Building Strengths and Skills: A Collaborative Approach to Working with Clients

JACQUELINE CORCORAN

OXFORD UNIVERSITY PRESS

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PREFACE

A movement has recently emerged in the helping professions in which the focus is on people's strengths and circumstances rather than their pathology. Prior to this movement, the dominant ideology involved the "expert" practitioner diagnosing and determining what people should do to fix their problems; people were viewed largely in terms of their weaknesses, limitations, and problems. Now, with strengths-based (Saleebey, 2001), resilience (Werner & Smith, 2001), and positive psychology frameworks (Snyder & Lopez, 2002), the emphasis lies instead on people's resilience, strengths, and capacities. Unfortunately, practice models encompassing these frameworks are few. Those that do exist tend to lack balance between a focus on the strengths clients possess and the skills they need to develop. *Building Strengths and Skills: A Collaborative Approach to Working With Clients* takes into account both individual resources and the areas where client skills can be bolstered, offering an eclectic practice approach that interweaves and operationalizes both strengths-based and skills-based practice approaches.

In what has therefore been named the strengths-and-skills-building model, clients are assumed to have the necessary capacities to solve their own problems, and a major focus of treatment is bolstering motivation and resources. When these resources are exhausted or when deficits are identified as a substantial barrier to change, then skill building is introduced.

However, skills are taught in a collaborative fashion and, as much as possible, are made relevant to each client's unique circumstance. *Building Strengths and Skills* offers an assessment and intervention model for practitioners in the helping, social service, and mental health professions.

In addition, the helping process described in *Building Strengths and Skills* can fit any number of roles, including those of case manager, probation officer, caseworker, medical social service worker, counselor, crisis worker, and therapist. Because of this broad potential audience range and setting application, the terms *practitioner*, *clinician*, *worker*, and *helper* are used interchangeably in recognition that the skills offered in this book can be therapeutically applied to a wide range of helper relationships and roles with the client. Similarly, the strengths-and-skills-building model can be employed in the different modalities in which clients may be seen, whether individually, in families, or in groups. Regardless of the setting, the role of the helper, or the modality, the principles and techniques of the strengths-and-skills-building model are designed to make contacts with clients maximally therapeutic and productive.

Organization

Chapters 1 through 3 of this book provide an overview of each of the therapeutic approaches—solution-focused therapy, motivational interviewing, and cognitive-behavioral therapy—that together make up the strengths-and-skills-building model. Chapter 4 compares and contrasts the three approaches in terms of their underlying assumptions and discusses the theoretical framework of the strengths-and-skills-building model. Chapter 5 provides an overview of the helping process for the strengths-and-skills-building model, which comprises engagement, problem exploration, solution exploration, goal setting, taking action, and termination. Techniques under each phase of the helping process are delineated.

Chapter 6 has a dual purpose. Its central objective is to familiarize the reader with the strengths-and-skills-building model and to teach the perspective and the skills involved; its secondary purpose is to demonstrate how the model can be applied as crisis intervention in a hospital setting. The reader will see the importance of basic interviewing skills, including the use of open-ended questions and reflection of the client's message and feelings, and learn how these are used to effect in the strengths-and-skills-building model.[1] Chapter 6 further shows that the strengths-and-skills-

1. For an overview of foundation skills, the reader is encouraged to consult Cournoyer (2000); Evans, Hearn, Uhlemann, and Ivey (1998); and Hepworth, Rooney, and Larsen (2002). *Building Strengths and Skills: A Collaborative Approach to Working With Clients* assumes reader familiarity with these skills.

building model largely focuses on the strengths clients possess. If there is limited time for contact, such as in crisis intervention settings, practitioner efforts center on strengths and solutions, bolstering client resources for the challenges they face and building their motivation to expend further effort on finding solutions and learning new skills that can help them.

Chapters 7 through 15 focus on applications of the strengths-and-skills-building model to various client problems and populations. These chapters illustrate how the strengths-and-skills-building helping process (engagement, problem exploration, solution exploration, goal setting, taking action, and termination) may be applied in a flexible way to meet the demands of different situations practitioners may encounter. Contributors for these chapters were brought in for their expertise in certain topic areas. After they gained familiarity with the strengths-and-skills-building model, they applied it to their areas in creative and flexible ways. Applications are divided into two categories: diagnosable disorders, as defined by the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders*,[2] and problems with family violence, to include domestic violence between partners and child maltreatment.

Readers will note that Chapter 8 (on working with juvenile offenders) is the only chapter on youths; however, this does not preclude practitioners from practicing the model with teenagers and children. Chapter 9, the application of the strengths-and-skills-building model in an inpatient substance abuse treatment center, discusses how art therapy techniques can be integrated within the model to reinforce the helping process. Chapter 10 deals with both marital therapy and a situation in which one partner has an anxiety disorder. This chapter is indicative of real-life helping situations, in which a client rarely presents with only one problem; indeed, multiproblem presentations might be the norm in certain helping settings. The book concludes with a chapter covering strengths-based assessments and tracking tools. This chapter is seen as necessary because there are many resources that compile instrument tools measuring deficits, but very few emphasize the assessment of strengths.

The applications are meant to show the range of problems for which the strengths-and-skills-building model can be employed, but this does not mean that the model is limited to these populations and problems. Readers, once familiar with how to interweave the practice components, can feel free to adapt the model to other areas, including work with children, as long as they are knowledgeable about their practice areas and receive supervi-

2. Although the *DSM*'s focus on diagnostic labels and individual psychopathology is seen as at odds with a strengths-based approach, the *DSM* does provide a common nomenclature for problems so that professionals within and between disciplines can converse.

sion for their work. The assumption is that readers already armed with the fundamentals of interviewing can build on these capacities to help clients maximize both strengths and their skills.

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Building Strengths and Skills

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PART I

Introduction of the Strengths-and-Skills-Building Model

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1 Solution-Focused Therapy

Developed by de Shazer, Berg, and colleagues (Berg, 1994; Berg & Miller, 1992; Cade & O'Hanlon, 1993; DeJong & Berg, 2001; de Shazer et al., 1986; O'Hanlon & Weiner-Davis, 1989), solution-focused therapy emphasizes the strengths people possess and how these can be applied to the change process. Solution-focused therapy is influenced by the philosophies of constructivism and social constructionism, as well as by strategic family therapy. Constructivism involves the perspective that reality does not exist as an objective phenomenon; instead, it is a mental construction comprised from the assumptions that people hold about themselves and the world (Gergen, 1994; Neimeyer & Mahoney, 1995). Social constructionism takes the position that these mental constructions are formed through social interaction (Berg & DeJong, 1996). In the therapeutic context, worker and client share perceptions through language and engage in dialogue because this is the medium by which reality is shaped (de Shazer, 1994). In solution-focused therapy, language is used to influence the way clients view their problems (as in the past and as surmountable) to help them see the potential for solutions (through past successful attempts and imagining a future without the problem) and to create an expectancy for change (Berg & DeJong, 1996).

Strategic family therapy models from which solution-focused therapy

is derived include the Mental Research Institute (MRI) brief therapy model (e.g., Weakland, Fisch, Watzlawick, & Bodin, 1974) and Haley's strategic family therapy (e.g., Haley, 1984). Solution-focused therapy, while maintaining the brief orientation of the MRI model, concerns itself with the development of solutions derived from nonproblem times rather than a problem focus (de Shazer et al., 1986). Haley's model of strategic family therapy was influenced by Milton Erickson, who believed that individuals possess the strengths and resources to resolve their problems and that the practitioner's job is to help clients discover these resources and activate them. Many times, this involves an amplification of symptomatic behavior through the use of paradoxical directives. Solution-focused therapy maintains the strengths-based orientation but relies on paradox as a last resort when more direct attempts to elicit positive behavior have failed.

In this chapter, the assumptions of solution-focused therapy are delineated, and the techniques are briefly summarized. A discussion of solution-focused treatment outcome studies follows.

Assumptions

Solution-focused therapy utilizes a strengths-based perspective in that client strengths, abilities, and resources are emphasized (Durrant, 1995; O'Hanlon & Weiner-Davis, 1989). Clients are assumed to be able to solve their own problems through resources that can be found by eliciting and exploring times when the problem does not exert its negative influence and/or when the client has coped successfully.

Rather than focusing on the past and a history of the problem, attention is oriented to a future without the problem to build vision, hope, and motivation for the client. Extensive historical information is not viewed as necessary because understanding the past will not change the future without action. The past is explored only for exception finding; the focus of conversation between the practitioner and the client becomes how these exceptions—when problems do not occur—can be applied in the future.

The assumption in solution-focused therapy is that change occurs in a systemic way. Small change is all that is necessary as a "spiral effect" takes place: The client takes a step in the right direction; others in the context respond differently; the client feels more empowered and is encouraged toward further change. Both behaving differently and thinking differently are part of the processes of change (de Shazer, 1994). Rapid change is possible; all that is necessary in treatment is for a small change to occur, as this will reverberate into change throughout the system.

Because no one holds the objective truth, individuals are valued for their unique perspectives, with the right to determine their own goals. Cli-

ents are encouraged to find the solutions that fit their own worldviews. The practitioner works collaboratively with the client to build the client's awareness of strengths. These strengths are then mobilized and applied to problem situations.

Empirical Basis for Solution-Focused Therapy

The evidence basis for solution-focused therapy is building slowly. Part of the reason for this is the constructivist roots of solution-focused therapy. Assumptions underlying constructivism, such as the importance of subjective meaning and the use of language to form meaning, are antithetical to the positivist, quantitative roots of treatment outcome research. However, a small knowledge base has accumulated. In 2000, Gingerich and Eisengart conducted a review, categorizing 15 studies according to their quality in terms of research design. Five well-controlled studies were identified, all of which showed positive outcomes. More research of solution-focused therapy needs to be conducted, however.

Techniques

Only an overview of techniques is provided here, as specific techniques are integrated into the strengths-and-skills-building model (Chapter 5) and illustrated in subsequent chapters. For a more complete rendering of techniques, along with case examples, see DeJong and Berg (2001).

Solution-Focused Language

Underlying all solution-focused techniques is the use of language to influence perception. One way language is used is to place problems in the past as if they are no longer exerting their negative influence. For example, "So you were losing your temper?" replaces "So you lose your temper?" The implication is that change is already in process.

Another strategic use of language is through what is referred to as definitive rather than possibility phrasing. Definitive phrasing through the employment of words such as *when* and *will* implies that change *will* occur. For example, a practitioner asks, "*When* you are better, what *will* you be doing?" Possibility phrasing with the use of words such as *if* and *could* is used only for the purposes of preparing clients to prevent further problems: "*If* you feel the urge to use drugs, what *could* you do to prevent it from going any further?" The strategic use of language stems from the social constructivist roots of solution-focused therapy in that language is the medium by which reality is shaped.

Joining Strategies for Client Relationships

Solution-focused therapy places a heavy emphasis on joining, which involves building a basis for collaborative work with clients. The attention to language begins with how the practitioner approaches opening contact with the client. See Table 1.1 for sample opening language and its rationale.

A central aspect of the joining process is assessing the relationship the client has with the helping process. Indeed, one of the advantages of solution-focused therapy is that, unlike other approaches that assume a voluntary client is willing to do what is necessary to change, solution-focused therapy acknowledges the different reasons clients may present for treatment and services. Three different client relationships are posed within the model: the customer, the complainant, and the visitor. The customer type of relationship is the client who is motivated and willing to participate in the change process. The complainant type of relationship is motivated chiefly for change in another person rather than for change in the self. The visitor type of relationship is a client who is typically unmotivated and is attending only because he or she has been mandated to do so. Strategies have been designed for each type of client relationship, although they can be used interchangeably. See Table 1.2 for an outline.

Table 1.1

Language on Opening Contact

Use	Avoid	Rationale
Words *concern* or *issue*	Word *problem*	*Problem* seen as pathologizing; *concern* seen as conveying the event as a part of life that the client will have to manage, surmount, or solve
"What would you like to see happen as a result of our talking?"	"What brings you here today?" "How can I help you?"	Want to imply internal locus of control (client is capable of resolving problems in collaboration with the worker) rather than external locus of control (something is taking control of the client, someone else can solve the problem)
"What will be happening in your life when our talking has been successful?"	Tentative language: *could, if*	Use definitive language to imply that change will occur and that the work will be successful

Note. From "Client Strengths and Crisis Intervention: A Solution-Focused Approach," by G. J. Greene, M. Y. Lee, R. Trask, and J. Rheinscheld, 1996, *Crisis Intervention, 3*, pp. 43–63.

Table 1.2

Strategies to Engage Clients

Client relationship/ description	Strategies	Description of strategies
Customer: Voluntary; willing to make changes	Orienting toward change	"What will your life look like when your work here is successful?"
Complainant: Motivated for somebody else to change	Coping questions	What resources have been drawn upon to cope with the situation?
	Normalizing	Depathologizing clients' concerns as normal life challenges
	Reframing	Introducing the positive elements of a behavior initially viewed as negative
	Orienting toward goals	"What would you like _____ to be doing instead of [complaint]?"
Visitor: Nonvoluntary; mandated into treatment	Orienting toward meeting the requirements of the mandate	"Whose idea was it that you come here?"
		"What does _____ need to see to know you don't have to come here anymore?"
	Relationship questions	Asking clients to view themselves from the perspective of another
	Siding with the client against an external entity	"What will we need to do to convince _____ you no longer need to come here?"
	Getting client to identify a desired goal	What is something the client is motivated to pursue?
All (Bertolino & O'Hanlon, 2002; Metcalf & Thomas, 1994)	Orienting toward change	"What is concerning you most at this point?"
	Collaborating on client perspective	"What would you like to change or have different in your life?"
	Determining progress toward goals	"What goals do you have for yourself?"
		"What did you [hope/wish/think] would be different as a result of coming to treatment?"
		"How will you know when things are better?"
		"How will you know when the problem is no longer a problem?"

(*continued*)

Table 1.2 (continued)		
Strategies to Engage Clients		
Client relationship/ description	Strategies	Description of strategies
		"What will indicate to you that coming here has been successful?"
		"How will you know when you no longer need to come here?"
		"What will be happening that will indicate to you that you can manage things on your own?" (Bertolino & O'Hanlon, 2002, pp. 83, 91)
	Encouraging collaboration	"What ideas do you have about how I can help you?"
		"In what ways do you see me helping you reach your goals?"
		"Are there certain things that you want to be sure that we talk about?"
		"How has this conversation been helpful?"
		"In your opinion, do we need to meet again?" (to further empower the client regarding the continuation of therapy based on his/her choice)
		"How will you know when we can stop?" (a collaborative question to define client criteria for termination)
		"What did we do today that you felt make a difference?" (to learn what is instigating change and what is helpful in the process) (Bertolino & O'Hanlon, 2000, p. 82)

The joining techniques discussed here are using idiosyncratic language, relationship questions, and complimenting. Chapter 5 covers other solution-focused joining techniques.

Using Idiosyncratic Language

Practitioners should attune themselves to the idiosyncratic phrasing of the client and adopt this language (Berg, 1994; O'Hanlon & Weiner-Davis,

1989).[1] The assumption is that clients feel understood when the worker uses their language. If a client describes herself as being "down in the dumps," the practitioner should use that term rather than using the term *depression*. If a client describes her "nerves" as acting up, then the practitioner should direct questions about those things that can "soothe her nerves" rather than talking about the client's "anxiety." Professional jargon should be avoided as it emphasizes the practitioner's "expert" role instead of allowing clients to be the experts on their own lives.

Relationship Questions

Relationship questions ask clients to view themselves from the perspective of another (DeJong & Berg, 2001). They are derived from the family systems therapy intervention of circular questioning. Circular questions are often nonthreatening to clients because the questions are posed in such a way that one comments on a situation from the view of an outside observer, typically family members (Fleuridas, Nelson, & Rosenthal, 1986). When people are stuck in a problem, it is often difficult for them to see alternatives. By viewing the problem from another person's point of view ("What would your partner say needs to happen in our work together to know that our time has been successful?"), they can sometimes see other possibilities. Similar to circular questions, relationship questions have the added advantage of allowing people to increase their ability to take on other people's perspectives and see the impact of their behavior on other people.

Compliments

Clients may feel defensive when they first see a practitioner, expecting to be judged and criticized. "Complimenting clients is a way to enhance their cooperation rather than defensiveness and resistance. . . . Clients are usually surprised, relieved, and pleased when they receive a compliment from the clinician. A consequence of therapeutic compliment is that clients are usually more willing to search for, identify, and amplify solution patterns" (Greene, Lee, Trask, & Rheinscheld, 1996, p. 56). The practitioner should be generous with compliments throughout the change process to reinforce the strengths and resources that individuals display. Compliments may be connected to the presenting problem or relate to other aspects of the client's life.

DeJong and Berg (2001) suggest a form of complimenting called "indirect complimenting" in which positive traits and behaviors are implied. Examples of indirect complimenting are "How were you able to do that?"

1. Practitioners who work with adolescent clients may want to use caution with this technique, as adolescents may not respect and/or trust a practitioner who adopts teenage slang.

and "How did you figure that out?" These questions push the client to figure out the resources he or she used to achieve success.

Exceptions: Nonproblem Times

A key intervention technique in solution-focused therapy is delving into the details of exceptions, times when the problem does not occur. The purpose is to help people access and expand upon the resources and strengths they use to combat difficulties. Helping individuals find abilities that have served them in the past is easier than teaching them entirely new behaviors (Bertolino & O'Hanlon, 2002). Exception finding also reduces the dichotomous thinking that often afflicts people when they are embroiled in problems. Exceptions help people shrink the all-encompassing nature of problems and see their problems as much more fluid and changeable.

Some guidelines for identifying exceptions include inquiring about incremental rather than radical differences (Murphy, 1997), such as asking "when are things a little better?" rather than when things are "wonderful." A second guideline is to start in the most recent past and then go back in time since recent evidence may exert a more powerful influence (Bertolino & O'Hanlon, 2002). If clients cannot identify any successes, the practitioner can inquire about when a problem is less severe, less frequent, less intense, or shorter in duration (O'Hanlon & Weiner-Davis, 1989). Once an exception is identified, its components are deconstructed. The practitioner asks investigative types of questions, such as those outlined in Table 1.3, to help the client discover the contextual details of the exception. People come to understand, through the process of exception finding, that behaviors are triggered by specific contexts and personal choices rather than ingrained

Table 1.3

Investigative Questions for Exceptions

Who	Who is there when the exception occurs? What are they doing differently? What would they say you are doing differently?
What	What is happening before? What is different about the behavior? What happens afterward?
Where	Where is the exception occurring? What are the details of the setting that contribute to the setting?
When	How often is this happening? What time of the day is it?
How	How are you making this happen? What strengths, talents, or qualities are you drawing on?

personality characteristics and hence more under their control than they previously believed.

Externalizing the Problem

Another way to build exceptions is through a technique called externalizing the problem. This technique was originally developed by Michael White from the narrative school (White & Epston, 1990) and has been adopted by solution-focused writers (e.g., Berg, 1994; Bertolino & O'Hanlon, 2002; Dolan, 1991). In externalizing, a linguistic distinction is made between the presenting problem and the person in which the problem behavior is personified as an external entity (the urge to drink, the invitation to argue, the anger). The purpose is to free the person from the belief that the problem is a fixed and inherent quality. It introduces fluidity into the problem, which may have become rigid and seemingly fixed. Externalizing may also introduce a note of humor into the work. Children may select playful names, such as "the crap" (oppositional behaviors; Corcoran, 2002), "the tornado," or "the volcano" (anger). In this way, the oppressive nature of the problem is lifted, and more options for behavior may be revealed. Our experiences of the advantages of "problem talk" led to a compromise between solution-focused therapy and its emphasis on solution talk and the narrative idea of externalization. Dyes and Neville (2000) suggest a further advantage of externalizing, which is to validate people's talk about problems while providing a bridge to discussion of solutions.

After identifying the externalized entity, the next step is to empower people to fight against it by asking relative influence questions. Answering these questions helps clients determine when they have control over the problem and when the problem has control over them. The following questions can be employed (Bertolino & O'Hanlon, 2002, p. 133):

"What's different about the times you're able to control the _____?"
"When can you resist the urge to _____?"
"When are you able to overcome the temptation to _____?"
"What percentage of the time do you have control over _____?"
"How has _____ come between you and your _____?"
"When has _____ recruited you to do something that you later got in trouble for?"
"What intentions do you think _____ has for you?"
"When have you been able to take a stand against _____?"
"Tell me about times when _____ couldn't convince you to _____?"

Individuals can also be invited to extend their awareness of how they combat their problems through a homework task recommended by Murphy

(1997). In this task, clients are asked to pay attention to the times they are able to resist the urge to engage in the problem behavior. "This language highlights people's choices and creates an assumption of accountability, rather than blame or determinism. If the person is not the problem, but has a certain relationship to the problem, then the relationship can change. If the problem invites rather than forces, one can turn down the invitation. If the problem is trying to recruit a client, he or she can refuse to join" (Bertolino & O'Hanlon, 2002, p. 133).

Miracle Question

To help people turn from a problem-focused view to one where change is possible, the miracle question, one of the signature techniques of solution-focused therapy, can be employed. Through the miracle question, people are asked to detail a future when the problem is no longer a problem. The miracle question is phrased as follows: "If a miracle happened in the night while you were sleeping but you didn't know it, what would be the first thing you noticed when you woke up in the morning to let you know that the miracle had occurred and the problem that you came here for was solved?" (de Shazer, 1988).

After posing the scenario, the practitioner works to elicit specific, behavioral details, taking into account the context of the miracle and the different relationships involved: "What will be happening?" "What will happen next?" "What will _____ notice about you?" "What will _____ say?" "Then what will you do?" The miracle question orients clients toward a more hopeful future when the problem does not dominate the picture. By eliciting the concrete details of the actions the client will take, a blueprint is being drawn on how change can occur (Cade & O'Hanlon, 1993).

Scaling Questions

The intervention of scaling questions is primarily designed for goal setting but also acts as a springboard for other techniques, such as relationship questions, exception finding, and task setting. In scaling questions, a rank-order scale of 1 to 10 is created, with 10 representing when the problem is no longer a problem. The practitioner then engages the client in a process of identifying specific and concrete behavioral anchors for 10. Clients are asked for their perception of their current functioning on the scale and then engaged in relationship questions to determine how people influenced by the problem see their behavior. Exception finding can follow ("So you're already a 4? What have you been doing to get yourself to a 4?" "What would _____ say you are doing?"). Incremental change is pursued by asking clients to figure out how they will move one number on the scale to-

ward their goal before the next time they are seen for an appointment. In this way, they are accountable for the tasks they will perform to meet their goals, and progress is measured in a quantifiable fashion over time.

Pessimistic Stance

When individuals have difficulty coming up with exceptions and seem stuck in a problem orientation, as a last-resort intervention the practitioner can take a pessimistic stance. In this technique, the practitioner sides with the client's view of the problem, that it is very serious and difficult. The pessimistic stance involves the following types of questions:

"It sounds like the problem is very serious. How come things are not worse?"
"What are you doing/what steps have you taken/what has helped to keep things from getting worse?" "What else?"
"How has that been helpful? How has that made a difference?" "Would _____ agree?"
"What are you doing to keep going?"
"What is the smallest thing that you could do that might make a difference in your situation?"
"What could others do?"
"How could we get that to happen a little now?"

Asking these questions allows the practitioner to side with the client's position that change will not occur. Consideration of these questions can sometimes produce a shift, with the client beginning to take the opposite view and argue for change.

Homework

Solution-focused writers recommend several formula homework assignments to attune people to their resources and abilities. These include the formula first-session task, keeping track of current successes, the prediction task, and pretending the miracle has happened. Homework assignments are all phrased as suggestions rather than as prescriptions, with the overall purpose of helping people build awareness of their resources and what they are doing well. See Table 1.4 for a delineation of homework assignments.

Termination

Because change is oriented toward a brief time frame in the solution-focused model, work is oriented toward termination at the beginning of

Table 1.4

Solution-Focused Homework Tasks

Tasks	Description	Uses
Formula first-session task	"Between now and next time, notice all the things that are happening that you want to continue to happen." Murphy's (1997) variation: "Observe when the problem is not occurring or is just a little better, and pay attention to how you are able to make that happen."	The task most often recommended by SFT writers; Greene et al. (1996) suggest it for clients who have difficulty defining specific problems on which they would like to work and those who are challenged to concretely formulate exceptions.
Keeping track of current successes	"Pay attention to and keep track of what you do to overcome the temptation or urge to _____ [perform the symptom or some behavior associated with the problem]."	To help people understand the resources they use to circumvent their problem behaviors
Prediction task	"In the prediction task, the client is asked to predict or rate something, such a 'First thing each morning, rate the possibility of _____ [an exception behavior] happening before noon' (Greene et al., 1996, p. 58)."	When people experience the problems as being outside their control, often clients find that the behavior follows their prediction; as a result, they discover they are much more in control of outcomes than they previously believed.
Pretend the miracle has happened	Select a day to pretend the miracle has occurred and the presenting problem is resolved; keep track of what is different about the day or the individual or how others react	This tasks shows clients that they can enact positive feelings, thoughts, and behaviors that will help them reach a nonproblem state.

treatment. Questions include "What needs to happen so you don't need to come back to see me?" and "What will be different when therapy has been successful?" (Berg, 1994). Once clients have maintained changes on the small concrete goals they have set, the practitioner and client start to discuss plans for termination, as it is assumed that achievement of these small changes will lead to further positive change in the client's life. Termination is geared toward helping clients identify strategies so that change will be maintained and the momentum developed will cause further change to occur. While the practitioner does not want to imply that relapse is inevi-

table, the client must be prepared with strategies to enact if temptation presents itself or if the client begins to slip into old behaviors. Therefore, it is during termination that possibility rather than definitive phrasing is used. For example, "What *would* be the first thing you'd notice *if* you started to find things slipping back?" "What *could* you do to prevent things from getting any further?" and "*If* you have the urge to do drugs again, what *could* you do to make sure you didn't use?" might be typical inquiries to elicit strategies to use if there is a return to old behavior.

Termination also involves building on the changes that have occurred, with the hope they will continue into the future. Selekman (1993, 1997) has proposed a number of such questions, including "With all the changes you are making, what will I see if I was a fly on your wall 6 months from now?" and "With all the changes you are making, what will you be telling me if I run into you at the convenience store 6 months from now?" (Selekman, 1997). Questions are phrased to set up the expectation that change will continue to happen.

Summary

Solution-focused therapy, a brief treatment model, emphasizes client strengths, resources, and abilities (O'Hanlon & Weiner-Davis, 1989). Because no one holds the objective truth, each person's perspective and way of solving problems is unique and valued. The practitioner's job is to help build client awareness of these strengths and to amplify change toward its application in problematic situations. Rather than being focused on the past and a history of the problem, attention is oriented to a future without the problem to build vision, hope, and motivation for the client. The helper empowers clients to view themselves as capable and resourceful and encourages small, concrete behavioral change, which is assumed to fuel further change in a systemic way.

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2 Motivational Interviewing

Developed over the last 20 years (Dunn, Deroo, & Rivara, 2001), motivational interviewing is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). Developed for the treatment of substance abuse, motivational interviewing is now being applied to other areas of change, such as diet and exercise (Moyers & Rollnick, 2002). It has been employed both as a stand-alone treatment and as a way to engage people in other intervention approaches (Walitzer, Dermen, & Conners, 1999).

Motivational interviewing is enacted within the framework of the stages of change model, with its conceptualization that people need different interventions depending on the level of their motivation to change. Because the stages of change model acts as a backdrop, the model is first described, followed by the guidelines and techniques of motivational interviewing.

Stages of Change Model

In acknowledgment of the reluctance of many substance abusers to change their patterns, Prochaska and colleagues (Connors, Donovan, & Di-

Clemente, 2001; Prochaska & Norcross, 1994) developed the transtheoretical stages of change model. The model offers a novel conceptualization that allows for many different theoretical approaches that are employed at the point where they will be most effective. Six stages of change have been formulated:

1. Precontemplation
2. Contemplation
3. Determination
4. Action
5. Maintenance
6. Relapse

Particular techniques from different theoretical orientations match the relevant stage of change, with a primary focus on building motivation for individuals to take action toward their goals and to maintain changes. Each stage of change is more fully examined in the following sections, with strategies for increasing client's motivation so that movement toward the next change can occur. See Table 2.1 for a summary of the stages and the possible strategies within each one.

Precontemplation

In precontemplation, the individual believes there is no problem behavior and is therefore unwilling to do anything about it. At this stage, the individual sees the problem behavior as possessing more advantages than disadvantages. Individuals in this stage are typically defensive and resistant about their behavior. They lack awareness of the problem, and if in treatment have usually been coerced or pressured to do so by others. In treatment, they are not willing to participate (Connors et al., 2001).

In the precontemplation stage, the practitioner, rather than focusing on behavioral change, focuses on building the client's motivation to change and on increasing awareness of the negative aspects of the problem behavior. Prochaska, DiClemente, and Norcross (1994) advise asking about the impact of the problem both on the individual and on family members and other people who are affected by the problem. For the client to move to the next stage, the advantages of changing have to outweigh the disadvantages.

If a client in precontemplation is initially uninterested in change, the decision can be made to work with family members. For example, reinforcement training (Sisson & Azrin, 1986), also called unilateral therapy (Thomas & Ager, 1993), and the pressures to change model (Barber & Gilbertson, 1997) have effectively induced individuals with substance abuse problems to reduce their intake and seek treatment.

Table 2.1

The Stages of Change and Strategies at Each Stage

Stage of change	Characteristics	Change strategies
Precontemplation	Individual is unwilling to do anything about the problem Individual sees the problem behavior as possessing more advantages than disadvantages Individual is usually coerced or pressured to do so by others	Linking the client with social liberation forces Motivational enhancement interviewing
Contemplation	Individual begins to consider there is a problem and the feasibility and costs of changing the behavior Individual wants to understand own behavior and frequently feel distress over it Individual thinks about making change in the next 6 months	Providing education on the disorder and the recovery process Bolstering the advantages of changing and problem-solving about how to ameliorate or lessen the disadvantages Self-monitoring Functional analysis Alternative reinforcers for the problem behavior are considered Identifying social support systems
Preparation (determination)	Individual is poised to change in the next month	Goal setting Developing a change plan Developing coping skills
Action	Individual has started to modify the problem behavior and/or the environment in an effort to promote change in the past 6 months	Appraisal of high-risk situations and coping strategies to overcome these are a mainstay of this stage Alternative reinforcers to problem behaviors should also be applied Assessment of social support systems continues to be essential so that others are a helpful resource for change rather than a hindrance

(*continued*)

Table 2.1 (continued)

The Stages of Change and Strategies at Each Stage

Stage of change	Characteristics	Change strategies
Maintenance	Sustained change has occurred for at least 6 months	The practitioner should help the individual find alternative sources of satisfaction and enjoyment and continue to support lifestyle changes Assisting the individual in practicing and applying coping strategies Continued vigilance of cognitive distortions that might be associated with the problem and ways to counteract Maintaining environmental control
Relapse	The problem behavior has resumed, another cycle is begun, and the individual reenters at the stage of either precontemplation or contemplation	An opportunity for greater awareness of high-risk situations and the coping strategies needed to address these challenges

Note. Adapted from *Substance Abuse Treatment and Stages of Change: Selecting and Planning Interventions*, by G. Connors, D. Donovan, and C. D. Clemente, 2001, New York: Guilford.

The practitioner can also expose the client in precontemplation to social liberation, which offers people information about the problem and public support for change efforts. Much of this involves harnessing the forces that are already present to help people with problem behaviors. For example, a large self-help network exists for a range of problems, including substance use, overeating, and mental disorders.

Contemplation

In contemplation, individuals begin to consider that there is a problem, and they also begin to consider the feasibility and costs of changing the behavior. They want to understand their behavior and frequently feel distress over it. During this stage, individuals think about making change within the next 6 months. While they may have made attempts to change their

behavior in the past, they are not yet prepared to take action at this point; they are engaged in the process of evaluating the advantages and disadvantages of the problem (Connors et al., 2001).

The practitioner's role during this stage is to continue to enhance the client's motivation and to educate him or her on aspects of the disorder and the recovery process. The practitioner works to help bolster the advantages of changing and to brainstorm about how to ameliorate the situation or at least lessen the disadvantages. For instance, if a person identifies, as an advantage of drinking, that he or she handles social situations more smoothly, then perhaps the client's social skills need work so confidence can be inspired without alcohol.

Self-monitoring of problem behavior can help the individual gain awareness of the frequency and intensity of the behavior, the cues that elicit problem behavior, and the consequences that follow. Alternative reinforcers for the problem behavior are considered. Identification of social support systems is critical during this change, so that others can promote change efforts.

Determination

In determination (also called preparation), the individual is poised to change in the next month. Readiness to change is bolstered through goal setting and developing a change plan (Connors et al., 2001). To be prepared to resist problem behaviors, the individual should develop and rehearse coping skills, such as relaxation, visualization of successful outcomes, cognitive restructuring, communication skills, and avoidance of environmental cues, before being placed in high-risk situations.

Action

In action, the individual has started to modify the problem behavior and/or the environment in an effort to promote change in the past 6 months. The individual at this point is willing to follow suggested strategies and activities for change (Connors et al., 2001).

In the action stage, the practitioner works toward maintaining client engagement in treatment and supports a realistic view of change through helping the individual achieve small, successive steps. The practitioner should acknowledge and empathize with the difficulties associated with the early stages of change. Appraisal of high-risk situations and coping strategies to overcome these are a mainstay of this stage. Alternative reinforcers to problem behaviors should also be applied. Assessment of social support systems continues to be essential so that others are a helpful resource for change rather than a hindrance.

Maintenance

In maintenance, sustained change has occurred for at least 6 months. The individual is working to sustain changes achieved to date, and attention is focused on avoiding slips or relapses (Prochaska & Norcross, 1994). The practitioner helps the individual find alternative sources of satisfaction and enjoyment and continues to support lifestyle changes. The practitioner also continues to assist the individual in practicing and applying coping strategies. Clients have to be aware of cognitive distortions that might be associated with the problem. For example, if an individual with an alcohol problem begins to think, "Life is no fun without drinking," recognizing this as a high-risk thought is essential so that the validity of the thought can be questioned: What were the consequences of my drinking? Were they always fun? How else can I experience fun and enjoyment in my life without drinking?

Maintaining environmental control is critical at this stage. For example, an individual with a weight problem has to avoid buying junk food "for the sake of the children." As much as possible, the individual should not put temptation in his or her way. However, he or she must also be armed with the necessary skills to face high-risk situations if they do occur. Continued practice with skills is necessary for this reason.

Relapse

Rather than as failure, DiClemente, Prochaska, and associates (Connors et al., 2001; Prochaska & DiClemente, 1984, 1992) view relapse as an opportunity for greater awareness of high-risk situations and the coping strategies to be developed to address these challenges. The notion that change is a spiral process rather than linear in nature means that relapse is just a normal part of the process of change. In other words, there is one step backward for two steps forward.

Motivational Interviewing

Motivational interviewing is a brief treatment model (one to four sessions) formulated to produce rapid change in which the client's motivation is mobilized. Motivational interviewing avoids prescriptive techniques and training the client in skills; instead, the client's own motivation is galvanized (Miller & Rollnick, 2002). Motivational interviewing is suggested when clients are initially low in motivation for change, specifically, in the precontemplation and contemplation stages of change. Indeed, research supports this finding; the motivational interviewing condition was espe-

cially helpful when clients were initially low in motivation (Project MATCH Research Group, 1997).

Empirical Support

Research has been conducted on both the stages of change model and motivational interviewing. Prochaska and DiClemente (1984, 1992) and other originators of the stages of change model claim that it is empirically derived, and it has garnered much research support (e.g., Prochaska, DiClemente, & Norcross, 1994; Velicer, Hughes, Fava, Prochaska, & DiClemente, 1995). According to a recent comprehensive review, however, there is as yet no evidence that people progress systematically through each stage of change (Littell & Girvin, 2002). However, a meta-analysis of 47 studies did reveal that cognitive-affective processes were more indicative of the stages of contemplation or preparation (an effect size of .70), whereas behavioral processes were more common in the action stage (an effect size of .80) (Rosen, 2000). This generally supports the hypothesized movement of change from a cognitive to a more behavioral process as people become ready to take action toward change.

Miller and colleagues have performed extensive research studies on motivational interviewing. Dunn et al. (2001) quantitatively reviewed 29 studies, mainly on substance abuse but also on smoking, HIV risk reduction, and diet and exercise. Moderate to large effects were found for reducing both substance abuse and substance dependence, with maintenance of effects over time. Motivational interviewing was also found to promote engagement in more intensive substance abuse treatment. Although studies have largely been conducted on adults, adolescent substance use also showed significantly positive results from motivational interviewing (Burke, Arkowitz, & Dunn, 2002).

Overall, motivational interviewing was superior to no-treatment control groups and less viable treatments; it was equivalent to more credible alternatives that were often two to three times longer in duration. For example, in the Project MATCH Research Group study (1997, 1998), 952 individuals with alcohol problems from outpatient clinics and 774 from aftercare treatment were provided with either 12-step facilitation (12 sessions), cognitive-behavioral coping skills therapy (12 sessions), or motivational enhancement therapy (4 sessions). Motivational enhancement fared as well as the other two treatments with three times as many sessions, both at posttest (Project MATCH Research Group, 1997) and 3 years later (Project MATCH Research Group, 1998).

In addition to alcohol problems, drug addiction, and dual diagnoses, motivational interviewing has been effective for health-related behaviors related to diabetes, hypertension, and bulimia nervosa. Only mixed find-

ings, however, have been indicated for the use of motivational interviewing for quitting cigarette use and for increasing physical exercise, and no support has been indicated for motivational interviewing for the reduction of HIV risk behaviors in the few studies to date (Burke et al., 2002).

Techniques of Motivational Interviewing

Several guiding principles underlie the techniques of motivational interviewing: expressing empathy, developing discrepancy, rolling with resistance, supporting self-efficacy, and developing a change plan. The general guidelines for motivational interviewing are also expressed in a list of do's and don'ts in Box 2.1. The principles are enacted through listening reflectively and demonstrating empathy, eliciting self-motivational statements, developing strategies to handle resistance, and enacting a decisional balance.

Listening Reflectively and Demonstrating Empathy

The first step for the practitioner is to listen empathically to clients' concerns, reflecting the content of the their messages as well as the underlying feelings. In this way rapport is built, and people feel heard and understood. With the practice of empathy, the practitioner is able to more accurately assess the individual's problems and the person's relationship to the process of change.

Empathic listening and affirming statements are not only practiced initially but also continued throughout the change process. Although these techniques are drawn from nondirective counseling (Rogers, 1951), they differ in several key ways. In nondirective counseling, the client is allowed to decide the content and direction of the discussion, whereas in motivational interviewing, the practitioner systematically directs the process toward building client motivation. Another difference between the approaches is the use of empathy. In contrast to nondirective counseling, in which empathic reflection is used noncontingently, in motivational interviewing empathy reinforces client statements about changing. In nondirective interviewing, the practitioner explores the in-the-moment conflicts and emotions that arise; in motivational interviewing, in order to bolster motivation for change, the practitioner works to create discrepancies between the client's values and goals (such as long-term health) and how the problem stands in the way of these goals (Miller & Rollnick, 1991). Motivational interviewing employs specific techniques to gear the client toward behavior change (Moyers & Rollnick, 2002). The practitioner selectively reflects and affirms change talk and asks the client to elaborate on statements about change.

Box 2.1

Guidelines for Motivational Interviewing

Do's

1. Set a tentative agenda, allowing for flexibility.
2. Begin where the client is.
3. Explore and reflect client's perceptions.
4. Use empathic reflection selectively when clients express reasons to change.
5. Reflect by making paraphrasing and summarizing statements rather than using questions.
6. Use affirmation and positive reframing of the client's statements to bolster self-efficacy.
7. Present a brief summary at end of each contact.
8. Use phrases like "I wonder if…" and "some people find…" to probe about problem behaviors gently.

Don'ts

1. Argue, lecture, confront, or persuade.
2. Moralize, criticize, preach, or judge.
3. Give expert advice at the beginning.
4. Order, direct, warn, or threaten.
5. Do most of the talking.
6. Debate about diagnostic labeling.
7. Ask closed-ended questions.
8. Ask a lot of questions (more than three in a row) without reflecting.
9. Offer advice and feedback until later stages, when sufficient motivation has been built.

Note. Adapted from "Shifting the Balance: Motivational Interviewing to Help Behaviour Change in People with Bulimia Nervosa," by S. Killick and C. Allen, 1997, *European Eating Disorders Review* 5(1), pp. 35–41; *Motivational Interviewing: Preparing People to Change Addictive Behavior* (2nd ed.), by W. Miller and S. Rollnick, 2002, New York: Guilford; and "A Practical Guide to the Use of Motivational Interviewing in Anorexia Nervosa," by J. Treasure and W. Ward, 1997, *European Eating Disorders Review, 5*, pp. 102–114.

Eliciting Self-Motivational Statements

The next step in the change process is to elicit from clients arguments in favor of change. The practitioner avoids advice giving at this point and simply poses a series of questions that the client might answer in a way that favors change. Conversation leads to exploring the disadvantages of the status quo and the advantages of changing. The exploration helps the individual examine the discrepancy between goals and values in terms of health, future well-being, success, and family relationships, on the one hand, and current behaviors, on the other. The practitioner inquires about how the problem affects the individual and those close to him or her and