make bolder choices, moving from adaptation to stretch goals. Clients tend to take action if two conditions are fulfilled:

- ***Outcome expectations:*** Clients tend to act if they see that their actions will most likely lead to certain desirable results or accomplishments: "I will end up with a better relationship with Sophie."
- ***Self-efficacy beliefs:*** People tend to act if they were reasonably sure that they have the wherewithal—for instance, working knowledge, skill, time, stamina, guts, and other resources—to successfully engage in the kind of behavior that would lead to the desired outcomes. "I have the ability deal with the conflicts Sophie and I have. I can do this. I'm going to do this."

Now let's see these two factors operating together in a few examples. Yolanda, who has had a stroke, not only believes that participation in a rather painful and demanding physical rehabilitation program will literally help her get on her feet again (an outcome expectation) but also that she has what it takes to inch her way through the program (a self-efficacy belief). She therefore enters the program with a very positive attitude and makes good progress. Yves, on the other hand, is not convinced that an aggressive drug rehabilitation program will lead to a more fulfilling life (a negative outcome expectation), even though he knows he could "get through" the program (a self-efficacy belief). So he says no to the therapist. Even though the therapist has "promised" him a "drug free" life, Yves keeps saying to himself, "Drug free for what?" He sees being drug free as an instrumental goal. But he has not yet come up with an attractive ultimate goal. Xavier is convinced that a

series of radiation and chemotherapy treatments would help him (a positive outcome expectation), but he does not feel that he has the stamina and courage to go through with them (a negative self-efficacy expectation). He, too, refuses the treatment.

Outcome expectations and self-efficacy beliefs are factors not just in helping but in everyday life. Do an Internet search on that term and you will find a rich literature covering all facets of life—for instance, applications to education (Lopez, Lent, Brown, and Gore, 1997; Multon, Brown, & Lent, 1991; Smith & Nadya, 1999; Zimmerman, 1996), health care (O'Leary, 1985; Schwarzer & Fuchs, 1995), physical rehabilitation (Altmaier, Russell, Kao, Lehmann, & Weinstein, 1993), and work (Donnay & Borgen, 1999).

Help Clients Develop Self-Efficacy

People's sense of self-efficacy can be strengthened in a variety of ways (see Mager, 1992). Self-efficacy is not a paradigm that applies only to the weak. Take the case of Nick, a very strong manager who wanted to change his abrasive supervisory style but was doubtful that he could do so. "After all these years, I am what I am," he would say. It would have been silly to merely tell him, "Nick, you can do it; just believe in yourself." It was necessary to help him do a number of things to help strengthen his sense of self-efficacy in supervision.

Skills. *Make sure that clients have the skills they need to perform desired tasks.* Self-efficacy is based on ability and the conviction that the ability can be used to get a task done. Nick first read about and then attended some training sessions on building such "soft" skills as listening, responding with empathic highlights, giving feedback that is soft on the person yet hard on the problem, and constructive challenging. In truth, he had many of these skills, but they lay dormant. These short training experiences put him back in touch with some things he could do but didn't do. A caution: Merely acquiring skills does not by itself increase clients' self-efficacy. The way they acquire them must give them a sense of their competence. "I now have these skills and I am positive that I can use them to get this task done."

Corrective feedback. *Provide feedback that is based on deficiencies in performance, not on deficiencies in the client's personality.* Corrective feedback can help clients develop a sense of self-efficacy by clearing away barriers to the use of resources. Since I attended many meetings with Nick, I routinely described the ups and downs of his performance. I'd say such things as this:

> "Nick, in yesterday's meeting, you listened to and responded to everyone's ideas. Let me make a suggestion. You don't have to respond, as you did, in a positive way to every suggestion. Crap is still crap. Do some sorting as you listen and respond. Show why good ideas are good and why lousy ideas are bad. Then, whether the ideas are good or bad, everyone learns something."

When corrective feedback sounds like a personality attack, the client's sense of self-efficacy declines. The feedback helped boost Nick's self-efficacy belief because it pointed out that he could be decent and listen well and still use his excellent critical abilities. People would leave the room enlightened, not angry. When you give feedback to a client, you would do well to ask yourself, "In what ways will this feedback help increase the client's sense of self-efficacy?"

Positive feedback. *Provide positive feedback and make it as specific as corrective feedback.* Positive feedback strengthens clients' self-efficacy by emphasizing their strengths and reinforcing what they do well. This is especially true when feedback is specific. Too often negative feedback is very detailed, while positive feedback is perfunctory: "Nice job." This and other throwaway phrases probably sound like clichés. Here's one bit of feedback I gave Nick:

> "Yesterday, you interrupted Jeff, who was engaging in another one of his monologues. You summarized his main ideas. Then, with a few questions, you showed him why only part of his plan was viable. The others were glad you took Jeff on. He learned something. And you saved a lot of time."

The formula for giving specific positive feedback goes something like this. "Here's what you did. Here's the positive outcome it had. And here's the wider upbeat impact." Helping Nick see the value of this pattern of behavior helped him engage in it more frequently and increased his sense of self-efficacy: "I can combine the hard stuff and the soft stuff." Clients need to interpret feedback as information they need to accomplish tasks.

Using success as a reinforcer. *Challenge clients to engage in actions that produce positive results.* Even small successes can increase a client's sense of self-efficacy. Success is reinforcing. Often success in a small endeavor will give a client the courage to try something more difficult: "I can do even more." Nick began delegating a few minor tasks to some of his direct reports. They handled their assignments very well. When I commented, "They seem to be doing pretty well," Nick replied, "I think that I can safely begin to put more on their plates. They like it, and I like seeing them succeed." Successful delegation increased Nick's sense of supervisory self-efficacy. He could say to himself more assuredly, "I can delegate without worrying whether it's going to get done or not." Make sure, however, that the link between success and increased self-confidence is forged. A series of successes on its own does not necessarily increase the strength of a client's self-efficacy beliefs. Success has to be linked to a sense of increased competence.

Models. *Help clients increase their own sense of self-efficacy by learning from others.* I asked Nick to name the best manager in the division. He mentioned a name. "What's he like?" I asked. Of course, Nick talked about how competent this guy was, how effective he was in getting results, and how tough he was. Tongue in cheek, I remarked, "But I suppose that he's not very good with people." Nick exploded. "Of course he's fair. He's as good at all of this soft stuff as anyone else." He went on to name ways in which the guy was "good with people." Then suddenly he stopped, looked at me, and smiled. "Caught me, didn't you?" Learning makes clients more competent and increases their self-efficacy. Learning from models is, as we have seen, a bit tricky. Nick had too much pride to think that he could learn very much from others.

Providing encouragement. *Support clients' self-efficacy beliefs without being patronizing.* We took a brief look at encouragement in Chapter 11. However, if your support is to increase clients' sense of self-efficacy, your support must be real, and what you support in them must be real. Encouragement and support must be tailored to each

client and in each instance. A supportive remark to one client might sound patronizing to another. Had I patronized Nick—"Give it a try, Nick, I know that you can do it"—I would have been dead. My encouragement was, let's say, more subtle and indirect.

Reducing fear and anxiety. *Help clients overcome their fears.* Fear blocks clients' sense of self-efficacy. If clients fear that they will fail, they will be reluctant to act. Therefore, procedures that reduce fear and anxiety help heighten their sense of self-efficacy. Deep down, Nick was fearful of two things regarding changing his supervisory style: messing up the business and making a fool of himself. As he tentatively changed some of his supervisory practices, business results held steady. He even noticed that two of his team members seemed to become more productive. Helping him allay his fear of making a fool of himself by being too soft was a bit trickier. His behavior outside the office came to the rescue. Although he was often an ogre in the office, Nick was very upbeat when we visited teams out in the field. He was as good at "rallying the troops" as anyone I had ever seen. And he was real. Discussions about his two different styles helped him get rid of fears that he would make a fool of himself with his direct reports by engaging them instead of driving them.

Stage II and Action

The work of Step II-A—developing possibilities for a better future—is just what some clients need. It frees them from thinking solely about problem situations and unused resources and enables them to begin fashioning a better future. Once they identify some of their wants and needs and consider a few possible goals, they move into action.

Francine is depressed because her aging and debilitated father has been picking on her even though she has put off marriage to take care of him. Some of the things he says to her are quite hurtful. The situation has begun to affect her productivity at work. A counselor suggests to her that the hurtful things her father says to her are not her father but his illness speaking. This gives her a whole new perspective and frees her to think about other possibilities. She spends a bit of time brainstorming answers to the counselor's question—"What do you want for both yourself and your father?" She says things like, "I'd like both of us to go through this with our dignity intact" and "I'd like to be living the kind of life he would want me to have if his mind weren't so clouded." Once she brainstorms some possibilities for a better arrangement with her father, she needs little further help. Her usual resourcefulness returns. She gets on with life.

For other clients, Step II-B is the trigger for action. Shaping goals helps them see the future in a very different way. Once they have a clear idea of just what they want or need, they go for it.

Nero, a man in his early twenties, had a car accident while driving under the influence of alcohol—an accident that took his wife's life. Strangely, Nero is filled with self-pity rather than remorse. The counselor, at her wits' end, confronts him about remaining wrapped up in himself. She says, "Who's the most decent person you know?" After fudging around a bit, he names Saul, an uncle. "Describe his lifestyle to me," she urges. "What makes him so decent?" With some prodding, Nero describes the lifestyle of this decent man. Then she says, "Do the description again, but instead of saying 'Saul' say 'Nero.'" Nero sweats, but the session has an enormous impact on him. The picture of the contrast between his uncle's lifestyle and his own haunts him for days after. But he begins to stop feeling so sorry for himself. He visits his wife's parents and begs their forgiveness. He begins to see that there are other people in the world besides Nero.

For still other clients, the search for incentives for commitment is the trigger for action. Once they see what's in it "for me"—a kind of upbeat and productive selfishness, if you will—they move into action.

Callahan is seeing a consultant because he is very distressed. He owns and runs a small business. A few of his employees have gotten together and filed a workplace discrimination suit against him. The "troublemakers," he calls them, meaning a few women, a couple of Hispanics, and three African Americans. The consultant finds out that Callahan believes that they are "decent workers." The fact is that they are more than decent. Callahan tells the counselor that he is paying them "scale." The fact is that he is underpaying them. Callahan also says that he doesn't expect his supervisors to "bend over backwards to become their friends." The fact is that some supervisors—all but two are white males—are sometimes abusive.

The counselor convinces Callahan to attend an excellent program on diversity "before some court orders you to." A couple of weeks after returning from the program, he has a session with the consultant. He says that he had never even once considered the advantages of diversity in the workplace. All the term had meant to him was "a bunch of politicians looking for votes." Now that he saw the business reasons for diversity, he knew there were a few things he could do, but he still needed the consultant's help and guidance. "I don't want to look like a soft jerk." Callahan's newly acquired "human touch" is far from being soft. He remains a rather rough-and-tough business guy.

Callahan didn't change his stripes overnight, but finding a package of incentives certainly helped him move toward much-needed action. Who knows, the whole situation might have even made a dent in his deeply ingrained prejudices.

The Shadow Side of Goal Setting

Despite the advantages of goal setting outlined in the last three chapters, some helpers and clients seem to conspire to avoid goal setting as an explicit process. It is puzzling to see counselors helping clients explore problem situations and unused opportunities but stopping short of asking them what they want and helping them set goals. As Bandura (1990) put it, "Despite this unprecedented level of empirical support [for the advantages of goal setting], goal theory has not been accorded the prominence it deserves in mainstream psychology" (p. xii). Years ago, the same concern was expressed differently. A U.S. developmental psychologist was talking to a Russian developmental psychologist. The Russian said, "It seems to me that American researchers are constantly seeking to explain how a child came to be what he is. We in the USSR are striving to discover how he can become what he not yet is" (see Bronfenbrenner, 1977, p. 528). One of the main reasons that counselors do not help clients develop realistic life-enhancing goals is that they are not trained to do so.

There are other reasons. First, some clients see goal setting as very rational, perhaps too rational. Their lives are so messy, and goal setting seems so sterile. Both helpers and clients object to this overly rational approach. There is a dilemma. On the one hand, many clients need or would benefit from a rigorous application of the problem-management process, including goal setting. On the other hand, they resist its rationality and discipline. They find it alien. Second, goal setting means that clients have to move out of the relatively safe harbor of discussing problem

situations and of exploring the possible roots of those problems in the past and move into the uncharted waters of the future. This can be uncomfortable for clients and helpers alike. Third, clients who set goals and commit themselves to them move beyond the victim-of-my-problems game. Victimhood and self-responsibility make poor bedfellows.

A fourth reason that clients might resist developing goals is that goal setting involves clients' placing demands on themselves, making decisions, committing themselves, and moving to action. If I say, "This is what I want," then at least logically, I must also say, "Here is what I am going to do to get it. I know the price and I'm willing to pay it." Since this demands work and pain, clients will not always be grateful for this kind of "help." Fifth, goals, though liberating in many respects, also hem clients in. If a woman chooses a career, she might not be able to have the kind of marriage she would like. If a man commits himself to one woman, he can no longer play the field.

There is some truth in the ironic statement "There is only one thing worse than not getting what you want, and that's getting what you want." The responsibilities accompanying getting what you want—a drug-free life, a renewed marriage, custody of the children, a promotion, the peace and quiet of retirement, freedom from an abusing husband—often open up a new set of problems. Even good solutions create new problems. It is one thing for parents to decide to give their children more freedom; it is another thing for them to watch them use that freedom. Finally, there is a phenomenon called post-decisional depression. Once choices are made, clients begin to have second thoughts that often keep them from acting on their decisions.

As to action, some clients move into action too quickly. The focus on the future liberates them from the past, and the first few possibilities are very attractive. They fail to get the kind of focus and direction provided by Step II-B. So they go off half-cocked. Failing to weigh alternatives and shape goals often means that they have to do the process all over again.

Effective helpers know what lurks in the shadows of goal setting both for themselves and for their clients and are prepared to manage their own part of it and help clients manage theirs. Helpers must receive training in the entire problem-management process and be able to share a picture of the entire process with every client. Then goal setting, described in the client's language, will be a natural part of the process. Artful helpers weave goal setting, under whatever name, into the flow of helping. They do so by moving easily back and forth among the stages and steps of the helping process even in brief therapy.

Evaluation Questions for Step II-C

- What do I need to do to help clients commit themselves to a better future?
- What do I do to make sure that the goals that clients set are really their goals and not mine or those of a third party?
- How effectively do I help clients examine the benefits of goals they are choosing as measured against the costs?
- In what ways do I help clients focus on the appealing dimensions of the goals being set?
- How effectively do I perceive and deal with the misgivings clients have about the goals they are formulating?
- To what degree do I help clients enter into self-contracts with respect to the accomplishment of goals?
- What am I doing to help clients identify, explore, and manage competing agendas?
- What do I do to help clients move to initial goal-accomplishing action?
- What do I do to help clients acquire and increase their sense of self-efficacy?

PART FIVE

Stage III: Helping Clients Develop Strategies to Accomplish Their Goals

Stage III is an important part of solution-focused helping. Once clients are helped to establish goals, they often still need help planning the actions or strategies that will enable them to accomplish their goals. These actions or strategies are solutions with a small s. Chapter 18 provides an introduction to Stage III and discusses strategies in terms of possibilities. Just as Step II-A focused on goals in terms of possibilities for a better future, Step III-A talks about the many different paths to any given goal. It is about options. Chapter 19, Step III-B, is about helping clients choose the strategies or paths are best fit the needs, style, and resources of the client. It is about choosing the right options. Finally, Chapter 20, Step III-C, is about taking chosen goals and strategies and turning them into a problem-managing or opportunity-developing plan. Planning, whether formal or informal, often plays a key role in problem management and opportunity development.

CHAPTER

18

STEP III-A: "HOW MANY WAYS ARE THERE TO GET WHAT I NEED AND WANT?" ACTION STRATEGIES

INTRODUCTION TO STAGE III
- Step III-A: Strategies
- Step III-B: Best-fit strategies
- Step III-C: Plans

MANY DIFFERENT PATHS TO GOALS
- Help Clients Brainstorm Strategies for Accomplishing Goals
- Develop Frameworks for Stimulating Clients' Thinking About Strategies
  - Individuals
  - Models and exemplars
  - Communities
  - Places
  - Things
  - Organizations
  - Programs

"WHAT SUPPORT DO I NEED TO WORK FOR WHAT I WANT?"

"WHAT WORKING KNOWLEDGE AND SKILLS WILL HELP ME GET WHAT I NEED AND WANT?"

LINKING STRATEGIES TO ACTION

EVALUATION QUESTIONS FOR STEP III-A

INTRODUCTION TO STAGE III

Planning, in its broadest sense, includes all the steps of Stages II and III; that is, it deals with solutions with a big S and a small s. In a narrower sense, planning deals with identifying, choosing, and organizing the strategies needed to accomplish goals. Whereas Stage II is about outcomes—goals or accomplishments "powerfully imagined"—Stage III is about the activities or the work needed to produce those outcomes.

Clients, when helped to explore what is going wrong in their lives, often ask, "Well, what should I do about it?" That is, they focus on the actions they need to take to "solve" things. But, as we shall see, action, though essential, is valuable only to the degree that it leads to problem-managing and opportunity-developing outcomes. Accomplishments or outcomes, also essential, are valuable only to the degree that they have a constructive impact on the life of the client. The distinction between action, outcomes, and impact is seen in the following example:

> Lacy, a 40-year-old single woman, is making a great deal of progress in controlling her drinking through her involvement with an AA program. She engages in certain activities—for instance, she attends AA meetings, follows the 12 steps, stays away from situations that would tempt her to drink, and calls fellow AA members when she feels depressed or when the temptation to drink is pushing her hard. The outcome is that she has stayed sober for over seven months. She feels that this is quite an accomplishment. The impact of all this is very rewarding. She feels better about herself, and she has had both the energy and the enthusiasm to do things that she has not done in years—developing a circle of friends, getting interested in church activities, and doing a bit of travel.
>
> But Lacy is also struggling with a troubled relationship with a man. In fact, her drinking was, in part, an ineffective way of avoiding the problems in the relationship. She knows that she no longer wants to tolerate the psychological abuse she has been getting from her male friend, but she's afraid of the vacuum she will create by cutting off the relationship. She is, therefore, trying to determine what she wants, almost fearing that ending the relationship might turn out to be the best option.
>
> She has engaged in a number of activities in attempting to manage the relationship. For instance, she has become much more assertive with her friend. She now cuts off contact whenever her companion becomes abusive. And she no longer lets him make all the decisions about what they are going to do together. But the relationship remains troubled. Even though she is doing many things, there is no satisfactory outcome. She has not yet determined what the outcome should be; that is, she has not determined what kind of relationship she would like and if it is possible to have such a relationship with this man. Nor has she determined to end the relationship.
>
> Finally, after one seriously abusive episode, she tells him that she is ending the relationship. She does what she has to do to sever all ties with him (action), and the outcome is that the relationship ends and stays ended. The impact is that she feels liberated but lonely. The helping process needs to be recycled to help her with this new problem.

Stage III has three steps, in our usual definition of *step*. They are all aimed at action on the part of the client.

Step III-A: Strategies. Help clients develop possible strategies for accomplishing their goals. "What kind of actions will help me get what I need and want?"

Step III-B: Best-fit strategies. Help clients choose strategies tailored to their preferences and resources. "What actions are best for me?"

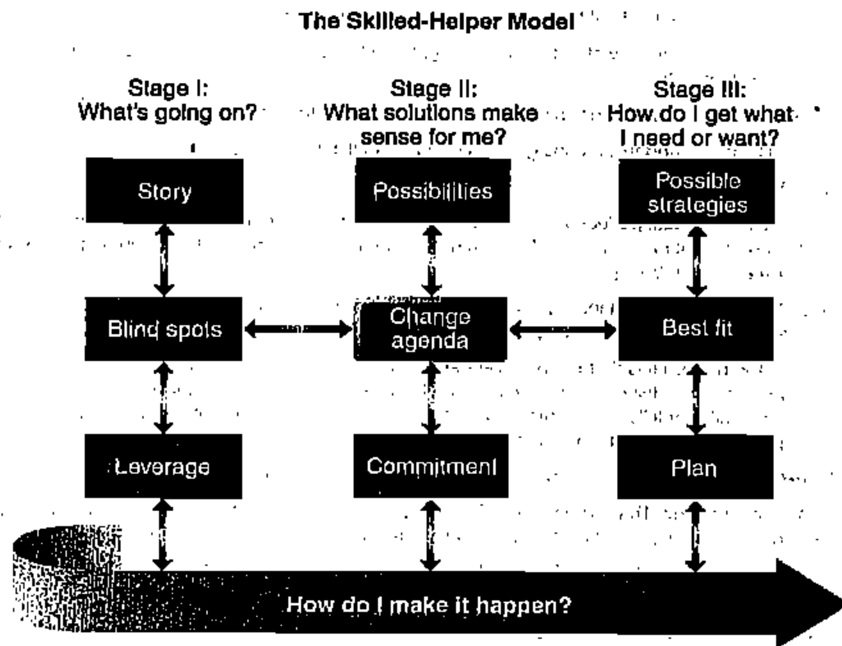

FIGURE 18-1
The Helping Model—Stage III

Step III-C: Plans. Help clients formulate actionable plans. "What should my campaign for constructive change look like? What do I need to do first? second? third?"

Stage III, highlighted in Figure 18-1, adds the final pieces to a client's planning a program for constructive change. Stage III deals with the "game plan." However, these three "steps" constitute *planning* for action and should not be confused with action itself. Without action, a program for constructive change is nothing more than a wish list. The implementation of plans is discussed in Part Six.

Strategy is the art of identifying and choosing realistic courses of action for achieving goals and doing so under adverse conditions, such as war. The problem situations in which clients are immersed constitute adverse conditions; often clients are at war with themselves and the world around them. Helping clients develop strategies to achieve goals can be the most thoughtful, humane, and fruitful way of being with them. This step in the counseling process is another that helpers sometimes avoid because it is too "technological." They do their clients a disservice. Clients with goals but no clear idea of how to accomplish them are still at sea.

Strategies are actions that help clients accomplish their goals. Step III-A, developing a range of possible strategies to accomplish goals, is a powerful exercise. Clients who feel hemmed in by their problems and unsure of the viability of their goals are liberated through this process. Clients who see clear pathways to their goals have a greater sense of self-efficacy: "I can do this."

Many Different Paths to Goals

Once again it is a question of helping clients stimulate their imaginations and engage in divergent thinking. Most clients do not instinctively seek different routes to goals and then choose the ones that make most sense.

Help Clients Brainstorm Strategies for Accomplishing Goals

Brainstorming, discussed in Chapter 15, plays an important part in strategy development. The more routes to the achievement of a goal, the better. Consider the case of Karen, who has come to realize that heavy drinking is ruining her life. Her goal is to stop drinking. She feels that it simply would not be enough to cut down; she has to stop. At first, she thought the way forward was simple enough: Whereas before she drank, now she wouldn't. Because of the novelty of not drinking, she was successful for a few days; then she fell off the wagon. This happened a number of times until she finally realized that she could use some help. Stopping drinking, at least for her, is not as simple as it first seemed.

A counselor at a city alcohol and drug treatment center helps her explore a number of techniques that could be used in an alcohol-management program. Together they come up with the following possibilities:

- Just stop cold turkey and get on with life.
- Join Alcoholics Anonymous.
- Move someplace declared "dry" by local government.
- Take a drug that causes nausea if followed by alcohol.
- Replace drinking with other rewarding behaviors.
- Join some self-help group other than Alcoholics Anonymous.
- Get rid of all liquor in the house.
- Take the "pledge" not to drink; to make it more binding, take it in front of a minister.
- Join a residential hospital detoxification program.
- Avoid friends who drink heavily.
- Change other social patterns; for instance, find places other than bars and cocktail lounges to socialize.
- Try hypnosis to reduce the urge to drink.
- Use behavior modification techniques to develop an aversion for alcohol; for instance, pair painful but safe electric shocks with drinking or even thoughts about drinking.
- Change self-defeating patterns of self-talk, such as "I have to have a drink" or "One drink won't hurt me."
- Become a volunteer to help others stop drinking.
- Read books and view films on the dangers of alcohol.
- Stay in counseling as a way of getting support and challenge for stopping.

- Share intentions to stop drinking with family and close friends.
- Spend a week with an acquaintance who does a great deal of work in the city with alcoholics, and go with him on his rounds.
- Walk around skid row meditatively.
- Have a discussion with members of the family about the impact drinking has on them.
- Eat foods, such as sweets, that can help reduce the craving for alcohol.
- Get a hobby or an avocation that demands time and energy.
- Substitute a range of self-enhancing activities, such as exercise or surfing the Web, for drinking.

This list contains many more items than Karen would have thought of had she not been stimulated by the counselor to take a census of possible strategies. One of the reasons that clients are clients is that they are not very creative in looking for ways of getting what they want. Once goals are established, getting them accomplished is not just a matter of hard work. It is also a matter of imagination.

If a client is having a difficult time coming up with strategies, the helper can "prime the pump" by offering a few suggestions. Driscoll (1984) put it well.

> Alternatives are best sought cooperatively, by inviting our clients to puzzle through with us what is or is not a more practical way to do things. But we must be willing to introduce the more practical alternatives ourselves, for clients are often unable to do so on their own. Clients who could see for themselves the more effective alternatives would be well on their way to using them. That clients do not act more expediently already is in itself a good indication that they do not know how to do so. (p. 167)

Although the helper may need to suggest alternatives, he or she can do so in such a way that the principal responsibility for evaluating and choosing possible strategies stays with the client. For instance, there is the "prompt and fade" technique. The counselor can say, "Here are some possibilities. . . . Let's review them and see whether any of them make sense to you or suggest further possibilities." Or "Here are some of the things that people with this kind of problem situation have tried. . . . How do they sound to you?" The "fade" part of this technique keeps it from being advice giving. It remains clear that the client must think over these strategies, choose the right ones, and commit to them.

Elton, a graduate student in counseling psychology, is plagued with perfectionism. Although he is an excellent student, he worries about getting things right. After he writes a paper or practices counseling, he agonizes over what he could have done better. This kind of behavior puts him on edge when he practices counseling with his fellow trainees. They tell him that his "edge" makes them uncomfortable and interferes with the flow of the helping process. One student says to him, "You make me feel as if I'm not doing the right things as a client."

Elton realizes that "less is more"—that becoming less preoccupied with the details of helping—will make him a more effective helper. His goal is to become more relaxed in the helping sessions, free his mind of the "imperatives" to be perfect, and learn from mistakes rather than expending an excessive amount of effort trying to avoid them. He and his supervisor talk about ways he can free himself of these inhibiting imperatives.

SUPERVISOR: What kinds of things can you do to become more relaxed?

ELTON: I need to focus my attention on the client and the client's goals instead of being preoccupied with myself.

SUPERVISOR: So a basic shift in your orientation right from the beginning will help.

ELTON: Right. . . . And this means getting rid of a few inhibiting beliefs.

SUPERVISOR: Such as . . .

ELTON: That technical perfection in the helping model is more important than the relationship with the client. I get lost in the details of the model and have forgotten that I'm a human being with another human being.

SUPERVISOR: So "rehumanizing" the helping process in your own mind will help. . . . Any other internal behaviors need changing?

ELTON: Another belief is that I have to be the best in the class. That's my history, at least in academic subjects. Being as effective as I can be in helping a client has nothing to do with competing with my fellow students. Competing is a distraction. I know it's in my bones. It might have been all right in high school, but . . .

SUPERVISOR: Okay, so the academic-game mentality doesn't work here . . .

ELTON (interrupting): That's precisely it. Even the practicing we do with one another is real life, not a game. You know that a lot of us talk about real issues when we practice.

SUPERVISOR: You've been talking about getting your attitudes right and the impact that can have on helping sessions. Are there any external behaviors that might also help?

ELTON (pauses): I'm hesitating because it strikes me how I'm in my head too much, always figuring me out. . . . On a much more practical basis, I like what Jerry and Philomena do. Before each session with their "clients" in their practice sessions, they spend 5 or 10 minutes reviewing just where the client is in the overall helping process and determining what they might do in the next session to add value and move things forward. That puts the focus where it belongs, on the client.

SUPERVISOR: So a mini-prep for each session can help you get out of your world and into the client's.

ELTON: Also, in debriefing the training videos we make each week, I now see that I always start by looking at my behavior instead of what's happening with the client. . . . Oh, there's another thing I can do. I can share just what we've been discussing here with my training partner. She can help me refocus myself. . .

SUPERVISOR: I'm not sure whether you bring up the perfectionism issues when you're the "client" in the practice sessions or in the weekly lifestyle group meetings.

ELTON (hesitating): Well, not really. I'm just coming to realize how pervasive it is in my life. . . . To tell you the truth I think I haven't brought it up because I'd rather have my fellow trainees see me as competent, not perfectionistic. . . . Well, the cat is out of the bag with you, so I guess it makes sense to put it on my lifestyle group agenda.

This dialogue, which includes empathy, probes, and challenges on the part of the supervisor, produces a number of strategies that Elton can use to develop a more client-focused mentality. He ends by saying that all these can be reinforced through his interactions with his training partner.

Develop Frameworks for Stimulating Clients' Thinking About Strategies

How can helpers find the right probes to help clients develop a range of strategies? Simple frameworks can help. Consider the following case:

Jackson has terminal cancer. He has been in and out of the hospital several times over the past few months, and he knows that he probably will not live more than a year. He would like the year to be as full as possible, and yet he wants to be realistic. He hates being in the hospital, especially a large hospital, where it is so easy to be anonymous. One of his goals is to die outside the hospital. He would like to die as benignly as possible and retain possession of his faculties as long as possible. How is he to achieve these goals?

You can use probes and prompts to help clients discover possible strategies by assisting them in investigating resources in their lives, including people, models, communities, places, things, organizations, programs, and personal resources.

Individuals. What individuals might help clients achieve their goals? Jackson gets the name of a local doctor who specializes in the treatment of chronic cancer-related pain. The doctor teaches people how to use a variety of techniques to manage pain. Jackson says that perhaps his wife and daughter can learn how to give simple injections to help him control the pain. A friend of his has mentioned that his father got excellent hospice care and died at home. Also, he thinks that talking every once in a while with a friend whose wife died of cancer, a man he respects and trusts, will help him find the courage he needs.

Models and exemplars. Are there people presently doing what clients want to do? One of Jackson's fellow workers died of cancer at home. Jackson visited him there a couple of times. That's what gave him the idea of dying at home, or at least outside the hospital. He noticed that his friend never allowed himself to engage in poor-me talk. He refused to see dying as anything but part of living. This touched Jackson deeply at the time, and now reflecting on that experience may help him develop the same kind of upbeat attitude.

Communities. What communities of people are there through which clients might identify strategies for implementing their goals? Even though Jackson has not been a regular churchgoer, he does know that the parish within which he resides has some resources for helping those in need. A brief investigation reveals that the parish has developed a relatively sophisticated approach to providing various services for the sick. He also does an Internet search and discovers that there are of number of self-help groups for people like him.

Places. Are there particular places that might help? Jackson immediately thinks of Lourdes, the shrine to which Catholic believers flock with all sorts of human problems. He doesn't expect miracles, but he feels that he might experience life more deeply there. It's a bit wild, but why not a pilgrimage? He still has the time and money to do it. He also finds a high-tech place—an Internet chat room for cancer patients *and* their caregivers. This helps him get out of himself and, at times, become a helper instead of a client.

Things. What things exist that can help clients achieve their goals? Jackson has read about the use of combinations of drugs to help stave off pain and the side effects of chemotherapy. He has heard that certain kinds of electric stimulation can ward off chronic pain. He explores all these possibilities with his doctor and even arranges for second opinions.

Box 18-1 Questions on Developing Strategies

- Now that I know what I want, what do I need to do?
- Now that I know my destination, what are the different routes for getting there?
- What actions will get me to where I want to go?
- Now that I know the gaps between what I have and what I want and need, what do I need to do to bridge those gaps?
- How many ways are there to accomplish my goals?
- How do I get started?
- What can I do right away?
- What do I need to do later?

Organizations. What groups or institutions are available to help clients? Jackson runs across an organization that helps young cancer patients get their wishes. He volunteers. In his role as helper, he finds he receives as much help, motivation, and solace as he gives.

Programs. Do any ready-made programs exist to help clients in this position? He learns that a new hospice in his part of town has three programs. One helps people who are terminally ill stay in the community as long as they can. A second makes provision for part-time residents. The third is a residential program for those who can spend little or no time in the community. The goals of these programs are practically the same as Jackson's.

Box 18-1 outlines some questions that you can help clients ask themselves to develop strategies for accomplishing goals.

"What Support Do I Need to Work for What I Want?"

Step III-A can also be seen as helping clients get the resources, both internal and environmental, they need to pursue goals. Many clients do not know how to mobilize needed resources. One of the most important resources is social support. A great deal is said in the literature about the kind of support helpers should provide their clients (Alford & Beck, 1997; Arkowitz, 1997; Castonguay, 1997; Yalom & Bugental, 1997). In a sense, this entire book is about that kind of support. But if clients are to pursue goals "out there" in their real lives, they also need social support. Unfortunately, as Robert Putnam (2000) shows with a great deal of evidence, such support is not always easy to find. His central thesis is that in North American society, the supply of "social capital"—both informal social connectedness and formal civic

engagement—has fallen dangerously low. Putnam reports that we belong to fewer organizations that hold meetings, know our neighbors less, meet with friends less frequently, and even socialize with our families less often. This is the environment in which clients must do the work of constructive change.

However, social support is a key element in change (see Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996).

> Social support has . . . been examined as a predictor of the course of mental illness. In about 75% of studies with clinically depressed patients, social-support factors increased the initial success of treatment and helped patients maintain their treatment gains. Similarly, studies of people with schizophrenia or alcoholism revealed that higher levels of social support are correlated with fewer relapses, less frequent hospitalizations, and success and maintenance of treatment gains. (p. 628)

In a study on weight loss and maintaining the loss (Wing & Jeffery, 1999), clients who enlisted the help of friends were much more successful than clients who took the solo path. This is called "social facilitation" and is quite different from dependence. Social facilitation, a positive-psychology approach, is energizing, while dependence is often depressing. Therefore, a culture of social isolation does not bode well for clients. Of course, all of this reinforces what we already know through common sense. Which of us has not been helped through difficult times by family and friends?

When it comes to social support, there are two categories of clients. First, there are those who lead an impoverished social life. The objective with this group is to help them find social resources, to get back into community in some productive way. But as Putnam (2000) points out, even when clients, at least on paper, have a social system, they may not use it very effectively. This second group provides counselors with a different challenge, that is, helping clients tap into those human resources in a way that helps them manage problem situations more effectively.

Indeed, the Basic Behavorial Science Task Force (1996) study previously quoted showed that people who are highly distressed and therefore most in need of social support may be the least likely to receive it because their expressions of distress drive away potential supporters. Which of us, at one time or another, has not avoided a distressed friend or colleague? Therefore, distressed clients can be helped to learn how to modulate their expressions of distress. Who wants to help whiners? On the other hand, potential supporters can learn how to deal with distressed friends and colleagues, even when the latter let themselves become whiners.

The Task Force study suggests two general strategies for fostering social support: helping clients mobilize or increase support from existing social networks and "grafting" new ties onto impoverished social networks. Both of these come into play in the following case:

> Casey, a bachelor whose job involved frequent travel literally around the world, fell ill. He had many friends, but they were spread around the world. Because he was neither married nor in a marriage-like relationship, he had no primary caregiver in his life. He received excellent medical care, but his psyche fared poorly.
>
> Once out of the hospital, he recuperated slowly, mainly because he was not getting the social support he needed. In desperation he had a few sessions with a counselor, sessions that proved to be quite helpful. The counselor challenged him to "ask for help" from his local friends. He had underplayed his illness with them because he didn't want to be a "burden." He discovered that his friends were more than ready to help. But since their time was limited, he, with some hesitancy, "grafted" onto his rather sparse hometown social network some very caring people from the local church. He was fearful that he would be deluged with piety, but instead he found people like himself. Moreover, they were, in the main, socially intelligent. They knew how much or how little care to give. In fact, most of the time their care was simple friendship. Finally, he hired a couple of students from a local university to do word processing and run errands for him from time to time. They also provided some social support.

As the Task Force authors note, it's important not only that people be available to provide support but also that those needing support perceive that it is available. This may mean, as in Casey's case, working with the client's attitudes and openness to receive support.

Eventually, all clients have to make it without the help of a counselor. Therefore, effective helpers right from the beginning try to help them explore the social-support dimensions of problem situations. At the action arrow stage, questions like the following are appropriate: Who might help you do this? Who's going to challenge you when you want to give up? With whom can you share these kinds of concerns? Who's going to give you a pat on the back when you accomplish your goal?

Although social support is often key, it is not the only resource clients need to pursue their goals. Effective helpers build some kind of resource census into the helping process.

"What Working Knowledge and Skills Will Help Me Get What I Need and Want?"

It often happens that people get into trouble or fail to get out of it because they lack the needed life skills or coping skills to deal with problem situations. If this is the case, then helping clients find ways of learning the life skills they need to cope more effectively is an important broad strategy. Indeed, the use of skills training as part of therapy—what years ago Carkhuff (1971) called "training as treatment"—might be essential for some clients. Challenging clients to engage in activities for which they don't have the skills is compounding rather than solving their problems. What kinds of working knowledge and skills does this client need to get where he or she wants to go? Consider the following case:

> Jerzy and Zelda fell in love. They married and enjoyed a relatively trouble-free honeymoon period of about two years. Eventually, however, the problems that inevitably arise from living together in such intimacy asserted themselves. They found, for instance, that they counted too heavily on positive feelings for each other and now, in their absence, could not "communicate" about finances, sex, and values. They lacked certain critical interpersonal communication skills. Furthermore, they lacked understanding of each other's developmental needs. Jerzy had little working knowledge of the developmental demands of a 20-year-old woman; Zelda had little working knowledge of the kinds of cultural blueprints that were operative in the lifestyle of her 29-year-old husband. The relationship began to deteriorate. Since they had few problem-solving skills, they didn't know how to handle their situation.

Jerzy and Zelda needed skills. This is hardly surprising. Lack of requisite interpersonal communication and other life skills is often at the heart of relationship

breakdowns. One marriage counselor I know works with groups of four couples. Training in communication skills is part of the process. He separates men from women and trains them in tuning in, active listening, and sharing empathic highlights. For skills practice, he begins by pairing a woman with a woman and a man with a man. Next he pairs a man and a woman, but not spouses, for skills practice. Finally, spouses are paired, taught a simple version of the problem-management process outlined in this book, and then helped to use the skills they have learned to engage in problem solving with each other. In sum, he equips them with two sets of life skills: interpersonal communication and problem solving.

The literature is filled with programs designed to equip clients with the working knowledge and skills they need to manage problems and lead fuller lives. Some of them focus on specific problems. For instance, Deffenbacher and his associates (Deffenbacher, Thwaites, Wallace, & Oetting, 1994; Deffenbacher, Oetting, Huff, & Thwaites, 1995) have devised and evaluated programs for general anger reduction. Although programs such as these need to be tailored to individual clients, they are often gold mines of strategies for accomplishing goals. Tailoring such generic programs to clients will be discussed in the next chapter.

Linking Strategies to Action

Although all the steps of the helping process can and should stimulate action on the part of the client, this is especially true of Step III-A, which deals with possible actions. Many clients, once they begin to see what they can do to get what they want, begin acting immediately. They don't need a formal plan. Here are a couple of examples of clients who, once they were helped to identify strategies for implementing their goals, acted on them.

Jeff had been in the army for about ten months. He found himself both overworked and, perhaps not paradoxically, bored. He had a couple of sessions with one of the educational counselors on the base. During these sessions, Jeff began to see quite clearly that not having a high school diploma was working against him. The counselor mentioned that he could finish high school while in the army. Jeff realized that this possibility had been pointed out to him during the orientation talks, but he hadn't paid any attention to it. He had joined the army because he wasn't interested in school and, being unskilled, couldn't find a job. Now he decided that he would get a high school diploma as soon as possible.

Jeff obtained the authorization needed from his company commander to go to school. He found out what courses he needed and enrolled in time for the next school session. It didn't take him long to finish. Once he received his high school diploma, he felt better about himself and found that opportunities for more interesting jobs opened up for him in the army. Achieving his goal of getting a high school diploma helped him manage the problem situation.

Jeff was one of those fortunate ones who, with a little help, quickly set a goal (the "what") and identified and implemented the strategies (the "how") to accomplish it. Notice, too, that his goal of getting a diploma was also a means to other goals: feeling good about himself and getting better job opportunities in the army.

Grace's road to problem management was quite different from Jeff's. She needed much more help.

As long as she could remember, Grace had been a fearful person. She was especially afraid of being rejected and of being a failure. As a result, she had an impoverished social life. She had held a series of jobs that were safe but boring. She became so depressed that she made a half-hearted attempt at suicide, probably more an expression of anguish and a cry for help than a serious attempt to get rid of her problems by getting rid of herself.

During her stay in the hospital, Grace had a few therapy sessions with one of the staff psychiatrists. The psychiatrist was supportive and helped her handle both the guilt she felt because of the suicide attempt and the depression that had led to the attempt. Just talking to someone about things she usually kept to herself seemed to help. She began to see her depression as a case of "learned helplessness." She saw quite clearly how she had let her choices be dictated by her fears. She also began to realize that she had a number of underused resources. For instance, she was intelligent and, though not good-looking, attractive in other ways. She had a fairly good sense of humor, though she seldom gave herself the opportunity to use it. She was also sensitive to others and basically caring.

After Grace was discharged from the hospital, she returned for a few outpatient sessions. She got to the point where she wanted to do something about her general fearfulness and her passivity, especially the passivity in her social life. A psychiatric social worker taught her relaxation and thought-control techniques that helped her reduce her anxiety. As she became less anxious, she was in a better position to do something about establishing some social relationships. With the social worker's help, she set goals of acquiring a couple of friends and becoming a member of some social group. However, she was at a loss as to how to proceed. She thought that friendship and a fuller social life were things that should happen "naturally." She soon came to realize that many people had to work at acquiring a more satisfying social life, that for some people there was nothing automatic about it at all.

The social worker helped Grace identify various kinds of social groups that she might join. She was then helped to see which of these would best meet her needs without placing too much stress on her. She finally chose to join an arts and crafts group at a local YMCA. The group gave her an opportunity to begin developing some of her talents and to meet people without having to face demands for intimate social contact. It also gave her an opportunity to take a look at other, more socially oriented programs sponsored by the Y. In the arts and crafts program, she met a couple of people she liked and who seemed to like her. She began having coffee with them once in a while and then an occasional dinner.

Grace still needed support and encouragement from her helper, but she was gradually becoming less anxious and feeling less isolated. Once in a while, she would let her anxiety get the better of her. She would skip a meeting at the Y and then lie about having attended. However, as she began to let herself trust her helper more, she revealed this self-defeating game. The social worker helped her develop coping strategies for those times when her anxiety seemed to be higher.

Grace's problems were more severe than Jeff's, and she did not have as many immediate resources. Therefore, she needed both more time and more attention to develop goals and strategies.

Evaluation Questions for Step III-A

How effectively do I do the following?

- Use probes, prompts, and challenges to help clients identify possible strategies
- Help clients engage in divergent thinking with respect to strategies
- Help clients brainstorm as many ways as possible to accomplish their goals
- Use some kind of framework in helping clients be more creative in identifying strategies
- Help clients identify and begin to acquire the resources they need to accomplish their goals
- Help clients identify and develop the skills they need to accomplish their goals
- Help clients see the action implications of the strategies they identify

CHAPTER 19

Step III-B: "What Strategies Are Best for Me?" Best-Fit Strategies

"What's Best for Me?" The Case of Bud
Helping Clients Choose Best-Fit Strategies
Specific strategies
Robust strategies
Realistic strategies
Strategies in keeping with clients' values
Strategy Sampling
A Balance-Sheet Method for Choosing Strategies
A Sample Balance Sheet
Realism in Using the Balance Sheet
Linking Step III-B to Action
The Shadow Side of Selecting Strategies
Wishful thinking
Playing it safe
Avoiding the worst outcome
Striking a balance
Evaluation Questions for Step III-B

"What's Best for Me?" The Case of Bud

In the last two steps of Stage III, clients are in decision-making mode once again. After brainstorming strategies for accomplishing goals, they need to choose strategies ("packages") that best fit their situations and resources and turn them into some kind of plan for constructive change. Whether these steps are done with the kind of formality outlined here is not the point. Counselors, understanding the "technology" of planning, can add value by helping clients find ways of accomplishing goals (getting what they need and want) in a systematic, flexible, personalized, and cost-effective way. Step III-B involves ways of helping clients choose the strategies that are best for them. Step III-C deals with turning those strategies into some kind of step-by-step plan.

Some clients, once they are helped to develop a range of strategies to implement goals, move forward on their own; that is, they choose the best strategies, put together action plans, and implement them. Others, however, need help in choosing strategies that best fit their situations, and so we add Step III-B to the helping process. It is useless to have clients brainstorm if they don't know what to do with all the action strategies they generate.

Consider the case of Bud, a man who was helped to discover two best-fit strategies for achieving emotional stability in his life. With these, he achieved outcomes that surpassed anyone's wildest expectations.

One morning, Bud, then 18 years old, woke up unable to speak or move. He was taken to a hospital, where catatonic schizophrenia was diagnosed. After repeated admissions to hospitals, where he underwent both drug and electroconvulsive therapy (ECT), his diagnosis was changed to paranoid schizophrenia. He was considered incurable.

A quick overview of Bud's earlier years suggests that much of his emotional distress was caused by unmanaged life problems and the lack of human support. He was separated from his mother for four years when he was young. They were reunited in a city new to both of them, and there he suffered a great deal of harassment at school because of his "ethnic" looks and accent. There was simply too much stress and change in his life. He protected himself by withdrawing. He was flooded with feelings of loss, fear, rage, and abandonment. Even small changes became intolerable. His catatonic attack occurred in the autumn on the day of the change from daylight saving to standard time. It was the last straw.

In the hospital, Bud became convinced that he and many of his fellow patients could do something about their illnesses. They did not have to be victims of themselves or of the institutions designed to help them. Reflecting on his hospital stays and the drug and ECT treatments, he later said he found his "help" so debilitating that it was no wonder that he got crazier. Somehow Bud, using his own inner resources, managed to get out of the hospital. Eventually, he got a job, found a partner, and got married.

One day, after a series of problems with his family and at work, Bud felt himself becoming agitated and thought he was choking to death. His doctor sent him to the hospital "for more treatment." There Bud had the good fortune to meet Sandra, a psychiatric social worker who was convinced that many of the hospital's patients were there because of lack of support before, during, and after their bouts of illness. She helped him see his need for social support, especially at times of stress. In the inpatient counseling groups that she ran, Sandra also discovered that Bud had a knack for helping others. Bud's broad goal was still emotional stability, and he wanted to do whatever was necessary to achieve it. Finding human support and helping others cope with their problems—instrumental goals—were his best strategies for achieving the stability he wanted.

Outside, Bud started a self-help group for ex-patients like himself. In the group, he was a full-fledged participant. Sandra, the social worker, also coached Bud's wife on how to provide support for him at times of stress. As to helping others, Bud not only founded a self-help group but also turned it into a network of self-help groups for ex-patients.

This is an amazing example of a client who focused on one broad goal—emotional stability; translated it into a number of immediate, practical goals; discovered two broad strategies—finding ongoing emotional support and helping others—for accomplishing those goals; translated the strategies into practical applications; and by doing all that, found the emotional stability he was looking for.

Helping Clients Choose Best-Fit Strategies

The criteria for choosing goal-accomplishing strategies are somewhat like the criteria for choosing goals outlined in Step II-B. These criteria are reviewed briefly here through a number of examples. Strategies to achieve goals should be, like goals themselves, specific, robust, prudent, realistic, sustainable, flexible, cost-effective, and in keeping with the client's values. Let's take a look at a few of these criteria as they apply to choosing strategies.

Specific strategies. Strategies for achieving goals should be specific enough to drive behavior. In the preceding example, Bud's two broad strategies for achieving emotional stability—tapping into human support and helping others—were translated into quite specific strategies: keeping in touch with Sandra, getting help from his wife, participating in a self-help group, starting a self-help group, and founding and running a self-help organization. Contrast Bud's case with Stacy's.

Stacy was admitted to a mental hospital because she had been exhibiting bizarre behavior in her neighborhood. She dressed in a slovenly way and went around admonishing the residents of the community for their "sins." Her condition was diagnosed as schizophrenia, simple type. She had been living alone for about five years, since the death of her husband. It seems that she had become more and more alienated from herself and others. In the hospital, medication helped control some of her symptoms. She stopped admonishing others and took reasonable care of herself, but she was still quite withdrawn. She was assigned to "milieu" therapy, a euphemism meaning that she was helped to follow the more or less benign routine of the hospital—a bit of work, a bit of exercise, some programmed opportunities for socializing. She remained withdrawn and usually seemed moderately depressed. No therapeutic goals had been set, and the nonspecific program to which she was assigned was totally inadequate.

So-called milieu therapy did nothing for Stacy because in no way was it specific to her needs. It was a general program that was only marginally better than drug-focused standard care. Bud's strategies, on the other hand, proved to be powerful. They not only helped him gain stability but also gave him a new perspective on life.

Robust strategies. Strategies are robust to the degree that they challenge clients to use their resources and, when implemented, actually achieve goals. Not only was Stacy's program too general, but it also lacked bite. Bud's strategies, on the other hand, were substantive, especially the strategy of starting and running a self-help organization. What could be done for Stacy?

A newly hired psychiatrist, who had been influenced by Corrigan's (1995) notion of "champions of psychiatric rehabilitation," saw immediately that Stacy needed more than either standard

psychiatric or milieu-centered care. He involved her in a new comprehensive social-learning program, which included cognitive restructuring, social-skills training, and behavioral-change interventions based on incentives, shaping, modeling, and rewards. Stacy responded very well to the new, rather intensive program. She was discharged within six months and, with the help of an outpatient extension of the program, remained in the community.

For Stacy, this program proved to be not only robust but also specific, prudent, realistic, sustainable, flexible, cost-effective, and in keeping with her values. It was cost-effective in two ways. First, it was the best use of Stacy's time, energy, and psychological resources. Second, it helped her and others like her to get back into the community and stay there. It was in keeping with her values because, even though some staff members at the hospital had concluded that all she wanted was "to be left alone," Stacy did value human companionship and freedom. She did better in a community setting.

Realistic strategies. If clients choose strategies that are beyond their resources, they are doing themselves in. Strategies are realistic when they can be carried out with the resources the client has, are under the client's control, and are unencumbered by obstacles. Bud's strategies would have appeared unrealistic to most clients and helpers. But this highlights an important point. Just as we should help clients set stretch goals whenever possible, so we should not underestimate what clients are capable of doing. In the following case, Desmond moves from unrealistic to realistic strategies for getting what he wants.

Desmond was in a halfway house after leaving a state mental hospital. From time to time, he still had bouts of depression that would incapacitate him for a few days. He wanted to get a job because he thought that a job would help him feel better about himself, become more independent, and manage his depression better. He answered job advertisements in a rather random way and was constantly turned down after being interviewed. He simply did not yet have the kinds of resources needed to put himself in a favorable light in job interviews. Moreover, he was not yet ready for a regular, full-time job.

On his own, Desmond does not do well in choosing strategies to achieve even modest goals. But here's what happened next:

A local university received funds to provide outreach services to halfway houses in the metropolitan area. The university program included finding companies that were willing, on a win-win basis, to work with halfway-house residents. A counselor from the program helped Desmond get in contact with companies that had specific programs to help people with psychiatric problems. He found two that he thought would fit his needs. Some of their best workers had a variety of disabilities, including psychiatric problems. After a few interviews, Desmond got a job in one of these companies that fitted his situation and capabilities. The entire work culture was designed to provide the kind of support he needed.

There is, of course, a difference between realism and allowing clients to sell themselves short. Robust strategies that make clients stretch for a valued goal can be most rewarding. Bud's case is an exceptional example of that.

Strategies in keeping with clients' values. Make sure that the strategies that clients choose are consistent with their values. Let's return to the case of the priest who had been unjustly accused of child molestation.

In preparing for the court case, the priest and his lawyer had a number of discussions. The lawyer wanted to do everything possible to destroy the credibility of the accusers. He had dug into their past and dredged up some dirt. The priest objected to these tactics. "If I let you do this," he said, "I descend to their level. I can't do that." The priest discussed this with his counselor, his superiors, and another lawyer. He stuck to his guns. They prepared a strong case without the sleaze.

After the trial was over and he was acquitted, the priest said that his discussion about the lawyer's preferred tactics was one of the most difficult issues he had to face. Something in him said that since he was innocent, any means to prove his innocence was allowed. Something else told him that this was not right. The counselor helped him clarify and challenge his values but made no attempt to impose either his own or the lawyer's values on his client.

Box 19-1 Questions on Best-Fit Strategies

- Which strategies will be most useful in helping me get what I need and want?
- Which strategies are best for this situation?
- Which strategies best fit my resources?
- Which strategies will be most economic in the use of my resources?
- Which strategies are most powerful?
- Which strategies best fit my preferred way of acting?
- Which strategies best fit my values?
- Which strategies will have the fewest unwanted consequences?

Box 19-1 outlines the kinds of questions you can help clients answer as they choose best-fit strategies.

Strategy Sampling

Some clients find it easier to choose strategies if they first sample some of the possibilities. Consider this case:

Two business partners were in conflict over ownership of the firm's assets. Their goals were to see justice done, to preserve the business, and, if possible, to preserve their relationship. A colleague helped them sample some possibilities. Under her guidance, they discussed with a lawyer the process and consequences of bringing their dispute to the courts, they had a meeting with a consultant-counselor who specialized in these kinds of disputes, and they visited an arbitration firm.

In this case, the sampling procedure had the added effect of giving them time to let their emotions simmer down. They agreed to go the consultant-counselor route.

Karen, the woman who, with the help of her counselor, brainstormed a wide range of strategies for disengaging from alcohol, decided to sample some of the possibilities.

Surprised by the number of program possibilities there were to achieve the goal of getting liquor out of her life, Karen decided to sample some of them. She went to an open meeting of Alcoholics Anonymous, attended a meeting of a women's lifestyle-issues group, visited the hospital

that had the residential treatment program, and joined up for a two-week trial physical fitness program at a YMCA. She engaged in these activities frantically. She tried them out and then discussed them with her counselor. Her search for the programs that were best for her did occupy her energies and strengthened her resolve to do something about her alcoholism.

Of course, some clients could use strategy sampling as a way of putting off action. That was certainly not the case with Bud. His attending the meeting of a self-help group after leaving the hospital was a form of strategy sampling. Although he was impressed by the group, he thought that he could start a group limited to ex-patients that would focus more directly on the kinds of issues he and other ex-patients were facing.

A Balance-Sheet Method for Choosing Strategies

Some form of balance sheet can be used to help clients make decisions in general. The methodology could be used for any key decision related to the helping process—to get help in the first place, to work on one problem rather than another, or to choose this rather than that goal. Balance sheets deal with the acceptability and unacceptability of both benefits and costs. A balance-sheet approach, applied to choosing strategies for achieving goals, poses questions such as the following:

- What are the benefits of choosing this strategy for myself? for significant others?
- To what degree are these benefits acceptable to me? to significant others?
- In what ways are these benefits unacceptable to me? to significant others?
- What are the costs of choosing this strategy for myself? for significant others?
- To what degree are these costs acceptable to me? to significant others?
- In what ways are these costs unacceptable to me? to significant others?

Let's return to Karen. She used the balance-sheet method to assess the viability not of a goal but of strategies to achieve a goal. Karen's goal was to stop drinking. One possible strategy for accomplishing that goal was to spend a month as an inpatient at an alcoholic treatment center. This possibility appealed to her. However, since choosing this strategy would be a serious decision, the counselor, Joan, helped Karen use a balance sheet to weigh possible costs and benefits. After filling it out, Karen and Joan discussed Karen's findings. She chose to consider the pluses and minuses for herself and for her husband and children.

A Sample Balance Sheet

Benefits of Choosing the Residential Program

- *For me.* It would help me because it would be a dramatic sign that I want to do something to change my life. It's a clean break, as it were. It would also give me time just for myself. I'd get away from all my commitments to family, relatives, friends, and work. I see it as an opportunity to do some planning. I'd have to figure out how I would act as a sober person.

- *For significant others.* I'm thinking mainly of my family here. It would give them a breather, a month without an alcoholic wife and mother around the house. I'm not saying that to put myself down. I think it would give them time to reassess family life and make some decisions about any changes they'd like to make. I think something dramatic like my going away would give them hope. They've had very little reason to hope for the last five years.

Acceptability of benefits

- *For me.* I feel torn here. But looking at it just from the viewpoint of acceptability, I feel kind enough toward myself to give myself a month's time off. Also, something in me longs for a new start in life. And it's not just time off. The program is a demanding one.
- *For significant others.* I think that my family would have no problems in letting me take a month off. I'm sure that they'd see it as a positive step from which all of us would benefit.

Unacceptability of benefits

- *For me.* Going away for a month seems such a luxury, so self-indulgent. Also, even though taking such a dramatic step would give me an opportunity to change my current lifestyle, it would also place demands on me. My fear is that I would do fine while in the program but that I would come out and fall on my face. I guess I'm saying it would give me another chance at life, but I have misgivings about having another chance. I need some help here.
- *For significant others.* The kids are young enough to readjust to a new me. But I'm not sure how my husband would take this "benefit." He has more or less worked out a lifestyle that copes with my being drunk a lot. Though I have never left him and he has never left me, still I wonder whether he wants me back sober. Maybe this belongs under the "cost" part of this exercise. I need some help here. And, of course, I need to talk to my husband about all this. I also notice that some of my misgivings relate not to a residential program as such but to a return to a lifestyle free of alcohol. Doing this exercise helped me see that more clearly.

Costs of Choosing the Residential Program

- *For me.* Well, there's the money. I don't mean the money just for the program, but I would be losing four weeks' wages. But I've lost a lot of wages through drinking. The major cost seems to be the commitment I have to make about a lifestyle change. And I know the residential program won't be all fun. I don't know exactly what they do there, but some of it must be demanding. Probably a lot of it.
- *For significant others.* It's a private program, and it's going to cost the family a lot of money. The services I have been providing at home will be missing for a month. It could be that I'll learn things about myself that will make it harder to live with me—though living with a drunken spouse and mother is no joke.

What if I come back more demanding of them—I mean, in good ways? I need to talk this through more thoroughly.

Acceptability of costs

- *For me.* I have no problem at all with the money or with whatever the residential program demands of me physically or psychologically. I'm willing to pay. What about the costs of the demands the program will place on me for substantial lifestyle changes? Well, in principle I'm willing to pay what that costs. But I'm not sure what these are. I need some help here.
- *For significant others.* They will have to make financial sacrifices, but I have no reason to think that they would be unwilling. Still, I can't be making decisions for them. I see much more clearly the need to have a counseling session with my husband and children present. I think they're also willing to have a "new" person around the house, even if it means making adjustments and changing their lifestyle a bit. I want to check this out with them, but I think it would be helpful to do this with the counselor. I think they will be willing to come.

Unacceptability of costs

- *For me.* Although I'm ready to change my lifestyle, I hate to think that I will have to accept some dumb, dull life. I think I've been drinking, at least in part, to get away from dullness; I've been living in a fantasy world, a play world a lot of the time. A stupid way of doing it, perhaps, but it's true. I have to do some life planning of some sort. I need some help here.
- *For significant others.* It strikes me that my family might have problems with a sober me if it means that I will strike out in new directions. I wonder if they want the traditional homebody wife and mother. I don't think I could stand that. All this should come out in the meeting with the counselor.

Karen concludes, "All in all, it seems like the residential program is a good idea. There is something much more substantial about it than an outpatient program. But that's also what scares me."

Karen's use of the balance sheet helps her make an initial program choice, but it also enables her to discover issues that she has not yet worked out completely. By using the balance sheet, she returns to the counselor with work to do. This highlights the usefulness of exercises and other forms of structure that help clients take more responsibility for what happens both in the helping sessions and outside.

Realism in Using the Balance Sheet

Now let's look at a more practical and flexible approach to using the balance sheet. It is not to be used with every client to work out the pros and cons of every course of action. Tailor the balance sheet to the needs of the client. Choose the parts of the balance sheet that will add the most value with *this* client pursuing *this* goal or set of goals. In fact, one of the best uses of the balance sheet is not to use it directly at all. Keep it in the back of your mind whenever clients are making decisions. Use it as a filter to listen to clients. Then turn relevant parts of it into probes to help clients focus on issues they may be overlooking. "How will this decision affect the significant people in your life?" is a probe that originates in the balance sheet. "Is there any downside to that strategy?" might help a client who is being a bit too optimistic. There's no formula.

Linking Step III-B to Action

Some clients are filled with great ideas for getting things done but never seem to do anything. They lack the discipline to evaluate their ideas, choose the best ones, and turn them into action. Often this kind of work seems too tedious to them, even though it is precisely what they need. Consider the following case:

Clint came away from the doctor feeling depressed. He was told that he was in the high-risk category for heart disease and that he needed to change his lifestyle. He was cynical, a man very quick to anger, a man who did not readily trust others. Venting his suspicions and hostility did not make these feelings go away; it only intensified them. Therefore, one critical lifestyle change was to change this pattern and develop the ability to trust others. He developed three broad goals: reducing mistrust of others' motives; reducing the frequency and intensity of such emotions as rage, anger, and irritation; and learning how to treat others with consideration. Clint read through the strategies suggested to help people pursue these broad goals (see Williams, 1989). They included

- keeping a hostility log to discover the patterns of cynicism and irritation in one's life;
- finding someone to talk to about the problem, someone to trust;
- "thought stopping"—catching oneself in the act of indulging in hostile thoughts or in thoughts that lead to hostile feelings;
- talking sense to oneself when tempted to put others down;
- developing empathic thought patterns—that is, walking in the other person's shoes;
- learning to laugh at one's own silliness;
- using a variety of relaxation techniques, especially to counter negative thoughts;
- finding ways of practicing trust;
- developing active listening skills;
- substituting assertive for aggressive behavior;
- getting perspective, seeing each day as one's last;
- practicing forgiving others without being patronizing or condescending.

Clint prided himself on his rationality (though his "rationality" was one of the things that got him into trouble). So, as he read down the list, he chose strategies that could form an "experiment," as he put it. He decided to talk to a counselor (for the sake of objectivity), keep a hostility log (data gathering), and use the tactics of thought stopping and talking sense to himself whenever he felt that he was letting others get under his skin. The counselor noted to himself that none of these necessarily involved changing Clint's attitudes toward others. However, he did not challenge Clint at this point. His best bet was that through "strategy sampling" Clint would learn more about his problem, that he would find that it went deeper than he thought. Clint set himself to his experiment with vigor.

Clint chose strategies that fit his values. The problem was that the values themselves needed reviewing. But Clint did act, and action gave him the opportunity to learn.

The Shadow Side of Selecting Strategies

The shadow side of decision making, discussed in Chapter 14, is certainly at work in clients' choosing strategies to implement goals. Goslin (1985) puts it well:

> In defining a problem, people dislike thinking about unpleasant eventualities, have difficulty in assigning . . . values to alternative courses of action, have a tendency toward premature closure, overlook or undervalue long-range consequences, and are unduly influenced by the first formulation of the problem. In evaluating the consequences of alternatives, they attach extra weight to those risks that can be known with certainty. They are more subject to manipulation . . . when their own values are poorly thought through. . . . A major problem . . . for . . . individuals is knowing when to search for additional information relevant to decisions. (pp. 7, 9)

In choosing courses of action, clients often fail to evaluate the risks involved and to determine whether the risk is balanced by the probability of success. Gelatt, Varenhorst, and Carey (1972) suggest four ways in which clients may try to deal with the factors of risk and probability: wishful thinking, playing it safe, avoiding the worst outcome, and achieving some kind of balance. The first three are often pursued without reflection and therefore lie in the "shadows."

Wishful thinking. In this case, clients choose a course of action that might (they hope) lead to the accomplishment of a goal regardless of risk, cost, or probability. For instance, Jenny wants her ex-husband to increase the amount of support he is paying for the children. She tries to accomplish this by constantly nagging him and trying to make him feel guilty. She doesn't consider the risk (he might get angry and stop giving her anything), the cost (she spends a great deal of time and emotional energy arguing with him), or the probability of success (he does not react favorably to nagging). Wishful-thinking clients operate blindly, engaging in courses of action without taking into account their usefulness. At its worst, this is a reckless approach. Clients who "work hard" and still "get nowhere" may be engaged in wishful thinking, persevering in using means they prefer but that are of doubtful efficacy. Effective helpers find ways of challenging wishful thinking: "Jenny, let's review what you've been doing to get Tom to pay up and how successful you've been."

Playing it safe. In this case, clients choose only safe courses of action, ones that have little risk and a high degree of probability of producing at least limited success. For instance, Liam, a manager in his early forties, is very dissatisfied with the way his boss treats him at work. His ideas are ignored, the delegation he is supposed to have is preempted, and his boss does not respond to his attempts to discuss career development. His goals center around his career. He wants to let his boss know about his dissatisfaction, and he wants to learn what his boss thinks about him and his career possibilities. These are instrumental goals, of course, since his overall goal is to carve out a career path. However, he fails to bring these issues up when his boss is "out of sorts." On the other hand, when things are going well, Liam doesn't want to "upset the applecart." He drops hints about his dissatisfaction, even joking about them at times. He tells others in hopes that word will filter back to his boss. During formal appraisal sessions, he allows himself to be intimidated by his boss. However, in his own mind, he is doing whatever could be expected of a "reasonable" man. He does not know how safe he is playing it. The helper says, "Liam, you're playing pretty safe with your boss. And, while it's true that you haven't upset him, you're still in the dark about your career prospects."

Avoiding the worst outcome. Often clients choose means that are likely to help them avoid the worst possible result. They try to minimize the maximum danger, often without identifying what that danger is. Crissy, dissatisfied with her marriage, sets a goal to be "more assertive." However, even though she has never said this either to herself or to her counselor, the maximum danger for her is losing her partner. Therefore, her "assertiveness" is her usual pattern of compliance, with some frills. For instance, every once in a while, she tells her husband that she is going out with friends and will not be around for supper. He, without her knowing it, actually enjoys these breaks. At some level of her being, she realizes that her absences are not putting him under any pressure. She continues to be assertive in this way. But she never sits down with her husband to review where they stand with each other. That might be the beginning of the end. Early in one session, the counselor says, "What if some good friend were to say to you, 'Bill has you just where he wants you.' How would you react?" Crissy is startled, but she comes away from the session much more realistic.

Striking a balance. Ideally, clients choose strategies for achieving goals that balance risks against the probability of success. This "combination" approach is the most difficult to apply because it involves the right kind of analysis of problem situations and opportunities, choosing goals with the right edge, being clear about one's values, ranking a variety of strategies according to these values, and estimating how effective any given course of action might be. Even more to the point, it demands challenging the blind spots that might distort these activities. Since some clients have neither the skill nor the will for this combination approach, it is essential that their counselors help them engage in the kind of dialogue that will help them face up to this impasse.

Evaluation Questions for Step III-B

How well am I doing the following as I try to help clients choose goal-accomplishing strategies that are best for them?

- Helping clients choose strategies that are clear and specific, that best fit their capabilities, that are linked to goals, that have power, and that are suited to clients' styles and values
- Helping clients engage in and benefit from strategy sampling
- Helping clients in selected cases use the balance sheet as a way of choosing strategies by outlining the principal benefits and costs for self, others, and relevant social settings
- Helping clients manage the shadow side of selecting courses of action—that is, wishful thinking, playing it too safe, focusing on avoiding the worst possible outcome rather than on getting what they want, and wasting time by trying to spell out a perfectly balanced set of strategies
- Helping clients use the act of choosing strategies to stimulate problem-managing action

CHAPTER 20

STEP III-C: "WHAT KIND OF PLAN WILL HELP ME GET WHAT I NEED AND WANT?" HELPING CLIENTS MAKE PLANS

NO PLAN OF ACTION: THE CASE OF FRANK

HOW PLANS ADD VALUE TO CLIENTS' CHANGE PROGRAMS

- Plans help clients develop needed discipline
- Plans keep clients from being overwhelmed
- Formulating plans helps clients search for more useful ways of accomplishing goals—that is, even better strategies
- Plans provide opportunities to evaluate the realism and adequacy of goals
- Plans make clients aware of the resources they will need to implement their strategies
- Formulating plans helps clients uncover unanticipated obstacles to the accomplishment of goals

SHAPING THE PLAN: THREE CASES

- The case of Wanda
- The case of Harriet: The economics of planning
- The case of Frank revisited

HUMANIZING THE TECHNOLOGY OF CONSTRUCTIVE CHANGE

- Build a Planning Mentality into the Helping Process Right from the Start
- Adapt the Constructive-Change Process to the Client's Style
- Devise a Plan for the Client and Then Work with the Client to Revise It as Needed

TAILORING READY-MADE PROGRAMS TO CLIENTS' NEEDS

- A prevention program for pedophilia
- A program for helping people on welfare become successful at work
- General well-being programs: Exercise

EVALUATION QUESTIONS FOR STEP III-C

After identifying and choosing strategies to accomplish goals, clients need to organize these strategies into plans. This is the work of Step III-C. In this step, counselors help clients come up with plans, sequences of actions—"What should I do first, second, and third?"—that will get them what they want, their goals.

NO PLAN OF ACTION: THE CASE OF FRANK

The lack of a plan—that is, a clear step-by-step process to accomplish a goal—keeps some clients mired in their problem situations. Consider the case of Frank, a vice president of a large West Coast corporation.

> Frank was a go-getter. He was very astute about business and had risen quickly through the ranks. Vince, the president of the company, was in the process of working out his own retirement plans. From a business point of view, Frank was the heir apparent. But there was a glitch. Vince was far more than a good manager; he was a leader. He had a vision of what the company should look like five to ten years down the line. Early on, he saw the power of the Internet and used it wisely to give the business a competitive edge.
>
> Though tough, Vince related well to people. People constituted the human capital of the company. He knew that products *and* people kept customers happy. He also took to heart the results of a millennium survey of some 2 million employees in the United States. One of the sentences in the summary of the survey results haunted him: "People join companies but leave supervisors." In the "war for talent," he couldn't afford supervisors who alienated their team members.
>
> Frank was quite different. He was a "hands-on" manager, meaning, in his case, that he was slow to delegate tasks to others, however competent they might be. He kept second-guessing others when he did delegate, reversed their decisions in a way that made them feel put down, listened poorly, and took a fairly short-term view of the business: "What were last week's figures like?" He was not a leader but an "operations" man. His direct reports called him a micromanager.
>
> One day, Vince sat down with Frank and told him that he was considering him as his successor down the line but that he had some concerns. "Frank, if it were just a question of business acumen, you could take over today. But my job, at least in my mind, demands a leader." Vince went on to explain what he meant by a leader and to point out the things in Frank's style that had to change.
>
> So Frank did something that he never thought he would do. He began seeing a coach. Roseanne had been an executive with another company in the same industry but had opted to become a coach for family reasons. Frank chose her because he trusted her business acumen. That's what meant most to him. They worked together for over a year, often over lunch and in hurried meetings early in the morning or late in the evening. And, indeed, he valued their dialogues about the business.
>
> Frank's ultimate aim was to become president. If getting the job meant that he had to try to become the kind of leader his boss had outlined, so be it. Since he was very bright, he came up with some inventive strategies for moving in that direction. But he could never be pinned down to an overall program with specific milestones by which he could evaluate his progress. Roseanne pushed him, but Frank was always "too busy" or would say that a formal program was "too stifling." That was odd, since formal planning was one of his strengths in the business world.
>
> Frank remained as astute as ever in his business dealings. But he merely dabbled in the strategies meant to help him become the kind of leader Vince wanted him to be. Frank had the opportunity of not just correcting some mistakes but of developing and expanding his managerial style. But he blew it. At the end of two years, Vince appointed someone else president of the company.

Frank never got his act together. He never put together the kind of change program needed to become the kind of leader Vince wanted as president. Why? Frank had

two significant blind spots that the coach did not help him overcome. First, he never really took Vince's notion of leadership seriously. So he wasn't really ready for a change program. He thought the president's job was his, that business acumen alone would win out in the end. Second, he thought he could change his management style at the margins, when more substantial changes were called for.

Roseanne never challenged Frank as he kept "trying things" that never led anywhere. Maybe things would have been different if she had said something like this: "Come on, Frank, you know you don't really buy Vince's notion of leadership. But you can't just give lip service to it. Vince will see right through it. We're just messing around. You don't want a program because you don't believe in the goal. Let's do something or call these meetings off." In a way, she was a co-conspirator because she, too, relished their business discussions. When Frank didn't get the job, he left the company, leaving Roseanne to ponder her success as an executive but her failure as a coach.

How Plans Add Value to Clients' Change Programs

Some clients, once they know what they want and some of the things they have to do to get what they want, get their act together, develop a plan, and move forward. Other clients need help. Since some clients (and some helpers) fail to appreciate the power of a plan, it is useful to start by reviewing the advantages of planning.

Not all plans are formal. "Little plans," whether called such or not, are formulated and executed throughout the helping process. Tess, an alcoholic who wants to stop drinking, feels the need for some support. She contacts Lou, a friend who has shaken a drug habit, tells him of her plight, and enlists his help. He readily agrees. Objective accomplished. This "little plan" is part of her overall change program. Change programs are filled with setting "little objectives" and developing and executing "little plans" to achieve them.

Formal planning usually focuses on the sequence of "big steps" clients must take to get what they need or want. Clients are helped to answer the question, "What do I need to do first, second, and third?" The most formal version of planning takes strategies for accomplishing goals, divides them into workable steps, puts the steps in order, and assigns a timetable for the accomplishment of each step.

Formal planning, provided that it is adapted to the needs of individual clients, has a number of advantages.

Plans help clients develop needed discipline. Many clients get into trouble in the first place because they lack discipline. Planning places reasonable demands on clients to develop discipline. Desmond, the halfway-house resident discussed in the last chapter, needed discipline and benefitted greatly from a formal job-seeking program. Indeed, ready-made programs such as the 12-step program of Alcoholics Anonymous are in themselves plans that demand or at least encourage self-discipline.

Plans keep clients from being overwhelmed. Plans help clients see goals as doable, keeping the steps toward the accomplishment of goals "bite-size." Amazing things can be accomplished by taking bite-size steps toward substantial goals. Bud, the ex-psychiatric patient who ended up creating a network of self-help groups for ex-patients, started with the bite-size step of participating in one of those groups himself. He did not become a self-help entrepreneur overnight. It was a step-by-step process.

Formulating plans helps clients search for more useful ways of accomplishing goals—that is, even better strategies. Sy Johnson was an alcoholic. When Mr. Johnson's wife and children, working with a counselor, began to formulate a plan for coping with their reactions to his alcoholism, they realized that the strategies they had been trying were hit-or-miss. With the help of an Al-Anon self-help group, they went back to the drawing board. Mr. Johnson's drinking had introduced a great deal of disorder into the family. Planning would help them restore order.

Plans provide opportunities to evaluate the realism and adequacy of goals. This aspect of planning is an example of the "dialogue" that should take place among the stages of the helping process. When Walter, a middle manager who had many problems in the workplace, began tracing out a plan to cope with the loss of his job and with a lawsuit filed against him by his former employer, he realized that his initial goals—getting his job back and filing and winning a countersuit—were unrealistic. His revised goals included getting his former employer to withdraw the suit and getting into better shape to search for a job by participating in a self-help group of managers who had lost their jobs.

Plans make clients aware of the resources they will need to implement their strategies. When Dora was helped by a counselor to formulate a plan to pull her life together after the disappearance of her younger son, she realized that she lacked the social support needed to carry out the plan. She had retreated from friends and even relatives, but now she knew she had to get back into community. Normalizing life demanded ongoing social involvement and support. A goal of finding the support needed to get back into community was added to her constructive-change program.

Formulating plans helps clients uncover unanticipated obstacles to the accomplishment of goals. Ernesto, a U.S. soldier who had accidentally killed an innocent bystander during his stint in Kosovo, was seeing a counselor because of the difficulty he was having returning to civilian life. Only when he began pulling together and trying out plans for normalizing his social life did he realize how ashamed he was of what had happened to him in the military. He felt so flawed because of what had happened that it was almost impossible to involve himself intimately with others. Helping him deal with his shame became one of the most important parts of the healing process.

Formulating plans will not solve all our clients' problems, but it is one way of making time an ally instead of an enemy. Many clients engage in aimless activity in their efforts to cope with problem situations. Plans help clients make the best use of their time. Finally, planning itself has a hefty shadow side. For a good review of the shadow side of planning, see Dorner (1996, pp. 153–183).

Shaping the Plan: Three Cases

Plans need "shape" to drive action. A formal plan identifies the activities or actions needed to accomplish a goal or a subgoal, puts those activities into a logical but flexible order, and sets a time frame for the accomplishment of each key step. Therefore, there are three simple questions:

- What are the concrete things that need to be done to accomplish the goal or the subgoal?
- In what sequence should these be done? What should be done first, second, third, and so on?
- What is the time frame? What should be done today, tomorrow, next month?

If clients choose goals that are complex or difficult, it is useful to help them establish subgoals as a way of moving step-by-step toward the ultimate goal. For instance, once Bud decided to start an organization of self-help groups composed of ex-patients from mental hospitals, there were a number of subgoals he needed to accomplish before the organization would become a reality. His first step was to set up a test group. This instrumental goal provided the experience needed for further planning. A later step was to establish some kind of charter for the organization. "Charter in place" was one of the subgoals leading to his main goal.

In general, the simpler the plan the better. However, simplicity is not an end in itself. The question is not whether a plan or program is complicated but whether it is well shaped and designed to produce results. If complicated plans are broken down into subgoals and the strategies or activities needed to accomplish them, they are as capable of being achieved as simpler ones, assuming the time frame is realistic. In schematic form, shaping looks like this:

Subprogram 1 (a set of activities) leads to subgoal 1 (usually an instrumental goal).

Subprogram 2 leads to subgoal 2.

Subprogram *n* (the last in the sequence) leads to the accomplishment of the ultimate goal.

The case of Wanda. Consider Wanda, a client who set a number of goals to manage a complex problem situation. One of her goals was finding a job. The plan leading to this goal had a number of steps, each of which led to the accomplishment of a subgoal. The following subgoals were part of Wanda's job-finding program. They are stated as accomplishments (the outcome or results approach).

Subgoal 1: Resumé written.

Subgoal 2: Kind of job wanted determined.

Subgoal 3: Job possibilities canvassed.

Subgoal 4: Best job prospects identified.

Subgoal 5: Job interviews arranged.

Subgoal 6: Job interviews completed.

Subgoal 7: Offers evaluated.

The accomplishment of these subgoals leads to the accomplishment of the overall goal of Wanda's plan—that is, getting the kind of job she wants.

Wanda also had to set up a step-by-step process or program to accomplish each of these subgoals. For instance, the process for accomplishing the subgoal "job possibilities canvassed" included such things as doing an Internet search on one or more of the many job search sites, reading the "Help Wanted" sections of the local newspapers, contacting friends or acquaintances who could provide leads, visiting employment agencies, reading the bulletin boards at school, and talking with someone in the job placement office. Sometimes the sequencing of activities is important, sometimes not. In Wanda's case, it's important for her to have her resumé completed before she begins to canvass job possibilities, but when it comes to using different methods for identifying job possibilities, the sequence does not make any difference.

The case of Harriet: The economics of planning. Harriet, an undergraduate student at a small state college, wants to become a counselor. Although the college offers no formal program in counseling psychology, with the help of an advisor, she identifies several undergraduate courses that would provide some of the foundation for a degree in counseling. One is called Social Problem-Solving Skills; a second is Effective Interpersonal Communication Skills; a third is Developmental Psychology: The Developmental Tasks of Late Adolescence and Early Adulthood. Harriet takes the courses as they come up. The first course she can enroll in is Social Problem-Solving Skills. The good news is that it includes a great deal of practice in the skills. The bad news is that it assumes competence in interpersonal communication skills. Too late she realizes that she is taking the courses out of optimal sequence. She would have gotten much more from the course had she taken the communication skills course first.

Harriet also volunteers for the dormitory peer-helper program run by the Center for Student Services. The center's counselors are very careful in choosing people for the program, but they don't offer much training. It is a learn-as-you-go approach. Harriet realizes that the developmental psychology course would have helped her enormously in this program. It would have helped her understand both herself and her peers better. She finally realizes that she needs a better plan. In the next semester, she drops out of the peer-counselor program. She sits down with one of the center's psychologists, reviews the schools offerings with him, decides which courses will help her most, and determines the proper sequencing of these courses. The psychologist also suggests a couple of courses she could take in a local community college. Harriet's opportunity-development program would have been much more efficient had it been better shaped in the first place.

The case of Frank revisited. Let's see what planning might have done for Frank, the vice president who needed leadership skills. In this fantasy, Frank, like Scrooge, gets a second chance.

What does Frank need to do? To become a leader, Frank decides to reset his managerial style with his subordinates by involving them more in decision making.

Box 20-1 Questions on Planning

Here are some questions you can help clients ask themselves to come up with a viable plan for constructive change:

- Which sequence of actions will get me to my goal?
- Which actions are most critical?
- How important is the order in which these actions take place?
- What is the best time frame for each action?
- Which step of the program needs substeps?
- How can I build informality and flexibility into my plan?
- How do I gather the resources, including social support, needed to implement the plan?

He wants to listen more, set work objectives through dialogue, ask subordinates for suggestions, and delegate more. He knows he should coach his direct reports in keeping with their individual needs, give them feedback on the quality of their work, recognize their contributions, and reward them for achieving results beyond their objectives.

In what sequence should Frank do these things? Frank decides that the first thing he will do is call in each subordinate and ask, "What do you need from me to get your job done? How can I add value to your work? And what management style on my part would help you most?" Their dialogue around these issues will help him tailor his supervisory interventions to the needs of each team member. The second step is also clear. The planning cycle for the business year is about to begin, and each team member needs to know what his or her objectives are. It is a perfect time to begin setting objectives through dialogue rather than simply assigning them. So Frank sends a memo to each of his direct reports, asking them to review the company's strategy and business plan and the strategy and plan for each of their functions, and to write down what they think their key managerial objectives for the coming year should be. He asks them to include stretch goals.

What is Frank's time frame? Frank calls in each of his subordinates immediately to discuss what they need from him. He completes his objective-setting sessions with them within three weeks. He puts off further action on delegation until he gets a better reading on their performance. This is a rough idea of what a plan for Frank might have looked like and how it might have improved his chaotic and abortive effort to change his managerial style—on the condition, of course, that he was convinced that a different approach to management and supervision made personal and business sense.

Box 20-1 lists questions you can use to help clients think systematically about crafting a plan to get what they need and want.

Humanizing the Technology of Constructive Change

Some years ago, I lent a friend of mine an excellent, though somewhat detailed, book on self-development. About two weeks later, he came back, threw the book on my desk, and said, "Who would go through all of that!" I retorted, "Anyone really interested in self-development." That was the righteous, not the realistic, response. Planning in the real world seldom looks like planning in textbooks. Textbooks do provide useful frameworks, principles, and processes, but they are seldom used. Most people are too impatient to do the kind of planning outlined in the previous section. One reason for the dismal track record of discretionary change mentioned earlier is that even when clients do set realistic goals, they lack the discipline to develop reasonable plans. The detailed work of planning is too burdensome.

Therefore, Stages II and III of the helping process together with their six steps need a human face. If helpers skip the goal-setting and planning steps clients need, they shortchange them. On the other hand, if they are pedantic, mechanistic, or awkward in their attempts to help clients engage in these steps—if they fail to give these processes a human face—helpers run the risk of alienating the people they are trying to serve. Clients might well say, "I'm getting a lot of boring garbage from him." Here, then, are some principles to guide the constructive-change process from Step II-A through Step III-C.

Build a Planning Mentality into the Helping Process Right from the Start

A constructive-change mind-set should permeate the helping process from the very beginning. This is part of the hologram metaphor—the whole model should be found in each of its parts—mentioned in Chapter 2. Helpers need to see clients as self-healing agents capable of changing their lives, not just as individuals mired in problem situations. Even while listening to a client's story, the helper needs to begin thinking of how the situation can be remedied and through probes find out what approaches to change the client is thinking about—no matter how tentative these ideas might be. As mentioned earlier, helping clients act in their real world at the start of the helping process helps them develop some kind of initial planning mentality. If helping is to be solution-focused, thinking about strategies and plans must be introduced early. When a client tells of some problem, the helper can ask early on, "What have you done so far to try to cope with the problem?"

> Cora, a battered spouse, did not want to leave her husband because of the kids. Right from the beginning, the helper saw Cora's problem situation from the point of view of the whole helping process. While she listened to Cora's story, without distorting it, she saw possible goals and strategies. Within the helping sessions, the counselor helped Cora learn a great deal about how battered women typically respond to their plight and how dysfunctional some of those responses are. Cora also learned how to stop blaming herself for the violence and to overcome her fears of developing more active coping strategies. At home, she confronted her husband and stopped submitting to the violence in a vain attempt to avoid further abuse. She also joined a local self-help group for battered women. There she found social support and learned how to invoke both police protection and recourse to the courts. Further sessions with the counselor helped her gradually change her identity from battered woman to survivor and, eventually, to doer. She moved from simply facing problems to developing opportunities.

Constructive-change scenarios like this must be in the helper's mind from the start, not as preset programs to be imposed on clients but as part of a constructive-change mentality.

Adapt the Constructive-Change Process to the Client's Style

Setting goals, devising strategies, and making and implementing plans can be done formally or informally. There is a continuum. Some clients actually like the detailed work of devising plans; it fits their style.

> Gitta sought counseling as she entered the "empty nest" period of her life. Although there were no specific problems, she saw too much emptiness as she looked into the future. The counselor helped her see this period of life as a normal experience rather than a psychological problem. It was a developmental opportunity and challenge (see Raup & Myers, 1989). It was an opportunity to reset her life. After spending a bit of time discussing some of the maladaptive responses to this transitional phase of life, they embarked on a review of possible scenarios. Gitta loved brainstorming, getting into the details of the scenarios, weighing choices, setting strategies, and making formal plans. She had been running her household this way for years. So the process was familiar even though the content was new.

Here's another case:

> Connor, in rebuilding his life after a serious automobile accident, very deliberately planned both a rehabilitation program and a career change. Keeping to a schedule of carefully planned actions not only helped him keep his spirits up but also helped him accomplish a succession of goals. These small triumphs buoyed his spirits and moved him, however slowly, along the rehabilitation path.

Both Gitta and Connor readily embraced the positive-psychology approach embedded in constructive-change programs. They thrived on both the work and the discipline to develop plans and execute them. Many, if not most, people, however, are not like Gitta and Connor. The distribution is skewed toward the "I hate all this detail and won't do it" end of the continuum.

Kirschenbaum (1985) challenges the notion that planning should always provide an exact blueprint for specific actions, their sequencing, and the time frame. There are three questions:

- How specific do the activities have to be?
- How rigid does the order have to be?
- How soon does each activity have to be carried out?

Kirschenbaum suggests that, at least in some cases, being less specific and rigid about actions, sequencing, and deadlines can "encourage people to pursue their goals by continually and flexibly choosing their activities" (p. 492). That is, flexibility in planning can help clients become more self-reliant and proactive. Rigid planning strategies can lead to frequent failure to achieve short-term goals.

Consider the case of Yousef, a single parent with a mentally retarded son. He was challenged one day by a colleague at work. "You've let your son become a ball and chain, and that's not good for you or him!" his friend said. Yousef smarted from the remark, but eventually—and reluctantly—he sought counseling. He never discussed any kind of extensive change program with his helper, but with some stimulation from her, he began doing little things differently at home. When he came home from work especially tired and frustrated, he had a friend in the apartment building stop by. This helped him to refrain from taking his frustrations out on his son. Then, instead of staying cooped up over the weekend, Yousef found simple things to do that eased tensions, such as going to the zoo and to the art museum with a woman friend and his son. He discovered that his son enjoyed these pastimes immensely despite his limitations. In short, he discovered little ways to blend caring for his son with a better social life. His counselor had a constructive-change mentality right from the beginning but did not try to engage Yousef in overly formal planning activities.

On the other hand, a slipshod approach to planning—"I will have to pull myself together one of these days"—is also self-defeating. We need only look at our own experiences to see that such an approach is fatal. Overall, counselors should help clients embrace the kind of rigor in planning that makes sense for them in their situations. There are no formulas; there are only client needs and common sense. Some things need to be done now, some later. Some clients need more slack than others. Sometimes it helps to spell out the actions that need to be done in quite specific terms; at other times it is necessary only to help clients outline them in broad terms and leave the rest to their own sound judgment. If therapy is to be brief, help clients start doing things that lead to their goals. Then, in a later session, help them review what they have been doing, drop what is not working, continue what is working, add more effective strategies, and put more organization in their programs. If you have a limited number of sessions with a client, you can't engage in extensive goal setting and planning. "What can I do that will add the most value?" is the ongoing challenge in brief therapy.

Devise a Plan for the Client and Then Work with the Client to Revise It as Needed

The more experienced helpers become, the more they learn about the elements of program development and the more they come to know what kinds of programs work for different clients. They build up a stockpile of useful programs and know how to stitch pieces of different programs together to create new programs. And they can use their knowledge and experience to fashion plans for clients who lack the skills or the temperament to pull together plans for themselves. Of course, their objective is not to foster dependence but to help clients grow in self-determination. For instance, a helper can first offer a plan as a sketch or in outline form rather than as a detailed program. Then the helper can work with the client to fill out the sketch and adapt it to the client's needs and style. Consider the following case:

> Katrina, a woman who dropped out of high school but managed to get a high school equivalency diploma, was overweight and reclusive. Over the years, she had restricted her activities because of her weight. Sporadic attempts at dieting had left her even heavier. Because she was chronically depressed and had little imagination, she was not able to come up with any kind of coherent plan. Once her counselor understood the dimensions of Katrina's problem situation, she pulled together an outline of a change program that included such things as blame reduction, the redefinition of beauty, decreasing self-imposed social restrictions, and cognitive restructuring activities aimed at lessening depression (see Robinson & Bacon, 1996). She also gathered information from health-care sources about obesity and suggestions for dealing with

It. She presented these to Katrina in a simple format, adding detail only for the sake of clarity. She added further detail as Katrina got involved in the planning process and in making choices.

Although this counselor pulled together elements of a range of already existing programs, counselors are, of course, free to make up their own programs based on their expertise and experience. The point is to give clients something to work with, something to get involved in. The elaboration of the plan emerges through dialogue with the client and in the kind of detail the client can handle.

The ultimate test of the effectiveness of plans lies in the problem-managing and opportunity-developing action clients engage in to get what they need and want. There is no such thing as a good plan in and of itself. Results, not planning or hard work, are the final arbiter. The next and final chapter deals with turning planning into accomplishments.

Tailoring Ready-Made Programs to Clients' Needs

There are many ready-made programs for clients with particular problems. They are often tried-and-true constructive-change programs. The 12-step approach of Alcoholics Anonymous is one of the most well known. It has been adapted to other forms of substance abuse and addiction. Systematic desensitization, a behavioral approach, has been used to treat clients with PTSD, or post-traumatic stress disorder (Frueh, de Arellano, & Turner, 1997). This program includes sessions in muscle relaxation, the development of a fear hierarchy, and, finally, weekly sessions in the systematic desensitization of these fears. The program helps alleviate such debilitating symptoms as intrusive thoughts, panic attacks, and episodic depression. The manualized treatment programs outlined in Chapter 1 are also examples of ready-made programs. Donald Meichenbaum (1994) published a comprehensive handbook for dealing with PTSD that includes a practical manual.

Counselors add value by helping clients adapt "set" programs to their particular needs. Consider the following cases.

A prevention program for pedophilia. While there are many treatment programs for pedophilic clients *after* the fact, prevention programs are much scarcer. Consider this case:

After a couple of rather aimless sessions, the helper said to Ahmed, "We've talked about a lot of things, but I'm still not sure why you came in the first place." This challenged Ahmed to reveal the central issue, though he needed a great deal of help to do so. It turned out that Ahmed was sexually attracted to prepubescent children of both sexes. Although he had never engaged in pedophilic behavior, the temptation to do so was growing.

The counselor adapted a New Zealand program called Kia Marama (Hudson et al., 1995), a comprehensive cognitive-behavioral program for incarcerated child molesters, to Ahmed's situation. The original program includes intensive work in challenging distorted attitudes, reviewing a wide range of sexual issues, seeing the world from the point of view of the victim, developing problem-solving and interpersonal-relationship skills, stress management, and relapse-prevention training. The helper and Ahmed spent some time assessing which parts of the program might be of most help before embarking on an intensive tailored program.

The economics of prevention far outweigh the economics of rehabilitation. Not only did Ahmed stay out of trouble, but much of what he learned from the program—for instance, stress management—applied to other areas of his life.

A program for helping people on welfare become successful at work. One community-based mental-health center worked extensively with people on welfare. When new legislation was passed forcing welfare recipients to get work, they searched for programs that helped people on welfare get and keep jobs. They learned a great deal from one program sponsored by a major hotel chain (see Milbank, 1996). The hotel targeted welfare recipients because it made both economic and social sense. Because of the problems with this particular population, however, the hotel's recruiters, trainers, and supervisors had to become paraprofessional helpers, though they never used that term. The people they recruited—battered women, ex-convicts, addicts, homeless people, including those who had been thrown out of shelters, and so forth—had all sorts of problems. In the beginning, the hotel's staff did many things *for* the trainees.

> They drive welfare trainees to work, arrange their day care, negotiate with their landlords, bicker with their case workers, buy them clothes, visit them at home, coach them in everything from banking skills to self-respect, and promise those who stick with it full-time jobs. (Milbank, 1996, A1)

But the trainers also challenged their "clients" mind-set that they were not responsible for what happened to them, enforced the hotel's code of behavior with equity, and persevered. The hotel program was far from perfect, but it did help many of the participants develop much-needed self-discipline and find new lives both at work and outside.

The counselors from a local mental-health center who acted as consultants to the program learned that some of the new employees benefitted greatly from wholesale upfront involvement of trainers and supervisors in their lives. It kick-started a constructive-change process. They also saw that the recruiters, trainers, and supervisors also benefitted. So they started a volunteer program at the mental-health center, looking for people willing to do the kinds of things that the hotel trainers and supervisors did. They knew that both the clients and the volunteers would benefit.

General well-being programs: Exercise. Some programs that contribute to general well-being can be used as adjuncts to all approaches to helping. Exercise programs are probably one of the most underused adjuncts to helping (Burks & Keeley, 1989). McAuley, Mihalko, and Bane (1997) have explored the multidimensional relationship between exercise and self-efficacy. There is evidence showing that exercise programs can help in the treatment of schizophrenia and alcohol dependence. Such programs also help more directly to reduce depression, manage chronic pain, and control anxiety (Tkachuk & Martin, 1999). The self-discipline developed through exercise programs can be a stimulus to increased self-regulation in other areas of life. Kate Hays has done a comprehensive review of the positive psychology possibilities of exercise in *Working It Out: Using Exercise in Psychotherapy* (1999). To end on a personal note regarding exercise: Once, I got my gear together and started out to get some exercise. When I hesitated, I asked myself: "Have you *ever* regretted exercising?" I answered, "Never," and headed out the door.

Finally, not all useful ready-made programs are found in sophisticated manuals. Many are found in the best of the self-help literature. Books like *Thoughts and Feelings* (McKay, Davis, & Fanning, 1997) are filled with systematic strategies for the treatment of a wide variety of psychological problems. The best are realistic, practical translations of some of the best thinking in the field.

Evaluation Questions for Step III-C

Helpers can ask themselves the following questions as they help clients formulate the kinds of plans that actually drive action:

- To what degree do I prize and practice planning in my own life?
- How effectively have I adopted the hologram mind-set in helping, seeing each session and each intervention in the light of the entire helping process?
- How quickly do I move to planning when I see that it is what the client needs to manage problems and develop opportunities better?
- What do I do to help clients overcome resistance to planning? How effectively do I help them identify the incentives for and the payoff of planning?
- How effectively do I help clients formulate subgoals that lead to the accomplishment of overall preferred-scenario goals?
- How practical am I in helping clients identify the action needed to accomplish subgoals, sequence those actions, and establish realistic time frames for them?
- How well do I adapt the specificity and detail of planning to the needs of each client?
- Even at this planning step, how easily do I move back and forth among the different stages and steps of the helping model as the need arises?
- How readily do clients actually move to action because of my work with them in planning?
- How human is the technology of constructive change in my hands?
- How well do I adapt the constructive-change process to the style of the client?
- How effectively do I help clients tailor generic or ready-made change programs to their specific needs?

PART SIX

The Action Arrow: Making It All Happen

The action arrow of the helping model represents the difference between planning and action. The nine steps of Stages I, II, and III all revolve around planning for change, not change itself. However, the need to incorporate action into planning and planning into action has been emphasized throughout the book. That is, the "little actions" needed to get the change process moving right from the start have been noted and illustrated. We now take a more formal look at results-producing action—both the obstacles to action and the ways to overcome those obstacles.

CHAPTER

21

"How Do I Make It All Happen?" Helping Clients Get What They Want and Need

Helping Clients Become Effective Tacticians
Help Clients Develop "Implementation Intentions"
Help Clients Avoid Imprudent Action
Help Clients Develop Contingency Plans
Help Clients Overcome Procrastination
Help Clients Identify Possible Obstacles to and Resources for Implementing Plans
Obstacles
Facilitating forces
Help Clients Find Incentives and Rewards for Sustained Action
Help Clients Develop Action-Focused Self-Contracts and Agreements
Help Clients Be Resilient After Mistakes and Failures
Social support
Cognitive skills
Psychological resources
Getting Along Without a Helper: Developing Social Networks for Supportive Challenge
Challenging relationships
Feedback from significant others
An amazing case of getting along without a helper
The Shadow Side of Implementing Change
Helpers as Agents

Client Inertia: Reluctance to Get Started
Passivity
Learned helplessness
Disabling self-talk
Vicious circles
Disorganization
Entropy: The Tendency of Things to Fall Apart
Choosing Not to Change

In a book called *True Success* (1994), Tom Morris lays down the conditions for achieving success. They include

- determining what you want—that is, a goal or a set of goals "powerfully imagined";
- focus and concentration in preparation and planning;
- the confidence or belief in oneself to see the goal through—that is, self-efficacy;
- a commitment of emotional energy;
- being consistent, stubborn, and persistent in the pursuit of the goal;
- the kind of integrity that inspires trust and gets people pulling for you;
- a capacity to enjoy the process of getting there.

The role of the counselor is to help clients engage in all these internal and external behaviors in the interest of goal accomplishment.

Some clients, once they have a clear idea of what to do to handle a problem situation or develop some opportunity, go ahead and do it, whether they have a formal plan or not. They need little or no further support and challenge from their helpers. They either find the resources they need within themselves or get support and challenge from the significant others in the social settings of their lives. However, other clients, although able to choose goals and come up with strategies for implementing them, are, for whatever reason, stymied when it comes to action. Most clients fall between these two extremes.

Discipline and self-control play an important part in implementing change programs. Kirschenbaum (1987) found that many things can contribute to not getting started or giving up: low initial commitment to change, weak self-efficacy, poor outcome expectations, the use of self-punishment rather than self-reward, depressive thinking, failure to cope with emotional stress, lack of consistent self-monitoring, failure to use effective habit-change techniques, giving in to social pressure, failure to cope with initial relapse, and paying attention to the wrong things—for instance, focusing on the difficulty of the problem situation rather than the attractiveness of the opportunity.

We have seen that self-determination and self-control are essential for action. Kanfer and Scheff t (1988, p. 58) differentiate between two kinds of self-control. In *decisional self-control*, a single choice terminates a conflict. For instance, a couple makes the decision to get a divorce and goes through with it. In *protracted self-control*, continued resistance to temptation is required. For instance, it is not enough for a client to decide that she has to keep her anger under control when disagreements with others arise. Each time a conflict arises, she has to renew her resolve. It helps enormously if she develops the attitude that conflicts are learning opportunities and not just interpersonal struggles. This is a positive way of staying on guard.

Most clients need both kinds of self-control to manage their lives better. A client's choice to give up alcohol completely (decisional self-control) needs to be complemented by the ability to handle inevitable longer-term temptations. Protracted self-control calls for a preventive mentality and a certain degree of street

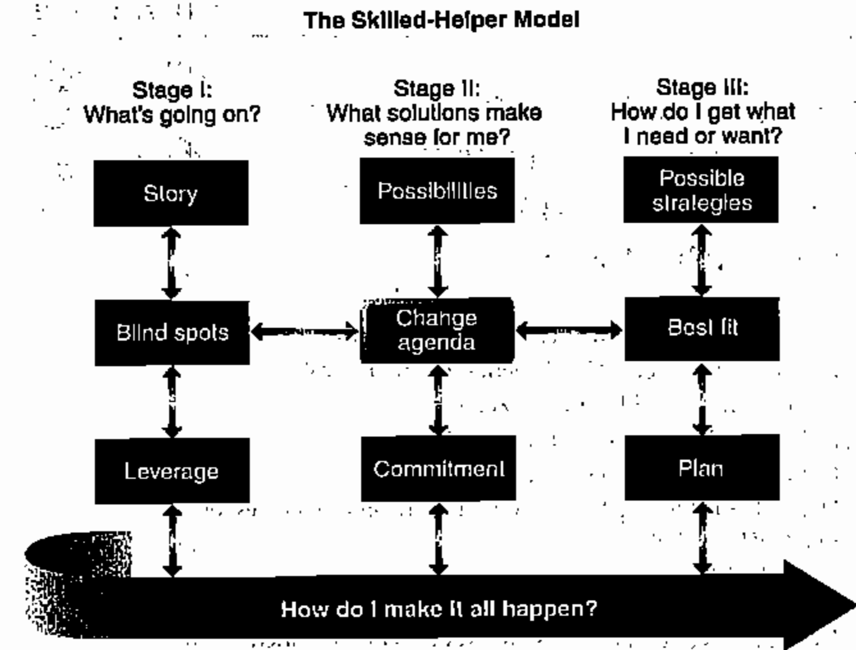

FIGURE 21-1
The Helping Model—Complementing Planning with Action

smarts. It is easier for the client who has given up alcohol to turn down an invitation to go to a bar in the first place than to sit in a bar all evening with friends and refrain from drinking.

Figure 21-1 adds the action arrow to the helping model.

Helping Clients Become Effective Tacticians

In the implementation phase, strategies for accomplishing goals need to be complemented by tactics and logistics. A strategy is a practical plan to accomplish some objective. Tactics is the art of adapting a plan to the immediate situation. This includes changing the plan on the spot to handle unforeseen complications. Logistics is the art of providing the resources needed to implement a plan in a timely way.

During the summer, Rebecca wanted to take an evening course in statistics so that the first semester of the following school year would be lighter. Having more time would enable her to act in one of the school plays, a high priority for her. But she didn't have the money to pay for the course, and at the university she planned to attend, prepayment for summer courses was the rule. Rebecca had counted on paying for the course from her summer earnings, but she would not have the money until later. Consequently, she did some quick shopping around and found that the same course was being offered by a community college not too far from where she lived. Her tuition there was minimal, since she was a resident of the area the college served.

In this example, Rebecca keeps to her overall plan (strategy). However, she adapts the plan to an unforeseen circumstance, the demand for prepayment (tactics), by locating another resource (logistics).

Since many well-meaning and motivated clients are simply not good tacticians, counselors can add value by using the following principles to help them engage in focused and sustained goal-accomplishing action.

Help Clients Develop "Implementation Intentions"

Commitment to goals (see Chapter 17) must be followed by commitment to courses of action. Gollwitzer (1999) has researched a simple way to help clients cope with the common problems associated with translating goals into action: failing to get started, becoming distracted, reverting to bad habits, and so forth. Strong commitment to goals is not enough. Equally strong commitment to specific actions to accomplish goals is required. Good intentions, Gollwitzer points out, don't deserve their poor reputation. Strong intentions—"I strongly intend to study for an hour every weekday before dinner"—are "reliably observed to be realized more often than weak intentions" (p. 493).

> Implementation intentions are subordinate to goal intentions and specify the when, where, and how of responses leading to goal attainment. They have the structure of "When situation x arises, I will perform response y!" and thus link anticipated opportunities with goal-directed responses. (p. 494)

Gwendolyn, an aide in a nursing home, may say, "When Enid (a patient) becomes abusive, I will not respond immediately. I'll tell myself that it's her illness that's talking. Then I'll respond with patience and kindness." Her ongoing goal is to control her anger and other negative responses to patients. However, Gwendolyn keeps pursuing this goal by continually refreshing her strong implementation intentions. Since Enid has been a particularly difficult patient, Gwendolyn needs to refresh her intentions frequently. However, her initial strong intention to substitute anger and impatience with kindness and equanimity means that in most cases her responses are more or less automatic. The environmental cue—patient anger, abuse, lack of consideration—"triggers" the appropriate response in Gwendolyn. In a way, poor patient behaviors become "opportunities" for her responses. You can help clients enunciate to themselves strong specific intentions that will help them "automatically" handle many of the obstacles to goal implementation.

Help Clients Avoid Imprudent Action

For some clients, the problem is not that they refuse to act but that they act imprudently. Rushing off to try the first "strategy" that comes to mind is often imprudent.

Elmer injured his back and underwent a couple of operations. After the second operation, he felt a little better, but then his back began troubling him again. When the doctor told him that further operations would not help, Elmer was faced with the problem of handling chronic pain. It soon became clear that his psychological state affected the level of pain. When he was anxious or depressed, the pain always seemed much worse.

Elmer was talking this through with a counselor. One day, he read about a pain clinic located in a Western state. Without consulting anyone, he signed up for a six-week program. Within ten days he was back, feeling more depressed than ever. He had gone to the program with extremely high expectations because his needs were so great. The program was a holistic one that helped the participants develop a more realistic lifestyle. It included programs dealing with nutrition, stress management, problem solving, and quality of interpersonal life. Group counseling was part of the program, and training was part of the group experience. For instance, the participants were trained in behavioral approaches to the management of pain.

The trouble was that Elmer had arrived at the clinic, which was located on a converted farm, with unrealistic expectations. He had not really studied the materials that the clinic had sent him. He had bought a "packaged" program without studying the package carefully. Since he had expected to find marvels of modern medicine that would magically help him, he was extremely disappointed when he found that the program focused mainly on reducing and managing rather than eliminating pain.

Elmer's goal was to be completely free of pain, but he failed to explore the realism of his goal. A more realistic goal would have centered on the reduction and management of pain. Elmer's counselor failed to help him avoid two mistakes: setting an unrealistic goal and, in desperation, acting on the first strategy that came along. Obviously, action cannot be prudent if it is based on flawed assumptions—in this case, Elmer's assumption that he could be pain free.

Help Clients Develop Contingency Plans

If counselors help clients brainstorm both possibilities for a better future (goals) and strategies for achieving those goals (courses of action), then clients will have the raw materials, as it were, for developing contingency plans. Contingency plans answer the question, "What will I do if the plan of action I choose is not working?" Contingency plans help make clients more effective tacticians. The formulation of contingency plans is based on the fact that we live in an imperfect world. Often enough, goals have to be fine-tuned or even changed. The same is true for strategies for accomplishing goals.

Jackson, the man dying of cancer, decided to become a resident in the hospice he had visited. The hospice had an entire program in place for helping patients like Jackson die with dignity. Once there, however, he had second thoughts. He felt incarcerated. Fortunately, he had worked out alternative scenarios with his helper. One was living at the home of an aunt he loved and who loved him dearly, with some outreach services from the hospice. He moved out of the hospice into his aunt's home. He spent his final days at the hospice.

Contingency plans are needed especially when clients choose a high-risk program to achieve a critical goal. Having backup plans also helps clients develop more responsibility. If they see that a plan is not working, then they have to decide whether to try the contingency plan. Backup plans need not be complicated. A counselor might merely ask, "If that doesn't work, then what will you do?" As in the case of Jackson, clients can be helped to specify a contingency plan further once it is clear that the first choice is not working out.

Help Clients Overcome Procrastination

At the other end of the spectrum are clients who keep putting action off. There are many reasons for procrastination. Take the case of Eula:

Eula, disappointed with her relationship with her father in the family business, decided that she wanted to start her own. She thought that she could capitalize on the business skills she had picked up in school and in the family business. Her goal, then, was to establish a small software firm that created products for the family-business market.

But a year went by and she still did not have any products ready for market. A counselor helped her see two things. First, her activities—researching the field, learning more about family dynamics, going to information technology seminars, getting involved for short periods with professionals such as accountants and lawyers who did a great deal of business with family-owned firms, drawing up and redrafting business plans, and creating a brochure—were helpful, but they did not create products. The counselor helped Eula see that at some level of her being, she was afraid of starting a new business. She had a lot of half-finished products. Over-preparation and half-finished products were signs of that fear. So she plowed ahead, finished a product, and brought it to market on the Internet. To her surprise, it was successful. Not a roaring success, but it meant that the cork was out of the bottle. Once she got one product to market, she had little problem developing and marketing others.

Eula certainly was not lazy. She was very active. She did all sorts of useful things. But she avoided the most critical actions—creating and marketing products.

Help Clients Identify Possible Obstacles to and Resources for Implementing Plans

Years ago, Kurt Lewin (1969) codified common sense by developing what he called "force-field analysis." In ordinary language, this is simply a review by the client of the major obstacles to and the major facilitating forces for implementing action plans. The slogan is "forewarned is forearmed."

Obstacles. The identification of possible obstacles to the implementation of a program helps make clients forewarned.

Raul and Maria were a childless couple living in a large Midwestern city. They had been married for about five years and had been unable to have children. They finally decided that they would like to adopt a child, so they consulted a counselor familiar with adoptions. The counselor, in helping Raul and Maria work out a plan of action, helped them examine their motivation, review their suitability to be adoptive parents, contact an agency, and prepare themselves for an interview. After the plan of action had been worked out, Raul and Maria, with the help of the counselor, identified two possible obstacles or pitfalls: the negative feelings that often arise on the part of prospective parents when they are being scrutinized by an adoption agency, and the feelings of helplessness and frustration caused by the length of time and uncertainty involved in the process.

The assumption here is that if clients are aware of some of the "wrinkles" that can accompany any given course of action, they will be less disoriented when they encounter them. Identifying possible obstacles is, at its best, a straightforward census of likely pitfalls rather than a self-defeating search for every possible thing that could go wrong.

Obstacles can come from within the clients themselves, from others, from the social settings of their lives, and from larger environmental forces. Once an obstacle is spotted, ways of coping with it need to be identified. Sometimes simply being aware of pitfalls is enough to help clients mobilize their resources to handle them. At other times, a more explicit coping strategy is needed. For instance, the counselor arranged a couple of role-playing sessions with Raul and Maria in which she assumed the role of the examiner at the adoption agency and took a "hard line" in her questioning. These rehearsals helped them stay calm during the actual interviews. The counselor also helped them locate a mutual-help group of parents working their way through the adoption process. The members of the group shared their

hopes and frustrations and provided support for one another. In short, Raul and Maria were trained to cope with the restraining forces they might encounter on the road toward their goal.

Facilitating forces. In a more positive vein, counselors can help their clients identify unused resources that can facilitate action.

Nora found it extremely depressing to go to her weekly dialysis sessions. She knew that without them she would die, but she wondered whether it was worth living if she had to depend on a machine. The counselor helped her see that she was making life more difficult for herself by letting herself think such discouraging thoughts. He helped her learn how to think thoughts that would broaden her vision of the world instead of narrowing it down to herself, her discomfort, and the machine. Nora was a religious person and found in the Bible a rich source of positive thinking. She initiated a new routine: The day before she visited the clinic, she began to prepare herself psychologically by reading from the Bible. Then, as she traveled to the clinic and underwent treatment, she meditated slowly on what she had read.

In this case, the client substituted positive thinking, an underused resource, for poor-me thinking. Brainstorming resources that can counter obstacles to action can be very helpful for some clients. Helping clients brainstorm facilitating forces raises the probability that they will act in their own interests. They can be simple things. George was avoiding an invasive diagnostic procedure. After a brainstorming session, he decided to get a friend to go with him. This meant two things. Once he asked for his friend's help, he "had to go through with it." Second, his friend's very presence distracted him from his fears. Or consider Lucy, who had a history of letting her temper get the better of her. This was especially the case when she returned home after experiencing crises at work. Her mother-in-law and children became the targets of her wrath. After a counseling session, she took two photographs with her to work. One was a wedding-day picture that included her mother-in-law. The second was a recent picture of her three children. When she parked the car at work, she placed the pictures on the driver's seat. Then, when she got in the car in the evening, the first things she saw were the two photographs of her life at its best. This made her think on the way home about how she wanted to enter the house.

Help Clients Find Incentives and Rewards for Sustained Action

Clients avoid engaging in action programs when the incentives and the rewards for not engaging in the programs outweigh the incentives and the rewards for doing so.

Miguel, a policeman on trial for use of excessive force with a young offender, had a number of sessions with a counselor from an HMO that handled police health insurance. In the sessions, the counselor learned that, although this was the first time Miguel had run afoul of the law, it was in no way the first expression of a brutal streak within him. He was a bully on the beat and a despot at home, and he had gotten into run-ins with strangers when he visited bars with his friends. Some of this came out during the trial.

Up to the time of his arrest, he had gotten away with his aggressive behavior, even though his friends had often warned him to be more cautious. His badge had become a license to do whatever he wanted. His arrest and now the trial shocked him. Before, he had seen himself as invulnerable; now, he felt very vulnerable. The thought of being a cop in prison understandably horrified him. He was found guilty, was suspended from the force for several months, and received probation on the condition that he continued to see the counselor.

Beginning with his arrest, Miguel had modified his aggressive behavior a great deal, even at home. Of course, fear of the consequences of his aggression was a strong incentive to change his behavior. The next time, the courts would show no sympathy. The counselor took a tough approach to this tough cop. He confronted Miguel for "remaining an adolescent" and for "hiding behind his badge." He called the power Miguel exercised over others "cheap power." He challenged the "decent person" to "come out from behind the screen." He told Miguel point blank that the fear he was experiencing was probably not enough to keep him out of trouble in the future. After probation, the fear would fade and Miguel could easily fall back into his old ways. Even worse, fear was a "weak-man's" crutch.

In a more positive vein, the counselor saw in Miguel's expressions of vulnerability the possibility of a much more decent human being, one "hiding" under the tough exterior. The real incentives, he suggested, came from the "decent guy" buried inside. He had Miguel paint a picture of a "tough but decent" cop, family man, and friend. He asked Miguel to come up with "experiments in decency"—at home, on the beat, with his buddies—to get first-hand experience of the rewards associated with decency.

The counselor was not trying to change Miguel's personality. Indeed, the counselor didn't believe in personality transformations. But he pushed Miguel hard to find and bring to the surface a different, more constructive set of incentives to guide his dealings with people. The new incentives had to drive out the old.

The incentives and the rewards that help a client get going on a program of constructive change in the first place may not be the ones that keep the client going.

Dwight, a man in his early thirties who was recovering from an accident at work that had left him partially paralyzed, had begun an arduous physical rehabilitation program with great commitment. Now, months later, he was ready to give up. The counselor asked him to visit the children's ward. Dwight was both shaken by the experience and amazed at the courage of many of the kids. He was especially struck by one teenager who was undergoing chemotherapy. "He seems so positive about everything," Dwight said. The counselor told him that the boy was tempted to give up, too. Dwight and the boy saw each other frequently. Dwight put up with the pain. The boy hung in there. Three months later, the boy died. Dwight's response, besides grief, was, "I can't give up now; that would really be letting him down."

Dwight's partnership with the teenager proved to be an excellent incentive. It helped him renew his resolve. While the counselor joined with Dwight in celebrating his newfound commitment, he also worked with Dwight to find backup incentives for those times when current incentives seem to lose their power. One was the possibility of marrying and starting a family despite residual limitations resulting from the accident.

Constructive-change activities that are not rewarded tend over time to lose their vigor, decrease, and even disappear. This process is called extinction. It was happening with Luigi.

Luigi, a middle-aged man, had been in and out of mental hospitals a number of times. He discovered that one of the best ways of staying out was to use some of his excess energy helping others. He had not returned to the hospital once during the three years he worked at a soup kitchen. However, finding himself becoming more and more manic over the past six months and fearing that he would be rehospitalized, he sought the help of a counselor.

Luigi's discussions with the counselor led to some interesting findings. He discovered that, whereas in the beginning he had worked at the soup kitchen because he wanted to, he was now working there because he thought he should. He felt guilty about leaving and also thought that doing so would lead to a relapse. In sum, he had not lost his interest in helping others, but his current work was no longer interesting or challenging. As a result of his sessions with the counselor, Luigi began to work for a group that provided housing for the homeless and the elderly. He poured his energy into his new work and no longer felt manic.

The lesson here is that incentives cannot be put in place and then be taken for granted. They need tending.

Help Clients Develop Action-Focused Self-Contracts and Agreements

Earlier we discussed self-contracts as a way of helping clients commit themselves to what they want—that is, their goals. Self-contracts are also useful in helping clients both initiate and sustain problem-managing action and the work involved in developing opportunities. For instance, Feller (1984) developed the following "job-search agreement" to help job seekers persist in their searches. In the agreement, clients respond "true" to all the statements and then act on those "truths." By so doing, clients commit themselves not only to job-seeking behavior but also to sound psychological practices that promote the right mentality for such behavior.

I agree that no matter how many times I enter the job market, or the level of skills, experiences, or academic success I have, the following appear TRUE:

1. It takes only one YES to get a job; the number of no's does not affect my next interview.
2. The open market lists about 20% of the jobs presently open to me.
3. About 80% of the job openings are located by talking to people.
4. The more people who know my skills and know that I'm looking for a job, the more I increase the probability that they'll tell me about a job lead.
5. The more specifically I can tell people about the problems I can solve or outcomes I can attain, rather than describe the jobs I've had, the more jobs they may think I qualify for.

I agree that regardless of how much I need a job, the following appear TRUE:

6. If I cut expenses and do more things for myself, I reduce my money problems.
7. The more I remain positive, the more people will be interested in me and my job skills.
8. If I relax and exercise daily, my attitude and health will appear attractive to potential employers.
9. The more I do positive things and the more I talk with enthusiastic people, the more I will gain the attention of new contacts and potential employers.
10. Even if things don't go as I would like them to, I choose my own thoughts, feelings, and behaviors each day.

It is easy to see how similar "agreements" could act as drivers of action in many different kinds of problem-managing and opportunity-developing situations. Self-contracts and agreements with others focus clients' energies.

Here is another example. In this case, several parties had to commit themselves to the provisions of the contract.

A boy in the seventh grade was causing a great deal of disturbance by his outbreaks in class. The usual kinds of punishment did not seem to work. After the teacher discussed the situation with the school counselor, the counselor called a meeting of all the stakeholders—the boy, his parents, the teacher, and the principal. The counselor offered a simple contract. When the boy disrupted the class, one and only one thing would happen: He would go home. Once the teacher indicated that his behavior was disruptive, he was to go to the principal's office and check out without receiving any kind of lecture. He was to go immediately home and check in with whichever parent was at home, again without receiving any further punishment. The next day he was to return to school. All agreed to the contract, though both principal and parents said they would find it difficult not to add to the punishment.

The first month, the boy spent a fair number of full or partial days at home. The second month, however, he missed only two partial days, and the third month only one. The truth is that he really wanted to be in school with his classmates. That's where the action was. And so he paid the price of self-control to get what he wanted.

The counselor had suspected that the boy found socializing with his classmates rewarding. But now he had to pay for the privilege of socializing. Reasonable behavior in the classroom was not too high a price.

Help Clients Be Resilient After Mistakes and Failures

Clients, like the rest of us, stumble and fall as they try to implement their constructive-change programs. However, everyone has some degree of *resilience* within that enables them to get up, pull themselves together, and move on once more. The ability to bounce back is an essential life capability. Holaday and McPhearson (1997) have compiled a list of common factors that influence resilience. Although their study focused on severe-burn victims, what they have to say about resilience applies to all of us and our clients. They distinguish between *outcome* resilience and *process* resilience. While resilience in general is the ability to overcome or adapt to significant stress or adversity, outcome resilience implies a return to a previous state. This is "bounce back" resilience. Dora goes through the trauma of divorce, but within a few months she bounces back. Her friends say to her, "You seem to be your old self now." She replies, "Both older and wiser." Process resilience, on the other hand, represents the continuous effort to cope that is a "normal" part of some people's lives. The sufferers Holaday and McPhearson studied would say such things as, "Resilience? It's my spirit and it's the reason I'm here," and resilience "is deep inside of you, it's already there, but you have to use it," and "To do well takes a lot of determination, courage, and struggling, but it's your choice" (p. 348).

You can encourage both kinds of resilience in clients. Take outcome resilience. Kerry finds himself in a financial mess because of a tendency to be a spendthrift and because of a few poor financial decisions. Although he makes a couple more mistakes, he works his way out of the mess. Once he reaches his goal, he puts himself on a strict budget, and things stabilize. It's not difficult for him to walk the financial straight and narrow because the mess has been too painful to repeat. Now a couple of examples of process resilience. Oscar finds that controlling his anger is a constant struggle. He has to keep finding the resources within himself to keep plugging away. And then there is Nadia. Suffering from chronic fatigue syndrome, she has to dig deep within herself every day to find the will to go on. Like many people suffering from this condition, she wants to do her best and make a good impression (see Albrecht & Wallace, 1998). On the days she's successful in pulling herself together, the people she meets cannot believe that she is ill. Running into this kind of disbelief on the part of otherwise intelligent people is part of the grind.

Holaday and McPhearson (1997, 1999) suggest that the factors that go into resilience are social support, cognitive skills, and psychological resources.

Social support. This includes the overall values of a society toward people, especially people in trouble; community support—that is, support in the neighborhood, at work, at church, and so forth; personal support through friends and other special relationships; and familial support—the "affectional ties within a family system." One burn victim said, "My wife made me get out of the hospital bed and learn to walk again."

Cognitive skills. It seems that at least average intelligence contributes greatly to resilience. But there are different kinds of intelligence: academic intelligence, social intelligence, street smarts, and so forth. And, as Holaday and McPhearson (1997) point out, "intelligence is also associated with the ability to use fantasy and hope" (p. 350). Cognitive skills also include coping style. For instance, a "belligerent style" (Zimrin, 1986) rather than a passively enduring, accepting, or yielding style often contributes more to resilience: "I don't care what others say, it's *not* over; don't tell me I can't do something." Clients can also cope by discussing feelings. One burn victim said, "Sometimes I still choose to feel sorry for myself and have a bad day, and that's OK." Other useful coping strategies include avoiding self-blame and using the energy of anger to cope with the world rather than damage the self. One client said, "When I was little, I wanted the scars to go away, but now I don't care about them any more. They're part of me." Other cognitive factors in resilience include the degree and the way clients exercise personal control in their lives and how they interpret their experiences. One client who fell off the wagon and got drunk for a couple of days said, "It's a glitch, not a pattern. I can expect a glitch now and again. Glitches can be dealt with. Patterns are damaging."

Psychological resources. Certain personality characteristics or dispositions protect people from stress and contribute to bounce back. They include an internal locus of control, empathy, curiosity, a tendency to seek novel experiences, a high activity level, flexibility in new situations, a sense of humor, the ability to elicit positive regard from others, accurate and positive self-appraisal, personal integrity, a sense of self-protectiveness, pride in accomplishments, and a capacity for fun.

However, lest this sound like a recitation of the Boy Scout oath, the point is this: There is a range of "resilience levers" in every client. Your job is to help them discover the levers, pull them, and bounce back. Resilience is "deep inside you" and inside your clients. It's part of their self-healing nature.

Getting Along Without a Helper: Developing Social Networks for Supportive Challenge

In most cases, helping is a relatively short-term process. But even in longer-term therapy, clients must eventually get on with life without their helpers. Ideally, the counseling process not only helps clients deal with specific problem situations and

unused opportunities, but also, as outlined in Chapter 1, equips them with the working knowledge and skills needed to manage those situations more effectively on their own.

Because adherence to constructive-change programs is often difficult, social support and challenge in their everyday lives can help them move to action, persevere in action programs, and both consolidate and maintain gains. When it comes to social support and challenge, there are a number of possible scenarios at the implementation stage and beyond:

- Counselors help clients with their plans for constructive change, and then clients, using their own initiative and resources, take responsibility for the plans and pursue them on their own.
- Clients continue to see a helper regularly in the implementation phase.
- Clients see a helper occasionally, either on demand or in scheduled stop-and-check sessions.
- Clients join some kind of self-help group together with one-to-one counseling sessions, which are eventually eliminated.
- Clients develop social relationships that provide both ongoing support and challenge for the changes they are making in their lives.

Support was discussed earlier, and the literature tends to focus on caring *support*, so a few words about caring *challenge* in everyday life are in order.

Challenging relationships. It was suggested earlier that support without challenge can be hollow and that challenge without support can be abrasive. Ideally, the people in the lives of clients provide a judicious mixture of support and challenge.

> Harry, a man in his early fifties, was suddenly stricken with a disease that called for immediate and drastic surgery. He came through the operation quite well, getting out of the hospital in record time. For the first few weeks he seemed, within reason, to be his old self. However, he had problems with the drugs he had to take following the operation. He became quite sick and took on many of the mannerisms of a chronic invalid. Even after the right mix of drugs was found, he persisted in invalid-like behavior. Whereas right after the operation he had "walked tall," he now began to shuffle. He also talked constantly about his symptoms and generally used his "state" to excuse himself from normal activities.
>
> At first Harry's friends were in a quandary. They realized the seriousness of the operation and tried to put themselves in his place. They provided all sorts of support. But gradually they realized that he was adopting a style that would alienate others and keep him out of the mainstream of life. Support was essential, but it was not enough. They used a variety of ways to challenge his behavior, mocking his "invalid" movements, engaging in serious one-to-one talks, turning a deaf ear to his discussions of symptoms, and routinely including him in their plans.

Harry did not always react graciously to his friends' challenges, but in his better moments he admitted that he was fortunate to have such friends. As clients attempt to change their behavior, counselors can help them find people willing to provide a judicious mixture of support and challenge.

Feedback from significant others. Gilbert (1978), in his book on human competence, claimed that "improved information has more potential than anything else I can think of for creating more competence in the day-to-day management of performance" (p. 175). Feedback is certainly one way of providing both support and

challenge. If clients are to be successful in implementing their action plans, they need adequate information about how well they are performing. Sometimes they know themselves; other times they need a more objective view. The purpose of feedback is not to pass judgment on the performance of clients but rather to provide guidance, support, and challenge. There are two kinds of feedback.

- ***Confirmatory feedback.*** Through confirmatory feedback, significant others such as helpers, relatives, friends, and colleagues let clients know that they are on course—that is, moving successfully through the steps of their action programs toward their goals.
- ***Corrective feedback.*** Through corrective feedback, significant others let clients know that they have wandered off course and what they need to do to get back on.

Corrective feedback, whether from helpers or people in the client's everyday life, should incorporate the following principles:

- Give feedback in the spirit of caring.
- Remember that mistakes are opportunities for growth.
- Use a mix of both confirmatory and corrective feedback.
- Be concrete, specific, brief, and to the point.
- Focus on the client's behaviors rather than on more elusive personality characteristics.
- Tie behavior to goals.
- Explore the impact and implications of the behavior
- Avoid name-calling.
- Provide feedback in moderate doses. Overwhelming the client defeats the purpose of the entire exercise.
- Engage the client in dialogue. Invite the client not only to comment on the feedback but also to expand on it. Lectures don't usually help.
- Help the client discover alternative ways of doing things. If necessary, prime the pump.
- Explore the implications of changing over not changing.

The spirit of these "rules" should also govern confirmatory feedback. Very often people give very detailed corrective feedback and then just say "nice job" when a person does something well. All feedback provides an opportunity for learning. Consider the following statement from a father talking to his high school son who stood up for the rights of a friend who was being bullied by some of his classmates:

> "Jeb, I'm proud of you. You stood your ground even when they turned on you. They were mean. You weren't. You gave your opinion calmly, but forcefully. You didn't apologize for what you were saying. You were ready to take the consequences. It's easier now that a couple of them have apologized to you, but at the time, you didn't know they would. You were honest to yourself. And now the best of them appreciate it. It made me think of myself. I'm not sure that I would have stood my ground the way you did. . . . But I'm more likely to do so now."

While brief, this is much more than "I'm proud of you, son." Being specific about behavior and pointing out the impact of the behavior turn positive feedback into a learning experience.

Of course, one of the main problems with feedback is finding people in the client's day-to-day life who see the client in action enough to make it meaningful, who care enough to give it, and who have the skills to provide it constructively.

An amazing case of getting along without a helper. As indicated earlier, many client problems are coped with and managed, not solved. Consider the following real-life case of a woman who certainly did not choose not to change. Quite the contrary. Her case is a good example of a no-formula approach to developing and implementing a program for constructive change.

> Vickey readily admits that she has never fully "conquered" her illness. Some 20 years ago, she was diagnosed as manic-depressive. The picture looked something like this: She would spend about six weeks on a high; then the crash would come, and for about six weeks she'd be in the pits. After that she'd be normal for about eight weeks. This cycle meant many trips to the hospital. Some seven years into her illness, during a period in which she was in and out of the hospital, she made a decision. "I'm not going back into the hospital again. I will so manage my life that hospitalization will never be necessary." This nonnegotiable goal was her manifesto.
>
> Starting with this declaration of intent, Vickey moved on, in terms of Step II-B, to spell out what she wanted: (a) She would channel the energy of her "highs"; (b) she would consistently manage or at least endure the depression and agony of her "lows"; (c) she would not disrupt the lives of others by her behavior; (d) she would not make important decisions when either high or low. Vickey, with some help from a rather nontraditional counselor, began to do things to turn those goals into reality. She used her broad goals to provide direction for everything she did.
>
> Vickey learned as much as she could about her illness, including cues for crisis times and how to deal with both highs and lows. To manage her highs, she learned to channel her excess energy into useful, or at least nondestructive, activity. Some of her strategies for controlling her highs centered on the telephone. She knew instinctively that controlling her illness meant not just managing problems but also developing opportunities. During her free time, she would spend long hours on the phone with a host of friends, being careful not to overburden any one person. Phone marathons became part of her lifestyle. She made the point that a big phone bill was infinitely better than a stay in the hospital. She called the telephone her "safety valve." She even set up her own phone-answering business and worked very hard to make it a success.
>
> At the time of her highs, she would do whatever she had to do to tire herself out and get some sleep, for she had learned that sleep was essential if she was to stay out of the hospital. This included working longer shifts at the business. She developed a cadre of supportive people, including her husband. She took special care not to overburden him. She made occasional use of a drop-in crisis center but preferred avoiding any course of action that reminded her of the hospital.

It must be noted that the central driving force in this case was Vickey's decision to stay out of the hospital. Her determination drove everything else. This case also exemplifies the spirit of action that ideally characterizes the implementation stage of the helping process. Here is a woman who, with occasional help from a counselor, took charge of her life. She set some simple goals and devised a set of simple strategies for accomplishing them. She never looked back. And she was never hospitalized again. Some will say that she was not "cured" by this process. But her goal was not to be cured but to lead as normal a life as possible in the real world. Some would say that her approach lacked elegance. But it certainly did not lack results.

Box 21-1 Questions on Implementing Plans

- Now that I have a plan, how do I move into action?
- What kind of self-starter am I? How can I improve?
- What obstacles lie in my way? Which are critical?
- How can I manage these obstacles?
- How do I keep my efforts from flagging?
- What do I do when I feel like giving up?
- What kind of support will help me to keep going?

Box 21-1 outlines the kinds of questions you can help clients ask themselves as they implement change programs.

The Shadow Side of Implementing Change

There are many reasons why clients fail to act in their own behalf. Four are discussed here: helpers who do not have an action mentality, client inertia, choosing not to choose, and client entropy. As you read about these common phenomena, recall what was said about "implementation intentions" earlier. They can play an important role in managing the shadow-side obstacles outlined here.

Helpers as Agents

Driscoll (1984, pp. 91–97) discusses the temptation of helpers to respond to the passivity of their clients with a kind of passivity of their own, a "sorry, it's up to you" stance. This, he claims, is a mistake.

> A client who refuses to accept responsibility thereby invites the therapist to take over. In remaining passive, the therapist foils the invitation, thus forcing the client to take some initiative or to endure the silence. A passive stance is therefore a means to avoid accepting the wrong sorts of responsibility. It is generally ineffective, however, as a long-run approach. Passivity by a therapist leaves the client feeling unsupported and thus further impairs the already fragile therapeutic alliance. Troubled clients, furthermore, are not merely unwilling but generally and in important ways unable to take appropriate responsibility. A passive countermove is therefore counterproductive, for neither therapist nor client generates solutions, and both are stranded together in a muddle of entangling inactivity. (p. 91)

To help others act, helpers must be agents and doers in the helping process, not mere listeners and responders. The best helpers are active in the helping sessions. They keep looking for ways to enter the worlds of their clients, to get them to

become more active in the sessions, to get them to own more of the helping process, and to help them see the need for action—action in their heads and action outside their heads in their everyday lives. And they do all this while espousing the client-centered values outlined in Chapter 3. Although they don't push reluctant clients too hard, thus turning reluctance into resistance, neither do they sit around waiting for reluctant clients to act.

Client Inertia: Reluctance to Get Started

Inertia is the human tendency to put off problem-managing action. With respect to inertia, I sometimes say something like this to clients who, I suspect, are reluctant to act: "The action program you've come up with seems to be a sound one. The main reason that sound action programs don't work, however, is that they are never tried. Don't be surprised if you feel reluctant to act or are tempted to put off the first steps. This is quite natural. Ask yourself what you can do to get by that initial barrier." The sources of inertia are many, ranging from pure sloth to paralyzing fear. Understanding what inertia is like is easy. We need only look at our own behavior. The list of ways in which we avoid taking responsibility is endless! We'll examine several of them here: passivity, learned helplessness, disabling self-talk, and getting trapped in vicious circles.

Passivity. One of the most important ingredients in the generation and perpetuation of the "psychopathology of the average" is passivity, the failure of people to take responsibility for themselves in one or more developmental areas of life or in various life situations that call for action. Passivity takes many forms: doing nothing—that is, not responding to problems and options; uncritically accepting the goals and solutions suggested by others; acting aimlessly; and becoming paralyzed—that is, shutting down or becoming violent, blowing up (see Schiff, 1975).

When Zelda and Jerzy first noticed small signs that things were not going right in their relationship, they did nothing. They noticed certain incidents, mused on them for a while, and then forgot about them. They lacked the communication skills to engage each other immediately and to explore what was happening. Zelda and Jerzy had both learned to remain passive before the little crises of life, not realizing how much their passivity would ultimately contribute to their downfall. Endless unmanaged problems led to major blowups until they decided to end their marriage.

Passivity in dealing with little things can prove very costly. The little things have a way of turning into big things.

Learned helplessness. Seligman's (1975, 1991) concept of "learned helplessness" and its relationship to depression has received a great deal of attention since he first introduced it (Garber & Seligman, 1980; Peterson, Maier, & Seligman, 1995). Some clients learn to believe from an early age that there is nothing they can do about certain life situations. There are degrees in feelings of helplessness—from mild forms of "I'm not up to this" to feelings of total helplessness coupled with deep depression. Learned helplessness, then, is a step beyond mere passivity.

Bennett and Bennett (1984) saw the positive side of helplessness. If the problems clients face are indeed out of their control, it is not helpful for them to have an illusory sense of control, unjustly assign themselves responsibility, and indulge in excessive expectations. Somewhat paradoxically, they found that challenging clients' tendency to blame themselves for everything actually fostered realistic hope and change.

The trick is helping clients learn what is and what is not in their control. A man with a physical disability may not be able to do anything about the disability itself, but he does have some control over how he views his disability and the power to pursue certain life goals despite it. The opposite of helplessness is "learned optimism" (Seligman, 1998) and resourcefulness. If helplessness can be learned, so can resourcefulness. Indeed, increased resourcefulness is one of the principal goals of successful helping. Optimism, however, is not an unmixed blessing; nor is pessimism always a disaster (Chang, 2001). While optimists do such things as live longer and enjoy greater success than pessimists, pessimists are better predictors of what is likely to happen. The price of optimism is being wrong a lot of the time. Perhaps we should help our clients be hopeful realists rather than optimists or pessimists.

Disabling self-talk. Challenging dysfunctional self-talk on the part of clients was discussed in Chapters 10 and 11. Clients often talk themselves out of things, thus talking themselves into passivity. They say to themselves such things as "I can't do it," "I can't cope," "I don't have what it takes to engage in that program; it's too hard," and "It won't work." Such self-defeating conversations with themselves get people into trouble in the first place and then prevent them from getting out. Helpers can add great value by helping clients challenge the kind of self-talk that interferes with action.

Vicious circles. Pyszczynski and Greenberg (1987) developed a theory about self-defeating behavior and depression. They said that people whose actions fail to get them what they want can easily lose a sense of self-worth and become mired in a vicious circle of guilt and depression.

> Consequently, the individual falls into a pattern of virtually constant self-focus, resulting in intensified negative affect, self-derogation, further negative outcomes, and a depressive self-focusing style. Eventually, these factors lead to a negative self-image, which may take on value by providing an explanation for the individual's plight and by helping the individual avoid further disappointments. The depressive self-focusing style then maintains and exacerbates the depressive disorder. (p. 122)

It does sound depressing. One client, Amanda, fit this theory perfectly. She had aspirations of moving up the career ladder where she worked. She was very enthusiastic and dedicated, but she was unaware of the "gentleman's club" politics of the company in which she worked and didn't know how to "work the system." She kept doing the things that she thought should get her ahead. They didn't. Finally, she got down on herself, began making mistakes in the things that she usually did well, and made things worse by constantly talking about how she "was stuck," thus alienating her friends. By the time she saw a counselor, she felt defeated and depressed. She was about to give up. The counselor focused on the entire "circle"—low self-esteem that produced passivity that produced even lower self-esteem—and not only the self-esteem part. Instead of just trying to help her change her inner world of

disabling self-talk, he also helped her intervene in her life to become a better problem solver. Small successes in problem solving led to the start of a "benign" circle—success that produced greater self-esteem that led to greater efforts to succeed.

Disorganization. Tico lived out of his car. No one knew exactly where he spent the night. The car was chaos, and so was his life. He was always going to get his career, family relations, and love life in order, but he never did. Living in disorganization was his way of putting off life decisions. Ferguson (1987) paints a picture that may well remind us of ourselves, at least at times:

> When we saddle ourselves with innumerable little hassles and problems, they distract us from considering the possibility that we may have chosen the wrong job, the wrong profession, or the wrong mate. If we are drowning in unfinished housework, it becomes much easier to ignore the fact that we have become estranged from family life. Putting off an important project—painting a picture, writing a book, drawing up a business plan—is a way of protecting ourselves from the possibility that the result may not be quite as successful as we had hoped. Setting up our lives to insure a significant level of disorganization allows us to continue to think of ourselves as inadequate or partially adequate people who don't have to take on the real challenges of adult behavior. (p. 46)

Many things can be behind this unwillingness to get our lives in order, such as defending ourselves against a fear of succeeding.

Driscoll (1984, pp. 112–117) has provided us with a great deal of insight into this problem. He described inertia as a form of control. He says that if we tell some clients to jump into the driver's seat, they will compliantly do so—at least until the journey gets too rough. The most effective strategy, he claims, is to show clients that they have been in the driver's seat right along: "Our task as therapists is not to talk our clients into taking control of their lives, but to confirm the fact that they already are and always will be." That is, inertia, in the form of staying disorganized, is itself a form of control. The client is actually successful, sometimes against great odds, at remaining disorganized and thus preserving inertia. Once clients recognize their power, helpers can help them redirect it.

Entropy: The Tendency of Things to Fall Apart

Entropy is the tendency to give up action that has been initiated. Kirschenbaum (1987), in a review of the research literature, uses the term *self-regulatory failure.* Programs for constructive change, even those that start strong, often dwindle and disappear. All of us have experienced the problems involved in trying to implement programs. We make plans, and they seem realistic to us. We start the steps of a program with a good deal of enthusiasm. However, we soon run into tedium, obstacles, and complications. What seemed so easy in the planning stage now seems quite difficult. We become discouraged, flounder, recover, flounder again, and finally give up, rationalizing to ourselves that we did not want to accomplish those goals anyway.

Phillips (1987, p. 650) identified what he called the "ubiquitous decay curve" in both helping and in medical delivery situations. Attrition, noncompliance, and relapse are the name of the game. A married couple trying to reinvent their marriage might eventually say to themselves, "We had no idea that it would be so hard to change ingrained ways of interacting with each other. Is it worth the effort?" Their motivation is waning. Wise helpers know that the decay curve is part of life and help clients deal with it. With respect to entropy, a helper might say, "Even sound action programs begun with the best of intentions tend to fall apart over time, so don't be surprised when your initial enthusiasm seems to wane a bit. That's only natural. Rather, ask yourself what you need to do to keep yourself at the task."

Brownell, Marlatt, Lichtenstein, and Wilson (1986) provide a useful caution. They draw a fine line between preparing clients for mistakes and giving them "permission" to make mistakes by implying that they are inevitable. They also make a distinction between "lapse" and "relapse." A slip or a mistake in an action program (a lapse) need not lead to a relapse—that is, giving up the program entirely. Consider Graham, a man who has been trying to change what others see as his "angry interpersonal style." Using a variety of self-monitoring and self-control techniques, he has made great progress in changing his style. On occasion, he loses his temper but never in any extreme way. He makes mistakes, but he does not let an occasional lapse end up in relapse.

Choosing Not to Change

Some clients who seem to do well in analyzing problems, developing goals, and even identifying reasonable strategies and plans end up by saying—in effect, if not directly—something like this: "Even though I've explored my problems and understand why things are going wrong—that is, I understand myself and my behavior better, and I realize what I need to do to change—right now I don't want to pay the price called for by action. The price of more effective living is too high."

The question of human motivation seems almost as enigmatic now as it must have been at the dawning of the history of the human race. So often we seem to choose our own misery. Worse, we choose to stew in it rather than endure the relatively short-lived pain of behavioral change. Helpers can and should challenge clients to search for incentives and rewards for managing their lives more effectively. They should also help clients understand the consequences of not changing. But in the end, clients make their own choices.

The shadow side of change stands in stark contrast to the case of Vickey. Savvy helpers are not magicians, but they do understand the shadow side of change, learn to see signs of it in each individual case, and, in keeping with the values outlined in Chapter 3, do whatever they can to challenge clients to deal with the shadow side of themselves and the world around them.

Evaluation Questions for the Action Arrow

How well do I do the following as I try to help this client make the transition to action?

- Understand how widespread both inertia and entropy are and how they are affecting this client
- Help clients become effective tacticians
- Help clients form "implementation intentions" especially when obstacles to goal attainment are foreseen
- Help clients avoid both procrastination and imprudent action
- Help clients develop contingency plans
- Help clients discover and manage obstacles to action
- Help clients discover resources that will enable them to begin acting, to persist, and to accomplish their goals
- Help clients find the incentives and the rewards they need to persevere in action
- Help clients acquire the skills they need to act and to sustain goal-accomplishing action
- Help clients develop a social support-and-challenge system in their day-to-day lives
- Prepare clients to get along without a helper
- Come to grips with what kind of agent of change I am in my own life
- Face up to the fact that not every client wants to change

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