SAMPLE CHAPTER 7
Involuntary Client Situations
Court-Ordered, Spouse-Ordered, Parent-Ordered

The pages of this Sample Chapter may have slight variations in final published form.
Involuntary Client Situations
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Man is a living creature of varied, multiform, and ever-changing nature.
—Chaldean saying (7th century BC)

People select particular words to reflect their experiences. The words chosen carry with them certain connotations for the speaker. To the extent that as therapists we match our clients’ language, clients typically come to believe that we understand, appreciate, and identify with their subjective experiences.
—William O’Hanlon and Michele Weiner-Davis

It is beyond the scope of this text to discuss the areas of crisis intervention and interventive therapy for persons with psychoses. It is also beyond the purview of this text to discuss persons who are undergoing drug or alcohol rehabilitation programs or who are in batterer’s intervention or sex-offender programs. Many of these areas involving both severity or chronicity require mental health professionals with specialized experience and training in highly focused treatment programs.

Many of these professionals are today’s unsung heroes. They are the dedicated counselors, therapeutic specialists, and practitioners who are relentless in their pursuit of effecting positive change in these highly troubled segments of the population who are in treatment. To a great extent, these difficult fields are understandably avoided by most introductory texts because they treat patients and clients who typically cannot be helped effectively by the more traditional forms of psychotherapy. Clinical severity in many of these cases may often involve brain organicity, neurological damage, body chemistry imbalances, serious substance-related conditions, and exceptionally dysfunctional family backgrounds.

Most introductory textbooks justifiably limit discussion of these difficult areas for many reasons. First, psychiatric interventions may be necessary, and only medical doctors are allowed to perform those protocols. They may involve the prescribing of medications, and most state laws do not allow counselors to dispense medications. However, traditional
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Involuntary Clients act as adjuncts in many of these areas, supplying psychotherapy and maintenance support, working collaboratively with psychiatrists.

Secondly, introductory texts also avoid this difficult area because it would necessarily involve a discussion of the use of specialized training in interventive methods and procedures (i.e., highly specialized protocols not generally employed nor appropriate in the general psychotherapeutic population). For instance, most couples involved in battering situations do not do particularly well in traditional couples therapy. They usually require the use of different approaches under the guidance of specialized therapists to effect a higher rate of therapeutic effectiveness. There are also many patients in this segment of the therapeutic spectrum who have severe mental problems (psychoses) and cannot be immediately helped with traditional forms of therapy. They usually require assistance under supervised conditions at home or in private, community, or state-related facilities.

Several other groups are not covered in introductory texts. Many individuals manage to evade mental health care and fall through the cracks of today’s highly mobile society, often becoming street people, enduring unthinkable kinds of existences. By contrast, other groups of people are in relatively stable transition; for instance, in the process of leaving rehabilitation programs (such as drug rehabilitation centers), rather than returning immediately to mainstream society, they are often placed in halfway houses to insure an easier transition into everyday societal pressures. There are also those patients who regularly visit community-based centers on an outpatient basis for medications, monitoring, evaluations, maintenance, and educational programs. This group may consist of patients, for instance, who have been diagnosed with schizophrenia and who need continued community-based support services, family, and other support systems.

Involuntary Clients and Patients

At the other end of the spectrum of clients (or patients) that includes those briefly mentioned above are those people who come to psychotherapy of their own volition. These are the voluntary clients (or patients). This part of the spectrum is most readily identified as the clients (or patients) who go for “traditional” psychotherapy. However, there is yet another part of the spectrum that remains to be examined, which consists of those individuals who are “asked” or “required” to attend therapy.

For illustrative purposes only, this group has been arbitrarily designated a position on the continuum somewhere between the two extremes, as shown in Figure 7.1. This group has also been identified by varying positions in and around the center to reflect the different possible levels of chronicity, severity, or incapacitation on the one hand and the different levels of client unwillingness to attend therapy on the other. By and large, this in-between

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FIGURE 7.1

chronicity or severely or incapacitated

"asked"
by spouse or parent(s)

voluntary

court-ordered
(involuntary clients)
category of involuntary clients mainly consists of court-ordered individuals, or those ordered (or “asked”) by spouse or significant other, or by parents.

Given the introductory scope of the text, this chapter deals with this in-between population of clients typically including court-ordered clients, spouse-ordered clients, and parent(s)-ordered clients, referred to as **involuntary clients** (Walter Peller, 1992, pp. 247–253).

At the outset, it must be mentioned that in addition to being labeled involuntary clients here, they are typically perceived as being difficult—though, in reality, not necessarily resistant to change. Involuntary clients seem to present difficult situations because they have often experienced to one degree or another a sense of coercion generated by people in their personal lives or by legal agencies. This coercion varies in quality and intensity according to the people involved and the kind of relationship that exists. Types of coercion that may have been imposed upon the client include the threat of jail time, separation, divorce, or fear of parental punitive actions, or, simply, parental fears and concerns. This coercive aspect, usually experienced by the involuntary client, is an issue that should be addressed in the early portion of the therapy session.

**Icebreaker Compliment or Positive Statement**

Generally speaking, when therapy begins with an involuntary client, one tool that is worth employing as a matter of course involves the use of an **icebreaker compliment or positive statement**. The creative use of an appropriate remark in the form of a compliment or some kind of positive statement to the client can go a long way in easing tension in the client. It is considered creative when it requires the counselor to immediately incorporate incidental elements in an appropriate and credible context for a compliment directed at the client; or, it may simply state something positive to set the tone. The contexts for the compliment or the positive statement may include:

- Relating situational factors, such as the client’s attendance or promptness for that day or the client’s care and persistence in filling out the required office forms
- Thanking the client for coming to the session despite environmental factors such as the weather (good or bad) and any other reasonably credible conditions relating to the client.

The icebreaker compliment or positive statement is deemed pre-emptive because the counselor delivers it at the very beginning of the first session. It is poised and intended to make the client feel relaxed and welcomed.

**Examples of Icebreaker Compliments or Positive Statements**

I’d like to thank you for getting here so promptly today. I do appreciate that very much.
I’d like to thank you for taking the time to come in today.
I’d like to thank you for filling out all those forms.
I’d like to thank you for answering all those questions on the forms you filled out.
I’d like to thank you for coming in and giving me the time to go over some things with you.
I’d like to thank you for coming on time today on such a gloomy (or gorgeous) day.
Involuntary Client Schema

Citing original work done by Insoo Kim Berg (1990) together with Eve Lipchik regarding initial approaches in dealing with involuntary clients, Walter and Peller present a useful involuntary client schema that reflects and encapsulates the joint efforts of all four counselors. Their collective work centers on the employment of a specific sequence of questions aimed at overtly clarifying the relationship between the counselor and the involuntary client (or patient) at the outset of the first session (Walter and Peller, 1992, pp. 247–253). The purpose of this schema is to effect a transformation of the mindset of an involuntary client into that of a voluntary client in the sense that the then-converted voluntary client may care to propose a goal which can become the focus of therapy.

Before proceeding with the illustration of the schema, a few conditions warrant consideration. If the therapist does not succeed in negotiating this new mindset with the use of the schema, and if the involuntary client chooses to remain the same (i.e., not establish a goal), and if the series of appointments must be continued because of contractual arrangements (e.g., by the courts or by other agencies), then all the possible consequences (the resulting constraints) will be explained to the client. One possible consequence may involve the fact that future therapy sessions may be terminated by the therapist despite the existence of a contractual agreement with outside agencies (courts). This factor often compels clients to rethink their position.

Even if the client is resistant to change and does not admit to the existence of a problem, there is hope that during the session the client could have a change of heart and may want to discuss the problem and establish a related goal (p. 253).

The schema shown in Figure 7.2 illustrates the basic approach to changing the mindset of clients from an involuntary to a voluntary status. Those questions posed by the therapist make reference to the person or agent who initiated the request (or order) to have the client attend therapy. The initiator may be a spouse, a parent, or a court judge. Walter and Peller’s schema is carried out with involuntary clients in the following manner.

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Our work with them follows this schema:
Whose idea is it that you come here?
What makes ______ think you should come here?
What does ______ want you to be doing differently?
Is this something you want? (Goal frame)

If yes, proceed as with a voluntary client.
If no, ask: Is there something you would like out of coming here?
(�GOal frame )
If yes, proceed as with a voluntary client.
If no, explore the consequences of not coming to sessions.

FIGURE 7.2
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After the client understands the therapist’s clarification of the consequences, Walter and Peller suggest asking the client again “what the referring person expects out of the client coming in for therapy.” If that is not clear, it should be clarified by seeking the specifics. Again, if the client still insists on not abiding by the referring person’s goal, two options remain for the therapist: “say goodbye” to the client or “state conditions for further sessions if continued sessions are required by the court or agency policy” (p. 248).

In a nutshell, this is a flexible and effective general approach that will usually expedite the process of therapy. Like all strategies, there is no guarantee that it will work in all cases. Nonetheless, it is a highly recommended strategy because of the following considerations.

- It allows clients to think seriously about the decision to accommodate or not to accommodate the referring person’s goal.
- It allows clients to consider what they want to get out of coming to therapy.
- It is particularly advisable as an initial approach because regardless of the outcome the client knows the options from the outset.
- There are no hidden agendas, and a sense of collusion between the therapist and outside agencies or family initiators is completely avoided.
- The process can help to pre-empt many unexpected problems from becoming greater problems. Even if the sessions become difficult, the relationship between therapist and client at least had been clarified and the options were plainly spelled out.

By contrast, therapists who attempt to treat involuntary clients as voluntary clients (i.e., like any other client) in the initial session without the use of the schema (as presented by Walter and Peller or by a similar pre-emptive strategy) will most likely find their difficulties intensified in conducting therapy. If such is the case, then the therapist-client relationship in the initial and in forthcoming sessions may prove to be frustrating.

After this initial strategy is employed with the involuntary client, the client may choose to become a voluntary client. If that is the case, then any number of approaches, including those suggested in the prior chapter, are readily available to begin the process of therapy, which would also include discussing the problem and establishing a goal.

Integrative Strategies with Involuntary Clients

Should an involuntary client choose to remain resistant and not opt to discuss the problem openly and possibly set a goal, and the therapist is willing to proceed with therapy, then the following tools, strategies, and techniques are recommended. Although these tools, strategies, and techniques were not specifically designed for involuntary clients, they may be integrated into an overall strategy and will prove to be particularly useful in many instances. Some of these approaches were presented in some prior chapters, whereas some will be new to the reader.

- Utilization strategy
- Dyadic questioning and triadic questioning
- Normalizing
- Deframing
- Positive connotation
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Utilization Strategy

The utilization strategy, discussed in Chapter 2, is worth reexamining in view of involuntary clients. The utilization strategy, one of the most powerful Ericksonian strategies, is based on a simple concept. It involves the therapist learning from the outset as many of the specific strengths and resources the client possesses. This usually means asking clients questions that will evoke positive data. The therapist could then process and integrate those data expeditiously in the early process and possibly accelerate the course of therapy.

Utilization may also include thoroughly exploring certain particulars of the client’s intake form, looking for relevant particulars that, when incorporated in the process, could offer a possible winning combination in an attempt to effectively enter a reluctant client’s cosmos. These particulars involve aspects of the client’s life experience, attitudes, overall strengths and talents such as in the following:

- Work history in a particularly interesting or difficult job
- Interesting profession
- Challenging work experiences
- Hobbies
- Talents
- Interests
- Sense of humor
- Desire for change
- Positive attitudes
- Use of language
- Beliefs
- Intentions
- Narrative abilities
- General experiences.

Because Erickson pragmatically concluded from his studies that patients know (consciously and otherwise) their strengths and resources best, he believed that it was natural for the therapist to utilize those strengths and resources as early as possible, including those...
in the client’s “environmental” areas such as familial and community relationships. In the therapeutic session, Erickson focused on utilizing patient strengths and resources as a matter of course, not as remote theoretical options. Utilization has the immediate advantage of not having to search elsewhere, especially in time-consuming excavational protocols.

**Example of Utilization Strategy**

**Therapist:** I understand that you do artwork. Is that right?

**Client:** Yes. I do portraits at home and also commercial stuff.

**Therapist:** Could you tell me about when you first started?

**Client:** I always drew and doodled as a kid. Then, as a teenager, I discovered I could paint and get paid for it too. So, it's been about 20 years since I've been painting privately and working as a commercial artist.

**Therapist:** What does your wife think about this talent that you possess?

**Client:** She's my biggest fan and, of course, my biggest critic.

**Therapist:** How is she your biggest fan?

**Client:** She supported and encouraged me in some of the lean years when my stuff wasn’t selling and when things were slow and the commercial world gave me the pink slip. She was there whenever things got bad or I began to doubt myself.

**Therapist:** I'm just curious about something. How fast does your wife pick up on things in general?

**Client:** I'd say pretty fast, but it all depends on what you're talking about.

**Therapist:** Does she pick up on how things are going in your life?

**Client:** Yes. She's pretty good at that. Yes, she is.

**Therapist:** Do you have any examples as to when she definitely picked up on something, and it proved to be beneficial to the two of you?

**Client:** I was forced to stop work some years ago, and she picked up that I was prone to depression when things got too stressful for me.

**Therapist:** How did she help you then?

**Client:** Well, at first, I fought her tooth and nail. (pause).

**Therapist:** And, what else?

**Client:** I guess I was stubborn.

**Therapist:** How's that?

**Client:** I thought that depression just couldn't happen to me, and so I fought all the way.

**Therapist:** In what sense, all the way?

**Client:** Denial. I denied all the way to the hospital. Things had gotten so bad that I started to drink. That was something I didn’t usually do. I went
T: What sense do you make of that event in your life?
C: She was right on the money.
T: How did it turn out?
C: I was only in the hospital for a few days. I was diagnosed with depression. Then I was discharged. While I was there, they ran tests. They discovered that I also had a liver disease that I never knew about. If I had continued drinking, I would have been dead a long time ago.
T: Have you had it checked out by your doctor since then?
C: Several times. My liver is doing fine.
T: That sounds like great news. I imagine you must be happy about that.
C: Yes, I am.
T: I understand your wife has some other concerns about you right now. Would you like to talk about them?

Before the preceding dialogue took place, the therapist had perused the client’s paperwork (intake). As in most intake forms, client attitudinal responses to intake questions vary. The answers to specific questions can often be left blank, barely stated or understated, or sometimes even overstated. It is the therapist’s responsibility to read and perhaps utilize any information that may offer the key to unlocking the door to the client’s world.

Prior to the therapy session in the preceding example, the therapist gleaned from the intake form some items that could possibly offer easier access to the client’s cosmos. From these items, the therapist learned that:

- The client had identified himself as a commercial artist.
- He presented depression as the problem.
- He had prior psychiatric care.
- He had been requested by his wife to attend therapy.
- He was married for 15 years.

The therapist mingled these important factors and hypothesized that they could prove to be useful as a means to enter the client’s cosmos as naturally as possible. The therapist attempted this by initially utilizing the client’s talents as they might present an opportunity to both empower the client and join the client from the outset. Once the session had begun, the therapist quickly utilized the apparent strengths possessed by both the client’s wife and himself. These became the context and prelude to discussing the presenting problem.

This example illustrates how utilizing client information in the form of strengths and resources could effect a jump-start in the initial interview of a client who is requested or ordered by the spouse to attend therapy. However, as with any therapeutic attempts at entering the client’s world, they may fail to achieve the desired results, and the therapist must move on to alternative strategies. When such is the case, dyadic and triadic questions may be helpful.
Dyadic and Triadic Questions

Dyadic and triadic questions are clever means of making dialogue possible between therapists and reluctant clients. When involuntary clients hesitate to talk about themselves, the therapists may find dyadic and triadic questioning particularly helpful in gathering data.

Direct questions asked by a therapist to a client are called monadic questions. Monadic denotes the number one (i.e., the client). “What is it like to be in jail?” is a monadic question. A therapist may also ask a client speculative questions such as what another person might think about the client and client situation. Those questions are called dyadic because dyad refers to the number two: the client and someone else. If no headway is made with the use of monadic questions, a dyadic question will often serve as a strategic maneuver to allow the client more psychological space to answer. The dyadic question, “What do you think your wife felt about your being in jail?” involves two people: the client and his wife. In this case, the client will probably be more apt to answer.

Similarly, a triadic question merely adds a third person to the dyad. The triadic question, “What do you think your mother thought about your wife’s view of your being in jail?” involves three people. Strategically, the triadic question often further distances the client from the painful immediacy of the situation by “letting someone else” describe it.

The crucial importance of a dyadic or triadic question lies in the oblique manner a therapist is able to phrase questions. It serves as an indirect route to access client data. While there are no guarantees that clients will respond favorably to dyadic or triadic questions, clients who do not care to answer questions about themselves are more likely to answer questions that are posed from an oblique perspective.

These questions act as a bypass or a detour, cleverly couched and positioned as if the answers are coming from the thoughts and feelings of other people. The client’s voicing of what others might believe and what others might be saying or thinking paradoxically allows the therapist access into the client’s world. In effect, dyadic and triadic questions permit the clients, on the one hand, to hide and partially protect themselves and, on the other, to reveal the nature and quality of their interactive relationships.

Examples of Dyadic Questions

How does your wife feel about your drinking problem?
What do you think are your husband’s feelings about the affair you had?
How does your mother feel about your getting stopped for a DUI?
What does your father think about your being asked to leave college?
What would your favorite hero think about your actions?

Examples of Triadic Questions

What does your mother think about the way your wife feels about your drinking problem?
What would your mother think about your husband’s feelings about your affair?
What does your father think about your mother’s feelings about your getting stopped for a DUI?
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How does your mother feel about your father’s thoughts about your being asked to leave college?
What would your father feel about your favorite hero’s thoughts about your actions?

When a client is responsive to dyadic or triadic questions, the therapist will usually ask more related questions. In this instance, the questions could take the form of an amplification that would yield more in-depth information. Here the therapist is definitely offered an opportunity to explore and learn about the client’s cosmos.

Example of a Dyadic Question Followed by Amplification

**Therapist:** What does your father think about your being asked to leave college?

**Client:** He’s pissed, he’s real pissed at me.

**T:** How did he show that?

**C:** He said that if I didn’t go to therapy, he’d take the car away from me. And the car is under his name. I’m not 18 yet. I won’t be for another seven months. I started college a year early. I was in a special program in high school.

**T:** Wow, so you’re a year ahead of most high school students your age. Could you tell me how you achieved that?

The client in the above scenario had initially been reluctant to talk about himself when the therapist employed monadic questions, but when asked a dyadic question, he responded with little hesitation. Generally speaking, reluctant clients are more apt to answer dyadic questions because they are probably perceived as less troublesome. Surely there are many operative reasons why clients find them easier to respond to, and those reasons vary from person to person. As is often the case, the client most likely found little difficulty acting as “spokesman” for his father’s “thoughts and feelings.”

When dyadic and triadic questions fail to achieve success with involuntary clients, another strategy, normalization, should be considered.

**Normalization**

Normalization is generally defined as a therapist’s use of indirect or direct statements that refer to client problems not necessarily viewed “as pathological manifestations but as ordinary difficulties of life” (O’Hanlon & Weiner-Davis, 1989, p. 93). The goal of this strategy is to pre-emptively depathologize client problems and the client’s view of the problems. However, normalization does not mean that criminal acts are honored, approved, or condoned as being normal. Rather, normalization attempts to reframe client problem situations as being understood as human. The normalization statement also contains the counselor’s implicit acceptance of the client. It recalls Rogers’s sense of respect for the client and the client situation. In conducting psychotherapy with people who have committed criminal acts, normalization occurs when the therapist accepts the ease with which vulnerable people can fall into criminal patterns. It does not mean acceptance of the crimes.
Examples of Indirect Normalizing Statements

When therapists normalize the difficulties clients bring to therapy, clients seem relieved. Imagine the calming effect when the “expert” appears unruffled by your description of the problem. This reaction influences clients to think that perhaps things aren’t as bad as they had thought. This is an area where it is perhaps best to communicate indirectly, by what is not said, by what one remains unruffled about. The most common way we normalize during the session is to say things such as, “Naturally,” “Of course,” “Welcome to the club,” “So what else is new?” and, “That sounds familiar,” when people are reporting things they think are unusual or pathological. (p. 94)

More complicated than the indirect normalization and its typically implicit suggestion of understanding the client situation, normalization can also take the form of a direct statement that may also be expressed as a compliment. Direct normalization usually depends on incorporating material (content) that the client has just related. The direct statement requires more work and creativity on behalf of the therapist. It also has a larger overview, and it can be particularly effective and uplifting to the client when the therapist manages to find the right wording and metaphors to deflate the emotional overlay of pathological fears the client may be experiencing. In reality, normalization is a special form of reframe, a strategy already discussed in Chapter 6. Normalization, in effect, emphasizes human qualities such as one’s vulnerability in experiencing problems in living (O’Hanlon & Beadle, 1997, p. 40).

The reality of the human condition involves experiencing reactions to those life events and situations that are unforeseen or are simply normal transitions in the life cycle. To all losses, to all adjustments and changes, there characteristically ensue conditions that are sometimes difficult and unmanageable. Unfortunately, self-blaming, low self-worth, and poor support systems exacerbate these conditions. However, normalization may often become a first step in lessening the impact of these negative reactions. Normalization can offer recognition (a compliment) of the client’s efforts or persistence in coping with the problem (O’Hanlon & Weiner-Davis, 1989, pp. 99–100).

Examples of Direct Normalizing Statements

- When the two of you tell me that you’re earning just above minimum wage and are working full-time and raising five kids, I can’t help but admire your efforts at stretching the dollar so well.
- Given the fact that you lost everything you owned in the fire last year, I’m moved by your determination to wait it out and do with what little you have right now until you receive the insurance money to rebuild.

Another Example of a Direct Normalizing Statement

Client: We’re having a rough time being a blended family. The kids resent him as my new husband.
Therapist: Maybe you expected there to be instant intimacy or closeness, or you hoped things would gel more quickly. Most people find they have “lumpy” families for quite a while before they get blended (O’Hanlon & Beadle, 1997, p. 40).

More Examples of Direct Normalizing Statements

Client: Since the divorce, the kids have been absolutely rebelling against everything and everybody. And that includes me! I feel as if I’m the captain, and the crew is out to get me.

Therapist: That’s often the case with teenagers when major life changes occur to them. It may mean sitting down and plotting a new course with them.

Client: I really can’t see the sense of doing this anger management thing for the courts when I’ve been this way all of my life. That’s my personality. That’s me! Ever since I can remember I’ve been this way.

Therapist: The fact that you can talk about that experience with such feeling and determination and that you’ve been angry all of your life is the first step on the journey. Welcome to the program.

Normalizing client statements involves the therapist’s respecting and accepting the client and the client situation and acknowledging the client’s humanity and the client’s struggles and frailties. In agreement with Maslow’s philosophy, normalization focuses more on the acceptance of and empathy for human struggles and less on pathology. While normalization downplays the pathological implications of the human situation, there is a corresponding reframing that focuses on acknowledging the individual’s efforts and struggles in dealing with human challenges. Again, normalization is a special kind of reframe, and as with all reframes, it is an attempt to accommodate the client and hopefully join the client sooner.

Deframing

Deframing is a strategy that works hand-in-hand with normalization. Like normalization, deframing is useful in many areas of therapy, but it can be particularly effective with involuntary clients. Deframing is defined as a strategy that introduces uncertainty into the client’s present and past view of things which have not been shown to be useful (O’Hanlon & Beadle, 1997 p. 35). Generally speaking, deframing focuses on the process of deconstructing past or present embedded, nonfunctional beliefs. It begins that process by introducing uncertainty into the therapeutic conversation.

The therapist functions from a position of influence. What a therapist says or does not say in the course of a therapeutic interview influences the client. What is emphasized or ignored also makes a difference. Wording, phrasing, interrupting, or remaining silent: all influence what the client is feeling and thinking in the therapeutic relationship.

In fact, for any given client statement, the therapist has the choice to take that statement in many directions. These choices usually involve—in some way—reifying the...
problem (i.e., lending credence to the fact that there is a problem). Deframing is another option. It works in the opposite direction of reification, and it effectively challenges the existence—or at least the power—of the problem (O’Hanlon & Weiner-Davis, 1989, pp. 52–53).

Because postmodernist therapy views the congruent therapist as forming a system with the client, the therapeutic unity that evolves in that process represents a co-creative effort at finding a solution or dissolution to the problem. And so, it becomes clear that deframing—introducing uncertainty and doubt into the client’s cosmos—can be a powerful tool for influencing the client when dealing with a client’s dysfunctional, useless embedded beliefs.

**Examples of Deframing Questions**

- How do you know that to be so?
- What makes you say that?
- How is that so?
- Where did you get that idea?
- On what basis have you reached that conclusion?
- What do you think is the origin of that belief?
- What is the foundation on which you rest your case?
- Did you ever have any doubts about those thoughts?
- Are you sure that’s accurate?
- What makes you so sure?
- What are the benefits in believing that?
- What influenced you to think along those lines?
- Why would you want to stick with that belief?

**Example of a Deframing Sequence**

**Therapist:** How do you know that having a baby now will make you feel better?
**Client:** It’ll be part of me. It’ll be something I can call my own.
**T:** How is it important for you, right now, to have something you can call your own?
**C:** It’s normal. That’s for sure.
**T:** And what makes you say that?
**C:** It’s all around me.
**T:** What’s all around you?
**C:** Kids.
**T:** I’m sorry. I don’t understand. What does that mean?
**C:** You know. Kids! My mother had 10. Lots of my girlfriends already have one or two.
**T:** And how old are your friends?
**C:** Sixteen.
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T: How is it that they had children at 16?
C: Well, there’s no sense going to school if you’re failing semester after semester.
T: So, they were failing all along?
C: Yes. They were.
T: I understand you’re still attending school. How are you doing in school?
C: Barely hanging in there.
T: Barely? How’s that?
C: I’m passing, but barely passing.
T: What are some things that passing could mean to you?
C: I don’t know. I guess a lot of things: bad and good.
T: Could you describe for me some of the good things?

Deframing can be especially useful in the preceding example because it avoids a possible confrontation with a person who is firmly entrenched in an opposing belief system. It also avoids a certain kind of preachiness that can easily deteriorate the immediate relationship with the client. Deframing, as a deconstructive tool, effectively calls into question the validity of a client’s beliefs and motivations. In most cases, employing logic, for instance, a direct common-sense approach exhorting the teenager to stay in school and not have children, could easily prove to be ineffectual. Dealing with beliefs or belief systems head-on, in this case with an adolescent mindset, not always grounded in long-range perspectives, is usually doomed to failure. Deframing, instead, seems to offer a greater opportunity for success at penetrating a deeply embedded belief by inserting doubt into the client’s mindset.

Deframing is achieved by calling into doubt the client’s beliefs or belief system. Another strategy related to deframing deals with the entire area of what a client may have intended but was not subsequently realized, or was manifested in strange and not easily recognizable ways. Positive connotation, a strategy that is easily overlooked, calls into play the whole area of client intentions, which can yield valuable information.

Positive Connotation

Positive connotation, a term derived from the Milan School, is an approach combining reframing and joining efforts whereby the therapist—after examining the family interactional patterns—asccribes worthy motives and noble intentions to what otherwise might be considered only symptomatic behavior. In contrast to deframing, which actively seeks to deconstruct useless beliefs, positive connotation seeks to reconstruct new possibilities based on prior good intentions that were not realized. In essence, positive connotation deflates the symptomatic dimensions of a problem while focusing on the potential stabilizing prospects of positive intentions, which are sought because they demonstrate a more positive evaluation of family behavior. This tactic serves as a means to enter the family trust at the intentions level, uncharted territory where feuding or alienated family members
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rarely travel. Thus exploring the intentions of family members can make the process of therapy more responsive and effective (Simon, Stierlin, & Wynne, 1985).

Example of Positive Connotation in Referring to a Specific Family Member

An 8-year-old boy stopped doing well in school after the death of his grandfather. He also started talking and acting like a caricature of a little old man. The boy insisted that his grandfather was following him when he took walks with his father. The therapist stated to the boy, “I understand that you considered your grandfather to be the central pillar of your family. Without your grandfather’s presence, you are afraid something would change, so you thought of assuming his role, perhaps because you’re afraid the balance in the family would change” (Sauber et al., 1993, p. 303).

In the preceding example, it is important to note that the symptomatic behavior (i.e., doing poorly in school) is not what is connoted as positive. What is key to understanding positive connotation is the ascribed intent underlying the behavior that is connoted as positive, in that the child’s desire to perpetuate a sense of family stability is personified in the figure of the grandfather. Positive connotation, in effect, deframes the strength and power of the symptomatic behavior by ascribing good intentions as being present behind symptomatic behaviors. Once the deframing is accepted, the therapist may proceed to process, for instance, how the other family members present in the session feel about this perspective, the positive connotation.

Example of a Brief Amplification of a Positive Connotation

Father: At first, the new interpretation struck me as far-fetched: seeing the acting out and doing poorly in school as connected to his desire to see the family remain in balance. I think I could stretch a little and see it as some way fitting into the situation facing the family.

Therapist: How would all of you see it fit?

Mother: Well, I can see it fit very easily. My father-in-law is missed a lot by just about everybody. He was well-liked and loved. And, I guess kids can be pretty complex creatures despite their age. I could see how his acting and pretending to be his grandfather means he misses him a lot and misses all the things he stood for.

T: What could be done?

F: I guess we can talk about my father, include him more in our conversation.

T: What are the kinds of things you’ll be saying?

M: We could say how much we miss him. We can talk about what he might have said or done about things that come up in our lives.

F: We could visit the gravesite more often, bring flowers, and things like that.

For family members troubled by certain familial situations, positive connotation can often act as a catalyst, helping family members to generate new ideas and new ways to handle
problems. Positive connotation has the capacity to do this because it can call into question—as deframing does—uncertain beliefs and perspectives, but it can also serve to remove the negatively charged emotional overlay of symptomatic behaviors. It makes this possible by introducing (within reasonable credibility) the possibility of good intentions on behalf of a client and his or her intentions.

If deframing or positive connotation does not produce some practicable results, then other strategies can be utilized. One such strategy is coping questions.

**Coping Questions**

The strategy of coping questions could be employed in many areas of therapy, but it is particularly useful as a tool with difficult clients. Often clients adamantly decline invitations to speak about the times in the past when exceptions to their problem existed (i.e., periods of time when the problem was not present). They also can be vehemently opposed to any therapeutic plan of action, which can be frustrating for the therapist. One possible source for motivating the client to move forward in the therapeutic conversation is the introduction and use of coping sequences. They are introduced by coping sequence questions.

**Example of the Use of Introductory Coping Questions**

With families that . . . do not respond well . . . I shift gears and mirror their pessimistic stance by asking them: “How come things aren’t worse?”; “What are you and others doing to keep this situation from getting worse?” Once the parents respond with some specific exceptions, I shift gears again and amplify these problem-solving strategies and ask: “How did you come up with that idea!?”; “How did you do that!?”; “What will you have to continue to do to get that to happen more often?” (Selekman, 1993, pp. 65–66)

The employment of a coping sequence involves exploring the problem at its present level of intensity and why the problem has remained at that particular level. In short, why hasn’t it gotten any worse? In explaining how it hasn’t gotten worse, the client usually alludes to something having been done right—even if minimally. It is that kind of minor breakthrough that now allows the therapist to expand on the positive action that is actualized in the problem situation. Potentially, that breakthrough can be a gateway to more positive developments, thus moving the therapeutic conversation forward in search of more solutions toward resolving the problem or toward dissolving the problem.

**Example of a Coping Sequence**

*Therapist:* What brings you here today?

*Client:* Literally, my husband. He’s waiting outside. He’s been insisting I see a therapist.

*T:* How is it that he wants you to seek counseling?

*C:* Because he says I’m pretty much impossible to live with.

*T:* What is the specific nature of the situation that brought you here?
There’s no more communication. We barely speak the way we used to. Sex has become a sprint; there’s no intimacy. We both have difficult jobs with long hours, and barely enough time to do anything.

C: How many years have you been married?
C: Five years. No kids. It’s just the two of us.
C: I see it as starting a year ago.
C: That’s just it. He doesn’t realize there’s a problem with him. Everything is okay by him. Work, work, and save money. That’s it in a nutshell. He started on that kick a year ago. Since then, we’ve done nothing else but that. But he thinks there’s something wrong with me. That’s why he forced me to be here today. He’s got me thinking that I’m going crazy.

T: I’m just very curious as to how come things haven’t gotten any worse?
C: He’s a good provider. He doesn’t run around. He has no vices, and he does love me.
C: So what else is there that has prevented things from getting any worse?
C: Well, we love our home. It’s in a gorgeous neighborhood. Our house should be paid off in about five more years.
C: What else have you been doing so that things aren’t getting worse?
C: Well, two weeks ago, I got him to see a play downtown?
C: Very! It was the first time in ages that we actually spent money to see a play.
C: How did you get him to do that?
C: One evening, when he seemed cheerful, I just sat down with him. I said I really wanted to see this play with him and he agreed. I was shocked. It seemed so easy.
C: So, it seems like something positive has already begun. How did you get that to happen?
C: Well, I told him how important it was for me. It was a play we had seen together when we were dating, and I remembered that it was one of the few musicals he enjoyed. He normally hates musicals.

T: Sounds great. So what other changes do you think you might have started and not have realized until our conversation today?

In the preceding example, the coping sequence questions did their job well. They accounted for the creation of a new therapeutic context that in turn offered the possibility of
a significant shift in direction in which other forgotten or discarded solutions could come to the fore. In addition, other positive conditions could also be pursued. Once coping questions arrive at the level of recognizing patterned improvements, these patterns serve to confute the client’s initially negative script, and the therapist could develop different strategies toward solution to the client problem or toward dissolution of the problem.

As with all strategies, there are no guarantees, and coping sequences are no exception to that rule. When coping sequences do not achieve success, a follow-up strategy of pessimistic questions may help bring the session forward.

**Pessimistic Questions**

The strategy of **pessimistic questions** involves the therapist’s joining the pessimism of the client(s). As a tactic, it allows the therapist to launch questions of a different nature, which might prove to be effective almost immediately in some cases. Strategically, pessimistic questions can be effective in evoking client responses because these questions gain their strength by yielding to an anticipatory sense of worsening client scenarios. In effect, the therapist’s act of joining clients in their worsening situation helps to create a reverse psychology scenario where the therapist—now being one of them, so to speak—is suggesting pre-emptively a kind of hopelessness that, ironically, the client might best handle with some kind of positive activity.

**Example of the Use of Introductory Pessimistic Questions**

Often this line of questioning will enable family members to generate some useful problem-solving and coping strategies to better manage their difficult situation. Typical examples of pessimistic questions are as follows: “What do you think will happen if things don’t get better?”; “And then what?”; “Who will suffer the most?”; “Who will feel the worst?”; “What do you suppose is the smallest thing you could do that might make a slight difference?”; “And what could other family members do?”; “How could you get that to happen a little bit now?” (Selekman, 1993, p. 72)

**Example of a Pessimistic Question Sequence**

**Therapist:** You seem to be telling me that at home things went from bad to worse. If things don’t get better now, what do you think will happen?

**Client:** She’ll pick up and leave. *(pause).*

**T:** And then what?

**C:** It’ll be a real mess then, because she knows I love her. We both had a drug habit, but now she’s clean, but I’m not. *(pause).*

**T:** Who will suffer the most if she leaves?

**C:** I will.

**T:** In what way?

**C:** I don’t want her to leave. I love her too much for her to leave. It’s a cruel world out there. I like her a lot, and she knows that. We had plans
to get married. I want her to be my wife. I’m not looking for other women.

T: And so, what do you suppose is the smallest thing you can do to make things just a little bit better, however slight?

C: I’d say I’d have to go cold turkey.

T: What makes you say that?

C: Because that’s how she did it.

T: And?

C: She’ll expect me to do the same thing.

T: Do you know that for sure?

C: She told me so.

T: How did she go cold turkey?

C: Willpower. She’s a pretty strong person.

T: What do you suppose could be done in your situation?

C: I guess I’d have to ask her for help.

T: In what way?

C: I don’t know. Maybe I can ask her for some ideas.

T: What made you think of asking her for some ideas?

C: I don’t know . . . just an idea I had.

T: It’s not just an idea. It’s a great idea. What made you think of that?

C: Well, she’s resourceful.

T: In what ways do you think she’ll be resourceful when you ask her?

C: Maybe she’ll come up with ways that’ll help me cope with going cold turkey.

T: I bet you know some of those things already.

C: Yeah, I noticed some of the things she did.

The main objective of pessimistic sequences is to assist the individual client, a couple, a family, or anyone in a relationship to come up with new ideas or to recall successful strategies (exceptions) from their respective pasts. Once new ideas or tried-and-tested exceptions from the past are accessed and amplified, they in turn help to generate not only coping skills in the present but also major creative ways to solve problems. That is the essence of pessimistic sequences.

Clients may be so entrenched in their problems that pessimistic sequences and coping sequences have little or no affect on them. In this case, the strategy of problem-tracking sequences can be tried. Problem tracking can be used as a new introductory strategy that serves to discover new contexts by starting at the rock bottom of fundamentals, namely, the interactive patterns (the behaviors) that maintain the problem situation (Selekman, 1993, pp. 76–77).
Problem Tracking

Problem tracking involves tracing past behavioral transactions for the express purpose of noting problem-interaction sequences; however, problem tracking is not an end in itself. The use of problem-tracking interactions goes back to the Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974, pp. 110–115). Postmodern therapy has since adopted the problem-tracking interaction strategy when it becomes necessary to explore past interactive sequences. This strategy is often called into service when clients have difficulty responding openly to basic questions or struggle to piece together the results of prior interviewing sequences. Backtracking to past interactive behaviors that are related to the problem-maintaining patterns can offer notable results. Problem tracking can often serve as a basis for returning to a present or future context for creating solutions or dissolutions.

Examples of Problem-Tracking Questions

“If you were to show me a videotape of how things look when your brother comes home drunk, who confronts him first [asking a sibling of the identified client], your mother or your father?”; “After your mother confronts him, what does your brother do?”; “How does your brother respond?”; “Then what happens?”; “What happens after that?” Ideally the brief therapist will secure a detailed picture from the family members regarding the specific family patterns that have maintained the presenting problem. (Selekman, 1993, pp. 76–77)

In the next example, a consultant was asked for a one-time consultation in an ongoing treatment with a family that suffered from an unyielding problem concerning the children’s “unmanageable, disruptive behavior.” The heart of the consultation interview consisted of about 10 questions, which have been condensed into the following outline.

Example of a Problem-Tracking Sequence

**Therapist:** The children are both equally disruptive, or is one more disruptive than the other?

**Client:** Both equally.

**T:** Disruptive outside the house mostly, or inside, or both?

**C:** Only in the house.

**T:** I see. At any particular time or circumstance?

**C:** During dinner.

**T:** So, what happens?

**C:** Well . . . [Goes on to explain details of escalating disruption.]

**T:** And then who tries to stop this?

**C:** Mother.

**T:** What does she do?
When affect and cognition are difficult to ascertain, problem tracking becomes a key strategy. This helps explain the key role that problem tracking plays especially when dealing with reluctant clients or with clients who present many difficulties.

Figure 7.3 illustrates the topics covered in this chapter thus far.

**Problem Tracking and its Pivotal Position.** In general, when therapeutic strategies do not seem to be working effectively, the strategic use of problem tracking may jump-start the therapeutic process. It may bring to light the problem-maintaining sequences of familial interactions (i.e., negative or unwanted behaviors that perpetuate themselves). However, once those unwanted interactive behaviors are examined in the therapeutic process, the palpable knowledge of their existence may often become the basis for the generation of new kinds of questions that may lead to the successful resolution of the client problem.
Because problem-tracking sequences are often able to overcome client reluctance to engage in dialogue, they acquire pivotal positions from which many other therapeutic strategies may be launched in the resolution of problems.

**Integrative Options**

Once problem tracking has proved to be successful in disarming client reluctance or client resistance (when prior strategies weren’t able to do so), this becomes an opportunity to revisit and utilize prior strategies. While problem tracking is useful by itself (examination of behavioral interactions), it acquires more worth by being a conduit to other strategies and allowing them to perform their functions. Once problem tracking has performed its job, the therapist—in an integrative format—may return any number of strategies.

Figure 7.4 illustrates some of the strategies (sequences) already discussed in this text that would be available after a problem-tracking sequence has taken place.

When the problem-tracking strategy overcomes a roadblock in the process of interviewing, many strategies become available. The therapist has immediate access to a host of strategies, such as the ones discussed in prior chapters (for instance, utilization, dyadic/triadic, normalization, deframing, coping, and pessimistic sequences). In addition, therapists may also employ other prominent strategies such as those listed below.

- Exception-oriented questions
- Miracle question sequence
- Problem dissolution.

Figure 7.5 illustrates some of the aforementioned strategies. The exception-oriented strategy and the miracle question strategy have already been discussed at length in Chapter 6. The problem dissolution strategy is the focal point of the next topic. The problem dissolution strategy seems to be underutilized, yet it constitutes one of the typically important postmodernist strategies.
Integrated Approaches

Problem Dissolution

While therapists may choose the exception-oriented question or the miracle question strategy, there frequently exists a third possibility, problem dissolution. Its resolution is achieved through a dismantling, a deconstruction of the problem, so that in the course of therapy the problem appears to be losing its intensity and becoming a non-issue.

This outcome can and does occur with considerable frequency with postmodernist therapists. Postmodernist perspectives simply allow it to happen, because pathology is downplayed and wellness is emphasized. Integrative therapists O’Hanlon and Weiner-Davis begin “with the assumption that it is possible to negotiate a therapeutic reality that dissolves the idea that there is a ‘problem’” (1989, p. 57). When the therapeutic patterns of questioning offer new opportunities for clients to experience reasonably acceptable alternative perspectives in which their problem dramatically becomes a non-issue, a dissolution has taken place.

The dissolution of the problem takes place because postmodernists regularly employ strategies that include deframing sequences that challenge the clients’ unhelpful certainties (p. 73). These usually deal with present beliefs into which the clients have been recruited, either by others or by themselves. This scenario frequently comes about, for instance, when clients have simply discarded or have forgotten the use of effective tools (strategies) that they had previously used in the past and that have been supplanted by dysfunctional ones. When specifically asked how they had once coped and managed in the past, many clients readily remember and offer effective answers in rapid succession. When this near-miraculous awareness occurs, it has the paradoxical effect of dissolving the reason why they came in the first place on that particular day for counseling. After the problem is viewed as being dissolved, the case is brought to termination.

The following example is a case already discussed in Chapter 6 under the heading of conversational-questions approach. It deals with a 23-year-old single mother who has trouble dating and re-enrolling at her local community college. Also, for years she has been angry with her mother, whom she has viewed as a poor role model, self-indulgent, and unable to hold a man in her life for any significant period of time. What’s more, the process of therapy also reveals that the client has unwittingly established many self-imposed limitations. She had cognitively made a connection to her way of thinking that she was doomed to replicate her mother’s undesirable patterns of behavior. The client attended a total of three sessions.

Example of Problem Dissolution. To reach the client’s immediate goal—to recapture the will to re-enroll at her local community college—the therapist, among other initial queries, engages the client in discussing her relationship with her mother. In the course of therapy, what ultimately evolves is a focus on the client’s dysfunctional belief that with time she will necessarily become like her mother, whom the client depicts as self-centered, vain, and reckless in her unending vortex of serial marriages and self-abusive dating patterns.

Problem dissolution involves the client’s processing the new information emerging from the deframing sequences so that the problem is ultimately dismantled and, in effect, disappears. A beginning therapist might best understand this procedure when it is viewed in many respects as a large deframing process. This involves introducing uncertainties that
challenge the client’s dysfunctional beliefs and past dysfunctional behaviors, and debunks and demystifies them.

Dissolution of the problem is achieved when the client realizes the dysfunctional aspects of her identification process with her mother. As the therapist challenges those damaging beliefs and assists her in deframing her dysfunctional way of thinking, she realizes how she is different from her mother. When the client sees the self-imposed maladaptive identification process in her mind for what it was worth, she is unshackled from the fiction. She has learned to deconstruct her negative, dysfunctional constructs.

When the client eventually reconstructs a new perspective for herself, replacing dysfunctional constructs with healthy realistic ones, the basic problem that brought the client to seek therapy becomes dissolved (a non-issue). Several days after the session, the client phoned the therapist’s office to cancel her next appointment, reporting that she had re-enrolled at her community college.

Figure 7.6 indicates the importance in problem tracking of the three most recently mentioned strategies: exception-oriented and the miracle question (both located in Chapter 6), and problem dissolution (also covered in Chapter 3).

There are times when even problem tracking, for all its many positive and powerful attributes, isn’t effective and alternatives need to be explored. These alternatives include three other major strategies: circular questions, externalization of the problem, and conversational questions. Figure 7.7 illustrates the relationship of these strategies to problem tracking. While all three of these strategies have been discussed in Chapter 6, conversational questions are further developed here.

**Conversational Questions**

Circular questioning and externalization of the problem (two strategies discussed in Chapter 6) can be useful if problem tracking (search for behavioral patterns) has proved to be ineffective. In these instances, circular questions serve as a more intense strategy to elicit fresh information whose focus deals with deciphering the nature of the problem. Similarly, externalization of the problem can assist the therapeutic process by treating the problem in a special way so that it allows the client to speak more freely.
However, if the therapist has not had success with problem tracking sequences, circular questioning, or externalization of the problem, then the therapist may proceed with conversational questions. When clients are reluctant to discuss affect, cognition, and especially behavior (problem tracking), **conversational questions** can become a major strategy. This option has been found to be particularly useful, for instance, with “highly entrenched and traumatized families” and in cases where there are “family secrets” (Selekman, 1993, pp. 77–79).

Conversational questions allow the use of dialogical choices that usually involve returning to eliciting basics, with a postmodernist twist. The questions embody a special therapeutic focus that employs a not-knowing attitude and, similarly, a unique therapeutic focus on posing questions. The strategy is based on a profoundly elemental sense of curiosity as professed by Anderson and Goolishian in the espousal of their conversational approaches that emphasize a high collaborative relationship with the client.

The therapist thereby establishes an open-ended agenda that requires starting from a new beginning. The process is akin to starting at the origin of the client reason for being there and a host of general questions that encourage clients to talk, dialogue, and interact verbally in the session. Nothing is taken for granted. Clients are encouraged to speak freely about their situation, what brought them there, and virtually anything else that is on their minds that seems important at the moment. Despite whatever feelings of discomfort clients may experience on this therapeutic turf, conversational questions as a strategy help create the new conditions for a fresh start.

Conversational questions maintain effectiveness not only because of the engaging attitude of the therapist, but also because of the quality and substance of well-chosen questions. Clients might be asked about what kinds of questions they felt the therapist should have or could have previously asked in the session (but didn’t); or about what kinds of things prior therapists did that could have been done differently or better; or what they did that was totally useless and ineffectual. In all, this strategy constitutes an elemental therapeutic process of entering and expanding the areas of the unsaid or the not-yet-said (Anderson & Goolishian, 1988, p. 381).

This unique process of questioning might be compared to a metaphoric rite of passage. Once therapists are offered privileged access into this once uncharted and inviolable precinct, they may find that it contains a painful family secret, a dilemma that seems uniquely impenetrable to clients, or simply a difficult situation that appears to be not easily discussed at the moment.

The following six conversational questions are examples taken from Selekman’s work. They offer a rich flavor of the kinds of questions that therapists can ask to insure the certainty of this new openness with its unquestionably “non-agenda” agenda condition. From an integrative perspective, it is an all-out approach at loosening up and breaking through familial barriers and through the mountainous accumulation of family members’ failed attempts at dealing with their issues in order to reach family members who now may feel all the more stymied in the throes of therapy.

**Examples of Conversational Questions**

You have seen many therapists. What do you suppose they overlooked or missed with you?
If I were to work with another family just like you, what advice would you give me to help that family out?
Who had the idea in the family to go for therapy?
If there were one question you were hoping I would ask, what would that be?
If there were one issue in this family that has not been talked about yet, what would that be?
Who in the family will have the most difficult time taking about this issue? (Selekman, 1993, p.78)

**Examples of More Conversational Questions**

Who probably had the most difficult time coming here today?
What is one major thing holding everyone back?
What is one major reason for not talking together as a family?
What are some things I should be asking about you?
If you’ve been to other therapists, what are some of the things you didn’t like about the questions they asked or how they asked the questions?
What do you think are some needs that we should discuss first, before moving forward?
What did you like or dislike about your prior therapists?
What people in the family could change things if they had the power?
What people do you trust the most? Why is that so?
What is one small thing that could be changed to help get us started today?

In sum, the use of conversational questions may be a major tool when a client or an entire family is reluctant to speak openly or when the therapeutic dialogue comes to a grinding halt. It is the therapist’s hope that conversational questions such as the ones above will create the new and necessary conditions for a more expanded focus and a continuance of the therapeutic conversation. Whenever breakthroughs occur in this manner, it means that situational issues, family stories, family problems, and family secrets become acceptable topics. This increases the possibility of bringing about therapeutic conversations.

Figure 7.8 indicates three levels of a limited number of strategies that might follow as probable paths after a problem tracking sequence. Level 1 indicates some of the simpler strategies. Level 2 indicates, generally speaking, an increase in difficulty. Level 3 indicates strategies that require more experience of the therapist. It is not an exhaustive list, and it is meant to be a summation in a diagram format of the most recent strategies discussed.

**Scaling Questions and Percentage Questions: An Overview**

Scaling and percentage questions are two powerful strategies that are useful with reluctant clients. They can help not only to obtain valuable client information, but also to set goals and to negotiate change and motivation. Scaling questions and percentage questions do not profess to be scientific measurements. They are designed to evoke client responses, and they are subjective and relative. Yet, their worth is invaluable because they offer a quick means for obtaining the relative values of specific components measured on select continua being examined and explored.
Both kinds of questions (scaling and percentage) may be used in a variety of therapeutic situations. These approaches are all tied in with the clients’ willingness to be open to change. Both scaling and percentage questions were developed and generously employed in de Shazer’s solution-focused therapy in the 1980s and throughout the 1990s (de Shazer, 1985, 1991, 1994). His work and that of his associates (e.g., Berg, 1995a, 1995b) have inspired a significant growth in the use of scaling and percentage questions in solution-oriented models (e.g., O’Hanlon & Weiner-Davis, 1989; Selekman, 1993, pp. 67–72). Collectively, these and other practitioners have since animated therapists both within and without family and systems to embrace these two useful strategies throughout the 1990s and well into the new millennium.

Scaling Questions

Scaling questions involve the use of simple mathematical values employed in a relative way, typically from one to ten. In response to a specific question posed by the therapist, the client ascribes a mathematical value to describe the level of intensity regarding an affect, a behavior, a thought, or any other related query. For instance, a therapist may ask, “On a scale from one to ten, how painful was it for you to come here at the beginning of this session? Ten being no pain, and one being very painful.” If the client answers “Two” to that question, the response implies that coming to therapy must have been a rather painful time for the client. By the same token, that relative value acquires greater importance when the client answers the next question, “How does that pain feel right now?” If the client’s answer is a higher value such as six, then it means that the pain has lessened to a considerable degree relative to the first stated value. The movement from two to six, though admittedly not scientifically accurate, carries high value for the therapist nonetheless, because the client has perceived a significant decrease in pain. This scenario illustrates one major function of scaling as a comparative evaluative tool.

Scaling questions may also serve another major purpose in that they become a negotiating tool with questions that are posed in the form of embedded commands. Instead of comparing values, such as those from the past to those in the present as exemplified in the previous illustration, the negotiating strategy can also compare past (or present) values to future values. In this fashion, the process creates a new (future) condition acting as an embedded command for the client as a negotiating tool. For example, the
therapist might ask, “If the number one stands for a low level of confidence to lose five pounds and ten stands for a high level of confidence to lose five pounds, what was your level of confidence at the beginning of this session?” If the client answers, “three,” it indicates it was a relatively low level of confidence. For the scale to become a negotiating tool, the therapist could then ask, “What would it take to bring your level of confidence up to a four? What needs to happen?” The last two related questions are in essence embedded commands. They are subtly serving, in effect, as a tool for negotiating client change.

The pragmatic design of scaling questions and their aesthetic simplicity are in no small measure responsible for their effectiveness, not only in estimating relative values but also—and more importantly—in exerting motivational leverage on the client. The scaling process entails an inherently important amplification sequence: a process in which clients delineate what they might do to fulfill the embedded command for change.

**Example of a Scaling Question Sequence (Negotiation and Amplification)**

**Therapist:** On a scale of one to ten, one stands for difficult and ten stands for easy. With regard to the difficulties you spoke about in dealing with your children and the separation from your husband, at what number were you last week before you called for an appointment to come for counseling?

**Client:** I was at a two. Barely hanging in there. Though not quite a one yet.

**T:** How did those difficulties feel during the time between the phone call and coming here?

**C:** I’d say about a three.

**T:** So you felt it was already easier before coming to counseling. To what do you attribute that decrease in difficulty?

**C:** I’m not sure, but I’d say I felt a little better knowing I finally did something for myself.

**T:** What do you think you could do this week to go up another half a point?

**C:** I guess there are a few things I could do. I can get myself to work out in the gym.

**Amplification**

**T:** How would that help you?

**C:** I like exercising. Though it’s something I haven’t done in ages. And I know that I nearly always feel better after working out.

**T:** When you come home and feel better, how would that help you?

**C:** I’d have more patience with the kids and I could handle the separation with my husband better.

**Example of a Scaling Question Sequence**

**Therapist:** On a scale of one to ten, ten stands for totally relaxed, and one is very anxious. This question is with regard to the anxious feelings
you had dealing with your stepchildren visiting on weekends. At what number do you feel you’re at today if your stepchildren were to visit this afternoon and stayed overnight as they have done in the past?

Client: I’d say I’d be a two.

T: Is there something you could do to bring it up to a three? (pause).

C: I could pretend that some things won’t bother me as much. I could do that.

T: Have you ever pretended before in your life?

C: Yes. I pretend at work when I see things happening, and I have no control over them.

T: So how has pretending worked for you on the job?

C: It seems to work most of the time. I find that sometimes I have fewer headaches.

T: How do you see pretending being helpful at home when the children come next time?

C: I’ll pretend that my husband will take charge of those things I don’t particularly like to do. I’ll leave most things in his hands, and I’ll pretend not to worry so much especially about the small stuff.

T: Is this something new for you? Pretending when the kids are around?

C: I’ve never tried pretending at home with them around, just at work.

T: What are some specific things you might pretend to do?

C: I guess there are a few things I could do. I could pretend their father is in control even if things get loud. I could pretend I’m hearing classical music instead.

Amplification

T: How would that help you?

C: I like classical music. I used to play the violin years ago. Music relaxes me. It fills me up inside so that I don’t have to scream or yell when the pressure builds up.

T: So what will you be pretending you’re listening to?

C: Probably Mozart. His music is crisp and exact.

T: How would his music help you?

C: It’s the kind of music that doesn’t allow outside things to intrude or interfere. His music is very mathematical, and you have to concentrate to feel it. When I listen to Mozart I feel better. It gives me a kind of clean feeling, and I feel in control of myself.

T: Before we spoke today what might have been your level of confidence in succeeding in these kinds of matters at home with the kids visiting? Ten stood for a lot of confidence and one for little confidence.
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C: In the past, I'd say my level of confidence would have been close to a three.
T: The next time they visit and you pretend, what do you think your level of confidence will be in having success for yourself?
C: I'd guess about a six.
T: That's high. To what do you attribute such a high number for success?
C: Well, the only thing I can go by is my pretending at work. Sometimes, pretending helped me pull through some pretty ugly days at the office.

A classic story illustrating the powerful effects of scaling may be appreciated in de Shazer's repertoire of scaling examples.

We have found that scales can be used with small children, developmentally disabled adults, and even those who tend to be very concrete. That is, anyone who grasps the idea that 10 is in some way(s) "better" than 0 and that 5 on this sort of scale is better than 4 can easily respond to scaling questions.

For example, a cute little eight-year-old child was brought to therapy in the aftermath of having been molested by a stranger in a shopping mall. During session four the therapist drew an arrow between a 0 and a 10 on the blackboard, with 10 standing for the time when therapy was finished. The therapist asked the child to indicate how far she had come in therapy by drawing an "x" on this line. The child drew her x about the 7 mark. She was next asked what she thought it would take to go from x to 10. After several minutes, during which she shifted her weight from side to side, she hit upon an idea and said, "I know what!" "What?" asked the therapist. The little girl replied in a rather somber voice, "We will burn the clothes I was wearing when it happened!" The therapist, amazed at the creative idea, said, "That's a wonderful idea!" Soon after this session, the child and her parents had a ritual burning and then went out to dinner in a fancy restaurant to mark the occasion (the end of therapy). (de Shazer, 1994, pp. 94–95)

Percentage Questions

Although percentage questions have many commonalities with scaling questions, they are inherently different in that percentage questions, as their name implies, must deal with the idea of one hundred. Percentage questions can be useful in many of the same ways as scaling questions, such as include gathering information, goal setting, and measuring progress and motivation. Percentage questions are particularly important because of their ease in establishing double descriptions from the mass of information regarding the problem situation. Once double descriptions (alternate descriptions to the problem situation) are created, they can actively assist in shaping the psychological space that in turn serves as a foundation for problem dissolution or for building solutions.

Example of a Percentage Question with Amplification, Reframe, and Negotiating

Therapist: What percent of the time would you say you feel down?
Client: I'd say it would be about 80 percent of the time.
Establishing a double description—an exception

T: What is it like during the other 20 percent of the time?
C: That’s hard to say. I never really looked at it that way. (pause).
T: What if you imagined yourself at home in your familiar surroundings, what might that 20 percent look like?
C: Well, I’m retired. I have lots of free time. It seems one day goes right into the next. So when I’m depressed, everything seems all gray without definition. I just don’t know. (pause). I guess that 20 percent might be when I’m away from the TV and I’m in the garage. That’s when I don’t think about my depression.
T: And when you’re in the garage, what do you do?
C: I work with wood.

Reframe

T: So, you’re a craftsman, then?
C: I guess you might say that.
T: How long has that been part of your life?
C: I’ve always worked with my hands. I was a machinist for over 30 years. I just discovered working with wood right before I retired. I started it, I dropped it, and then I picked it up again.
T: How much do you enjoy it?
C: Most of the time. I enjoy it quite a bit.
T: Is there anything else you do that gets your mind off things?
C: A little gardening helps a lot.
T: Is there anything else that you haven’t done that you’d like to do?
C: I really need to get out and buy some tools. I also need to get myself some pizza. I’m too lazy to make it myself, and where I live they don’t deliver.

Negotiating an increase in a positive behavior

T: Does this mean that when you increase—just a little bit—your time with woodworking, and do just a little extra gardening, and go out for pizza, you could raise the 20 percent to 25 percent in the coming week?
C: I guess I could.
T: What would it be like when the next time you see me, you moved up to 25 percent?
C: It means that I’ve spent less time feeling in the dumps since my wife passed away.
A further expansion of negotiating an increase in a positive behavior

T: What do you think your wife would tell you if she were here?
C: You mean about going out for pizza?
T: Yes, that, and just about anything else.
C: She'd probably say I need to get off my butt and get with the program.
T: Why do you think she'd say that?
C: She was always an active woman. She worked in church groups, held a job, cleaned up around the house. (pause). Yeah, she'd probably say to get off my fat butt.

The above excerpt illustrates how the therapeutic dialogue can be channeled into a solution direction. In response to a percentage question, the client is often able to separate depressive from nondepressive moments into relative percentage points. Working with the space created by the nondepressive moments, amplification, and a host of other strategies such as embedded commands could expand the dialogue into more liberating scenarios, all starting with small changes that are within the realm of the reasonable and achievable.

Use of Silence

The use of silence as a strategy has been deferred to the end of the chapter because silence as a strategy is usually performed only after most other strategies have failed for one reason or another. The use of silence should not be confused with a pause in the interview process, which is intended to be momentary. The pause serves to give the client time and psychological space to think especially if the therapist’s question involves something painful. Silence, instead, is a strategy that brings the therapist’s questions to a grinding halt. Silence may also be an effective tool at the beginning of the session if conditions warrant it. For instance, if an involuntary client is totally nonresponsive and does not care to communicate at all, then employing silence as a strategy at the beginning of the hour is understandable, though not usually the case.

In dealing with the involuntary client, early options should be presented that include the use of an interviewing schema, such as the one discussed earlier by Walter and Peller, or any other pre-emptive tactic geared to involuntary clients. When all attempts yield little or nothing and the therapist surmises that the client is maintaining a silence even after being made aware of the consequences of not having future sessions, it may be time for the therapist to introduce silence into the interview. Before embarking on extended periods of silence, the therapist should inform the client that, for the time being, silence will prevail only because there has been no real communication, but if the client cares to speak and begin a conversation, that will be welcomed. Once the strategy of silence is implemented, a staring contest will usually ensue.
Part II  •  Integrated Approaches

Three Examples of Preparatory Statements Prior to the Use of Silence

Example 1

Therapist: So far we’ve spent about 30 minutes together, and you’ve said very little. We’ve already discussed the consequences of your not coming to future sessions. Your parole officer or the court may decide to change your status. I’ll remain quiet for a while, and whenever you feel you’d like to say something to get things going, I’ll welcome your remarks.

Example 2

Therapist: So far we’ve spent about 20 minutes together, and you’ve said very little. We’ve already discussed the consequences of your not coming to future sessions. Your spouse may decide to take action that may not please you. I’ll remain quiet for a while, and whenever you feel you’d like to say something to get things moving along, I’ll welcome your remarks.

Example #3

Therapist: So far we’ve spent about 15 minutes together, and you’ve said very little. We’ve already discussed the consequences of your not coming to future sessions. Your parents may decide to take action that may not please you. I’ll remain silent for a while, and whenever you feel like saying something to get things moving along, I’ll welcome your remarks.

Silence can function as a tool to negotiate a new beginning for the client-counselor relationship. By contrast, this chapter, as a whole, invites the beginning counselor to examine a substantially rich foundation of versatile strategies and to utilize them in an effective integrative manner in interviewing involuntary clients. The involuntary client schema, a key protocol to be used at the beginning of the first session with involuntary clients, was specifically designed to minimize possible roadblocks at the outset of the therapeutic process.

While accessing and utilizing effective integrative strategies, it is important to remember that the counselor’s posture (attitude) is a major ingredient in establishing and maintaining a collaborative relationship with the involuntary client. Being able to enter the client cosmos and empathically understand the specifics of the client’s frame of reference, especially client rationales and purported defenses, is one of the major keys to success. The following extract corroborates what many postmodernist proponents have said all along.

The biggest lesson of my 25 years in this work is that when you align with the client’s defenses, you have essentially removed the need for them. And it is only when the clients’ defenses soften—whether they are court-mandated clients or self-referred—that they are able to take the first steps toward looking at themselves, connecting with others and ultimately taking responsibility for their lives. (Borash, 2002, p. 22)
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Study Guide of Key Names, Terms, or Phrases

**voluntary clients:** Individuals who seek and attend psychotherapy of their own volition.

**involuntary clients:** Individuals who attend psychotherapy sessions ordered by the court system (or other legal agencies), by spouse (or significant other), or by parent(s).

**icebreaker compliment or positive statement:** The creative use of an appropriate remark in the form of a pre-emptive compliment or some kind of positive statement to the client.

**involuntary client schema:** A specific technique employed in the early part of a session with an involuntary client to effect a change in the client mindset so that the client thinks more as a voluntary client and less as an involuntary client.

**utilization strategy:** Learning at the outset of therapy as many specific strengths and resources as possible that the client possesses or that are within the client’s environment. Much of this might be obtained from the intake forms as a start, but also from questions posed in the early part of the interview.

**dyadic and triadic questions:** Clever means of making dialogue possible between counselors and reluctant clients when the clients avoid talking about their situations. When no headway is made with a direct question (e.g., “What is it like to be in jail?”), the same question hypothetically viewed from another person’s perspective (a dyadic question) can serve as a strategic maneuver that allows the client more psychological space to answer. For instance, “What do you think your wife felt about your being in jail?” involves two people (i.e., the client and his wife).

The triadic question often serves to further distance the client from the painful immediacy of the situation by “letting someone else” describe it. A triadic question adds another person to the dyad. Thus, the question, “What do you think your mother thought about the way your wife viewed your being in jail?” involves three people.

**normalization:** Indirect or direct statements by the therapist that refer to client problems as not necessarily viewed “as pathological manifestations but as ordinary difficulties of life” (O’Hanlon & Weiner-Davis, 1989, p. 93). This strategy pre-emptively depathologizes client problems. However, normalization does not mean that criminal acts are honored, approved, or condoned as being normal. Rather, it attempts to reframe client problem situations as being understood as human; and the normalization statement contains the therapist’s implicit acceptance of the client. In cases of psychotherapy dealing with criminal activities, normalization means that the therapist understands the ease with which vulnerable people can fall into problems and even criminal patterns. It does not mean acceptance of crimes.

**deframing:** A strategy that introduces uncertainty into the client’s present and past perspectives that have not shown themselves to be useful (O’Hanlon & Beadle, 1997 p. 35). Generally speaking, deframing focuses on the process of deconstructing embedded, nonfunctional beliefs, past or present. It begins that process by introducing uncertainty in the therapeutic conversation. Like normalization, deframing is useful in many areas of therapy, and it can be particularly effective with involuntary clients.

**positive connotation:** A technique combining reframing and joining efforts whereby the therapist—after scrupulously examining the family interactional patterns—ascribes worthy motives and “noble intentions” to what otherwise might be considered only symptomatic behavior. In essence, it is a deframing of the symptomatic dimension. It is based on a family therapy notion that familial behavioral patterns (functional or dysfunctional) are attempts to maintain family balance and cohesion and serve as stabilizers. Positive intentions are sought because they demonstrate how the exploration of possible positive intentions beneath or behind family members’ actions can encourage family members to verbalize new and more positive evaluations of their actions.

**coping questions:** A strategy to explore what has occurred that is responsible for not making things get worse; in other words, how family members have coped with the problem situation so that, at the very least, things are the same and not worse. In explaining how things haven’t gotten worse, the clients usually allude to something being done correctly, even if minimally. It is that kind of minor breakthrough that often allows the therapist to expand upon the positive event that has actualized in the problem situation.
Part II • Integrated Approaches

Potentially, that breakthrough can be a gateway to more positive developments, thus moving the therapeutic conversation forward in search of more solutions toward resolving the problem or toward dissolving the problem.

**Pessimistic Questions**: A strategy wherein the therapist joins the pessimism of the client and creates a new context from which the therapist can launch questions of a different kind that might prove to be more effective than the prior coping questions. Strategically, pessimistic sequence questions can often evoke client response because pessimistic questions gain their strength by yielding to an anticipatory sense of worsening client scenarios. The therapist’s joining clients in their worsening situation helps to create a reverse psychology scenario where the therapist—now one of them, so to speak—suggests pre-emptively a kind of hopelessness that ironically the client might best handle with a positive activity.

**Problem Tracking**: Tracing past behavioral interactions for the express purpose of noting problem-interaction sequences; however, problem tracking is not necessarily an end in itself. This strategy is often called into service when clients have difficulty responding openly to basic questions or when they struggle to piece together the results of prior interviewing sequences. Backtracking to past interactive behaviors relative to problem-maintaining patterns can offer notable results. It can often serve as a basis for returning to a present or future context for creating solutions.

**Problem Dissolution**: The point in the course of therapy when the client readily admits that the problem no longer exists and it becomes apparent that the problem has been dissolved. This positive scenario is usually brought about by the deconstructive efforts of deframing, whose thrust progressively eliminates the original impact of the problem to the point where the problem evolves into a non-issue. This kind of outcome can and does occur with regular frequency among postmodernist therapists, because their strategies and perspectives downplay pathology and emphasize wellness.

**Conversational Questions**: In a sense, a deep return to eliciting basics, and a major resourceful strategy when clients are reluctant to discuss their affect, behavior, and cognition. It has been found to be particularly useful with “highly entrenched and traumatized families” and in cases where there are “family secrets.” It embodies a special tripartite therapeutic focus on employing a not-knowing attitude, a unique therapeutic focus on posing questions based on a profoundly elemental sense of curiosity, and a healthy introduction of uncertainty.

**Scaling Questions**: A strategy using simple mathematical values in a relative way, typically from one to ten, where a client ascribes a mathematical value to describe the level of intensity regarding an affect, a behavior, a thought, or any other related query. For instance, a therapist may ask, “On a range from one to ten, how painful was it for you at the beginning of this session? With one being very painful and ten being no pain whatsoever.” If the client answers, “one” to that question, the response implies that coming to therapy must have been a rather painful time for the client. Scaling questions can also serve as a negotiating tool in which questions are posed in the form of embedded commands.

**Percentage Questions**: Like scaling questions, may be employed as tools for both gathering information and for negotiating conditions for change by posing questions as embedded commands. These include burrowing out double descriptions from the mass of information in the problem situation, measuring progress once a trajectory of progress has been established, negotiating new growth along that trajectory, and goal-setting. The negotiating process expands the possibilities toward building solutions or dissolving the problems.

**Use of Silence**: A strategy that is generally used only after most other strategies have failed for one reason or another. Silence can also be an effective tool at the beginning of a session, if the conditions warrant it. Pre-emptive tactics, such as the involuntary client schema developed by Walter and Peller, are designed to encourage the client to communicate openly, thereby avoiding the therapist’s use of silence. If the use of silence becomes necessary, the therapist should inform the client of the reason and should make it clear that the client is welcome to speak and begin a conversation.
Chapter 7 Exercises

Part I Comprehension Exercise • What This Chapter Is Not About

1. Does this chapter deal with crisis intervention situations? Psychotic patients? Drug and alcohol rehabilitation patients? Batterers intervention or sex-offenders? Why not?
2. What are some other clinically severe situations that typically require psychiatrists or highly specialized and trained counselors?
3. Can counselors dispense prescription medicine in most states of the United States? If not, give some possible reasons.
4. What do you imagine are some of the specific dangers in allowing mental health professionals who are not physicians to dispense prescription medicine?
5. Do counselors, in general, routinely work collaboratively with psychiatrists and other physicians who traditionally dispense medications?
6. Why don’t most introductory texts—such as this one—deal with severely incapacitated patients or clients or those who require highly specialized attention and treatment?

Part II Comprehension Exercise • Involuntary Clients

There are many ways to illustrate the general classification of clients. In this chapter dealing with involuntary clients, one expeditious way involves creating a continuum. At one end, there are the chronically ill or severely incapacitated who require psychiatric attention. At the other end of the spectrum there are voluntary clients, people who decide at one point in time that they want assistance from mental health professionals.

For the sake of simplification, there is a third group, identifiable separate and distinct, called involuntary clients or patients. This group term involuntary clients is useful and convenient, but it does not fully explain the label’s meaning. The members of this group are special and distinct in that they have been “asked” verbally or legally ordered to go for counseling. It is for this special reason that in the continuum they have been located somewhere around the middle.

1. Generally speaking, how are involuntary clients or patients usually perceived as a group?
2. Is that perception generally true?
3. A sense of coercion is understandably one of the attendant feelings experienced by involuntary clients and patients. Name some of the different general categories that contain involuntary clients and patients.
4. Does it make practical sense to discuss in session the nature of the coercion and to what degree the client or the patient may be experiencing a sense of coercion?
5. Does it also make practical sense to talk about it at the beginning of the first session?
6. If so, what might be some of the benefits immediately available to both the client (or patient) and the counselor?

Part III Comprehension Exercise • Icebreaker Compliment or Positive Statement

1. Why would an icebreaker compliment or a positive statement be useful especially with an involuntary client?
2. Why should either choice (the icebreaker compliment or positive statement) be both appropriate and credible with respect to the client?
3. What are two general areas from which icebreaker compliments or positive statements may be easily created?
4. Exercised as one of the earliest strategies in the session, an icebreaker compliment or a positive statement has often been characterized as being pre-emptive. What does that mean?
5. In addition to the ones listed in this text, list four more examples of icebreaker compliments or positive statements.
Part IV Comprehension Exercise • Involuntary Client Schema

1. Who were the four practitioners mentioned in this text who collectively developed the proposed involuntary schema?
2. What is its main purpose besides being facilitative and practical?
3. Why was clarifying the relationship between the counselor and the involuntary client from the outset so important to the creators of this schema?
4. Why is getting the client to propose a goal for the therapy session so important?
5. The schema consists of six or seven basic questions. Does that seem excessive?
6. Is this schema a foolproof method? Why or why not?

7. Why is it generally advisable to employ this method (or a comparable method) as opposed to simply beginning the interview and ignoring the fact that the client is involuntary?
8. Give two specific reasons why this schema or a similar one should be used as a matter of course with involuntary clients or patients.
9. What is the danger in treating an involuntary client as a voluntary client?
10. Even if the client does not react favorably to the schema and initially refuses to offer a tentative goal, is it important that the involuntary schema was at least attempted? Why? Is it possible that the client (patient) may exercise that option and create a goal later in the session?

Part V Comprehension Exercise • The Utilization Strategy with Involuntary Clients (Patients)

The utilization strategy is based on a simple concept. With few exceptions, clients or patients have many past experiences which potentially represent opportunities for discovering positive information, unique circumstances, resources, and generally speaking, avenues for opening up therapeutic conversations. The first place to begin this strategy is to glean data found in the intake form before meeting with the client. This inquiry functions as a starting point from which the counselor will pursue client information during the interview.

The textbook provides a list of different categories of sources, including client (patient) experiences, attitudes, and strengths. That list in not meant to be exhaustive, but to be the beginning of many more possibilities. Using the portion of the text regarding the utilization strategy as a foundation, answer the following questions.

1. Name three or four specific areas not mentioned in the textbook that one might pursue as valuable sources of positive client information and experiences.
2. What if a client has a talent for playing a musical instrument? Create a brief sequence consisting of a minimum of four dialogue exchanges in which the counselor and client discuss the playing of an instrument. What kinds of questions would the counselor ask? Empowering ones? Problem-oriented ones?
3. Suppose the client has a sense of humor. What kind of questions might a counselor ask that utilizes that talent?
4. What if the client has strong religious convictions? How could the counselor utilize those strengths?
5. What if a client demonstrates a strong desire for change in a certain area of his or her life? How would the counselor utilize that?
6. Suppose a client does special work in a health-related facility dealing with children with physical handicaps. What kinds of questions could the counselor ask?
7. Suppose a client demonstrates a great interest in classical music and teaches music in a local high school. What kinds of questions could be asked?
8. What if a client works in an interesting profession, such as doing layout work for a hi-tech furniture designer? How could the counselor utilize that fact even if the counselor knows little about the field?
9. Ironically, how could a counselor’s lack of knowledge about the client’s particular field become a distinctly positive situation regarding the counselor’s ability to create and deliver empowering questions as opposed to mediocre questions?
10. If the client’s experiential landscape serves as a major resource for finding all sorts of positive data, in what way could it be useful for saving therapy time (efficiency) in addition to being immediately relevant?
11. Despite the counselor’s good intentions (such as immersing oneself in client data derived from intake forms), is it possible that information...
Chapter 7 • Involuntary Client Situations

Part VI Comprehension Exercise • Dyadic and Triadic Questions

When someone is specifically asked direct questions about oneself, these kinds of questions are called monadic questions. [Examples: “How do you feel?” “What would you like to talk about?” “Mention one thing you would like to discuss today.”] Monadic questions are normally employed in therapeutic conversations. Yet at times they can prove to be trying and intrusive with some clients and patients, particularly those who are involuntary.

Dyadic and triadic questions are clever strategies that make dialogue possible when clients (patients) hesitate or refuse to engage in dialogue. Particularly useful with involuntary cases, dyadic questions involve two people: the person being interviewed and someone else (who may or may not be present in the session). Correspondingly, triadic questions involve three people: the person interviewed and two other people (who may or may not be present in the session).

1. Generally speaking, why do dyadic questions and triadic questions seem to work when monadic questions often fail?
2. Is the nature of dyadic and triadic questioning oblique or direct? Explain.
3. Why would hesitant clients (or patients) answer a dyadic or triadic question when just a moment earlier they would not answer a monadic one?
4. Do dyadic and triadic questions offer a measure of protection to the client (patient)? If so, how might that work?
5. When answering dyadic and triadic questions, do clients (patients) nonetheless reveal some portions of their interactive world? If so, how is that possible?
6. For the following scenarios of involuntary clients (patients), create first a dyadic question and then a corresponding triadic question.

Example:
A married man (who reportedly drinks excessively) was requested by his wife to go to counseling.

Answer (dyadic): How does your wife feel about your drinking?

Answer (triadic): What are your mother’s thoughts about how your wife feels about your drinking?

• A 21-year-old student, arrested for a DUI, was court-ordered to go to counseling.
• A 16-year-old high school junior, caught with illicit drugs on campus, was requested by his parents to go to counseling.
• A 30-year-old man, having frequent interpersonal disputes with fellow workers, was requested by company owners to go to anger management therapy.
• A 40-year-old male, who lost his high-paying job and is now depressed, was requested by his wife to go to counseling.
• A 25-year-old bulimic woman was requested by her husband to go to counseling.
• A 13-year-old boy who had repeatedly acted promiscuously in public was requested by his parents to go to counseling.

Part VII Comprehension Exercise • Normalization

Normalization is a strategy (a special reframe) that involves diminishing the pathological implications of a problem so that a problem situation is first and foremost viewed as a human event. Normalization neither condones nor approves criminal acts, but does attempt to make an empathic gesture of understanding, acknowledging human frailty and the ease with which one may fall into unlawful activity. In many respects, it comes close to the kind of understanding suggested by Rogers’s unconditional positive regard; but, in addition to being an attitude of respect, normalization is also a special type of reframe.

1. One kind of normalization is indirect. It is characteristically brief and simple, and in general it acts like an icebreaker. The text cites some fairly obvious and common indirect normalizing statements, such as, “naturally,” “of course,” and “that sounds familiar.” These statements are usually responses occurring at a point right after clients or patients initially unburden themselves of the gathered from an intake form and utilized in the interview does not always work favorably? Why?

12. When utilization strategies (such as unearthing client or patient resources) do not work, what options are there, especially when clients (patients) refuse to talk about themselves or offer lukewarm reactions to a counselor’s empowering questions?
problem. It is precisely at these times that a normalization statement is appropriate. Based on the text's examples of indirect normalizing statements, create four similar statements that could serve the same purpose.

2. In addition to indirect normalizing statements, there are also direct normalizing statements. These are typically longer, more complicated, and more engaging, as they incorporate recently disclosed client data. These are typically more challenging for the counselor because they require not only the processing of client data but also the creation of an appropriate normalizing statement that fits the context of the presenting problem. It is a reframe that addresses the problem in a positive way or offers a compliment to the client. Based on the text's example of direct normalizing statements and the following four distinctly different scenarios, create a counselor response in the form of a direct normalizing statement response to each of the client statements.

Client: It’s been a year since my divorce, and I still feel like a fish out of water.

Client: I love my husband, but I’m still angry over the money he lost in a stupid deal that he claimed would make us rich overnight.

Client: I just never thought that I would ever be raped. It happened two years ago. Yet, I feel as if it happened just yesterday. I hate men.

Client: I never thought that being a stepfather would have ever put me in such a terribly hateful situation. They hate me, and there seems to be no way out.

Part VIII Comprehension Exercise • Deframing

Deframing introduces uncertainty in the client’s world with regard to client beliefs and perceptions that have not shown themselves to be useful or beneficial. In essence, it is a strategy whose embedded questions serve to deconstruct (pare down and dismantle) nonfunctional beliefs: past or present. As a strategy, deframing consists of deframing questions and their related deframing sequences in an effort to systematically dismantle and dissolve dysfunctional perceptions and beliefs.

1. Based on the text’s examples of deframing questions, create four original deframing questions. Example:

What makes you so sure about that thought?

2. For each of the following client scenarios, assume that the clients were asked to attend a therapy session. Start with each client statement and create an initial deframing question. Develop a dialogue sequence to show how a therapist might proceed with the process of deframing each scenario. In each scenario, create the appropriate questions to deconstruct client’s dysfunctional beliefs and perceptions. Limit each scenario to three dialogue exchanges. These exercises are meant to be only the beginning of a much longer process, not the conclusion. Refer to the example in the text for developing a deframing sequence.

Client: I guess I’ll never amount to anything—given my lousy parents. My wife says I use that “lousy parents” thing as a convenient excuse.

Therapist:

Client: My husband doesn’t understand that I hate smoking, but I can’t get myself to stop; and, I don’t believe I’ll ever be able to get myself to stop. I know of two people who tried and failed to stop smoking.

Therapist:

Client: I worked all of my life. I’m 66 and retired, and I feel lost without my job.

Therapist:

Client: I’m addicted to Internet pornography and I don’t know how to stop. My wife gave me an ultimatum to clean up my act or face a divorce.

Therapist:

3. Deframing is a powerful tool because it avoids confrontation. How does that work?

4. How is it that traditional logic, common-sense reasoning, and rational approaches often don’t work with clients, yet deframing, using a different kind
Chapter 7 • Involuntary Client Situations

Part IX Comprehension Exercise • Positive Connotation

Positive connotation deals with the world of good intentions. It is a much-overlooked strategy that can often yield valuable information. Positive connotation attempts to reconstruct from client or patient data as to what was intended, but for one reason or another was not fulfilled. The intention (the wished-for change) was thwarted and unable to be realized.

Positive connotation therefore explores those things that might have been. One of the effects of this exploration, especially in couples or family therapy, is that others have the opportunity to learn about these useful unknowns (good intentions). Learning about what another person intended will often have new and refreshing implications that may be woven into the remainder of the therapeutic conversation.

For the following scenario, develop some possible ideas that might have been. One of the effects of this exploration, especially in couples or family therapy, is that others have the opportunity to learn about these useful unknowns (good intentions). Learning about what another person intended will often have new and refreshing implications that may be woven into the remainder of the therapeutic conversation.

Therapeutic Situation
A husband is requested to attend therapy. Husband and wife discuss the marked increase in their arguments and poor communication in the few months preceding. The wife claims that the troubles all began when the husband started a second job. The second job allowed him neither to have dinner with his wife and their two preschoolers nor to spend time reading bedtime stories to the children before they fell asleep.

Task: For the preceding scenario, create only four or five dialogue exchanges. Refer to the example in the text for developing a positive connotation sequence.

Scenario
After 30 minutes of interviewing, the husband and wife are deadlocked. He argues that the household needs more money, and she argues that family time was something she never had as a child with her father, who was rarely around. Now she wants their children to spend more time with their father and, in general, they should be more of a family.

Therapist: (to wife). Could you talk some more about that?

Wife: I always resented my father never being around. It was work, work, work.

Husband: I don’t quite understand how I fit into that situation. He used to drink with his buddies after work. I don’t and never will. You know I don’t drink.

W: I wasn’t implying that you drink. I know you don’t do that sort of thing.

H: Well, as long as you know that when I finish work I come straight home, I don’t see the problem. Granted, I come home tired, but I put in a long day.

W: I don’t doubt for a minute that you work hard. I just want us to spend time together.

H: I can see that’s important to you, but we’re getting closer to putting together a down payment to buy a house. Don’t you want that, or do you want to pay rent forever?

W: I’ve never heard you say that. You never told me about that.

H: That’s been my intention all along. I thought that was clear to you and that you understood. That’s all we ever talked about before we got married. Don’t you remember our conversations about buying a house instead of renting?

Task: Amplify the preceding sequence with four additional dialogue exchanges.

Part X Comprehension Exercise • Coping Questions

Coping questions are employed in many areas of interviewing, but they can be particularly useful with involuntary clients (patients) who have not cared to respond to many of the strategies that were recently illustrated. Because of the unique nature of coping questions, ostensibly encapsulating both empathic and commiserative qualities, paired with an oblique sense of empowerment, coping questions such as, “Why haven’t things
gotten worse?" can often serve as an initiating force, offering new avenues that propel therapeutic conversations forward.

Therapeutic Situation
A teenager is requested to attend psychotherapy with his parents. Since her sixteenth birthday, she has regularly resorted to illicit drugs and drinking. The parents discuss their constant battles with one another about their daughter, an only child. For the past three months, things remained unchanged despite their daughter’s promise to eradicate drugs and drinking—once given the opportunity. With no visible change to speak of, they are at an impasse with her, and blaming has become the apparent mode of communication for all three clients.

So far, after 20 minutes of interviewing and at an apparent deadlock, all three continue to blame each other for the present state of affairs. Each one appears wounded, disappointed, and angered over one another’s attitude and behavior.

Scenario
Therapist: (to all present) We seem to be caught in a stalemate. Yet, there is something that really intrigues me. I’m wondering how things haven’t gotten worse. Do all of you think you can talk about that for a while?

Mother: I’ve always given her everything she could have ever wanted. Many of her girlfriends work after school just to keep up with the latest clothing fads: she doesn’t. She gets all she wants for the asking. Maybe, just maybe, she’s slowly beginning to realize how cushy she has had it all these years.

Father: I think maybe she feels she’s stuck with someone and can’t get out of the situation.

Daughter: I’m not stuck with anyone. I just like my friends. I don’t have brothers or sisters. Sometimes I just need to talk to someone.

M: Well, why can’t that someone be me? I’m not an ogre. I was a teenager once, too.

Task: Amplify the preceding scenario with four or more dialogue exchanges.

Part XI Comprehension Exercise • Pessimistic Questions

When coping questions fail to open doors, the pessimistic questions strategy can be used. Unlike coping questions, the counselor uses pessimistic questions to join in the client’s pessimism. Suddenly, the client who has systematically resisted speaking of positive exceptions in presenting the problem begins to feel that even the counselor has yielded to the severity of the situation and that in effect there appears to be no way out of this dismal situation. The new position created by the pessimistic strategy may ironically offer the counselor fresh opportunities to direct questions from a different angle.

The different angle was realized by the counselor’s joining the client and participating in an anticipatory sense of worsening scenarios for the client. Paradoxically, this will often evoke in the client a reverse psychology effect in that the client will be compelled to look for positives. While this is not always the case, the phenomenon occurs frequently enough and it is worth employing. The typical pessimistic question, “What do you think will happen if things don’t get better?” is the opening question to the pessimistic question sequence that usually ensues.

Therapeutic Situation
The court orders a 25-year-old man to attend anger management therapy. He comes from a family of four male siblings, two of whom have done jail time in the past. He has a poor history of work experience and a history of drugs and drinking. He has just completed three months of jail time for assault.

So far, after 20 minutes of interviewing, the client appears defensive and generally impenetrable, offering little in the way of exceptions in a problem-saturated past. Quick to defend his ways, replete with excuses for all of his problems, he avoids considering any discussion of his coping abilities or talents. In response to the client’s adamant defensiveness, the counselor poses a pessimistic question.

Scenario
Therapist: I think I’m beginning to understand more about the troubles you’ve encountered in your life. What do you think will happen if things don’t get better?

Client: I really don’t know. (long pause).

T: If they get any worse, where do you think you’ll be?

C: I’m not sure. Maybe in jail again.

T: It sounds like a tough option.

C: I know. I hate the damn place.

T: You’re right: it’s not a great place to visit.

C: Two of my brothers did some time a while ago. One ended up going back, but the other one didn’t.
Part XII Comprehension Exercise • Problem-Tracking Questions

Clients may be so entrenched in their problem situation that a coping question or a pessimistic question strategy will have little impact. When this is the situation, problem-tracking strategies may be useful, in a sense the bedrock of interviewing fundamentals. Problem tracking is characterized by examining the problem from the vantage point of interactive patterns that seem to sustain the problem behaviors, which seem to maintain the problem situation and its recurrence, and deal with the following relationships: who does what to whom, what happens, how does everyone react or not react to what happens, who is affected, to what degree, and who isn’t affected by what happens. In short, problem tracking involves a determined effort to understand the problem from an interactional point of view. This recently acquired knowledge dealing with problem-related patterns then goes on to serve as a new foundation for considering other available options that did not seem possible before the problem-tracking strategy.

Therapeutic Situation

A husband is requested to attend therapy or face separation. He and his wife have three children: Bobby is 5, Jamie is 7, and Melissa is 10. His wife is concerned about the traumatic effects her husband regularly conveys to the children when he comes home drunk on Friday nights after drinking with his friends from work.

The therapist decides to employ the problem-tracking strategy as the initial strategy to gather interactional information. After barely a few minutes of joining, the family members are asked what it is like when Dad comes home with the problem situation.

Scenario

Therapist: I’d like to discuss what all of you do on Friday night when Dad comes home.

Wife: I worry and I show my worry by being protective of the kids. I try to keep them away from my husband.

Task: For the preceding scenario, develop some possible ideas that might evolve when the counselor employs a pessimistic question strategy after encountering no success with a coping question strategy. Create four or five dialogue exchanges. Refer to the example in the text for developing a pessimistic question sequence.

Part XIII Comprehension Exercise • Integrative Options

1. Aside from the fact that problem tracking as a strategy deals basically with behaviors, why is it also considered to be one of the most pivotal strategies?

2. Once a problem-tracking sequence has been processed, may one return (in an integrative sense) to most of the strategies such as utilization, dyadic
and triadic questions, normalization, coping questions, and pessimistic questions? If so, why?
3. Can one return to any one of the seven strategies discussed and developed in Chapter 6, such as reframing, exception-oriented questions, circular questioning, the miracle question, externalization of the problem, relative influence questioning, and conversational questions? If so, why is this possible?
4. Even if problem tracking has not been processed completely and there is a sufficient amount of behavioral data available because of the problem tracking, may one go directly to other strategies? If so, why is this possible?
5. If problem tracking has not proved to be high in quality information in that interactional data are sparse or not clear, why are the following strategies excellent back-up approaches to getting closer to understanding the problem: circular questioning, externalization of the problem, and conversational questions?
6. Problem dissolution is a strategy that is underutilized. Postmodernists are reporting with greater frequency that problem dissolution can be achieved by deframing clients' unhelpful certainties and by downplaying pathology. Why?

Part XIV Comprehension Exercise • Scaling Questions

1. Is scaling an evaluative tool? If so, how does it work?
2. Does scaling profess to be scientific in any absolute sense? Why not?
3. Does it deal with absolute values or relative values?
4. As an evaluative tool, what three broad areas of the client's psyche does scaling measure?
5. Who assigns the values to scaling: the counselor or the client?
6. As a negotiating tool, what elements of the client's personality does scaling measure?
7. Is scaling subjective and relative? If so, how does it work in a discipline that claims to be scientific?
8. In scaling, what range of numeric values is normally used?
9. Is scaling designed to be simple or complex?
10. How can scaling become an embedded command?
11. What author and practitioner popularized scaling as a strategy?
12. Is scaling for client confidence or willingness to change evaluative or negotiative?

Part XV Comprehension Exercise • Two Scaling Sequences

Sequence 1
Therapist: On a scale of one to ten, one stands for painful and ten stands for relaxed with regard to the stress you experience at your workplace. Let's start with when you first called to make an appointment. What number would you say you were at then?
Client: I'd say I was at a three. I was really in pain. I couldn't handle the stress.

Task: Create a simple dialogue of four exchanges in which you, as counselor, employ scaling to discern what numeric value a client assigns to the severity of the problem at four distinctly different points in time. These four points in time are as follows:
- After making the initial phone call
- During the time of a possible pretreatment change
- During the middle of the first session
- During the client's return to the second session.

Sequence 2
Therapist: On a scale of one to ten, one stands for no confidence in the marriage and ten stands for confidence in the marriage being successful. Let's start with how each of you felt when you first came here today.
Husband: I'd say a six.
Wife: Realistically speaking, the way things went this morning, I'd have to say a four.

Task: Create a dialogue of four exchanges in which you are negotiating the element of change which a husband and wife will hopefully consider. The focus is on three points in time. They are:
- How each one felt today about the success of marriage when they started the session
- How each one feels right now after being in the session for thirty minutes
- How they might feel when they return for the second visit if they continue to work on improving the quality of their marriage.
Chapter 7 • Involuntary Client Situations

Part XVI Comprehension Exercise • Percentage Questions

1. Like scaling questions, can percentage questions gather information and negotiate conditions for change?
2. Can percentage questions be based on the number ten as most scaling questions are? Why or why not?
3. While scaling questions and percentage questions have much in common as strategies, how are percentage questions also notably different?
4. The use of percentages allows what phenomenon to take place that is peculiar to the notion of percentage and not to scaling?
5. What is the advantage of developing a double description in a percentage situation?
6. When a client says that he is depressed only 40 percent of the time, what does that lead one to believe?
7. What would it mean if the therapist and client examine and identify the things that are occurring during the 60 percent period of time identified as the non-problem time? Could one use that data learned in the non-problem time to cut down on the 40 percent depressive time? How?
8. If a therapist were to embark on a plan to cut down on the 40 percent problematic time, should the changes introduced be large or small? Why?

Part XVII Comprehension Exercise • Percentage Sequence

Scenario

Therapist: You say that you've always had problems focusing on studying more actively?

Client: Well, when I study, I get easily distracted. And now, I'm in the nursing program. It's intense and packed with information. It's hard keeping up.

T: So it's not so much that you don't devote blocks of time to studying. It's more a problem in that when you do study, you get easily distracted. Is that it?

C: That's it in a nutshell.

T: On an average day, how many hours do you devote to study time?

C: About five hours every day.

T: During those five hours, what percentage of the time do you really focus on studying?

C: About 50 percent of the time.

Task: A full-time student attending a prestigious university is compelled by her parents to go to counseling to raise her grades or risk not being supported financially in the coming semester. The parents are both professionals earning high incomes and steadfast in not tolerating a low achiever in the family. Create a simple dialogue in which you, as counselor, employ percentage questions to learn how much time the client devotes to studying versus the time she spends on non-study activities. In creating a double description with the use of percentages, how can you assist the client to study more effectively?

It is assumed that the session in the preceding scenario began several minutes earlier. The dialogue is well on its way to approaching a percentage sequence. Develop the remainder of the preceding scenario in about ten dialogue exchanges.

Part XVIII Comprehension Exercise • Use of Silence

1. How is it that silence may be employed as a strategy?
2. How does one generally distinguish the employment of silence as a strategy from simply using a long pause?
3. When silence is employed as a strategy, could it be an arbitrary decision or should there be other considerations?
4. Should there have been other strategies that preceded it? Why?
5. While the use of silence as a strategy does not occur frequently, it does occur with some frequency with involuntary clients. Why is that so?
6. Why should the counselor be selective on timing the use of silence as a strategy?
7. Should an involuntary client schema be at least attempted and employed before considering the use of silence as a strategy? Why?
8. Why is the involuntary client schema, or similar protocols, called pre-emptive, and how is their use related to silence as a strategy?
9. Before imposing silence as a strategy, the counselor must clearly mention the possible negative consequences that may ensue. For example, a court-ordered client may have to do jail time in lieu of...
therapy time; a spouse may act on an ultimatum that directly affects the client; a significant other or parents may resort to unpleasant punitive actions. Has the counselor done his or her job fairly and correctly when these things are explained to the client before the use of silence as a strategy is enacted? Why?

10. In addition to using a protocol like the involuntary client schema with involuntary clients, is it advisable that the counselor also make some kind of statement regarding his or her willingness to assist the client in getting started in the therapy session?