CHAPTER

21

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

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 Schefft (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

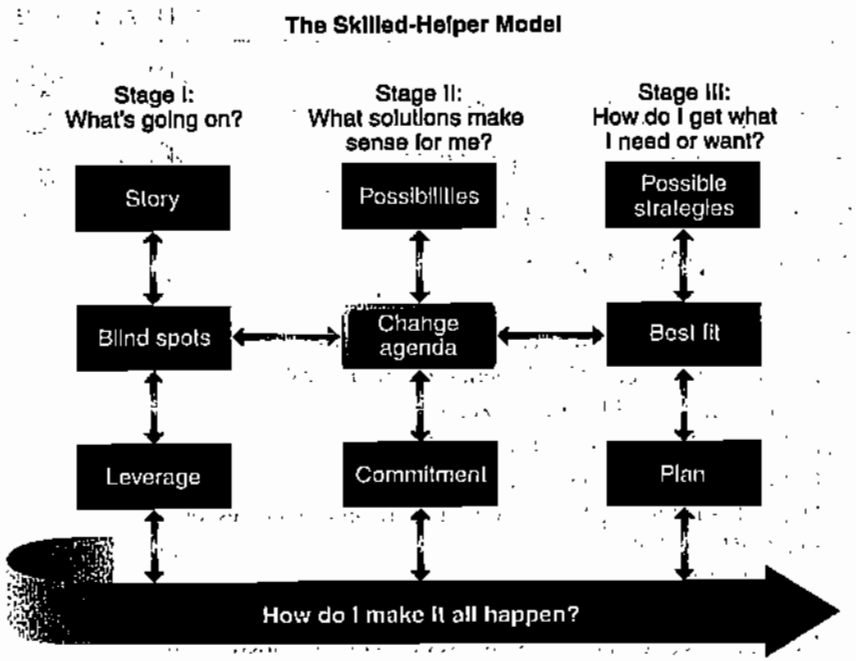

FIGURE 21-1
The Helping Model—Complementing Planning with Action

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.
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> 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.
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> 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.
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> 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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