Clinical Supervision with Difficult Cases: Using the Science of Change to Enhance Effectiveness with Difficult Cases in Mental Health and Substance Abuse

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About this Training Program: This program is based on a book entitled *Second-Order Change in Psychotherapy: The Golden Thread that Unifies Effective Treatments,* published in 2007 by American Psychological Association Books, authors J. Scott Fraser and Andrew D. Solovey. The objective is to provide supervisors with the most up to date scientific knowledge about how change occurs in psychotherapy. The information content is on a general level of abstraction and should not be construed as a cookbook. Psychotherapy is a highly complex process and will always involve a certain amount of clinical creativity. This is especially so when cases are viewed as difficult. At the same time there is fundamental information that stems from the literature on psychotherapeutic change that can be used to organize clinicians' creative efforts.

This training program contains 6 sections including the introduction. You will find subsections entitled *Implications for Supervisors* in each of the sections of the program. These are designed to summarize key points and illustrate important implications for clinical practice. There is a bibliography after each section where references are used, for those of you who may be interested in doing further research on key points that are made in the program.

Introduction:

Section 1

Here are some factors that make cases difficult for clinicians and for clinical supervisors

a. Clients that have Multiple or Severe Problems

- The big hook is that we may feel pressured to make multiple or big changes right away, this internal pressure occurs at an instinctual level

- Research shows that change occurs best when we prioritize and move toward change a more gradual way

- This is even more the case when clients have serious problems

- This means that when working with difficult cases there is a need to oppose our internal instinct to immediately correct situations that are spinning out of control, and move in a slow yet confident manner

b. Multiple Systems Involvement

- The more systems, the more experts, the more potential confusion

- The more systems involved in a client's life, the more political change becomes, as each system will have investment in the outcome

- Our challenge is that to be effective we must adapt our approach to help our clients meet the demands of potentially competing interests

c. Stage of Change

- Interventions that presume that a client is in the action stage work if the client is in the action stage of change

- Interventions geared for action are doomed if the client is not in the action stage and will create a very difficult case

Implications for Supervisors

There is strong research evidence that change occurs in stages that begin with pre-contemplation, and progress to action, and then to maintenance where relapse is common. Pre-contemplation is the time where a person does not consider him or herself to have a problem. Over time, it becomes clearer that something is not working and so a person with an unfolding problem makes a small but significant shift. He or she begins to consider the possibility that something is wrong. As the problem process continues the problem-solver will experiment with change before finally engaging in a change project. After change has been made and integrated into a person's life there is risk for relapse. The evidence is clear that treatment is most effective when it is geared for the stage of change that a person is in. Each stage of change has a different set of tasks. So it is most important that the clinician assist the client with accomplishing the tasks of the stage of change that the client is in. For example, the main task of the pre-contemplation stage is coming to accept that one has a problem. Treatment for pre-

contemplators should be geared to accomplish this task. Prematurely pushing pre-contemplators into action will most likely increase their resistance to change. Consequently, interventions that are not stage-based are likely to increase resistance and inadvertently contribute to making a case difficult. (See references at end of section)

d. Rigid Simplicity or Complexity

- It's simple, why don't you just *********

- "I fully realize that I have not succeeded in answering all of your questions. Indeed, I feel that I have not answered any of them completely. The answers that I have found only serve to raise a whole new set of questions, which only lead to problems, some of which we weren't even aware were problems. To sum it up, I feel just as confused as ever in some ways, but I believe we are confused at a higher level."

Implications for Supervisors

Clients generally enter treatment with preconceived notions about the nature of their problem and how they think it should be solved. This may be part of the problem as some clients might view the problem as overly simple while others see it as more complicated than it needs to be. A parent who has a child with ADHD may think that all that is needed to curb the child's impulsive behavior is an old fashioned spanking. On the other extreme is a parent that is frightened to show any kind of firmness towards the child because she is intimidated by the neurological aspects of ADHD. Clients who are desperate for change and highly protective of their theories of causation can be very difficult to work with.

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Section 2

The Science of Change

The problems of difficult cases can be made easier to address for clinicians and supervisors by applying the science that describes how change works.

There is now strong evidence that psychotherapy works, although probably not for the reasons that are espoused by theoreticians who have created the various treatment models.

a. The central question is no longer, "*Does* what we do work?" Attention now converges on the issue, "*How* does therapy work?" (Fraser & Solovey, 2007)

- What is the common denominator across effective therapies?
- What do effective therapists do?

b. Researchers are engaging in a debate over the active ingredients in the change process. There are two warring camps. On one side are technicians who argue for the supremacy of one treatment method, over another. Treatment methods that have the support of controlled studies are referred to as Empirically Supported Treatments or EST's. The other side of the argument includes researchers who argue that the quality of the therapeutic relationship is more important than the technique that is selected.

c. There is robust evidence that supports the efficacy of specific treatment models.

- The proponents of EST's have amassed an imposing body of experimental evidence that, from their perspective, hands down, makes their case for the effectiveness of specific techniques for particular disorders.
- Recent texts, like *A Guide to Treatments That Work (2nd Edition)* (Nathan & Gorman, 2002) and *Clinical Handbook of Psychological Disorders, Third Edition: A Step-by-Step Treatment Manual* (Barlow, 2001) are encyclopedic in their review of empirically supported treatments for a wide range of client problems.
- So impressive are these results that state and federal regulatory bodies are demanding that reimbursement from their resources become contingent upon providers proving that they have used an EST appropriate to the problem treated.

d. On the other side is equal if not stronger evidence for the power of the therapeutic relationship. This is referred to as the Common Factors argument.

- Common factors refer to Rogerian facilitative conditions that include empathy, positive regard, and genuineness/congruence, and cognitive components of the relationship including consensus about and commitment to the goals of therapy, and to the means or tasks of therapy by which these goals may be attained

- Michael Lambert (Lambert, 1992; Asay & Lambert, 1999) surmised that a therapist's model or technique accounts for no more than 15% of the successful outcome variance while common factors account for 30% of change

- Wampold's (2001) meta-analysis showed therapeutic technique accounts for 8% of change while nonspecific factors that include common factors account for 70% of change

Note: Therapeutic techniques such as cognitive restructuring are referred to as specific factors

e. It is argued in this program that there is merit to both sides of the argument and that specific and common factors can fit together to form a unifying model of change. A unifying model of change is exceptionally helpful when addressing the needs of clients that have difficult problems.

Implications for Supervisors

- **A unified approach can assist clinicians and supervisors develop alternative treatment interventions when adherence to a treatment manual is not meeting the needs of a client**

- **A unified approach can assist with selective integration of approaches when clients present with multiple problems**

- **A unified approach can assist clinicians and supervisors with addressing the needs of clients who enter treatment before they are ready to make a change on their presenting problem**

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 33-56). Washington, DC: American Psychological Association Press.

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Section 3

The Unifying model of Change

The unifying model of change begins with 2 seemingly simple questions about the nature of change. The nature of change is both simple and complex.

- What does it mean when we say that someone has changed?
- Why shouldn't change be easy? I used to do it this way, now I do it that way?

a. The unifying model of change answers these questions and is taken from the concepts of first and second-order change as were outlined by the Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974). Here is what is meant by first and second-order change.

- First –order change refers to adjustments or shifts that maintain the homeostasis of a system
- First-order change provides stability and so is often wanted
- First-order solutions come in opposites and represent the first set of premises that are applied to a problem
- First –order change becomes misguided if the goal is to change the status quo. When first-order solutions are repeated despite unwanted results they are referred to as a problem-maintaining pattern or pattern of failed solutions or a vicious cycle

- A problem maintaining pattern may be extremely difficult to let go of

Key to Understanding the Nature of Psychological Problems

- **Human beings are capable of a wide range of experiences, some pleasurable and others not so pleasurable. For this reason, aberrant behavior itself is not considered a problem. It is just life. Problems usually develop when a person or persons oppose aberrant behavior and in response the aberrant behavior is continued or escalated. For example, the human psyche may generate a panic attack for no apparent reason. If the person, who has the attack, experiences it, and then moves on without judging it, a disorder will not develop. If on the other hand, the person who experiences panic judges the experience as a sign of some grave emotional or physical condition, and determines further that it should never reoccur, then a syndrome is likely to develop. The person may take a position of opposing all experiences of anxiety and then place pressure on him or herself to avoid all situations that stimulate anxious feelings. This self-pressure will of course increase the person's anxiety and the subsequent need for more avoidance. Eventually the person will meet criteria for Panic Disorder with Agoraphobia. In this way, the diagnosis Panic Disorder with Agoraphobia may be understood as a relationship between anxiety and the premise that anxiety must be avoided at all costs. Avoidance becomes the theme that defines a pattern of failed solution attempts.**

- **We find that in general a wide range of mental and emotional disorders follow this rule of thumb. An aberrant behavior is exhibited and is followed by attempts to oppose it, by self or others. A vicious cycle ensues such that the more an aberrant behavior is exhibited, the more efforts are made to oppose it, which are then followed by more aberrant behaviors and more failed opposition efforts and so forth.**

- **An exception to the theme of opposition is a pattern in which aberrant behavior is followed by the opposite extreme: non-response or ignoring. Here the cycle may unfold such that the more aberrant behavior is displayed, the more it is ignored, the more it is displayed, the more it is ignored and so forth. This is the proverbial fiddling while Rome burns approach. An example where this sometimes occurs is alcohol and drug addiction problems.**

- **What both patterns have in common is that the problem solver repeats the same solution over and again hoping for a different result that never occurs. This is referred to as a vicious cycle.**

- **The vicious cycle is part of most theories of psychopathology but may be identified by different labels such as repetition-compulsion in dynamic theory, reinforcement in learning theory, or a positive feedback loop in systems theory.**

- **Most empirically supported treatments are geared to address the most commonly occurring vicious cycle in a disorder. With alcohol and other drug problems the most frequent vicious cycle is referred to as a demand-withdraw cycle. Here, loved ones repeatedly demand that the addict quit his or her addiction while the addict withdraws further into addictive behavior, claiming that his or her addiction is not a problem. In these situations loved ones may be encouraged to stop the pattern of demands so that the addict can "hit bottom" and realize the problem. This strategy is most often found in ALANON. Because this is the most common problem cycle in addictions the exceptional pattern may be missed. The exception is a pattern of failed solutions that involve mutual withdrawal. Here the more the addict sinks into addiction, the more nothing is said about it. As you might guess, encouraging loved ones who are not commenting on an addiction problem to stop demands that the addict stop using will not be effective.**

Sometimes interventions that become popularized inadvertently contribute to problem formation. An example is a now discredited tradition in the chemical dependency field referred to as an intervention. It was thought that a group of concerned loved ones could make the case for change with an addicted person and push the addict into the action stage of recovery. This was done in a meeting where loved ones would each take turns explaining to the addict how his or her addictive behavior negatively impacted on them. These meetings were scripted in advance outside of the awareness of the addict. Research on this technique has shown that while it often resulted in the addict seeking hospitalization, the long term results were not generally favorable. From the perspective of the unifying model of change, it is argued that such interventions, though intuitively appealing, represent more of the same to the addict when there is a demand-withdrawal cycle of failed solutions. That is pressure is placed on the addict to change when he or she is not ready for action. The most common response is for the addicted person to temporarily comply with loved ones by entering treatment and then withdraw back into the old addiction pattern.

- **The unifying theory of change accounts for both types of vicious cycles and predicts that when a problem has developed, failed solutions will lie on either side of a continuum. Either too much pressure is being applied to bring about change or no pressure at all.**

- **The unifying theory also posits that first-order change strategies usually work. Opposing or ignoring aberrant behavior most often produces wanted results. For this reason, problems represent situations that are exceptions to the rule of opposites. When the exceptional aspects of the situation are missed, stability occurs around a cycle of solutions that unwittingly promote the problem. In most situations persons are not aware that their attempts to solve the**

problem are supporting it or making it worse. In fact, failed solutions are often motivated by the best of intentions. This is one of the important reasons for why change can be so difficult. Failed solutions are applied because they seem reasonable, and are fueled by good intentions.

b. When solutions to a problem are not producing wanted results then problem solvers must change the process by which they are trying to bring about change. Second- order change is change of the change process and has the following characteristics.

- It often seems counterintuitive
- It involves a change *of* a group or system's primary premises, and related rules and interaction patterns. For example, in the case of addiction and the presence of a demand/withdraw cycle, the premise that the addict can be talked out of his or her addictive behavior must be changed
- It involves stopping or reversing the solutions that are producing unwanted stability
- This means thinking or doing the opposite of the opposite. For example, with anxiety the opposite solution is to avoid situations that produce anxiety. The opposite of the opposite is to seek out situations that produce anxiety. Of course, convincing a person who is anxious to seek out anxiety producing situations is what the art of therapy is all about
- Second-order change cannot be defined in the absence of first-order change
- Effective psychotherapy modalities are delivery systems that ultimately assist clients with achieving second-order change

Key to Understanding Second-Order Change

As stated above, responses to aberrant behaviors are often extreme and involve opposites. When this produces unwanted results there is a need to change the process of bringing about change. To change the process of change, problem solvers need to do the opposite of what they are doing. If a problem-solver is avoiding the problem he or she will need to go toward it. If the problem is being ignored then it will need to be recognized. Analysis of major treatment frameworks for a variety of conditions including anxiety, depression, chemical dependency, behavioral disruptive disorders, borderline personality disorder, and marital problems indicates that opposite of the opposite strategies for change are built in.

Implications for Supervisors

The MRI indicated that vicious cycles are formed and maintained in three ways. Knowing the pathways to problem formation and maintenance is extremely helpful with assessing problems and developing interventions. Virtually all presenting problems regardless of diagnosis will follow one of these pathways. These pathways are as follows:

(1)The first way is when *action is necessary but is not taken*.

This first pathway involves under-reactions to problem situations as may occur with the withdraw/withdraw cycle described above.

(2)The second option is when *action is taken when it should not be*.

There are two types of actions taken when they should not be. The first involves attempts to avoid or trivialize problems as is common with anxiety and depressive disorders. The second is when solutions to problems are over-pursued as occurs with anger management, parenting, and marital issues. Here the unnecessary action is to try and force change.

(3)The third option is when *action is taken at the wrong level*.

This occurs when problems solvers make mistakes in how they conceptualize problems and solutions. There are two types of conceptual errors. These include attempting second-order change when a first-order solution will do or using a first-order strategy when second-order change is needed. For example, the strategy of trying to get a student to want to study versus seeking behavioral compliance with studying requires that the student reorganize his feelings and beliefs around studying. This is far more complicated that asking the student to study more. Here the problem solver is seeking second-order change when first-order change will do. This can be thought of as over-complicating the problem. Errors can also occur on the other side of the continuum. Hidden complexities or exceptions to a situation are missed and so a solution is repeated despite the need to shift to a second-order strategy. If a parent uses consequences over and over to try and make the student study, to no avail, then a more complex strategy is needed. Using a first-order approach when a second-order strategy is needed can be thought of as over-simplicity.

Based on these pathways we can predict with a high level of confidence the categories of treatment strategies that will need to be employed if treatment is to be successful. These treatment categories are generic and so there are many modalities of treatment that can work. The 5 treatment strategy categories are correlates of the pathways of problem formation and maintenance. These are outlined below:

- **Strategies that go toward the problem**
- **Strategies that stop problem pursuit**
- **Strategies that lead to acknowledgement of the problem**
- **Strategies that simplify the problem**
- **Strategies that acknowledge the complexity of the problem**

Again, the success of the strategy is dependent on the idea that it is the opposite of the failed strategy that is being used to solve the problem. For example, strategies that go toward the problem are helpful when the failed strategy involves avoidance or some other approach that is designed to move away from it. The success of the strategy is also dependent on the quality of the treatment relationship. This will be discussed later in the program.

There are a series of questions that can be used to assess the pathway of problem formation. These are important questions that provide information about what has been tried, what advice has been given, and what the client's position on change is. The position on change will be addressed later in the program:

- **What is the problem and how is it a problem for the client?**
- **When did it start?**
- **What is the history of attempted solutions**
- **What is the history of medical involvement?**
- **What advice has the client received from others about how to solve the problem?**
- **What actions have been taken on the advice that has been given?**
- **What are the client's beliefs about whether the problem can be changed or what change will take?**

It is noted that these questions may not be included in standard intake formats. The reason is that standard intake formats are designed to assist the clinician with rendering a DSM IV diagnosis. The DSM IV diagnosis generally does not provide important information about the patterns that promote problem development. Also, interactions that promote problem development may cross over many diagnoses. For this reason supervisors may need to assist clinicians with obtaining this information and embedding it in the standard format. Information that describes problem patterns of interaction is important to all cases and especially critical when a case is difficult.

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Section 4

The Treatment Relationship

In this section the treatment relationship will be defined, and the research on its relative changing power will be presented. The role of establishing mutual goals in the change process will be described. This section will conclude with discussion about how the relationship can produce second-order change through hope restoration.

a. Although it may seem clear for many clinicians, psychotherapy researchers have grappled over the precise definition of the treatment relationship and therapeutic alliance for many years. This has been an argument that the technicians have made against claims that relationship factors are the most powerful ingredients in the change process. That is, the relative changing power of the relationship is difficult to calculate because definitions of the alliance and relationship differ. For this reason, the APA Division of Psychotherapy convened a task force to review and comment on scientific evidence related to empirically supported relationships (EST's) (Norcross, 2002). That group decided to put to rest issues around differing definitions by adopting a general operational definition of the psychotherapy relationship and alliance. In so doing the task force advanced the definition of the treatment relationship offered by Gelso and Carter (1985; 1994). The therapeutic relationship was defined as:

The Therapeutic Relationship

- The relationship is the feelings and attitudes that the therapist and client have toward one another, and the manner in which these are expressed.
- The Alliance
- Rogerian facilitative conditions empathy, positive regard, and genuineness/congruence
- Goal Consensus and Collaboration

Therapeutic Alliance

The definition of the therapeutic alliance was taken from the work of Adam Horvath. Adam Horvath has been one of the most prominent recent researchers and interpreters of the literature on the alliance. As part of the APA Task Force on EST's, he adopted

a definition that embraced Bordin's (1975; 1989; 1994) work while also incorporating emerging consensus in the field:

- The alliance refers to the quality and strength of the client-therapist relationship
- This includes positive bonds such as mutual trust, liking, respect and caring
- It also includes cognitive components of the relationship including consensus about and commitment to the goals of therapy, and to the means or tasks of therapy by which these goals may be attained
- It involves a partnership where all parties are actively committed to their roles in the process of therapy and belief that all others are also enthusiastically engaged in the same process
- The alliance is a conscious and purposeful aspect of the relationship where all parties can describe the quality of the alliance and that there is a therapist or helper committed to providing assistance to the client or clients (Horvath and Bedi, 2002).

As you can see that there is some overlap in the concepts of the alliance and the relationship. From the perspective of second-order change, we will focus our attention on goal consensus, collaborative involvement, and empathy.

a. An important aspect of facilitating change is the process by which therapists engage clients in establishing mutually agreed upon goals. Orlinsky, Grawe and Parks (1994) define *goal consensus* as patient-therapist agreement on the goals and expectations of therapy. A subtle yet key point is the relationship between **goal consensus and empathy.**

- Goal consensus correlates with empathy because clients regard collaboration on goals and tasks as a sign of empathic understanding (Horvath and Greenberg 1986)

- Research shows further that responding to clients goals, intentions and values is equally important to empathy as it is for the therapist to resonate with their feelings

- Tryon and Winograd (2002) highlight engagement, goal consensus and collaborative involvement as pantheoretical concepts applying to all types of therapy and contexts. Collaborative involvement refers to the degree of mutual engagement of the client and therapist in therapy and is usually measured by homework completion, measures of cooperation and resistance, and involvement in the patient role

- They define *engagement* as the degree of involvement of the therapist and patient in the therapeutic process, often measured by patients returning to therapists after initial and successive sessions

- They also site research that suggests that client engagement in the first session is critical to their continuing treatment

Implications for Supervisors

In sum, research shows that an important aspect of the treatment process involves engaging clients in establishing mutual goals. Goal setting is universal and cuts through all major therapeutic modalities. By establishing goals that the client desires, the therapist shows that he or she understands the wants and needs of the client. Clients take this as a sign of empathy and so become willing to engage in making changes in their approaches to problems. A satisfactory goal setting process is critical to whether clients will come back for more therapy sessions and complete treatment. For clinical supervisors this is critical information. When cases present as difficult it is possible that the treating clinician has not established mutually agreed upon goals. This becomes an important area of investigation for clinical supervision. Clinical supervisors should not assume that establishing consensual goals is easy or that the supervisee has a highly developed skill set in this area. In the mental health system it is often assumed that goals are mutual when the client has signed off on the treatment plan. While this sign-off meets regulatory requirements it does not necessarily mean that the client and therapist have established a mutual contract for change. In many situations the signing of treatment plans is conducted in such a perfunctory manner as to have little meaning.

The following three questions reflect key concepts in the mutual goal setting process. There are many ways to ask these questions. From a supervisory standpoint, it is important to understand the concepts behind the questions when assisting staff with acquiring mutual goal setting skills.

1. **What are the client's aspirations and how do the client's symptoms conflict with or support his or her aspirations?**
2. **What will the client be doing differently when his or her goals have been achieved?**
3. **What will be the first sign that the client is heading in the right direction?**

The first question about the client's aspirations helps the clinician to know what the client wants in an overall sense. It also helps the clinician to know the extent to which there are discrepancies between the client's behavioral health problems and his or her wants and desires. Research, by William Miller, and Rollnick (2002) in

the substance abuse field, shows that discrepancy is a significant factor in motivation to change. If a person has a drinking problem and wants to be a good father then a discrepancy may exist between the person's view of himself as a parent and drinking. The idea that drinking too much alcohol conflicts with good parenting can then become an important motivating force in a decision to become sober. In this situation the clinician may work with the client on establishing goals for abstinence and parenting.

On the other hand, lack of discrepancy can result in little motivation for change. A client who has lost his family, job, and home may have little to aspire too and so may not have much incentive to stop drinking. A therapist trained in Integrated Dual Disorder Treatment (IDDT) might work with the client on building discrepancy by first assisting the client in fulfilling his most immediate aspirations. Here, the client might express an immediate desire to find a job or place to live. Rather than pushing sobriety as an initial step in treatment the IDDT clinician may work with the client on achieving these aspirations first. Once the person has a job and place to stay there may be discrepancy that can be explored. Sobriety may make more sense as the client has something important to lose if he continues to drink. It may seem worthwhile to stop drinking to keep his job and perhaps upgrade his living situation. (This is an important point for supervisors in the chemical dependency field since this approach is in direct contrast to approaches that have traditionally been used. The old approach involved using basic needs as a reward for sobriety. This approach was not usually effective and resulted in high program drop-out rates.)

The second question reflects the end point of therapy. It is important to have an idea of client's view of the treatment end point. Research has shown that clients tend to stop treatment when they think it should stop versus stopping on the therapist's timetable. Understanding the client's long term goals helps the clinician to handle terminations in a more planned manner and is good for the clinician's sense of accomplishment. This reduces the number of vague terminations where the clinician can only speculate as the whether the client is doing better. Also notice that this question requires a behavioral answer. Behavioral goals are considered to be more powerful drivers of change than goals that are internal to the client because they can be measured. When change goals are behavioral they are also more observable to self and others. As clients change in the treatment process they become more confident and confidence in turn inspires more change. Having measurable and observable goals seems to inspire this confidence.

Sometimes clients will express interest in working on an internal state. A desire to change one's self-esteem is an example of a desired change that is internal to the client. A goal that is left in the internal language cannot be observed or measured. This makes it more difficult to know when it has been accomplished. To convert an internal state goal into a behavioral goal it is useful to ask client to describe what they will be doing differently, when their internal goal is achieved. For example with self esteem, the therapist might inquire about what the client will be doing

differently when her self-esteem is improved. This might be followed with questions about how significant others will also know when the client's self-esteem is improved. In some situations a client will not be able to convert an internal goal into behavioral language. When this occurs scaling questions can be used. For example, the client can be asked to rate their self-esteem on a 1-10 scale now and then indicate what their scale score will be when they are ready to be done with treatment. This is less desirable but does place the goal in a more measurable framework.

The third question establishes the first marker of change. Sometimes clients see change as an either/or proposition. Consequently they will see themselves as either totally better or unchanged. When change begins occurring they may not notice because they have not achieved their ultimate goal. This may interfere with the client's confidence in the treatment experience and undermine the unfolding therapeutic relationship. By asking the client to describe the first sign of change, the therapist subtly reframes the treatment process as incremental. The client can then begin to focus on small changes. This makes the prospect of change less overwhelming and more doable for the client. In a pragmatic way, it also helps the clinician to know if the clinical course of change is proceeding in a way that is positive for the client. If the client is not achieving the first marker of change within the first few sessions then the clinician should consider renegotiating the marker or making a change in the treatment strategy.

Notice that all three questions imply the use of injunctive versus negation language in the way that clients and therapists think about the outcome of treatment. The language of negation involves the words no, not, and don't or what is not desired. A goal for depression based on negation language would be to no longer feel depressed. Injunctive language refers to descriptions of what will replace the problem. For example, if the client is not feeling depressed, then what will be happening instead? A client once stated that he would be flossing his teeth 3 times per week when his depression was beginning to improve. This was an important sign since he noted that poor hygiene was a symptom that he was experiencing as part of his depressed state. It is believed that a clear picture of a desired state is more powerful driver of change than a statement that only describes what is not wanted. Expert clinicians accept goals that are stated in negation terms and then assist the client in converting the negation goal into a goal that describes replacement behaviors. The work of DiClemente (2003) indicates that the identification of replacement behavior is essential to the maintenance phase of recovery from addictive behaviors. It is suggested that this is the case for problems in general.

In sum, the process of goal setting itself can trigger a second-order change for clients. Clients tend to come into therapy with a present-past orientation around their problem. They can see the problem in the here and now and in the past but cannot envision a future without the problem. Mutual goal setting reverses this orientation from present-past to present-future in the desire state. For some clients setting mutual goals with the therapist is actually an intervention that has powerful

change properties. This will be further discussed when hope is addressed later in this section.

b. Empathy

Most behavioral health professionals have had at least some exposure to Carl Rogers and his work on empathy. In this sub-section there will be a definition of empathy, and some nuances that are not always made clear. Data on the relative changing power of empathy will also be presented.

- The most broadly used definition of empathy is that of Carl Rogers (1980) where he defined it as: "…the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference
- The results of general meta-analyses of 47 studies relating empathy to outcome across all sources of ratings reported an effect size between 25% and 32% (Bohart, et al., 2002). This is a significant finding when taking into account the size effect of therapeutic techniques which was earlier cited as 8%. (The size effect of techniques is used as a general measure because when techniques have been compared against each other in meta-analytic studies the effect size has been consistently less than 1 %.)

After this, there is a bit of a departure from Rogers in the research literature. Rogers used reflective listening as a means for conveying empathy. Reflective listening is a process in which the therapist warmly and compassionately reflects feelings and meanings back to the client. Reflecting is done is such a manner that the therapist tries to avoid imparting his or her values on the client. The style of response may be best characterized as nurturing. Clinicians trained in this style of responding to clients may not vary their manner as a warm and nurturing approach may be understood to be universally empathetic. It is here that the literature introduces an important nuance. It turns out that what is viewed as empathic is not universal. In fact, research shows that empathy may be experienced differently by different clients and is best predicted by clients. This means that the warm reflective style of Rogers is one way that empathy can be conveyed. There are other styles that can be equally effective depending upon the unique needs of the client.

- *Client* measures of their experienced empathy predicted outcome the best at 25%, followed closely by *observer* measures at 23%, and finally by *therapist* ratings of their own empathy at 18% (Barrett-Lennard, 1981) Clients thus best judge what is empathic, and when they experience it they are more likely to succeed in therapy

- Clients probably have a different need and capacity for receiving what therapists traditionally view as empathic communication (cf. Beutler et al., 1972; Beutler et al. 1973; Ham, 1987; Henry et al., 1986)
- Several sources suggest that clients who are highly sensitive, suspicious, poorly motivated or reactive to authority tend to do worse with more empathic, involved and accepting therapists (Beutler et al., 1986). Mohr and Woodhouse (2000) found that some clients prefer business like relationships over those judged as warm and empathic

Implications for Supervisors

The clinician's expression of empathy dovetails with the process of establishing mutual goals in the treatment. This aspect of the psychotherapy process is very powerful. Researchers have studied when change usually occurs in the therapy process and have found that it begins early in treatment. In fact, in many cases most change occurs during treatment planning, prior to the administration of any specific change methods. Snyder (Snyder, et. al., 1999) reports that 56% to 71% of outcome variance related to total client change can be accounted for by change that occurs in the early stages of treatment. This phenomenon has been supported further by other researchers (Fennell & Teasdale, 1987; Howard et al., 1993). This evidence, from what is referred to as dose-response research, lends strong support to the power of goal setting, empathy, and engagement as critical variables in effective psychotherapy.

For this reason it is recommended that clinical supervisors pay careful attention to the cases of supervisees in the early going. Although the relationship continues to unfold throughout the course of therapy, lack of progress in the early phase of treatment may indicate a poor fit between client and therapist. If the goodness of fit cannot be improved it may be appropriate to refer the client to another clinician on staff. Since the evidence indicates that empathy is perceived differently by different clients there is no one style of empathy that will fit all clients. Clinicians will be able to connect with more clients if they can alter their empathic styles. A clinician may need to exude more warmth with a client who starts treatment with a strong positive belief in therapy, and be more business-like with a skeptical client. Some clinicians may not be able to be flexible enough to meet a particular client's need for empathic communication. This is when transfer to another clinician that has a different style may be beneficial.

c. Empathy and the Science of Hope

In work that has become legion amongst many clinicians interested in integrative or eclectic psychotherapy, Jerome and Julia Frank (1991) established a linkage between the relationship, intervention, and hope restoration with positive psychotherapy outcomes.

The Franks ‘contended that clients do not actually seek treatment for psychiatric problems per se. Instead they presented evidence that prospective clients wait for considerable lengths of time before they finally decide to contact a therapist. Consequently, when clients seek psychotherapy it is because they have become demoralized from their failed attempts at self-correction. Demoralization is the ultimate condition that psychotherapists treat.

- The reason for the delay in seeking help is that prospective clients are hopeful that if given enough time they will solve their problem on their own. It is when the prospect of solving the problem on their own becomes hopeless that most clients finally seek assistance. Clients often come to therapy in a state of demoralization. Demoralization is defined as a loss of hope.

- As a result of demoralization the client may assume that no one can understand their situation or that they are crazy for having a problem.

- The Franks’ argue further that during periods of demoralization clients become increasingly conservative about making changes. This comes from a fear of a loss of status in their reference important groups.

- A person’s sense of belongingness to reference groups is considered an important aspect of his or her humanity. When we become depressed or anxious or develop other types of behavioral symptoms we fear that if our condition worsens we will lose standing in the groups that we aspire to belong too. A consequence of this fear is that we become more afraid to change our strategies when seeking change. After all, if the change doesn’t work we could become worse off and even more incapable of relating to significant others. (A group can be family, friends, fellow workers, the community at large or even relationships that occur in our minds that come from the print media, radio talk shows, magazines, etc.)

- An additional problem is that we may receive ongoing advice from others about how to resolve our problems and find that their counsel does not work. For example, we may try to will ourselves into a better mood, as others have told us, but find that our condition is growing worse. The result is an increased sense of isolation and alienation. How can we tell others that there well intended advice is making us feel worse? This is a pathway, as stated above, that can lead a person with a behavioral problem to believe that know one can understand his or her problem.

    - It is here that the therapeutic relationship comes to play. Through the relationship the therapist may express empathy for the plight of the client and offer words that show that the therapist does understand. This has the potential for second-order changing power provided that the client has selected the therapist to be a member of his or her reference group.

Implications for Supervisors

For Mental Health or Substance Abuse Services to be effective, the client must view the clinician as an important reference person. When this occurs the client and the therapist form a reference group that the client aspires to be part of. The therapist gains this status through the process of understanding the client's problems and collaborating on goals. The therapist's understanding can reverse assumptions related to "no one can understand the nature of my problem." This is a second-order change that comes from the relationship building aspect of the therapy process and may on its own result in remoralization. The remoralization process involves a mutual but parallel assessment. While the clinician is assessing the client's problems the client is assessing the clinician. The client wants to determine if the clinician is competent enough to address his or her problems. If the client decides affirmatively then he or she will empower the therapist to return empowerment to the client in reciprocal fashion. Once this mutual form of empowerment has been established the therapist's advice becomes very meaningful for the client. Through mutual empowerment the client gains hope that change will occur. Hope makes it possible for the client to stop or reverse the pattern of failed solutions.

Over the years hope has been empirically defined and researched as it applies to psychotherapy outcome. Snyder and colleagues have been on the leading edge of defining and researching hope.

- Hope has been defined as a function of agency and pathways thinking. Agency thinking involves the client's belief that he or she is capable of achieving his or her goal. Pathways' thinking is defined as the client's belief that she or he knows how to achieve a goal (Snyder et al., 1999)

- From this perspective, difficulties in coping are considered a result of being unable to envision a pathway or make movement toward a desired goal (Klinger, 1975; Snyder, 1996; 1998).

An important note is that envisioning a pathway to change and believing that the pathway can be followed may be enough to produce a change even though the client does not actually follow the pathway that has been envisioned. It is not unusual for a client to not follow an assignment or to alter it in some way that the therapist did not intend, and yet come back for a follow-up appointment to report that significant change has occurred. It is believed that this is a function of hope restoration or remoralization.

- When therapists explicitly or implicitly send the message that the client can expect successful change, increases occur in the client's opportunities for critical agency and pathways thinking (Snyder, McDermot, et al., 1996)

- Through the experience of being understood the client may form the assumption that, "Because my therapist understands me, I know she can help me." This can have an immediate and powerful impact on agency and pathways thinking, resulting in a burst of change activity
- Through understanding the problem and establishing mutually agreed upon goals the client's vision of a more desirable future state is crystallized. If the client-therapist generated goal(s) seems reasonable to the client, then hope is born about the possibilities of achieving it. In many cases the client will begin progress toward the goal before the clinician begins working with the client on intervention strategies
- Researchers that have documented this early treatment effect, including Snyder et al, (1996), conclude that the reversal of demoralization to hope is the most parsimonious explanation for why change occurs before formal intervention strategies have been introduced (Goldstein, 1962; Peake & Archer, 1984; Peake & Ball, 1987; Wickramasekera, 1985; Wilkins, 1979; 1985).

Snyder et al., (1999) referring to experiments where change was measured during the assessment process of treatment concluded:

"…such dramatic improvement occurring so early in treatment can hardly be a result of specific effects or interventions because clients have not usually learned the 'active mechanism' for change by the time that improvement occurs in these early stages of treatment (p. 184)."

Implications for Supervisors

Supervisors should be on the look-out for hope restoration when clinicians present cases. Clients do not have to follow assignments to improve as long as the treatment process restores hope of recovery. Clinicians who are preoccupied with treatment compliance may miss change when it occurs. For this reason supervision sessions will be more effective if they center on how the client is doing with his or her presenting problem. It is important that the supervisor emphasize that improvement of the presenting problem is the ultimate goal. If the client believes that he or she can solve the presenting problem and that he or she has a method that will work then treatment will most likely be successful. If the client remains skeptical about the psychotherapy process then hope may not be restored. Compliance with treatment protocols may not be enough to bring about change. Contrarily the client may say, "I have tried everything you have told me to do and nothing works".

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Section 5

Validation and Client Positioning

In this section of the program we will describe the role of validation and therapeutic rationales in the change process. We will also discuss how therapeutic positioning around the client's ambivalence to change is a powerful intervention.

a. Validation

Validation of the client may be understood as a crossover intervention that lays at the intersection of relationship building and intervention strategies. It is related to the concept of empathy. Validation is a therapist-initiated process in which the client's thoughts, feelings, and behaviors are accepted, and considered completely understandable, given the client's subjective experience of the world. The therapist genuinely accepts the client' presentation at face value and holds the belief that the client is doing the best he or she can, the therapist respects the client's experience of the problem by emphasizing its importance, and the therapist empathically offers total justification of the client's experience (Duncan, Solovey, & Rusk, 1992).

Linehan (1993) breaks the process of validation into three steps: (1) active observations of direct communication and public acts as well as intuiting the patient's unstated emotions, thoughts, values, and behaviors, and beliefs; (2) reflection of the patient's feelings thoughts, thoughts, assumptions, and behaviors (3) direct validation in which the "therapist looks for and reflects wisdom or validity of the patient's response, and communicates that the response is understandable…. the patient's feelings, thoughts and

actions make perfect sense in the context of the person's current experience and life to date (p. 424)."

The definition of validation and steps in the process suggests that validation is a directional empathic process. In other words, validation involves understanding the client's perspective in the direction of justifying his or her incorrect assumptions and corresponding actions that drive first-order change. In some cases validation is an intervention that produces second-order change by itself. As stated above, it is not unusual for problems to develop in a manner that the client is inadvertently invalidated by people in his support system. Simply hearing the therapist demonstrate how his symptoms reflect some form of misunderstood inner wisdom can reverse demoralization and produce a second-order change. Here again, the change is at the level of changing the client's belief that his or her problem is so strange, weird, or deviant that know one could possibly understand it.

Some clinicians are troubled by the idea that the validation process involves justification of incorrect premises. A common fear is that such justification is insincere or manipulative, if the therapist truly believes that the client is operating from incorrect premises. For example, some therapists might have difficulty justifying parents who are inconsistent with giving their child consequences for poor behavior. Validation of incorrect premises is genuine, by definition, when the clinician is mindful of the context; that is when the clinician is aware that incorrect premises' are an artifact of the client's circumstances. Parents may be inconsistent with a child because they are worn out from the amount of power struggles that their child engages them in. They may be afraid of their own aggressive impulses if they are forced to follow-through every time that their child misbehaves. When understood this way, it is clear that the parents are literally doing as well as possible under the circumstances. Justifying the difficulty of applying consistent consequences with a challenging child shows understanding for the parents' plight. There is no insincerity or manipulation here.

Another common concern is that justification of a false premise may reinforce it. This fear is quite understandable however, it is important to remember here the directional nature of validation. Starting where the client is at, is a means towards suggesting changes. For example, when a parent is viewed as too harsh, showing understanding for why the parent is this way becomes a first step in the process of asking the parent to experiment with a more positive approach.

c. Rationales

The Franks' indicate that an aspect of therapy that is critical to outcome is providing clients with rationales for their problems and the procedures that will be used to bring about change. This is a component of therapy that is common to all psychotherapy models. (The changing power of rationales will be further discussed later in the program.) Clients for the most part have a need to not only understand the nature of their problem but to feel that they are justified for having the problem in the first place. Therefore, the process of validation is more than affirming a client's goodness as a person. For

treatment to be effective validation must also be built into rationales that both explain the client's dilemma and validate it. For example, an expert clinician who uses a cognitive-behavioral approach to the treatment of anxiety may explain that cognitive thinking errors are responsible for a person's difficulty with managing panic attack symptoms. At the same time the kind of thinking errors that the client is making are common for persons that have panic attacks. The errors are not intentional and are very difficult to avoid under certain circumstances that fit with the client's reports. As you can see, validation is embedded in the rationale. This is common for psychotherapeutic frameworks that have been found to be effective. In essence, the embedded validation provides a graceful way out of self-defeating thinking or behaving. Expert clinicians avoid rationales that invalidate or blame clients. For example, an expert clinician would not tell a client that his or her problem is due to moral weakness or an underlying need to be distressed.

d. Client's Position on Change

From the section on hope above, it is clear that the client's position on change is important to successful treatment. The client's position on change reflects his attitude, beliefs and expectations about if, and how change will occur. The client may be optimistic or pessimistic about change for a variety of reasons. For example, previous treatment experiences that the client has had may affect his or her hopefulness about professional helpers. Similarly, unsupportive experiences with persons representing important reference groups may also impact the prospective client's hope that treatment will be helpful. As has been suggested earlier in this training program, the prospect of change itself creates ambivalence because to change, problem-solvers often must take the risk of abandoning a solution strategy that makes intuitive sense. For this reason, validating the client's perspective on change is yet another level of treatment where validation is critical to success.

e. Change-Don't Change Duality

As stated above, regardless of previous experience with therapists, clients enter into treatment with ambivalence about change. The client knows that she must change to do better but does not know how much change is going to be needed to improve her problem. The problem-solver does not wish to make a dramatic shift because dramatic shifts seem risky. She is therefore caught in a change-don't change duality. The client is trying to change and prevent change at the same time. This is a dialectical dilemma. An analogy is a person who is running downhill. In so doing, the person must both attempt to run and stop himself to slow the pace and not lose control.

In effective therapy the clinician must find a way to validate both sides of the client's ambivalence about changing. Validation of the problem along with mutual goal setting accomplishes this purpose. Validation of the problem symbolically validates don't change and goal consensus symbolically validates change. This is a synthesis. In other words, the therapist is saying, "I both justify your problem and your desire to do better."

“You are free to either stay the same or pursue your goals”. This can be a powerful intervention when persons in the client’s support system are lining up on one side or the other of the change-don’t change duality. In fact, because of the natural tendency to oppose extreme behavior it is unlikely that the client has persons in his social network that are taking such a complex dialectical and affirming position. This means that affirmation of both sides of the client’s ambivalence may be a novel experience and represents a reversal from “either/or” to “and”. The concept of “and” can be understood as the opposite of either/or and so represents a second-order shift. From the client’s perspective the permissiveness that is implied may inspire hope that he or she cannot fail in the context of the therapeutic relationship. Hope releases the pressure that is keeping the client caught in the pattern of failed solutions attempts. Ironically, once the client feels free to change or not change experimentation with new solutions is less serious and so the client becomes more open to trying different approaches.

The Franks’ (1991) transtheoretical contextual model offers another way of understanding the role of validation in the change process. From their perspective, defense mechanisms are developed as a form of self-protection against foreign ideas that could alter a person’s world view. Ordinarily defense mechanisms are adaptive and aid in our ability to experience a stable sense of reality. On the other hand, defense mechanisms can lose their adaptability when change is needed. The defenses that protect can also ward off novel ideas that are needed to make important life changes. From the Franks’ perspective the client’s self-protection system will permit changes if current premises are justified and linked to changed premises in a manner that appears plausible for solving the problem. From this view, the tendency to repeat failed solutions over and again is considered to be related not only to missing an exception to a rule, and losing hope, but also to the self-protective quality of human thinking. Put more simply, as persons we don’t like to be wrong in our thinking and endeavor to protect ourselves when we are confronted with errors in the way that we approach problem solving. The full array of Freudian defenses such as rationalization, intellectualization, and so forth can be construed as elaborate methods by which human beings attempt to protect the correctness of their failed solutions to problems. The need to protect ourselves from criticism throws a monkey wrench into the spokes of change. It is difficult if not impossible to entertain new ideas when we are busy justifying old ones. From this perspective, the process of validation takes on special significance. By conveying that the client is OK for having the problem and OK for desiring change the clinician creates a context where the client can drop his or her natural defensiveness about change. This is what justifies a second-order shift for clients and makes it possible for clients to drop the past and move towards an improved future. The following is a case example, from Fraser and Solovey (2007), which demonstrates this principle.

A client named Sally had a history of physical abuse by her husband. The premise that kept her in the marriage was that Sally believed she could stop the abuse by being a better wife. In response to hearing this aspect of Sally’s story the therapist validated the complexity of Sally’s relationship with her husband. The therapist further indicated that it was understandable how Sally could see it this way. After each outburst from her husband, he would give a qualified apology. This entailed expressing remorse and then

stating that he would try to control his temper if Sally would try harder to meet his needs. As the pattern went, Sally would agree to this arrangement after which the relationship would go smoothly for a while. The period of tranquility was wonderful and Sally's husband was very attentive and gentle during these periods. Sally believed that this made him a "good guy". The honeymoon period would characteristically last until her husband became upset over some minor issue such as Sally forgetting to iron his slacks in a certain way. Sally's husband would then explode while complaining that Sally deliberately slighted him, again. As the therapist continued to respond to Sally, she stated that "although physical confrontations are not acceptable under any circumstances, it makes sense that given the honeymoon period that follows your husband's outbursts, you would think that you can keep the honeymoon going by your own behavior." The therapist ended the session by telling Sally that her decision to stay with her husband or leave is very difficult. The therapist thought that establishing a safety plan might be a better first step rather than trying to solve this question of staying or leaving the marriage, just yet. Through this interaction the therapist both justified the client's assumption and change. The change message came in the form of the statement that the therapist made that physical abuse is not acceptable. Following this intervention Sally came back for a follow-up session and indicated that she had decided to leave her husband. She stated that she had come to realize that there was no justification for abuse and that the pattern of abuse in her marriage needed to be stopped. She was convinced that leaving was the only way to accomplish this.

The assumption that there is no acceptable reason for abuse ran directly counter to Sally's premise that the abuse was her fault and so an important question might be raised. Why would this apparent contradiction of her premise be taken as validation? As stated above, the contradiction was a form of double validation. Other information provided by Sally indicated that at the time she came for therapy Sally was actually seeking help to leave her husband vs. save the marriage. Her premise and corresponding belief system did not provide her with justification for following through on this action. She was struggling with a complex set of assumptions about the nature of her husband and what the abuse meant about him as a person. This is what was keeping her stuck. If her husband was really a good guy, then the abuse was her fault. On the other hand Sally's support group had told her that he was a bad guy and that the abuse was his fault. If this were the case then maybe he was a bad guy masquerading as a good guy. In essence, Sally's attempts to protect her premises were preventing her from taking necessary action. She was in a double bind and so at a standstill. To continue with the premise that she could be a good enough as a wife to meet her husband's needs was to continue the abuse. To accept the premise of her support group would mean that her view of her husband was entirely wrong. No matter which way Sally might turn there was a stinging loss that she would have to endure.

By stating that abuse was not acceptable the therapist separated the abuse from the personhood of her husband. This uncomplicated the conceptual web that was keeping Sally stuck. Resolving marital issues in other ways, than through violence stood out as a justifiable goal. Sally could easily accept the idea that abuse is wrong. She did not really need to judge her husband to make this determination and so this assumption was not too

threatening to her premises about her husband's true nature. She could now be right for seeing the situation as complex and right for not putting up with further abuse. Sally now only needed to gain her husband's commitment to this goal. She further understood that qualified apologies about violence meant that her husband was not ready to commit to stopping the abuse. This then became the justifying link between her former and current thinking. Lisa, Sally's therapist had effectively threaded the needle. The result was that Sally initiated a divorce process based on her own thinking. Additional information from Sally's case indicated that there were points in the divorce process that Sally's husband attempted to reconcile with her. At each of these points her husband maintained his premise albeit in a disguised manner; that everything would be OK if they could only compromise. The compromise would be his trying harder to curb his temper and Sally trying harder to be a better wife. Sally continued to see her husband's offers as a prescription for more abuse and so she followed through with her plan for a divorce. Another question that might be raised is what would have happened if Sally were not seeking justification or validation for leaving her husband? The answer to this question is the therapist would have needed a different approach. The reason the approach worked here was that it fit with this specific situation.

f. Therapist Positioning

While the relationship itself is an intervention therapists do sometimes need to provide advice on alternative strategies that the client might use to improve the problem. The issue then becomes knowing when to advise the client on what to do and when to focus more on building motivation to change. Information that provides a clue to this comes from the change-don't change duality. At the onset of treatment, and throughout the therapy process clinicians need to assess where the client is in the change-don't change duality. Interventions can be made on one of 2 levels. The first level is the problem level. Problem level interventions involve advice about how the client might block or reverse failed solutions patterns. The second level represents interventions that occur at the motivation for change level. Here the emphasis is on changing the client's position on her problem. In some cases a change of position is all that is necessary. In other situations, the client may be ready to request advice on changing the problem once his position has changed. The following more fully describes the process of positioning.

Positioning represents a class of relationship interventions that are variations on validation. Positioning is used to assist clients with making movement in the dialectical change-don't change duality. This duality is best thought of as a continuum versus a static position. Clients enter treatment at varying places along this continuum. Some may be anchored more on the change side while others are anchored on the-don't change side of the continuum. According to the Stages of Change Model (Prochaska & DiClemente, 1992), clients anchored on change side fit the description of the action stage. It's not that these problem-solvers are totally lacking in ambivalence, it is that at this point they are highly motivated and so their ambivalence about changing may not be apparent. In some situations clients in the action stage may begin a second-order shift during the time that transpires between calling for the initial appointment and the first session. It is not

unusual that under these circumstances clients will progress far enough that they only need support to maintain the changes that they are already making. This support will come in the form of validating the change, validating difficulties that the client has overcome to make the change, and validating difficulties that may be yet be to come. Expert clinicians will not offer a change method to clients who are in the process of self-change. To offer a change methodology to a client who is already changing on his own could undermine his confidence in what he has accomplished and unwittingly facilitate a step back into demoralization.

g. Pro-change Position:

Many clients are highly motivated to change but don't know how to accomplish their goal. In response to this client position, the skilled therapist will validate difficulties in making a change and also express optimism that the client will fulfill his therapeutic destiny. This type of response may be referred to as the pro-change therapist position. From this position, the clinician may give assignments that offer opportunities for making second-order shifts.

One of the therapeutic pitfalls with highly motivated clients is that therapists may become so caught up in the client's high motivational level that they miss the need to validate his don't change ambivalent side. The clinician may adopt a cheerleading stance and lose credibility with the client if speed bumps develop in the change process. To protect the therapeutic relationship against such eventualities the seasoned clinician will make statements about change along the lines of, "I am very optimistic that therapy will be a worthwhile experience because you are so motivated to change, yet I am aware that change can at times be very difficult even for persons who are as highly motivated as yourself." This statement emphasizes change while accepting whatever ambivalence the client may have. It creates a win-win proposition for the client. If he changes without difficulty he can surprise the therapist in a very pleasant way. If the client runs into difficulties he won't need to be concerned about losing validation within the client-therapist group. The client is now in a position where he will receive validation either way. This reduces pressure for the client and makes second-order change easier.

h. The Neutral Position:

Some clients come for psychological treatment in a state that is close to the mid-point of the change-don't change continuum. These clients are regarded as highly ambivalent about change. They may be somewhat suspicious of behavioral health providers based on previous experiences or cultural considerations. Highly ambivalent clients may have issues such that a compelling case can be made for either changing or not changing. In these situations expert clinicians are careful about being overly optimistic about the change process since this might actually have the reverse effect of alienating the client. Here, a more neutral stance or position on change will be beneficial. A neutral stance frees the problem solver from expectations that he must change and creates space for the

client to create his own decision. From the neutral position the clinician validates the wisdom that is inherent to both sides of the change-don't change continuum. Because both sides are equally valid, the clinician cannot rightfully know what is best. However, through mutual exploration of the up and downsides of his problem situation, the client will be able to discover his inner wisdom and arrive at his own conclusions about whether change is needed.

Through this exploration the clinician refrains from advocating a pathway that the client should follow. The objective of this therapeutic stance is to convey to the client that he will receive validation whether or not he makes a change. In some situations this therapist position is so powerful that the client will not only decide to change but will also realize that he knows how to create a self-induced second-order shift. In this case, the expert clinician will support the client from a *pro-change position*. On the other hand, after the shift the client may express a need for a change method. This is a green light for the clinician to work with the client on a change method that fits his concerns. In some cases the client will decide that change is not needed. The expert clinician will validate the client's decision to not change at this time and invite the client to come back to therapy if the need arises in the future. It is not uncommon for problem solvers to follow through on this and seek the therapist out again when they are more ready to actively engage in the psychotherapy process.

Multicultural counseling practices (cf. Gonsales et al., 1994; Sue & Lam, 2002) imply another situation where a neutral therapeutic stance is often in order. Clients who are members of non-dominant cultures may be accustomed to members of the dominant culture applying their norms and using their positions of power and privilege in relationships. The multicultural sensitive therapist, who takes the one-down "not-knowing" position of a learner about the clients' perspectives, offers a powerful reversal or second-order shift in the traditional power-up relationship of therapists and clients. This may be a particularly powerful experience for ethnic minority clients or otherwise non-dominant clients who are not accustomed to having their views and positions respected and privileged.

i. The Don't-Change Position:

In very difficult cases problem-solvers may enter psychotherapy with a highly defensive posture. In such situations demoralization has set in and has gotten a foothold on the client. She is experiencing super-ambivalence, she is under great pressure to change but the pressure to not change is greater. She knows she must change and feels that she can't do what is necessary to resolve her problem. In her own mind the forces that are preventing her from changing are too powerful to overcome. This client has reached a point of desperation and that is why she is seeking psychological assistance. Yet despite her desperation she remains resistant to change.

In situations where problem-solvers are resistant to change the expert therapist takes a position that anchors the client's resistance. This position must be taken carefully since clients in a state of resistance are also highly sensitive to invalidation. In practice, the

expert clinician will make statements such as, "I know that it is important that you change, but perhaps this is not the best time given all of the stress that you have been under." Here the therapist is validating both sides of the change continuum, but the emphasis is on not changing. For some therapists this type of therapeutic stance may seem counterintuitive or paradoxical. Beutler, Molerio and Talebi (2002) make it clear that clients' who may appear reactant or resistant to therapy have been demonstrably helped by such paradoxical looking therapeutic relationships (see also meta-analysis by Hampton, 1988; Hill, 1997; and Shoham-Solomon and Rosenthal, 1987.) Likewise, Horvath and Goheen (1990) found that patients with high levels of trait-like resistance improved with "paradoxical" interventions and maintained their gains beyond the period of active treatment. The important point is that when clinicians adopt a "don't change" position in a manner that is respectful of the client's world view, it is not unusual for the client to begin defending change. This creates a reversal of the usual client-therapist roles and a second order shift occurs on this level. The therapist, who is symbolically viewed as an agent of change, promotes reasons for the client to not change. The client on the other hand, becomes the advocate for change. The clinician may introduce intervention approaches from the "don't change position" but she will do so by casting doubt on their utility. She might say, "If you were able to change, I would recommend that you become involved in some daily exercise activities so that there was not so much time to dwell on your problems. But this would be unrealistic given how depressed you are right now." In response the client might come back to the next session and announce that he has just begun a new exercise regimen to help with his depression. Again, role reversals that emerge from the therapeutic "don't change stance" are only helpful when the clinician fully understands the client's needs and aspirations. There must be a logical link in the mind of the clinician that connects the client's need for consensual validation with his goals. The "don't change" position is merely a logical extension of the neutral stance. The client is placed in a win-win situation. He will be validated if he does not change and will ultimately earn the therapist's respect by changing beyond her expectations. In this sense the "paradox" is in the eyes of the describer rather than in the interventions (cf. Fraser, 1987).

In sum, expert clinicians carefully evaluate client position prior to introducing a rationale and intervention approach. When clients are in the don't change or neutral position interventions will be targeted at shifting the client's position vs. changing the presenting problem. Interventions that target client problems will be reserved for clients who are in the pro-change position.

Implications for Supervisors

There are a number of keys from the above to assisting clinicians with difficult cases.

1. The fundamental pattern of change involves a process where the clinician validates the client before suggesting a different problem solving approach. Sequentially, the clinician listens to the problem and validates it before engaging in goal setting or making suggestions on what to do differently. While this sequence

seems obvious it is deceptively easy for the clinician to get the sequence out of order. For example, the clinician may move into goal setting without adequately understanding the problem or may jump too quickly into advising the client on what to do about the problem. These types of errors are very easy to make when a client is desperate or is describing emotionally compelling circumstances. When this occurs the supervisor may have the clinician acknowledge to the client that he or she is feeling a bit lost and so would like to go back and clarify the problem that is of most concern for the client. In this way the clinician can validate the problem and restart the change sequence.

2. Supervisors should listen carefully to the language that the clinician uses when presenting a difficult case. Pejorative language, even in jest, suggests that the clinician may not be comfortable with validating the client. Clinicians may have difficulty placing themselves in the shoes of the client for a wide range of reasons. It is important for supervisors to remember that learning to be non-judgmental is difficult process that unfolds over many years. It can be useful for supervisors to assist clinicians in coming up with multiple charitable views of the client and his or her circumstances. The objective is to inspire curiosity. A curios approach makes it more difficult to be judgmental. In the end, most clinicians become willing to experiment with adopting a more charitable outlook when they discover how much better their clients respond. In difficult cases supervisors should consider conducting conjoint interviews with supervisees to demonstrate non-judgmental approaches.

3. It is important that supervisors assess the rationales that are used by clinicians. The words used are important. Any hint of blaming can interfere with the effectiveness of the treatment. The more difficult the case, the more carefully rationales must be thought through as there is great variance in how people interpret feedback. It should be remembered that a rationale can be technically correct and disempowering for some people. For example, there are some clients that respond well to complex rationales for problems while others respond much better to more simple explanations. A technically correct complex rational may make some clients feel so overwhelmed and subsequently disempowered. On the other hand a simple yet accurate rationale may come across as trivializing the problem.

4. An important aspect of learning to work with difficult cases is determining when to work with the client on changing solution strategies or when to build motivation for change by focusing more directly on the client's change position. The general rule of thumb in effective therapy is to match the client's language. Suggestions for how to change the problem are not likely to be successful when the client describes his or her perspective in ambivalent or skeptical terms. At the same time, the most difficult cases usually involve clients who are in either highly skeptical or ambivalent about changing their problems.

It is important to remember that stances that are usually effective with clients that are anchored on the "don't change" side of the "change-don't change" duality can be very difficult to take, especially if the clinician lacks experience in this area. It is important that lack of skill development in this area not be underestimated. Even highly skilled clinicians may struggle with stances that seem paradoxical, especially in difficult cases. Modeling and role playing are good ways to help clinicians learn this type of relationship matching. It also needs to be emphasized with clinicians, that the positions that they being asked to take are powerful forms of validation. There is no sarcasm involved. Matching the client's position should be done with the utmost respect.

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Section 6

Second-Order Change Strategies

Common Second-Order Intervention Strategies will be described within the context of the therapeutic relationship.

As you can see, because of the power of relationship building the line that separates intervention techniques from relationship is quite blurred. While all interventions involve relationship at some level, there is also a time for prescribing, describing, and giving advice on how to make a problem better. We will now turn to interventions methods as a means of facilitating change.

By now it should be clear that if an intervention method is to be effective it must emanate from the therapist-client relationship. By understanding the client and sharing his aspirations the clinician communicates in a powerful way that she is on his side and wants what he wants. It is the client's sense that the clinician is on her side that makes it possible for the therapist to effectively intervene. This solidifies the client-therapist group. The consensual validation that comes from this group makes the pain of correcting first-order errors worthwhile. As was stated earlier in this program, the first step in intervening involves the client transferring the power of consensual validation to the therapist so that the therapist may in turn validate changes that the client makes in how he is addressing his problem.

The contextual model of Jerome Frank posits that a frequent source of social invalidation is when individuals have troubling emotional experiences that are so complex that they defy explanation, either within one's self or with others. Because we are social beings and meaning makers it is important that we can make sense of our experiences so that we can relate them to others. The loss of the ability to share meaning can result in a person feeling alienated from his significant social groups. He is carrying significant experiences that he cannot explain to himself or others so he cannot be validated for what he is experiencing. This leads to assumptions that he is different from his group. In turn he may think that he is "going crazy" and fall into a demoralized state. From the perspective of Franks' contextual model the ultimate objective of psychotherapy is to restore hope in such individuals.

a. The Rationale or "Myth"

With this in mind, Frank describes a two step process that is crucial to intervening. The therapist first provides an explanation or rationale for the client's symptoms. Then the therapist offers a procedure that is designed to change the way that the client is trying to solve the problem. The rationale and procedure may be based on Western science or be rooted in an ancient ritual or myth. Evidence supports this two-step process as having healing potential whether or not the client carries out the therapeutic task. A logical description of the problem can reverse the client's alienation by restoring his ability to talk about his issues with others. The client's hope in getting better is elevated when the client believes that the procedure will work. This then feeds back to the relationship and increases the therapist's credibility in a virtuous cycle.

The use of the terms "myths" and "rituals" in the same breath with rationales, and procedures may require some further explanation as this may be a controversial confluence of concepts for some. The work of Jerome Frank was meant to be transtheoretical. In this case, the contextual model is not only transtheoretical but is transcultural as well. Since science is highly valued in Western culture we are naturally impressed with rationales and procedures that have a scientific basis. However, not all cultures place the same emphasis on science. Consequently, people from more indigenous cultures may reject scientific explanations for psychological problems and instead embrace mythical rationales and corresponding rituals. Since psychological healers from indigenous cultures have documented success rates that equal results in the West, Frank pays respect to the many different forms of psychological healing with use of this terminology.

Given that varying types of psychological healing are effective throughout the world, and that there are many science-based healing rationales and procedures that work equally well, an important question is raised. That is, to what extent must a rationale and given set of procedures be scientifically valid to be effective? In other words, what happens if through advancements in science-based knowledge we discover that there is little connection between energy release in catharsis and cure? What if it is demonstrated that there is no connection between eye movements in Eye Movement Desensitization Reprocessing and relief of PTSD symptoms? Does this rule these methods out as powerful treatment approaches? The contextual model says no.

From the perspective of the contextual model, powerful treatment methods do not have to be scientifically true to be effective. Instead, rationales must provide an explanation of the client's symptoms in way that makes sense to the client. In other words, the explanation must be plausible to the client and so therefore believable. Since the therapist must be congruent and sincere as part of the relationship building process, the explanation or rationale for symptoms must also be plausible and believable to the therapist. Procedures that are designed to change the client's problem solving approach must be linked to the explanation of symptoms in a way that likewise makes sense to the client and the therapist. In other words, the logical connection between the rationale and procedure must create a belief in the client that the procedure will be effective. Research shows (Wampold, 2001) that therapists must also believe in the efficacy of psychological procedures if they are to be effective. In fact, Wampold's meta-analysis shows that it is

more important for the therapist to believe in her procedure than to perform it in a way that is in perfect conformance with a manual.

Here, the term contextual comes out loud and clear. For rationales, conceptual schemes, and procedures to be effective they must be aligned with the belief system, values and culture of the client. Take for example two chemical engineers who enter treatment for depression. Both are to receive a similar treatment method, however one of the engineers is an atheist and the other has recently converted to Christianity. This difference in religious faith could have a significant effect on how they respond to a science-based rationale and treatment procedure. Even though the Christian engineer is a scientist he may not appreciate a secular framework for understanding and treating his depression. On the other hand, the non-believing engineer would probably not appreciate a therapeutic rationale and treatment framework that emphasizes Christian metaphors. Plausibility and compatibility trump science when offering rationales and procedures.

This should not be taken in any way as a denigration of psychotherapy change frameworks. In fact, Frank lists six important functions of rationales, conceptual frameworks, and procedures in effective psychotherapy. The contextual model indicates that psychotherapy change frameworks combat alienation and demoralization as described above. The idea that the therapist has a method that is developed specifically for the client's problem, and that she conveys confidence in using the framework despite difficulties that may arise in the treatment process, links hope with the client's expectations that he will improve. Another aspect of the treatment process is emotional arousal. Here Frank indicates that for many clients, learning that they can tolerate painful emotional experiences is critical to treatment success and so emotional arousal is another important function. The clinician demonstrates that she can tolerate the client's emotional arousal and so within the bonds of the therapeutic alliance the client discovers that he can manage unpleasant emotions as well. This then leads to the idea of new learning experiences, which is the chief goal of psychotherapy. New learning experiences create opportunities for clients to experiment with alternative solutions in the problem solving process. Because first-order change processes tend to become habitual it is not expected that clients will make one reversal and be forever changed. On the contrary, there is usually a need to practice reversals in different situations to ingrain the change. An important function of psychotherapy change frameworks is that they provide a structure for practicing and maintaining change over time (Wampold, 2001). Once a change has been integrated, the client develops a sense of self-mastery over the problem and so hope is further enhanced. The client now has confidence if the problem should reoccur, he would know how to successfully manage it.

In designing procedures to bring about change there are basic strategies that are found in the literature. The objective of a treatment strategy is to change the client's direction in the problem solving process. As previously stated, if the client is going away from the problem then the strategy will be designed to go towards it. If the client is over-pursuing the problem then a strategy will be designed to assist the client with stopping the pursuit and granting space, and so on. In other words, strategy is about deliberately designing a plan for the client to achieve a second-order shift. The following is a list of second-order strategies that are embedded in psychotherapy frameworks that have empirical support.

You will notice that relationship interventions previously described are included in the list.

b. Blocking/Acceptance

Blocking strategies are defined as approaches designed to stop solutions that are failing to solve a problem. *Blocking* and *acceptance* strategies are found in a number of different empirically supported therapies. An example is psycho-educational approaches where *acceptance* is embedded in the educational framework. Clients are educated about the psychobiology of panic and how it works. The process is natural. The client may have mistaken their reactions for something else, but there is nothing to resolve. This is an *acceptance* strategy. For some clients, this is enough to help them relax. They don't need to use their solutions. Their panic goes away. *Blocking* can also take the form of engaging in behaviors that are mutually exclusive from the solution pattern. Mutually exclusive behaviors stop attempts to solve the problem by getting the problem solver involved with doing something else. Clients may be asked to find those situations that bring on different levels of anxiety and scale them. They are to locate exactly where their body begins to respond, how the response occurs and scale this. They are to keep thought records and note the kinds of thoughts that they are having when they become anxious. They are then asked to examine how true these thoughts and fears might be. Paying attention and scaling symptoms are actions that are mutually exclusive from escape. In following the assignment the problem solver must stay with the symptom to accomplish the task that has been assigned. Staying with the symptom is a subtle way of going towards it.

c. Reversals

Reversals are defined as approaches that are designed to help the client employ solutions that are counter or opposite to the solutions that are being used to solve the problem. For example since avoidance is the theme with a panic-stricken client, the opposite would be strategies that direct the client to go towards her symptom. A reversal for panic might entail asking a client to imagine successively more anxiety provoking situations while maintaining relaxation. Clients may be offered a "be spontaneous" paradox. This entails asking the client to experience anxiety and the sensation of being out of control, in a controlled and deliberate way. Panic symptoms are notorious for occurring spontaneously, they seem to come out of the blue. The problem solver has the experience that she is unable to control her mind. Asking the client to deliberately engage in the symptom is inviting her to perform a naturally occurring experience on purpose. Doing something willfully is the opposite of having it occur involuntarily. This reverses the cycle. Instead of having panic attacks involuntarily the problem solver is now trying to have panic attacks on purpose. Whatever anxiety she can conjure up will be more manageable because she has made it happen by her own choosing. This shift reestablishes the problem solvers confidence in her ability to control her self.

Invariably, in each of the empirically supported approaches to panic a context is created where clients must go toward the symptom. Mastery is gained through the process. The theoretical rationales that support these interventions vary widely. They implicitly share,

however, the common target of intentionally or unintentionally producing second order change.

The use of panic to illustrate the use of reversals is only an example of how this type of strategy is used in effective treatment. Reversals are also used with clients suffering from depressed states. Here the clinician may invite the client to explore depressed feelings more deeply, or see if the client can obsess on a troubling thought on purpose. In marital therapy the therapist may ask a couple to initiate an argument on purpose so that they can work on relapse prevention. Analytically oriented therapists are using a reversal strategy when they tell clients that the immediate goal is not to make the symptom go away but is to understand its origin.

d. Restraining Change

Restraining clients from moving too quickly, or prohibiting them from directly attempting to achieve their desired goal, often produces a second-order shift. This is accomplished through the use of “soft restraints” such as giving the client a directive to go slowly toward their goal, and “hard restraints” which involve either prohibiting a goal-oriented action or offering challenges to clients. A very subtle version of a soft restraint is simply the absence of a directive to change. An example of this might involve a therapist giving a client the homework assignment of thinking about what changes he might want to make in therapy. This assignment does not contain a message that directs the client to change the problem. A harder restraint might involve the therapist giving a prohibition against changing or directly working on the problem. The client might be told that the problem is too complicated and must be understood more completely before even thinking about taking actions. Restraining techniques are based on the rationale that problem solvers often engage in too much self-pressure around change. Pressuring oneself to change builds up strong internal resistance that enhances the likelihood of making errors in the change process. Also, as stated earlier clients seek therapy to change. The expectation is that the therapist is an agent of change. Psychotherapy is essentially a powerful change context. Restraining the problem solver from change takes the pressure of changing the problem off and is a reversal at the psychotherapy context level.

A classic example of a restraint to change intervention is the sensate focus procedure that is used with couples that are experiencing sexual difficulties. With sensate focus the couple is instructed to refrain from having sex while they engage in a series of activities that are designed to increase arousal. The underlying cause of sexual dysfunction that is not physically based is anxiety. As anxiety increases the couple experiences more and more difficulty with sexual intercourse. The prohibition against sexual intercourse relieves this anxiety while the arousing activities increase sexual interest. Interest minus the anxiety allows for nature to take its course.

e. Normalizing

This intervention attempts to put clients at greater ease by contextualizing their difficulties as normal reactions, given the constraints of their situations. This is another variant of a position of *acceptance*. Allowing clients to relax their self-pressured efforts to solve a perceived difficulty, normalizing helps them depathologize themselves and whatever they are struggling with. With normalization the therapist doesn't deny that the client is feeling or acting badly. Instead the client is told that acting or feeling badly is expected under the circumstances. To emphasize this point the therapist might indicate that it is surprising that the client isn't functioning even worse given the set of circumstances that she is facing. The client might be given outside readings; psychoeducation or direct explanations about her condition to further illustrate this point. Reversing the perception of being abnormal can result in a second-order shift.

f. Framing, Reframing, and Deframing

Framing involves placing a person, situation, action, or problem in a particular context. An important aspect of the psychotherapy process is framing or describing the problem(s) that will be worked on. As stated previously, problem solvers often come for therapy in a state of demoralization. Their problem solving efforts have gone awry. They may feel exhausted and thoroughly befuddled. Hope for solving the problem is quickly being lost. When the therapist listens to the concerns a problem solver and feeds them back in a way that she can make sense of what is wrong, loss of hope is reversed. Taking a problem that is confusing or that defies description and defining it in such a way that opportunities for change are apparent is a reversal of the problem at the problem description level. In some cases this is enough of a reversal to support second-order change.

Reframing is the formal name for a class of interventions that involve shifts in the classification of meanings. This type of intervention involves putting a person, situation, action or problem in an alternate but equally sensible and more useful context. In the process of therapeutic reframing the objective is to increase complexity by considering the possibility that there is some unexpected good in a situation that on the surface appears to be all bad. There are generally three ways that reframes are used in effective psychotherapy. (1)Reframes may be used to help the problem solver think differently about a problem. In this use of reframing the clinician is not suggesting either explicitly or implicitly that the client change their behavior although a change in behavior may result in a new way of thinking. For example, a clinician may reframe angry expressions made by family members as a sign that the family is highly invested in one another. This may result in family members behaving in a more compassionate way even though the clinician has not suggested this change. (2) Reframes may be used as rationales for initiating new action in the problem solving process. In other words, reframes may be given along with a directive to do something that is contrary to current problem solving effort. Good reframes make such shifts seem reasonable. (3) A reframe may also be given where new action is implied but not given directly as a homework task. For example persons with social anxiety typically withdraw from social situations because they are afraid of making social miscues. The therapist may reframe social mistakes as necessary

because making such mistakes provides opportunities for social learning. The therapist may then use this new construct as a rationale for suggesting that the client deliberately make social mistakes as part of a homework assignment. On other hand, the therapist could also give such a reframe and ask the client to think about ways that she may make mistakes, on purpose, but not yet act on them. In the former example action based on the new construct is explicit. In the latter example new action is implicit since the logic of the reframe suggests that solutions are opposite of what they seem. At the same time the clinician is restraining the client from employing the solution. Well-formed reframes reverse constructs that support problems and are used to create new or different problem solving efforts. The type of reframe selected will be dependent on the client's position on change, as was previously described.

Deframing may be understood as a class of interventions that is opposite of reframing. Whereas reframing creates new mental constructs by adding levels of complexity, deframing reduces levels or separates classes that have been mixed in ways that are unhelpful to the problem solver. The process of deframing involves deconstruction of the context of a particular frame of reference to eliminate it as the cause of a problem, challenge its absolute reality base, or simply point out that it is a point of view. For example, pharmaceutical companies have had a powerful effect on consumers of mental health services. It is common for persons with serious behavioral disorders such as bi-polar disorder to refer to themselves as suffering from brain chemical imbalances. While on one hand this frame has reduced stigma about taking medicine it may also create a new set of problems. Take the problem solver with bi-polar disorder who has adopted the brain imbalance theory and now relates all shifts in mood, no matter how insignificant, to brain chemistry. Since medicine is what balances the chemistry of the brain it becomes reasonable to assume that any perturbation in mood requires chemical adjustment. This sort of approach may well trigger a cycle of visits to the doctor for increases and shifts in medication. This problem can be further complicated by the fact that the medicines used to treat bi-polar disorder can have unpleasant effects and feed into the cycle. In the end the problem solver may end up on multiple medications at very high dosage levels. The objective of therapy in such situations is to deframe chemical imbalance theory. This might be done by having the problem solver begin to think about the possibility that some changes in mood may be normal fluctuations or expected responses that anyone might have in response to certain stresses. The intent of this deframe is to separate behavior that is "bi-polar" and in need of medicine from behavior that might be best classified in another way. Over time the elements in the bi-polar category are significantly reduced. Since reducing the category is opposite to growing it this represents a second-order change.

g. Positioning

Positioning was discussed more thoroughly in the previous section. To summarize, therapeutic positioning involves taking positions relative to problem solvers that are designed to facilitate change. Therapist positions may include "cautious optimism", "a one down position" where the clinician deemphasizes her authority as an expert, "strategic pessimism" or other position that is counter to the expectation of the client. Here again, the psychotherapy change context comes with certain expectations for how

the therapist should behave. Demonstration of concern and acceptance of the client while behaving in ways that are unexpected can help the client to free himself from a rigid mindset. Take the clinician who works with substance abuse clients. When clients enter treatment with substance abuse concerns they generally expect that the therapist will give them a lecture on the evils of substance. Clinician's that have been trained in Motivational Interviewing (Miller, and Rollnick, 2002) will usually take an unexpected position. They will instead initially focus the therapeutic conversation on how alcohol and or other drugs have been useful in the life of the client. This line of questioning will come from the clinician's acceptance of the difficulties that are inherent in changing addictive behaviors. The clinician will be truly understanding of the idea that the client would not be using alcohol or other drugs if certain of the clients needs were not being met through use. When reversals at this level clients may begin defending the need to change and become more willing to admit to having a problem. When this occurs the clinician needs to support change while continuing to emphasize the difficulties that are involved. Little else in the way of interventions may be needed.

h. Prescribing Symptoms

Prescribing symptoms has a broad use in psychotherapy practice and may be used explicitly or be embedded in particular therapeutic frameworks. Symptom prescription involves asking clients to engage purposefully in some variation of the described problem behaviors. There are generally two types of situations where prescribing the symptom is used. The first is when a symptom or problem behavior is experienced as automatic or "just happening". Such prescriptions make the problem pattern less "automatic" or more in the client's control. As explained earlier explicit examples of symptom prescriptions may be used with anxious or depressed clients where for example, the therapist explains to a client that the first step to controlling a panic attack is learning to have one on purpose. The treatment protocol for Cognitive Behavioral Therapy (CBT) with clients that have phobias provides an example of symptom prescription that is embedded in the treatment protocol. In phobia treatment CBT methodology calls for an extensive assessment prior to initiating the exposure component of the treatment protocol. As part of the assessment the client is asked to enter into situations that create anxiety and measure them on a self-rating scale. The ostensive purpose of this procedure is to develop a hierarchy of phobic fears that will be used when the exposure aspect of the treatment is introduced. From the perspective of second-order change you can easily see that the assessment actually involves a symptom prescription and so is an intervention. This helps to explain the earlier presented research which shows that change primarily occurs early in treatment, before formal interventions are introduced. As it turns out CBT was one of the treatments investigated as part of the dose-response research. In CBT,

The second type of situation where symptom prescriptions are used involves problem solvers who have difficulty forming cooperative relationships with therapists or other authority figures. Some problem solvers are extremely threatened about submitting to the authority of others and behave defiantly in an effort to protect their right to self-determination. In such cases carefully constructed symptom prescriptions can provide the client with a face saving way of changing a problem pattern. In this scenario the problem solver improves by defying the therapist. This use of symptom prescriptions occurs at the

therapeutic alliance level of psychotherapy and reverses the client's efforts to be uncooperative. When symptom prescriptions are used with clients that have special challenges with cooperation, great care must be taken in how the prescription is worded. It is important that the clinician delivers the symptom prescription with compassion and that there is not any hint of sarcasm in her delivery. For example, a clinician may say to a person with an alcohol problem that while conventional wisdom dictates the clinician to advise the client to abstain from alcohol, the client has made an impressive case for why he should continue to drink. Therefore, perhaps the goal of therapy should be to come to accept that the client will continue to drink and to be prepared for whatever consequences that may come along. In this example the symptom prescription is implicit since acceptance means that the client is being directed to keep drinking. Clients who are inclined to be defiant with authority figures may choose to defy the therapist by refusing to accept their problem and to quit drinking instead. On the other hand, if the client follows the clinician's advice he will be cooperating with an authority figure. Through the process of cooperation the clinician might suggest that the client experiment with sobriety to see if it makes a difference in the client's life.

i. Predicting or Prescribing Difficulties or Relapses

Predicting or prescribing difficulties or relapses is a class of interventions used to deflect problem solvers from being discouraged by perceived setbacks or to consolidate gains by reencountering old perceived dangers. For example clients might be warned that first efforts to bring about change might not work as well as expected and that the problem may actually worsen a bit before improvement occurs. Once the problem begins to show improvement the therapist might normalize the possibility of relapse, discuss relapse prevention strategies or even prescribe a relapse so that relapse prevention can be practiced. The sense of relief about making significant changes in a problem can lead to self-pressure about the problem never occurring again. This can lead to a relapse. Relapse preventions strategies are designed to reverse this pressure and reduce the likelihood or severity of a relapse. Predicting or prescribing relapses is a variation on symptom prescription. As with a symptom prescription it is important that the clinician deliver messages that predict or prescribe relapse in a respectful manner.

There may be circumstances in which relapse could spell disaster for the client. This may occur in situations involving addictive behaviors or where morale responsibility is an issue such as an affair. In these situations the clinician will not prescribe or predict a relapse but instead will assist the client in developing a prevention plan. The clinician should also make herself accessible to the client as part of the plan. In the old school of substance abuse treatment stigma was attached to relapse and clients were refused reentry into the program if they relapsed. This was an unfortunate practice and is now discouraged. The more useful approach is to create a context in which clients feel unashamed to come back into treatment if they relapse or feel vulnerable to a relapse.

j. Adopting a Goal-Oriented Future Position

As indicated earlier in the program, when clients come for therapy they are under the influence of their problems. They are locked into a present-past orientation meaning that they can see the problem from present to past and past to present. In a demoralized state

they cannot see beyond the problem to the future when their situation will be better. The state of better may not be conceivable. An important process in psychotherapy is the process of establishing goals. The process of establishing goals involves a reversal from present –past to the future and describes the hoped for condition. This reversal represents another type of second-order change that is inextricably tied to the therapeutic alliance. It is sometimes accounts as the main factor in outcome variance and so should not be underestimated.

Implications for Supervisors

1. The nature of change is that there are a wide range of treatment options that are available for any given problem. When supervising difficult cases it is more important that an intervention targets a pattern of concern to the client then the intervention be from any particular modality. If the intervention is straight from the manual but does not address an important issue for the client than it will not work. For example, a parent may present her main concern as an inability to get her child to go to bed on time. If the clinician fails to address this need and instead attempts to address another issue that is less important to the parent, the intervention is likely to fail.

2. The effectiveness of interventions is based on the sequence of change. The client must feel validated before they will make a shift. If an intervention is not working, it is important to check to see if the clinician has sufficiently validated the client.

3. It is most important that interventions flow from the therapeutic relationship. In effect, interventions may be understood as extending the therapeutic relationship. For example, when understood in context symptom prescriptions may be seen as validating the change-don't change duality. Agreement on goals validates the client's desire to change and prescription of the symptom validates don't change. Paradoxical interventions should not come across as gaming the client out of his or her symptom. If this appears to be the case then the intervention will not work.

4. Clinicians should be prepared when interventions don't work. It is critical that the clinician take responsibility and not become defensive or blame the client. The objective is to maintain rapport because rapport is ultimately the key to change.

5. The client's response to an assignment should be understood as information. If the client fails to do an assignment it means that offering the assignment stimulated the client to come up with her own solutions to the problem or the assignment was not relevant to the client or the clinician misunderstood the client's position on change. It is important that clinician's approach failure to perform therapeutic tasks from a position of curiosity. This will allow the clinician to adjust his approach to best meet the needs of the client.

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Clinical Supervision with Difficult Cases

Post Test Questionnaire

1. When working with difficult cases it is important to:

    a. Work as quickly as possible
    b. Develop an accurate DSM IV diagnosis
    c. Address the biggest problem first
    d. Oppose our internal instinct to immediately correct situations that are spinning out of control, and move in a slow yet confident manner

2. When clients have very serious problems the clinician should:

    a. Gear treatment for the stage of change that the client is in.
    b. Confront the client if he or she is in denial
    c. Move the client to take action on the problem as quickly as possible
    d. none of the above

3. When seeking assistance clients generally:

    a. Have not thought much about their problem
    b. Have preconceived notions about the nature of their problem and how they think it should be solved
    c. May understand their problem in terms that are either overly simple or too complex.
    d. b and c are both correct

4. There is strong evidence in research that shows:

    a. Psychotherapy works for the reasons that are espoused by theoreticians
    b. Psychotherapy works, although probably not for the reasons espoused by theoreticians
    c. The question as to whether therapy works is still being debated
    d. None of the above

5. In psychotherapy research there are:

    a. Multiple warring camps that debate what works
    b. Two main camps, one supporting common factors and the other supporting the therapeutic relationship
    c. Two camps, one supporting the treatment relationship as more important than specific treatment methods and the other values the importance of treatment methods as the ingredient most important to change
    d. Researchers generally agree on what works

6. Wampold's meta-analysis showed that:

a. Non-specific factors including the therapeutic relationship account for 70% of change
b. Specific techniques account for 8% of change
c. Change is a phenomena that is beyond mathematical calculations
d. a and b are both correct

7. This program argues that

a. Non-specific factors are most important with change
b. Specific factors are most important despite meta-analytic findings
c. Both specific and non-specific factors are important
d. It is not important for supervisors to understand the research findings on psychotherapy outcome.

8. The unifying theory of change answers the question:

a. Why is change easy for most people?
b. Why change can be so difficult?
c. Whether third-order or second-order change most important?
d. None of the above

9. The following best describes first-order change

a. First –order change refers to adjustments or shifts that maintain the homeostasis of a system
b. First-order change provides stability and so is often wanted
c. First-order solutions come in opposites and represent the first set of premises that are applied to a problem
d. All the above

10. The following best describes second-order change:

a. It involves a change of a group or system's primary premises, and related rules and interaction patterns. For example, in the case of addiction and the presence of a demand/withdraw cycle, the premise that the addict can be talked out of his or her addictive behavior must be changed

b. It involves stopping or reversing the solutions that are producing unwanted stability

c. This means thinking or doing the opposite of the opposite. For example, with anxiety the opposite solution is to avoid situations that produce anxiety. The opposite of the opposite is to seek out situations that produce anxiety.

d. All of the above

11. Human problems are formed around a process that involves:

a. Repressing ideas that are threatening to the ego
b. Being a member of a dysfunctional family
c. A chemical imbalance in the brain
d. Applying too much or no pressure at all to bring about change

12. True or False There are three basic pathways for developing problems as follows:

(1)The first way is when action is necessary but is not taken.
(2)The second option is when action is taken when it should not be
(3)The third option is when action is taken at the wrong level.

13. True or False A main second-order strategy involves plowing through the problem.

14. True or False The questions given for assessing the pathway of a problem are usually found in most standard intake formats.

15. When setting goals in therapy it is most important that:

a. Goals reflect the therapist's ideas about what is best for the client
b. Goals reflect what the client thinks is best for him or herself
c. Goals reflect a mutual consensus agreement between client and therapist
d. Goals are merely regulatory requirements

16. True or False Goal consensus has been shown by researchers to correlate with empathy

17. True or False When it comes to change a discrepancy between the persons problems and his wants and needs is unimportant.

18. The question, "what will the client be doing differently when his or her goals in therapy have been achieved", is important because:

a. The answer determines the diagnosis
b. The answer sheds light on the client's view of the treatment end point.
c. This not a good question to ask
d. The answer determines the treatment modality of choice

19. Empathy:

a. Is not important in therapy
b. Is a very powerful factor in change
c. Cannot be measured
d. All of the above

20. Most change occurs in treatment

    a. After formal interventions have been introduced
    b. During treatment planning
    c. After treatment has been completed
    d. Most clients don't make significant changes

21. It is important that clinical supervisors begin paying attention to cases in supervision:

    a. In the early going
    b. After the treatment plan has been established
    c. After formal interventions have been delivered
    d. None of the above

22. Most clients enter treatment:

    a. When they are ready to grow
    b. Too late to be helped
    c. When client's self-help methods lead to demoralization
    d. None of the above

23. True or False   Research shows that for mental health or substance abuse services to be helpful the client must view the therapist as an important reference person.

24. True or False   Hope restoration is more important than clients actually following homework assignments

25. True or False   Validation may be understood as a crossover intervention that lays at the intersection of relationship building and intervention strategies.

26. True or False   Validation involves understanding the client's perspective in the direction of justifying his or her incorrect assumptions and corresponding actions that drive first-order change.

27. True or False   Providing clients with rationales for their problems and the procedures that bring about change is unimportant.

28. The client's position on change:

    a. Is important to assess
    b. Is unimportant to change
    c. Is less important than the correct diagnosis
    d. Unknowable

29. True or False   It is important to match where the client is on the change-don't change duality.

30. If a client is skeptical about change the clinician should:

a. Attempt to encourage the client to be more optimistic
b. Dismiss the client due to lack of motivation
c. Talk about change while at the same time matching the client's skepticism
d. None of the above

31. True or False The fundamental pattern of change involves validating the client before suggesting a different problem solving approach.

32. True or False The intervention method is separate from the therapeutic relationship

33. True or False The objective of intervention is to change the client's direction in the problem solving process.

34. True or False Common treatment strategies found in empirically supported treatments include blocking/acceptance, reversals, restraining, normalizing, deframing, and reframing

35. True or False Expert clinicians never prescribe symptoms

36. True or False The clients response to an assignment determines the type of person that he or she is.

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

Signature: ____

HOME STUDY EVALUATION FORM

In the interest of continued improvement, we greatly appreciate your evaluation of this workshop. Please be as specific as possible. Thank you for your assistance.

A: Home Study Workshop: Clinical Supervision With Difficult Cases

B: Date Evaluated: ____

C. What is your overall evaluation of this home study workshop?

1 2 3 4 5 6 7 8 9 10
poor average excellent

D. The material was interesting and informative. It held my interest.

1 2 3 4 5 6 7 8 9 10
strongly disagree — neither agree nor disagree — strongly agree

E. I feel like I learned something useful to my work.

1 2 3 4 5 6 7 8 9 10
strongly disagree — neither agree nor disagree — strongly agree

F. Was the process of using our website, downloading the text and sending in the test easy?

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no OK yes

G. Would you recommend this workshop to a colleague?

1 2 3 4 5 6 7 8 9 10
no Maybe yes

Additional Comments:

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