

# **THE HANDOUT BOOK**

**Complete handouts  
from the workshops of  
Bill O'Hanlon**

## **Welcome to Handout Land**

This compilation of my handouts has evolved over the course of a number of years. When I first began giving workshops and seminars, I would often read on the feedback forms, “Wish there would have been handouts since there was so much information.” So, I started making handouts. I guess I got a little carried away, though, as you can see with this book. Workshop sponsors started sweating a bit when I sent 25 or 30 pages of handouts (I was restraining myself-I wanted to send 50). So, to save trees and to make them available again after they have been out of print for some years, they are back, newly revised and compiled.

Years ago, someone came up to me at a workshop and declared, “You give good handout!” I hope you agree. I have endeavored to chock these pages full of useful information and summaries.

The work in this edition owes a great deal to my former assistant, Martha Geske, who died unexpectedly recently, and to my current assistant, Bianca Sivan. Work on previous editions was done by Mary Nathan and Steffanie O’Hanlon. Thanks to them all. I produce a great deal of original work, but organizing it and making these compilations is not my forte. Without their good work, this would very likely not exist.

Because I am committed to spreading these ideas, you have my permission to reproduce and of these handouts for colleagues, friends or clients. Please do not use them in any commercial (i.e., money-making) activities or products, though, and please keep my name and contact information on them when you share them.

Because this is an online version, we can make changes relatively easily. Please let us know about any corrections or suggestions that occur to you.

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# **Brief, Solution & Possibility Therapy**

## **THE ACCEPT FRAMEWORK**

### **Acknowledging, Validating, and Valuing**

☛ *It is important to attend carefully to clients, acknowledging their points of views and feelings. It is also important to communicate a basic liking for and valuing of the person. One can also give a sense that the points of view and feelings of the person are valid or within the realm of normal human experience.*

### **Clarifying Concerns, Complaints and Goals or Directions**

☛ *Collaboratively explore clients' concerns and complaints, that is, what they believe is troubling enough to have sought your help. The idea to seek help may be someone else's and it is just as important to explore this. Then find out what the clients' (and/or the people who think the client needs help) view of what would constitute a successful outcome. Get such goals, outcomes and destinations in action terms (so that one could see and hear what would be happening at that time). If the client doesn't want goals that are so specific, one can always inquire about directions that would be preferred rather than specific outcomes.*

### **Changing the Viewing, the Doing and the Context**

☛ *Help people challenge patterns of their meaning-making (stories), what they are attending to, patterns of action and interaction, and any aspects of the context around the problem (cultural, gender, family background, neurological/physiological, spiritual aspects of clients' lives).*

### **Evaluating Progress, Results and Outcomes**

☛ *Check in with people throughout the process to find out whether what you are working on with them is relevant and helpful. Use scaling and percentage questions, as well as feeling questions to assess how things are going according to clients.*

### **Planning Next Steps**

☛ *Plan assignments for out of session experiments. Ask about when the next meeting should be according to them. Ask people whether they want to come back, whether they have made enough progress in the direction they wanted to stop the process of counseling or therapy or to take a break. Plan follow-up contacts and relapse prevention or recovery.*

### **Terminating Treatment**

☛ *Stop treatment by mutual agreement, leaving the possibility open for return for any future problems or recurrence of previous problems.*



## **ACKNOWLEDGMENT AND POSSIBILITY IN INTERVIEWING**

It is important to both acknowledge and validate clients without closing down the possibilities for change for them. Too much emphasis on change and possibility can give clients the message that the therapist does not understand or care about their suffering or dilemmas. Too much emphasis on the acknowledgment side can give the message that the client cannot change or might encourage wallowing in the pain and hopelessness. The following methods are designed to combine both acknowledgment and invitations to change and possibility. Remember that these are methods and if they start to become formulaic, they can be used disrespectfully or superficially. They are designed, however, to be respectful and to deeply empathize with clients' suffering and possibilities.

### **Carl Rogers With a Twist: Introducing possibilities into past and present problem reports**

1. Reflect back clients' problem reports into the past tense.

*Client: I'm depressed.*

*Therapist: So you've been depressed.*

2. When clients give generalities about their problems, introduce the possibility that the problem is not so general. Reflect clients' problem reports with qualifiers, usually of time (e.g., recently, in the last little while, in the past month or so, most of the time, much of the time), intensity (e.g., a bit less, somewhat more) or partiality (e.g., a lot, some, most, many)

*Client: I've been really depressed.*

*Therapist: You've been depressed most of the time lately.*

3. Translate clients' statements of the truth into statements of clients' perceptions or subjective realities.

*Client: From the things she has said and done, it is obvious she doesn't care for me or our marriage.*

*Therapist: Some of the things she's done have given you the sense she doesn't care.*

### **The Moving Walkway: Introducing a future with possibilities**

1. Recast a problem statement into a statement about the preferred future or goal.

*Client: I think I'm just too shy to find a relationship. I'm afraid of women and being rejected.*

*Therapist: So you'd like to be able to get into a relationship?*

2. Use present or future tenses to reflect reports of past helpful attention, action and viewpoints.

*Client: I stopped myself from bingeing by calling a friend..*

*Therapist: So one of the things you do to stop bingeing is call friends.*

3. Presuppose positive changes and progress toward goals by using words like "yet," "so far," "when," and "will."

*Client: I broke up with my girlfriend and can't seem to find another relationship.*

*Therapist: So you haven't gotten into a relationship yet. When you get into a relationship, we'll know we've done something useful here.*

## **ACKNOWLEDGMENT, VALUING AND VALIDATION**

- **Acknowledging**—Letting people know that you have noted their experience, points of view and actions.
- **Validating/valuing**—Letting people know that their experiences and points of view are valid and valued. Letting them know that some of their actions are valued (e.g., ethical actions that lead toward their goals) and some are not (e.g., physical violence).
- **Giving permission**—Letting people know that they can feel, experience, think or do things and that they don't have to feel, experience, think or do things. Normalizing is a form of permission.
- **Including**—Incorporating whatever concerns, experiences, objections and barriers people show/express into the conversation without it becoming a block to moving on towards solution. Inviting the person to include even devalued and unwanted aspects of themselves into their experience and definition of themselves. Both/and thinking.
- **Participating with patterns**—Matching verbal and nonverbal patterns with people.
- **Calling to accountability**—Holding people accountable for their actions without blaming them.

## ASSESSMENT QUESTIONS

### **For the client**

\*How will we know when it's time for you to leave therapy, when we've been successful? [Ask for a video description or get a scaling estimate.]

\*What happened that gave you or whoever thought you should be here the idea that therapy would be the best place to sort out the difficulty (difficulties)?

\*After you finish coming here, what kind of changes do you think you'll make in your life?

\*What's the first sign you'll be able to notice that therapy had been helpful to you?

\*What's the first sign others will be able to see when you start to *(feel better; get better; feel more hopeful; really know you want to live; etc.)*?

\*If you've experienced a similar difficulty before, how'd you deal with it?

\*How about one of the times when the difficulty started to develop, but you stopped it before it went too far? [If they don't report any positive coping experience, reply, "So you can't remember any time like that right now."]

\*What was the high point of the last year for you?

\*Can you remember a time recently when you pleasantly surprised yourself or did something out of character that pleased you?

\*What medications or therapy approaches have worked best for you, if any?

\*What hobbies or interests do you have or have you had in the past? What was interesting or valuable about those activities?

\*What kind of work do you do or have you done?

\*(For adolescent) What was/is your favorite subject or class in school? Why?

\*(For reports of previously overcome problems) You told me you used to use drugs or alcohol and then stopped. How did you do that? or You told me you were suicidal last fall. How did you get through that time without harming yourself or doing yourself in?

### **For the referral source/family member**

\*What gives you the idea that the person needs to be in treatment?

\*Who has been most upset or vocal about the client's behavior?

\*How will you know that treatment has been successful and that I have done a good job? [Get a video description.]

\*What has been the most pleasantly surprising thing you've seen or heard from or about the client recently?

\*What would you like me to do to keep you informed on the client's progress or to keep getting your input?

## ASSESSMENT QUESTIONS-INPATIENT

### FOR THE PATIENT

- ❖ How will we know when it's time for you to leave the hospital, when we've been successful? [Ask for a video description.]
- ❖ Who decided it was a good idea for you to enter the hospital?
- ❖ What happened that gave them/you the idea that the hospital would be the best place to sort out the difficulty (difficulties)?
- ❖ After you get out of the hospital, what kind of changes do you think you'll make in your life?
- ❖ What's the first sign you'll be able to notice that we'd been helpful to you while you're here?
- ❖ What's the first sign others will be able to see when you start to (feel better; get better; feel more hopeful; really know you want to live; etc.)?
- ❖ If you've experienced a similar difficulty before, how'd you deal with it?
- ❖ How about one of the times when the difficulty started to develop, but you stopped it before it went too far? [If they don't report any positive coping experience, reply, "So you can't remember any time like that right now."]
- ❖ What was the high point of the last year for you?
- ❖ Can you remember a time recently when you pleasantly surprised yourself or did something out of character that pleased you?
- ❖ What medications or therapy approaches have worked best for you, if any?
- ❖ What hobbies or interests do you have or have you had in the past? What was interesting or valuable about those activities?
- ❖ What kind of work do you do or have you done?
- ❖ (For adolescent) What was/is your favorite subject or class in school? Why?
- ❖ (For reports of previously overcome problems) You told me you used to use drugs or alcohol and then stopped. How did you do that? or You told me you were suicidal last fall. How did you get through that time without harming yourself or doing yourself in?

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### **FOR FAMILY MEMBERS**

- ❖ What did (the patient) do that gave you (or whoever initiated hospitalization) the idea that he/she needed to be in the hospital?
- ❖ Has (the patient) ever experienced a similar problem or shown similar behavior in the past? If so, how did you or they get through that time? What helped the most? How did that episode stop?
- ❖ How will you know that we have done our job here at the hospital after (the patient) gets out? [Get a video description.]
- ❖ Tell me about a time when you or anyone in your family was pleasantly surprised by something (the patient) did.

### **FOR THE REFERRAL SOURCE**

- ❖ What gives you the idea that the person needs to be in the hospital?
- ❖ Who has been most upset or vocal about the patient's behavior?
- ❖ How will you know that the hospitalization has been successful and that we have done a good job? [Get a video description.]
- ❖ Do you have any concerns based on your past experience with hospitalizing someone here that we should be aware of?
- ❖ What would you like us to do to keep you informed on the patient's progress or to keep getting your input?

## **THE BASIC ORIENTING QUESTIONS OF CONSUMER-ORIENTED THERAPY**

**1. What brings you here or concerns you (or the person who suggested you come see me)?**

This is sometimes called “determining the customer.” It also clarifies the complaint that drove someone to seek or recommend therapy. If the therapist does not find this out and keep it in mind during the treatment, it usually indicates that the therapist believes that his or her theories about the person’s or family’s issues is more important than the clients’.

**2. What do you (or they) want as a result? What will show you and others that this result has been achieved?**

This helps define a stopping point for successful therapy according to clients’ definitions, rather than therapists’ values and agendas. The question about showing self and others is important because it is hard to know when it is time to stop if it isn’t defined in a clearly observable way.

**3. What has worked in regard to your concern and what hasn’t? This could include past help you have received or past attempts by you or others to resolve your concerns.**

This information helps avoid mistakes from the past and helps to focus on what things have helped and what is important to change.

**4. Is what we are talking about relevant and helpful? Is what we are doing working?**

This information helps keep the therapy on track and can allow for mid-course corrections during the interview and between meetings.

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## **BRIEF SOLUTION-ORIENTED THERAPY SUMMARY**

- **Validate and acknowledge each person's feelings and points of view without closing down the possibilities for change**  
Reflect back feelings and points of view about the problem in the past tense ("were," "have been")  
Reflect back points of view as if they are points of view and not the truth ("seen," "looked to you," "had the impression," "got the sense")  
Create little openings in generalizations ("most of the time," "usually," "a lot")
- **Search for exceptions to the problem**  
Gently steer the focus to what has happened when the problem hasn't  
Don't try to convince them of exceptions, let them convince you  
Highlight any exceptions you hear
- **Translate labels and vague words into action descriptions**  
Find video descriptions for labels ("What does codependent look like?")  
Get specific about vague words and phrases ("Something's bothering you? What specifically?" "Everything?")  
Find action correlates for feelings ("Tell me what kinds of things you do when you are depressed.")
- **Focus on achievable goals and outcomes**  
Obtain a video description of actions that are under the person's control that will be happening when the problem is solved.
- **Search for evidence of change and internal or external resources**  
When the person relates some positive change from the distant or recent past, find out in detail how they got the change to happen or influenced it  
Who or what has been helpful when they have been stuck or having difficulties previously
- **Suggest new ways of thinking about things or doing things**  
Suggest different interpretations and actions involving the problem
- **Make an action plan for between meetings**  
Write down a specific task that has been negotiated during the session and follow up on the task at the next session  
Make sure it is realistic and the person has agreed to it

## BRIEF THERAPY ASSUMPTIONS AND ASSESSMENT

### Assumptions

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- Assessment and interviewing are interventions; clients and therapists co-create problem definitions and therapy realities.
- What gets focused on in the therapy session and conversation increases in clients' and therapists' awareness and in its prevalence.
- Clients have resources and strengths to solve problems.
- People are changeable in some areas of their lives; rapid resolution of complaints is possible.
- It is not always necessary to know the true cause, history or function of a problem in order to resolve it.
- People are accountable for their actions and can change actions at any moment regardless of background, mental status or emotional state.
- Clients are resistant and/or uncooperative when we haven't listened to them, have blamed or invalidated them or are not being helpful to them.

### Assessment Considerations

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- Assessment is always an ongoing process, changing as you learn more about the client. You don't have to get "the right diagnosis" before making interventions.
- Who is complaining or alarmed? Who thinks there is a problem? What is the person complaining about? This becomes the focus of treatment.
- What are the goals? How will we know when we are done?
  - Get specific about the problem-free future.
  - What's the smallest noticeable change? [Hint: It may have already happened.]
- What is the person motivated for? What does he or she want?
- What does the person do well? (Find contexts of competence.)
  - Skills, hobbies, sports, activities, avocations, life experiences, etc.
  - Exceptions/previous solutions/times when situation was better
  - Best coping moments
    - Past-Problem-related; non problem-related
    - Present-During interview
    - Future-Miracle question; video question
- What are the patterns of the problem? How is it performed?
  - Search for regularities of action and interaction, time, place, body behavior, etc. Get specific (so one could imagine seeing/hearing the problem on a videotape)
- Scan for potentially harmful actions of clients or others in clients' lives (e.g., physical violence, drug/alcohol abuse, sexual abuse, self-mutilation, suicidal intentions/attempts, etc.) that may not be obvious or may be minimized during an initial interview.
- Acknowledge and validate each client and his/her points of view without closing down the possibilities for change.

## BRIEF THERAPY RESEARCH/DATA

- ❖ In well-designed psychotherapy studies, distinguished by experienced therapists, clinically representative clients and appropriate controls and follow-up, brief therapy has been shown to be as effective as longer courses of treatment. [Koss and Butcher (1986) "Research on brief psychotherapy," (pp. 627-670) in Garfield and Bergin (Eds.) **Handbook of Psychotherapy and Behavior Change**. NY: Wiley.]
- ❖ Average duration of therapy is 5-8 sessions in both private practice and community mental health centers, regardless of the theoretical orientation or techniques used by the clinician. Clients generally expect to stay in therapy about 6-10 sessions and no longer than 3 months. [Garfield (1978) "Research on client variables in psychotherapy," in Garfield and Bergin (Eds.) **Handbook of Psychotherapy and Behavior Change**. NY: Wiley; Taube, Burnes & Keesler (1984) "Patients of psychiatrists & psychologists in office-based practice: 1980," *American Psychologist*, 39: 1435-1447; National Institute of Mental Health (1981) "Provisional data on federally funded community mental health centers, 1978-79," U.S. Gov. Printing Office; Howard, Kopta, Krause, & Orlinsky (1986) "The dose-effect relationship in psychotherapy." *American Psychologist*, 41: 159-164.]
- ❖ 75% of those clients who benefit from therapy get that benefit within the first 6 months in therapy. The major positive impact in therapy happens in the first 6-8 sessions, followed by continuing but decreasing positive impact for the next 10 sessions. No one form of psychotherapy is demonstrable better than others for the wide range of clients and problems. [Lambert, Shapiro and Bergin, 1986, "The effectiveness of psychotherapy," in Garfield and Bergin (Eds.) **Handbook of Psychotherapy and Behavior Change**. NY: Wiley. and Smith, Glass, and Miller (1980) **The Benefits of Psychotherapy**. Baltimore: Johns Hopkins University Press]
- ❖ Many studies have shown that even very brief course (1 session or 6 sessions) can dramatically reduce the use of both inpatient and outpatient (best estimates are between 9 and 24% reduced general medical savings) even up to five years after the brief therapy. Biodyne Institute did a study involving people who visited a doctor more than 20 times a year and gave them an average of 7 therapy sessions. The therapy reduced patients' use of medical services by 22% for those on Medicaid; 34% for Federal employees. [Cummings, N.A. & Follette, W.T. (1968) "Psychiatric services and medical utilization in a prepaid health plan setting, Part II," *Medical Care*, 6:31-41; Cummings, N.A. & Follette, W.T. (1976) "Psychotherapy and medical utilization: An eight-year follow-up," In H. Dorken (Ed.), **Professional Psychology Today** (pp. 176-197). San Francisco: Jossey-Bass; Cummings, N.A. (1991) "Arguments for the financial efficacy of psychological services in health care settings. In Sweet, J.J., Rozensky, R. G., & Tovian, S.M. (Eds.) **Handbook of clinical psychology in medical settings** (pp. 113-126) NY: Plenum Press; Cummings, N.A. (1994) "The successful application of medical offset in program planning and clinical delivery," *Managed Care Quarterly*, 2, 1-6; Goldberg, I.D., Krantz, G., & Locke, B.Z. (1970) "Effect of a short-term outpatient psychiatric therapy benefit on the utilization of medical services in a prepaid group practice medical program," *Medical Care*, 8, 419-428; Jones, K.R. & Visci, T.R. (1979) "Impact of alcohol, drug abuse and mental health treatment on medical care utilization: A review of the literature," *Medical Care*, 17(suppl.), 1-82; Munford, E., Schlesinger, H.J. & Glass, G.V. (1978) "A critical review and indexed bibliographical of the literature up to 1978 on the effects of psychotherapy on medical utilization," NIMH: Report to NIMH under Contract No. 278-77-0049-M.H.; Pallak, M.S., Cummings, N.A., Dorken, H. & Henke, C.J. (1993) "Managed mental health, medicaid, and medical cost offset," *New Directions for Mental Health Services*, 59, (Fall), 27-40; Cummings, N.A. & VandenBos, G.R. (1981) "The twenty-year Kaiser-Permanente experience with psychotherapy and medical utilization: Implications for national health policy and National Health Insurance," *Health Policy Quarterly*, 1(2), 159-175.]
- ❖ Emotionally disturbed children and their families who received a brief assessment and a follow-up interview showed more improvement (closer to the goals set by the therapist at the initial session) in a 4-year follow-up than those families who had time-unlimited psychodynamic therapy or time-limited (12-session) psychodynamic therapy. [Smyrniotis and Kirkby (1993) "Long-term comparisons of brief vs. unlimited psychodynamic treatments with children and their parents," *Journal of Consulting and Clinical Psychology*, 61, pp. 1020-1027.]

- ❖ Several studies have indicated that one session is the most common length of treatment (30% in one study, 39% in another, and 56% in another) across the range of clinicians, whether biologically-oriented psychiatrists, psychoanalysts, or eclectically-oriented therapists. Surprisingly, follow-up research indicates that a large percentage (78% in one study) felt that they got what they wanted and that their problem was better or much better from that one session. [Talmon (1990) **Single Session Therapy**. SF: Jossey-Bass and Pekarik & Wierzbicki (1986) "The relationship between expected and actual psychotherapy duration," *Psychotherapy*, 23: 532-534.]
- ❖ Research done through the Milwaukee Brief Family Therapy Center on solution-focused therapy showed that 77% felt they had met their treatment goal and 14% thought they had made progress toward their treatment goal. In an 18-month follow-up of 164 cases 51% reported their problem was still resolved and 34% reported that the problem was not as bad as when they started therapy (85% then thought they experienced long-term improvements). All these clients, who presented with diverse problems and from diverse ethnic populations and genders) received less than 10 sessions of therapy (average of 3.0 sessions). [Research done by Dave Kaiser and reported in Wylie, M.S. (1990) "Brief Therapy on the Couch," *Family Therapy Networker*, 14: 26-34, 66.]
- ❖ Research done in Sweden found that 80% of the clients completing solution-focused therapy accomplished their stated treatment goals. Average length of treatment was 5 sessions. [Andreas, B. "A follow-up of patients in solution-focused brief therapy," Paper presented at the Institution for Applied Psychology, University of Lund, Sweden.]
- ❖ The more "solution-talk" (discussion of solutions and goals by clients) in the initial session, the more likely the client was to complete therapy (vs. dropping out). [Shields, C.G., Sprenkle, D. H., & Constantine, J.A. (1991) "Anatomy of an initial interview: The importance of joining and structuring skills," *American Journal of Family Therapy*, 19, pp. 3-18.]
- ❖ Many of Freud's early cases were very short-term. Analyst Sandor Ferenczi was analyzed by Freud in just 6 weeks, 3 weeks in 1914 and 3 in 1916. Freud successfully treated Bruno Walter, a symphony conductor with a crippling pain in his conducting arm, in 6 sessions. [Jones (1955) **The Life and Work of Sigmund Freud, Vol. 2**. NY: Basic Books and Walter (1946) **Theme and Variations: An autobiography**. NY: Knopf, pp. 167-168.]
- ❖ Therapists who were given a 12-hour training program in brief therapy obtained lower rates of attrition (unplanned/non-mutual treatment termination) and recidivism (return for treatment) and higher success rates than non-trained or self-trained therapists. The therapists in the study ranged from beginners to experienced therapists and the results held among all skill levels. However, once experienced therapists accepted the value of brief therapy, their effectiveness increased. [Burlingame, Fuhrman, Paul, and Ogles (1989) "Implementing a time-limited therapy program: Differential effects of training and experience," *Psychotherapy*, 26, pp. 303-313.]
- ❖ Programmatic training has been shown to change therapists' attitudes concerning the value and provision of brief therapy. Therapists who do brief therapy sometimes drift away from using brief therapy methods, but ongoing supervision can help keep them focused on using their brief therapy skills. [Koss and Shiang, (1992) "Research in Brief Psychotherapy," in Garfield and Bergin (Eds.) **Handbook of Psychotherapy and Behavior Change**. NY: Wiley.]

## **BRIEF THERAPY SUPERVISION**

### **Challenge assumptions**

Get the therapist to translate labels and jargon into video (specific) descriptions.

Challenge attributions of negative intentions/motivations by therapists to clients:

*"She really wants to hold on to her problems."*

*"He really doesn't want to change."*

Challenge ideas about the impossibility of change therapists hold:

*"This person got inadequate parenting and never developed a sense of herself."*

*"She's a borderline, don't expect much change. You are in for a rough ride."*

### **Focus on achievable goals and outcomes**

What is the client upset about and what does he she or do they want to change?

How will the client(s) know when they are done with therapy?

What will be the first sign that change is happening (or has happened)?

What is the smallest change that would indicate that they are headed in the right direction?

### **Search for evidence of change and resources**

What signs of change has the therapist seen so far?

What does the client do well?

What does the client have a lot of energy or motivation for?

How has the client coped with his/her difficult situation so well so far?

Can the client change his or her situation in any small way, even for the worse?

### **Validate/support the therapist**

Help the therapist identify what he or she has been doing that the client benefits from or appreciates.

What interventions/approaches have not worked or have alienated the client?

Compliment the therapist on what he or she has done with a difficult situation so far.

### **Suggest new methods and techniques**

Help free the therapist from the restraint of having to follow some ideal rules, methods or theories rather than attend to what is ethical, intuitive and helpful to the client.

*For example, some therapists are taught never to speak about themselves during therapy, to answer any personal questions, to give advice even when it is requested, etc.*

*Don't get so attached to any theory or method, even solution-oriented, that it gets in the way of doing what is helpful for clients*

## CHANGING PATTERNS

### Identifying Problem Patterns

- ❖ Identify problem patterns by noticing actions that are repetitive, what people in several settings (home, work) complain about, and/or a similar label that people give you in various settings.
- ❖ Remember to focus on the doing of the problem, not being the problem or the feeling associated with the problem. (You can feel shy but you do not have to do shy.) Use videotalk to describe how they do the problem. How do they do anger, jealousy, shyness, or borderline? Recognize triggers (invitations) to the patterns. What are the typical steps leading up to the problem?
- ❖ With interpersonal patterns, either person can change the problem pattern—it's hard to do a tango when the other person starts doing the fox trot. Remind clients that the ability to change a problem pattern does not mean that they are to blame for the creation of that pattern or problem.

### Changing Problem Patterns

- ❖ When they would usually do the pattern, get the person or the couple/family members/friends to do anything different from their old patterns that is legal, ethical, and not harmful.  
*Change actions (sequence, antecedents, consequences, repetitive/invariant actions and interactions, body behavior).*  
*Change location/setting.*  
*Change timing (frequency, time of occurrence, duration).*  
*Use humor.*  
*Change the non-verbals (voice tones, gestures, body movements, eye contact, etc.) around the pattern.*
- ❖ Search for exceptions. What is the person or others around him or her doing when the problem doesn't happen? Identify the solution or exception patterns and get them to do more of those patterns in place of those that don't work.
- ❖ Search in another setting for patterns that work better (at work, with friends, in other family relationships, with hobbies). Borrow the skills and creativity they use in those other settings and apply them to changing the pattern.

***Remember what Rita Mae Brown and some twelve steppers say: "Insanity is doing the same thing over and over again and expecting different results."***

## **COLLABORATIVE TASK ASSIGNMENTS: BASIC PRINCIPLES**

- ◆ Task assignments are to help bring about changes in doing (action/interaction), changes in viewing (perceptions/attention/frame of reference) or changes in the context (time/space, gender-based patterns, cultural patterns, family of origin patterns, and biochemical/physiological aspects) in the situation involving the complaint or negotiated problem in therapy. They are directed toward having people make changes outside the therapy session.
- ◆ The assignment should emerge from the conversation and be co-created and negotiated between client(s) and therapist. Be sure to include or preempt any objections or barriers to carrying out the task assignment before finalizing it. This is a collaborative intervention, not one that the therapist imposes on clients.
- ◆ Frame the task assignment as an experiment. The clients are to make no conclusions before doing the experiment. Make it time limited and adjust the assignment as needed.
- ◆ Use presuppositional language when giving the assignment, e.g., "After you do this, I will want you to tell me exactly what happened, as if you could have seen it on a videotape."
- ◆ Direct the assignment to breaking up patterns of doing and viewing. Find the places where the pattern seems especially repetitive and predictable and direct the assignment to making the smallest noticeable difference.
- ◆ Include multiple levels of meaning (symbols and metaphors) that may speak to the multiple levels of meaning of the situation, if possible.
- ◆ Write down the assignment and keep a copy for your files to increase the likelihood of follow-through and continuity.
- ◆ If the assignment isn't done between sessions, don't immediately assume resistance. Discuss the matter with clients and, if necessary, make adjustments in the assignment until one that works for all parties emerges. If clients still don't perform assignments, confront them about motivation or find another direction for intervention.

## COLLABORATIVE THERAPY

A collaborative therapy is one in which:

- ❖ The expertise of clients is given at least as much weight as the expertise of therapists.
- ❖ Clients are regularly part of the treatment planning process:
  - ✓ Clients are consulted about goals, directions and responses to the process and methods of therapy
  - ✓ Diagnostic procedures, conclusions and case notes are available, transparent and understandable to clients (no jargon or theoretical or technical terms which aren't explained in plain, simple language).
- ❖ The therapist asks questions and makes speculations in a non-authoritarian way, giving the client ample room and permission to disagree or correct the therapist. Therapists give clients many options and let them coach the therapist on the next step or the right direction. If the therapist has an idea and is keeping it as a hidden agenda, he or she makes it public, putting it out in the conversation not as the truth or the right direction, but as an idea, a personal perception or an impression.
- ❖ The therapist is wary of "theory countertransference." Theory countertransference is evident when the therapist continues to "discover" the same kinds of problems in client after client (e.g. "unresolved losses," or Multiple Personality Disorder). This also means not imposing one's beliefs and therapeutic values on clients' lives. The therapist claims no special knowledge about the best way for the client to live after resolving his or her therapeutic concerns (e.g., that it is best for clients to use "I" messages or always express their feelings).
- ❖ Other helpers are given respect and no attributions of bad intentions or wrong approaches are implied regarding their treatment. They are invited into cooperative relationships by inquiring about what their views of the situation are and what the outcomes they expect from treatment are. If they are willing to say, you can ask them about how you might help with or at least not interfere with their treatment. This does not mean that one has to accept or support everything other helpers do. The first loyalty is to the client(s). So, as usual, stories of impossibility, blame, invalidation and determinism are gently and subtly challenged by acknowledging their possible validity and introducing alternate possibilities.
- ❖ Clients (consumers) are given the opportunity to comment on the process of helping (critiquing, appreciating or coaching) and to share their expertise with others, thereby elevating their status from passive needy recipients to active expert contributors.



## **CONTRASTING TRADITIONAL THERAPY TO SOLUTION-ORIENTED APPROACHES**

Impairment/deficit----->Competence/ability  
Pathology----->Health  
Bad/hidden agendas/resistance----->Good intentions/cooperation  
Cure----->Consultation/small changes  
Authoritarian/colonization----->Collaboration/shared expertise  
Working through/working on/insight----->Goal/results  
Past focus----->Present/future orientation  
Expression of emotion----->Validation of felt experience  
Diagnose stuckness ----->Change orientation  
Identity/personality problems/structure ----->Action/process descriptions

## DEEP LISTENING

- ❖ Sit with the person's pain and suffering with compassion instead of offering positive stories or trying to fix, giving advice or suggestions. Be willing to do nothing, just be with, acknowledge and honor the person, their pain and their suffering. Just having told one's story can often be powerfully therapeutic.
- ❖ Attend to the person you are sitting with's story and experience rather than your idea of the truth or what they should experience or do.
- ❖ Be aware of the bias many of us have and our culture has toward redemptive stories. Do not try to change, rewrite, reframe or invalidate the person's non-redemptive, non-happy ending stories.
- ❖ Give credit for small or large efforts, endurance or strength in facing challenges without being patronizing.
- ❖ Keep one foot in acknowledgment and one in possibilities, but do not insist on always speaking the possibilities.
- ❖ Avoid platitudes:
  - Everything will work out.
  - God doesn't give you more than you can handle.
  - You are going to be all right.
- ❖ Avoid glib explanations:
  - Why did you create this?
  - I wonder what you are meant to learn from this?
  - What part of you needs or benefits from this pain?
- ❖ Speak to the complexity of the situation, including seeming contradictions:
  - You can't go on suffering like this and you don't want to die.
  - You want to give up and you don't want to give up.

Frank, Arthur. (1998) "Just Listening: Narrative and Deep Illness," *Families, Systems and Health*, 16(3): 197-212.

Kleinman, A. (1988) *The Illness Narratives: Suffering, Healing and The Human Condition*. NY: Basic Books.

Kushner, Harold S. (1981) *When Bad Things Happen to Good People*. NY: Avon.

## **DESIGNING PATTERN AND FRAMING INTERVENTIONS**

### **Pattern Interventions = Changing the Doing**

*Depatterning - Alter current patterns of action around the complaint.*

*Repatterning - Provide alternate new patterns as substitutes for the complaint.*

1. Change the body behavior involved in the complaint.
2. Change the location of the complaint.
3. Change the timing of the complaint (duration, time of day, etc.).
4. Change the modality of expression of the complaint (e.g. speaking into writing, speaking to someone else into speaking into a tape recorder).
5. Change the antecedents and consequences of the complaint.
6. Change any invariant quality involved in the complaint or the pattern around the complaint.
7. Introduce a new element into the pattern.

### **Framing Interventions = Changing the Viewing**

*Deframing - Challenge current frames of reference.*

*Reframing - Offer new frames of reference.*

1. Offer a new evaluation (either positive or negative) of the complaint or situation.
2. Offer a new causal explanation for the complaint or situation.
3. Use puns and humor to make new associations.
4. Make distinctions. [Splitting]
5. Use analogies, anecdotes to normalize, open up new possibilities or suggest new associations.
6. Orient the person's attention to some aspect of their situation or complaint they haven't been attending to previously.
7. Give their complaint a new name.
8. Externalize their complaint (suggest that the problem is outside of their personality or self).

## DISCOURAGING VS. POSSIBILITY THERAPY

### EXPLANATORY STYLES

	<b>Discouraging therapy</b>	<i>Examples</i>	<b>Possibility Therapy</b>	<i>Examples</i>
<b>Permanence of Problems</b>	Problems are persistent and lasting	<i>It took a long time to develop this problem, so it will take a long time to resolve it.</i>	Problems are temporary and changeable	<i>So far you haven't found a way through this problem.</i>
<b>Globalization of Problems</b>	Problems are pervasive and occur throughout the person's life, although they may be masked in some circumstances	<i>This symptom is just a manifestation of some deeper, underlying problem.</i>	Problems do not happen all the time and everywhere; there are always exceptions	<i>You said you have felt like killing yourself all month and yet last night was the first time you acted on that.</i>
<b>Identification with Problem</b>	The person is the problem	<i>He is a perpetrator; she is a borderline</i>	The problem is the person, the person does, is influenced by or experiences the problem	<i>He molested a child; she is hallucinating. Temper tantrums have been running the show, huh?</i>
<b>Determinism vs. Choice</b>	The past or the person or the person's family cause the problem and/or created certain unchangeable qualities in the person. The person is determined by his/her past, personality, genetics, family background, etc.	<i>It seems to me that your parents were so needy that they couldn't fulfill your needs and that's why you have developed this problem.</i>	Causes are complex and uncertain, so the focus is on what to do to change the situation in the present and the future	<i>So you came from a dysfunctional family and that goes a long way towards explaining why you have your current problems, but the more pressing issue is what you can do about the problems now.</i>

## ELEMENTS OF A COLLABORATIVE CONVERSATION

- 1) Value each person and his/her contribution to the conversation (diversity vs. integration; honoring multiple voices and visions).
- 2) Validate people's points of view and feelings, giving the message that each person has a potentially valid feeling and/or point of view
  - ❖ No invalidating
  - ❖ No blaming
- 3) Ask curiosity questions rather than agenda questions.
- 4) Allow room for the others to articulate their thoughts/position.
  - ❖ Hear it
  - ❖ Not finishing the sentence in your own mind literally or figuratively
- 5) Make room for gray areas, polarities, and contradictions without having to resolve/reconcile them (both in conversations with others and within oneself).

*"Consistency foolishly held is the hobgoblin of small minds." –Ralph Waldo Emerson*

*"The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time and still retain the ability to function." –F. Scott Fitzgerald*
- 6) On an ongoing basis, identify and reduce conversation stoppers (things like blaming, discouraging comments) and increase conversation enhancers (things like validating, descriptive comments). Check with participants about which is which.

## **ELEMENTS OF CONTEXTS**

Every behavior, experience, feeling, interaction, perception, memory, symptom, etc. has a context. There are contextual cues that surround, evoke and support it. Gregory Bateson asked the provocative question, "How do your clients know when they are supposed to have their symptoms? They don't have them everywhere at all times. So they must be responding to some contextual cues that let them know when, how and where to have them." What follows is a list of the elements of contexts. The obvious possibilities are to start to change the contextual cues and patterns involved in and surrounding symptoms.

### **INDIVIDUAL**

*Neurological/physiological/muscular patterns*  
*Biochemical patterns*  
*Action patterns*  
*Thinking/associational patterns*  
*Memory patterns*  
*Perceptual/attention patterns*  
*Language/speaking patterns about or to oneself (Individual framing)*

### **INTERPERSONAL**

*Interaction patterns*  
*Perceptual/attention patterns of others involved in the pattern*  
*Language/speaking patterns to others or by others (Social framing)*

### **SOCIO-CULTURAL**

*Racial/cultural patterns*  
*Gender training*  
*Who names and defines the problem*  
*Who specifies what constitutes normal and correct functioning, action or feeling*

### **OTHER CONTEXTUAL ELEMENTS**

*Spacial patterns*  
*Temporal patterns*  
*Context markers/cues*  
*Spiritual sense (beyond the isolated personality)*

## ESSENTIALS OF POSSIBILITY THERAPY

- ❖ Be sure to acknowledge and validate clients' experience, concerns, views of their problem situations and goals or desired directions for treatment.
- ❖ Challenge or cast doubt on four kinds of ideas about clients or their problems:
  - Impossibility ideas
  - Blaming ideas
  - Invalidation ideas
  - Non-accountability ideas
- ❖ Suggest or effect changes in repeating action patterns surrounding or involving the problem.  
This is done by:
  - Breaking up repeating problematic patterns  
or
  - Importing solution patterns from other contexts or the past
- ❖ Create a collaborative environment in which clients, therapists and other treatment providers' ideas and suggested interventions are included and respected, always checking with clients to ensure the ideas and interventions are experienced as respectful and effective.

## **EVOKING CLIENT SOLUTIONS AND COMPETENCE**

The idea is not to convince clients that they have solutions and competence, but to ask questions and gather information in a way that convinces you and highlights for them that they do.

### **1. Ask clients to detail times when they haven't experienced their problems when they expected they would**

- ❖ Exceptions to the rule of the problem
- ❖ Interruptions to the pattern
- ❖ Contexts in which the problem would not occur (e.g. work, in a restaurant, etc.)

### **2. Find out what happens as the problem ends or starts to end**

- ❖ What is the first sign the client can tell the problem is going away or subsiding?
- ❖ What has the person's friends/family/co-workers, etc. noticed when the problem has subsided or started to subside?
- ❖ What will the person be doing when their problem has ended or subsided different from what he or she is doing when the problem is happening or present?
- ❖ Is there anything the person or significant others have noticed that helps the problem subside more quickly?

### **3. Find evidence of choice in regard to the problem**

- ❖ Determine variations in the person's reactions or handling of the problem when it arises. Are there times when he or she is less dominated by it or have a different/better reaction to it or way of handling it than at other times?
- ❖ Have the person teach you about moments of choice within the problem pattern.

### **4. Resurrect or highlight alternate identity stories that don't fit with the view that the person is the problem**

- ❖ Find out from the person (or from his or her intimates) about times when the person has acted in a way that pleasantly surprised them and didn't generally fit with the view that the person is the problem.
- ❖ Get the person (or intimates) to trace back some evidence from the past that would explain how or why the person has been able to act in a way that doesn't fit with the problem identity.

### **5. Search for other contexts of competence**

- ❖ Find out about areas in the person's life that he or she feels good about, including hobbies, areas of specialized knowledge or well-developed skills, and what other people would say are the person's best points.
- ❖ Find out about times when the person or someone he or she knows has faced a similar problem and resolved it in a way that he or she liked

### **6. Ask why the problem isn't worse**

- ❖ Compared to the worst possible state people or this person could get in, how do they explain that it isn't that severe? This normalizes and gets things in perspective.
- ❖ Compare this situation to the worst incident and find out if it is less severe. Then track why or how.

### **7. Get clients to teach you how to do what they do when things work**

- ❖ Could they teach you or someone else how to do what works?
- ❖ Play other people in the situation and get them to coach you on how to act in a way that would produce better responses.



## **FINDING A FOCUS IN THERAPY**

It's important for therapists to know what they are being asked to accomplish and to clarify the goal of the person or people who are asking for help. This is what I call developing a focus. This focus takes into account the multiple customers/complainants with different agendas. If it is not mutual and all parties do not agree on what constitutes a successful outcome, there may be trouble. Here are some questions and guidelines to help clarify this crucial issue in therapy.

### **The Complaint(s): What is bothering someone enough to get them to seek or get sent to treatment?**

- Who is complaining?
- Who is alarmed about something?
- What are they complaining or alarmed about?
- Translate vague and blaming words into action descriptions (videotalk).
- When has the complaint typically occurred?
- Where has the complaint typically occurred?
- What are the patterns surrounding or involved in the complaint?
- How does the person, the customer, or others involved in the situation explain the complaint?

### **The Customer(s)/Complainant: Who is willing to pay for therapy and/or do something to effect change? Whose concerns will constrain or affect therapy? Who is pushing for change?**

- Who is paying you?
- Who is complaining the most?
- Who will be able to terminate therapy?
- What are the legal and ethical restraints or considerations (suicidal plans/attempts, homicidal & violence plans/history, court/legal involvement, etc.)?

### **The Goal(s): How will the client(s) or customer(s) know when therapy has been helpful enough to terminate or when the agreed upon results have been achieved?**

- What are the first signs that will indicate (or already have indicated) progress towards the goal(s)?
- What are the final actions or results (again in videotalk—seeable, hearable, checkable if possible) that will indicate that this is no longer a problem?
- How will I know when therapy is done, when it has been successful?
- Get goal description in video terms. Translate labels or theoretical concepts into action descriptions if possible. If not, get the client to rate the subjective experience of the problem on a scale and select a target number for success on that scale.

Take the complaints, the customers/complainants and the goals into consideration when finding a focus for therapy. Develop a mutually agreeable goal and then focus on attaining that goal with your interventions. Do not let therapy stray too far afield from the focus and always check new information and ideas for relevance to the focus.

## INTERVIEWING FOR POSSIBILITIES

### ACKNOWLEDGE, VALIDATE AND JOIN

- Body/language mirroring and matching
- Acknowledging feelings and points of view without closing down possibilities

### FOCUS ON EXCEPTIONS, SOLUTIONS AND STRENGTHS

- “What is different about the times when \_\_\_\_\_ (you are getting along, there are dry beds, he does go to school, and so on)?” Ask details of solution sequence.
- “How do you get that to happen?”
- “What difference does it make to you when \_\_\_\_\_, how does it make your day go differently?” (Each person could be asked this question.)
- “Who else noticed that \_\_\_\_\_?”
- When a client reports something which appears to be new or different, even if they place little emphasis upon it, ask, “How is that different from the way you might have handled it \_\_\_\_\_ (one week, or one month, etc.) ago?”
- When clients talk about the problem pattern, ask about how the problem ended. “How did you get her to stop \_\_\_\_\_ (throwing the temper tantrum, nagging)?” “How did you get the fight to end?”
- “Have you ever had this difficulty in the past?” If yes, “How did you resolve it then? What would you need to do to get that to happen again?”
- Ask about hobbies, interests and things they do well. For example, “What subjects do you like best in school?” “What kinds of things do you do for fun?” “What do you do for a living?”

### USE SOLUTION LANGUAGE

- Refer to the problem in the past tense, using “were” or “have been” vs. “are”
- Create expectancy for positive change. “When” vs. “if,” “will” vs. “would,” “yet”
- Depathologize through relabeling
- Use presuppositional questions and statements
  - ❖ Avoid yes and no questions.  
Instead of “Was there anything you ever did that worked?” ask, “What have you done that has worked?”
  - ❖ Giving credit—Suggesting that success was a result of the client’s efforts.  
In response to any report of worthwhile things occurring ask, “How did you get that to happen?” “What did you do to get things back on track?” “How are you preventing things from getting worse?”
  - ❖ Assuming past and present problem-free times. Included in this category are exception questions above.  
“What happens when you. . .” (suggest a solution-oriented action, e.g. “simply tell him that he has to go to school, whether he likes it or not?”) rather than “Have you ever tried \_\_\_\_\_?” “What has worked in the past?” “So, what brings you in?”, rather than “What problem can I help you with?”
  - ❖ Fast forward questions—Assuming the change will occur and painting a picture of it in full detail.  
“Who will be the first to notice?” “Second?” “Who outside the family will find out that \_\_\_\_\_ (the problem is solved)?” “How will they find out, who will tell them?”  
“How will your boss, teacher, etc. respond when you \_\_\_\_\_?”

#### **LISTEN FOR SOLUTION THEMES AND OPENINGS**

- Listen for descriptions of things that have changed for the better, evidence of alternative identity stories or views that show competence, strength or abilities, and for small openings in the discouraging reports.
- Create connecting themes that allow the client to resolve several issues at once.

#### **USE MULTIPLE CHOICE QUESTIONS AND OPTIONS**

- Give clients several choices for answers to channel their responses in directions that will allow problems to be solved and give clients some idea what information/response you are searching for. Give multiple choices when suggesting task assignments or potential courses of action. This method lets clients teach you what fits for them.

#### **NORMALIZE**

- As clients are talking about a response which they believe to be problematic, say, "Of course," "Naturally," "Me too."
- Make normalizing distinctions by asking questions like, "How can you tell the difference between depression and teenage moodiness?" ". . . between his being quiet because he is mad at you or his being quiet because he is just thinking about his day?"
- Tell a story about someone who was thought to have a problem but grew out of it; a normal developmental stage. (*Terrible twos, a late bloomer*)
- Before clients have the opportunity to describe the symptom, beat them to the punch.
- Make sure you don't minimize, deny, or alienate clients by normalizing what they see as severe or what clearly is not typical.

#### **INTRODUCE DOUBT INTO UNHELPFUL CERTAINTIES**

- "When you have what you call an anxiety attack, what happens?"
- "Where did you get the idea that . . . ?"
- ". . . doing things that he calls independent."
- "I don't know whether you don't trust people or are just appropriately cautious until you're sure the person is trustworthy."

#### **RESIST INVITATIONS TO BLAME AND NONACCOUNTABILITY**

- Hold each person accountable for his/her actions, regardless of the background or provocation for those actions or the mental/emotional state of the person who did the actions.
- Do not blame the person who did the actions in question. Blaming means attributing bad/evil intentions or characteristics.

#### **TRANSFER COMPETENCE ACROSS CONTEXTS**

- Discover the client's hobbies, interests, passions and expertise.
  - ❖ "You're a marketing expert. Tell me how you sell things to people. Can you use similar ideas with your spouse?"
  - ❖ "Mother, you said you used to be shy and awkward around people, just like your kids are now. How did you overcome that?"
  - ❖ "Your marriage is in bankruptcy right now. How would you turn around your business if it were in danger of going under?"

## INVESTIGATING HOW PEOPLE “DO” THEIR PROBLEMS

- Get people to teach you how you could reproduce the problem if you tried to create it.

*Example: If I were going to gain weight, as you said you have, how would I go about it?*

*Example: Teach me your method for doing depression.*

- Get details of the thoughts, feelings, sensations, fantasies, actions, interactions and contexts when the problem typically happens.

*Example: Tell me what kind of thoughts go through your mind just before you make yourself vomit.*

*Example: What do you notice in your experience as you are getting anxious?*

- If you had control of all the body's physiological functions, how would you create this problem?

*Example: If I were going to do a good anxiety attack, I would increase the body's heart rate and increase sweating in the hands.*

*Example: If I were going to create impotence, I would decrease the blood flow to the genitals.*

- How would the person make the problem worse or better, if they could?

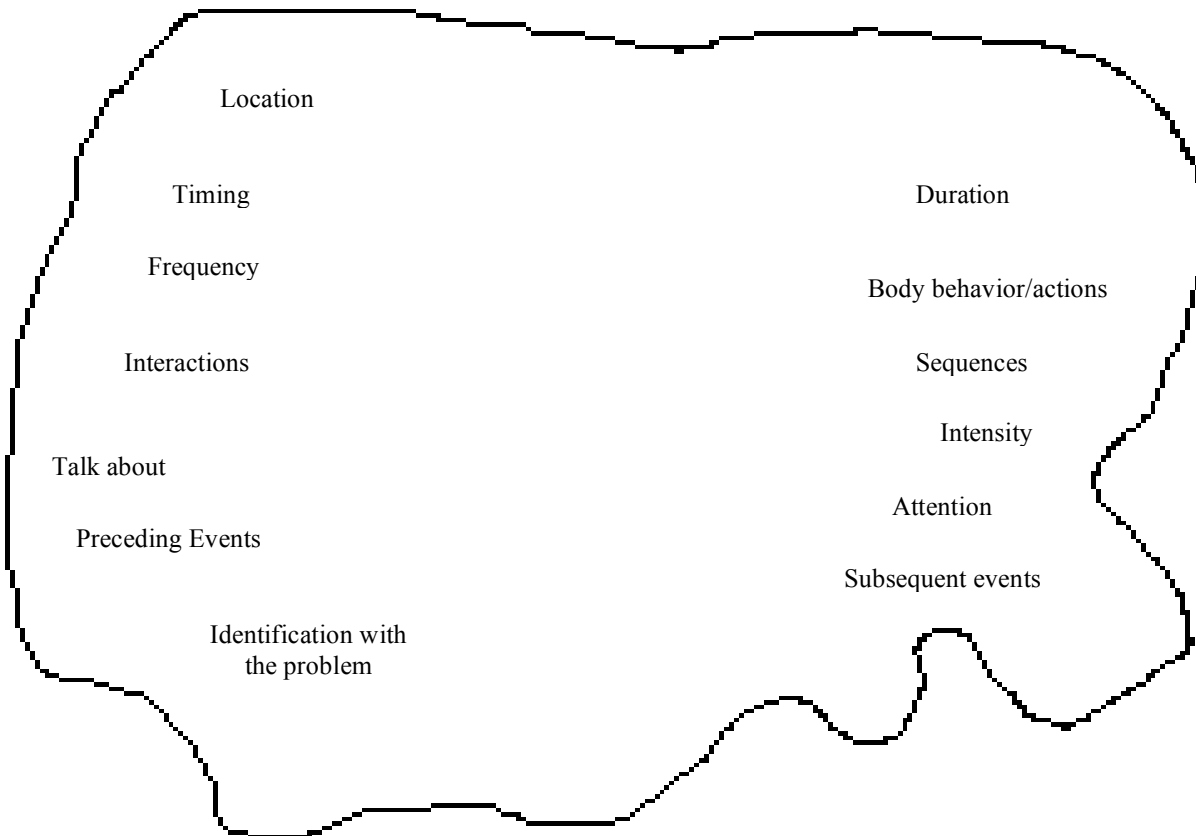
*Example: If I was going to learn how to make the insomnia even worse than it is, what would I have to do if I were you?*

*Example: Is there anything you have done that seems to help you go to sleep and stay asleep?*

## A MAP OF PROBLEM-LAND

"We are not things, but patterns that persist." –Norbert Weiner

### Map of Problem-Land



To be a problem, something must happen again and again, someone must notice it, someone must consider it bad or wrong, and the person, couple or family must consider it to be involuntary at least in part.

1. A problem can be *dissolved* by blurring its boundaries, by valuing it or by giving the problem performer a clear sense that he or she has the ability to change the problem situation.
2. A problem can be *solved* by changing the patterns of attention, action, interaction, meaning or talk involved in or surrounding the problem or by changing the context (background, location or situation) that is usually associated with the problem.

## THE META MODEL

### Deletion

This occurs when the speaker leaves out the actor or the acted upon or object in the utterance.

#### **Missing actor or subject:**

*Client: My heart was broken.*

*Therapist: By whom?*

#### **Missing acted upon or object:**

*Client: I was angry.*

*Therapist: With whom or about what?*

#### **Comparatives:**

When the speaker uses adjectives with *-er* suffixes or *more/less* in front of them.

#### **Superlatives:**

When the speaker uses adjectives preceded by *most/least* or with *-est* suffixes.

*Client: I think she is better.*

*Therapist: Better than whom or what? Or Better compared to whom or what?*

*Client: That is the least difficult part..*

*Therapist: Least difficult with respect to what?*

#### **-ly adverbs**

Adverbs ending in *-ly* may contain deletions. Try dropping the *-ly* from the adverb and start a phrase with "It is . . ." followed by the non *-ly* form of the word. If it still means the same thing as the previous phrase, there is likely a deletion. Apply the previous challenges.

*Client: Obviously, you don't really like me.*

*Therapist: That is obvious to whom?*

#### **Modal operators of necessity**

These are phrases or sentences in which something is said to be necessary (or unnecessary, mostly in therapy we challenge the necessary side). What is left out is the consequence of not doing the thing that is said to be necessary.

*Client: I have to keep my job!*

*Therapist: Or what would happen?*

#### **Modal operators of possibility**

These are phrases or sentences in which something is said to be impossible (or possible; again, mostly in therapy we challenge the impossibility side). What is left out is what prevents or stops the person from doing the thing that is said to be impossible.

*Client: I can't quit my job!*

*Therapist: What stops you from quitting your job?*

### **Cause and effect claims**

These are phrases or sentences in which the speaker claims that something or someone compels them to feel, think, do or be something. What is deleted is the means by which this cause is effected.

*Client: My mother drives me crazy.*

*Therapist: What, specifically, does she do when you feel driven crazy?*

### **Distortion**

This occurs when the speaker speaks about things in such a way as to limit his or her ability to act and increase his or her potential for pain due to the information that is distorted.

### **Nominalizations**

These are words in which a verb is turned into a noun, or, said another way, an action is turned into a thing. This makes it harder to change and distorts the action's true nature, often leaving out the fact that someone took some action and that the process or action could change at any moment. If something is spoken of as a thing, you can apply this simple test to find out whether it is truly an object or a process that has been linguistically turned into an object: Imagine putting it into a wheelbarrow. If you can, it is a real object in the world. If not, it is a nominalization. For example, you can put a *marble* into a wheelbarrow, but not *communication* or *tension*.

*Client: The decision to return home bothers me.*

*Therapist: What would happen if you changed your mind and decided not to return home? Or Who is deciding to return home?*

*Client: My fears are overwhelming me.*

*Therapist: What, specifically, are you afraid of?*

### **Presuppositions**

Presuppositions are assumptions about some truth upon which the utterance rests, but which may remain unspoken.

*Client: I guess you weren't aware that, as a codependent, I cannot change.*

*Therapist: What gave you the idea that you are codependent and couldn't change? And who convinced you that codependents couldn't change?*

### **Mind-Reading**

In which the speaker purports to know the thoughts, intentions, feelings, meanings or experiences of another without specifying how he or she got the information.

*Client: She loves to bait me.*

*Therapist: How do you know she loves to bait you?*

### **Generalization**

This occurs when the speaker speaks shifts from particular experiences to global conclusions about the past, present, future, other people, the world, etc. For example, "Lois doesn't like me," gets translated into "Women don't like me."

#### ***Referential indices***

These are phrases or sentences in which the specific thing or person being referred to is missing.

*Client: Some things bother me.*

*Therapist: Can you give me an example of one thing that bothers you?*

#### ***Universal quantifiers***

These are phrases or sentences in which the specific thing or person being referred to is missing and in which the speaker refers to an entire class of things or people.

*Client: I never get to do what I want.*

*Therapist: Never?*

#### ***Incompletely specified verbs***

These are phrases or sentences in which the specific action being referred to is missing.

*Client: She really hurt me.*

*Therapist: How, specifically, did she do that?*



## NEGOTIATING A PRESENTABLE PROBLEM

“If your train is on the wrong track, every station you come to is the wrong station.”  
–Bernard Malamud

### Creating an initial therapeutic reality

- Ground rules
- Emphasis on change and results
- “How can I help you to solve the problem?”
- Checkable and solvable “problems” and results
- Determining customership

### Operations for building rapport and connection

- Matching the client's/family's vocabulary and nonverbals
- Clarifying expectations and previous therapy approaches

### “Neutral” questions

- “What brings you here?” rather than “What is the problem?”
- Introducing doubt/benevolent skepticism
  - ❖ Acknowledge their ideas, but keep the inquiry open
  - ❖ The multifactor rap to answer queries/theories about causes
- Challenging attributions and deductions
  - ❖ “How is that relevant to the problem?”
  - ❖ Asking for evidence to support the conclusions  
“How do you know?”
  - ❖ Suggesting alternative attributions and deductions
- Challenging evaluations
  - ❖ “So what?” or “How is that a problem?”
- Challenging prerequisites
  - ❖ Providing counterexamples or possibilities of different routes to solution

### “Channeling” questions, statements and actions

- The road not taken
  - ❖ Catharsis, past events causing current problem, multi-generational or childhood issues, blame, etc.
- Minimally structured unspecified questions
  - ❖ Video frame
- Multiple choice questions/comments
- Therapeutic interrupting
- Pre-empting, roadblocks and detours
- Giving the punchline (a class of info or interventions)
- Normalizing/depsychologizing/depathologizing
  - ❖ Everyday vocabulary
  - ❖ “Me too.”
  - ❖ Giving a recipe for the problem
- Suggesting absurd alternatives

### “Loaded” questions, statements and actions

- Blocking unhelpful or destructive remarks or questions
- Presuppositional questions and statements
- The suggestive use of verb tenses
- “Have you got one of these?”
- Summarizing with a twist
- Taking the (wise) words out of the client's mouth

## NEW POSSIBILITIES FOR THERAPEUTIC CONVERSATIONS

### Traditional conversations therapists have:

- Conversations for true explanations
  - ◆ Searching for evidence of functions for problems (the functions attributed may be either benevolent or malevolent)
  - ◆ Searching for or encouraging searches for causes and giving or supporting messages about determinism (biological/developmental/psychological)
  - ◆ Focusing or allowing a focus on history as the most relevant part of the person's life
  - ◆ Engaging in conversations for determining diagnosis, categorization, and characterization
  - ◆ Supporting or encouraging conversations for identifying pathology
- Conversations for inability
- Conversations for insight/understanding
- Conversations for expression of emotion
  - ◆ Eliciting clients' expressions of feelings and focusing on expression of feelings
- Conversations for blame and recrimination
  - ◆ Attributions of evil/bad personality or evil/bad intentions
- Adversarial conversations
  - ◆ The therapist believes clients have hidden agendas that keep them from cooperating with treatment goals/methods
  - ◆ Using trickery/deceit to get the client to change
  - ◆ The therapist is the expert and clients are nonexperts

### The new tradition:

- Collaborative conversations
  - ◆ Clients and therapists are partners in the change process
  - ◆ Clients are experts in teaching the therapists about what they are experiencing, have experienced, what they want and what fits for them
- Conversations for change/difference
  - ◆ Highlighting changes that have occurred in clients' problem situations
  - ◆ Presuming change *will* happen and *is* happening
  - ◆ Searching for descriptions of differences in the problem situation
  - ◆ Introducing new distinctions or highlighting client distinctions
- Conversations for competence/abilities
  - ◆ Presuming client competence/ability
  - ◆ Searching for contexts of competence away from the problem situation
  - ◆ Eliciting descriptions of exceptions to the problem or times when clients dealt with the problem situation in a way they liked
- Conversations for possibilities
  - ◆ Focusing the conversation on the possibilities of the future/goals/visions
  - ◆ Introducing new possibilities for doing/viewing into the problem situation
- Conversations for goals/results
  - ◆ Focusing on how clients will know that they have achieved their therapeutic goals
- Conversations for accountability/personal agency
  - ◆ Holding clients/others accountable for their actions
  - ◆ Presuming actions derive from clients' intentions/selves
- Conversations for actions/description
  - ◆ Channeling the conversation about the problem situation into action descriptions
  - ◆ Changing characterizational/theoretical talk into descriptive words
  - ◆ Focusing on actions clients can take that can make a difference in the problem situation

## OVERVIEWS OF BRIEF SOLUTION-ORIENTED THERAPY

### TASKS

1. **Change the viewing** of the complaint.
2. **Change the doing** of the complaint.
3. Evoke abilities, **resources**, strengths, evidence of change and solutions from the client's life.
4. **Validate** clients' **perceptions and feelings** without agreeing that they are true or set in stone and **without closing down the possibilities for change**.
5. **Learn** from **clients** their **motivations, concerns and goals for treatment**.

### USING TIME

1. **PRESENT** - Start with the present and find the client's goal and his or her view of the complaint.
2. **FUTURE** - Keep opening up the possibilities for the future and focus on the goal.
3. **PAST** - Focus the attention on strengths and abilities from the past rather than deficits, trauma or pathology.
4. **LINK PAST, PRESENT AND FUTURE** - Drawing on previous strengths, solutions and positive trends, create new realities in which the client is empowered to solve the difficulty or to see that he or she is already solving it.

### ELEMENTS

1. Get clear on the goal, the complaint and the customer.
2. Acknowledge everyone's (client's, family members', other helpers', etc.) feelings and perceptions in the situation.
3. Open up possibilities and let the clients teach you what will work for them by using solution language and multiple-choice options.
4. Deal with (include) objections and barriers to change and solution.
5. Identify, amplify and support abilities, strengths and solutions without disqualifying the person's pain or trying to deny the problem.
6. Create a collaborative environment.
7. Hold people accountable for their actions.

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## **POSSIBILITY THERAPY: Key Concepts and Methods**

- Focus on eliciting and highlighting client and family strengths rather than focusing so much on the pathologies, deficits and hidden agendas clients and families might have.
  
- Foster a sense of collaboration with clients and families by being respectful and acknowledging clients' and families' expertise and competencies. This translates in part as not saying something behind closed doors or in case notes that you wouldn't say to the client and the family. Do not use technical jargon with a client or family, speak in everyday English. The client should not be required to learn your theory or to believe your beliefs in order to benefit from treatment.
  
- Assessment is an intervention. Remember that your ideas, values and biases can be reflected in what you see in the client. Therefore it is incumbent upon you to take care not to project your ideas onto the client and to develop ideas and assessment methods that foster possibilities for treatment progress rather than hopelessness and unchangeability.
  
- Use questions and comments that create an expectancy for change and progress.
  
- Focus on learning and attaining clients' and families' goals, based on their perceptions of the problem, rather than just on what you have decided they need to work on.
  
- Negotiate attainable goals for treatment. Changing someone's personality disorder is not a job for treatment. Do not attempt to solve all potential present or future problems. Focus on the treatment goals and link them to larger, out of therapy, goals.

## **POSSIBILITY THERAPY SUMMARY**

- ◆ **Acknowledge each person's (clients' and other customers') feelings and points of view without closing down the possibilities for change**
- ◆ **Validate the person and hold him/her accountable for his/her actions**
- ◆ **Search for exceptions to the problem**
  - Gently steer the focus to what has happened when the problem hasn't
  - Don't try to convince them of exceptions, let them convince you
- ◆ **Translate labels and vague words into action/process descriptions**
  - Find video descriptions for labels ("What does codependency/schizophrenia, etc. look like?")
  - Get specific about vague words and phrases ("Something's bothering you? What specifically?" "Everything?")
  - Find action correlates for feelings and qualities ("Tell me what kinds of things you do when you are depressed." "What would I see him doing when he is being narcissistic?" "How would I do a good depression if I learned your way of doing depression?")
- ◆ **Focus on achievable goals and outcomes**
  - Obtain a video description of actions or results that are under the person's/family's control that will be happening when the problem is solved.
- ◆ **Search for evidence of change and internal or external resources**
  - When the person relates some positive change from the distant or recent past, find out in detail how they got the change to happen or influenced it
  - Who or what has been helpful when they have been stuck or having difficulties previously
- ◆ **Suggest new ways of thinking about things or doing things**
  - Suggest different interpretations and actions involving the problem
- ◆ **Make an action plan for between meetings**
  - Write down a specific task that has been negotiated during the session and follow up on the task at the next session
  - Make sure it is realistic and the person/family has agreed to it
- ◆ **Create a collaborative climate**
  - Equalize and include clients' views, reactions and expertise whenever possible
  - Give suggestions in a more tentative way and acknowledge when your theories or biases are influencing you or steering the interview or interventions in a particular direction.

## **PRINCIPLES OF THE COLLABORATIVE LANGUAGE SYSTEMS THERAPY APPROACH**

- Personal reality, including the problem people bring to therapy, is constituted by language and co-created socially.
- The therapist is responsible for creating a context in which dialogue and collaborative conversation can readily take place.
- Each session and client is unique. The therapist takes care not to impose his or her agenda or pace on the client or the course of therapy.
- The client's language, metaphors and stories are paramount and the therapist is to listen carefully, knowing that he or she will never fully understand the client's world.
- The therapist uses possibility language and questions that lead to further questions and open up the possibilities for new views of familiar, taken-for-granted experiences and ideas.
- The therapist asks questions and makes speculations in a non-authoritarian way, giving the client ample room and permission to disagree or correct the therapist. Give clients many options and let them coach you on the next step or the right direction. If the therapist has an idea and is keeping it as a hidden agenda, he or she is to make it public, putting it out in the conversation not as the truth or the right direction, but as an idea, a personal perception or an impression.
- The therapist doesn't try to resolve contradictions in what the client or his or her significant others are saying, but instead honors multiple points of view and contradictory ideas between and within people.

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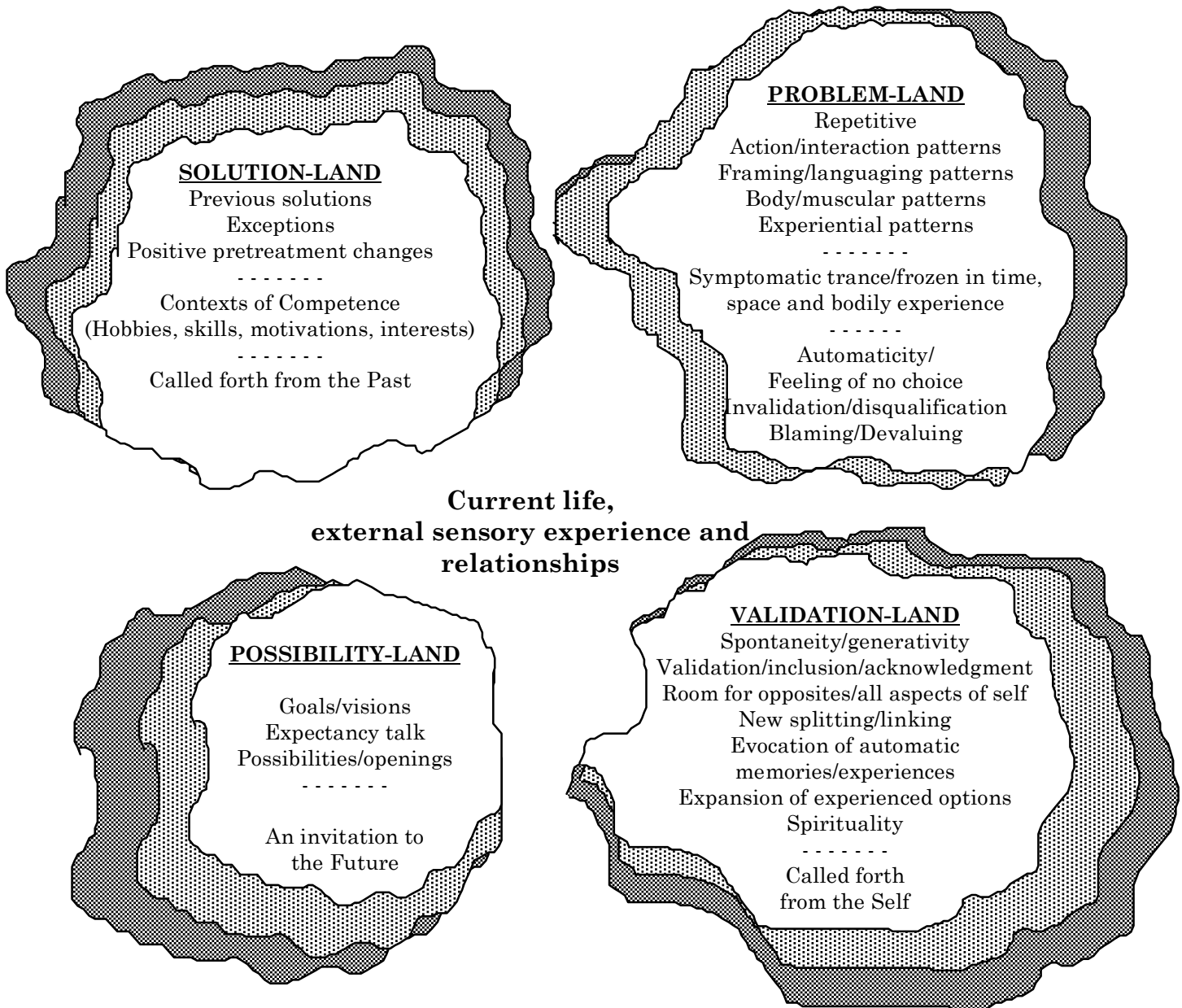
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## PROBLEM/SOLUTION MAP





## PROBLEMATIC STORIES

### ❖ Challenge or cast doubt on four kinds of stories about clients or their problems:

#### ❑ *Impossibility ideas*

Clients or therapists hold ideas that suggest that change in the situation or with a person is impossible.

*Example: This is an Axis II, so don't even bother staffing the case.*

*Example: She'll never change.*

*Example: Once a bulimic, always a bulimic.*

#### ❑ *Blaming ideas*

Clients or therapists blame clients or others for bad intentions or bad traits.

*Example: This client is playing games and doesn't really want to change.*

*Example: I guess I must cut myself to get attention.*

*Example: This patient is a narcissist and can't handle any confrontation.*

#### ❑ *Invalidation ideas*

Ideas that lead to clients' personal experience or knowledge being undermined by others (therapists or people in their personal lives).

*Example: You mean you never cried after your father's death.*

*Example: You're too sensitive.*

*Example: Just let it go and move on.*

#### ❑ *Non-choice/deterministic/non-accountability ideas*

Ideas that suggest that someone has no choices about what he or she does with his or her body (voluntary actions) or no ability to make any difference in what happens in his or her life.

*Example: My other personality cut me.*

*Example: I was raised in a home where violence was the only way to express anger, so when I get angry, I hit.*

*Example: If she didn't nag me, I wouldn't hit her.*

### ❖ Challenge or cast doubt in three ways:

#### ▲ Transform the story by acknowledging and softening or adding possibility

*Validate the current or past problematic points of view but add a twist that softens a bit or adds a sense of possibility.*

#### ▲ Find counterevidence

*Get the client/family or others to tell you something that doesn't fit with the problematic story.*

#### ▲ Find alternative stories or frames to fit the same evidence or facts

*Give the facts a more benevolent interpretation. Reframe.*

## SETTING ACHIEVABLE GOALS IN THERAPY

- ❑ Achievable goals consist of clients' actions or conditions that can be brought about by clients' actions. Often they include time elements: how often (frequency), when (date/time/deadline), and how long (duration). Define the goal in terms of final resolution of the therapy concern or of enough progress to terminate or take a break from therapy.
  - ❑ The goal must be mutual. If there is more than one client, or the customer (the person who initiated therapy and is motivated to make things change) is not the client, all parties must agree that the goal is relevant and achievable.
  - ❑ Translate vague, non-sensory-based words and phrases into action-based language. Goals are more checkable if clients state them as if they could be viewed/heard on a videotape player. Find outer (observable) correlates for feelings and inner states/qualities. Sometimes quantifying inner experiences or qualities by rating them on a scale is helpful. Then find action steps the client could do that would improve the rating to the desired level.  
*Example: On a scale of 1 to 10, where would you rate your current or recent feelings of self-esteem and where will it be on that scale when you have reached your therapy goal successfully?*
  - ❑ Provide multiple choice answers when clients hesitate in stating clear goals or when they continue to answer your queries about their goals with vague words and phrases.
  - ❑ Sometimes it is important to inform clients that you are searching for an achievable goal and give them a rationale for your search.  
*Example: I keep going back to this issue of how we'll know when we've been successful and can stop meeting because I want to make sure we're working on your goals, not mine.*
- OR: I get concerned that what we're doing in here could become (or has become) part of the problem instead of the solution. I think defining a goal will help avoid that because we'll have a clearly defined stopping place.*
- OR: Sometimes therapy becomes a slippery business. It's like nailing jell-o to a tree. It can be discouraging wondering whether I'm really helping people change or just passing the time. So it would help me to pin down a specific goal.*
- ❑ Focus on the goal and a successful outcome as early as you can without alienating the client. If you are getting messages that the client is irritated with the focus on goals, either explain your purpose or back off and refocus on what they are indicating is more important to discuss.  
*Example: This may seem a funny place to start, but I always like to know where I'm going, so I can listen better for what will be helpful to you. So, if you can, tell me what you hope will be happening in your life when we've been successful in here. What will you be doing after therapy? How will others know you've changed? How will you know? And if you can, I'd like to hear it in a way that I can imagine seeing on a videotape.*
  - ❑ Assume that therapy will be successful. Use words like "will," "when," and "yet," when speaking about the client's therapy (or post-therapy) goals.  
*Example: So you haven't asked a woman out for a date yet and you'd like to be able to get into a relationship?*  
*Example: When you're feeling better, less depressed or not depressed, you'll be getting up earlier and spending more time with friends?*

## SOLUTION TALK

This is “personal benchmarking.” You are going to start seeding the virus of solutions in the conversation when there is a problem. The idea is not to convince people that they have solutions and competence, but to ask questions and gather information in a way that convinces and highlights for them that they do.

### **Method #1 Exceptions to the Problem Rule**

Ask people to detail times when they haven't experienced the problem when they expected they would or solved the problem when they thought they wouldn't. This includes exceptions to the rule of the problem, interruptions to the pattern of the problem, and asking about contexts in which the problem would not occur (e.g. home, in a restaurant, etc.) or in which they naturally solve problems well.

*Example: “Tell me about the last time you started to get anxious or scared but somehow calmed yourself. What things did you do differently then?”*

### **Method #2 The End Game**

Find out what happens as the problem ends or starts to end. What is the first sign the person can tell the problem is going away or subsiding? What will the person be doing when their problem has ended or subsided different from what he or she is doing when the problem is happening or present?

*Example: “You've had down times before and come out of them. So when you start coming out of the depression, what things do you start to do differently?”*

### **Method #3 Highlighting Choice**

Find evidence of choice in regard to the problem. Determine variations in the person's reactions or handling of the problem when it arises. Are there times when he or she is less dominated by it or have a different/better reaction to it or way of handling it than at other times? Have the person teach you about moments of choice within the problem pattern.

*Example: “I know things are really bad for you right now and most things that could change the situation seem impossible or beyond you. Is there anything that you can think of that you could you do right now that could help?”*

### **Method #4 Find Contexts of Competence**

Search for other contexts of competence. Find out about areas in the person's life that he or she feels good about, including hobbies, areas of specialized knowledge or well-developed skills, and what other people would say are the person's best points. Find out about times when the person or someone he or she knows has faced a similar problem and resolved it in a way that he or she liked.

*Example: “If you were on the golf course and you faced this kind of situation, how would you handle it?”*

### **Method #5 Worst Case Comparison**

This is a backwards way of identifying competence and solutions. Compared to the worst possible situation people or this person could get in, how do they explain that it isn't that severe? Compare this situation to the worst incident and find out if it is less severe. Then track why or how.

*Example: “I know you are unhappy with how much you weigh, but I am curious, how come you don't weigh more?”*

### **Method #6 Tapping into Altruistic Expertise**

Ask people to help you help other people who might be experiencing the same issues, to share what they have learned about what is helpful to solve or better the situation.

*Example: “You say you've already dealt with your sexual abuse and don't need to talk about it any more. Can you tell me what you have learned from your dealing successfully with this issue that others might find helpful?”*

## **SOLUTION-BUILDING STEPS**

### **Step 1: Ask Solution or Exception Questions**

**When there is a problem, attempt to build solutions by asking simple solution-evoking questions:**

*What has been working?*

*Can you think of a time when you solved a situation like this?*

*Can you remember a time when you would have expected the problem to occur but it didn't?*

#### **Backwards ways of finding solutions or exceptions**

Sometimes people will tell you or you will have the sense that there are no solutions moments to draw upon. There still may be a way to find solutions. At these times, use "backwards" ways of finding solutions by asking questions like:

*Why isn't the problem worse? How have you or someone kept it from being worse?*

*Can you teach (or describe) how to create this problem if someone were going to learn to make it happen?*

*Can you teach (or describe) how to make this problem situation worse?*

*What happens as the problem starts to subside or when things get a little better within the problem? What is the first sign you (or another person) can tell the problem is going away or subsiding?*

#### **Future methods of finding solutions**

What if there are truly no moments of solution or exception that you can identify from the past? No problem. Strangely, you can find solutions in the future, even though it hasn't happened yet. Here are a few "future solution methods."

#### **Scale the problem and the goal, then take small steps to move toward those goals**

*Where are you now on a scale of 1-10 or 1-100, the higher number being closer to where you want to be?*

*What number will you rate yourself (or your department or your company) when you reach your goal or solve the problem?*

*What would it take to increase your level by 1 point or more?*

#### **Future solution visioning and working backwards to the present**

*Imagine a future in which the problem either isn't happening or has been resolved. What is happening in that future? Is there any action that you could take right now from that imagined future?*

### **Step 2: Get a Specific Description of Actions, Difference or Change**

As soon as some moment or example of solution is discovered (and you often won't discover it if you don't go looking for it), the next step is to get details of how it came about. *How*, not *why*. When you first ask people to tell you how the exception came about, they will often tell you their theory or explanation for why the exception or moment of solution occurred. While this explanation may occasionally be helpful, most of the time it begs the question. Usually, you will need detailed descriptions of what someone did to make the situation work.

Getting a description of *how* instead of *why* can be helpful in two ways:

- 1) a *How* description contains information about actions, rather than theories, feelings, attitudes or circumstances that are hard to change by deliberate actions in the future. If the person says that things were better because it rained or that they just felt happier that day, they typically can't have any effect on the situation in the future because they don't directly control the weather or their mood.

- 2) People feel empowered to have some control over the problem—they aren't just helpless victims of circumstances. In philosophy, they call this a sense of personal agency—that people feel they are agents who can choose and act rather than that they are being acted upon by others, the world, or their circumstances.

### **Step 3: Get a Specific Description of Interactional Difference or Change**

The next step often, in situations which involve more than one person is to get an interactional (or systems) description. It may take two to tango, but either person can change the steps of the problem dance to create a solution.

*When he or she changed, what did you do differently in response?*

*When the situation was better, if someone followed you around with a video camera, would the video show you doing or saying anything different from what you would usually do or say in the more typical problem situation?*

### **Step 4: Help People Bring the Solutions Evoked into the Present and the Future**

Many times people will spontaneously begin using the solutions that have been evoked. But if they don't, there are some specific ways that you can help them put these solutions into practice in the present and the future.

#### **Use language to move the solutions from the past to the present and the future**

➤ Change verb tenses from past to present to future when discussing or asking about the solution.

*Example: How did you keep from arguing? Then: How do you keep from arguing? Then: How will you keep from arguing?*

➤ Use expectancy talk to create a sense of the inevitability of using solutions in the future

*Example: So you haven't done what you use to do to get yourself out of this depression yet.*

#### **Suggest trying some small experiment based on the solutions evoked**

*You said when you were feeling better about yourself you would be making more eye contact. Would you be willing to try looking people in the eye several times this week?*

## **SOLUTION-ORIENTED INTERVIEWING**

### **ACKNOWLEDGE, VALIDATE AND JOIN**

- Physical mirroring
- Language matching
- Acknowledging feelings and points of view without closing down possibilities
  - ❖ "So you haven't gotten any help so far?"
  - ❖ "So you've seen her as being controlling when she's done that."
  - ❖ "So you call that expressing your feelings and she calls it verbal abuse."

### **FOCUS ON EXCEPTIONS, SOLUTIONS AND STRENGTHS**

- "What is different about the times when \_\_\_\_\_(you are getting along, there are dry beds, he does go to school, and so on)?" Ask details of solution sequence.
- "How do you get that to happen?"
- "What difference does it make to you when \_\_\_\_\_, how does it make your day go differently?" (Each person could be asked this question.)
- "Who else noticed that \_\_\_\_\_?"
- When a client reports something which appears to be new or different, even if they place little emphasis upon it, ask, "How is that different from the way you might have handled it \_\_\_\_\_(one week, or one month, etc.) ago?"
- When clients talk about the problem pattern, ask, "How did you get her to stop \_\_\_\_\_(throwing the temper tantrum, nagging)? How did you get the fight to end?"
- "Have you ever had this difficulty in the past?" If yes, "How did you resolve it then? What would you need to do to get that to happen again?"
- Ask about hobbies, interests and things they do well. For example, "What subjects do you like best in school? What kinds of things do you do for fun? What do you do for a living?"

### **USE SOLUTION LANGUAGE**

- Refer to the problem in the past tense, using "yet", "were" or "have been" vs. "are"
- "When" vs. "if", "will" vs. "would"
- Depathologizing through relabeling  
Hoarding-->keeping; crisis-->transitional period; "the old you"; independent---->doing things on your own initiative or self-sufficient
- Presuppositional questions
  - ❖ Avoid yes and no questions.  
Instead of, "Did you take any action to show her you meant business?", ask, "What action did you take...?"  
Instead of, "Were there any good things that happened?" ask, "What were the good things that happened?"  
Instead of "Was there anything you ever did that worked?" ask, "What have you done that has worked?"
  - ❖ Giving credit - Suggesting that success was a result of the client's efforts.  
In response to any report of worthwhile things occurring ask, "How did you get that to happen?" "What did you do to get things back on track?" "How are you preventing things from getting worse?"
  - ❖ Assuming past and present problem-free times. Included in this category are exception questions above.  
"What happens when you. . . (suggest a solution-oriented action, e.g., simply tell him that he has to go to school, whether he likes it or not?)" rather than "Have you ever tried\_\_\_\_?" "What has worked in the past?";  
"So, what brings you in?," rather than "What problem can I help you with?"
  - ❖ Fast forward questions - Assuming the change will occur and painting a picture of it in full detail.  
"Who will be the first to notice?" "Second?" "Who outside the family will find out that \_\_\_\_\_(the problem is solved)?" "How will they find out, who will tell them?"  
"How will your boss, teacher, etc. respond when you \_\_\_\_\_?"  
"Once you and your spouse are getting along well, how will your children react differently?"

### **LISTEN FOR SOLUTION THEMES AND SOLUTION OPENINGS**

Client: "She used to keep every ticket she ever had . . ."

Therapist: "She used to? So she's not doing that anymore?"

### **USE MULTIPLE CHOICE QUESTIONS AND OPTIONS**

- Give clients several choices for answers to channel their responses in directions that will allow problems to be solved and give clients some idea what information/response you are searching for. Give multiple choices when suggesting task assignments or potential courses of action. This method lets clients teach you what fits for them.

### **NORMALIZE**

- As clients are talking about a response which they believe to be problematic, say, "Of course," "Naturally," "Me too."

*Example:*

*Client: "So, when I grounded him, he stayed home but he complained about it."*

*Therapist: "Naturally. But he did stay home?"*

*Cl.: "Yes."*

*Th.: "Good."*

- Make normalizing distinctions by asking questions like, "How can you tell the difference between depression and teenage moodiness?" ". . . between his being quiet because he is mad at you or his being quiet because he is just thinking about his day?"
- Tell a story about someone who was thought to have a problem but grew out of it; a normal developmental stage. (Terrible twos, a late bloomer)
- Before clients have the opportunity to describe the symptom, beat them to the punch.
- Make sure you don't minimize, deny, or alienate clients by normalizing what they see as severe.

### **INTRODUCE DOUBT INTO UNHELPFUL CERTAINTIES**

- "What gives you the impression that you are depressed?"
- "When you have what you call an anxiety attack, what happens?"
- "Where did you get the idea that . . . ?"
- ". . . doing things that he calls independent."
- "I don't know whether you don't trust people or are just appropriately cautious until you're sure the person is trustworthy."

### **RESIST INVITATIONS TO BLAME AND NONACCOUNTABILITY**

- Hold each person accountable for his/her actions, regardless of the background or provocation for those actions or the mental/emotional state of the person who did the actions.
- Do not blame the person who did the actions in question. Blaming means attributing bad/evil intentions or characteristics. Stand against self-blaming by the recipient of the actions as well.

### **TRANSFER COMPETENCE ACROSS CONTEXTS**

- Discover the client's hobbies, interests, passions and expertise.
  - ❖ "You're a marketing expert. Tell me how you sell things to people. Can you use similar ideas with your spouse?"
  - ❖ "Mother, you said you used to be shy and awkward around people, just like your kids are now. How did you overcome that?"
  - ❖ "Your marriage is in bankruptcy right now. How would you turn around your business if it were in danger of going under?"

## **SYMBOLS & HEALING RITUALS**

### **Find a Symbolic Object**

\*Find or create a concrete object that is associated with or represents the trauma, person or feeling. This can be done by determining what object represents the situation that you have in your possession or can get or by writing, drawing, sculpting, or buying some object that can serve to represent the situation. This may be done using a resource symbol. That is, rather than finding a symbol for the trauma or problem, you can find a solution symbol, something that represents safety, good feelings, etc.

### **Create a Healing Transition Ritual\***

1. Clarify what the purpose of the ritual is and what is still unfinished for you.
2. Prepare for the ritual by deciding what symbols you will use, when you will do the ritual, who else will be included, what you will wear, where you will perform the ritual, and what you need to do to get ready emotionally/psychologically to do the ritual. You might want to fast or write before doing the ritual.
3. Do the ritual.
4. Find a way to make a transition from the ritual back into your everyday life. Take a bath, go for a short or long trip, go for a walk, write, fast, meditate, etc.
5. If it is appropriate, arrange for friends, significant others or family members to attend a celebration of the completion of the ritual and your determination to move on.

### **Create Healing Connective Rituals**

1. Recall some regular habit or activity from the time before the trauma or disruption that helped connect you to yourself or to others. If you cannot recall any or the ones you recall are not appropriate, create a habit or an activity for connection.
2. Make a regular (daily, weekly, seasonally, yearly, etc.) habit of doing the activity. You may need to schedule it until it becomes habitual.

\*The word ritual has negative associations for some people. "Ceremony" or "healing task" might be better terms for those people.



## THERAPEUTIC SYMBOLS / RITUALS

### Phases

1. Introduction/co-creation/symbol identification; 2. Preparation; 3. Doing the ritual; 4. Cleansing/transition/respice; 5. Integration/celebration

### When to Use

1. Unfinished business; 2. Stuck; 3. To enhance separation (splitting) or connection (linking)

### Symbols

- ❖ Concrete objects that are connected with (*Linked symbols*) or represent some situation, experience or person (*Created symbols*)
- ❖ Used to externalize/concretize an internal experience

#### Connective/Continuity Rituals: Regularly repeated activities

*Daily; Seasonal; Holidays*  
*Activities you can count on; stability*

#### **Continuity rituals**

*Restoring previous rituals*

#### **Connecting rituals**

*Prescribing a ritual that restores or makes connections to people or situations*

#### **Rituals of Remembering**

*Rituals that help connect with memories, the past, and disconnected resources*

#### **Rites of Inclusion**

*Designed to make people part of a social group or relationship*

A meta-analysis of 13 studies done by Joshua Smyth of SUNY, Stonybrook, shows that writing, even for only 20 minutes per day for as little as three days about traumatic events in one's life has positive effects on immune system and reported illness, as well as decreasing work absenteeism and improving grades for students. Reported in *USA Today*, 4/1/96, p. 6D.

#### Transition Rituals: Special activities marked out from everyday life

*Special time(s), place(s), clothing, foods, scents, activities*  
*Restricted to special people*

#### **Rites of passage**

*Designed to move people from one role or developmental phase to another and to have that validated and recognized by others in their social context*

#### **Rites of Exclusion**

*Designed to eject or bar people from a social group or relationship*

#### **Rites of Mourning/Leaving Behind**

*Designed to facilitate or make concrete the end of some relationship or connection*

## TYPES OF QUESTIONS AND STATEMENTS IN SOLUTION-BASED THERAPY

### ❖ **Scaling Questions**

**Designed to get continual assessment and feedback from the person/family and get them to realize changes or gray areas in the problem situation.**

*Example: On a scale of one to a hundred, one hundred being no depression and one being the most depressed you could be, where have you been in the past week?*

*Example: What would it take to get you to have a 'seven' week instead of the 'six' week you had last week?*

### ❖ **Difference Questions**

**Designed to highlight differences and get the person to compare and contrast things about the problem, exceptions or solutions.**

*Example: So was that different from the way you have usually handled it?*

*Example: So his asking questions was different from his typical mode of making accusations?*

### ❖ **Accomplishment Questions**

**Designed to get the person or family to recognize that something positive happened as a result of their efforts.**

*Example: How did you manage to stop bingeing?*

*Example: How did you do that?*

### ❖ **Goal Questions**

**Designed to get the person or family to tell you what they are interested in accomplishing or setting the end point for therapy or problem resolution.**

*Example: How will you know when therapy is successful and we can end?*

*Example: What will you be doing after therapy? How will others know you've changed?*

### ❖ **Compliments/Praise**

**Designed to give clients credit for their accomplishments, good intentions or level of functioning.**

*Example: Wow! How did you do that?*

*Example: Most couples wait until their relationship is on the verge of divorce to seek help. How did you two decide to come in while your relationship was still doing relatively well?*

### ❖ **Atypical Experiences in Regard to the Problem (Exceptions)**

**Designed to elicit descriptions of times when things went differently from the usual problem situation.**

*Example: Can you recall a time when you thought you would binge, but instead you resisted the urge?*

*Example: Can you tell me about a time when John was able to sit quietly and surprised you or himself?*

### ❖ **Description Questions**

**Asking the person or the family to describe the problem or solution situation in observable terms.**

*Example: How did you manage to stop bingeing?*

*Example: How did you know that he was having a better day? What would I have seen on a videotape on that day?*

*Example: How would I know he was doing something you call passive-aggressive?*

❖ **Smaller Step Questions/Comments**

**Designed to get people to scale back their grand ideas about their goals or progress into more achievable ends or progress.**

*Example: That sounds like a big goal and dream. What kinds of things would be happening in the next week if you were headed in the direction of those big dreams?*

*Example: What is the first sign you would see that you were doing what you needed to do to get over your depression?*

❖ **Highlighting Change/New Stories**

**Designed to get people to notice or acknowledge changes or differences in their perceptions of themselves or other people's views of them.**

*Example: What do you think your friends would think about you since you have come to think of yourself as able to stand up for yourself?*

*Example: What effect does knowing that you're resolved not to cut yourself anymore have upon your view of yourself?*

❖ **Motivation Questions**

**Designed to assess people's motivation to change and to determine whether you have a "customer" for change.**

*Example: Do you want to change anything or is it just a concern of your parents?*

*Example: On a scale of one to ten, how eager are you to change this situation right now?*

## UNEXAMINED ASSUMPTIONS IN PSYCHOTHERAPY

- The reason people have “symptoms” (i.e. presenting complaints) is that “symptoms” serve a function or purpose for the person or the “system.”
- Individuals’ behavior and experience is determined by their past experience, their genetic material, their “unconscious,” their families (or the interaction around the individual), and/or their environment.
- There are hidden, underlying causes, reasons, motivations, and/or functions for “symptoms.”
- “Symptoms” are signals alerting one to conflict or stress.
- If the “symptom” is resolved without resolving the “underlying cause,” “symptom substitution” will result.
- Children’s “problems” indicate or reflect the presence of a marital conflict or a structural/organizational “dysfunction.”
- People are psychologically/emotionally flawed, disturbed, ill or insane.
- People have fixed psychological/emotional characteristics (e.g. “personality traits”) and/or disorders.
- People (or “parts of people”) who seek therapy don’t want, or are resistant to obtaining the results they say they want.
- Therapists can know about the clients’ internal experience (feelings, thoughts, perceptions, sensations), motivations and intentions without being told by clients about those things.
- Therapists can know the cause of a symptom.
- Therapists are experts in how to deal with life and know best how to resolve difficulties.
- Everyone needs and can benefit from therapy.
- Rigid, automatic functioning and behavior are inherently undesirable and produces symptoms.
- Insight, conscious understanding or awareness is desirable and a prerequisite for therapeutic results.
- The longer the therapy, the better, deeper or more enduring the results.
- Emotions are enduring entities and can be discovered. (e.g. “He has a lot of unexpressed anger.”)
- Emotions can be “worked through.”
- Unexpressed or “unexperienced” emotion builds up and expresses itself in some way.
- The person is the problem or contains the problematic qualities.
- It is better to have more choices than fewer choices.

## USE OF TIME IN POSSIBILITY THERAPY

PAST	PRESENT	FUTURE
<p>Exceptions to problem                      Contexts of competence                      Doing of the problem                      Evidence for alternative                      identity stories</p>	<p><i>Relationship of therapist to client:</i>  <i>Respect</i>  <i>Collaboration</i>  <i>Acknowledgment</i>  <i>Validation</i>  <i>Permission</i>  <i>Inclusion</i>  <i>Holding accountable</i>  <i>Matching</i>  <i>Pattern participation</i>                      Negotiate a different narrative and identity story</p> <p>Gently challenge:  <b>Unhelpful frames of reference</b>                      Self-imposed limitations                      Self-blaming                      Blaming from others                      Invalidation from others                      Disempowering labels                      Unhelpful certainties                      Non-accountability                      Closed down possibilities</p>	<p>New possibilities                      Presuppositions of results/change                      Goals/visions specified as actions                      Future self/preferred identity story</p>

Change doing / Change viewing / Change context

## VARIETIES OF TASK ASSIGNMENTS

### **Pattern Interventions**

- \*Designed to change the performance, setting, sequence or interactions involved in or surrounding the complaint (problem).
- \*Introduce small changes in any repetitive or invariant aspect of the pattern.

### **Skill Building Tasks**

- \*Designed to add or amplify existing skills or to introduce new skills into the person's or family's repertoire.
- \*If necessary, evoke motivation and link the task to the person's goals or what they want to avoid (negative motivation, as in ordeals).
- \*Get as specific as possible about the actions you want the person to take.
- \*Start small if necessary.

### **Paradoxical Interventions**

- \*Designed to reverse the direction of striving of the client and/or of others involved in the problem.
- \*Can be given without or without a rationale.
- \*The intervention can be directed at internal or external behavior, intentions, functions, the problem, roles or rules/injunctions.

### **Ambiguous Function Tasks**

- \*Designed as an activity upon which people project meanings or solutions.
- \*Pick an object, location or activity that has no apparent connection to the complaint (problem).
- \*After the person does the task, challenge them to find the meaning and purpose in it.

### **Perceptual Tasks**

- \*Designed to get people to re-orient their attention, perceptions or focus in regard to the complaint (problem).
- \*Can be given to the client and/or to those around him/her.
- \*Direct the person to attend to some aspect of the problematic situation that they had not previously been perceiving.

### **Symbolic Tasks**

- \*Designed to represent the complaint (problem) or solution in a concrete way.
- \*Can involve an activity and/or an object.
- \*A rationale may or may not be given.
- \*Can be used to externalize the problem.

### **Rituals**

- \*Designed to help people mark transitions in roles, relationships or life/developmental phases.
- \*Varieties: Continuity rituals; Rites of passage; Rituals of inclusion/exclusion; Rituals of mourning/leaving behind.
- \*You can introduce new permanent rituals, give one-time only rituals, give contingent rituals or reinstate previous rituals.
- \*May be combined with symbolic tasks, ambiguous function tasks, perceptual tasks, or pattern interventions for maximal effect.

**Ericksonian Therapy  
&  
Solution-Oriented Hypnosis**

## CLASS OF PROBLEMS/CLASS OF SOLUTIONS MODEL

Specific----->	Specific Intervention----->	<b>TRANSFER TO</b>
Presenting	<i>Analogy</i>	<b>PROBLEM</b>
Problem	<i>Anecdote</i>	<b>CONTEXT</b>
	<i>Trance phenomenon</i>	
	<i>Task</i>	
	<i>Interpersonal move</i>	

**D**  
**E**  
**R**  
**I**  
**V**  
**E**

**E**  
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**O**  
**K**  
**E**

Class of Problems----->	Class of Solutions
	(Pattern of experience)
	(Resource/skill)



## DEVELOPING AND DELIVERING THERAPEUTIC METAPHORS

\*Metaphor includes stories, jokes, puns, anecdotes, analogies, riddles and symbols - Anything that speaks about one thing to refer to another [Gr. *meta*, to carry and *pherien*, across]

### ☐ Purposes:

- To introduce new possibilities
- To assess which possibilities appeal to the client(s)
- To evoke resources (feelings, memories, frames of reference, previous solutions)
- To transfer know-how/resources from one context to another
- To deal with objections
- To channel the discussion
- To join
- To normalize
- To guide associations

### ☐ Elements:

- Stories include outline words, which give just enough structure while leaving room for clients to fill in their own details.
- Many words in the story are therefore unspecified as to person, place, time, thing and action.
- Stories include characters and action.
- Stories have beginnings, middles and ends.
- Stories are told in a novelistic way, using enough description to hold people's attention and get the listener involved in the narrative.
- Gestures and nonverbals are used to enhance the story.

---

Specific----->Specific Intervention-----> **TRANSFER TO  
PROBLEM  
CONTEXT**

Presenting  
Problem

*Analogy*  
*Anecdote*  
*Trance phenomenon*  
*Task*  
*Interpersonal move*

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Class of Problems----->Class of Solutions  
(Pattern of experience)

(Resource/skill)

## DOING SOLUTION-ORIENTED HYPNOTHERAPY

### The Indicators

#### VOLUNTARY/DELIBERATE ACTIVITY COMPLAINTS -CONTRAINDICATED

*Actions*

*Interactions*

*Deliberate (nonautomatic) thoughts*

#### INVOLUNTARY/AUTOMATIC COMPLAINTS - INDICATED

*Somatic/physiological difficulties unresponsive to medical interventions*

*Experiential difficulties*

*Obsessive/automatic thinking*

*Affective difficulties (shame, anxiety, etc.)*

*Hallucinations/Flashbacks*

### The Point

#### EVOKE ABILITIES, PREVIOUS SOLUTIONS AND PATTERNS OF EXPERIENCE

#### EDIT/REORGANIZE EXPERIENCE

*Splitting (New distinctions)*

*Linking (New associations)*

*Altering (New internal actions)*

*Reframing (New cognitions)*

*Shifting focus of attention (New perceptions)*

#### RECONTEXTUALIZE

*Update previous beliefs*

*Introduce new flexibilities*

*Arrange for new perceptions and contact with others and the current environment*

#### VALIDATE/INVITE TO INCLUSIVE SELF

*Invite the person into a validating/valuing relationship with all their experience/aspects*

### Methods for Evocation

#### ANECDOTES, STORIES, ANALOGIES, COMMON EVERYDAY PROCESSES, EXPERIENCES OR OBJECTS

*Universal*

*Specific to the person's background*

*They've told you about them*

*You've gathered indirectly or have guessed*

*Imagery - Usually given in a one-step removed manner*

*Specific; General/Vague; Different sensory modalities*

*Situations/activities*

#### PRESUPPOSITIONS, EXPECTATIONS

*Rate*

*Variations*

*Before/after/during*

*Awareness*

*Multiple choice alternatives*

#### INTERSPERSAL

*Emphasizing certain words or phrases nonverbally*

*Puns*

#### DIRECT PERMISSIVE SUGGESTIONS

*Possibility words and phrases*

## ELEMENTS OF SOLUTION-ORIENTED INDUCTION

### ☐ Establishment of trust and inclusion

*Any response/behavior/experience is valid*

*Any response can be evidence of hypnotic response or be the thing that leads to the hypnotic response*

*Permissive ("can", "might") vs. Predictive ("will") or Attributional ("are")*

*Observing and incorporating responses*

### ☐ Presupposition/Implication/Contextual Cues

*Verbal presupposition: Illusion of alternatives; before, during and after; rate; awareness*

*Behavioral presupposition*

*Contextual cues*

*Altering communication/behavior patterns*

### ☐ Matching

*Nonverbal: Rhythms, postures, voice qualities, breathing rate, ongoing observable behavior [mirroring/cross-mirroring]*

*Verbal: Vocabulary, syntax*

### ☐ Description

*Videotalk*

*Truisms*

### ☐ Permission and empowering words

*Possibility words; outline words*

*Ronald Reagan words: Unspecified as to person, place, time, thing or action*

*Directing attention and guiding associations*

### ☐ Directing attention

*Whatever gets mentioned is more likely to get noticed*

*Create bridges from where attention is currently to where it could be*

### ☐ Splitting

*Conscious/unconscious*

*Here, present, external/there, past or future, internal*

*Verbal and nonverbal*

### ☐ Linking

*Verbal and non-verbal*

*Bridging*

*Re-evoking trance-like experiences*

### ☐ Interspersal

*Nonverbal emphasis on words or phrases*

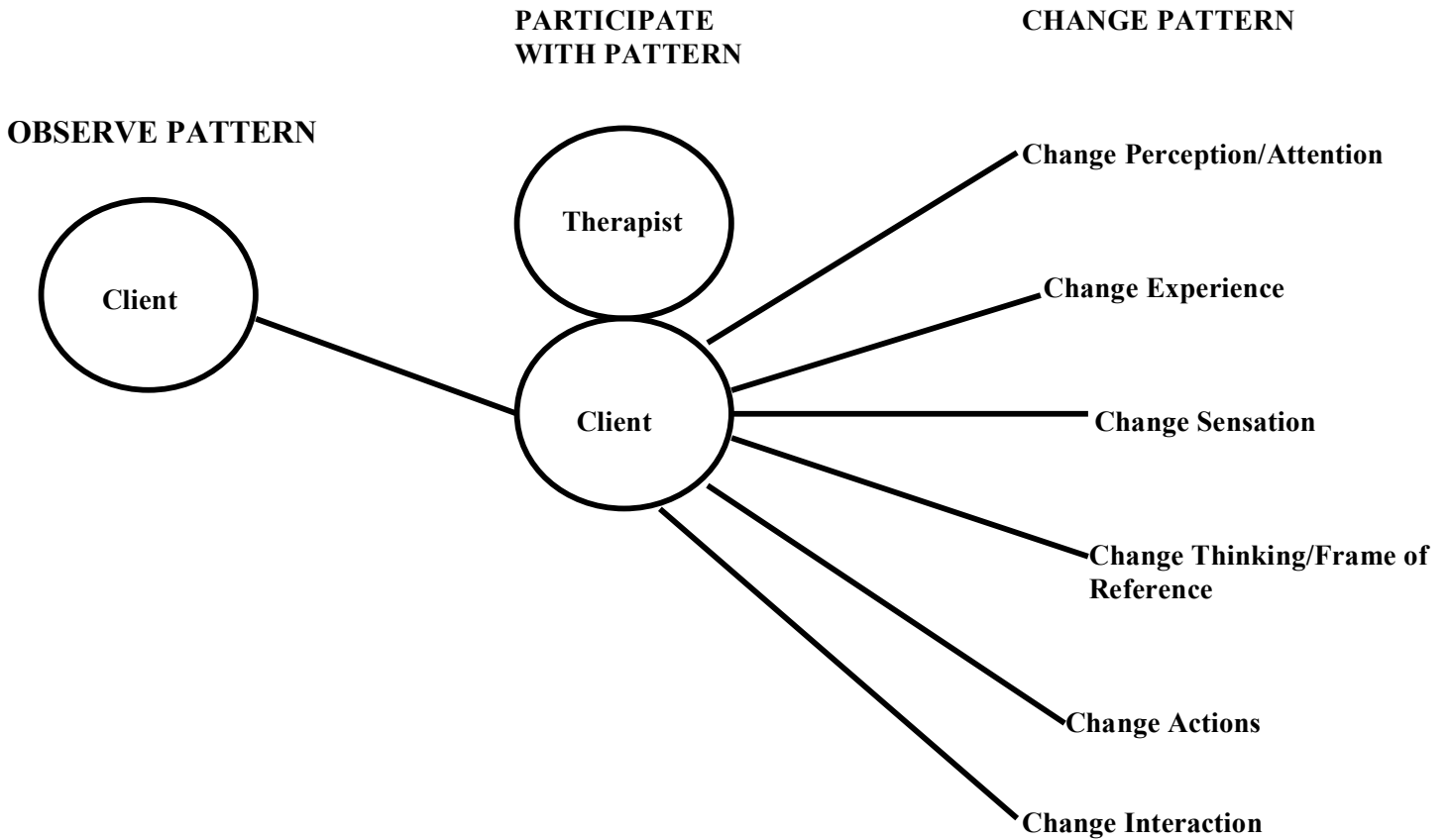
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## COMMON ABSORPTION/AUTOMATICITY INDICATORS

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Flattening of facial muscles; change in skin color; immobility; decrease in orienting movements; catalepsy in a limb; changes in blinking and swallowing; altered breathing and pulse; autonomous motor behavior (jerkiness); faraway look; fixed gaze; changed voice quality; time lag in response; perseveration of response; literalism; dissociation; relaxed muscles

## ERICKSON'S THERAPEUTIC PATTERN



## ESCAPING NEGATIVE SYMPTOM TRANCES

\*A **negative symptom trance** is repetitive, self-devaluing and closes down possibilities. It is a repetition of past states of being/patterns that are not updated to fit with current contexts. That *self* is bigger than *symptom* is forgotten.

There are three ways to escape from negative symptom trances:

1. Go into healing trance. **Healing trance** is validating, empowering and opens up possibilities. It can help you get in touch with your inner resources and learn to trust your intuition and perceptions. It can also invite you into a different relationship with yourself.

Symptom Induction Processes	Healing Induction Processes
*Invalidation; blame; violating boundaries; intrusion	*Validation; valuing; respecting boundaries
*Mystification; binds; double binds	*Inclusive language/both-and
*Coalitions; secrets; negative dissociation	*Helpful distinctions; resourceful dissociation
*Predictions of failure or trouble; threats	*Presuppositions of health/healing; protection; safety
*Rigid role assignment; mind reading	*Positive attributions; avoidance of intrusive interpretations
*Repetition of negative experiences/injurious/self-injurious behavior	*Opening of possibilities for changes in experience or behavior, new options; changes in patterns
*Negative injunctions (You can't, you shouldn't, you will, you are, you have to)	*Empowering/permissive affirmations (You can, it's okay, you may, you could, you have the ability to, you don't have to)
*Repression; amnesia	*Flexible remembering and forgetting

2. Break up the patterns of action and language that you have developed around the symptom. Trance, whether negative or positive, depends on repetition. Change the time, location, body behavior, sequence, etc. of the "problem."

3. Acknowledge, come to terms with and embrace whatever experience, sensation, feeling, perception or memory you have been trying to avoid or get rid of or that has been dominating you. Value all aspects of who you are, especially those that you find the most difficult to accept. Separate yourself as a person from the problem. Your symptom is not your identity, but you have a relationship to your symptom.

## **EVOKING AMNESIA**

### **Everyday things/images that are similar or analogous**

- ❖ Vault/safe/wall/room/box/sealed envelope
- ❖ Sand flowing through fingers

### **Anecdotes/common everyday experiences**

- ❖ Name or fact on the tip of the tongue
- ❖ Looking at a picture and not remembering being there for it
- ❖ Hearing family members tell stories about things you've done but don't remember doing

### **Presupposition/expectation**

**Presuming the outcome and speculating on the process or awareness of the process or outcome**

- ❖ "How much will your unconscious mind choose to have you forget?"
- ❖ "When will you discover that you have forgotten something?"

### **Interspersal**

**Nonverbally emphasizing or marking out certain phrases or words**

- ❖ "And I don't want you to forget to take care of yourself in any way you need to while in trance."

### **Direct permissive suggestion**

- ❖ "You can remember to forget all that you need to forget."
- ❖ "You can leave behind in trance the things that are for trance and bring out of trance the things for your conscious mind to recall."

### **Amplification of response**

- ❖ "That's right. And you can forget other things besides your hand."

### **Link response to other desired responses or the clinical outcome**

- ❖ "And as you forget about those other things perhaps you can remember things that are more helpful."

## **EVOKING HAND/ARM LEVITATION**

### **Everyday things/images that are similar or analogous**

- ❖ Helium balloon
- ❖ Ball of energy pushing underneath the palm
- ❖ Block/tackle

### **Anecdotes/common everyday experiences**

- ❖ Industrial clock story
- ❖ Putting on the brakes from the back seat or passenger's side
- ❖ Opening your mouth to get baby to open his/hers
- ❖ Trying to move the bowling ball after it leaves your hand
- ❖ Parent reaching out to hold child when stopping quickly in a car

### **Presupposition/expectation**

#### **Presuming the outcome and speculating on the process or awareness of the process or outcome**

- ❖ How quickly will your unconscious mind lift that hand and arm?"
- ❖ Which hand will your unconscious mind lift first?"

### **Interspersal**

#### **Nonverbally emphasizing or marking out certain phrases or words**

- ❖ Your unconscious mind can come up with something that can let you know it is working for you."
- ❖ You can let your unconscious give you a hand in moving towards your goals."

### **Direct permissive suggestion**

- ❖ Your hand and arm can lift up to your face automatically."
- ❖ It can lift even more. That's right."

### **Amplification of response**

- ❖ That's right. Lifting a little more."
- ❖ And those little movements can lead to bigger movements."

### **Link response to other desired responses or the clinical outcome**

- ❖ And just as you have experienced this automatic movement, you can experience an automatic change in your feelings as you speak up in staff meetings."
- ❖ Just as the muscles in your hands and arms can change automatically, the muscles in your neck can relax automatically when it's necessary and eliminate your cluster headaches."

## GENERIC PATTERNS IN ERICKSON'S WORK

- ❑ Pattern Intervention
  - ❖ Utilization of current patterns
    - The patient's language
    - The patient's interests and motivations
    - The patient's beliefs and frames of reference
    - The patient's behavior
    - The patient's symptoms
    - The patient's resistance
    - Matching current patterns
  - ❖ Altering existing patterns
    - Modalities of pattern intervention
  - ❖ Establishing new patterns
    - The yes set
    - The reverse set
    - The no set
- ❑ Splitting/Linking
  - ❖ Splitting
    - Illusion of alternatives
    - Apposition of opposites/oxymoron
    - Dissociation
    - Splitting in time
    - Body/voice splitting and interspersal
    - Reject one (or the worse) alternative
  - ❖ Linking
    - Symptom transformation
    - Constructing new associations
    - Contingent suggestions
    - Time suggestions for symptom resolution
    - Anchoring the resistance/symptom
- ❑ Parallel communication
  - ❖ Analogies
  - ❖ Stories
  - ❖ Riddles
  - ❖ Puns
  - ❖ Jokes
  - ❖ Class of problems/class of solutions
  - ❖ Symbolic tasks/objects and communication
- ❑ Implication
  - ❖ Presupposition
    - Linguistic
    - Behavioral/contextual
  - ❖ The Implied Opposite
  - ❖ The Implied Prerequisite
  - ❖ The Implied Entailment
- ❑ Reframing
  - ❖ Facts vs. Frames
  - ❖ The Elements of Frames
  - ❖ Deframing, Framing and Reframing
- ❑ Ambiguity
  - ❖ Ambiguous words
  - ❖ Ambiguous actions
    - Evocation



## **The Hitchhiker's Guide to Solution-Oriented Hypnosis**

*Step 1: Take off the pressure and validate the person where he/she is and will be*

❖ Give people permission to feel/think/experience whatever they are and what they might in the future.

Example: "You can just let yourself be where you are. If you are nervous, that's okay. You don't have to be relaxed to be inside. You don't have to listen to or believe everything I say."

❖ If they respond in some way or do something that they might think is wrong or distracting, validate it and include it in the experience.

Example: "That's right. You can open your eyes whenever you want and look around. You may want to close them again or just leave them open and stay in trance, whatever is more comfortable for you."

*Step 2: Get rhythm*

❖ Speak only when the person exhales. Even if you skip a breath or two, start speaking again on the exhalation.

*Step 3: Create an expectancy for responding to the experience and suggestion*

❖ Presume that the person will get into the experience and will get the intended results.

Example: "I don't know how quickly or deeply you will go inside. Each person is different."

Example: "You may or may not notice when you first start to relax more and feel more comfortable."

*Step 4: Suggest some automatic changes*

Example: "Your hand may start to lift up automatically, just a bit at a time."

Example: "You may be experiencing some numbness in some part of your body. That numbness could increase until you really notice it."

*Step 5: Once you get a response, validate, extend and direct the change towards the clinical goal*

Example: "And as that hand lifts up, you can be going deeper inside and getting ready to relax even more. Your body can prepare to control the bleeding so that you have just enough to clean out the area and no unnecessary bleeding."

*Step 6: Invite the person to reorient to external reality and suggest future positive results*

Example: "Now at your own rate and pace, you can come back from that inner focus and reorient all the way, bringing with you relaxation and the ability to control your discomfort. You can continue to eliminate any unnecessary discomfort and attend only to the necessary pain."

## **METAPHOR CLUSTERS**

### Discussion as travel

This discussion is leading nowhere. We seemed to have reached a dead end. Our discussion seems to have gotten derailed or sidetracked. Now we're on the right track. I don't like the direction this discussion is taking. Now we're right back to where we started this discussion.

### Thinking and ideas as food and cooking

Let these ideas just simmer on the back burner for a while. Digest these ideas. Half-baked theories. I'll have to let that notion percolate for a while. I was stewing about that. I just can't swallow that. Raw facts. Food for thought. The idea hasn't jelled yet. A voracious reader. This is the meaty part of the paper.

### Love as madness

I'm crazy about him. She drives me out of my mind. He constantly raves about her. He's gone mad over her. I'm just wild about Harry. I'm insane about her. Love as war. He is known for his many rapid conquests. She fought for him, but his mistress won out. He fled from her advances. He won her hand in marriage. She is besieged by suitors. He has to fend off the women.

### Money as liquid

Liquid assets. Frozen assets. Floating a loan. Cash flow. Slush fund. Draining your capital. Siphoning off cash.

Adapted from Metaphors We Live By. Lakoff and Johnson. (U. of Chicago Press, 1980).

## MODELS OF METAPHOR

### DAVID GORDON/NLP MODEL

(Gordon, D. Therapeutic Metaphor. Cupertino, CA: Meta, 1978.)

Isomorphism - Characters/Relationships/Events/Processes

A/B/C----->X/Y/Z

Beginning State (Matching analogy)-->Connecting Strategy-->End state (Desired outcome)

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### THE LANKTON'S MULTIPLE EMBEDDED METAPHOR MODEL

(Lankton, S. and Lankton, C. The Answer Within. NY: Brunner/Mazel, 1983.)

Orientation

Re-orientation

Matching metaphor begins. . . . . Matching metaphor ends

Resource metaphor begins . . . . . Resource metaphor ends

Direct interventions

Task assignments

Direct suggestions

Punchlines

Etc.

## PHASES OF ERICKSON'S THERAPY

- ❑ Establishing rapport/engaging
  - ❖ Matching
  - ❖ Joining
  - ❖ Utilization
  - ❖ Fixating attention
  
- ❑ Gathering information
  - ❖ About the symptom-observation and/or description
  - ❖ About behavior and patterns of responses
  
- ❑ Bypassing or interfering with self-imposed limitations and beliefs
  - ❖ Surprise/shock
  - ❖ Confusion/ambiguity
  - ❖ Deframing/reframing
  - ❖ Hypnosis
  - ❖ Metaphor
  - ❖ Tasks - pattern interventions
  - ❖ Riddles
  
- ❑ Evoking abilities
  - ❖ Methods of evoking abilities
    - Stories, hypnotic phenomena, tasks
    - Interspersal
    - Interpersonal influence
    - Hypnosis
  - ❖ What is to be accessed
    - Accessing emotions
    - Accessing skills
    - Accessing motivation
    - Accessing understandings
  
- ❑ Building skills
  - ❖ Practicing
  - ❖ Small steps towards bigger goals
  
- ❑ Linking abilities to the problem context
  - ❖ Post-hypnotic suggestion
  - ❖ Task assignment
  - ❖ Reassociation
  
- ❑ Terminating therapy and follow up
  - ❖ Naturalistic follow-up
  - ❖ Abrupt termination
  - ❖ The check-up model

## **THE PROCESS OF SOLUTION-ORIENTED INNER WORK**

1. Assess the complaint(s) and identify the goal(s). Seed changes and create expectancy for change.
2. Determine that the complaint is an automatic process. (If it is not, pursue non-hypnotic interventions.)
3. Introduce the notion of inner work. Reassure and reframe if necessary.
4. Induce an inner focus, evoke resources, get responses and help the person rearrange their experiential reality (splitting, linking, altering, deleting, creating sensations, perceptions, physiological, muscular, psychological or emotional experiences). Offer a series of possibilities and notice which ones the person responds to.
5. Link evoked resources and alterations to the future and to appropriate contexts.
6. Complete the inner work.
7. Discuss the experience as much or as little as the person wants. Normalize and reassure if necessary. Continue seeding changes and creating expectancies for change.
8. At the next contact, gather information on post-session response/results and utilize those.
9. Induce the inner state. Continue or expand the responses that helped. Offer new possibilities if necessary.
10. Repeat steps 7-9 as often as necessary until both you and the client are certain you are complete.
11. Arrange for follow-up through scheduled visits, postcards, letters, phone calls, etc.

## SEQUENCE OF HYPNOTIC INDUCTION

- STEP 1:** Presupposing responses
- STEP 2:** Explaining what to expect  
p Give permission  
v can  
v don't have to
- STEP 3:** Dissociate  
p Conscious  
v resistance  
v skepticism  
v distractions  
v barriers  
p Unconscious - automatic experiential changes (perceptions, feelings, bodily sensations, memories)
- |   |
|---|
| <b>STEP 3A:</b> (With new trance subjects) - Use analogies, images and anecdotes that normalize, demystify and evoke everyday trance-like or trance experiences |
|---|
- STEP 4:** Give permission (to or not to) and inclusion of responses or potential responses
- STEP 5:** Inviting responses or changes that head towards the hypnotic or therapeutic goal(s)
- STEP 6:** Validating and amplifying desired responses
- STEP 7:** Invite to completion and give post-hypnotic suggestions and validations

## **STRATEGIES FOR PAIN CONTROL**

1. **ANESTHESIA** - Lack of feeling in all or part of the body.
2. **ANALGESIA** - Lack of pain in all or part of the body.
3. **AMNESIA** - Forgetting previous pain.
4. **DISSOCIATION** - Detaching conscious awareness or experience from some aspect of experience.
5. **REINTERPRETATION** - Changing the frame of reference or perception regarding the sensations of pain.
6. **TIME DISTORTION** - Expanding the subjective experience of time when the person feels more comfortable, condensing time when the person feels pain.
7. **ALTERING SENSATIONS AND PHYSIOLOGICAL PROCESSES** - Changing the sensations associated with pain (to tingling or coolness, for example) and/or changing physiological processes associated with pain (like muscle tension or blood flow).
8. **RE-EVOKING PAIN-FREE OR PAIN-INCOMPATIBLE MEMORIES** - Getting the person involved in memories of more pleasant times or experiences or times when pain has been diminished or eliminated.
9. **DISTRACTION OR ABSORPTION OF ATTENTION** - Refocus the person's attention on some experience other than pain.
10. **DISPLACEMENT OF PAIN** - Putting the pain in another location in the body or in the world.
11. **CREATING A COMPELLING SENSE OF A PAIN-FREE OR PAIN-DIMINISHED FUTURE** - Using presupposition, analogy, metaphor, age progression and/or imagery (positive hallucination), get the person to open up the idea that the future holds the likelihood of less or no pain.

**SYMPTOMATIC TRANCE----->HEALING TRANCE**

<b>Symptom Induction</b>	<b>Healing Induction</b>
*Invalidation; blame; violating boundaries	*Validation; permission; respecting boundaries
*Mystification; binds; double binds	*Possibility words and phrases
*Coalitions; secrets; negative dissociation	*Helpful distinctions
*Predictions of failure or trouble; threats	*Post-hypnotic suggestions; presuppositions of health/healing
*Rigid role assignment; mind reading	*Positive attributions; avoidance of intrusive interpretations
*Repetition of negative experiences/injurious/self-injurious behavior	*Opening of possibilities for changes in experience or behavior
*Negative injunctions (You can't, you shouldn't, you will, you are)	*Empowering/permissive affirmations (You can, it's okay, you may, you could, you have the ability to, you don't have to)
*Repression; amnesia	*Reversible forgetting/remembering

**\*Symptomatic trance** is repetitive, self-devaluing and closes down possibilities. It is a repetition of past states of being that are not updated to fit with current contexts. Self as more than symptom is forgotten.

**\*Healing trance** is validating, empowering and opens up possibilities. It is responsive to current contexts. Self as more than symptom is remembered.

**SYMPTOMATIC TRANCE/HEALING TRANCE BIBLIOGRAPHY**

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- ☐ Ritterman, Michele (1983) *Using Hypnosis in Family Therapy*. San Francisco: Jossey-Bass.
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## TRANCE PHENOMENA

<b>MODALITY</b>	+	-
<b><u>PERCEPTUAL</u></b>		
External sensory perception	Positive hallucination V/A/T/G/O	Negative hallucination V/A/T/G/O
Internal sensations	New/different sensations	Analgesia/anesthesia
Orientation in space	Reorientation	Disorientation
<b><u>MEMORY</u></b>		
Memory	Hypermnnesia	Amnesia
Orientation in time	Age progression	Age regression
Time flow	Expansion	Contract
<b><u>BODY/PHYSIOLOGY</u></b>		
Muscle movements	Levitation/ Autom. writing/ ideomotor	Catalepsy
Heart/blood	Increased heart rate/blood flow	Decreased heart rate/blood flow
Temperature	Warmth/heat	Cool/cold
<b><u>AFFECT/ ASSOCIATIONS</u></b>		
Association	New associations	Dissociation
Affect	New feelings	Losing old feelings

## **TRANCEPORTS: THE FOUR DOORWAYS**

### **INTO ALTERED STATES**

#### **☐ Spacing Out/Defocusing**

*Lying on the grass looking at the clouds*  
*Hypnogogic/hypnopompic states*  
*Meditating/relaxation states*  
*Listening to a boring class/lecture*

#### **☐ Absorption/focused awareness**

*Involved in a movie/television/book*  
*Listening to a riveting speaker*  
*Absorbed in music*  
*Absorbed in some activity or work*  
*Absorbed in a conversation*

#### **☐ Dissociation/splitting of awareness and/or activity**

*Playing an instrument (once you've mastered it)*  
*Playing a sport (once you've mastered it)*  
*Doodling*  
*Eating popcorn in the movies*

#### **☐ Rhythmic/pattern/repetitive behavior**

*Chanting*  
*Dancing*  
*Mantras*  
*Running*  
*Rocking*

## USING PRESUPPOSITION IN HYPNOSIS

1. Giving two or more options that lead in the desired direction.
  - Would you like to go into trance now or later?*
  - I don't know if you'd like to close your eyes to go into a trance or if you'll keep your eyes open.*
  - Would you like to use the recliner or stay where you're seated to go into a trance?*
2. Presuming that something is about to happen.
  - Before you go into trance, there are some myths about hypnosis that I'd like to dispel.*
  - Have you ever been in trance before?*
  - When you're in trance, you can do something nice for yourself.*
  - Don't go into trance too quickly.*
3. Presuming that something is happening.
  - You can go deeper.*
  - That's right, just continuing.*
  - As your unconscious mind continues to help you do what you need to do. .*
4. Presuming that something just happened.
  - How was that?*
  - Welcome back!*
  - How did that trance compare with the last one?*
  - . . . and your unconscious mind can now solve other problems that we haven't even talked about.*
5. Implying that something is happening, will happen, or just happened by talking about its rate of occurrence.
  - Don't go in too quickly.*
  - I don't know when your unconscious will solve that for you.*
6. Implying that something is happening, will happen, or just happened and wondering aloud whether that person is aware of that.
  - I don't know whether you have noticed that your breathing has changed.*
  - You probably aren't aware that your unconscious mind is doing a lot of work for you.*

## **WORDSMITHING IN SOLUTION-ORIENTED INNER WORK**

### **1. Use possibility, permission and empowering words and phrases.**

- *"Feel free to tune out anything that I say that doesn't fit for you."*
- *"You can just let yourself respond in whatever way you do and validate that response."*

### **2. Use inclusive language and phrases.**

- *"You can be distracted as you go into an inner state or you might be focused on just what I say or you might be concentrating in a relaxed way."*
- *"You don't have to be relaxed and you can relax."*

### **3. Make distinctions (Splitting).**

- *"You can distinguish between the things that you did and the things that were done to you."*
- *"One part of you can be paying attention to the sounds around and another can pay attention to the sounds inside."*

### **4. Attribute resistance, distractions, skepticism and analysis to the conscious mind and automatic experience and ability to the unconscious.**

- *"Your conscious mind may be thinking that you can't go deeply inside and at the same time your unconscious mind is beginning the process of going deeper inside."*

### **5. Propose linkages and associations (Linking).**

- *"As your breathing starts to change, you can find yourself drifting a little and letting your muscles relax even more."*
- *"And in the future, when you need it, your unconscious can give you access to the resources you need to solve your difficulties."*

### **6. Encourage desired responses and include potentially troublesome ones.**

- *"You can open your eyes, as you just did, and still be internally focused. They might close or remain open . . . I don't know what will be right for you."*

### **7. Presuppose certain responses and then speculate as to how and when the responses will occur.**

- *"I don't know how quickly that hand will lift up to your face."*
- *"I don't know exactly what you'll accomplish when you are inside. Perhaps you won't even be able to tell for sure until after you come out."*

### **8. Use words that are unspecified as to person, place, time, thing, or action. Use outline words for which the client has to provide much of the specific meaning.**

- *"There are lots of learnings that you have had in the past that you have consciously forgotten about."*
- *"You can draw upon experiences, wishes, hopes, dreams, skills, abilities and anything else you need to accomplish your goals."*
- *"You can go to a certain time and certain place to get what you need; it might be a time in the past or a time in the future; it might be nearby or far away."*

# **Narrative Therapy**

## EXTERNALIZING PROBLEMS

**Externalize** symptoms and problems and ideas about blame, determinism and “unchangeable” problem identity ideas.

*Motto: The person is never the problem; the problem is the problem.*

- 1. Name/Personify**—Talking to the person or family as if the problem was another person with an identity, will, tactics and intentions which often have the effect of oppressing, undermining or dominating the person or the family.  
*Example: “When Paranoia whispers in your ears, do you always listen?”*  
*Example: “So Depression has moved in with you for the last month?”*  
*Example: “How long has Anorexia been lying to you?”*
- 2. Find out how the problem has affected the person and others**—Finding out how the person has felt dominated or forced by the problem to do or experience things he or she didn't like. Be careful about using causal statements (“makes,” “causes,” “gets”).  
Investigate areas of: 1. Experience, feelings arising from the influence of the problem; 2. Tactics or messages the problem uses to convince people of limitations or to discourage people; 3. What actions or habits the problem invites or encourages the person or the family to do; 4. Speculations about the intentions of the problem in regard to the person or relationships; 5. Preferences or differences in points of view the person has with the problem.  
*Example: “When has jealousy invited you to do something you regretted later?”*  
*Example: “What kinds of foods does Anorexia try to get you to avoid?”*
- 3. Find moments when things went better or different in regard to the problem**—Finding out about moments of choice or success the person has had in not being dominated or forced by the problem to do or experience things he or she didn't like. Inquire about differences the person has with the problem.  
*Example: “Tell me about some times when you haven't believed the lies Anorexia has told you.”*  
*Example: “How have you stood up to the Temper Tantrum Monster?”*
- 4. Use these moments of choice or success as a gateway to alternate (hero/valued) stories of identity**—Encourage the person or his/her intimates to explain what kind of person they are such that they had those moments of choice or success.  
*Example: “How do you explain that you are the kind of person who would lodge such a protest against Anorexia's plans for you?”*  
*Example: “What qualities do you think you possess that give you the wherewithal to oppose Depression in that way?”*
- 5. Find evidence from the person's or families past that supports the valued story**—Finding historical evidence explaining how the person was able to stand up to, defeat or escape from the dominance or oppression of the problem.  
*Example: “What can you tell me about your past that would help me understand how you've been able to take these steps to stand up to Anorexia so well?”*  
*Example: “Who is a person that knew you as a child who wouldn't be surprised that you've been able to reject Violence as the dominant force in your relationship?”*
- 6. Get them to speculate about a future that comes out of the valued story**—Get the person or the family to speculate on what kinds of future developments will result if the path of resisting the problem is continued or expanded.  
*Example: “As you continue to stand up to Anorexia, what do you think will be different about your future than the future Anorexia had planned for you?”*  
*Example: “As Jan continues to disbelieve the lies that delusions are telling her, how do you think that will affect her relationship to her friends?”*
- 7. Develop a social sense of the valued story**—Find a real or imagined audience for the changes you have been discussing. Enroll the person as an expert consultant on solving/defeating the problem. Situate the problem in a current social/political/values context.  
*Example: “Who could you tell about your development as a member of the Anti-Diet League that could help celebrate your freedom from Unreal Body Images?”*  
*Example: “Are there people who have known you when you are not depressed who could remind you of your accomplishments and that your life is worth living?”*

## METAPHORICAL FRAMES IN NARRATIVE THERAPY

FRAME	PROBLEM METAPHORS	SOLUTION METAPHORS
<b>Oppression</b>	Intimidate; try to silence; coerce; oppress	Resist; withstand; passive resistance; speak up
<b>Prison/Hostage</b>	Imprison; incarcerate; put in a concentration camp; sentence you to death; take hostage; hold hostage; brainwash	Liberate; escape; release; served your time; parole; time off for good behavior; reprieve; pardon; appeal
<b>Spy</b>	Infiltrate; recruit; disinformation campaign	Uncovering the truth; expose; counterespionage
<b>Undermine</b>	Undermine; get you to doubt yourself; gaslight	Believe in yourself; trust yourself
<b>Sports</b>	Get a grip on; tackle; pin you; get you on the mat; on the ropes; in the corner; foul; body check; kidney punch; choke hold	Loosen its grip; play fair; get back up; release; get out of the corner; get off the ropes; win a goal against
<b>Spatial/Size</b>	Diminish; disappear; make you smaller; overshadow; loom large; stand over	Stand up to; grow larger; reappear; show up; move away from; push it away
<b>Fighting/War</b>	Attack; bully; pushed around by; defeated by; lost ground to; lost territory; pillaged; ransacked	Counterattack; fight against; marshal your forces; hold your ground; liberate territory; building your strength; attacking its flank; strategizing
<b>Seduce</b>	Coo; seduce; entice; promise; sweet talk; sweet nothings in your ear; promise you the moon; invite	Close your ears to; faithful; keep a level head; say no; reject; spurn; set limits
<b>Supernatural</b>	Monster; possess; vampire (drink your blood); haunt; ghost	Kill the monster; exorcise the ghost; drive a stake through its heart
<b>Club membership</b>	Lifetime member; member under false pretenses; sneak in	Cancel membership; revoke membership; decertify

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## **RESURRECTING OR DISCOVERING ALTERNATE IDENTITY STORIES AND POINTS OF VIEW**

- ❖ Find out about other people who do not view the client or family as disabled, unable, sick or crazy.
- ❖ Find out about hidden or non-obvious aspects of the person or the person's life which do not fit or are incompatible with their disempowered (hopeless, helpless or stuck) views about themselves or the problem. Ask the person or his or her intimates how they explain the incompatibility.
- ❖ Find out about their best moments in thinking about or experiencing themselves.
- ❖ Connect them with others who may have experienced similar things or struggles and either found different ways to think about it or deal with it. This can be through books, tapes, letters, or support groups.
- ❖ Normalize by letting them know that others have or do experience similar things.
- ❖ Get the person and his or her family and friends to experiment with different ways of acting that are outside the usual expected identity patterns.
- ❖ Encourage clients and significant others to avoid making premature conclusions and stories, but to stick with the experience and consider multiple stories and meanings.

## TYPES OF QUESTIONS IN NARRATIVE THERAPY

In the narrative approach, questions are designed to both get information and give information.

### ❖ Negative Tactics of the Problem

**Designed to highlight and get the person/family to see that the problem uses underhanded methods to subvert or oppress the person/family.**

*Example: What kinds of things does guilt try to tell you?*

*Example: What kinds of tricks does trouble use on you to get you to go along with it?*

### ❖ Negative Intentions of the Problem

**Designed to highlight and get the person or family to see that the problem does not have the person's or family's best interests at heart.**

*Example: Why do you think that Anorexia wants you to go to your grave without realizing you are dying?*

*Example: Why do you think that Violence wants you to go against your value of protecting and loving your partner?*

### ❖ Preferences

**Designed to get the person or family to tell you if they like the effects of the problem in their lives or a direction their lives are taking.**

*Example: Do you like the times that you are in charge rather than violence?*

*Example: Is this a development that you like in your life and would like to continue?*

### ❖ Relevance/Direction of Interview

**Designed to get the person or family to tell you what is relevant for them to talk about and to check out whether a particular interview topic is helpful to them or of interest.**

*Example: Is what we're talking about helpful to you? Is this a direction that you'd like us to continue to pursue?*

### ❖ Appreciative Others' Perceptions

**Designed to elicit clients' ideas about others' perceptions of some situation, direction or personal quality.**

*Example: What do you think your best friend would say if she could hear you talk about your small victories over self-harm?*

*Example: What things that you told me about not giving in to your temper do you think would shock your previous therapist?*

### ❖ Atypical Experiences in Regard to the Problem (Exceptions)

**Designed to elicit descriptions of times when things went differently from the usual problem situation.**

*Example: Can you recall a time when you thought you would be dominated by the urge to binge, but instead you stood up to the urge?*

*Example: Can you tell me about a time when John was able to sit quietly and surprised you or himself?*

### ❖ Explanations of Exceptions

**Asking the person or the family to speculate or tell you their ideas about the atypical experiences in regard to the problem.**

*Example: How did you manage to stop bingeing?*

*Example: If this was a new trend in your relationship, what do you think made it possible for you two to take this new direction?*

❖ **Valued Identity/Qualities**

**Designed to get people to rethink their ideas about the identities or qualities of the person who has been having the problem based on the exceptions and explanations about the exceptions that have been offered.**

*Example: What does your decision to stop bingeing tell you about yourself?*

*Example: What do you think John's decision to ignore the whispers of paranoia tell you about him that you wouldn't have otherwise known?*

❖ **Highlighting Change/New Stories**

**Designed to get people to notice or acknowledge changes or differences in their perceptions of themselves or other people's views of them.**

*Example: What do you think your friends would think about you since you have come to think of yourself as able to stand up for yourself?*

*Example: How do you think my view of you has changed since hearing you describe yourself as incredible?*

*Example: What effect does knowing that you're resolved not to cut yourself anymore have upon your view of yourself?*

❖ **Relationship Change**

**Designed to invite people to consider the effects of the new story on the person's or the family's relationships.**

*Example: How do you think your parents will be able to treat you differently now that they know that you see yourself as a person who is capable of defeating temper tantrums?*

*Example: What affect is hearing that Patrice views herself as incredible having on your relationship with her?*

❖ **Political/Cultural Ideas/Practices**

**Designed to highlight oppressive ideas, beliefs and practices that come from the culture.**

*Example: How do you think society's ideas about what it means to be a man have influenced your marriage?*

*Example: Do you think your taking responsibility for all the household tasks is a reflection of traditional ideas about women's responsibilities?*

❖ **Historical Evidence for Valued Identity/Qualities**

**Designed to get people to rethink their ideas about the identities or qualities of the person who has been having the problem based on the exceptions and explanations about the exceptions that have been offered.**

*Example: Is there someone who knew you when you were growing up who wouldn't be surprised by the fact that you've been able to stand up to the alcoholism bully?*

*Example: What incidents from your past would help me understand how you've been able to take the extraordinary steps you've taken despite hallucinations whispering in your ear?*

❖ **Alternative Future of Valued Identity**

**Designed to invite people to consider new possibilities for the future based on the answers to the previous unique outcome, account, and redescription questions.**

*Example: Can you tell me something about how knowing that you see yourself as incredible will affect what you do next?*

*Example: What new possibilities will open up for you now that you have realized that you are onto the tricks anorexia has played on you?*

❖ **Relationship to Oneself**

**Designed to invite people to consider new possibilities for the future based on the answers to the previous unique outcome, account, and redescription questions.**

*Example: How do you think that realizing you are onto the illusion of hallucinations will help you think of yourself differently?*

*Example: What difference will your acting out of the sense of yourself as incredible make to your relationship with yourself?*

❖ **Relationship to Others**

**Designed to invite people to consider new possibilities for the future based on the answers to the previous unique outcome, account, and redescription questions.**

*Example: When you have been consistently acting out of this new understanding of yourself, how do you think the hospital staff will interact with you when they see?*

*Example: How do you think Jim's new sense of himself as competent will affect your trust in him?*

## TYPES OF QUESTIONS IN WHITE'S NARRATIVE THERAPY

In the narrative approach, questions are designed to both get information and give information. Michael White and his colleagues want to discover and highlight for the person and his or her social system alternative stories and views of the person who has been seen as having a problem. White, in (1988a) "The process of questioning: A therapy of literary merit?," *Dulwich Centre Newsletter*, Winter, pp. 8-12, provides this typology of the questions he uses and their purposes. Here, minus some jargon, is a summary.

### ❖ Unique Outcome Questions

**Designed to elicit descriptions of times when things went differently from the usual problem activities (akin to solution-focused exception questions).**

**Direct Unique Outcome Questions**—These questions ask the person or family members about times when the problem didn't happen.

*Example: Can you recall a time when you thought you would be dominated by the urge to binge, but instead you stood up to the urge?*

*Example: Can you tell me about a time when John was able to sit quietly and surprised you or himself?*

**Indirect Unique Outcome Questions**—These questions ask someone to speculate about the perceptions of others about the exceptions.

*Example: Can you understand how I might be surprised by your strength in standing up to the urge to binge?*

*Example: What things that you told me about not giving in to your temper do you think would shock your previous therapist?*

### ❖ Unique Account Questions

**Designed to elicit the internal experience or explanations about how the unique outcome came about.**

**Direct Unique Account Questions**—These questions ask the person to explain the exceptions reported.

*Example: How did you manage to stop bingeing?*

*Example: If this was a new trend in your relationship, what do you think made it possible for you two to take this new direction?*

**Indirect Unique Account Questions**—These questions ask someone to speculate about how others would explain the exceptions reported.

*Example: What do you think your parents are making of the fact that you stopped bingeing?*

*Example: How do you think I see your decision to take a new path in your life?*

### ❖ Unique Redescription Questions

**Designed to get people to rethink and reevaluate themselves and others based on the answers to the unique outcome and account questions.**

**Direct Unique Redescription Questions**—These questions ask people to rethink their ideas about the identities or qualities of the person who has been having the problem based on the exceptions and explanations about the exceptions that have been offered.

*Example: What does your decision to stop bingeing tell you about yourself?*

*Example: What do you think John's decision to ignore the whispers of paranoia tell you about him that you wouldn't have otherwise known?*



**Indirect Unique Redescription Questions**—These questions ask the person who has been having the problem to speculate about how others might be reevaluating their ideas about the “problem person’s” identity or qualities based on the exceptions and explanations about the exceptions that have been offered.

*Example: What do you think your friends would think about you since you have come to think of yourself as able to stand up for yourself?*

*Example: How do you think my view of you has changed since hearing you describe yourself as incredible?*

**Relationship to Self Unique Redescription Questions**—These questions ask the person who has been having the problem to talk about effect of the previous discussion in the session on his or her relationship to him or herself.

*Example: What's it like for you to hear yourself describe yourself as incredible?*

*Example: What effect does knowing that you're resolved not to cut yourself anymore have upon your view of yourself?*

**Relationship to Others Unique Redescription Questions**—These questions asks someone to talk about the effect of the previous discussion in the session on their current sense of their relationship with someone else.

*Example: Can you speculate about how this view of yourself as incredible is changing how you're relating to me right now?*

*Example: What affect is hearing that Patrice views herself as incredible having on your relationship with her?*

**Historicizing Unique Redescription Questions**—These questions asks someone to talk about people or events in the past that provide evidence that the unique outcome could have been predicted or is not so surprising.

*Example: Is there someone who knew you when you were growing up who wouldn't be surprised by the fact that you've been able to stand up to the alcoholism bully?*

*Example: What incidents from your past would help me understand how you've been able to take the extraordinary steps you've taken despite hallucinations whispering in your ear?*

#### ❖ Unique Possibility Questions

Designed to invite people to consider new possibilities for the future based on the answers to the previous unique outcome, account, and redescription questions.

**Direct Unique Possibility Questions**—These questions ask about what new possibilities have been opened up for the person or his/her family by the discussion so far.

*Example: Can you tell me something about how knowing that you see yourself as incredible will affect what you do next?*

*Example: What new possibilities will open up for you now that you have realized that you are onto the tricks anorexia has played on you?*

**Indirect Unique Possibility Questions**—These questions ask someone to speculate about what new possibilities have been opened up in someone else's view by the discussion so far.

*Example: How do you think your parents will be able to treat you differently now that they know that you see yourself as a person who is capable of defeating temper tantrums?*

*Example: How do you think your having consolidated this new view of yourself will affect my consultation with you?*

**Relationship to Self Unique Possibility Questions**—These questions ask the person to predict what changes the discussion so far will bring about in his or her relationship to him or herself.

*Example: What difference will your acting out of the sense of yourself as incredible make to your relationship with yourself?*

*Example: How do you think that realizing you are onto the illusion of hallucinations will help you think of yourself differently?*

**Relationship to Others Unique Possibility Questions**—These questions ask someone to speculate about what changes will happen in the relationship with someone else as a result of the discussion so far.

*Example: When you have been consistently acting out of this new understanding of yourself, how do you think the hospital staff will interact with you when they see?*

*Example: How do you think Jim's new sense of himself as competent will affect your trust in him?*

## **Couples, Families & Relationships**

## **ACCOUNTABILITY AND CHANGE IN VIOLENT BEHAVIOR**

- 1) Invite and encourage descriptions of the violence that has occurred.
  - ❖ Avoid blaming or agreeing with blame or determinism
  - ❖ Acknowledge current feelings and points of view without agreeing or closing down the possibilities for change
  - ❖ Ask curiosity rather than agenda questions
  - ❖ Record the description (by writing, audio or video)
  
- 2) Ascertain therapy goals and preferences and wishes for the relationship.
  - ❖ Ask what brought the person, couple or family to therapy and how therapy could help
  - ❖ Ask about what kind of relationship he or she wants with his or her partner/family
  - ❖ Highlight especially any ideas or wishes for a non-violent relationship
  
- 3) Ask about what has and hasn't worked in the past regarding violence.
  - ❖ Ask about unsuccessful attempts to avoid or stop violence
  - ❖ Ask about successful actions or points of view that have helped avoid or stop violence
  - ❖ Suggest changing or interrupting action and thinking patterns that don't work and doing more of the actions and thinking that do work
  
- 4) Ask the person, couple or family about recent trends in the relationship, especially in regard to violence and how they would prefer their relationship to be.
  
- 5) Externalize ideas, habits and feelings that have dominated the person, couple or family or have allowed anyone not to recognize choices and accountability.
  - ❖ Challenge fixed, problematic ideas about each person
  - ❖ Challenge non-accountability, blame, devaluing ideas and actions
  - ❖ Highlight each person's accountability in relationship to those actions and ideas
  
- 6) Ascertain the person who has been violent's readiness and commitment to pursuing and being responsible for a non-violent life.
  - ❖ Ask about commitment to accepting accountability for past violence
  - ❖ Ask about/challenge the readiness or commitment to change
  
- 7) Help the person, couple or family make action plans for safety and ensuring non-violence
  - ❖ Get specific about when, where, how, who and what
  - ❖ Develop a credible (and private) escape plan and codes for the abused person
  
- 8) Develop a relapse prevention plan
  - ❖ Identify warning signs
  - ❖ Get a commitment to preventive actions if warning signs appear

## **ACKNOWLEDGMENT**

Sometimes your partner wants you to listen and hear his or her feelings or points of view. He or she may also want a change in actions, but first let the other person know that you've understood and heard their feelings or thoughts. You don't necessarily have to agree with them, but don't invalidate them (that is, suggest that they are silly, not reasonable, wrong or invalid).

### **Key Points: Ways to Acknowledge**

- Repeat back to your partner what he or she has just said in similar words to show you have heard and understood. Examples: "So you were upset when I was late," or "You don't think I do anything around the house."
- Tell your partner that you understand how they could see or feel about things the way they do. Examples: "I can understand that you were upset by that," or "You really feel burdened by the housework and think I don't participate the way I should."
- There's no need to tell your partner you agree with their point of view, just take care not to give him or her the message that he or she shouldn't feel or see things that way. That means not saying things like, "That's crazy!" or "You are so wrong about that," or "Why are you so sensitive?"

### **Actions Steps: Acknowledgment**

- ⇒ Get your partner to tell you about a time when he or she did not feel heard or understood and what you did or said that contributed to their sense of not being acknowledged.
- ⇒ Get your partner to tell you about a time when he or she felt really heard or understood by you and what you did or said that contributed to their sense of being acknowledged.
- ⇒ Practice deliberately increasing the actions that gave your partner a sense of being acknowledged for the next week.

## **ACTION COMPLAINTS**

Instead of telling your partner/family member that the problem is what he or she is, it is usually less threatening and more conducive to change to focus on what he or she does that is a problem for you. Sometimes we complain to our partners/family members in “packaged words”—words and phrases that may mean something specific to us, but in which the meanings are not clear to our partners/family members. It's best to unpack those vague words and phrases and get specific.

### **Key Points: Action Complaints**

- Translate packaged words into specifics. The listener must be able to see/hear it as if it's on a video.
- Focus on actions, voice tones, voice volumes, facial expressions, gestures, and specific words.
- Avoid blame, diagnosis, mind-reading and generalizations.
- Complain about actions, not personalities or theories.
- Talk about specific incidents.
- Don't guess about the other person's intentions or feelings.
- Archaeological digs for the past hurts are not helpful because the facts are obscured by time and there is little the person can do to change the past. Focusing on recent events is helpful.
- Telling the person your interpretation (story) about their actions can be okay. Just remember to distinguish it from the facts (videotalk) and to realize the other person may have, in fact probably does have, an entirely different story about the same situation.

### **Action Steps: Action Complaints**

- ⇒ Tell your partner/family member three things that he or she has done that you haven't liked. Do not give them your theory or story about why they did it or a prediction about what they will do about it in the future. Avoid generalizing or labeling. Get specific about what it looked like and sounded like.
- ⇒ Get your partner/family member to tell you three things that you have done that he or she hasn't liked. If they give you their theory or story about it or are vague, gently steer them back to getting specific with videotalk by suggesting that you really want to know what they would like you to change.

## **ACTION PRAISE**

Sometimes we neglect to tell our partners/family members the things we appreciate about what they do. Even when we do comment on what we like about our partner/family member or the relationship, sometimes we are vague or general. Being in a relationship can be a constant learning experience if you both consistently give each other praise that is specific.

### **KEY POINTS: ACTION PRAISE**

- Use videotalk to describe current or past actions you liked when your partner/family member did them.
- It's okay to talk about general categories, for example, "I like it when you think of me when I'm not around," as long as your partner/family member has enough specific examples to be able to understand what you mean.

### **ACTION STEPS: ACTION PRAISE**

- ⇒ Catch your partner/family member doing something that you appreciate once each day for the next week. Let your partner/family member know about it as specifically and quickly as possible after he or she does it. If you like the results, consider making it a habit!
- ⇒ Write a love letter to your partner/family member telling him or her about a time when you felt really close to him or her or especially cared for. Be sure to include specific descriptions of what your partner/family member did that led to your feelings.

## **ACTION REQUESTS**

Action requests involve asking your partner/family member to do something different in the future. Instead of trying to get your partner/family member to change his or her insides, it is usually less threatening and more conducive to change to focus on what they could do that you would like. Sometimes we phrase our requests in vague language. It's best to get specific. Here are some hints about how to do that.

### **Key Points: Action Requests**

- Avoid vague phrases and words and stories (explanations and theories about why they have or haven't done things) when making requests.
- Make sure the requests are as specific as possible about time and actions.
- Teaching the other person what "love," "respect," and other vague words look like and sound like for you can lead to you getting more of what you want (and less of what you don't want) in the relationship.
- If the request does not work, re-phrase the request or see if there was a misunderstanding about the actions requested.

### **Action Steps: Action Requests**

- ⇒ Get your partner/family member to fill in the blank in the following sentence. "I would like you to \_\_\_\_\_ (description of some action your partner/family member would like you to do in the future) by \_\_\_\_\_ (fill in the date)."
- ⇒ Give your partner/family member one request using action language. "I would like you to \_\_\_\_\_ (description of some action you would like your partner/family member to do in the future) by \_\_\_\_\_ (fill in the date)."



## ACTIONS, STORIES, AND EXPERIENCE

### Actions

- Actions–videotalk
  - Interactions
  - Patterns of actions
  - No added meanings (X=X)
- 
- 

**Some actions are okay (ethical, not harmful to self/others, and lead toward a better relationship) and some are not okay (unethical, harmful to self/others and lead away from or block better relationships).**

**Encourage the okay actions and discourage, block, or provide consequences for actions that are not okay.**

### Stories

- Ideas, points of view, hypotheses, explanations and beliefs that people have about themselves or others.
  - Stories can be about the past, the present, the future or one's identity.
- 
- 

**Some stories are okay (help the relationship) and some are not (hinder the relationship).**

**Use stories that are not blaming, that validate, that open up possibilities for change, that create closeness, and that hold people accountable for what they do.**

**Discourage stories that are self-blaming, blame others, create distance, suggest that change is impossible, or view self or others as nonaccountable.**

### Experience

- Feelings
  - Sensations
  - Fantasies
  - Automatic thoughts
  - Core sense of self
- 
- 

**Experience is all okay.**

**Acknowledge all your and your partner's experience.**

## CONJOINT INTERVIEWING STRATEGIES

### 1. Summarize, validate and soften

*This strategy ensures that the therapist is listening adequately, as well as validating each person without taking sides. In addition, through slight word changes, the therapist can soften what might be a blaming or discouraging communication from one person to another.*

### 2. Self-disclosure/storytelling

*This strategy has several functions. One is to join and more equalize the relationship (we all have issues and struggles in relationships, not just clients). Another is to normalize by helping couples realize that others may have the same kinds of issues, points of view or feelings. The last element of this strategy is to suggest new possibilities for actions or points of view.*

### 3. Identifying and tracking problem patterns

*This strategy, often combined with getting specific, helps the therapist understand what the couple, family or one member is concerned about and how he or she experiences the problematic situation. In addition to getting an idea of the problem, the therapist is searching for typical patterns in the problematic interactions or situations.*

### 4. Identifying and tracking solution patterns

*This strategy, again often combined with getting specific, is used to evoke and highlight more helpful actions and points of view related to the problem based on the couple's or family's past experience.*

### 5. Suggesting possibilities

*This strategy offers ideas from the therapist's experience that might be helpful in the future, either based on what the couple or family has said so far (usually derived from the solution patterns) or based on some ideas the therapist has. It is important to give these suggestions in a tentative manner, not to impose them on couples or families. But it is just as important not to leave the therapist's ideas out of the conversation in the name of neutrality or a non-expert position.*

### 6. Getting specific/action descriptions

*This strategy involves getting the couple or family to tell the therapist about specific incidents and actions, so the therapist can understand the couples situation without having to project or interpret as much as would be necessary with more vague descriptions. This often involves the use of what I call "videotalk," that is, having people describe the situation as if it could be seen and heard on a videotape.*

### 7. Naming classes of solution or problems and initiating searches

*This strategy involves using vague, general words or inquiries to facilitate the evocation and organization of problem or solution categories or specific incidents that could be examples of those categories.*

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## CONTRASTING APPROACHES TO THE TREATMENT OF DOMESTIC VIOLENCE

### Traditional Approaches

- Advocate for the victim only
  
- Confront the man's denial
  
- Get the man to admit his violence, responsibility for his violence and learn to express his feelings in other, less violent ways
  
- Violence is seen only as a means for men to control women
  
- Women's violence is de-emphasized or seen only as a result/response to men's violence
  
- Views the man as unable or unwilling to control his violence
  
- Never see the couple together in treatment until the man has gone through the program, admitted his violence and responsibility for his violence
  
- Focuses on times of violence

### Possibility Therapy

- Advocate for both partners and, if they want, for the relationship
  
  - Acknowledge the violence by getting a sensory-based description, perhaps even recording the description
  
  - Goals are individualized for each client or couple. While the goals need to include non-violence, they also include what is important to each partner and to the couple
  
  - Violence is viewed as having multiple meanings, some of which the partners or couples will provide if asked respectfully
  
  - Both partners are held accountable for violent behavior, regardless of larger social issues/patterns, which can be acknowledged, but never offered as an excuse for non-accountability
  
  - Views the man as capable and willing to control his violence and finds evidence through investigating past successes at avoiding violence
  
  - Couples may be seen together or apart, depending on the level of violence, the safety factors, the preferences of the couple and each partner
  
  - Focuses on exceptions to violence and success patterns
-

## **ESCALATING INTERVENTIONS FOR DESTRUCTIVE/HARMFUL BEHAVIOR IN RELATIONSHIPS**

- ❖ Clarify the limits and requests in the area of dangerous behavior.
  - ❖ Clarify accountability.
    - Make sure each person is held accountable for his/her actions.
    - Clarify the boundaries for acceptable behavior in videotalk.
  - ❖ Change the patterns around the problem.
    - Any of the people involved may make changes in the pattern, but make sure the person who has been doing the destructive behavior continues to get the message that he/she is accountable for the destructive behavior.
  - ❖ Help the family or the person set and apply consequences.
    - These consequences may be escalating from light to severe, including involvement of the legal authorities and severing the relationship.
  - ❖ Get the boundary violator to make amends and to reaffirm his/her commitment to staying within the limits.
    - Often this involves actions more than words. The boundary violator must show consistent trustworthy behavior over time to reestablish the others' trust in the safety of the situation. Find out how long the person has gone in the past staying within limits and use that as a yardstick to measure progress. You may have to arrange for regular long-term follow-up to ensure that the destructive behavior is not recurring.
-

## **FIVE LEVELS OF INTERVENTION IN COUPLES' THERAPY**

1. Acknowledge/validate each partner's points of view and feelings without necessarily agreeing with them. Get them to stop blaming, invalidating, closing down possibilities, and inviting, suggesting or allowing nonaccountability.
  2. Get people to translate blame (attributions of bad intentions/bad character), vague, mind reading or characterizing (attributions of unchangeable and determining personality traits) statements/questions into "videotalk."
    - \*Action complaints*
    - \*Action requests*
    - \*Action praise*
    - \*Negotiated agreements*
  3. Gather video descriptions of patterns of interaction involved in or around the complaint and get both or either partner to change their part of the pattern.
    - \*Change the location, time, nonverbals, etc.*
    - \*If it works, don't fix it; if it doesn't, do something different*
    - \*Import workable patterns from earlier in the relationship*
  4. Help to determine clear (videotalk) boundaries/limits for acceptable and unacceptable actions.
    - \*Coach the person whose boundaries are violated to give consequences when boundaries are violated.*
    - \*Coach the person who has violated the boundaries to acknowledge and be accountable for the violation, reestablish trust and make amends.*
    - \*If appropriate, help the couple or individual design and carry out a healing ritual.*
  5. Do individual work when an individual within a couple has something they want to work on that would be relevant to achieving the goal(s) of the conjoint work.
-

## **GUIDELINES FOR COUPLES' COMMUNICATION**

### **1. Action Complaints**

Don't give the person your theory/explanation (why they did what they did) along with your complaint.

Tell the person what they did that didn't work for you.

Use videotalk. If the person can't picture/hear it, you aren't being specific enough to ensure your message will be heard.

Avoid blame, diagnosis and generalizations.

### **2. Action Requests**

Use videotalk.

Ask the person to do something different in the future.

Don't tell them what is wrong with them when you make the request.

Don't assume they won't do it. Give them a chance to show you.

Get specific about when or how often you would like them to do what you've asked.

### **3. Acknowledgment**

Listening/acknowledging the other person's feelings and points of view.

No rebutting. Just listen. See if you can understand what the other person is trying to communicate to you.

You don't have to agree that what they are saying is correct, but don't give them the message they are crazy for seeing things that way. Don't dismiss or minimize.

### **4. Breaking Patterns**

Change your part of any pattern that you notice isn't working.

Do anything that is not cruel or unethical that would be different from what you usually do in the situation.

If it's working, don't fix it. If not, do something different.

*Remember: "Insanity is doing the same thing over and over again and expecting different results." – Rita Mae Brown*

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## **INTEGRITY, BOUNDARIES/LIMITS, CONSEQUENCES AND AMENDS**

### **INTEGRITY = KEEPING YOUR WORD AND RESPECTING LIMITS/BOUNDARIES**

- ❖ Keep your word and your agreements. Do what you say you'll do and don't do what you say you won't do.
- ❖ Get clear on the limits and boundaries (in videotalk, explicit descriptions of actions or results) and abide by them. Boundaries, limits and agreements may be explicit or implicit. If there is a problem, make sure that they are made explicit and clearly identifiable.

### **ACKNOWLEDGING BROKEN AGREEMENTS AND BOUNDARY VIOLATIONS**

When you've broken your word or violated a boundary:

- ❖ Acknowledge it to the people affected
- ❖ Be accountable. Don't give excuses or blame others for your actions.

### **CLEANING UP YOUR INTEGRITY AND REESTABLISHING BOUNDARIES**

- ❖ Offer to make amends (if possible)
- ❖ Ask what you could do (if anything) to reestablish the person's trust in you
- ❖ Reaffirm the boundaries and agreement, if appropriate

### **PROVIDE CONSEQUENCES FOR THE BOUNDARY VIOLATOR IF THE VIOLATIONS CONTINUE**

- ❖ If one person continues to violate the established agreements or limits, get the other to set up escalating consequences that will affect the boundary violator in ways he or she will care about
  - ❖ Start small and work up to more serious and unwanted consequences
  - ❖ The ultimate (relational) consequence is to sever all contact with the violator if that is necessary for safety
-

## INTIMACY

Each person's view of intimacy may be different, but in our culture there seem to be some universal actions or categories of actions that enhance intimacy. Without turning them into rules, these are offered to help you create or enhance intimacy in your relationships.

### **The Martian's Guide to Intimacy**

- Affiliation (Being near and spending time with)
- Authentic communication (Showing vulnerable feelings, hopes and dreams)
- Discussing the relationship
- Affectionate touching (Sexual touching/contact)
- Daily loving behaviors

### **Key Points: Ways to Create Intimacy**

- Teach your partner what intimacy looks like and sounds like to you and the things he or she has done to help you feel closer.
- Eliminate criticism or judgment of your partner's insides or core self, that is, about the way the person is rather than what they do.
- Eliminate barriers, such as anger styles and lack of boundaries around the relationship, that hamper intimacy.

### **Action Steps: Intimacy**

- ⇒ Get your partner to tell you about a time when he or she felt closest to you. What did you do or say that contributed to that closeness?
  - ⇒ Get your partner to tell you about a time when he or she felt distant from you and what you did or said that contributed to your partner's sense of distance. Listen without defending yourself or trying to correct your partner. Just receive the information and let it soak in for a while.
  - ⇒ Tell you partner about a time when you felt closest to him or her and what your partner did to facilitate that feeling of closeness.
-



## **LOVE**

### **Key Points: Love**

- ❖ Create the setting for love to grow. You cannot make someone else love you, but you can create an environment where love is likely to grow.
- ❖ Take 100% responsibility for the relationship. Don't wait for him or her to do their half first.
- ❖ If you wait for them to do something first, before you love them, you may end up missing the boat.
- ❖ Transcend your story about what love is—the map. Consider that what they are doing right now may be their way of showing love.
- ❖ Remember that love is essentially a mystery; verbs are not the only form of speech or a complete vocabulary. Actions aren't everything.
- ❖ Rather than looking for love, come from love. You can control the power to let your love shine, rather than waiting for someone to throw the switch.

### **Action Steps: Love**

- ⇒ When you go home tonight, act as if the person you are with is the love of your life. Imagine the voice tones you would use, how you would touch them, what you would say—then let all your actions be consistent with love.
-

## **LOVE IS A VERB SUMMARY POINTS**

- ❖ Your stories about the way it is might not be the way it is.
    - ☞ Avoid stories that blame, invalidate, discourage or hinder the relationship.
  - ❖ Remember to acknowledge the other person's experience (e.g. feelings, thoughts, fantasies, points of view, etc.). That doesn't mean you agree with them, just that they have a right to their own perceptions and feelings.
  - ❖ Feelings, thoughts and stories don't control your actions, you do!
  - ❖ Talk about what you like and would like in videotalk, complain about what you don't like in videotalk.
  - ❖ When what you are doing isn't working, try something different.
  - ❖ Find what actions work and do more of them or do them more consistently.
  - ❖ If necessary, set specified limits for the other person's actions and give consequences when those boundaries are crossed. Use videotalk.
  - ❖ Learn about what looks and sounds like intimacy and love to your partner and start doing those actions more consistently. Teach them what looks like intimacy and love to you.
  - ❖ When you're hot, you're hot and when you're not, you're not.
  - ❖ Communicate about what you like and don't like about your partner's sexual actions with you. Ask for what you want sexually, don't demand it.
  - ❖ Be 100% accountable for making the relationship work.
  - ❖ Remember to come from love rather than waiting for it to come to you.
-

## **MAKING RELATIONSHIPS LAST**

### **Key Points: Making Relationships Last**

- How big is your bowl? What are you willing to stay through?
- Life is composed of many transitions. If you stick through them and learn to love your partner through the changes, you will have a relationship that lasts.
- Don't be a relationship wimp.
- Ethics, commitment, skills, and humor are key ingredients to making relationships last.

### **Actions Steps: Making Relationships Last**

- ⇒ If you feel like leaving, postpone it, unless you are in danger.
  - ⇒ Avoid legal actions unless you are certain that you should leave. Once a legal battle starts, it is much harder to turn things around.
  - ⇒ Look at the big picture of how your life has gone through stages both as an individual and as a couple. Realize that change in all of life is inevitable.
-

## MIX'N'MATCH SEXUAL MENU

### Doers

Fingers

Tongue

Mouth

Penis

Vagina

Hand

### Does

Mouth

Clitoris

Penis

Vagina

Breasts

Nipples

Anus

Skin

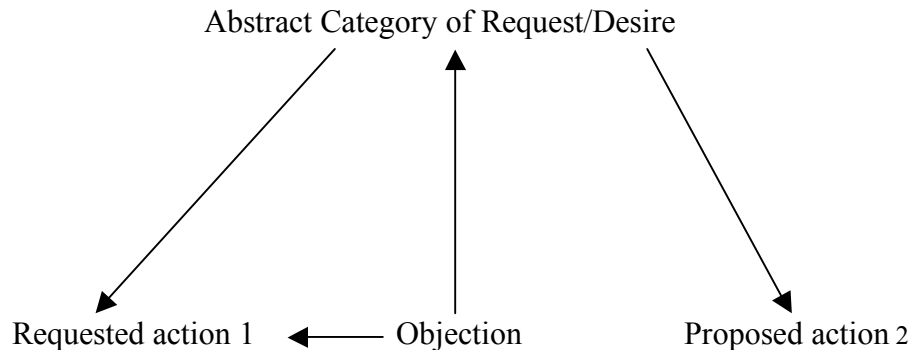
This list is offered to facilitate communication between couples about sexual interests, preferences and experiments. Each partner is to draw lines between items in the doers column to items in the does column to indicate an interest in that particular combination.

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## NEGOTIATED AGREEMENTS

### Four Methods of Resolving "Intractable" Disagreements

#### Find a new action that meets the same request or desire



#### Compromise

Requested action  
by one person

Objection

Split the difference

Objection

Requested action  
by the other  
person

#### Time-limited experiments

Try doing it each person's way for a time, then check each person's experience and results.

#### Drop it for a time

Agree to disagree and not make a decision or take any hasty or radical actions. Focus on other areas of the relationship that can be changed or negotiated.

## **REWRITING LOVE STORIES: BRIEF COUPLES' THERAPY**

1. Acknowledge/validate each person's feelings and points of view without closing down the possibilities for change.
2. Move the discussion from complaints about things the couple hasn't liked in the past to what they would like to have happen in the future.
3. Get people to translate blame (attributions of bad intentions/bad character), vague, mind-reading, invalidating or characterizing (attributions of unchangeable and determining personality traits) statements/questions into "videotalk."
  - \*Action complaints
  - \*Action requests
  - \*Action praise
4. Identify and negotiate mutually agreeable goals and plans in "videotalk."
5. Gather video descriptions of patterns of interaction involved in or around the complaint and get both or either partner to change their part of the pattern.
  - \*Change the location, time, nonverbals, etc.
  - \*If it works, don't fix it; if it doesn't, do something different
  - \*Identify and encourage solution patterns
6. Help to determine clear (videotalk) boundaries/limits for acceptable and unacceptable actions.
  - \*Coach the person whose boundaries are violated to give consequences when boundaries are violated.
  - \*Coach the person who has violated the boundaries to acknowledge and be accountable for the violation, reestablish trust and make amends.
  - \*If appropriate, help the couple or individual design and carry out a healing ritual.
7. Co-design with clients task assignments to help translate in-session changes to the couples' life. Give clients an idea of the kind of tasks you think would be helpful and elicit their collaboration in designing their specific task. Elicit any objections or barriers to carrying out the task(s) before it is finalized and agreed to. Write down the task and keep a copy. Follow up by asking about the task at the beginning of the next interview.
8. Use humor to help the couple lighten up and see the possibilities for change.
9. Do individual work when an individual within a couple has something they want to work on that would be relevant to achieving the goal(s) of the conjoint work. Make sure that you don't imply that the person you are doing individual work with has the "real" relationship problem.

## **SEXUALITY**

### **Key Points: Sexuality**

- Use the same principles of action complaints, action requests, action praise and negotiated agreements detailed in earlier handouts and apply them to sexual actions and interactions. Avoid complaining about your partner's being ("You aren't sexy." or "You've gained too much weight.") and focus instead on things he or she can change (actions).
- It's okay to have your fantasies and attractions. Remember that you have choices about what you do about those fantasies and attractions. Be accountable for your actions and challenge shame about your inner experience (fantasies, attractions, preferences, etc.)
- It's okay to ask for what you want sexually, but don't demand it or force it on your partner. Don't shame them for asking for what they want. Politely but firmly refuse to do something you are uncomfortable doing or don't want to do.
- Don't try to pretend or force yourself to be sexually excited when you are not. That doesn't mean you can't do sexual activities if you are not aroused.
- Try varying your sexual routines. Couples often fall into habits, which can lead to boredom or block the discovery of new and interesting sexual patterns.

### **Actions Steps: Sexuality**

- ⇒ Get your partner to tell you what he or she likes best about your sexual actions.
- ⇒ Tell your partner what you like best about his or her sexual actions with you.
- ⇒ Both partners fill out the Mix'n'Match Sexual Menu (see handout) and exchange it with each other.
- ⇒ Give each other Pleasure Teaching Sessions, having one partner focus on stimulating the other and having the stimulated partner tell the other partner what feels the best and what he or she would like more and less of.

## **SOLUTION-ORIENTED COUPLE AND FAMILY THERAPY**

### **□ Indications for Conjoint Sessions**

- \*When one person complains about another
- \*When one or more people complain about the relationship
- \*When individual therapy isn't working

### **□ Directions for Intervention**

- \*Change the viewing (perceptions/frames of reference) of family members of each other and the situation
- \*Change the doing (actions/interactions/languaging) of family members and others involved in the situation
- \*Evoke solutions/abilities/strengths/creativity of family members to resolve their situation

### **□ Places and Methods for Intervention**

#### **\*In-Session**

- Solution-oriented interviewing and assessment
- Storytelling/metaphor
- Evoking contexts of competence
- Interrupting repetitive negative interactions
- Redirecting vague/blaming conversations
- Acknowledging each person's feelings and points of view
- Opening up or emphasizing change possibilities and processes
- Externalizing blaming/shaming ideas and stories

#### **\*Between Sessions**

- Action plans/ideas to remember or consider
- Letters/phone calls/books/tapes
- Individual sessions



## SOLUTION-ORIENTED RELATIONSHIP COUNSELING

Step 1 Distinguish between the facts and the stories (frames)

*Search for video descriptions amid the explanations and blame*  
*Use benevolent skepticism - Cast doubt on unhelpful stories/labels*  
*Impossibility stories*  
*Blaming stories*  
*Invalidation stories*  
*Non-accountability stories*

Step 2 Acknowledge each person's feelings and points of view

Step 3 Identify goals and if possible, find abstract mutual goals

Step 4 Search for exceptions to the problem

*Previous solutions*  
*Good times*  
*From contacts with previous helpers*

Step 5 Use stories and analogies to reframe the situation

Step 6 Get people to say what they don't like and what they would like instead in specific terms (videotalk)

**Action Complaints**

*Unpack packaged and empty words to video descriptions and equivalences*

**Action Requests**

*Specifies who is to do what actions*  
*Time frames*  
*Checkpoints*  
*Specific actions, results or classes of action*

Use multiple choice questions and examples that are slanted towards action descriptions

Step 7 Link the requested actions to the other partner's self-interest/motivations or the mutual goals

*Tit for tat*  
*Consequences - desirable or undesirable*

Step 8 Task assignments

**Pattern interventions**

*When in a dilemma, introduce novelty*  
*Alter time, place, actions, voice tone, voice volume, gestures, words, other nonverbals, any regularity*

**Changes in perceptions**

*Notice what is happening that you want to have continue*  
*Catch each other doing something right*  
*Change identity stories*

Step 9 Accountability, limits and consequences

Acknowledge each person's actions as their own and hold them accountable  
Get clear on limits/boundaries and help them set consequences and follow-through on those limits and consequences

## **STEP-PARENTING HINTS**

### **3 approaches to stepparenting that usually don't work**

- ❖ You and your ex screwed up these kids and now I'm going to fix them
- ❖ We're an instant family with instant love
- ❖ "Why don't you get your kids to . . .?" or "Do you know what your kids did?"

### **Some hints about what might work**

- Beware the triangle—use one-to-one communication when possible
- Circle the wagons—draw boundaries around the marital relationship and around the new/blended family
- Take your parenting disagreements behind closed doors and present a united front with the kids
- Don't take it personally—Use action language and escalating consequences
- Build up credits in the relationship bank before you make withdrawals
- Remember that no one has a lock on "correct" parenting
- If all else fails, try the roommate or friend models for being a stepparent

# **Sexual Abuse**

## **ADULTS MOLESTED AS CHILDREN FIVE SESSION GROUP OUTLINE**

### **Session 1**

- ◆ Purpose of the group: To help participants move on and get unstuck, not necessarily to resolve every issue. Recovery may take a long time, but treatment can be brief.
- ◆ Participants introduce themselves. I ask each participant to imagine a future in which they have resolved the abuse and it no longer haunts them. What kinds of things would they be doing, thinking, feeling and experiencing that they don't typically have in their lives currently? How would other people know that they had resolved these issues or reached that future? What would be the first sign that they are moving in that direction? (It may have happened already since they signed up for the group.) I ask each participant to rate where they are on a scale on 1-100 where they are in respect to that future.
- ◆ Participants each get a copy of Yvonne Dolan's Solution Focused Recovery Scale, which they fill out between the first and second group.
- ◆ I tell the story of my abuse by a grandfather, to help participants feel more comfortable speaking about their abuse.
- ◆ I ask each participant in turn one question about some aspect of the abuse (see my list of questions in another handout). They can pass (not answer), say they don't know or aren't sure, say they aren't willing to answer or they can answer. Hearing each person answer the questions normalizes and gives permission for many different experiences and for recognizing the similarities of experience. Speaking about these things out loud in front of others often removes some of the shame or discomfort associated with acknowledging the abuse. Getting the story one piece at a time helps the person avoid collapsing into reliving the abuse experience. After each participant has answered the questions and said anything else they want to say, I tell them a story about a woman who told someone about her sexual abuse and then coached him on how he was to respond. I ask each participant to teach the group and me what they need to hear or to do after having just publicly acknowledged the abuse. Sometimes there are things that the group can do or say right there and we do.
- ♣ Lastly, I give a short "healing trance," which participants can join or watch. Some choose to keep their eyes open and some close their eyes.

### **Session 2**

- ◆ We begin the group by discussing what changes and results came from the last session or just happened between groups. Some participants want to expand or amend their answers to the previous week's questions. I ask each participant to again rate their progress on a scale of 1-100.
- ◆ Next I give a little mini-lecture about dissociated, devalued and disowned aspect of self and symptoms of inhibition or intrusion/compulsion. Participants discuss their symptoms and we get some idea about what aspect of themselves they might have split off and devalued. Each participant makes a plan for taking one step toward valuing the devalued aspect.
- ♣ We end with another, slightly longer healing trance.

### **Session 3**

- ◆ We again begin the group by discussing what changes and results came from the last session or just happened between groups. I ask each participant to again rate their progress on a scale of 1-100.
- ◆ The topic for this week's mini-lecture is patterns. I talk about recognizing and breaking up patterns that don't serve you well (problem patterns) and finding your solution and resource patterns. Each participant makes a plan for doing one thing to break up a problem pattern in the next week.
- ♣ We end with another healing trance.

#### **Session 4**

- ◆ We again begin the group by discussing what changes and results came from the last session or just happened between groups. I ask each participant to again rate their progress on a scale of 1-100.
- ◆ The topic for the mini-lecture is boundaries. Using analogies of castles and doors, I talk about having too many boundaries (a castle with no openings becomes an isolating prison; a door which has no doorknob traps you in your room) and having no or poor boundaries (a castle with the brickwork falling down; a door that only opens from the outside). I help each person identify specific patterns in their lives related to boundaries and find a comfortable balance (a castle with a drawbridge; a door that is locked from the outside but can open easily from the inside). Each participant makes a plan for doing one thing to change their boundary patterns in the next week.
- ◆ I give each person another copy of Yvonne Dolan's Solution-Focused Recovery Scale to complete before the last group meeting. They are asked to bring both the first one they filled out and the latest one to the next group.
- ♣ We end with another healing trance.

#### **Session 5**

- ◆ We again begin the group by discussing what changes and results came from the last session or just happened between groups. I ask each participant to again rate their progress on a scale of 1-100. Each person goes over the highlights of their Solution-Focused Recovery Scale and how it has changed since the group started.
- ◆ The topic for the mini-lecture is rituals, both connection/stability rituals and transition rituals. I explain the difference and the use and together we help each participant to plan and perhaps perform their rituals (some can be done right in the group).
- ◆ Then each person speaks about the changes they have made through the group and gives messages to anyone in the group that they want to in order to finish.
- ♣ We do a long healing trance and then say our good-byes.  
I ask participants to write me in a month to let me know what changes they have made and what has happened since the group ended and to let me know how I could make the group better.

## **BEWARE OF OVERDIAGNOSING MULTIPLE PERSONALITY DISORDER (MPD)**

❖ For years, Multiple Personality Disorder (MPD) was rarely diagnosed. True cases of MPD were often missed or misdiagnosed. Recently, the situation has reversed. MPD is now epidemic (North, C.S.; Ryall, J.M.; Ricci, D.A.; & Wetzel, R.D. **Multiple Personalities, Multiple Disorders: Psychiatric Classification & Media Influence.** New York & Oxford: Oxford University Press, 1993.). Colin Ross, well-known expert on MPD writes: "Within a span of ten years, we may evolve from extreme underdiagnosis of MPD to a situation in which the major problem is false positive diagnosis." (Ross, C.A. **Multiple Personality: Diagnosis, Clinical Features, & Treatment.** New York: Wiley, 1989)

❖ Prior to 1944, there were a total of **76** cases of Multiple Personality Disorder reported in the psychiatric literature (Taylor, W.S. & Martin, M.F., "Multiple personality," *Journal of Abnormal Social Psychology*, 39: 281-300, 1944). Because they were so rare and dramatic, most cases were probably written up. By 1970, 14 more cases had been reported, 6 of which were by one clinician, making for a total of **90** cases, almost all of which were in North America (Aldridge-Morris, R. **Multiple Personality: An Exercise in Deception.** London: Erlbaum, 1989). By 1986, it was estimated that **6000** cases of MPD had been diagnosed in North America (Coons, P.M., "The prevalence of multiple personality disorder," *Newsletter of the International Society for the Study of Multiple Personality and Dissociative Disorders*, 4: 6-7, 1986; Aldridge-Morris, 1989, p. 108; Ross, 1989, p. 5). In 1986, Frank Putnam wrote that "more cases of MPD have been reported within the last five years than in the preceding two centuries." (Putnam, F.W., "The scientific investigation of multiple personality disorder," in Quen, J.M. (ed.) **Split Minds/Split Brains: Historical and Current Perspectives.** New York: New York University Press, 1986, pp. 109-125)

❖ The average number of personalities "discovered" has risen from **2** from 1840 until 1944 to **25** in 1990. The maximum number of personalities reported has risen from **3** in 1850 to over **300** in 1990 (and still rising) (North, C.S.; Ryall, J.M.; Ricci, D.A.; & Wetzel, R.D., 1993)

❖ Following their account of the treatment of multiple personality in **The Three Faces of Eve**, authors Thigpen and Cleckley received a flood of inquiries and requests for treatment from individuals who had been diagnosed by their therapists or had self-diagnosed MPD. They found virtually no cases of true MPD among the cases referred to them. They wrote that MPD patients seem to have "a competition to see who can have the greatest number of alter personalities. (Unfortunately, there also appears to be a competition among some therapists to see who can have the greatest number of multiple personality cases)." (Thigpen, C.H. & Cleckley, H.M., "On the incidence of multiple personality disorder: A brief communication," *International Journal of Clinical and Experimental Hypnosis*, 32: 63-66, 1984)

❖ Martin Orne, in the Hillside strangler case, showed that he could suggest and co-create a personality that other clinicians accepted as legitimate. (Orne, M.T.; Dinges, D.F. & Orne, E.C., "On the Differential Diagnosis of Multiple Personality in the Forensic Context," *International Journal of Clinical and Experimental Hypnosis*, 32: 118-169, 1984)

## **BREAKING THE BAD TRANCE:**

### **KEY POINTS IN WORKING WITH COUPLES IN WHICH ONE OF THE PARTNERS HAS BEEN TRAUMATIZED**

1. People who have been abused often get triggered into a “bad”/symptomatic state that is like a trance. They go on automatic and lose contact with their resources, often feeling dissociated or acting in a dissociated, incongruent manner.
2. Couples often get into patterns of communication and interaction, which trigger off each other’s bad trance. Typical patterns are communications that blame, invalidate, close down possibilities, vague/ambiguous language or interactions that are repetitive and negative.
3. There are three main ways of helping couples avoid getting into bad trances together:
  - Help them use “videotalk” and stop trying to analyze, change or fix each others’ insides
  - Change patterns of actions between the two of them
  - Use externalization to change the relationship of the couple to the problems/symptoms and avoid self-blaming or other blaming

## **CONTRASTING APPROACHES TO THE TREATMENT OF THE AFTEREFFECTS OF SEXUAL ABUSE**

### **Traditional Approaches**

- Therapist is the expert and has model about sexual abuse to which the client needs to submit (Colonization/missionary model)
- Client is viewed as damaged by the abuse (Deficit model)
- Remembering abuse and the expression of repressed affect (catharsis) are goals of treatment
- Interpretation and management of transference
- Past-oriented
- Problem/pathology-oriented
- Must be long-term treatment or is seen as colluding in denial and minimization
- Invites conversations for insight and working through

### **Possibility Therapy**

- Client and therapist both have particular areas of expertise (Collaborative model)
- Client is viewed as influenced but not determined by the abuse history, having strengths and abilities (Resource model)
- Goals are individualized for each client, but do not necessarily involve catharsis or remembering
- Acknowledgment, permission, validation/valuing, inclusion and opening possibilities
- Present/future-oriented
- Solution-oriented
- Variable/individualized length of treatment
- Invites conversations for accountability and action and declines invitations to blame and invalidation

Parts of this chart were adapted by Bill O'Hanlon, M.S. from "Overcoming the Effects of Sexual Abuse: Developing a Self-Perception of Competence," by Michael Durrant and Kate Kowalski in **Ideas for Therapy with Sexual Abuse**, edited by Michael Durrant and Cheryl White (1990) Dulwich Centre Publications (Adelaide, Australia).



## **DEVELOPING A RELATIONSHIP WITH DEVALUED/DISOWNED/DISSOCIATED ASPECTS OF SELF**

“Love your suffering. Do not resist it; do not flee from it. It is only your aversion that hurts—nothing else.” –Herman Hesse

“Every part of us that we do not love will regress and become more primitive.” –Carl Jung

Sometimes people dissociate, disown and/or devalue aspects of themselves. They consider these aspects as “it” rather than “me,” bad rather than good or valuable, and have a sense that the experience happens outside their sense of themselves. These are usually feelings, "personality traits," "subpersonalities," memories, their bodies, parts of their bodies, certain sensations, or certain perceptions. What follows is a guide to helping people reestablish links with dissociated and/or devalued aspects of themselves.

- ❑ Acknowledging the existence of the aspect or experience.  
*This acknowledgment can be done to oneself and/or to others. Acknowledgment just means to take note of the experience, perception or aspect.*
- ❑ Developing a respectful relationship or dialogue with the aspect or experience.  
*This is a step beyond mere acknowledgment and may involve writing, drawing, inner or outer dialogue or any other method that allows for you and your experience to start to communicate on a respectful and mutual basis.*
- ❑ Making room for the aspect or experience. Allowing it to exist within the boundaries of the Self.  
*Instead of trying to get rid of or suppress the experience or aspect, this means to give it permission to exist within your experience or your self.*
- ❑ Valuing the aspect or experience.  
*Moving from considering yourself or the aspect or experience as bad, evil, unnecessary, etc. to actually considering yourself or the aspect good, valuable or helpful.*
- ❑ Embracing the aspect or experience.  
*Actively moving towards the aspect or experience rather than merely tolerating or allowing it.*
- ❑ Incorporating the aspect or experience.  
*Realizing experientially, not just intellectually that the aspect or experience is you and experiencing “it” in your body.*

## **FACTUAL QUESTIONS ABOUT SEXUAL ABUSE**

How old were you when you were first sexually abused?

How old were you when the sexual abuse stopped (if it ever has)?

How long did the sexual abuse last?

How or why did the sexual abuse stop?

Who did you tell about the sexual abuse (if anyone) at the time?

How did they respond when you had told them?

Did they do anything to help or protect you or stop the sexual abuse?

How many times (approximately) were you sexually abused?

Were you abused by a member of your immediate family of origin (parent(s), stepparent(s), brothers, sisters)?

Were you abused by a member of your extended family (aunts, uncle(s), grandparent(s), stepgrandparent(s), cousin(s))?

Did a friend of the family or person whom your family trusted abuse you?

Did the person or people who abused you touch your breasts/chest during the abuse?

Did the person or people who abused you touch your vagina during the abuse?

Did the person or people who abused you touch your penis during the abuse?

Did the person or people who abused you touch your clitoris during the abuse?

Did the person or people who abused you touch your anus during the abuse?

Did the person or people who abused you put his/her fingers inside your vagina during the abuse?

Did the person or people who abused you put his penis inside your vagina during the abuse?

Did the person or people who abused you put his/her fingers inside your anus during the abuse?

Did the person or people who abused you put his penis inside your anus during the abuse?

Did the person or people who abused you put his penis inside your mouth during the abuse?

Did the person or people who abused you have you touch his penis (or her vagina) during the abuse?

Did the person or people who abused you masturbate in front of you during the abuse?

Did the person or people who abused have you masturbate in front of him/her/them during the abuse?

Did the person or people who abused you put anything besides parts of their body inside your anus/vagina or mouth during the abuse?

Did the person or people who abused you tell you not to tell anyone about the abuse?

What did they say would happen if you told about the abuse?

Did the person or people who abused you threaten you if you told?

Did the person or people who abused you say anything to you during the abuse? What?

Who have you ever told about the abuse?

How did the people or person you told about the abuse respond?

### **Feelings/Experience/Perceptions During and After the Abuse**

Did you think at the time that the abuse was okay?

Were you confused during the abuse?

Were you scared during the abuse?

Did you feel physical pain during the abuse?

Did you feel physical pleasure during the abuse?

Did you enjoy the attention that the abuser gave you during the abuse?

Did you (do you) think the abuse was your fault in some way?

How do you feel about the abuse now?

[Note: These questions are designed to be used for clinical purposes, not for cases in which there is or will be forensic/legal involvement.]

## FUNDAMENTALISM IN SEXUAL ABUSE TREATMENT

“Our primary and ultimate loyalty as clinicians must be to our patients and their needs, not to our colleagues and their theories.” –Alan Gurman

“Nothing is as dangerous as an idea when it is the only one you have.” –Emile Chartier

“For every complex question, there is usually a simple answer. And it's usually wrong.”  
–H.L.

Menken

Fundamentalism is the belief that there is one true or correct interpretation or approach to any situation. It often gives rise to violence and the attempt to silence those who do not abide by its tenants and practices.

What follows are some common fundamentalist ideas that are found in the literature and workshops on treating sexual abuse victims/survivors.

- Survivors of sexual abuse must relive/re-experience the trauma in order to resolve it.
- Everyone who has experienced childhood abuse is psychologically, emotionally, or sexually damaged by the experience. If they do not know they are damaged, they are in denial or are dissociating.
- Treatment of the aftereffects of sexual abuse must be long-term or it is minimizing or denying the real trauma or post-traumatic effects. Short-term therapy is necessarily “band-aid” treatment and can never resolve the deeper underlying issues.
- Because many have denied or minimized sexual abuse, therapists must believe anything clients report about their abuse. Children never lie or distort perceptions and adult memories of abuse are always accurate and to be believed.
- Male therapists cannot and should not treat female clients for issues of sexual abuse.
- Clients who were victimized as children never had a choice about or were accountable for their actions in the abuse situation.
- All current symptoms or problems were caused by the abuse.

## GUIDELINES FOR AVOIDING FALSE MEMORIES OF SEXUAL ABUSE

- ❑ Children do not always tell the truth (about sexual abuse or other matters), but it is best in most cases to err on the side of caution in protecting the child. Finding physical evidence and witnesses, of course, is important. But sometimes in the absence of these, with compelling enough testimony from the child that seems uncoerced, it is best to ensure that the person who has been accused of perpetrating abuse does not have unsupervised access to the child until the matter is settled. There are some circumstances that are more doubtful about the accusation, however:
  1. *When a child claims or children claim repeated, group abuse and no physical evidence or witnesses outside the child or children can be found.*
  2. *When there was no recollection or report of abuse by the child until repeatedly or persistently questioned by a therapist.*
  3. *There is a custody battle or bitter divorce going on and there was no evidence or accusation of abuse before the battle started. A study conducted by the U. of Michigan Family & Law Dept. concluded that more than 50% of the allegations of sexual abuse made during custody cases were untrue.*
- ❑ Adults remembering childhood abuse is another story. With them, it's best to err on the side of caution in going public with the accusation, confronting the alleged abuser(s) with the accusation, and cutting off contact with the alleged abuser(s) or the family.
- ❑ Allegations or memories of sexual abuse cannot be conclusively proven by the presence of symptoms without corroborating physical evidence or direct witnesses.
- ❑ Most people who have been traumatized do remember the trauma.
- ❑ While the issue is not yet scientifically settled, there is evidence that memory is not always accurate (like a tape recorder) and can be distorted by input, coding or recall errors. Memory can also be influenced by current contexts and beliefs and direct and indirect suggestions.
- ❑ Remember to separate legal issues from therapy issues. If you are not a trained forensic investigator, be wary of validating claims of abuse or remembered abuse. Forensic investigators often audiotape or videotape their interviews with their subjects so the process can be reviewed by other parties to determine if a bias or influence was present.

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## **INHIBITION AND INTRUSION: POLARITIES OF TROUBLESOME AFTEREFFECTS OF TRAUMA**

The aftereffects of trauma often come in one of two polarities:

1.) Inhibited experience, sensations, perceptions or activities.

*Inhibited aspects are missing or lacking from the person's life or experience. The person has no room for or space for the aspect.*

or,

2.) Intrusive experience, sensations, perceptions or activities.

*Intrusive aspects dominate the person's experience at times. The person also might feel compelled to experience or do something.*

These aftereffects may occur occasionally or with regularity. A person might only experience one side of the polarity or may experience both sequentially or simultaneously.

In the table below are some examples of commonly reported aftereffects of both varieties.

<b>Inhibited/lacking</b>	<b>Intrusive/compulsive</b>
No sexual response/sensations	Compulsive/"addictive" sexuality
No anger, muted anger, compulsively nice	Rage; violence
Doesn't cry; never feels sadness	Convulsive crying, continued crying, crying with no clear trigger or reason
No memories (Might be lacking only visual, auditory, gustatory, olfactory, or kinesthetic or some combination)	Flashbacks (Might be visual, auditory, gustatory, olfactory, or kinesthetic or some combination)
Inhibited or muted perceptions (hysterical deafness, hysterical blindness, etc.)	Intrusive perceptions (intrusive or amplified sounds, visuals, smells, etc.)
No body awareness; lack of connection with certain body parts (e.g., the arms)	Somatic/medical symptoms; eating disorders; self-mutilation

Inhibited aspects of a person may be dealt with by having the person approach rather than avoid the aspect in whatever way makes sense to them and is acceptable. For example, a person might look through family scrapbooks or talk to family members to begin to approach missing memories. Or a person who rarely experiences anger may be given the suggestion to think of something that angers him or her and just let the anger be there without having to get rid of it, justify it or do anything about it. A person who lacks body awareness may get a massage.

Intrusive aspects can be dealt with in (at least) three ways: 1.) Time delays—putting a delay between the impulse to act and the action (e.g., having the person walk around the block five times before bingeing); 2.) Externalizing—putting the experience out into the world so the person can get some distance from it and some perspective on it (e.g., having them draw their flashbacks or cut a doll instead of themselves, naming the problem and coaching them to stand up and fight against its domination in their life); and, 3.) Agreements to limits—having the person agree to experience the impulse but not act on it (e.g., have them feel like cutting themselves but not act on that compulsion).

## INTERNALIZING AND EXTERNALIZING MOVES IN POSSIBILITY THERAPY

**Externalize** when the person has developed a “spoiled identity” or identified him/herself as the problem. Invite the person into a “hero identity” in which he or she is valued and seen as a personal agent who has stood up to, overcome or protested against giving in to the problem or the problem identity. Externalize **actions** that don't serve the person well or **stories** that blame, invalidate, give the person a sense of non-accountability or close down possibilities for change.

Externalizing does not necessarily mean throwing parts of the person out of his/her life. It usually means changing the relationship between the person and the problem and/or problem actions and stories. Often this can be communicated by using spatial metaphors.

Example: “So would you like to keep realistic hope closer to you and keep your distance from false hopes and unrealistic expectations?”

**Internalize**, embrace, and include **experience** when the person has been doubting or invalidating his/her experience or being devalued for or devaluing him/herself. Sometimes people dissociate, disown and/or devalue aspects of themselves. They consider these aspects as “it” rather than “me,” bad rather than good or valuable, and have a sense that the experience happens outside their sense of themselves. These are usually feelings, “personality traits,” “subpersonalities,” memories, their bodies, parts of their bodies, certain sensations, or certain perceptions. What follows is a guide to helping people reestablish links with dissociated and/or devalued aspects of themselves.

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- Developing a respectful relationship or dialogue with the aspect or experience.
- Making room for the aspect or experience. Allowing it to exist within the boundaries of the Self.
- Valuing the aspect or experience.
- Embracing the aspect or experience.
- Incorporating the aspect or experience.

## **MOVING ON: HEALING FROM SEXUAL ABUSE**

### **ACKNOWLEDGMENT**

- Tell the truth (to yourself and/or others) about what happened.
- Recognize, articulate and validate your feelings about and in the matter of sexual abuse.

### **GET CLEAR ON ACCOUNTABILITY**

- Accountability—Hold whoever did the abuse accountable for their actions without blaming them or excusing them.
- Get clear about what you did and what was done to you. Remove blame and invalidation about your part in the matter.
  - Blaming**=Attributing bad/sick/evil intentions or character traits to oneself or others
  - Invalidating**=Minimizing, denying or undercutting a person's felt experience, sense of self or point of view in a way that devalues them

### **USE STRENGTHS/RESOURCES/SURVIVAL SKILLS**

- Recognize and amplify strengths, survival skills and coping mechanisms.
- How did you survive and cope at the time of the abuse?
- What abilities did you develop in the past or have you developed since you have grown up?
- When have you surprised yourself at the competent or different way you dealt with something?

### **CHANGING PATTERNS**

- Challenge old (unworkable) patterns that continue as habits of that dominate your current life.
- Escape/avoidance patterns
- Self-destructive patterns
- Relationship patterns
- Introduce small changes in the patterns that constitute and surround the problem.
- Make changes in: location, body behavior, timing (duration, frequency, rate and schedule), intensity, clothing, antecedents, consequences, interactions or any other repetitive aspect of the situation.

### **CHANGING YOUR RELATIONSHIP TO THE PROBLEM**

- Recognize experience/feelings/sensations/thoughts.
- Develop a respectful relationship with those experiences. Establish communication with them.
- Embrace those experiences. Recognize them as part of you. Integrate them into your Self.
- Stand opposed to any oppressive and disrespectful ideas or actions that the problem tries to convince you about.



## **POSSIBILITY THERAPY WITH SURVIVORS OF SEXUAL ABUSE**

- Find out what the client is seeking in treatment and how she will know when treatment has been successful.
- Ascertain to the best of your ability that the sexual abuse is not current. If it is, take whatever steps necessary to stop it.
- Don't assume that the client needs to go back and work through traumatic memories. Some people will and some won't. Remember that everybody is an exception.
- Use the natural abilities the client has developed as a result of having to cope with abuse (e.g., being facile at dissociating). Turn the former liability into an asset.
- Look for resources and strengths. Focus on underlining how they made it through the abuse and what they have done to cope, survive and thrive since then. Look for nurturing and healthy relationships and role models they had in the past or have in the present. Look for current skills in other areas. Have the person tell you how they stopped themselves from acting on destructive impulses, got themselves to seek therapy, etc. despite having the aftereffects of sexual abuse.
- Validate and support each part of the person's experience and self.
- Use symbolic tasks and objects to help mark transitions from the past and to help externalize the problem or some experience to be worked on.
- Make provisions (e.g., contracts) for safety from suicide, homicide and other potentially dangerous situations if necessary. Make these mutual.
- Keep focused on the goals of treatment rather than getting lost in the gory details.
- Do not give the message that the person is "damaged goods" or that their future is determined by having been abused in the past. Remember that change can occur in the interpretations and actions/interactions associated with the event(s).
- Gently challenge self-blaming or invalidating identity stories the person has or has accepted from others.

## RECOGNIZING AND STANDING FOR YOUR BOUNDARIES

### ❑ Boundaries around self

- \*Letting others touch you/various parts of your body
- \*Others telling you what you think/feel/experience/are
- \*Letting others communicate with you (talking/writing/contacting/visiting/phoning)
- \*Access to home (keys, visits, phone calls warnings)
- \*Giving money to others/accepting money from others
- \*Touching others/various parts of their bodies
- \*Telling others what you think/feel/experience

### ❑ Limits

- \*Boundaries around relationship
- \*Limits for the other person's behavior when they are with you and when they are not with you
- \*Keeping your word/others keeping their word

### ❑ Hints

- \*Where/with whom have you not put up boundaries/limits when it would have served you well to do so?
- \*Where/with whom have you not let people, feelings in when it would have served you well to do so?
- \*You have the right to set boundaries, to say no and say yes.
- \*Get clear on your boundaries/limits
- \*Stand for your boundaries/limits
- \*Ask for respect of boundaries/limits from those with whom you interact
- \*If the boundaries/limits have been violated, get/give a clear statement of accountability, an apology (if appropriate), and a reestablishment of the commitment to the boundary. Arrange for restitution/amends if necessary.

## **SOLUTION-ORIENTED THERAPY WITH SEXUAL PERPETRATORS**

- ❖ Avoid using shame/blame-laced labels like “pedophile,” “sexual deviant,” “pervert,” or “sociopath” with perpetrators. Shame does not create an environment in which the perpetrator is likely to open up about his or her problem and cooperate in the change process.
- ❖ Do not devalue the person if he or she has violent/abusive fantasies. “[Perpetrators] should know that if they have thoughts or urges about using coercion in being sexual, that there are people who can talk to them, not judge them, and not respond to them in a punitive way.” (Judith Becker, Ph.D., President, Association for the Treatment of Sexual Abusers, quoted in *APA Monitor*, January 1994, Vol. 25, #1, p.1)
- ❖ Find out from the person about how he or she has resisted the urge to perpetrate or has broken the pattern.
- ❖ Research has shown that treatment can make a difference:
  - ❑ Sex offenders who complete their treatment programs have a lower recidivism rate than those who quit or fail their regimen. Stephen Kramer, Ph.D., in a study of 201 subjects at a state-run facility in Salt Lake City, showed that of the 124 who completed the program, 7.5% of the pedophiles were later caught in another offense; 12% of rapists were repeat offenders. All the exhibitionists (only 3 in the sample) reoffended. Those who completed treatment showed less deviant arousal when measured on a penile plethysmograph. Married men are more likely to stay in treatment than their single counterparts. Incest perpetrators were more likely to complete the treatment program than exhibitionists. Those who completed the program showed a reduced recidivism rate. (Michael Miner, Ph.D., on research carried out at U. of Minnesota Human Sexuality program) (Reported in *APA Monitor*, January 1994, Vol. 25, #1, p.34)
  - ❑ William Pithers, Ph.D., director of the Vermont Treatment Program for Sexual Aggressors, reports that of the 473 sexual offenders (including rapists and child molesters) who completed the treatment, 6% reoffended, versus recidivism of 38% for untreated offenders in follow-up of up to eight years. Janice Marques, Ph.D., of the California Dept. of Mental Health, studied sex offenders serving the last two years of their prison sentence. At a three-year follow-up, the group that received treatment reoffended at a rate of 5.4% and 798 days between reoffenses vs. 7.2% and 407 between reoffenses for those who refused treatment. (Source: *APA Monitor*, July 1992)
- ❖ Make a distinction between feelings/fantasies/urges and actions. It's okay to have inner experience of any kind, as long as you do not act on it. Make it acceptable to acknowledge the inner experience while setting clear limits about acceptable actions. Hold the person accountable for any actions he/she takes.

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## **SOLUTION-ORIENTED TREATMENT OF SEXUAL ABUSE AFTEREFFECTS**

### **ACKNOWLEDGE FEELINGS, PERCEPTIONS AND DESCRIPTIONS**

- Acknowledge the clients' experience/feelings about the abuse, even if she or he does not remember abuse or is uncertain abuse has happened.
- Acknowledgment is not the same as believing the abuse occurred or being able to prove it in a court of law. Remember you are not doing a legal investigation when you are providing treatment. Leave that to forensic psychologists and psychiatrists and to the lawyers and legal system.

### **FOCUS ON THE CONCERN THAT BROUGHT THE CLIENT TO THERAPY**

- What is the client complaining about? What is not working or is bothering them in their **current** life? Beware of focusing on the past because your therapeutic model/belief holds that the past must be delved into before the current problem is resolved.
- Sometimes clients have been convinced by books, other therapists, media stories or just the current fashionable beliefs that they must remember details about the abuse in order to resolve their current problem or in order to be okay. You can acknowledge this view and gently offer another view—that focusing on the current issue can be a way of resolving and possibly even remembering.

### **USE STRENGTHS/RESOURCES/SURVIVAL SKILLS**

- Recognize and amplify strengths, survival skills and coping mechanisms.
- How did the client survive and cope at the time of the abuse?
- What positive abilities or qualities did they develop as a result of the abuse?
- When have they been surprised by the competent or different way they dealt with something?

### **CHANGE PROBLEM ACTION PATTERNS**

- Introduce small changes in the patterns that constitute and surround the problem.
- Make changes in: location, body behavior, timing (duration, frequency, rate and schedule), intensity, clothing, antecedents, consequences, interactions or any other repetitive aspect of the problem situation.

### **CHANGE PROBLEM FRAMES OF REFERENCE AND IDENTITY STORIES**

- Encourage clients to value their experience/feelings/sensations/thoughts/body.
- Challenge shame, spoiled identity and self-devaluing through new actions and views.

### **FOCUS ON GOALS AND WHAT THE CLIENT IS MOTIVATED TOWARDS**

- Focus on resolving what the client complaining about. What do they want in the future and what are they motivated for? What is their meaning, purpose and bliss?
- How will the client know when treatment is complete? What are the first and final signs of resolution?

## **STEPS TO HEALING FROM CHILDHOOD SEXUAL ABUSE**

1. Acknowledge to yourself (and to others if that is all right and important to you) what happened to you.
2. Take steps to ensure that you are not abused further in the present or the future by the person or people who abused you in childhood. This might involve criminal or other legal proceedings against them, not being alone with that person, cutting off the relationship you had with them, etc.
3. Get clear on what your abuser(s) was(were) accountable for (i.e., what they did to you) and what you were and are accountable for (your actions then and now). Challenge others' and your own attributions of blame or devaluing regarding the abuse (e.g., "I must have deserved it," "I must have brought it on myself," "I liked the attention, so I let it happen, therefore I'm partially to blame," "I am bad," "You made me do it to you," "You wanted it as much as I did," "You're a slut," etc.).
4. Make room for your feelings, perceptions and responses to the abuse then and now. Don't try to forget or get rid of your experience because it isn't normal, right or acceptable. Acknowledge and value all the aspects of yourself and your experience as an antidote to shame. This may involve publicly acknowledging the abuse or your experience. It may involve dialoguing with aspects of your experience from which you've been alienated.
5. Value your body. Stop doing things that injure or punish you physically or put you physically at risk of injury. Start doing things that value and enhance your physical well-being.
6. Change patterns of action, thinking and interaction that don't work. Find out what you've been repeating in those areas again and again that leads to pain, frustration or impasses. Make the smallest change that will make a difference and build on that change.
7. Challenge ideas about yourself and your life from yourself or others that blame you, invalidate or undercut your trust in yourself, or close down the possibilities for positive change.
8. Perform symbolic, healing or transition rituals to help you leave the trauma or victim identity in the past where it belongs.

## **THINGS THAT CAN MAKE A POSITIVE DIFFERENCE FOR CHILDREN WHO HAVE BEEN SEXUALLY ABUSED**

In my experience, there are four major things, in addition to the severity and duration of the abuse, that make a difference in how severe the aftereffects of sexual abuse become for children:

### **◆ ACKNOWLEDGING THE ABUSE**

The child can acknowledge to him- or herself that the abuse occurred or deny or forget about the abuse.

The child can acknowledge to someone else that the abuse occurred.

If the abuse never gets acknowledged, there seem to be more negative aftereffects for most (but not all) people, later in life.

### **◆ HAVING THE CHILD'S EXPERIENCE VALIDATED**

There are two ways to invalidate:

1. To blame the child for having caused the abuse or having let it happen;
2. To accuse the child of lying or making it up.

The child may validate his or her own experience, but much of the time it is more powerful and effective to have the experience externally validated.

### **◆ PROTECTING THE CHILD FROM ABUSE IN THE PRESENT AND FUTURE**

This may involve consequences for the abuser, blocking access to the child from the abuser and potential future abusers, giving the child information about reporting abuse and appropriate body boundaries, etc.

### **◆ THE CHILD HAVING CONTACT WITH SOMEONE WHO VALUES THEM OR GIVES THEM A MESSAGE THAT THEY ARE WORTHWHILE**

Many times, children who are abused get the message or come to the conclusion that they are bad or unlovable or that something is very wrong with them. Many adults who were abused can remember some crucial relationship that gave them a counter message. Researchers have shown that children from difficult circumstances (parents in prison, single-parent homes, family drug abuse) who do well have gotten more attention and concern at home and typically have a warm relationship with a teacher, a parent, another relative, a friend of the family or a friend. (See Milgram, N. and Palti, G., *Journal of Research in Personality*, 27: 207-221, Wolin, S. and Wolin, S. (1993) **The Resilient Self: How Survivors of Troubled Families Rise Above Adversity**. New York: Villard Books).

## TREATMENT OF SELF-MUTILATION

### ◆ Why people self-mutilate

- ❖ Dissociation
  - Often associated with a history of sexual and/or physical abuse
- ❖ Ritualized
- ❖ Phenomenology/purposes
  - Recreation of previous bad feelings
  - Escape from other feelings
  - Relieving internal pressure
  - Anesthesia
  - Reconnection with the body

### ◆ Bad (symptomatic) trance

- ❖ Recreation of original abuse
- ❖ Double messages and binds
- ❖ Bad (self-devaluing/harmful) splitting
  - Somatic splits
  - Sexual splits
  - Personality splits
  - Memory splits
  - Perceptual splits – negative hallucination/flashbacks
  - Time splits – freezing time

### ◆ Waking the person from bad trance

- ❖ Alternate rituals
- ❖ Externalizing the mutilation
  - Action/symbolic externalization
  - Identity externalization
- ❖ Evoking and giving access to resources
- ❖ Revaluing the body
  - Massage, physical fitness, imagery, etc.
- ❖ Finding symbols of comfort and security-internal or external
- ❖ Setting limits and providing consequences
- ❖ Making contracts for safety (link to motivation)
- ❖ Pattern intervention
  - Altering the time, location (in the world or in the body), performance, duration, sequence, etc. of the pattern



## USING THE INCLUSIVE SELF IN TREATING DISSOCIATED, DISOWNED AND DEVALUED ASPECTS OF SELF

### Injunctions

Determine the injunctions that may have dominated the person. These are conclusions that the person has made about himself or herself or ideas that other people have suggested to them or told them are true. They can usually be thought of in two forms:

- ❖ Have to/Should/Must (as in, "You must always be perfect," or "I have to hurt myself.")
- or
- ❖ Can't/Shouldn't/Don't (as in, "You shouldn't feel sexual feelings," or "I can't be angry.")

### Binds

Sometimes the person is stuck with dueling or seemingly opposite injunctions operating simultaneously. For example, "You must be perfect," paired with "You never do anything right!" "You have to listen; don't hear this."

### Self-Devaluing

Sometimes the person has come to the conclusion, consciously or unconsciously, that he or she is bad or that parts of him/her is bad. He might say, "If you only knew what I am like inside, you would see that I am evil." She might have the sense that anger is bad and she shouldn't feel it or show that she is angry. If she does, she thinks she is very bad or anger is very bad.

### Valuing, Permission and Inclusion as Antidotes

1. Give the person **permission to and permission not** to have to experience or be something. For example, "You can feel angry and you don't have to feel angry." Or, "It's okay to be sexual and you don't have to be sexual." Be careful when giving permission about actions.
2. Suggest the **possibility of having seeming opposites or contradictions coexist** without conflict. For example, "You can tell me and not tell me about the abuse." "You can forgive and not forgive at the same time."
3. **Allowing for the opposite possibility** when speaking about the way it was, is or will be. "You'll either get better or you won't." "That was either a terrible thing or it wasn't." "I'm shy except when I'm not."

## **WORKSHEET FOR DEVELOPING A RELATIONSHIP WITH DEVALUED/DISOWNED/DISSOCIATED ASPECTS OF SELF**

1. Identify any aspect of yourself or your experience that you have found difficult to tolerate or have avoided or inhibited). If you don't really have a clue, this is some part of your life in which your experience is intruded upon (like flashbacks) or in which you are inhibited or numb (as in you never get angry or you go numb when you start to have sex). This might involve parts of your body (e.g., your genitals, your face), your body in general (e.g., you have found it difficult to look at your body in the mirror, you always dress in the closet out of sight), your relationships with other people (e.g. rejection or conflict), your feelings (e.g., anger is not okay, sadness is intolerable), your sensations (e.g., sexual feelings, tickling), or perceptions (smells really get to you, you are haunted by images of the abuse).
2. Plan one thing you could do to start to approach and value that aspect of your experience rather than avoid or inhibit it.
3. Imagine yourself feeling or experiencing that aspect of your experience in the presence of someone who cares for you unconditionally.
4. List and challenge any blaming, impossibility, self-devaluing or non-choice beliefs your problem is trying to convince you of.

# **Drug and Alcohol Misuse**

## ALTERNATIVE TREATMENT OF ALCOHOL AND DRUG MISUSE

- Find out what the person who is seeking your assistance wants and what they are concerned about. Each case is different. Beware of theory countertransference.
- Hold people accountable for their actions. Chemical use or a relationship to someone who is misusing chemicals does not abrogate personal agency and responsibility.
- Search for clients' goals. What are their missions or visions for therapy and/or for life. Develop a co-mission with them.
- Develop a co-mission as well with other treatment and legal people that are involved in the situation.
- Search for times when the person who has been misusing the chemicals has cut back, delayed using or stopped using the chemicals. Find out how the person did that, what they did differently at those times, or what different circumstances there were.
- Search for social and family patterns around or involved in the chemical misuse. Suggest pattern changes that are within the control of whoever is motivated to make changes. Collaboratively plan homework assignments to increase the likelihood of follow-through and success.
- Plan what the client(s) will do in case of the beginnings of a relapse.
- Schedule follow-up appointments for longer time spacings over the months (or years) after the initial course of treatment to ensure continued progress and to deal with potential relapses.

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## CONTRASTING APPROACHES TO TREATMENT OF DRUG AND ALCOHOL MISUSE

<b>Confrontation-of-Denial/ One Right Way</b>	<b>Collaborative Interviewing/ Possibility Method</b>
<input type="checkbox"/> Heavy emphasis on acceptance of self as “alcoholic” or “addict”; acceptance of diagnosis seen as essential for change	<input type="checkbox"/> De-emphasize on labels; acceptance of “alcoholism” or “addict” label seen as unnecessary for successful treatment
<input type="checkbox"/> Emphasis on disease of alcoholism which reduces personal choice and control	<input type="checkbox"/> Emphasis on personal choice regarding future use of alcohol and other drugs
<input type="checkbox"/> Therapist presents perceived evidence of alcoholism in an attempt to convince the client of the diagnosis	<input type="checkbox"/> Therapist conducts fact-based (descriptive) evaluation and focuses on eliciting the client’s own concerns and motivations
<input type="checkbox"/> Objective assessment data are used in a confrontive fashion, as proof of a progressive disease and the necessity of abstinence	<input type="checkbox"/> Objective assessment data are presented in a clear but low-key fashion, not imposing conclusions on the client
<input type="checkbox"/> Resistance seen as “denial,” a trait characteristic of alcoholics or addicts, requiring confrontation	<input type="checkbox"/> Resistance seen as interpersonal behavior pattern influenced by the therapist's behavior
<input type="checkbox"/> Resistance is met with argumentation and correction	<input type="checkbox"/> Resistance is met with acknowledgment and attempts to seriously deal with clients’ concerns
<input type="checkbox"/> Goal of treatment is always total and lifelong abstinence; client seen as in denial and incapable of making sound decisions	<input type="checkbox"/> Treatment goals are negotiated between client and therapist based on data and acceptability; client involvement in and acceptance of goals seen as vital
<input type="checkbox"/> Client must attend AA and must accept disease concept	<input type="checkbox"/> Client may attend AA or may find other means of treatment and change; disease concept seen as useful metaphor, but not the truth

## **OVERLAPS OF AA/NARRATIVE APPROACHES**

Alcohol is patient; your disease will wait for you forever.

Alcoholism is the only disease that will tell you you don't have it.

My disease is an elephant. As long as I remember it's there, I won't get stepped on.

It doesn't matter how you got here or why you got here, just that you're here.

My mind is out to get me.

I've failed, but I'm not a failure. I've made mistakes, but I'm not a mistake.

Alcohol tried to murder my soul.

Liquor used to do things for me, and then it began to do things to me.

That's your disease talking.

You've got to wrestle with the Beast (alcoholism).

What is your stinking thinking saying to you right now?

## **OVERLAPS OF AA/SOLUTION-ORIENTED APPROACHES**

Insanity: Doing the same thing over and over, expecting different results.

If it works, don't do anything to fix it.  
If it doesn't work, do anything to fix it.

It's not what happens to you but how it you perceive it.

Act as if.

Change is process, not an event.

God never closes a door without also opening a window.

Utilize, don't analyze.

Give yourself a little success every day.

Fake it until you make it.

The program (AA) is a marriage of hope and action, and it has to be both.

In the first year of sobriety, don't change anything except your playmates, playthings, and playgrounds.

If you keep bringing your body, your mind will follow.

Get out of the problem into the solution.

When what you're doing isn't working, try something else – anything else, but drinking.

Pain is inevitable, suffering is optional.

*Constructive criticism:* I tell you what is wrong with you.

*Destructive criticism:* You tell me what is wrong with me.

# **Spirituality**



## **ASSUMPTIONS OF A SPIRITUAL APPROACH TO THERAPY**

- People are not defined by or determined by the circumstances of their lives. There is more to people than nature or nurture, personality, genetics, biochemistry or cause and effect.
- People have spiritual resources, even when they are not religious or when they profess no spiritual sensibilities or beliefs.
- Therapists can bring a spiritual sensibility into therapy without imposing it on clients.
- People have already developed ways of tapping into a sense of something bigger than themselves.
- Drawing on spiritual resources can facilitate therapy outcomes.
- Religion is distinct from spirituality for some people.

## CONNECTION, COMPASSION AND CONTRIBUTION

The first C is **Connection**, that is, when people feel connected to something beyond their petty, little selves (or egos). Spirituality refers to what is beyond the "little self," or the personality. Anything that gives one an experience of the "bigger self," or what is beyond the limited personality can be a component of spirituality.

Here are some areas to examine and questions to consider regarding **Connection**:

- ✓ Do you feel connected to something bigger than petty or selfish concerns? Are you working or living for money alone, for status alone, or is there some bigger, less ego-concerned purpose?
- ✓ Is there ample opportunity for you in your life to re-connect with something bigger when they are feeling depleted or getting petty? Is there a chance for connecting through one of the seven pathways discussed above?

The second C is **Compassion**. This is the place where we can feel love towards others, and there is a softening of the usual mistrust, harshness or judgmental attitude we usually feel.

Here are some areas to examine and questions to consider regarding **Compassion**:

- ✓ Does your life create an atmosphere of compassion, rather than being judgmental or harsh? How could you create or enhance an atmosphere of compassion and kindness?
- ✓ If this person (or you) were your child or best friend, how would you view them or relate to them?
- ✓ Think of the most serene, compassionate or wise person or figure you know. How would he or she view this situation or deal with it?
- ✓ Remember a time when you were judgmental or critical of someone and then softened or were more compassionate. How did you make that shift? What changed after you made that shift? Can you apply any of that to your current situation?

The 3rd C is **Contribution** or Service. Usually this comes out of the first two Cs. When we feel connected to something beyond our petty, selfish selves and when feel connected, we are usually moved to make a contribution to others and to the world and to be of service.

Here are some areas to examine and questions to consider regarding **Contribution**:

- Become aware of some social injustice or victim situation that moves or touches you.
- Every time you experience some recurrent problem, do one thing to contribute to the relief of the victim's suffering or to righting some social injustice. It may be writing a letter, making a donation of money or time to some charitable group, praying, or some other action you are moved to.

## **DEVELOPING SELF-COMPASSION**

*“Lord, help me accept the truth about myself no matter how good it is.”*

Self-compassion involves feeling forgiveness or softening towards ourselves and a decrease in the usual judgmental or critical attitude we take toward ourselves.

### **There is scientific evidence that self-compassion is good for you:**

A study by Pargament found that people who are unable to forgive themselves or others also have an increased incidence of depression and callousness toward others. (Pargament, K.L., et al. Journal of Scientific Study of Religion 1998; 37:710-724)

### **Here are some questions to consider regarding Self-Compassion:**

- ✓ Is there any area in which you are critical or non-accepting of yourself?
- ✓ What do you think is your most unacceptable aspect or part of your body?
- ✓ What is one step you could take toward valuing or at least moving towards accepting that aspect?
- ✓ If that trait or aspect were one of your best friend's, how would you assure them it is okay?
- ✓ How have you softened or become more accepting of yourself in the past? Can you use any of that right now to help you become more self-compassionate?

### **Bumper Sticker:**

I honor and express all facets of my being, regardless of state and local laws.

## **ELEMENTS OF RELIGION THAT CAN BE INCORPORATED INTO SPIRITUALITY**

Some people are turned off by religion, because of past trauma or because they dislike the dogma associated with religion. But religion has developed a number of aspects that can be modeled on or tapped into to access spirituality.

### **❖ *Ritual***

Religion celebrates yearly, seasonal, remembrances and other special occasions with repeated rituals. These are actions imbued with meanings that one can count on. They usually engage the senses: Smell (incense, etc.), taste (bread, wine, etc.), sound (singing, chanting, prayer, responsive prayer), sight (special vestments, head covering, etc.), movement (kneeling, facing Mecca, making the sign of the cross, etc.) or touch (rosary beads, prayer books, hymnals, tallis, etc.).

### **❖ *Group action and interaction, finding or developing like-minded people, doing social action or good works in groups***

Religion involves getting groups of people together for a common purpose or in a common frame of reference. Sometimes religion organizes groups of people to do social action or good works.

### **❖ *Connecting to something bigger than self***

Religion invites people to transcend themselves and their personal, selfish interests. This can satisfy a yearning to be part of something bigger than oneself.

### **❖ *Finding atonement after immoral or shameful acts, thoughts or feelings***

Religion can help people find their way back to a sense of forgiveness, self-compassion and into reconnecting with others after they have done, thought or felt something about which they don't feel right.

### **❖ *Developing a moral sensibility***

Religion can help people develop and live by a moral code, a sense of what is right and what is wrong.

## **EXAMINING, CHALLENGING AND HEALING RELIGIOUS TRAUMAS AND PREMISES**

### **Premises about God and religion**

God is distant.

God is angry and punitive.

God doesn't care about me (or people)

God is male.

I have to be good or I will be punished.

God doesn't exist.

Religion is bad (with a corollary sometimes of: spirituality is good).

Religion and spirituality are superstitions or irrational or non-scientific.

Religion is the opiate of the people.

Too many terrible things have been done in the name of religion for me to believe or have a religious practice.

### **Religious transference: Often a person's premises reflect that person's relationship or view of their father (or mother) or some other significant relationship**

Who does this God resemble or remind you of?

What is this God in whom you don't believe like?

### **Investigating and Challenging Religious Premises**

Identify one or more of your premises about God or religion.

Where do you think this premise comes from?

Do you think it is true or accurate or is it distorted?

Think of one thing you could do to challenge such a premise or one thing a person with a premise like that would never do. Try that.

Think of another person you admire or love as a model for the kind of God or religion you would like to have in the world. What would this God or religion be like?

### **Healing Religious Traumas and Shame**

What traumas or shaming experiences have you had related to religion?

How do you think this has shaped your religious or spiritual life or views?

In what way have these traumatic or shaming experiences held you back from the kind of spiritual or religious practices or life you would like to have?

What do you imagine might be helpful in healing these old wounds?

How might these wounds be helpful in energizing your work or spiritual path?

What is one thing you could do or think that would stand up to or challenge the restraining effects these wounds have had on you?

## Four Ways the Soul Speaks to Us About What We Are Meant to Do with Our Lives

"I get up every morning determined both to change the world and have one hell of a good time. Sometimes, this makes planning the day difficult." —E.B. White

### Four signals from our souls that can guide us through life:

1. **Blissed:** What brings us alive, blisses us out, fascinates us, excites us or gives us energy.
2. **Blessed:** Who has blessed us about something; someone who told you you were good at something, believed in you, supported you at crucial and difficult moments, or mentored you. For example, a teacher who praised your writing; an uncle who thought you could sing amazingly; a friend who told you we were a great listener and should be a therapist; a parent who believed in you and told you we could do anything you set our mind to.
3. **Pissed:** What pisses us off. Righteous indignation. What we think needs to be improved in the world or some injustice or wrong that needs to be righted.
4. **Wounded:** What has wounded us (or our forebearers) that still affects us.

*"Everyone has his own specific vocation in life . . . Therein he cannot be replaced, nor can his life be repeated. Thus, everyone's task is as unique as is his specific opportunity to implement it." —Viktor Frankl (quoted in **Unstoppable**, Cynthia Kersey, Sourcebooks, Naperville, IL: 1998)*

### Follow Your Wound:

*"We all leave childhood with wounds. In time we may transform our liabilities into gifts. The faults that pockmark the psyche may become the source of a man or a woman's beauty. The injuries we have suffered invite us to assume the most human of all vocations—to heal ourselves and others." —Sam Keen*

The difference between a wound that festers and diminishes us and one that leads to growth is whether or not we use the wound to energize us to change something in the world or to make a contribution. If we withdraw due to the wound or shrink from engaging with the world or others, the wound will not lead to healing ourselves or the world.

*"If you won't limp your limp, someone else has to limp it for you." —Robert Bly*

## SOLUTION-ORIENTED SPIRITUALITY

### Connection

#### ❖ Revisiting a spiritual moment or time

Recall a time or phase in your life when you felt free, flowing, alive, energetic, expansive or resourceful.

#### ❖ Recreate the experience

How did you feel in your body during that moment or those times?

What was your thinking like at that moment or those times?

How did you relate to others during that moment or those times?

What actions did you take that were different from your usual actions during that moment or those times?

#### ❖ Bring that sense of spirituality to any situation in which you are having current difficulty or anticipate having difficulty in the future.

After recreating the spiritual experience, bring it to any current or future situation in which you have felt stuck, petty, selfish or frightened. Imagine in detail how you would feel in your body and what your thinking, actions and ways of relating to others would be from that more expansive, spiritual place.

### Compassion

- If this person were your child or best friend, how would you view them or relate to them?
- Think of the most serene, compassionate or wise person or figure you know. How would he or she view this situation or deal with it?
- Remember a time when you were judgmental or critical of someone and then softened or were more compassionate. How did you make that shift? What changed after you made that shift?

### Service

- ✓ Become aware of some social injustice or victim situation that moves or touches you.
- ✓ Every time you experience some recurrent problem, do one thing to contribute to the relief of the victim's suffering or to righting some social injustice. It may be writing a letter, making a donation of money or time to some charitable group, praying, or some other action you are moved to.

## **SPIRITUALITY IN THERAPY ASSESSMENT**

### **Spiritual History/Background**

- Have you ever had religious or spiritual beliefs or practices?
- What have been your religious affiliations, if any?
- Have those been helpful in any way?
- Harmful in any way?
- Any traumas connected with religion?
- Have you ever felt connected to something more than yourself, like nature, another person, humanity, the Universe, God, etc.?
- When or how?
- What has been your most profound spiritual experience, if any?
- What did each of your parents teach you or show you about religion or spirituality?
- Who else, if anyone, influenced you in regard to religion or spirituality?
- If you ever went away from religion or spirituality and then returned, how did that happen?
- What would you say is the single most profound experience of your life so far?
- What was the period in your life when you most relied on religion, spirituality or faith for strength?
- What did your family show you in the area of service or compassion?
- What charitable or volunteer activities happened in your family?
- Do a spiritual and/or religious genogram tracing family connections and experiences with spirituality or religion. This may detail religious affiliations or family history of compassion, contributions/service and connections.

### **Current Spirituality**

- What do you do or where do you go to recharge your batteries when you get a chance?
- What kind of artistic activities do you enjoy (doing or watching)?
- How do you connect with other people?
- How do you connect with something more than yourself?
- Do you think you have a purpose for being alive? If so, what is it?
- Are there any spiritual or religious practices that you do regularly?
- Is there any religious or spiritual figure or activity that you think would be helpful for you in this situation?
- What role, if any, does religion/spirituality play in your life currently?
- What would you say is the single most important ingredient for a spiritual life?
- If you had to pick the most sacred spot you've ever seen, where would it be?
- If you were to name the best aspect of religion, what would it be?
- What do you think is the worst aspect of religion?
- Describe the time or activity that makes you feel the most spiritual.
- Who is the most spiritual person you know?
- Who is the least spiritual person you know?
- If you had to name something that always seems to call or speak to your soul, what would you say?

### **Future Spiritual Hopes and Intentions**

- What kind of spiritual or religious activities would you like to do in the future, if any?
- Is there any area of your inner or spiritual life you would like to develop more?
- Is there any spiritual or religious figure that you would like to use as a model for you? In what way?
- What do you think happens to us when we die?
- What would be the one more thing you could add to your life that you think would make you more spiritual?
- If you were to die tragically tomorrow, who, other than blood relatives, would you want to raise your children?
- If you found out you were terminally ill and could do one thing to put your soul in order, what would it be?



## THE THREE Cs OF SPIRITUALITY

1. **Connection** – Moving from beyond your little, isolated ego or personality into connection with something bigger, within or outside yourself.
2. **Compassion** – Softening towards yourself or others by “feeling with” rather than being against yourself, others or the world.
3. **Contribution** – Being of unselfish service to others or the world.

Spirituality refers to what is beyond the “little self,” or the personality. Anything that gives one an experience of the “bigger self,” or what is beyond the limited personality can be a component of spirituality. These are possible pathways for people to connect with that something beyond. Any one may work. Some may not work for or appeal to some people.

### Seven Pathways to Spirituality Through Connection

[The word *religion* derives from Latin *re-ligare*=to reconnect]

1. *Connection to the soul, the deeper self, the spirit.* The deepest level within. This involves having a connection with oneself that is beyond the rational, logical or even the emotional. Many people find that meditating, journaling or just spending time alone helps them find this connection.
2. *Connection to through the body.* This may come through dancing, sex, athletics, yoga, eating fine foods, etc. Seeing Michael Jordan in the air about to make a basket or other great athletes in action can show the spiritual through the body—they seem to do things that are beyond usual human abilities and that seem transcendent.
3. *Connection to another.* Intimate one to one relationships. Martin Buber calls this the I-Thou relationship. This pathway does not always need to refer to a relationship with another person; it could be with an animal. For example I know someone who is suicidal and the only thing that keeps her alive is her connection with her dog.
4. *Connection to community.* This pathway involves one's relationship to one's group, causes greater than oneself to contribute to the community or the planet. If you have ever felt part of a family, extended family group, neighborhood, church group or workplace, you have taken this pathway.
5. *Connection through nature.* Being in and noticing nature and the physical environment. How many of us need to spend time in the outdoors every so often or we begin to feel small and disconnected? “I believe in God, only I spell Nature,” said Frank Lloyd Wright. One may also experience this sense of connection through a deep understanding and appreciation of the laws of nature, such as physics, mathematics. Being a liberal arts major, I think I'll stick with mountains and forests and lakes for my nature connection.
6. *Connection by participating in making or appreciating art.* Ever seen someone standing in front of a painting in a museum and being moved to tears or listening to a piece of music and feeling energized or moved? Depending on one's preferences, this may come through literature, painting, sculpture, theater, movies, photography, dance, etc. Many artists refer to a sense that they are not making the art they produce, but that it is coming to or through them.
7. *Connection to the Universe or higher power or God or Cosmic consciousness* or whatever word one uses for the sense that there is a greater being or intelligence than ourselves at work in life. This connection can happen through prayer, conversion, meditating, etc.

## THE TWO FUNCTIONS OF SOUL

4. **Energy, Aliveness, Passion** – Soul gives energy and alerts us to when we're in the presence of energy-givers or energy-drainers as we move through life.
  5. **Integrity or Integration** – Soul holds together the contradictory and conflicting aspects of ourselves. Soul lets us know when we are acting and being with integrity and when we are off the path of integrity.
- In some ways, these are complementary functions: one brings you alive, into action and gets you to seek challenge; the other gets you to slow down, attend to where you are and claim or reclaim more of who you are. One is chaos producing and one is order producing.

*Some questions and things to consider to access each function:*

### **Energy, Aliveness, Passion**

- Remember a time when you had energy and aliveness.
  - What did it feel like in your body?
  - What kinds of thoughts would you think?
  - How did you move?
- What brings you alive?
- What deadens you or drains your energy?
- What do you do that takes effort but you seek it out any time you get some time?
  - It could be hiking in the mountains, painting a picture, writing, spending time with your children, working, or other things.
- Who are your role models for aliveness and passion?
  - What are they like and how would you or could you be more like they are in the area of aliveness and passion?

### **Integrity or Integration**

- Remember a time when you experienced two seemingly contradictory feelings at the same moment without conflict.
  - It could be feeling anxious and calm at the same moment or happy and sad at the same time.
- How do you know when something you are doing or planning does not have integrity for you?
- What has helped you integrate more of who you are into your life?
- Who are your role models for integrity and integration?
  - What are they like and how would you or could you be more like they are in the area of integrity and integration?
- What do you do in an entirely unique and individual way?

**Handouts for Clients or  
The General Public**

## How to Change 101

### ***Step 1: Acknowledge***

- ◆ Acknowledge people and validate their points of view  
    Don't blame or make them wrong
- ◆ Get specific: Use action talk (videotalk\*) to avoid labeling or generalizing
- ◆ Acknowledge concerns (yours and others)
- ◆ Acknowledge problems
- ◆ Acknowledge what has worked: No need to throw the baby out with the bathwater

### ***Step 2: Find and agree on a direction/mission/vision***

- ◆ If you don't know where you're going, you'll probably end up somewhere else
- ◆ If possible, paint a vivid picture of the future, again in action talk (videotalk)
- ◆ Get consensus or at least mutual understanding of that future
- ◆ Use possibility talk (expect change, open up possibilities for change, etc.)

### ***Step 3: Acknowledge barriers and identify resources to achieving that future***

- ◆ What has stopped you or tripped you up in moving toward that future?
- ◆ What are internal barriers (fears, old habits, outdated or unhelpful beliefs) to moving on?
- ◆ What are real world barriers (money, lack of consensus, lack of information, actions that haven't been taken) to moving on?
- ◆ What or who are resources available to overcome or resolve the barriers?
- ◆ What has worked well in the past?
- ◆ Identify patterns of thinking, focus and action that do not help the situation change

### ***Step 4: Make an action plan***

- ◆ Start small
- ◆ SMART (Small, measurable, achievable, realistic, timeline) goals and directions are more likely to succeed

### ***Step 5: Act (Just Do It!)***

- ◆ Take action, notice results, adjust action if needed
- ◆ Break patterns of thinking, focus and action
- ◆ Decide who is going to take what action by when
- ◆ Get a promise and arrange to follow up
- ◆ Persist until goal is achieved

### ***Step 6: Acknowledge and celebrate progress and success***

- ◆ Give lots of credit
- ◆ Rituals/awards/celebrations to acknowledge milestones achieved and goals met

\**Videotalk* means to describe something only in terms of what one could see or hear if watching and listening to a videotape

## Changing Persistent Unhelpful Life Patterns

In many ways we are constantly changing, while in other ways, we seem to repeat the same patterns over and over again. Life moves on and we keep responding as if we were somewhere in the past or still relating to people from the past. Here are some suggestions for finally leaving behind old, unhelpful patterns.

### 1. Notice results you don't like that recur

Examples:

Always being in debt

Harmful addictive or compulsive behaviors, such as overdrinking, unsafe and inappropriate sexual activities, overeating, overworking and so on

The same kind of arguments or conflicts in intimate relationships

Being regularly taken advantage of by people

Accommodating to others in a way that compromises your integrity or well-being

### 2. Investigate and notice your actions, feelings and underlying ideas or thoughts in these recurring problematic situations

If you can, identify what outcome or feeling you are trying to prevent or avoid by reacting or acting the way you do. Often, our attempted solutions to some problem become the problem.

Examples:

You are afraid you will be controlled.

You blame the other person so you won't be blamed.

You leave first so you won't be left or rejected or abandoned.

You eat so you won't feel so lonely or sad or frightened.

You shop to distract yourself from an unhappy relationship or situation.

*Hint: If you are having trouble identifying any of these elements, ask for help from a trusted friend, a loving partner or an insightful therapist/coach.*

### 3. Do something different from your usual actions, reactions or patterns

Possible strategies:

Just notice the impulse to act or react.

Just notice and stay with the feeling you were trying to avoid.

Do something that might actually invite the avoided feeling.

Stay in a situation that you would normally leave from to avoid discomfort.

Write out or tell someone about the feeling, fear or outcome you were trying to avoid or forestall.

### 4. Rinse and repeat until you break the automatic pattern or stop getting the unwanted results

Examples:

You get out of debt and stay out of debt.

You stop having the same old argument or conflict in this or any relationship.

You stay in a relationship beyond the point you would have withdrawn or left.

You stop drinking or stop drinking in a way that messes up your life.

*Suggestion: If you find you can't change these patterns or you can only make so much progress, consider using some of the new rapid trauma resolution methods (like EMDR or EFT), that can often soften or diminish the energy that may be driving these recurrent unhelpful patterns.*

## **Some Guidelines for Constructive Conversations When Someone Is Upset**

When you are upset with someone or they are upset with you and you decide that the best way to deal with the situation is to speak to the other person or persons, here are some hints and guidelines for maximizing the likelihood of positive results from the conversation:

### **Use action talk to describe the situation or incident about which you are upset**

This means avoiding telling the person your label or interpretation for what they did and avoiding telling them what you think their motives, feelings or intentions might be. Action talk describes the actions you or the other person did that you could see or hear.

Tell the other person or persons your positive intention for speaking with them about the situation

*For example, "I really want to sort this out so I can be close to you." Or, "This incident has got me thinking about leaving but I want us to stay together, so it's important to me to have this discussion." Or, "I find myself avoiding you and I worry that if we don't clear this up we will lose our friendship."*

### **Don't attribute negative intentions to the person before talking it out**

Give the person the benefit of the doubt by assuring them that even though you are upset, you are not sure why they did what they did and would like to find out.

### **Ask out of curiosity rather than make accusations or assumptions about what the other person meant by what they said or did**

Much of the time, in the heat of the moment, and because we have old hurts and our own interpretations about what happened, we don't stop and check out the other person's understanding or intentions in the conflictual situation.

### **Make a personal feeling and perception statement**

This is the famous "I" statement. Tell the person your feelings and perceptions about the situation or incident. Be sure to own them as your feelings and perceptions, though.

### **Make a request**

Ask them to have a conversation with you about the matter and/or ask for future action changes. This usually includes a specific action you are requesting, a specific time to take that action or by which to take the action or a specific result you ask them to commit to producing.

## **DON'T BELIEVE EVERYTHING YOU THINK: How to Challenge and Escape the Domination of Unhelpful Thoughts**

### **You Are Not Your Mind**

You are bigger than your mind, but sometimes it seems as though your mind has you or thoughts are thinking you

*Disidentification*-Recognizing that your mind is just your mind and your thoughts are just your thoughts; they are not equal to your identity

*Externalizing*-Treating your thoughts as if they were an external person

*Mindfulness*-Just noticing thoughts or patterns of thinking rather than believing them

### **Challenge Thoughts**

*Use counterarguments*-Challenge unhelpful thoughts with facts that contradict them

*Make slight shifts in your self-talk or thoughts*-Instead of all or nothing self-talk, change it to mostly, usually, rarely, and so on; Instead of "why", change it to "how can I" and so on

### **Just the Facts**

*Use observational/sensory-based descriptions*-This helps to separate interpretations and imposed meanings from what happens; only describe what you could see or hear on a videotape about the situation or yourself

### **Go with the Thoughts Rather Than Fight or Oppose Them**

*Accept and soften towards one's thoughts*-Don't oppose or react; opposing gives the unhelpful thoughts energy; What you resist tends to persist.

*Exaggerate*-Amplify negative or fearful thoughts until they are absurd or lose their power

### **Get Into Dialogue and Out of Monologue**

*With another/others*-Talking to another person or several others can sometimes get you on a new track, provide a reality check and help you get perspective on your thoughts

*With self/thoughts*-Instead of accepting, fighting with or being dominated by unhelpful thoughts, engage in a dialogue with yourself or the thoughts and, as in conversations with others, new thoughts or perspectives might occur

### **Take Actions**

*Do something that is incompatible with the unhelpful thought*-Take an action that wouldn't be expected given the unhelpful thought

*Do something to refute the unhelpful thought*-Engage in some action that would disprove the unhelpful thought

*Action can help you get unstuck and move out of the thought*-Don't just sit there, do something; being in a different environment, moving your physical body and other actions can sometimes break you out of your mental rut

## **HOW NOT TO CHANGE: 10 STRATEGIES FOR STAYING STUCK**

### **Don't listen to anybody**

We sometimes get stuck in our own little ways of thinking about or doing things. Other people can be helpful to give us a new perspective or new possibilities

### **Listen to everybody**

At the same time, letting other people's views of the world or what is right for you dominate your life can put you in danger of losing yourself and your sensibilities.

### **Endlessly analyze and don't make any changes**

It's fine to understand what is going on with you, others or the world, but be careful of the analysis paralysis trap.

### **Blame others for your actions or problems**

Not everything is everybody else's fault. If you find that is your usual stance or interpretation, try imagining that you had a part in creating this situation.

### **Blame yourself or put yourself down regularly**

On the other hand, you are not always to blame. And putting yourself down regularly is probably something you took on long ago as a habit that doesn't serve you well. It can demoralize you and undermine your confidence.

### **Keep doing the same thing that doesn't work**

Do something different if what you are doing is not working. Remember that one definition of insanity is doing the same thing over and over again and expecting different results.

### **Keep focusing on the same things when that focus doesn't help**

Try shifting your attention in another direction. They say the only difference between a rut and a grave is the dimensions. Get out of your ruts.

### **Keep thinking the same thoughts when those thoughts don't help**

There's nothing as dangerous as an idea, when it is the only one you have, claims Emile Chartier. Don't believe everything you think!

### **Keep putting yourself in the same unhelpful environment**

While there are ways to transcend one's environment, it is often easier to get the heck out of there (unless that is your usual pattern; in that case, try sticking around). A tree that needs water doesn't do well in the desert. One difference between a tree and a human being is that the human can get up and move to a more nurturing environment.

### **Keep relating to the same unhelpful people**

It is probably wiser to minimize your contact with people who put you down, who gossip, who are acting in a mean-spirited way, or with whom you regularly end up feeling bad after your encounters with them.



## RECLAIMING YOUR ENERGY AND ALIVENESS

We begin life with abundant energy, whole and big. Through being shamed, traumatized, and just being socialized in our culture, our families and as male or females, our energy, integrity and bigness become diminished.

**We can reclaim our energy by attending to and following one or more of the four signals we get from deep inside that can guide us through life:**

5. **Blissed:** What brings us alive, blisses us out, fascinates us, or gives us energy. Charles Darwin was so excited about studying life that one time, when he discovered a new type of beetle, he found he only had room in his hands for two of the beetles out of the three he had found. He promptly popped one in his mouth and ran home with two in his hands and one in his mouth. That kind of energy and enthusiasm indicates bliss.
6. **Blessed:** Who has blessed us about something; e.g., a teacher who praised our writing; an uncle who thought we could sing amazingly; a friend who told us we were a great listener and should be a therapist; a parent who believed in us and told us we could do anything we set our mind to.
7. **Pissed:** What pisses us off. Righteous indignation. What we think needs to be improved in the world or some injustice or wrong that needs to be righted. Martin Luther King, Jr. was probably not following his bliss when he stood up for justice and civil rights.
8. **Wounded:** What has wounded us (or our forebearers) that still affects us. The difference between a wound that festers and diminishes us and one that leads to growth is whether or not we use the wound to energize us to change something in the world or to make a contribution. If we withdraw due to the wound or shrink from engaging with the world or others, the wound will not lead to healing ourselves or the world. "We all leave childhood with wounds. In time we may transform our liabilities into gifts. The faults that pockmark the psyche may become the source of a man or a woman's beauty. The injuries we have suffered invite us to assume the most human of all vocations—to heal ourselves and others." —Sam Keen

**Stephen Spielberg's parents divorced when he was young. His father was a computer technician and his mother a musician. In a crucial scene in Spielberg's movie "Close Encounters of The Third Kind," the two "alien" cultures finally discover how to connect and communicate by using computers to send musical notes to one another. Spielberg has said that he turns his fear and pain into movies (e.g., he was afraid of the unknown things beneath the surface of water and made "Jaws," and his pain from the legacy of the Holocaust turned into his movie "Schindler's List.").**

There are two major ways to make change happen and to reclaim our bigness from fear, learned limitations and habit:

1. **Do One Thing Different (see my book of the same name, HarperCollins, 2000)**
  - a. Change the doing: Change anything you have influence over about your actions or interactions, including where, when, how and what you do; each day do one thing which stands up to or challenges fear, shame or previous limitations until you have changed the thing you want to change; experiment with lots of little changes, which are easier to make than big changes, until you find one that makes a difference
  - b. Change the viewing: Change your focus of attention or your point of view in the situation
2. **Have a Good Breakdown (see my book Thriving Through Crisis, Penguin, Feb. 2004)**
  - a. Use crises as opportunities to make bigger and overdue changes that would be too hard to make or you would be too frightened to make in the usual course of life
  - b. Turn post-traumatic stress into post-traumatic success by finding and using opportunities for connection, compassion and contribution related to the trauma

## RECLAIMING YOUR LIFE FROM FEARS AND PHOBIAS

Fear has a way of getting us to restrict our lives and activities. It tells us a lie: "If you restrict yourself to the places and activities I tell you are okay, I will keep you safe and feeling okay." The reality is that most of the time, the more we give in and restrict our lives, the more fear dominates and we feel worse or even more afraid.

We tend to identify with fear or consider it an internal signal we need to heed. Instead, try thinking of fear as an external influence and not a particularly wise or useful advisor. For example, instead of thinking, "I will be hurt," you could say, "Fear is telling me that it would be awful to be hurt again," or "Fear is trying to keep me alone by telling me that I'll be safe if I isolate." "Fear is telling me to avoid elevators," or "fear is telling me it is too dangerous to travel." This way of framing fear can give you a little breathing room and moments to think without fear muddying your thinking and decision making.

✓ Identify places you have restricted your life due to fear

*Where and when have you:*

*Avoided going places or doing things*

*Avoided people or situations*

➤ Begin to challenge these restrictions either a little at a time (Baby steps, baby steps!) or in a big way

*Enlist the support of friends or others or do it on your own.*

*Keep moving beyond your old comfort zone.*

*You may start with either the hardest areas or the easiest, but whichever approach you take, keep moving.*

*The more you do this, the more territory you can reclaim from fear in your life.*

➤ Anticipate a counterattack by fear to keep you in its grip

*Learn to recognize the tactics fear uses to keep you in its thrall:*

*The messages – Doubts, self-criticism, catastrophic scenarios*

*The physical sensations – Racing heart, dizziness, butterfly stomach, tense muscles, paralysis*

➤ Practice deliberately creating the sensations of fear to desensitize yourself from them

*Examples:*

*If you get dizzy when you panic, sit in a chair and spin around until you are a little dizzy.*

*If you get racing heart, do jumping jacks or similar exercises to get your heart to race deliberately.*

*This way, you are in control and can break the association of fear to these sensations. They are merely sensations, after all (assuming you have ruled out real physical problems).*

**Note: The fear referred to here is emotional, psychological or social fear. If you feel you are in legitimate physical danger, attend to it and do what you can to minimize the risk. For example, if you are walking to your car alone on a dark night, take appropriate precautions.**

This handout has been inspired by and influenced by a number of sources, including narrative therapy and the work of Pastor Henry Wright of Pleasant Valley Church.

## The Writing Ritual

**Writing thoughts and feelings about trauma or crises for as little as 15 minutes a day for as few as four or five days has been shown to be correlated with:**

- Far fewer visits to the student health center for college students
- An increase in T-cells (immune system functioning)
- Increasing the likelihood and rapidity of getting a new job after being laid off
- Reduced anxiety and depression
- Improved grades
- Improved mental and physical health of grade-school students, people in nursing homes, arthritis patients, medical students, rape victims, new mothers, and prisoners

### **How to do the writing ritual:**

1. Write honestly and openly about your deepest feelings and thoughts about the situation you are in or went through. Make sure you keep these writings private or you may find yourself unconsciously censoring what you write and diluting the effects of the writing. Consider destroying what you wrote after it is complete, again for the same reason. Perhaps making a ritual of the burning or destroying of the writing. (See the next section of this chapter for some hints about doing that kind of ritual.)
2. Write for a relatively short time, say 15 minutes. This writing is often draining or emotionally difficult. Limiting the time makes it both a bit more tolerable and more likely that you will do it.
3. Write for only four or five days. This time limit seemed to work very well in the experiments that were done. They are not carved in granite, however, and if you find you need more time, you can take it. One of the points of this limit of a few days is again to contain the experience so it doesn't take over your life.
4. Try to find both a private and unique place to write, somewhere you can both be uninterrupted and someplace that won't be associated with other things or that have the usual smells, sights and sounds of places you already know well.
5. Don't worry about grammar or spelling or getting it right. Just write.
6. During the writing days, try to use the same time each day or evening to write. It's not crucial, but it can sometime give your unconscious mind some structure and preparation time if it knows exactly when the writing will take place. This can also help contain the emotions and intrusive thinking that may occur and interfere with your day or evening.
7. Writing seems to be the most powerful, but if for some reason, that won't work for you, you could try "writing" by speaking into a tape recorder or a video camera.
8. Ignore these guidelines if you discover something else works better for you. Everyone is unique.

**Sources:** *Opening Up: The Healing Power of Expressing Emotions*, James Pennebaker, NY: Guilford, 1990.  
*The Writing Cure: How Expressive Writing Promotes Health and Emotional Well-Being*, eds. Stephen J. Lepore and Joshua M. Smyth, APA: Washington, DC, 2002.

**Handouts That Don't Fit  
Anywhere Else**

## **CLASSES OF SOLUTION**

### **NON-HYPNOTIC**

#### **GO WITH THE FLOW**

- Sports analogies (Tennis, windsurfing, sailing)
- Chinese finger handcuffs
- Quicksand
- Fighting against the rapids gets you hurt; riding with them gives you the ability to use the force of the river to help you maneuver around obstacles
- Ride the horse in the direction it is going
- Frankl's high school stutterer

#### **THE MORE YOU GIVE IT AWAY, THE MORE YOU GET (SELFISH ALTRUISM)**

- Warm fuzzy story
- Grants rather than loans
- Mobil Oil sponsors PBS; Hallmark cards sponsors the Hall of Fame; good associations
- Drag other people up with you

#### **DO SOMETHING DIFFERENT (THE DIFFERENCE BETWEEN A RUT AND A GRAVE)**

- Rat and cheese story
- Rut/grave analogy
- Unsticking the jar lid
- Crack in the dam
- Channeling the water

#### **"NATURE ABHORS A VACCUUM"**

- If you stop doing the chores, waking him up in the morning, nagging him to get his chores done, etc., he'll eventually do something to fill the vacuum you left behind; Pat's comment after being laid up after the baby, "You're competent."
- William Onken's Monkey theory

#### **ACTING AS IF (OR FAKE IT TILL YOU MAKE IT)**

Act as if regardless of your feelings or don't let your feelings run your actions

- The ship with no captain
- Room of 1000 demons
- Jerry Jerome Marathon story
- Did you feel like a therapist at first? A driver?
- Priming the pump

#### **TAKE ACTION RATHER THAN TALKING ABOUT SOMETHING**

Take action to get something done rather than just think about it

- Ready, fire, aim
- Audrey Berlin story
- Wish in one hand and spit in the other - see which one fills up first.
- The talk/do ratio

### **EXPRESS WHAT'S INSIDE WITHOUT INVOLVING OTHERS/REPERCUSSIONS**

- Write down what you're feeling or thinking rather than saying it
- To hone what you want to say
- To drain it off
- To avoid getting fired or causing unnecessary pain

### **CHANGE YOUR INSIDES BY CHANGING YOUR ACTIONS**

- Raise self-confidence or self-esteem by doing "self-esteem" or confidence building actions
- Doing "not shy"

### **FACING FEAR DISSOLVES IT**

Facing feared tasks, situations or emotions dissipates rather than adds to fear

- Vishnu story
- Get back on the horse
- The girl who was afraid she'd wet her pants
- Callie confronts her abuser

### **CHANGING THE BODY CHANGES EMOTIONS**

Alter the physical performance or muscular components of the problem

- Woman who cried at work, remember to breathe
- Crisis clients' breathing

### **LETTING GO OF THE PAST**

- Steering the car by the rear-view mirror
- Zen story about monk, disciple and geisha

### **FEED FORWARD**

- Goal management workshops
- Athletic imagery of peak performance
- The soldier who was always looking for something

### **THE BRICK WALL (OR TOUGH LOVE)**

- Dad's brick wall story
- Mom's sick day rule
- The two-by-four mule story

### **TRANSFERRING KNOW-HOW ACROSS CONTEXTS**

- The horse trainer and her untrainable husband
- The psychiatrist's wife who got an appointment
- The mother with the imaginary croupy baby and the kids who got up her nose
- The overweight woman who knew how to get up in the morning
- Leslie Cameron's guided fantasy of the friend in the garden

### **CHANGE CAN HAPPEN QUICKLY**

- Dr. Wilk stops smoking

### **TAKE CARE OF YOURSELF SO YOU CAN TAKE CARE OF OTHERS**

- When traveling on an airplane with a child, whose oxygen mask should you put on first in an emergency?

### **STRENGTH OR INTENSITY OF STRUGGLE = STRENGTH OF SELF**

- Butterfly/cocoon
- Don Juan's "Allies"

### **VALUING YOURSELF**

- Cameron Bandler's Guided Fantasy
- Photograph of 5 yrs. ago—Diets Don't Work participant

### **HYPNOTIC**

#### **PHYSIOLOGY CAN CHANGE**

- Water running makes you have to pee
- Yawns are contagious
- The lemon candies that made me pucker up

#### **BLOOD FLOW CAN CHANGE**

- Blushing
- Wearing warm gloves inside
- Holding hands up to a fire
- Putting hands in warm water
- Biofeedback teaches people to warm hands to cure headaches

#### **SENSATIONS CAN CHANGE**

- Ambiguous sensations when hands are cold and you put them under running water

#### **POSITIVE HALLUCINATION IS POSSIBLE**

- Hearing someone call your name in a crowd
- Feeling a bug when the sheets move
- Itching when you've visited a place where the dog had fleas or the room was very filthy
- Thinking you hear the phone or the baby cry

#### **PERCEPTIONS OF TIME ARE CHANGEABLE**

- The industrial clock story
- Long car trips
- Reading an absorbing book
- Listening to an interesting or a boring lecture
- Flying home from Australia; in 2 minutes it will be yesterday

#### **INVOLUNTARY/AUTOMATIC MOVEMENT IS POSSIBLE**

- Parent holding an arm out in car for baby or child when the car stops abruptly
- Opening your mouth when trying to feed the baby
- Moving your body to make the bowling ball go in a different direction
- Putting on the brakes when you're in the back seat or driver's seat of the car

## **SIX STEP RECOVERY PROGRAM FOR ADULT CHILDREN OF DYSFUNCTIONAL THEORIES\***

- STEP 1. We admit that we are powerful enough to create the idea of pathology in those we work and interact with. We resolve to stop imposing our beliefs on others. We will give our theories up to a Lower Power.
- STEP 2. We vow to really listen to and acknowledge the feelings and points of view of the people we work with without closing down the possibilities for change for them in the future.
- STEP 3. We resolve to treat each person as an individual and tailor our treatment to individual needs, perceptions and goals.
- STEP 4. We resolve to confront and break through our denial about people's strengths, abilities and health. We recognize that not everything people say and do has a pathological motive. We have decided not to label others in a way that disqualifies, invalidates or discourages them. We will studiously avoid hardening of the categories.
- STEP 5. We recognize that humor helps break the cycle of hopelessness. People are grim enough as it is without therapy adding more to their sense of grimness. We vow to be sincere but never serious.
- STEP 6. We are committed to bringing ourselves into the therapy encounter, rather than remaining distant professionals doing techniques and methods on "our patients."

\*Thanks to Richard Schaub, M.S.W., for this phrase.



## A SKEPTICAL LOOK AT BIOLOGICAL PSYCHIATRY

It is widely assumed that biological psychiatry is a “scientific” approach whose claims have been shown to be true and whose effectiveness has been clearly demonstrated. A skeptical look at the best research data available casts a bit of doubt upon these assumptions, however. Many studies on biological psychiatry have used inadequate designs. That is, they have not measured patients in multiple sites or taken care to control for the influence of psychiatrists and patients knowing when the medications (as opposed to the placebo) have been given. These are some of the problems with the current research:

- Unknown degree of transparency of the double-blind design.
- Failure to use active placebos.
- Widespread adoption of “washout” procedures that bias measurement of placebo effects.
- Extreme selectivity of sampling procedures.
- Vagueness of quantitative definitions of what is a meaningful “therapeutic effect.”
- Overuse of multiple outcome measures and statistical tests.
- Contradictions in results from different sites in multicenter studies.
- Indifference about high recurrence rates.
- Focus on short-term vs. long-term outcome.
- The prevalence of serious side effects.
- Failure to establish substantial correlations between blood levels of drugs and their therapeutic power.
- Existence of alternative psychological treatments that may be equally as effective and less somatically damaging.

A California research group found that when doctors believed that the experimental treatments they were giving their patients (for asthma, ulcers and herpes) were effective, they were effective 70% of the time, despite the fact that all the treatments were later found to be ineffective. The usual placebo effect has been around 30% but many have suspected that without the use of active placebos (ones that have noticeable physiological effects), both doctors and patients have been able to guess when they were getting the real medication vs. the placebo. Roberts, et.al., *Clinical Psychology Review*, 13: 375-385. Roberts is at Scripps Clinic, Medical Psychology Division, 10666 Torrey Pines Rd., La Jolla, CA 92037

\* From: Fisher, S., & Greenberg, R.P. (1989). A second opinion: Rethinking the claims of biological psychiatry. In S. Fisher & R.P. Greenberg (eds.), *The limits of biological treatments for psychological distress: Comparisons with psychotherapy and placebo* (pp. 309-336). Hillsdale, New Jersey: Erlbaum.

## **WORKING WITH CHRONIC AND SEVERELY “MENTALLY ILL” PEOPLE AND THEIR FAMILIES**

### **General Principles**

1. Don't get hooked by the hopelessness of the situation.
  - Decline the invitation to be overwhelmed by anxiety, urgency, frustration, and over-responsibility. Remember to breathe and take your time.
2. For the moment, discard DSM diagnoses and relate to your client.
  - No therapist has ever helped a diagnostic category. Therapists only help people. Observe and pay close attention to what works and what doesn't work with this person and family.
3. Beware of others' evaluations.
  - Keep your head clear of pessimistic pronouncements, character assassinations, and nasty case notes. Form your own impressions and look out for theory countertransference.
4. Cultivate a “beginner's mind.”
  - It is often observed that therapists just starting out in the field enjoy better outcomes than the seasoned clinician. Experience is a two-edged sword. What one gains in practice confidence may be at the price of enthusiasm, flexibility and openness. Remember: *In the beginner's mind there are many possibilities; in the expert's mind there are few* -D.T. Suzuki.
5. Remember that these clients can and do change.
  - Long-term follow-up of chronic schizophrenics shows that 50-66% return to normal or are significantly improved as they get older (Harding, C.M., Zubin, J., & Strauss, J.S. [1987]. “Chronicity in schizophrenia: Fact, partial fact or artifact,” *Hospital and Community Psychiatry*, 38(5): 477-484; Harding, C.M. & Brooks, G.W. (1984) “Life assessment of a cohort of chronic schizophrenics discharged twenty years ago,” In S. Mednick, M. Harway, & K. Finello (Eds.) *The handbook of longitudinal research, II*. New York: Praeger.)

### **Specific Principles**

1. Determine the “customer” for therapy.
  - Know your client. The person sitting across from you may or may not be your “customer.” Your customer may actually be a family member, judge, agency, etc. Finding out what the *customer* wants to be different helps set the compass for your questions and interventions.
2. Acknowledge your clients' points of view.
  - A basic need of people, regardless of their mental status, is to be understood. Empathy, appreciation, genuineness, and trustworthiness are powerful allies in your work with the chronic or “disturbed” person. Just because clients may be hearing voices or believe in outlandish conspiracies they still deserve to be respected and to be heard.

#### **Example:**

*I do not know if the office is bugged. You are welcome to search and then decide if this is an OK place to talk right now.*

3. Ask what the person wants.
  - Part of acknowledging clients and building a collaborative relationship, even if they are behaving bizarrely, is to ask what they want to be different as a result of visiting with you. Everybody is motivated for something. Find out what the person's goals are for the therapy or consultation. Resist the temptation to know what's best.

**Examples:**

*What brings you here?*

*How will you know that you've gotten what you came for?*

*Dr. X asked that you see me, but I'm wondering what you want from our visit together?*

*You say that the XYZ Agency has really been hassling you. What do you need to do to get them off your back?*

4. Find out the person's strengths, competencies, resources, and interests.
  - As with any client, learn what the client/family does well. Look for exceptions to their complaints, in the present and past. Discover their vision of a better future for themselves.

**Examples:**

*You said you've always been bothered by the voices. Can you tell me about a time the voices were there but didn't bother you? Or how about a time when, for a little while, you were distracted and didn't really notice the voices?*

*Tell me about the last time you were tempted to fly off the handle, but kept your cool. How did you do that? What made the difference for you? How did it make the rest of your day go?*

*Let's pretend that we're watching a videotape of you in the future, at a time when life in your family is going more of the way you want it. In as much detail as possible, tell me what I'm seeing, what dialogue I'm picking up.*

5. Think small.
  - Forget finding the CURE. Holding out for the goal of transforming the client's personality, changing the family structure, or eliminating the disorder may rob you and the client of real opportunities for small, but meaningful change. Start small and collaboratively establish achievable goals that build success. A small change can make a big difference.
6. Separate the problem from the person.
  - Sometimes we inadvertently identify the person with their disorder or their symptoms. We refer to them as "my borderline" or "the schizophrenic." They and we can forget that there is more to them than their problem. One way of reminding yourself and them of this is to externalize and distinguish the problem or symptom from the person in the interview.

**Examples:**

*Schizophrenia really had you and your family on the run for awhile there. When did you get wise to the tricks schizophrenia was playing on you?*

*So hallucinations tried to convince you to quit your job, but this time you stood up to hallucinations and didn't let them rob you of the progress you've made?*

7. Do inclusive inner work to calm and value the person.
- Usually people who are disturbed and disturbing are caught in some internal and interpersonal binds. They go into a kind of "symptom trance," in which they forget their resources and tend to regress. Using inclusive logic (both/and) can be helpful to soothe them and help them resolve binds.

**Examples:**

*It's okay to be as close to me and as far away from me as you need to be. And you can be close and far away at the same time.*

*You can feel agitated and act in a way that serves you well.*

# Forms

**ACTION PLANS/IDEAS**

**Client:** \_\_\_\_\_

\_\_\_\_\_  
Next appointment time/date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's date

## AUDIO/VIDEOTAPING RELEASE FORM

I, \_\_\_\_\_, consent to and authorize the video and audio tape recording of my therapy session(s). I understand these tapes will be used for the purposes of training, research and education of professionals.

If at any time I change my mind about the material being used for the above purposes, I may ask for the tape(s) to be erased.

I want the following restrictions(s) placed on the showing of this (these) tapes:

If the tapes are to be sold, I understand that I will be contacted by Possibilities to give my approval for that further use.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

## CLIENT QUESTIONNAIRE

I want to continuously improve my service to you. I would appreciate it if you would take a few minutes and fill out this questionnaire. You can either give it back at your next session, if you are returning, or send it back.

1. What was the most useful aspect in today's session for you?
2. What is one thing that you learned or realized in today's session?
3. What is one thing (behavior or idea) that you will try out between now and next session? This may be something that you have had success with or something new that you want to try.
4. Note anything else that you would like me to know about what happened in session today.



## CLOSING NOTE

Client(s) Name(s): \_\_\_\_\_

1. Number of sessions:
2. Type of sessions (individual, marital, family):
3. Status of presenting problems (better/worse/unchanged):
4. Any objective/behavior changes:
5. Any subjective changes:
6. Reason that the case is being closed now:
7. Plans for follow-up:

**Circle one:**

Therapist to arrange further appointment in:

Await contact from customer

Await follow-up form response

Other (please specify)

8. Information given to referrer:
9. Any additional comments:

## FOLLOW-UP FORM

(\*Please circle those words that apply)

1. I\*/We\* had forgotten we came to see you.
2. The difficulties I\*/we\* sought help for have improved\*/are unchanged\*/have become worse\*.
3. I\*/We\* found the session(s) with Bill O'Hanlon helpful\*/very helpful\*/not helpful\*.
4. Are you having any other difficulties that you think are related to the one you brought to counseling?  
Yes/No. If yes, please describe.
5. Any suggestions as to how Bill's approach may be improved (please continue on the back of this form if you wish).
6. Any other comments you may wish to add (please continue on the back of this form if you wish).

{Optional}

Name (print please) \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

Thank you for taking time to complete this questionnaire.

# INITIAL INTERVIEW

CLIENT(S)

---

DATE \_\_\_\_\_ TIME \_\_\_\_\_ DURATION \_\_\_\_\_

PEOPLE PRESENT

---

MAIN COMPLAINANT/CUSTOMER

---

COMPLAINT

CONDITIONS OF SATISFACTION (OUTCOME MEASURERS)

THE BOTTOM LINE IN THIS CASE IS (i.e. What is the simplest thing that the complainant has to do so that the complaint will not be a complaint any more?):

PATTERNS OF THE COMPLAINT

Timing

Duration

Frequency

Location

Clothing

Actions

Interactions

Postures

Perceptions

Thoughts

Internal sensations

Interpersonal context

Triggers/cues

PREVIOUS SOLUTIONS ATTEMPTED

By the customer

By others

Did they work/help?

ASSESSMENT OF DANGEROUSNESS (Serious or previous suicidal/homicidal/ violent acts; drug/alcohol misuse patterns)

CUSTOMER'S IDEAS IN RELATION TO THE COMPLAINT (How can therapist utilize this map or change it?)

Causes/reasons for the complaint.

What do they think has to happen or what do they have to do in order for things to change?

CUSTOMER'S RESOURCES/ABILITIES/SKILLS (What do they do well?/What do they know really well?)

INTERACTIONS DURING SESSIONS

INTERVENTIONS GIVEN AT INITIAL INTERVIEW

THERAPIST'S OWN PRESUPPOSITIONS

What do I think has to happen before this complaint can be resolved?

What do I think caused or causes the complaint?

What do I think the real, underlying problem is?

DATE OF NEXT APPOINTMENT GIVEN \_\_\_\_\_

or

SESSION TO BE REQUESTED BY CLIENT \_\_\_\_\_

## SESSION NOTES

CLIENT(S) NAME(S)

---

DATE \_\_\_\_\_ TIME \_\_\_\_\_ DURATION \_\_\_\_\_

PEOPLE PRESENT

---

PRESENTING PROBLEM(S)

GOAL(S)

RESPONSE TO LAST INTERVENTION

OTHER RELEVANT EVENTS SINCE PREVIOUS SESSION

THERAPIST'S INTERVENTIONS IN THIS SESSION (AND RESPONSES)

Videotaped session?

Audio taped session?

Hypnosis used?

Task assignment given?

NEXT APPOINTMENT? \_\_\_\_\_