

Clinical Supervision: Combining Outcome and Process

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This workshop is designed for the use of current supervisors, or emerging supervisors, who wish to review simple, goal oriented methods which can be easily taught to supervisees and who wish to review common issues which affect service provision.

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Introduction:

Research tells us that beginning supervisees want to achieve four things from supervision:

1. **Competence**
2. **Autonomy**
3. **Purpose**
4. **Direction**

The beginning professional wants to become competent at their craft so that they can become independent and autonomous. In order to achieve this they must learn how to perform their work with a purpose in mind and a direction in which to proceed. They rightly expect their supervisor to teach them how to do this.

In addition, research tells us that beginning supervisees want their supervisor to display these characteristics:

1. **Support**
2. **Reassurance**
3. **Direction**
4. **Non-Critical Systemic Feedback**
5. **Teaching**

The beginning supervisee wants a supervisor who is supportive and reassuring, who gives direction, who gives feedback which is focused on the work, and who is a good teacher.

The successful supervisor is the person who can combine all of these characteristics while simultaneously teaching a method of service provision which enables to supervisee to practice competently, identify and deal with obstacles to service provision, overcome these obstacles and address common issues (hidden agendas) which affect how we perform our work.

This workshop is broken into 3 parts:

1. **A Generic Supervision Model:** presents a schema for performing interviews and recognizing “stuck points”.
2. **What to Recommend When Things Get Stuck:** how to overcome stuck points in the interviewing process.
3. **Common Issues Which Affect Clinical Work:** everything from motivation to status differences, predetermined beliefs, hiring and firing, cooperating with other staff, and services ordered by others.

A Generic Supervision Model

A. The Importance of Setting, Role and Personality:

Setting: Where we work changes how we behave. Our work is not performed in a vacuum. We work in a social world in which there are attitudes and expectations of us which change depending upon the clients we serve and where we serve them. It is totally different working in a prison versus working in a hospice. A hospital is not the same as a high school. Interviews are still interviews, but client and worker expectations are influenced by physical setting, client goals, family involvement, referral and funding source demands, and a host of other factors.

Role: What we do changes what clients and co-workers expect of us. Like it or not our clients and co-workers have attitudes about us which are influenced by our “status”. People with the word “doctor” next to their name are viewed differently than people who are called “case manager”, “counselor” or “social worker”. If we see clients in their home versus them coming to our office this also changes what clients expect appropriate behavior to be on our part. We cannot escape our client’s social interpretation of our role.

Personality: Who we are changes what clients and co-workers will allow us to do. If you are perceived as “deep” and “spiritual” you will likely be allowed to engage in certain acts that other people who are not perceived this way will not be allowed to engage in. If you are perceived as a “problem solver” clients may allow you to influence how they behave in order to test your abilities. If you are perceived as a “character” you may be permitted to speak in a manner which would normally not be acceptable, or you may be permitted to stretch the boundaries of acceptable topics to a client.

There is not a right or a wrong way for a worker to be. There is significant research evidence that what is important is that the worker be genuine.

B: Common Factors in All “Talk” Methods:

There is a book published every few years which exerts a lot of influence on social service provision. It is called the *Handbook of Psychotherapy and Behavior Change*. It contains the latest research on what actually works in psychotherapy and behavior change enterprises. One of the consistent findings in this book is that the services we provide actually work. Receiving services is better than doing nothing.

The authors have identified a few factors which appear to affect change regardless of the particular orientation of the provider. In simple words, the authors claim there are “common factors” which are effective no matter what type of clinical style is offered and delivered. So, if you provide psychoanalysis or cognitive behavioral or family systems types of services these common factors will still predominate. They are:

Client Factors: Outcome studies indicate that clients say that 40% of the time when things improve it is the result of changes that occur in the client's life which produces the change. For example, if a teenager is depressed because they broke up with their girlfriend or boyfriend, they might get better when they get another girlfriend or boyfriend. Or if an adult loses their job and becomes despondent, they might improve by getting another job. These factors can be very wide ranging. An experienced supervisor will teach the inexperienced supervisee to look for these factors in their client's life and encourage the client to keep trying so that the possibility of something improving increases.

Common Relationship Factors: Outcome studies indicate that clients say that 30% of the time when things improve it is the result of common relationship factors which are part of all brands of "talk" methods. These factors include Empathy, Warmth, Understanding, Genuineness and Acceptance. Clients respond very positively to being treated with concern. However, these traits on the part of providers cannot simply be modeled. They have to be genuine. This is why I suggest to you that "deep insight, touchy-feely, spiritual" providers and "blunt, problem solving" providers can achieve the same results. What is important is that the client perceive the provider as genuine, not as acting out a role. An experienced supervisor will assist an inexperienced supervisee to get comfortable with who they are and learn to use their natural skills to assist others.

Techniques: Outcome studies indicate that clients say that 15% of the time when things improve it is the result of our techniques. Techniques are specific skills that are employed in a particular brand of service provision. Examples might be relaxation and guided imagery techniques, psycho-educational materials unique to a particular problem, various exercises unique to a particular problem, group methods, family interventions or personal journaling. These are skills that are employed to address specific problems.

Placebo: Outcome studies indicate that clients say that 15% of the time they get better because they believe they are supposed to get better. The importance of projecting an expectation of change should not be underestimated. The experienced supervisor will teach the inexperienced supervisee to present an expectation of change, assuming there will be improvement. In addition, an experienced supervisor will teach an inexperienced supervisee to focus on what can be changed, not what is hopeless or unrealistic.

I believe that this research points us in a positive direction. If you take out the 15% of improvement that occurs as a result of techniques, we are left with 85% of change which occurs as a result of forming and utilizing good relationships. A good relationship will enable a provider to focus a client on factors in a client's life which might be helpful, on the near term future where all problems begin to be solved, to project acceptance of and warmth for the client, and to project an expectation of change.

Forming good relationships can be accomplished by adhering to 4 principles all of us were taught in college.

C. Four Things We Should Never Forget:

If you studied any type of counseling, social work, psychology or other helping profession in college you were probably taught these four principles. They represent acquired wisdom for forming good relationships.

- 1. *Start Where The Client Is At:*** Everyone is a customer for being listened to, for being paid attention to, for having their concerns taken seriously. The easiest way to engage a client is to acknowledge their point of view. I believe the single greatest reason that services fail is that we fail to engage our client by acknowledging their concern. This is not the same as agreeing with a client. We can disagree and still acknowledge their perspective. The experienced supervisor teaches the inexperienced supervisee to tie the client's goal to the provider's goal in a spirit of mutual respect.
- 2. *Be Positive:*** Projecting hopefulness and an expectation of positive change is essential to engaging the client and stimulating them to try something new and different. I believe that all clients want to believe in the possibility of positive change. Change, though, must be realistic and achievable. We do not want to promote unrealistic and unachievable change. The provider who realizes that change is constant and inevitable, and who understands that a lot of service provision is nothing more than helping clients to accept and adjust to change in small ways, will be a successful professional.
- 3. *Be Non-Judgmental:*** The provider who can accept difference without judging its value or merit will have a much easier time dealing with some of the clients they will meet. If you believe, as I do, that the resolution of most client problems lies within the client, then assuming a clinical posture that the client already has much of what they need to resolve their problem is a good thing. In order to do this the provider has to have a positive belief in the client's ability to change their behavior. Adopting this posture requires that the provider concentrate on the full range of possibilities within the client's frame of reference without discarding attributes which the provider can't grasp or understand. The experienced supervisor teaches the inexperienced supervisee how to identify and use the client's attitude, skills and abilities to the client's benefit.
- 4. *Build On Client Strengths:*** The provider who learns to focus on what clients can do, instead of what they can't, will find that client's improve more quickly and feel better about themselves for doing it. At the time we first meet many clients they are not focused on their strengths. Some situation or circumstance has left them questioning if they are capable of managing change. By focusing on what they learned in the course of their lives we help them re-orient to what is possible and achievable. The experienced supervisor teaches the inexperienced supervisee how

to interview for what client's know how to do, believe will work, has worked before, or consider the proper course to follow.

D. A Simple Model For Service Provision:

A service provision model is a guide for the interviewing process. It needs to be flexible enough to be utilized in a multitude of settings and with a multitude of different clients. It needs to yield specific information so that the provider can know what the problem is and how to intervene. It needs to have built in, general ideas about how to manage different types of problems. And, if properly followed, it needs to lead toward targeted interventions which clients will be willing to try and expect to succeed.

My model of service provision is a distillation of what I have learned from performing various types of short term, behavioral, systemic and motivational therapies. Like most providers I do not have a brand of talking to clients to which I am strongly tied. Instead, I have accumulated a variety of skills which I utilize depending upon the clients I am serving and the circumstances in which I'm working. My model, like the information just presented on "common factors" and "four things we should never forget", is simultaneously very simple and very broad. It is a guide to interviewing and is not intended to teach specific interventions. I believe specific interventions either come from the client's themselves, or from the learned experiences of providers which are applied to unique client situations.

I view my interviews as occurring in 5 steps. They are:

1. Engage:

I believe that my clients are reluctant to seek the services I provide. I do not think that they think this is an enjoyable experience and I believe they do not seek this experience until they feel they have to. Once they decide to seek help they encounter a stranger who asks them inappropriate questions about details of their lives they would rather avoid. I do not believe they are feeling good about their circumstances at the time they seek help and I believe they want this experience to be terminated as quickly as they can make positive change occur. I believe that my clients do not understand what motivates me to want to do this because they frequently ask me if I get tired of listening to people's problems all day. I believe that my clients view me much as they do their family doctor because they refer to me as "doctor" regularly. I believe that some of my clients believe I am responsible for the resolution of their difficulties. I believe that some of my clients view counseling or therapy as akin to a religious experience and others as akin to visiting an oracle.

Before I even have a chance to talk to my clients I give them 16 pages of paperwork which I ask them to fill out. This paperwork is highly technical and legalistic. They are asked to sign a Consent to Treat form which an attorney has written for me and which runs for 4 pages. It contains a lot of valuable information, but would take an

hour to read if done properly. I give them a Notice of Privacy Practices which runs 3 pages. At each step in the paperwork they are asked to sign legalistic documents which will be used in my defense if they decide they are unhappy and try to sue me. Surprisingly, few clients offer any concern about these documents.

I tell you about these attitudes of mine because I believe they influence the first few minutes of our first interview. It is during these first few minutes when clients are successfully engaged or left wondering just what they got themselves into. It is also during these first few minutes when we create a positive expectation about the services we provide and when we set some limits on the experience so that clients do not misunderstand what we can and cannot do for them.

Creating Harmony: In normal interviewing we usher our client(s) into our office, ask them to have a seat and ask them what brings them. They then tell us a story. This story usually lasts 1 to 4 minutes and contains a lot of helpful information about the client's circumstances. When they are finished telling the story we have been trained to say "What I hear you saying is" and repeat the story back to them. If the client believes you have understood them they nod their head affirmatively. If they feel you have not understood them they non-verbally indicate you missed something and they'll repeat the story again. In the most simple circumstances it only takes this few minutes to engage the client. I call this creating harmony. The harmony exists between what the client describes the problem as being and what the provider acknowledges the client as saying problem is. Please note that to acknowledge is not same as agreeing.

A few factors can alter this simple story telling. One is how the client tells the story. Some clients tell long winded stories which can last for 10 to 15 minutes, and can be very boring. The provider is at risk to be so bored that their eyelids may get heavy, their shoulders may get heavy and they may want to take a nap. I call this being inducted into a low grade hypnotic trance. Needless to say, this isn't helpful to the counseling process. My experience with clients telling long, boring stories is that the client may not really be a customer for the service. It may be that the client is not sure they want to do this, or they may believe they are not the one with the problem, or they may be non-voluntary and skeptical about the provider, or they may be a "veteran" client who wants something the agency is offering, but not this. When a provider finds themselves in a situation like any of these it can be a good idea to clarify with the client the provider's role and to elicit from the client what they really would like to see happen. Gently interrupting the story and changing the subject, or cutting to the chase about why we're meeting, can work depending upon the circumstances.

A second kind of long winded story is similar and yet opposite. These stories can last 30 to 40 minutes. The difference is their intensity. Instead of being boring, these stories are riveting. They command your attention. My experience with these kind of stories is that the client is often relating a story of abuse, mistreatment or trauma. The telling of the story may be the reason the client is even seeking help. I

would not interrupt this story, but let the client finish. Gentle process comments such as “I’m sorry” help to keep the provider in the process and maintain emotional contact with the client.

The provider should note a client who tells a story without making eye contact. For most of our clients the lack of eye contact is more important than what is in the story, but not for all. There are cultural groups who feel making eye contact is disrespectful, the opposite of what most clients will feel.

The provider should note the client whose verbal tone is obviously hostile, or overly solicitous. The tone may be the most important communication in the story, instead of the words themselves.

The provider should also not forget about the purpose of the interview. An open interview with a voluntary client is not the same as a specific interview with a non-voluntary client, such as an assessment of some kind.

Setting Limits: Providers should not assume that clients know what we do, how we do it, and to what purpose. Indeed, some clients may have gross misunderstandings about our role, power and authority. It is a good idea to begin setting limits on the process right from the start. The client could get a sense of these limits by reading the paperwork we give them, but I doubt they pay that much attention prior to the first interview. I would not immediately talk about limits because that could interrupt the process and turn clients away from seeking help at all. Rather, when an opportunity arises during the normal course of events inject a little limit setting. For example, if a client is telling their story and implies that the provider could help them by writing a letter to a court or testifying in a court, that is a good moment to state an employer imposed, or ethics imposed, or personally imposed limit on what a provider might or might not do. If a client implies during the telling of their story that the provider is “highly recommended” that is a good moment to good naturedly say “there is nowhere to go but down from there”. Limit setting can actually expand a provider’s flexibility by not specifying a predetermined outcome.

2. Assess:

Once we have engaged our client, the next step is to assess the many factors which will influence how we decide to treat the problem. It is important to remember that when our client tells his or her story, the story is in a kind of personal code. The client knows what the story means to them, but we don’t. We don’t know the meaning of particular words or phrases, much less the meaning of non-verbal acts or gestures. We don’t know the significance of specific sub-stories. All we know is that the story, or stories, are important. So we have to clarify by asking lots of questions which help us to understand what the client has just told us. In a normal,

simple interview the engaging phase might only take a few minutes. The assessing phase might take 15 to 30 minutes.

What Is The Problem: When we assess just what the problem is we ask our client a variety of questions related to the problem. Some of these questions include: Would you describe the problem very specifically? How long has the problem gone on? What have you tried to do about it? Does the problem happen in specific places? How often does the problem occur? How severe are the symptoms of the problem? Who else does the problem affect? Who else might be in a position to help with the problem? Have there been times when the problem is not as severe? If so, what did you do that made the problem better? The purpose of these questions is to get a highly detailed picture of the problem, its duration, its severity and possibly what needs to happen to address the problem. By asking these questions we also sometimes get a side benefit – the client, while describing various aspects of the problem, reveals some detail or details which are highly important.

Motivation: We assess motivation in order to make a judgment about the client's willingness to try something new or different, as well as who or what the client thinks needs to change. We do this by listening to the client's comments more than by asking specific questions. The client will reveal through their use of language a lot about their motivation. If during your conversation the client predominantly talks about other people, that may be a significant sign that the client does not think they are the problem or that they have to change. Obviously, if they aren't the problem we need to find out who is and how to get them to attend a meeting. This is far more common than supervisees might think. If the client is non-voluntary and complains at length about the person who sent them to the service, this is usually a sign that the client will be compliant, but isn't interested in changing their behavior.

If a client talks about themselves during an interview that is usually a sign that they think they have to change. But that doesn't mean they know what to do. If they cannot describe an outcome or a goal, but they know they have to change, then we can often determine that they are a customer for figuring out a goal.

If a client tells you during in interview about a time when things were better that may be a sign that they not only believe they have to change, but they might also know what has to change. The counseling process for a client like this may be no more complicated than asking them to do again what has worked before.

As a general rule the more specific the client is in their comments, then the more likely they are to be a customer for something. Conversely, the more vague the client is, the more likely they are not a customer. Also we should teach our supervisees to listen to see if the client talks mostly about the past, or is future oriented. All problems are solved in the future and a focus on the near term future, the next 7 days, is an important sign that a client is a customer.

For example, let's take a woman client who presents as having a marriage problem. She talks a lot about her husband and complains about his behavior. She is very specific about what she is unhappy about with her husband. She doesn't say much about herself or what she wants to do about her husband. From this simple example it is easy to imagine that we would be left thinking, Is she here for herself, the marriage, or her husband? She is specific, so we can guess she's a customer for something, but we don't know what. Further, she is not future oriented, but instead is focused on the past. Can she identify what a goal would be?

What is the Obstacle to Change: As we ask our client various questions about the problem and what to do about it a theme tends to emerge. The client will repeatedly mention or describe a particular aspect of the problem or the change they feel is necessary to address the problem. The thing they repeatedly mention is often the obstacle to improvement. If it isn't the obstacle to improvement then it is likely what the client perceives as the obstacle they have to deal with. It is very important that we properly understand this obstacle. This obstacle is likely to become the focus of our services. In my experience there are 4 broad obstacles which I label (1) a Behavioral problem, (2) a Relationship problem, (3) an Attitude or Belief problem, or (4) a Bio-Chemical or Medical problem.

Using the same example of the woman who presents with a marriage problem but predominantly talks about her husband, we could easily ask her about what she sees as necessary to make things better. If she remains vague and focused on what she is unhappy about with her husband we might conclude she is unhappy in her marriage. It is possible that this is an attitude or belief problem even though she's talking about her relationship. The reason for this would be if we determine that she really wants a divorce or separation, but can't bring herself to say so. If she gets specific about what she's unhappy about with her husband we might conclude she wants him to change, but we'll have to bring him into the meetings. This would be a relationship problem. However if she says the problem only occurs when he's been drinking we might determine this is a behavior problem even though she's talking about her relationship. Over time, but usually within a couple of visits, theme will emerge.

Using common ways of writing treatment plans we might think of the woman's situation this way:

Goal: Improve the marriage
Objective: Change the husband
Intervention: Stop drinking

Where is the Client in the Change Process: There is research about how people decide to change their behavior and we have to make a judgment about where our

client is in the change process. In simple terms we have to ask ourselves a few questions about our client:

1. Does the client identify a problem?
2. Is the problem them?
3. Are they specific about what needs to change?
4. Are they oriented to the future, meaning they talk about what needs to change as opposed to what is wrong?
5. Do they describe any efforts to change they have taken?
6. Do they express interest in any suggestions the provider might have for making things better?
7. Have they reached out to others before? Others meaning family members, friends, clergy, physicians or other professionals.

Depending upon the answers to these questions you can identify where the client is in the process of change. A client who does not identify a problem sees no reason to change. A client who sees a problem, but it isn't them, is a customer for changing someone else instead of themselves. A client who is specific but focused on the past will need assistance to orient to the future. A client who is specific and focused on the future is a customer for an intervention. A client who may be vague and confused, but expresses a lot interest in help may be a customer despite how they present.

Psychopathology: If we believe that the problem is bio-chemical or medical we need assess psychopathology. If we are required to make a DSM diagnosis we will also need to assess psychopathology. This involves asking about symptoms and asking about the severity of the situation. (Situations which involve potential harm to the client or another become crises. They have to be dealt with in specific ways and it is not our purpose here to go over that material.) In order to assess psychopathology a provider needs to be familiar with the DSM, its organization and the five axis model it uses. An experienced supervisor will want to teach an inexperienced supervisee how to use the DSM and then make the diagnosing of clients a regular feature of supervisory meetings.

3. Focus and Determine:

After we spend a few minutes engaging our client and then spend up to 30 minutes assessing various aspects of our clients' expectations, we can then move on to focusing with our client on what the problem is and determine how to intervene. In the last segment I placed a lot of emphasis on our client's presentation of the problem and whether there is a theme about the problem. I identified 4 possible themes: a Behavioral problem, a Relationship problem, an Attitude or Belief problem, or a Bio-Chemical or Medical problem. We will focus here on the first three themes. A Bio-Chemical or Medical problem usually needs an intervention by

a psychiatrist or physician.

Is This A Behavioral Problem: If during the course of your interview a theme emerges which clearly indicates the problem is a behavior then we have to determine what to do about it. I mentioned in the last segment that clients may be specific and future oriented about behavior, but this is unlikely. They are more likely to be specific but not future oriented. Why would someone come to us if they knew what was wrong and what to do about it? What is far more common is the client knows what is wrong, but has no idea what to do about it, or their ideas are unrealistic and/or unachievable.

If this occurs there are a couple of interviewing options I would recommend to you and your supervisees. One option is to simply negotiate the behavior. This is always preferred because it is the most simple and the most easily understood by clients. A sign that negotiating is likely to succeed is when the client is very specific about their circumstances. With enough specificity there is enough information to work with to make negotiating a viable option. A simple formula for negotiating is to either (1) look at what has worked in the past when things were better, or (2) look into the future at what the client feels should change, or, if neither of these yields any good interventions, (3) experiment. In my experience clients who are seeking help from a stranger are very likely to have tunnel vision, meaning they are focused on the problem and not seeing anything else. When you look into the past you are expanding your clients' vision to include possibilities that might have worked before. Most people have experienced troubles in their life and coped without the assistance of strangers. When you look into the future you're looking for what the client feels is the proper course of action and for change which the client is likely to be motivated about. If neither of these yields any helpful information then you can go to experimenting. If the client is willing to experiment the provider suggests some new behavior or change which the client might try to make things better.

If you decide not to negotiate, the second option is to use what Paul Watzlawick of the Mental Research Center in California calls "as if" questions to stimulate your clients thinking about their circumstances. When you use an "as if" question you ask the client to imagine a time as if the problem has been solved and describe for you what would be different. A well known example of an "as if" question is the Miracle Question as used by the Brief Therapy Center in Wisconsin. A provider would ask a client to pretend as if a miracle has happened and the problem is solved. Then they would ask the client to describe what would be different if the problem was solved. As if questions are used to begin a conversation with a client about how things would be different as a way of stimulating clients to "see" what they feel is the change which is needed.

Is This a Relationship Problem? A relationship theme will develop if the client(s) continually describe the problem as occurring between two or more people. Even if they talk about behavior, it is behavior which occurs within the context of a relationship. Again, the degree of specificity is very important. A highly specific

problem between two or more people can sometimes be negotiated provided the people have a common goal and a generally agreed upon description of the problem. Of course, would they really come to a stranger if these criteria were in evidence. What usually happens is two or more people are having a dispute and they don't agree about the goal or the circumstances. When they engage in mind-reading, as if they know more about what the other thinks they the other does, then you can often assume you're in for a contentious interview.

If the clients are civil and respectful with each other you can often negotiate some change each is willing to make. You do this by eliciting from each a very specific description of what they see the problem as being. The purpose is to try to identify some common ground which everyone agrees with. If the clients can agree on either what has taken place, or what should be done about what has taken place, then each is often willing to do something to show their partner they are willing to compromise. If they agree on this then, like with behavior, you can look into the past or into the future for an intervention, or you can experiment.

If the clients are unable to find common ground they you can use as if questions to solicit their impressions of what should happen. Again, the purpose is to use these descriptions to try to get onto some common ground.

One aspect of relationships, which you don't see with individual interviews, is a tendency on the part of some clients to remain stuck in negativity. These clients usually only describe what they are unhappy about and can't seem to move to a future orientation focused on what might change. They will occasionally focus solely on the attitude or beliefs of the other and appear unwilling to engage in problem solving. They may say that they can't give an inch because the other will only take advantage of them. I have seen this a lot with parents of young teenagers who are having difficulty adjusting to the teenagers increasing autonomy. I have also seen this with couples considering divorce. This type of behavior may be a sign that the client really isn't interested in change. If this occurs it is a good idea to ask the clients exactly what they came for and/or what they want the provider to do.

Is This an Attitude or Belief Problem: Some clients have a difficult time offering specific descriptions of behavior or relationships, yet they are customers for change. They may offer descriptions of past events but cannot see what to do. They may describe repeated attempts to solve their problem be doing, over and over, the same thing which hasn't worked before. They may express strong feelings about the way they feel things should be as opposed to the way things are. These clients, in my experience, often have what I call a "conviction" about something. A strongly held conviction about some behavior or relationship is destroying their sense of well being and/or peace of mind.

For example, I once knew a client who was having anxiety attacks at his job when confronted by his boss about working overtime. He hadn't worked overtime for 3

years, yet wanted to do so. Whenever the boss came to ask him to work overtime the boss pointed his finger at the client and the client went into a dissociative type state. The client went to 3 different counselors who all told him he must have a history of being abused. The client believed this was true. According to the client the counselors all told him he had to “see the abuse” so he could rework it. He was convinced he had to see the abuse and so he tried hypnosis, EMDR and other methods for recalling the abuse he was sure happened. At the time I first met him he had a conviction that he had to see the abuse. Despite no success at all in seeing the abuse he persisted in his attempts to do so.

When a provider meets a client who is focused on a particular attitude or belief, what I’m calling a conviction, negotiating and “as if” questions don’t seem to be much help in getting the client out of where they’re stuck. There is a technique that some family therapists use called “circular interviewing” and narrative therapists call “externalizing the problem” which I have found helpful. I call it going fishing. Instead of directly dealing with the problem as presented the provider asks about everything else in a client’s life. The purpose is to expand what is being talked about as a way of stimulating some information which may be useful in assisting the client.

When I went “fishing” with the client I just described I found a number of things out. He said he was a recovering alcoholic and a recovering overeater who went to AA, NA, OA and ACA meetings. He said he was Vietnam Vet, was married without children, and liked to play the guitar. He described at length how the 12 steps had helped him to cope with drinking and overeating. I’ll tell you later how this data helped me to help him.

4. Intervene

The bulk of our interview, particularly the first interview, is spent engaging, assessing and focusing/determining with our client. As we near the end of the interview we prepare to intervene. Hopefully our provider has been thinking about how to intervene during the entire session, weighing what it appears might work with this client and what looks unrealistic. Interventions are the end product of what we have assessed might be helpful. There are some guidelines for intervening which are helpful to keep in mind:

Is There a Best Practice Available: There is growing body of empirical data about what works and doesn’t work with various conditions. This work is not comprehensive, but should be known or consulted by our supervisee. You can find this information at the websites of various research entities, such as the National Institute of Mental Health, the National Institute of Alcoholism and Alcohol Abuse or the National Institute of Drug Abuse. Or there are written texts such as *What Works For Whom: A Critical Review of Psychotherapy Research* and *What Works*

For Whom: A Critical Review of Treatments for Children and Adolescents. These best practices are usually related to specific diagnoses. They should not be ignored. There are insurance companies which will only pay for treatments which have been empirically validated, and I'm assuming that public funding sources will be the same.

How Do You Manage Responsibility: The issue of responsibility is more important than is generally assumed. There are contradictions between the way we practice and the ethical and legal standards which govern practice. We practice in a very client centered manner with emphasis placed on client choice about how to proceed. Our ethics are founded on the medical model which has built in assumptions about who is "sick" and who is well. As a rule I recommend we not offer help until it is asked for. This helps us avoid the "responsibility trap" in which clients feel we are more responsible for the outcome of services than they are.

General Guidelines for Interventions: If there is not a best practice that we know of, or our client(s) are dealing with circumstances which are unique to them, we can follow these guidelines.

1. The simplest intervention is often the best intervention.
2. Your relationship with a client is an intervention. Don't underestimate the value of forming and maintaining good relationships.
3. Behavioral interventions are usually very specific, measurable and realistic. As I have already mentioned, they most often come out of the interviewing process.
4. Family therapists, and others who deal with relationships, generally recommend that we ask the clients to do the opposite of what is not working.
5. Attitudes and Beliefs require that we intervene in perceptions which can not be measured and observed. This can be very difficult. From my point of view we have 2 options: (1) enter into the client's belief system and look for logical inconsistencies, or (2) follow the client's perceptions to their logical conclusions. In both cases your trying to show your client how their perceptions are off without impairing your relationship.
6. A good intervention is one which can be implemented within 3 days and which can be measured, such as making a mark on a calendar. You want your client(s) to do something quickly and keep track of the progress.

Knowing When To Stop: As a rule we want to do the minimum to be helpful. The minimum can be hard to judge, but keep this in mind: If you are in a specific session and the client indicates that they like the recommendation then stop right there. If client is returning to a subsequent session then monitor their progress and make small adjustments accordingly. In our current day our job is to assist with behavior change. We do not engage in long term relationship building, as some of our older colleagues may have been taught to do, unless the situation requires it.

5. Monitor:

Up to this point I have outlined a perfect first interview. Rarely do interviews flow perfectly. What is more likely is that the information I have outlined is learned over 2 or 3 interviews. Nevertheless I would urge you to teach your supervisee that there is a window of opportunity with clients. My experience with all clients, regardless of setting or diagnosis, is that somewhere between the first and the fourth interview a step is taken in the right direction. If this doesn't happen the window may close for an undefined period of time until another crisis occurs.

If a step has been taken in the right direction I would urge your supervisees to slow down their active involvement and monitor progress. When we monitor progress we want to evaluate client assessment of success at each subsequent session. A good way to do this is with scaling questions, such as – On a scale of 1 to 10, 1 being no progress and 10 meaning we have no need to meet, how are you doing today, this week or since we last met? We can also scale confidence that this will continue. And we can ask if this is enough progress or if something more needs to change. We want to be very supportive of client progress, praising clients for their hard work, but not unrealistic. Clients see right through our faking it and that can destroy our credibility. We also want to monitor for signs of problems. Often clients don't want to disappoint us if they made progress, then had a setback. We must teach our supervisees to look for signs of slippage.

E: Stuck Points: Common Problems In Service Provision

Stuck points are circumstances which occur during the interviewing process which bring the process to a halt. Some of them occur between ourselves and the client, and some are part of the client's circumstances. In my experience they are what we end up talking about because it is where we become stuck. Finding a resolution to a stuck point is often what service provision is about.

There are a number of common stuck points. These are circumstances or situations which can cause service provision to fail, or can derail progress.

- 1. Language and Meaning:*** Language is the medium of exchange in service provision. Clients tell us stories about their experiences and reveal to us what these stories mean to them. Clients, just like us, have spent a lifetime accumulating and refining their stories. They acquire words, gestures and expressions which have significance to them, but which a person outside their intimate circle might not understand. This is why they tell us a story in a couple of minutes and then we spend up to 30 minutes asking clarifying question which help us understand what the story actually meant to them. Making sure we get the story and its meaning right is critical to service provision, because, if we fail to get it right, the client will usually tell the story again in order to help us. After they've told the story a couple of times,

however, they begin to doubt our ability to understand. If this occurs we are stuck with a client who thinks we don't understand and who is likely to be reluctant to go any further.

2. ***Stereotypes:*** Researchers tell us we can only know about 50 to 100 people really well at any given time. All the rest we have to stereotype in order to have some structure of our own to understand who we are speaking to. Thus, stereotyping is normal behavior. Despite the inevitability of stereotyping everyone wants to be seen and appreciated for their unique characteristics, experiences and culture. In a service field like ours, showing an interest in a client's uniqueness is an important aspect of engaging them. Both we and the client stereotype each other. If we cannot get beyond these stereotypes there is great likelihood of our becoming stuck. During the initial few minutes of the first interview an exchange takes place during which each party displays an interest in the other, or during which each party shows the other they are open minded. Failure to do this can derail service provision before it even begins.
3. ***Goals:*** In a perfect world all clients would be voluntary and goal driven. We all know the world isn't perfect. Sometimes we don't even know who the client is. Many public service workers work in an environment where they are funded to promote a particular outcome. For example, all case management is funded to keep clients out of hospitals and institutions. Most chemical dependency treatment is funded to promote abstinence or sobriety. This can be in conflict with a client who is more interested in learning how to control their behavior or who really wants to get an authority figure off their back. It is easy for workers to lose sight of who the client is. If you are evaluated by a funding agency for your ability to meet their goals instead of the goals of the person you're interacting with, it is easy to stop paying attention to the person you're speaking to and focus on what the payor wants. This can stop service provision in its tracks and create the conditions for a worker and client to be in conflict over the purpose of the service.
4. ***Responsibility:*** I mentioned earlier that we are taught to be client centered as a way providing good service. Our ethics and legal rules however are founded on the medical model. In simple terms we sell ourselves as being doctor-like providers of a medical service. It has been this way since the 1950's. The medical model begins with a philosophical belief that the patient is sick and the doctor is well, and the doctor's job is to nurse the patient back to a state of wellness. There is assumed to be an inherent disparity of power in the relationship. This is one of the fundamental aspects of our ethics. It is why the Code of Ethics mentions again and again a proscription against the exploitation, or possible exploitation, of the client. Some clients, viewing us as doctor-like providers of a medical service, believe that we, not they, are responsible for the outcome of services. Many social service providers do not see themselves as doctor-like providers of a medical service. Herein lies the potential for getting stuck over who is responsible.

5. ***Motivation:*** It is very important for the service provider to learn early in the interviewing process what it is the client wants to accomplish and how hard the client is willing to work to make this happen. We should not assume that an animated client is highly motivated. They may be, but they may also be expecting things which are unrealistic. It is often hard to gauge motivation until you recommend some homework, then see if the client tried it when they return for a second interview. It can also be hard to determine how motivated a client is if they were sent for services by someone else. Just because they didn't come on their own doesn't mean they aren't motivated. It is easy to get stuck when a worker thinks a client is motivated, then discovers they aren't.
6. ***Change Process Misunderstandings:*** Mistaking where a client is in the process of change is a common problem for service providers. Being careful to listen for what the client says about the problem is a way to avoid this problem, but the various pressures that workers experience can lessen their ability to slow down and pay attention. If we assume a client is ready to change their behavior when they really just want to complain will cause the client and the provider to have two different conversations at the same time. They will get stuck over which conversation is the right one until they sort out their differences. Conflict can occur if no one is willing to budge.

Clients are often stuck when they come to see us. When we are helpful we assist them to view their situation or circumstances in a new light, or we suggest some change which improves their relations, or we offer some feedback they hadn't considered, or we provide a safe place to say things they felt they couldn't say anywhere else. How we conduct these interviews, and conduct ourselves during these interviews, can make things better for the client or can disappoint them. When things get stuck clients often get quiet or show a lack of interest. It is a non-verbal way of registering their feeling that things are not looking good between them and us. Service providers can improve this circumstance by altering their interviewing style, soliciting feedback or information they perhaps missed, or slowing down and going over the beginning again.

Interventions For Themes Or Stuck Points

A: Behavioral Problems:

When a client tells our supervisee a story about the reason for their visit with us during the first interview that story will contain descriptions of behavior, descriptions of relationships and descriptions of attitudes and beliefs. It can be very difficult to determine exactly which of these concerns is primary, but if our supervisee is patient a theme will emerge. It is helpful to teach our supervisee a few guidelines to keep in mind. First, how specific or vague is the client? As a rule the greater the specificity the more likely this is a behavioral

problem. Second, is the client oriented to the near term future? When a client is specific about some behavior and oriented to the near term future it is highly likely they have a behavior in mind they want to address. Third, is the problem them or someone else? If the problem is them they certainly are going to be describing behavior which can be negotiated. If the problem is someone else they may be talking about behavior, but really addressing a relationship. I cannot emphasize enough the importance of our supervisee getting this right. When a provider and a client share an understanding of the purpose for services we then have achieved a state of “harmony” and the client will offer numerous non-verbal signs of cooperation. Failure to get this right will result in the client signaling their discomfort with the interviewing process.

In addition to listening to the client for specifics, a near term future orientation and a focus on themselves, our supervisee needs to listen for some other client signals. First, does the client describe any attempts on their part to address the problem? Regardless of the whether these attempts have been successful, they are a sign of client motivation. Motivated clients don’t wait for strangers with special skills to try to implement change. Second, does the client demonstrate an understanding they will have to do something to address this problem, or are they waiting for the provider to intervene? This is sometimes a signal that they don’t know what else to do, and sometimes a signal they believe the provider is responsible for change. It is really important that client’s accept they will have to be actively involved in deciding what action to take and how that action is to be implemented. Third, does the client express any interest or concern regarding the provider’s ability to be helpful? It is absolutely normal and proper for clients to check out if the provider has any experience with the kind of problem they are having and any success with how to address it.

Assuming our supervisee has achieved a state of harmony with their client here is what I would recommend they do to begin searching for a small, realistic, achievable change that might get the client on the path to changing their behavior.

1. Go over the description of the specific behavior, making certain the supervisee has a clear picture of when the behavior occurs, where it occurs, the problem it creates, the context in which it occurs and what they want to do about it.
2. Take time to ask “as if” questions to stimulate the client’s thinking about what they might do to change their behavior. These “as if” questions often yield descriptions of big changes which are not small, realistic and achievable.
3. Narrow the client’s focus by breaking down the descriptions of big changes into smaller steps which can be taken soon. Teach supervisee’s to ask “What is the first thing the client would do to begin the process of change”.
4. As the client narrows their focus listen for small changes the client would be willing to make, or try to make, within a few days time.
5. Teach supervisees to offer encouragement and support to clients to try something different. We should all remember that clients often do not do exactly what we would recommend, but alter a suggested change to fit what they feel is right. It is

important that the client change in a way which makes sense to them, not that they do exactly what we would suggest.

So here is a practical example.

I met a 20 year old woman and her mother. The young lady had recently been hospitalized for a heart attack. She had not been feeling well for a few days and suddenly felt very bad. She called her mother at work and requested her mom take her to an emergency room. At the emergency room she was diagnosed with a heart condition and hospitalized for a week. While in the hospital she was fitted with a pacemaker and told she came very close to passing away. It was also discerned that she had been drinking so much for the past 2 years that she had depleted certain nutrients in her body and this had set off the heart attack. Her mom was understandably alarmed about her heart condition and about her drinking.

The young lady described how she lived with her boyfriend for the past 2 years. She said her boyfriend drinks very heavily. She said she did not consider herself to be a heavy drinker when compared to her boyfriend. She said she had only been drinking for the past 2 years. When I asked her if she felt she had a drinking problem, she said no. She said that she believed that she had been controlled and abused by a boyfriend she had in high school. She said that when she managed to get out of that relationship “I just went wild”. She said she believed that she had pent up energy and wanted to have fun. Her mom said that her ex-husband, the young lady’s father, was an alcoholic and that her brother has also had alcohol and drug use problems. Further, the mom said the father left the family when the young lady was quite young. She said her kids had not seen their dad for many years. She said she believed that her daughter had repressed feelings about the loss of her father and this might have caused her drinking.

When I asked the young lady about symptoms of alcohol abuse and dependence she described blackouts and loss of control. She had an obvious medical problem related to drinking. She was less clear about withdrawal symptoms, but it wasn’t certain she had not experienced withdrawal. For any professional who knows anything about drinking problems it was a pretty clear case of alcohol dependence. I asked if the hospital doctors had suggested any treatment for drinking and the daughter said they encouraged her to go to an intensive outpatient program. She said she couldn’t go because she had no insurance.

When I asked the young lady what she wanted from our appointment she said she came to this meeting to satisfy her mom. She said she knows she cannot drink for a period of time because of the risk of heart attack. She said her doctors told her she cannot drink for an extended period until she can improve her health and have the pacemaker removed. She said her doctors said this would take 2 years. When I asked how she felt this might affect her boyfriend she said he has slowed his drinking and had agreed to not have alcohol in their house. When I asked her what she will do instead of drinking she said she planned to find a job and apply to college. When I asked how soon she could do this she said she needed to restore her health first and didn’t know when she might find a job or begin

college. When I asked what she might study in college she told me she wasn't a very good high school student and didn't know what interested her as a career. When I asked her mom what she hoped to gain from our appointment she said she wasn't sure. She said she just didn't want anything to further harm her daughter. When I asked if she believed her daughter had an alcohol dependency problem she said she wasn't sure.

While this is an extreme case of alcohol use causing serious health problems for a very young person who had not been drinking very long, it is a typical case for understanding how clients present their concerns. The young lady described behavior – the drinking. She described two relationships – with her mom and with her boyfriend. And she described an attitude – she did not believe she had a drinking problem. Further she described a second attitude – she “went wild” after getting away from the abusive boyfriend in high school. The mom contributed to the attitude with her description of the effects of missing her father. In addition, the young lady said she isn't the client. Her mom wanted this appointment, not her.

So what does a professional do? There is an obvious alcohol dependency problem which has already produced a serious medical problem. There is a lack of awareness of the severity of the drinking problem and what might be necessary to sustain sobriety. There is a rightly concerned mother who fears for her daughter's health and safety. There is a vague idea about what to do make the daughter's life better. The mother is the person who sought this appointment and can rightly be considered to be the client, even though she presented her daughter as the client. The daughter is minimally motivated about receiving services, but wants to restore her health. It is unclear if they will return considering that the daughter doesn't even see herself as the client.

If you believe, as I do, in the importance of engaging the client during the first contact and establishing what I call “harmony” our supervisee might take these actions. First, I expressed alarm about the heart attack, stating that such a severe outcome from heavy drinking was unusual. I complimented the daughter on going to the emergency room and following the doctor's orders by not drinking. Second, I told the mother that she had every reason to worry about her daughter's health and sympathized with any parent's fear of losing their child. Because I wasn't sure they would return and because the mother was the one who asked for this appointment, I addressed with the mother my concerns about alcohol dependency. I quickly reviewed the family history and symptoms of alcohol dependence and suggested that there might be more of a drinking problem here than she might think. I recommended the daughter continue to do what she is doing – stop drinking. I told the mother about how hard it can be for some people to stop drinking altogether and suggested she check in with her daughter about cravings, her boyfriend's drinking and other situations which could stimulate her daughter's desire to drink. I encouraged the mother to seek guidance, with or without her daughter, if she wasn't sure how to proceed. I told the daughter I agree with her doctor's suggestions – stop drinking and take care of her health. I told her my experience with other young people is that not drinking is sometimes not as easy as it might appear to be. And I told her I would be happy to assist her if she decided she wanted help.

B: Relationship Problems:

When a client, or clients, tells our supervisee about a relationship problem it isn't always obvious that the relationship is the theme. Normally there has been an incident of some kind. This incident always involves behavior and it becomes very important to separate the presenting incident from the underlying relationship. Further, it is common that relationships deteriorate for a long time before clients seek help from a stranger. Assuming this to be true, assessing the severity of the relationship problem and the willingness of the parties to compromise and work cooperatively becomes an important judgment on our supervisee's part. Lastly, it is helpful for our supervisee to keep in mind that many theorists in the field of family therapy suggest that the problem which is presented is actually an attempted solution to some relationship difficulty which has become stuck and rigid. The clients, not knowing what to do, repeat the problem sequence over and over in a rigid attempt to resolve what they cannot seem to change. Finally, in frustration they do something dramatic which produces the incident which brings them to us.

When our supervisee is presented with a scenario like this there are certain things to look for. First, when the clients first present their story does the story identify one of them as the problem, or does it identify the relationship as needing change? It is common that each person's story describes the other as the problem. This should not be considered a problem in itself unless the parties cling to their stories. Then it becomes the problem. The relationship cannot improve unless there is recognition that change is necessary for both parties, or unless the parties are in agreement that one of them is the problem. Common ground, or an agreement about what is the problem, is necessary for relationship change. Second, our supervisee needs to listen for specifics and a near term future orientation. Parties who have been stuck for a long time, 6 months or longer, will often talk about what the other has done to them in the past and will not have any idea what needs to change to make things better. Again, this is not a deal breaker. It is a sign about where our supervisee needs to address their efforts. If our clients cannot identify a step forward then we should help them see what this step might be. If they can identify a step forward then we should help them negotiate it. A particularly bad sign for a relationship is when the two parties engage in what I call "pathologizing", describing each other as sick, mentally ill, twisted by their upbringing, or in some other way incapable of change. When two people come to view each other this way it is very difficult to initiate change between them. Third, our supervisee should listen for each person's description of what they want us to do. It is common that each party wants the professional to agree with them vis-à-vis their partner. This is to be avoided except in circumstances which we are required to address – i.e. abuse, neglect, harm to self or others, felonies.

It is also helpful to assess the assets the people can draw upon to address their concerns. By assets I mean personal, social, legal, financial and relational resources at each person's disposal. For example, all people have what I call "veto" power. This is the power to say

no. Teenagers are often skilled at saying no. Unfortunately they have difficulty saying yes. They lack financial, legal and social resources they can utilize to make things better. Their parents often have far more of these last 3 resources that the teenager does. However, if parents back their teenager into a corner without a face saving exit the teenager will often respond with excess energy and risk taking which the parent cannot match. Conversely, two adults in a committed relationship might have many financial and social assets, but have limitations imposed by having a baby. They just can't leave the baby for even a few hours to focus on their relationship. They need others to help them care for the baby while they spend time with each other. The issue of power and authority cannot be dismissed when addressing these concerns. A stay-at-home parent is unlikely to leave if doing so would be a financial disaster. Conversely many working parents fear splitting up because they might lose daily contact with their children. No one is without power and no one is omnipotent. Each individual has the right to end a relationship, but both must agree to try to make the relationship better.

Here are the steps I would suggest our supervisee take with relationships:

- 1. Hear both sides. Listen carefully to what each says is the problem and what each says is necessary to make things better. Pay particular attention to your own counter-transference and avoid whatever biases you might have.**
- 2. Specifically ask for a willingness to cooperate to make things better. Do not assume this. Plenty of clients present as wanting help, but then you discover they have hidden agendas or aren't as willing to change as they say they are.**
- 3. Let the clients determine what specific changes are necessary for things to improve. If you make a suggestion, present it as a suggestion and not as a recommendation. Recommendations make you accountable, suggestions leave accountability in client hands. Clients with hidden agendas will seek our recommendations and then blame any failures on us.**
- 4. Discuss with clients what assets they have, pointing out the assets their partner has. Ask what clients are willing to do to make things better.**
- 5. Ask yourself how the problem behavior could be an attempt to solve the underlying problem and ask yourself what the opposite of this problem behavior might be. When doing this keep it very simple and practical.**
- 6. Avoid engaging in any talk about how sick, mentally ill, etc. any person might be, unless it is obvious to all that there is such a problem.**
- 7. Remember to build a relationship first, before doing any confronting.**
- 8. Complement all attempts at change, regardless of their success.**

Here are two examples of common relationship problems:

Example A: I met a couple with a 3 year old child who say they are on the brink of divorce. They said that 2 weeks prior to our meeting the husband, to assuage his own guilt, told his wife he had a one night affair with her sister. The couple, in their late 20's, said they have been married for 5 years and, while the woman was pregnant with their child, the husband had a sexual encounter with the woman's sister. The woman describes her sister as a

“slut”. She says she can no longer trust her husband. She says she had no thoughts about divorce and was not unhappy in her marriage until her husband revealed the affair to her. The husband says he has felt guilty ever since the brief affair and that he told his wife about it in order to make things better. He says he is remorseful and distraught.

The couple state that breaking up would be very difficult. The wife says she is a stay-at-home mom and does not want to go back to work right now. She says she wanted to have another child. The husband says he cannot pay for two homes, one for his wife and child, and the other for him. He says he simply doesn’t earn enough. Both agree that their extended family could not provide financially for these changes. Further, the husband says he would miss his baby. He is tearful about the possibility of ending their relationship.

When I ask about what they plan to do they say they’re not certain. The husband says he is hoping his wife can forgive him. He says he has moved out of their bedroom and now sleeps on the couch. He says he has offered to give her all of their financial assets if they split up. He says he has offered to babysit while she has a one night affair with anyone she chooses. She says she has no interest in having an affair. She says she has no interest in sexual relations with anyone right now. She says she hasn’t thought about what to do, she is just so upset with her husband. It is dominating her every thought.

When I ask the husband what he thought his wife’s response would be to his revealing the affair he says he knew she would be upset, but didn’t anticipate a divorce. He says he told her so things could get better. When I ask how he thought it would make things better he says he was always told by his parents to tell the truth. When I ask if he thinks she believes he wants to make things better he says he hopes so. The wife says she thinks he told her so he could leave without being responsible. She says she thinks he wanted her to “throw him out” so he wouldn’t have to be responsible for leaving on his own. When I ask if she thought he wanted to leave before his announcement she says she did think about it. She says their life has been stressful since she had the baby and stopped working. She says finances have been tight, the baby takes a lot of her time and they have not been able to spend time with each other like they did prior to having a baby. I ask if she regrets this and she says she wishes she had made plans for maintaining the marriage before they had the baby. When I ask if she thinks they could make plans now she says she isn’t sure.

I complemented the couple on seeking help for a very difficult situation. I said it appeared they need to think about what they want to do. I suggested to the husband he give his wife some time to consider her options. After all he took three years to tell her about his affair. In the meantime I asked him to consider what she might expect of him if she decided to remain married. I told the wife I’d like to hear more about her observations that things were stressful prior to his telling her about the affair. I told her he did not appear to be acting like a man anxious to leave his family. However I said she knows him well and maybe she sees something I can’t pick up. I asked her to think about what will need to happen whether they stay together or they split up. This ended my first session with these clients.

In my experience this is a common kind of relationship problem. There has been an incident which has produced a conflict. The husband claims the incident was intended to make things better. The wife feels betrayed, but ultimately adds that there was stress before the incident. To me, neither of these people is seeking a divorce. However, I don't want to be the one to say so. They have to come to that conclusion on their own. The husband appears ready to look forward. The wife is not ready. Of course he's had plenty of time to think about how to proceed and she has just been hit with a report of sexual infidelity with a member of her own family. I want to avoid explaining away his behavior and I want to avoid reinforcing her betrayal. If they decide they want to remain together they will come up with their own explanations and strategies for improving (which they ultimately did). And if they decide to split up they will have to decide how to manage their finances and their relationship with their child.

Example B: A mother called me about her teenage son. She said he was depressed. She said that since the previous summer he has been depressed and withdrawn. Now that he is back in school his school performance has dramatically decreased. She said he is close with a priest at his catholic high school and has confided to the priest that he feels suicidal at times, but would never actually hurt himself. The priest sent him to the school counselor who encouraged his mom to contact me.

I met with the boy and his mom. The mom was understandably concerned and worried about her son. The boy was reluctant to speak in front of his mom and was non-committal about any interest in counseling services. The boy became more responsive after I asked his mom if I could speak with him on his own for a few minutes. He told me that he has been depressed and has thought of hurting himself. He said to me, as he had to the priest, that he would never actually hurt himself. He told me felt morally distraught. He told me that during the previous summer he had drunk alcohol heavily on a daily basis and had experimented with other drugs. He told me that he had hooked up with a girl who had just broken up with a boyfriend of many years and they had engaged in sexual relations. He said he wasn't really interested in the girl other than as a sexual partner and that he believed she felt the same way toward him. He said that his friends over the summer were very different people from him and that he did not feel he really fit in with them. He described his friends as artistic and liberal, and himself as an engineer and a conservative. He said it was marijuana smoking that brought them together. He said that he did not know how to get out of the situation he was in and that was why he spoke to the priest.

I asked him what, if anything, he might want me to do. He said he wasn't sure and asked what I do for people. I told him that all I really do is talk with clients and some find this talking helpful. I shared with him that he would have to decide if me, or anyone else, would be acceptable to him. I explained that people who do what I do manipulate their own behavior to have a beneficial impact on others. He asked me if I was familiar with adolescents and if I was familiar with drinking and smoking marijuana. I said I was and that was why his school counselor gave out my name. He asked me how people decide if they drink too much and smoke marijuana too much. I asked him some questions about his drinking and about symptoms of alcohol abuse and dependence. It was obvious, on the

basis of his answers, that he was at risk for alcohol and marijuana use problems. He asked me what people do to cope with depression. I shared some information about coping strategies and about medicine. He was clearly not interested in medicine. He told me that he felt morally repugnant because he was taking advantage of his girlfriend even though he believed she was a willing partner in their sexual encounters.

After checking me out this way he asked me what I thought he should do. I told him I would stop drinking and smoking for a period of time, exercise regularly and refrain from sexual relations if he felt he was taking advantage of the young lady. He told me it would be very difficult to do all these things. I agreed with him that it would be difficult and I added that it would also be a source of pride for him if he was successful. He said he would think about it and asked me if he could come back for another appointment. He asked me not to tell his mom anything about our conversation. I asked him what I can tell his mom, given that she is one who made the call to me and she is the one who is paying for the service. He told me to reassure her he will not hurt himself and to tell her he is serious about changing his behavior. I asked him if he was concerned about his school performance. He told he had a history of good grades and was aware of his slack performance since this school year began. He said school was somewhat boring to him now, but didn't want to do anything to screw up his choice of colleges.

This is another common kind of relationship problem if you treat adolescents as I do. This situation involves multiple relationships – with the client's mother, with his girlfriend and other friends, and with his school. Some clinicians would consider his relationship with alcohol and marijuana as yet another relationship problem. We want to teach our supervisee to engage the client at their pace and let them decide if we're competent to handle their situation. This client, like many, was ambivalent about accepting help and needed to check me out first. The client was largely unaware of the potential impact of alcohol and marijuana use on his life. He had a strong sense of what is morally right and wrong. He didn't want his mom to worry, but also didn't want her too involved in his decision making at this point in his life. He was concerned about his school performance, but unsure how to get back on track.

If I had rushed into telling him what I thought of his drinking and marijuana use I would run the risk of offering help before it was asked for. I would suggest that this is a mistake. If I had expressed alarm about his suicidal thoughts I could have potentially turned him off as a potential client and, thus, severely limited my ability to help him. If I had insisted on telling everything to his mom I would have likely ruined any potential for him to see me as a helpful resource. In this case, as in many cases, successfully engaging the client, creating harmony and focusing the session resulted in the client essentially deciding for himself the steps he felt were important for him to make. When I met this client for the second session he told he decided to only drink on weekends because he needed to focus on school, that he decided he needed to stop smoking marijuana, and he said he broke up with his girlfriend because "it just wasn't right". Upon further follow up he maintained his weekend drinking rule, improved his school performance and said he felt much better about himself. His mom said she was very pleased. He expressed no suicidal thoughts after our first visit.

This is also a circumstance in which relationships are the focus, but you only really talk with one person. This complicates the counseling and necessitates that the counselor be careful so as to not adopt the client's perspective as their own. The supervisee has to bear in mind that every client presents a limited perspective regardless of their openness. Seasoned clinicians learn to ask what other parties would say or do in particular circumstances.

C: Attitude/Belief Problems:

Attitude and belief problems are the most difficult to deal with. They can't be seen or measured other than by self-report. Clients rarely describe their stuck point as an attitude or belief. Rather they present a story as they normally would, beginning with an incident and revealing other important information as necessary. The clinician begins to whittle down the story and discovers that it is an attitude or belief which the client cannot seem to resolve. The clinician works with the attitude or belief and, in my opinion, often discovers that the problem is not just an attitude or belief, but a conviction. A conviction to me is an attitude or belief which is strongly held. This conviction is often based on experience and is not necessarily a rational belief which can be challenged with facts or information. Thus it is difficult to change. Experience would tell me that attempting to challenge the belief is rarely helpful. So what would you teach a supervisee to do?

The client with an attitude or belief problem will often present their problem as any other client would. What our supervisee will discover is that none of our normal interventions seem to work with this client. The client seems to have an underlying attitude or belief which governs how they view this problem and how they view what to do about the problem. They have "tunnel vision". They cannot seem to "see" what is blocking a successful resolution of their problem. This is what I do to try to assist these clients:

- 1. Get a very clear description of the belief system the client is operating from and its significance to the client. This should be as detailed as you can get.**
- 2. Make an effort to understand the attitude/belief from the client's point of view.**
- 3. Look for logical inconsistencies in the attitude/belief system.**
- 4. Point out potential problems.**
- 5. Do not challenge the client's attitude/belief system until you have enough of a relationship that your challenge will not cause the client to question your skills, values or sensitivity to them.**

Attitudes and beliefs are really important to all of us. We don't respond well when someone suggests we're wrong, mistaken, misguided, ignorant, uninformed or just plain stupid. A supervisee who suggests any of these things risks the client thinking they are arrogant or believe they are superior to the client. Not only would this be factually wrong, but it would not be helpful to building a therapeutic relationship. The seasoned clinician learns to tread lightly around client's strongly held beliefs.

Some of those beliefs can be bizarre and disruptive. In my career non-psychotic clients have told me that the image of the virgin mary controls the earth, that they could live totally independently if only their parents would let them (this from numerous 15 year olds), that only stupid people become alcoholics, that they can predict the future, that all men (or all women) are the same, that plants talk to them, that pets think about the future and feel deep emotions, that crystals can transmit messages between the living and the dead, that they can read my mind and that the government has secret plans to send the population to distant planets to cope with global warming. I'm in no position to refute these beliefs factually. And if I could I doubt it would be helpful.

What I teach my supervisees instead is to enter into the client's way of seeing things and try to be helpful from the inside, or to expand what the clients "sees" in order to stimulate a more rounded vision of current reality on the client's part. Here are 2 practical examples to illustrate what I mean:

Example A: I met a man who told me wanted to work overtime. He couldn't because whenever his boss asked him to work overtime in went into a dissociative anxiety state. He worked on an assembly line and the boss would come down the line pointing his finger at employees and saying "You, Overtime!". The client first had this dissociative reaction three years ago and had not worked overtime since. He went to his family doctor who sent him to a psychologist. Before I met him he had been to 3 different psychologists, without success. He told me that they all told him that he must have been abused or traumatized. He said he could not remember any trauma, but was convinced that his mother had abused him. He said he had to "see the abuse" so he could rework it. He told me he had tried hypnosis, EMDR and other treatments, including medicine, but nothing had stopped the dissociative reaction to his boss. I was at a loss about how to be helpful. He clearly had a real problem, but he also had a conviction about what to do about it. In an effort to try to find something I could make use of I asked him about other things in his life. He told me he was married, had no children, played the guitar and was a member of Alcoholics Anonymous, Overeaters Anonymous, Vietnam Veterans Anonymous and Children of Alcoholics Anonymous. He said these support groups had been very helpful to him. At the end of our first session he asked if he could see me twice a week and if he could have my home phone number in case he had an anxiety attack and needed to talk to me.

When the client returned for the second session he told he that in between our sessions he had visited his mother's grave while it was raining. He said he got on his hands and knees on the grave and spoke to his mother. I asked him why he did this and he said he hoped to see the abuse by getting physically close to her. I asked if it was helpful and he said no. I then had an epiphany of my own and stumbled on an insight I didn't know I had until I had used it on him. I mentioned that he had attended AA, OA and COA meetings. He said yes he did. I mentioned that he said they were helpful and he said they had been, that his life was improved by his participation. I said he must know the steps and he said he did. I asked if he knew the first step (I am powerless over ____ and my life is unmanageable) and he said he did. I asked if he knew the second step (I made a decision to turn my life and my will over to a higher power) and he exclaimed "turn it over, turn it over". I said he must

have been successful in controlling his drinking and eating by surrendering his will to control them. He said he had. So I asked him why he continued to try to control his anxiety by force of will when he had been successful with surrendering his will. He literally looked to the heavens and exclaimed “Oh, yeah!, Oh, yeah!”.

When the client returned a week later he said he had gone to his job the day of our session and had worked overtime the same day. He said he was anxious but just ignored it. He said he worked overtime 3 times since our last visit. I followed him for 6 months and he worked overtime throughout that time. He experienced some anxiety, but this decreased over time. What I had stumbled onto was a discrepancy in his way of looking at things, a logical inconsistency. Pointing out this inconsistency caused him to “see” his situation differently and, in my opinion, opened for him possibilities he had not previously considered. From there he made his own adjustment to his situation. Don’t ask me how this changed his anxiety or bio-chemistry, because I don’t know. What I know is that he reported great satisfaction with his progress and that it lasted for 6 months. As far as I know he never saw the abuse. Once he felt better he never mentioned it again.

The technique of asking about other things in a person’s life has been called “Circular Interviewing” and “Externalizing the Problem”, but I call it “Going Fishing”. It enables a professional to expand a client’s vision of the problem in a non-intrusive way. The professional is hoping that, by expanding the client’s vision, the client will uncover helpful information they had not been considering. Without directly challenging the client’s conviction the professional is “looking” for information which will alter the client’s attitude or belief. It would behoove supervisees to learn how to go fishing.

Example B: I interviewed a woman told me her husband had recently gone out and bought a big screen TV, mounted it at the foot of their bed and was laying in the bed watching TV without talking to her. She was at a loss to figure out why this had happened. I did what all of us have been taught to do: I asked about any precipitant, event, etc. She drew a blank. She had no idea why this had occurred.

So I went fishing. I asked about the rest of their life together. She told me they were both from immigrant families, that they both worked blue collar jobs, that they did little socially together and that she had a good friend who she went to church with. She said they lived in a one bedroom apartment that consisted of one large room which was both a bedroom and a living room, and that they had a kitchen and a bath. I asked if they had children and she said no, for some reason they could not have children. I was about to move on when she said that while she had no children, she had her “kitties”. From the sound in her voice I could tell this was significant, but I had no idea what made it so. She had a tone in her voice that I often hear ladies use speaking about their children. I asked how many kitties there were. She said nine. This sounded like a lot to me for such a small apartment. Before I could ask anything else she spontaneously began telling me their names and ages. The cats were 18, 16, 14, 12, 10, 8, 6, 4 and 2. She got a cat every 2 years. The only name I remember is Fred, who was oldest at age 18.

It often happens that when you go fishing you catch a fish, but have no idea what it means. You just know you've got something to work with. I would recommend to supervisees that they learn to let the process play itself out and see what happens. In this case the lady said that Fred had recently had surgery for some kind of abdominal problem. It sounded very complicated to me, and expensive. I asked what the surgery cost and said \$1000. I thought that sounded like a lot of money to spend on an 18 year old cat. She really warmed up talking about the cats and about Fred's surgery. She told she couldn't afford to have Fred recuperate at the animal hospital, so she had to bring him home. She said she had to change Fred's bandages and care for him like you would a child. She said she didn't want Fred to have to sleep on a hard floor at night so she brought him into their bed. She said the other cats would then get into the bed as well.

Now I thought I had something. I asked what the big screen TV cost and she about \$1000. I expressed surprise and she suddenly asked me if I thought her husband may have bought the big screen TV out of anger that she spent \$1000 on Fred. I said I couldn't know but it was a possibility. It was as if the shackles had fallen away from her eyes. She quickly concluded that, in order to interact with her husband, she needed to get the cats out of the bed. Within minutes she formulated a plan to accomplish this. When I met her for a follow up she told me she had carried out her plan and did not feel she needed any further help.

This client simply couldn't "see" what was going on in her relationship with her husband. In contrast to the man in Example A she didn't have a strongly held conviction about what she needed to be done. She was just blind to what was right in front of her. If I had focused on her initial presentation I do not believe I would have gotten to the source of the problem. It was by going fishing and following what I uncovered that it all came into her awareness.

D. What To Do When Nothing Works:

I mentioned before the importance of harmony, of aligning yourself up with how the client presents the problem. I want to repeat that the purpose of this is to create the conditions to be helpful, not to reinforce that the client is right. When we are successful at creating harmony, we are often able to assist our client. When we fail to create harmony things can go awry. I make it all sound so simple, but it requires a lot of sophistication on our supervisee's part to do this on demand. Stuff happens.

When our supervisee doesn't get it right we need a process we can teach them to try to correct this problem. Here are some ideas:

- 1. Re-visit the goal: Go back and ask yourself if you're clear about what it is the client says they want. Ask the client if you have this right. Clarify what is the problem, who has it, where change should come from, when is it supposed to happen and how is it supposed to happen.**

2. **Re-visit the purpose:** In contrast to the goal, which is what is supposed to happen, ask yourself for what purpose is this change supposed to occur. What behavior, relationship or attitude/belief is supposed to be impacted, who is supposed to benefit and how are they supposed to benefit.
3. **Make sure you know who the client is:** The real client is the person most concerned about the problem. This is not necessarily the person who is said to be the client. For example, it is common that parents present a child as the client, but the parent is the one most concerned. It is also common that other authority figures say someone needs help, but that doesn't mean that the identified client thinks they need help.
4. **Make sure you know where the client is in the change process:** Supervisees can create a disconnection with the client if they think the client is ready for change when in reality the client either doesn't know they have a problem, or doesn't think the problem is them, or haven't concluded what specific change they should make.
5. **Ask yourself how motivated the client is:** Clients can present as very motivated when they really aren't, or they can present as lacking motivation when they are really just frustrated with the inability to effect change. Supervisees don't want to stray too far from where the client is at until they have engendered some hopefulness in the client.
6. **Ask yourself if there is confusion between the stuck point and the intervention:** In my experience the most common cause of service failure is when the worker thinks the problem is one thing and the client thinks it is another. You can imagine the confusion for the client if they think the problem is a relationship and I think it is a behavior.
7. **Ask yourself if you are working harder than the client:** This is the road to professional burnout. We should not work harder than our clients and we should not offer help before it is asked for. This is very difficult for beginning workers. We are so fired up to be helpful that we forget to ask the client if they want any help.

Common Issues Which Affect Clinical Work

Professional Outlook and Status Differences:

- a. **Professionals have multiple competing beliefs about why people are the way they are.** This is no widely agreed upon belief that governs practice. Some professionals believe we are the way we are due to bio-chemistry; some believe we are the way we are due to culture; some believe we are the way we are due to family experiences; some believe we are the way we are due to individual experiences; and some believe God put you on this earth, gave you free will and you make choices which define you. Most professionals recognize that all of these beliefs are true some of the time and none are true all of the time. I do not believe this will be resolved any time soon. What is important for supervisees who work with clients is to know what the client believes and align themselves in harmony with that.
- b. **For some reason we don't seem to pay a lot of attention to status in our work, but we should.** Like it or not we cannot escape the society in which we live and work. In that

society status, money, ambition and politics impact what we do with clients. To pretend otherwise is to do a disservice to our clients.

Social and Religious Beliefs:

- a. Some professionals have strong social beliefs which influence their judgment. They may feel an affinity to a particular social or clinical population, and even feel they have been “called” to work with this group of clients. There is nothing wrong with having such an orientation to a particular group. After all many people choose this line of work because they feel such an affinity. The problem comes when a professional puts their point of view above all others, especially when that point of view is not shared by the clients they serve.
- b. Like social beliefs, some professionals have strong religious beliefs which govern what they consider to be right and wrong behavior, or proper and improper treatment of another human being. Seeing one’s work as also being part of a “ministry” is nothing new in our field. As with social beliefs, problems can occur when the professional can’t align their religious beliefs with those of their clients.

When a Supervisor Also Hires and Fires:

- a. When your supervisor is also your boss supervisees may limit what they say to lessen any negative impact of their job or career. In a perfect world your supervisor would not also be the person who hires and fires. Of course, the world is seldom perfect. Employers can try to mitigate this problem with clearly written policies governing salary increases, promotions, disputes and terminations. The supervisee can also attempt to create relationships with seasoned co-workers and with colleagues to gain the kind of supervisory feedback they might be reluctant to ask for from someone who might use the information they share against them at some later date.

Cooperating With Staff From Other Agencies:

Cooperating is one of the most necessary, and one of the most frustrating, things we all have to do. I can tell you from experience that chronic cooperating is difficult. In order to try to cope with this problem I have a number of suggestions for supervisees:

- a. Serve food at joint meetings and express interest in the ideas of others. Food is the universal schmooze; everyone is a customer for food. When you show an interest in the ideas of others, they generally show an interest in your ideas.
- b. Make a note of who is the funding source. The person with the money often feels they have more say than do others.
- c. Make a note of who has the primary service responsibility for the client. No matter what others may say, the person who provides the service will ultimately decide how that service is delivered.
- d. Make a note of who, if anyone, has status or ambition issues.
- e. Make a note of any differences in clinical outlook.

- f. Create cooperation whenever you can and negotiate differences whenever you can.
- g. To the extent possible ignore personal conflicts.

Treatment Ordered By Others:

Here are some ideas supervisees might keep in mind when serving clients who have been ordered to get help by others:

- a. Some social institutions are created with social control of clients in mind, rather than focusing on client-centered issues. The savvy clinician learns to serve both interests.
- b. Some workers in social institutions have a hard time understanding why a mental health clinician isn't successful at stopping what they see as problem behavior quickly. Some workers in social institutions develop a lack of faith in the skills of mental health workers. Learning to prepare these workers for what can and can't be accomplished, and how quickly this can be done, is important.
- c. Maintaining open lines of communication with workers in social institutions helps our supervisee to create appropriate expectations regarding what can and cannot be accomplished, how quickly we can work and what reasonable goals for service might be. Success at these tasks increases our status with these workers and enables us to be successful and helpful at the same time.

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Post Test

- 1. Research tells us beginning supervisees seek to accomplish 4 things. They are:**
 - a. Competence, Autonomy, Independence and Satisfaction.**
 - b. Hopefulness, Clarity, Direction and Purpose.**
 - c. Competence, Autonomy, Purpose and Direction.**
 - d. Confidence, Freedom, Satisfaction and Clarity.**

- 2. Supervisees want their supervisor to display what characteristics:**
 - a. Support, Reassurance, Direction, Non-Critical Feedback and Teaching.**
 - b. Caring, Encouragement, Faith, Support and Teaching.**
 - c. Hopefulness, Caring, Faith, Encouragement and Support.**
 - d. Instruction, Concern, Reassurance, Teaching and Clarification.**

- 3. Setting refers to:**
 - a. What we do.**
 - b. Who we are.**
 - c. Our location.**
 - d. Where we work.**

- 4. Role refers to:**
 - a. What we do.**
 - b. Who we are.**
 - c. Our location.**
 - d. Where we work.**

- 5. Personality refers to:**
 - a. What we do.**
 - b. Who we are.**
 - c. Our location.**
 - d. Where we work.**

6. Research tells us that ___ % of the time Client Factors are what produce change:

- a. 30%**
- b. 40%**
- c. 50%**
- d. 25%**

7. Common Factors include which characteristics that professionals display:

- a. Confrontation, Support, Hopefulness, Empathy and Insight.**
- b. Support, Valuing, Acceptance, Distancing and Insight.**
- c. Concern, Contempt, Positive Regard, Insight and Empathy.**
- d. Empathy, Warmth, Understanding, Genuineness and Acceptance.**

8. If you take out Techniques what % of the time does the relationship appear to effect change:

- a. 65%**
- b. 85%**
- c. 75%**
- d. 95%**

9. The 4 things we should never forget are:

- a. Start where the client is at**
- b. Be positive**
- c. Be non-judgmental**
- d. Build on client strengths**
- e. All of the above**

10. Engaging most clients happens in what time frame:

- a. A few minutes.**
- b. A few hours.**
- c. A few sessions.**
- d. A few days.**

11. Harmony occurs when:

- a. The client accepts the counselor's version of events.**
- b. The client describes an experience and the counselor acknowledges that description.**
- c. The counselor asks for the client's version of events.**
- d. The client and counselor negotiate a shared understanding of events.**

- 12. A long winded, boring story is an indication that the client:**
- Doesn't feel they are the client.**
 - Doesn't believe what they're saying.**
 - Doesn't care about receiving help.**
 - Doesn't know what the counselor wants.**
- 13. A long winded, riveting story is an indication that:**
- The client has a lot to say.**
 - The client is confused.**
 - The telling of the story may be the purpose for the visit.**
 - The client is avoiding the real issues.**
- 14. Some of the things we assess in our first interview are:**
- What is the problem.**
 - How motivated is the client.**
 - Where is the client in the change process.**
 - What is the obstacle to change.**
 - All of the above.**
- 15. Two factors which are highly associated with our client being a customer are:**
- Insight and awareness.**
 - Specificity and future focus.**
 - Concern and worry.**
 - Vagueness and insight.**
- 16. If a client described themselves as having a problem and described what they have tried to do about it, they would be where in the process of change:**
- At the beginning.**
 - Considering what to do next.**
 - Ready to change.**
 - Ready for a confrontation.**
- 17. The 4 types of potential problems are:**
- behavioral, inspirational, contextual, relational.**
 - behavior, relationships, attitudes/beliefs and medical.**
 - sickness, distress, family and work.**
 - monetary, food sources, housing and work.**

18. Behavior change can be:

- a. understood.**
- b. confronted.**
- c. negotiated.**
- d. forced.**

19. Relationship change is often brought about by:

- a. recommending doing the opposite.**
- b. recommending doing the same thing over and over.**
- c. recommending sleep.**
- d. recommending having fun.**

20. Attitude/belief problems are often characterized by:

- a. rigid adherence to preferred methods.**
- b. convictions – strongly held beliefs.**
- c. worship of false dictums.**
- d. concern about one's appearance.**

21. The best intervention is often:

- a. the most difficult to achieve.**
- b. the easiest to understand.**
- c. the most complicated.**
- d. the simplest.**

22. The most common, positive intervention which clients report are:

- a. their relationship with the professional.**
- b. their relationship with family members.**
- c. their relationship with their pet.**
- d. their relationship with their pastor.**

23. The kind of question techniques used to assist the client stuck with a behavior problem are known as:

- a. negotiating questions.**
- b. clarifying questions.**
- c. unique questions.**
- d. as if questions.**

- 24. The general intervention to be used with relationship problems are:**
- a. recommend the opposite of what the clients had been doing.**
 - b. recommend the inside out of what the clients had been doing.**
 - c. recommend the reverse of what would normally be used.**
 - d. recommend the clients do more of the same.**
- 25. The kind of questions to be used with clients experiencing attitude/belief problems are:**
- a. externalizing the problem.**
 - b. circular interviewing.**
 - c. going fishing.**
 - d. All of the above.**
- 26. If nothing works the supervisee might consider:**
- a. re-visiting the goal.**
 - b. going home.**
 - c. asking for a consultation while in-session.**
 - d. calling a colleague.**
- 27. Working harder than the client does:**
- a. shows the client how much you care.**
 - b. puts the worker at risk for burnout.**
 - c. is necessary to effect change.**
 - d. A & C**
- 28. The competing beliefs about why people are the way they are can be described as:**
- a. Bio-chemical**
 - b. Cultural**
 - c. Family history**
 - d. Individual history**
 - e. Choice**
 - f. All of the above.**
- 29. Workers are less likely to tell the truth to supervisors who also hire and fire?**
- a. True**
 - b. False**

30. Providing food is a bad idea to facilitate cooperation between workers in different agencies?

- a. True**
- b. False**

I, _____ (name of participant) affirm that I am the person who completed this home study and am responsible for this post test.

Signature: _____

