# Chapter Four

# Action I: Helping Clients Act







Too much thinking about things can paralyze us. Shakespeare, in the person of Hamlet, talks about important enterprises, what he calls "enterprises of great pith and moment," losing "the name of action." Helping is an enterprise "of great pith and moment." It, too, can lose the name of action. It is my conviction that one of the principal reasons clients do not manage the problem situations of their lives effectively is their failure to *act* intelligently and prudently in their own best interests. Counselors fail by not helping their clients act. Helping becomes a process of too much talking and too little action.

Many approaches to helping discuss the need for clients to act and suggest ways of helping them do so, but too often action is tucked away at the end of the model, after all the talking is over—as if it were an afterthought. Too many clients do poorly because they fail to act or act ineptly on the good ideas produced in the counseling sessions. Frese and Sabini (1985) have suggested that psychology return to the pre-Watsonian notion of action as its fundamental unit.

The lack of outcome-achieving is not just an individual problem; it is a social problem. Magaro (1985) claims that deinstitutionalizing mental patients hasn't worked because of the lack of emphasis on behavior change in the community mental health movement. This is economic madness. Helping will not be cost-effective until fees for service are established through performance contracts based on *demonstrable behavior change*. Magaro refers to this as a rehabilitation model. He predicts the end of state-supported practitioners who fail to be responsible for behavior change.

Howard, Nance, and Myers (1987) endorse Argyris's (1957, 1962, 1964) list of tasks to be accomplished in moving toward adult maturity. All of them require, directly or indirectly, a "bias toward action" in people's lives:

1. Change from a passive to a more active state.
2. Change from a state of dependency on others to relative independence.
3. Change from behaving in a few ways to acting in many ways.
4. Change in interests—with erratic, shallow, and casual interests giving way to mature, strong, and enduring interests.
5. Change from a present-oriented time perspective to a perspective encompassing past, present, and future.
6. Change from solely subordinate relationships with others to relationships as equals or superiors.
7. Change from lack of a clear sense of self to a clearer sense of self and control of self (Howard, Nance, & Myers, 1987, pp. 90–91).

Helpers see many clients who have difficulties in one or more of these areas, clients who need assistance in becoming agents in their own lives.

## EXPERIENCES, ACTIONS, AND EMOTIONS

It is useful to distinguish action from experience in general and from that extremely important category of experience called *affect*.

- Clients talk about their experiences—that is, what happens *to* them. If a client tells you that she was fired from her job, she is talking about her problem situation in terms of an experience.
- Clients talk about their behavior—that is, what they do or refrain from doing. If a client tells you that he has sex with underage boys, he is talking about his problem situation in terms of his behavior.
- Clients talk about their affect—that is, the feelings and emotions that arise from or are associated with either experiences or behavior. If a client tells you how depressed she gets after drinking bouts, she is talking about the affect associated with her problem situation.

In practice, of course, clients talk about all three together. Consider this example. A client says to a counselor in the personnel department of a large company: "I had one of the lousiest days of my life yesterday." At this point the counselor knows that something went wrong and that the client feels bad about it, but she knows relatively little about the specific experiences, behaviors, and feelings that made the day a horror for the client. However, the client continues: "Toward the end of the day my boss yelled at me for not getting my work done [an experience]. I lost my temper [emotion] and yelled right back at him [behavior]. He blew up and fired me [an experience for the client]. And now I feel awful [emotion] and am trying to find out [behavior] if I can get my job back." Note that the problem situation is much clearer once it is spelled out in terms of specific experiences, behaviors, and feelings related to specific situations.

### Experiences

Most clients spend a fair amount of time, perhaps too much time, talking about what happens *to* them.

- "I get headaches a lot."
- "My ulcers act up when family members argue."
- "My wife doesn't understand me."

In contrast, they often talk about what *other people* do or fail to do, especially when others' behavior affects them adversely:

- "She doesn't do anything all day. The house is always a mess when I come home from work."
- "He tells his little jokes, and I'm always the butt of them."



As these examples suggest, clients often see themselves, rightly or wrongly, as victims of forces not in their control. If these forces are described as being *outside* them, they are *external*, or *overt*, experiences:

- "She never calls."
- "Company policy discriminates against women."
- "The economy is so lousy that there are no jobs."
- "No innovative teacher gets very far around here."

However, the "controlling" forces may be *internal*, or *covert*:

- "These feelings of depression come from nowhere and seem to suffocate me."
- "No matter what I do, I always feel hungry."
- "I just can't stop thinking of her."
- "It's the way I was educated. I was always taught to think of ethnics as inferior, and now it's just the way I think."

One reason that some clients are clients is that they see themselves as victims, as adversely affected by other people, the immediate social settings of life, society in its larger organizations and institutions, or cultural prescriptions. They feel that they are no longer in control of their lives. Therefore, they talk extensively about these experiences.

- "He treats me like dirt. But that's the way he is. He just doesn't care about people and their feelings at all. He's totally self-centered."
- "I can't control my appetite. I've heard that some people are like that. They have a different sort of metabolism. I must be one of those."
- "I keep hearing voices. They tell me to harm myself. I think they're coming from the devil."

For some clients, talking constantly about experiences is a way of avoiding responsibility: "It's not my fault. After all, these things are happening *to* me."

### Behaviors

Some clients talk freely about their experiences, but are much less willing to talk about their behaviors, that is, what they do and don't do. The reason for this is rather simple and relates to most of us. While we may not feel accountable for our experiences, what happens to us, we realize at some level of our being that we are responsible for what we do or actively refrain from doing. Or at least we sense that the possibility of accountability is much higher when it comes to behavior.

- "When he ignores me, I go off by myself and cry."
- "I haven't even begun to look for a job. I know there are none in this city."

- "When I feel the depression coming on, I take some of the pills the doctor gave me."
- "When I get bored, I find some friends and go drinking."

Note that in each of these examples, the behavior is a reaction to some experience. Whether or not it is a creative reaction is another matter.

### Affect

*Affect* refers to the feelings and emotions that proceed from, lead to, accompany, underlie, or give color to a client's experiences and behaviors.

- "I finished the term paper that I've been putting off for weeks and I feel great!"
- "I've been feeling sorry for myself ever since he left me."
- "I yelled at my mother last night and now I feel pretty ashamed of myself."
- "I've been anxious for the past few weeks, but I don't know why. I wake up feeling scared and then it goes away but comes back again several times during the day."

Of course, clients often express feelings without talking about them. Some clients feel deeply about things, but do their best to repress their feelings. But often there are cues or hints, whether verbal or nonverbal, of the feelings inside. A client who is talking listlessly and staring down at the floor may not say, in so many words, "I feel depressed." A dying person might express feelings of anger and depression without talking about them.

Some clients imply that their emotions have a life of their own and that they can do little or nothing to control them. This includes describing others as the causes of their emotions:

- "Whenever I see him with her, I feel hurt."
- "She can get my goat whenever she wants. She's always making me angry."
- "I can't help crying when I think of what they did to her."

One goal of the helping process is to help clients get out from under the burden of disabling feelings and emotions. As we shall see later on, people *can* learn how to control their emotions. Usually feelings and emotions cannot be controlled directly. Controlling them indirectly means controlling what goes on inside one's head. If I let myself dwell on the ways in which you have wronged me, I will inevitably get angry. But I can actively *refrain* from dwelling on such thoughts. On the other hand, some clients need to learn how to *express* emotions as part of their humanity and as a way of enriching their interactions with themselves and others.

Helpers tend not to have enough working knowledge about human emotions and the skills to help clients manage the affective dimensions of life well (Greenberg & Safran, 1989). On the other hand, some helpers err by focusing too exclusively on clients' emotions instead of dealing with them in the context of experiences and behaviors. In the best case, helpers can assist clients to become more effective agents in all dimensions of their lives.



## THE MANY FACES OF ACTION

Behavior, or action, comprises the things I *do* and the things I actively *refrain from doing*. Five ways of categorizing action are important in the helping process. First, actions can be *internal*, that is, "inside the head" of the client, or *external*, actions that can be seen by others (whether they are actually seen or not). Second, actions can take place *during* the helping sessions themselves or *outside* the sessions in the client's day-to-day life. Third, these actions may be *informal* (not part of an overall plan) or *formal* (part of an overall plan). Fourth, there are actions that clients take to *influence* existing realities and actions they take to *accommodate* themselves to these realities. Finally, actions can lead to *helpful* outcomes or *unhelpful* outcomes (in the latter category I would include actions that seem to lead nowhere in particular).

All these modes include both acting and actively refraining from action. The following case will help put some flesh and bones on these abstract categories.

> Ben, 48, lost his wife and daughter in a train crash. At the time he saw a counselor, more than a year later, he was still suffering from shock and blaming himself for letting them go on the trip without him. He lived in a cluttered house, found it difficult to focus on work, and had given up most social contacts. From time to time he got involved in drinking bouts, mostly on weekends. He suffered from depression running from mild to severe, falling on occasion "into the pit," as he put it, when he would sit in a dark room, steeped in his misery. When "in the pit" he was convinced that his life was over. Although he had been a churchgoer, he now alternated between "screaming at God," taking what had happened as punishment for his "sins and his life of selfishness," and believing in nothing. Thoughts of suicide arose from time to time, and once he found himself staring at a bottle of sleeping pills his wife had used on occasion. But he always dismissed suicidal thoughts as beneath him.
>
> Late one night Ben was found wandering the streets in a daze. Brought to a local hospital, he had a brief session with a counselor the next morning. He agreed to come back to see the counselor because, as he told someone later, he found that she was "compassionate but not sentimental" and "seemed to have a great deal of common sense." In the counseling sessions, Liz, the counselor, found Ben to be quite bright but with little ambition and a tendency to sell himself short.

The five ways of categorizing actions are all illustrated in Ben's story. As we discuss each in turn, we'll come back to Ben's case.

## External versus Internal Action

### External Actions

External action (overt behavior) is action that can be witnessed by others, whether it is actually witnessed or not. Some examples of overt behavior:

- "When he called me a name, I punched him."
- "I haven't told my husband about the affair."
- "I read pornography a lot."

In our example, Ben performed a number of external actions that moved him along. He agreed to a session with Liz, talked about himself during the session, and at the end made a second appointment. All these external actions related to the helping process itself. Eventually he needed to find new ways of acting in his everyday life. For instance, he had to come to grips with interactions with friends, relatives, and co-workers.

### Internal Actions

Many cognitive processes, those things that go on inside our heads, are really forms of internal behavior. These include such actions as thinking, expecting, attending to things inside or outside oneself, registering information, daydreaming, rehearsing behaviors in one's mind, turning things over in one's mind, making associations, imagining, thinking about one's emotions, thinking about one's thoughts or inner life, remembering, planning, deciding, and permitting thoughts to hang around (see Martin, Martin, Meyer, & Slemon, 1986). Here are some statements by clients that describe internal actions:

- "When he called me a name, I began thinking of the ways I could get back at him."
- "I like to daydream about having a child."
- "I never let myself think bad things about another person."
- "When she left me, I decided I'd find some way of getting back at her."
- "I try not to let thoughts of sex enter my mind."

People who feel that they have little or no control over what is going on inside their heads often describe internal actions as experiences:

- "I try to get into my work, but I just can't stop thinking of her and how she played me for a fool."
- "Sexual fantasies seem to keep popping up all the time. I just don't seem to have any control."
- "I know I get depressed and cry when I think of John on his deathbed, but I can't help thinking of him."



Attitudes and prejudices, as ingrained ways of thinking about things, are more like experiences than actions, but—as we know well—they can lead to powerful and sometimes destructive actions.

Part of the counseling process can be to help clients see that they can control their experiences, especially their internal or covert experiences, more than they first think. We can exercise control over many internal actions just as we can over our external actions, and we can work at changing our attitudes and prejudices. Indeed, some forms of therapy, such as Ellis's (Ellis & Dryden, 1987), are based on learning how to control what goes on inside one's head. In our example, Ben discovered that he was allowing himself—almost *encouraging* himself—to dwell morbidly on the death of his wife and daughter. He dwelled on thoughts that made him feel guilty. Learning how to refrain from such thoughts became one of the goals of counseling. Liz helped him find ways of remembering and mourning his wife and daughter that uplifted his spirit instead of destroying it. He discovered that he had not really mourned their deaths. Instead, he had indulged in guilt and self-recrimination.

For most clients, managing problems and developing opportunities demand a combination of thinking right (doing the right things inside their heads) and doing right externally. Rusk (1989) put it this way:

> Deliberate self-change requires a willingness to: (a) stand back from yourself far enough to question your familiar beliefs and attitudes about yourself and others, and (b) persist at awkward and risky experiments designed to increase your self-respect and satisfy your needs.

To manage his life better, Ben needed both kinds of action.

## Actions within the Helping Sessions versus Actions Outside

### Inside Helping Sessions

Clients need to participate in and *own* their part of the helping process. It cannot remain something that is done to them, something they merely experience. Ben did a number of things during the first helping session. He risked telling his story for the first time since the accident. And, struck by Liz's non-pushy, commonsense approach, he even let himself cry. These actions made him feel relieved and prompted him to set up another appointment.

I have expressed reservations about the amount of talking and the lack of acting that characterizes too much of what passes for helping. Without taking that back, I also know that talking within the session can be a form of outcome-producing action. Clients who have kept problems to themselves for years can make significant breakthroughs just by talking about them. Moreover, as indicated earlier, helping can be, even principally, a social-emotional reeducation process. Many clients have changed their negative views of themselves and made improvements in their interpersonal styles through their interactions with me. For instance, one client

significantly altered his bossy, confrontational style by first changing his style with me. In most cases, however, the ultimate fruits of social-emotional reeducation lie in changed behavior outside the helping sessions.

### Outside Helping Sessions

I know someone who participated in a counseling group for over 15 years. He looked forward to the meetings and felt bad if he had to miss one. Indeed, the group was an important part of his social life. But there is some question as to how effectively he translated what he learned inside the group to his everyday life. Now, it was his life, and he could do what he wanted with it. For me, however, becoming dependent on the helping process is itself a problem.

When Ben left the hospital, he went home, and, after a great deal of hesitation, called a sister who he knew would soon find out about his hospital stay and be alarmed. The phone call was very brief, but he did think of someone outside himself and he did, at least for the moment, reestablish a social contact. He did not have a "grand plan," but his experience in the hospital promoted him to *do something useful* and to do it right away.

## Formal versus Informal Action

As illustrated in the overview of the helping model, informal action—as opposed to action based on some specific plan—can start right from the first interview. In some cases, more is accomplished through informal action than through formal planning. A friend of mine who is highly successful did not set demanding career goals and then devise a plan for achieving them. Instead, he took an incremental approach. He said yes to offers that felt a little bit beyond his current level of expertise. He developed a pattern of stretching himself bit by bit. His approach to his career has been an informal, incremental approach, but it has been action-based and highly effective. Some clients prefer mostly informal actions and goals. Some are helped by formal planning involving explicit goals and action programs. Some need a combination of the two.

Ben began by doing a number of little things differently—things he didn't even discuss with the counselor. People at work had been very indulgent with him since the tragedy. They didn't expect him to be 100% himself. On his own, however, Ben, who had been coming to work late, started showing up on time. He still drank some, but not nearly as much as before. He took walks. Though solitary, these represented an advance over sitting in the dark of the house brooding. These actions and others were not part of a plan. In fact, Ben did not reflect on them a great deal. They were signs that something of the old Ben were beginning to stir. And his sessions with Liz helped trigger them.



On the other hand, actions that are part of a formal plan can be most useful. One of my clients, in rebuilding his life after a serious automobile accident, very deliberately planned both a rehabilitation program and a career change. Keeping to a schedule of carefully planned actions not only helped him keep his spirits up but also helped him accomplish a succession of goals.

## Influencing Realities versus Accommodating to Them

Weisz, Rothbaum, and Blackburn (1984; also see Rothbaum, Weisz, & Snyder, 1982; Weisz, 1983) use the terms *primary* and *secondary control* to discuss the cultural bias found in North America related to people's ability to control their destinies.

> There are at least two general paths to a feeling of control. In primary control, individuals enhance their rewards by influencing existing realities (e.g., other people, circumstances, symptoms, or behavior problems). In secondary control, individuals enhance their rewards by accommodating to existing realities and maximizing satisfaction or goodness of fit with things as they are. American psychologists have written extensively about control, but have generally defined it only in terms of its primary form. (p. 955)

Helping is the art of the possible. While most clients can do more to control their lives than they actually do, this does not mean that clients must substitute taking charge of everything for passivity and dependency.

> Debbie learned, to her chagrin, that she and her husband had more areas of incompatibility than she had imagined. Though she knew that he liked his work, she had no idea that it was his passion. Work came before almost everything else. However, she did not think that she could make him change. A counselor helped her find ways of coping. Instead of feeling sorry for herself, she developed friends and interests outside the home, activities in which he did not participate. In her mind, this was not the perfect solution. But it certainly made life fuller and more livable.

For some clients, a great deal of primary control might be possible; for others, secondary control might be the only realistic option; for most, the best available course is a combination of the two. Clients, like ourselves, have limitations. Like ourselves, they are in many ways not captains of their own fates. Some would say that what Debbie did amounted to giving up. Others would see it as practicing the art of the possible.

Although Ben influenced many of the realities of his life, he accommodated to others. While he did reestablish better relationships at work and some minimal social interactions with closer relatives (an occasional dinner at his sister's, for example), he also accommodated to a more solitary life. Perhaps he believed that no one could take the place of the two people he had lost, or perhaps he had no desire to develop further relationships.

Or perhaps he found something satisfying in a life that was in fact more solitary than it was lonely. Instead of brooding, he became more meditative and came to enjoy his newfound inner life. He was neither a hermit nor the more social person he had been before the tragedy. Although Liz had noted his apparent lack of ambition, Ben did not want to discuss his job or career prospects. He admitted, at least to himself, that he could be more, but he also realized that he did not particularly want to be. Even though he was underemployed, he kept the same job, and the company was glad to keep him.

Liz did not push Ben to explore the areas of life with which he was satisfied. Could he have ended up living a "fuller" life had he accommodated less and exercised more influence on realities? Perhaps. But there are no formulas.

### Action and Outcomes

To deserve the name of problem-managing or opportunity-developing action, action must lead to client-enhancing outcomes. What difference does it make if the clients leave helping sessions with smiles on their faces and songs in their hearts if their problems are not managed more effectively? (Unless the originating problem was the lack of a smile and the absence of a song.)

This issue has already been explored in Chapter 1 in the discussion on the goals of helping. Ideally, helping is both an effective and an efficient process. It is effective if clients manage problems and develop opportunities better. It is efficient if they do not waste a lot of energy getting to their goals. Thus, some client activities are a waste of time because they lead nowhere in particular. They may be *actions*, but they do not lead to helpful *outcomes*.

Early in my career, one of my clients kept a detailed record of everything that happened in the counseling sessions and everything outside that seemed in any way related. Good idea? Probably not. It took up a great deal of his time and in the end was probably his way of putting off problem-managing action. It made him focus excessively on the helping process itself instead of on behavioral change in his everyday life. He was spinning his wheels.

Even purposeful action can be relatively pointless in terms of the goals of helping. A client of a colleague of mine set goals and acted to accomplish them, but the goals had little to do with her principal concerns. For instance, she decided that looking more fashionable and getting a degree would help her with her self-image. She worked hard at both sets of goals and accomplished a great deal. But self-image was not one of her major problems. More significantly, her rather acerbic interpersonal style turned people off—family members, friends, co-workers. But she did not pursue



any substantial goals in this area. Perhaps she thought, at some level of her being, that a better self-image would take care of everything. In fact, her stormy relationships persisted. Reflecting on this case some months after she terminated the helping process, my friend mused, "I let her get away with murder."

Ben was fairly efficient in the use of counseling time. There were not many sessions—perhaps eight in all, spread out over a year's time. In the sessions he saw many things as they really were—his morbidity, the stupidity of total social withdrawal, the corrosive nature of his guilt—and he worked gradually and quietly to reestablish his equilibrium. He did not pursue issues during the sessions just to talk. He did not spin his wheels. He learned a few things, and he acted on his learnings. As he left his eighth session, he somehow knew it would be his last. And it was.

## THE MANY FACES OF INERTIA

What keeps clients from acting on their own behalf? In physics, the law of inertia states, in part, that a body at rest tends to stay at rest unless something happens to move it along. In counseling, inertia refers to clients' reluctance to act. Many clients are in trouble or stay in trouble because, for whatever reason, they are "at rest." The sources of inertia are many, ranging from pure sloth to paralyzing fear. In trying to help clients act, you will come up against the many faces of inertia. What is said here is meant to give you the flavor of inertia, not to exhaust its possibilities. Most of us can start by examining inertia in our own lives.

Let us not be quick to blame our clients for their inertia. Inertia permeates life and is one of the principal mechanisms for keeping individuals, organizations, and institutions mired in the psychopathology of the average. A friend of mine is a consultant to organizations. He told me about one larger organization in which he worked with senior managers to transform the place. They did it right: diagnosis, identification of key issues, establishment of objectives, formulation of strategies, drawing up of plans. My friend went away satisfied with a job well done. He returned six months later to see how the changes were working out. But there were no changes: No one from the president on down had acted on their plans. The managers looked sheepish and gave the excuses we all give—too busy, other things came up, couldn't get in touch with the other guy, ran into obstacles—the litany is endless. And this was a fairly successful company!

Earlier I noted that Howard, Nance, and Myers (1987) adapt a "situational leadership" model to counseling and therapy. The model identifies three sources of client inertia: lack of competence, lack of confidence, and lack of willingness. This in turn suggests three ways in which counselors can be helpful: by helping clients discover ways of developing competence,

including training as a form of treatment (for instance, training in interpersonal skills); by providing support and helping clients find ways of bolstering their confidence (for instance, through "little successes" related to the counseling process itself); and by challenging clients to act in their own behalf.

Often, clients are clients because they have problems with self-responsibility. The list of ways in which we avoid taking responsibility is endless. We'll examine several of them here: passivity, learned helplessness, disabling self-talk, and getting trapped in vicious circles.

## Passivity

Early in the history of modern psychology, William James remarked that few people bring to bear more than about 10% of their human potential on the problems and challenges of living. Others since James, while changing the percentages somewhat, have said substantially the same thing, and few have challenged their statements (Maslow, 1968). It is probably not an exaggeration to say that unused human potential constitutes a more serious social problem than emotional disorders, since it is more widespread. Maslow (1968) suggests that what is usually called "normal" in psychology "is really a psychopathology of the average, so undramatic and so widely spread that we don't even notice it ordinarily" (p. 16). Many clients you will see, besides having more or less serious problems in living, will also probably be chronic victims of the psychopathology of the average.

One of the most important ingredients in the generation and perpetuation of the psychopathology of the average is passivity, the failure of people to take responsibility for themselves in one or more developmental areas of life or in various life situations that call for action. Schiff (1975) discusses four kinds of passivity: (1) *doing nothing*, that is, not responding to problems and options; (2) *overadapting*, or uncritically accepting the goals and solutions suggested by others; (3) engaging in *random* or *agitated behavior*, or acting aimlessly; and (4) *becoming incapacitated or violent*, that is, shutting down or blowing up.

> When Zelda and Jerzy first noticed small signs that things were not going right in their relationship, they did nothing. They noticed certain incidents, mused on them for a while, and then forgot about them. They lacked the communication skills to engage each other immediately and to explore what was happening.

Zelda and Jerzy had both learned to remain passive before the little crises of life, not realizing how much their passivity would ultimately contribute to their downfall (see Egan, 1985, pp. 167–170). Endless unmanaged problems led to major blow-ups until they decided to end their marriage.



## Learned Helplessness

Seligman's (1975) concept of "learned helplessness" and its relationship to depression has received a great deal of attention since he first introduced it. Clients may have learned to believe from an early age that there is nothing they can do about certain life situations. Obviously there are degrees in feelings of helplessness. Some clients feel minimally helpless (and minimally depressed) and come to a helper primarily because they believe that getting help will be a more effective or efficient way of facing some problem or difficulty. Other clients feel totally helpless and overwhelmed by the difficulties of life and fall into deep, almost intractable depression.

Bennet and Bennet (1984) see the positive side of hopelessness. If the problems clients face are indeed out of their control, they say, then it is not helpful for them to have an illusory sense of control, unjustly assign themselves responsibility, and indulge in excessive expectations. Somewhat paradoxically, they found that challenging clients' tendency to blame themselves for everything actually fostered realistic hope and change. The trick is helping clients learn what is and what is not in their control. A man with a physical disability may not be able to do anything about the disability itself, but he does have some control over how he views his disability and the power to pursue certain life goals despite it. One answer to learned helplessness, as Simons and her colleagues (1985) have suggested, is "learned resourcefulness."

## Disabling Self-Talk

As has been shown by Ellis (1974, 1979; Ellis & Dryden, 1987) and others (Grieger & Boyd, 1980), people often get into the habit of engaging in disabling self-talk, thus talking themselves into passivity. They say to themselves such things as

- "I can't do it."
- "I can't cope."
- "I don't have what it takes to engage in that program; it's too hard."
- "It won't work."

Such self-defeating conversations with themselves get people into trouble in the first place and then prevent them from getting out. Ways of helping clients to manage their disabling self-talk will be discussed in later chapters.

## Vicious Circles

Pyszczynski and Greenberg (1987) developed a theory about self-defeating behavior and depression. They said that people whose actions fail to get

them what they want can easily lose a sense of self-worth and become mired in a vicious circle of guilt and depression.

> Consequently, the individual falls into a pattern of virtually constant self-focus, resulting in intensified negative affect, self-derogation, further negative outcomes, and a depressive self-focusing style. Eventually, these factors lead to a negative self-image, which may take on value by providing an explanation for the individual's plight and by helping the individual avoid further disappointments. The depressive self-focusing style then maintains and exacerbates the depressive disorder. (p. 122)

It does sound depressing. One client, Amanda, fit this theory to a tee. She had aspirations of moving up the career ladder where she worked. She was very enthusiastic and dedicated, but she was unaware of the "gentleman's club" politics of the company in which she worked and didn't know how to "work the system." She kept doing the things that she thought should get her ahead. They didn't. Finally, she got down on herself, began making mistakes in the things that she usually did well, and made things worse by constantly talking about how she "was stuck," thus alienating her friends. By the time she saw a counselor, she felt defeated and depressed. She was about to give up.

### Inertia as Staying Disorganized

I once knew someone who lived out of his car. No one knew exactly where he spent the night. The car was chaos, and so was his life. He was always going to get his career, family relations, and love life in order, but he never did. Living in disorganization was his way of putting off life decisions.

Like my acquaintance, some people seem to choose to remain disorganized. Ferguson (1987b) paints a picture that may well remind us of ourselves, at least at times.

> When we saddle ourselves with innumerable little hassles and problems, they distract us from considering the possibility that we may have chosen the wrong job, the wrong profession, or the wrong mate. If we are drowning in unfinished housework, it becomes much easier to ignore the fact that we have become estranged from family life. Putting off an important project—painting a picture, writing a book, drawing up a business plan—is a way of protecting ourselves from the possibility that the result may not be quite as successful as we had hoped. Setting up our lives to insure a significant level of disorganization allows us to continue to think of ourselves as inadequate or partially-adequate people who don't have to take on the real challenges of adult behavior. (p. 46)

Many things can be behind this unwillingness to get our lives in order, like defending ourselves against a fear of succeeding.

Driscoll (1984, pp. 112–117) has provided us with a great deal of insight into this problem. He sees inertia as a form of control. He uses a car



rental agency's motto—"Let us put you in the driver's seat"—to make the point of client action. He says that if we tell some clients to jump into the driver's seat, they will compliantly do so—at least until the journey gets too rough. The most effective strategy, he says, is to show clients that they have been in the driver's seat right along: "Our task as therapists is not to talk our clients into taking control of their lives, but to confirm the fact that they already are and always will be." That is, inertia, in the form of staying disorganized, is a form of control. The client is actually *successful*, sometimes against great odds, at remaining disorganized and thus preserving inertia.

Given the many faces of inertia, we cannot assume that clients will take action. In collaboration with them, we need to build action into the helping process right from the start.

## SELF-EFFICACY

The opposite of passivity is "agency" (Egan, 1970), "assertiveness," or "self-efficacy" (Bandura, 1977a, 1980, 1982, 1986; Bandura & Schunk, 1981; Bernier & Avard, 1986; Clifford, 1983; Devins & Edwards, 1988; Lee, 1983; Strauss & Ryan, 1987). Bandura has suggested that people's expectations of themselves have a great deal to do with their *willingness* to put forth effort to cope with difficulties, the *amount* of effort they will expend, and their *persistence* in the face of obstacles. In particular, people tend to take action if two conditions are fulfilled:

1. They see that certain behavior will most likely lead to certain desirable results or accomplishments (outcome expectations).
2. They are reasonably sure that they can successfully engage in such behavior (self-efficacy expectations).

For instance, Yolanda not only believes that participation in a rather painful and demanding physical rehabilitation program following an accident and surgery will literally help her get on her feet again (an outcome expectation), but also believes that she has what it takes to inch her way through the program (a self-efficacy expectation). She therefore enters the program with a very positive attitude. Yves, on the other hand, is not convinced that an uncomfortable chemotherapy program will prevent his cancer from spreading and give him some quality living time (a negative outcome expectation), even though he knows he could endure it, so he says no to the doctors. Xavier *is* convinced that a series of radiation and chemotherapy treatments would help him (a positive outcome expectation), but he does not feel that he has the courage to go through with them (a negative self-efficacy expectation). He, too, refuses the treatment.

People's sense of self-efficacy can be strengthened in a variety of ways:

- *Success.* They act and see that their behavior actually produces results. Often success in a small endeavor will give them the courage to try something more difficult.
- *Modeling.* They see others doing what they are trying to do and are encouraged to try themselves. For example, a counselor in the hospital can get Xavier to talk to patients who are "toughing it out" in the treatments.
- *Encouragement.* Others exhort them to try, challenge them, and support their efforts.
- *Reducing fear and anxiety.* If people are overly fearful that they will fail, they generally do not act. Therefore, procedures that reduce fear and anxiety help heighten the sense of self-efficacy.

As a helper, you can do a great deal to help people develop a sense of agency or self-efficacy. First of all, you can help them challenge self-defeating beliefs and attitudes about themselves and substitute realistic beliefs about their ability to act. This includes helping them reduce the kinds of fears and anxieties that keep them from mobilizing their resources. Second, you can help them develop the working knowledge, life skills, and resources they need to succeed. Third, you can help them challenge themselves to take reasonable risks and support them when they do.

There is a rich and growing literature on self-efficacy. It makes sense to stay in touch with it since it deals with the most ticklish of all problems, clients' failure to act. There are critics of self-efficacy theory (Bandura, 1984; Eastman & Marzillier, 1984; Marzillier & Eastman, 1984), but both academicians and practitioners in general find it most helpful. The usefulness of the self-efficacy construct is not limited to counseling. O'Leary (1985) has noted that perceived self-efficacy can play a significant role in the control of smoking, the management of pain, control of eating, successful recovery from heart attack, and adherence to preventive health programs.

## SELF-REGULATION

While self-efficacy deals with how clients think about action, self-regulation deals with how they go about it. There is a growing literature on self-regulation (Bandura, 1986, pp. 335–389; Kanfer & Schefft, 1988), including books on practical self-direction in everyday life (see Watson & Tharp, 1989; Williams & Long, 1988). Let's start with theory and move to practice.

### Self-Regulation Theory

Bandura (1986) does not see self-regulation as a feat of will power. Rather, he focuses on a group of subprocesses that contribute to self-regulation. These include such things as



- *self-observation*, which provides the information necessary for setting realistic performance standards and for evaluating ongoing changes in behavior;
- setting *internal standards* for judging and guiding one's actions;
- identifying *incentives* for one's own actions;
- setting one's own *improvement goals*, even when not encouraged by others to do so;
- *recognizing* and *evaluating* one's accomplishments at the service of self-respect and self-satisfaction.

Kanfer and Schefft (1988), too, underscore the importance of learning the processes and skills of self-regulation:

> An effective therapy program has at its core the development of self-regulatory skills to help the client reach realistic and attainable goals that meet his needs and are acceptable to the society in which he lives. This presupposes the goal of changing regulatory processes rather than just behavioral outcomes or products in a specific situation. The effectiveness of self-management therapies must be judged on process measures, not just product or outcome measures. (p. 59)

In other words, counselors not only can help clients achieve therapeutic outcomes but also can change the way they go about getting to these outcomes. There are all sorts of benefits for those who exercise reasonable self-control. Their self-esteem goes up, they feel freer, they are motivated to try things, they discourage others in their attempts to exercise control over them, their sense of self-efficacy and of autonomy is increased, social acceptance follows, and control in one area tends to spread to control in other areas.

### Self-Regulation Practice: Helping Clients Become Problem Solvers

The literature suggest a wide variety of ways in which counselors can help clients to become more effective in self-regulation. Counselors can help clients to

- become sensitive to cues indicating that some kind of self-regulation is called for,
- control inner behavior, such as resisting intrusive thoughts, self-doubt, and self-defeating urges and temptations,
- control emotions,
- identify problems as they begin to develop,
- set goals,
- establish a set of values to act as standards of evaluation,
- develop an effective planning style,

- turn good intentions into actions,
- engage in reasonable self-criticism, and
- learn the techniques of self-reward.

In short, counselors can help clients become better problem solvers—better problem managers and opportunity developers. Although this book is about a model and methods counselors can use to help clients, more fundamentally, it is about a problem-solving model and methods that clients can use to help themselves.

When people are presented with the basic steps of a problem-solving model, they tend to say: "Oh yes, I know that." Recognition of the logic of problem solving, however, is a far cry from using it.

> In ordinary affairs we usually muddle about, doing what is habitual and customary, being slightly puzzled when it sometimes fails to give the intended outcome, but not stopping to worry much about the failures because there are still too many other things still to do. Then circumstances conspire against us and we find ourselves caught failing where we must succeed—where we cannot withdraw from the field, or lower our self-imposed standards, or ask for help, or throw a tantrum. Then we may begin to suspect that we face a problem. . . . *An ordinary person almost never approaches a problem systematically and exhaustively unless he has been specifically educated to do so.* (Miller, Galanter, & Pribram, 1960, pp. 171, 174; emphasis added)

Over the past few years there has been a great deal of interest in the problem-solving abilities of people in general and of clients in particular (see Heppner, 1988; Heppner & Anderson, 1985; Heppner, Neal, & Larson, 1984). Furthermore, problem solving has been a useful approach with children as well as adults, and the technology for training children in problem-solving skills has been developed (Shure & Spivack, 1978; Spivack, Platt, & Shure, 1976; Spivack & Shure, 1974; Urbain & Kendall, 1980).

Clients often are poor problem solvers—or whatever problem-solving ability they have tends to disappear in times of crisis. The function of the helper is to get clients to apply problem solving to their current problem situations and, at the same time, help them adopt more effective approaches to future problems in living. So it is not just a question of using a problem-management framework to help clients work out *this* set of problem situations. Counseling can also be a training *process* whereby clients learn to do for themselves what counselors are helping them to do.

## THE SELF-HELP MOVEMENT

We live in a society that has become somewhat suspicious of and confrontational toward professional help. Further, there is a growing realization that help must begin at home, that is, with the person with the problem. In medicine there is the wellness movement, which is based on the idea



that we are in charge of our own bodies. The analog in mental health is the self-help movement: help can be found with your fellow sufferers. Since self-help methods tend to be pragmatic and action-oriented, it is only right to discuss them in a chapter on action.

### Self-Help Books

Studies show that many helpers use self-help treatment books in conjunction with counseling. There are at least two schools of thought on clients' use of such books. One school is somewhat pessimistic about their value and strongly suggests caution (see Forest, 1988; Rosen, 1987). Another school suggests that many helpers believe that such books can, under certain circumstances, help clients a great deal (see Holtje, 1988; Starker, 1988a, 1988b). Mahalik and Kivlighan (1988) urge helpers to distinguish between "succeeders" and "failers" in the use of do-it-yourself manuals, while Holtje and Starker call for an evaluation of do-it-yourself manuals themselves so that the wheat can be separated from the chaff. The point to be made is this: If you use self-help books in conjunction with your counseling, make sure that you use tested materials and that your clients are likely to benefit from their use.

### Self-Help Groups

Across the country groups have been established to help people cope with almost every conceivable problem. Twenty years ago, Hurvitz (1970, 1974) claimed that these groups were more effective and efficient than other forms of helping: "It is likely that more people have been and are being helped by [self-help groups] than have been and are being helped by all types of professionally trained psychotherapists combined, with far less theorizing and analyzing and for much less money" (1970, p. 48). His hypothesis probably still holds true today. A conservative estimate holds that over six million people are currently participating in such groups (Jacobs & Goodman, 1989). This figure might surprise a lot of professionals, Jacobs and Goodman say, because most groups are "quiet, small, and local" (p. 536). They range from such traditional groups as Alcoholics Anonymous to groups that help women cope with the aftermath of a mastectomy operation, from Weight Watchers to newly formed groups of people who are HIV positive but have not yet developed AIDS.

By definition these groups have the flavor of action. An issue of the *Self-Help Reporter* (Fall, 1985, p. 5) describes the elements of the pragmatic, democratic ethos of self-help groups:

1. A noncompetitive, cooperative orientation.
2. An anti-elite, antibureaucratic focus.
3. An emphasis on the indigenous—people who have the problem know a lot about it from the "inside," from experiencing it.

4. Do what you can do. One day at a time. You can't solve everything at once.
5. A shared, often circulating leadership.
6. Being helped through helping [others] . . . no necessary antagonism between *altruism* and *egoism*.
7. Helping is not a commodity to be bought and sold.
8. An accent on empowerment—control over one's own life.
9. A strong optimism regarding the ability to change.
10. Small . . . is the place to begin and the unit to build upon.
11. A critical stance toward professionalism, which is often seen as pretentious, purist, distant, and mystifying. Self-helpers like simplicity and informality.
12. An emphasis on the consumer. . . . The consumer is a producer of help and services.
13. Helping is at the center—knowing how to receive help, give help, and help yourself. Self-victimization is antithetical to the ethos.
14. The group is the key—de-isolation is critical.

The bias toward action of self-help groups might well be built in, because there is some evidence that those who join such groups are more motivated to take an active role in changing their lives (Levy, 1988). Self-help groups also use peer pressure to get passive group members to act.

Professional helpers tend to ignore self-help groups. Whether this is in reaction to the movement's suspicion of professionals is another matter.

> Lacking familiarity with the potential of the self-help groups to be a primary treatment of choice for any number of serious personal problems, the psychologist sometimes views them as mere inexpensive, naive adjuncts to therapy—hand-holding, morale-boosting, do-no-harm meetings of fellow sufferers. (Jacobs & Goodman, 1989, p. 536)

This, the authors say, is a mistake. There is a place for professionals, for the self-help movement, and for partnerships between the two.

> We will argue that self-help groups are well on their way to becoming a major and legitimate format for delivering mental health care in this country. If we psychologists do not play a significant part in this development, other professionals will, perhaps dropping our national relevance a notch. (p. 536)

Placing self-help groups in the context of the current health care revolution, the authors hypothesize that such groups will become a legitimate part of the overall mental and physical health-care scene, that they will grow and flourish, and that professionals will get involved with them without taking them over. I strongly urge helpers to stay in touch with developments in health care, in both the physical and social-emotional dimensions, and to learn about and get involved with the self-help movement. On the other hand, I do not encourage mindless referrals of your clients to any group whatsoever. As with self-help treatment books, it is a question of the right group for the right person. Riordan and Beggs (1987) lay down some commonsense criteria for helping clients find the group that makes sense for them. They also claim that not every client would profit from a self-help group and that for many clients the self-help group should be seen as an adjunct to rather than a replacement for personal counseling. This contention, of course, would be challenged by strict self-help group advocates.



## HELPERS AS AGENTS

Driscoll (1984, pp. 91–97) discusses the temptation of helpers to respond to the passivity of their clients with a kind of passivity of their own, a "Sorry, it's up to you" stance. This, he says, is a mistake.

> A client who refuses to accept responsibility thereby invites the therapist to take over. In remaining passive, the therapist foils the invitation, thus forcing the client to take some initiative or to endure the silence. A passive stance is therefore a means to avoid accepting the wrong sorts of responsibility. It is generally ineffective, however, as a long-run approach. Passivity by a therapist leaves the client feeling unsupported and thus further impairs the already fragile therapeutic alliance. Troubled clients, furthermore, are not merely unwilling but generally and in important ways unable to take appropriate responsibility. A passive countermove is therefore counterproductive, for neither therapist nor client generates solutions, and both are stranded together in a muddle of entangling inactivity. (p. 91)

In order to help others act, helpers must be agents and doers in the helping process, not mere listeners and responders. In my opinion, the best helpers are active in the helping sessions. They keep looking for ways to enter the worlds of their clients, to get them to become more active in the sessions, to get them to own more of it, to help them see the need for action—action in their heads and action outside their heads—in their everyday lives. And they do all this without violating the values outlined in Chapter 3. They don't push reluctant clients, thus turning reluctance into resistance, but neither do they sit around waiting for reluctant clients to act. They take seriously the collaborative nature of helping without taking over what the client should do.

I have suggested that the helping model itself can provide clients with a means of taking action. Before turning to the elaboration and illustration of each step of the model, we next focus on the basic communication skills helpers need to deliver the model in interactions with clients.