[The Power of Basics: Explore the Ingredients of Successful Helping](https://jigsaw.vitalsource.com/books/9780357191538/epub/OEBPS/9781305865716_toc.xhtml#toc-ch1)

LEARNING OBJECTIVES

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[Review the Roles of Both Formal and Informal Helpers **LO 1.1**](https://jigsaw.vitalsource.com/books/9780357191538/epub/OEBPS/9781305865716_toc.xhtml#toc-ch1-1)

Throughout history people the world over have held a deeply embedded conviction that, under the proper conditions, some of us are capable of helping others come to grips with problems in living. This conviction, of course, plays itself out differently in different cultures, but it is still a cross-cultural phenomenon. Today this conviction is often institutionalized in a variety of formal helping professions. In Western cultures, counselors, psychiatrists, psychologists, social workers, and ministers of religion among others are counted among those whose formal role is to help people manage the distressing problems of life.

A second set of professionals, although they are not helpers in the formal sense, also help people in times of crisis and distress. Included here are organizational consultants, dentists, doctors, lawyers, nurses, probation officers, teachers, managers, supervisors, police officers, and practitioners in other service industries. Although these people are specialists in their own professions, there is still some expectation that they will help those they serve manage, at least indirectly, a variety of problem situations. For instance, teachers teach English, history, and science to students who are growing physically, intellectually, socially, and emotionally and struggling with developmental tasks and crises. Teachers are, therefore, in a position to help their students, in direct and indirect ways, explore, understand, and deal with the problems of growing up. Managers and supervisors in work environments help workers cope with problems related to job performance, career development, interpersonal relationships in the workplace, and a variety of personal problems that affect their ability to do their jobs. This book is addressed directly to the first set of professionals and indirectly to the second.

To these professional helpers can be added any and all who try to help others come to grips with problems in living: relatives, friends, acquaintances, and even strangers (on buses and planes). This is informal helping. In fact, only a small fraction of the help provided on any given day comes from helping professionals. Informal helpers—bartenders and hairdressers are often mentioned—abound in the social settings of life. Friends help one another through troubled times. Parents need to manage their own marital problems while helping their children grow and develop. Indeed, most people grappling with problems in living seek help, if they seek it at all, from informal sources (Swindle, Heller, Pescosolido, & Kikuzawa, 2000). In the end, of course, all of us must learn how to help ourselves cope with the problems and crises of life. Sometimes we do this on our own, but at other times we seek help from mostly informal sources. This book is about the basic ingredients of successful helping. It is designed to assist you in becoming a better helper no matter which category you fall into.

Here is a broad definition of counseling agreed to by 29 major counseling organizations after years of debate: “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (see Kaplan, Tarvydas, & Gladding, 2014). It highlights three very important factors: the centrality of clients’ needs and wants; next the fact that clients themselves, empowered by the helping process, must act to achieve a better life; and finally that success is defined in terms of life-enhancing client outcomes—not just outcomes, but outcomes with impact.

[Appreciate the Power of Basics **LO 1.2**](https://jigsaw.vitalsource.com/books/9780357191538/epub/OEBPS/9781305865716_toc.xhtml#toc-ch1-2)

The basic working knowledge and skills that people need to engage in any human endeavor effectively are, of course, important. But because they are basic, they are often overlooked or taken for granted. For instance, the basic working knowledge and skills people need to live effective social lives—interpersonal communication and relationship-building skills—fall into this category. Many people think they have these basic skills when, in fact, they do not. In most societies these skills are not named or described in a direct way. Nor are they taught. People are expected to “know what these skills are” and “pick them up” along the way. Some people do; many do not. Many companies expect their employees to be “good communicators,” but they do not say what they mean by that term and often go on to hire people who are not good communicators, do little to help them develop these skills, and end up living with the consequences. Many see the basics as boring. In truth they are powerful.

I believe that The Skilled Helper has been successful over the years precisely because it focuses, not on the “latest thing” or on any particular model, method, or approach to counseling and therapy but on the basic working knowledge and skills that helpers need to do a competent job. The students who entered the graduate programs I have overseen quickly learned that they needed to show competence in the working knowledge and skills outlined and illustrated in this book if they wanted the degree. Occasionally this even meant begrudgingly retaking a course to acquire the skills and demonstrate competence. “I know I haven’t developed the skills, but I now know how important they are, so can’t I just move on?” one student pleaded.” “No” was the answer. Program directors owe it to the clients whom these students will ultimately serve to make sure that their helpers have competence in the basics. In my view even the helping professions too often overlook the power of the basics.

[Become Competent in the Key Ingredients of Successful Helping **LO 1.3**](https://jigsaw.vitalsource.com/books/9780357191538/epub/OEBPS/9781305865716_toc.xhtml#toc-ch1-3)

Let us call the basics in counseling and therapy “the key ingredients of successful helping.” This book is not just another model, approach, or school of helping (some say there are hundreds) nor is it an overview of the most common approaches to therapy (there are many books that review these). Rather it is a practical overview of the basic working knowledge and skills that any helper needs no matter which school or approach he or she chooses to use.

Many helpers and writers have used the term “**common factors**” to designate the essential ingredients of successful therapy. Why use the term “common factors”? To answer that question, consider the following situation. There are ten therapists. Each of these helpers espouses one of the following approaches to therapy: behavior therapy, rational-emotive-behavior therapy, narrative therapy, emotion-focused therapy, reality therapy, person-centered therapy, brief dynamic therapy, cognitive behavioral therapy, existential-humanistic therapy, and relational- cultural therapy. I have chosen these ten approaches because a book on each has been published recently by the American Psychological Association as part of an Introduction to Psychotherapy Series. Each of these ten therapists has ten clients. Each set of ten clients has similar problem situations with an analogous range of degrees of severity. That is, the ten groups are comparable. The common trait that these therapists share is that all ten are equally successful in that all hundred clients are successful in managing, within reason, the problem situations of their lives. All the therapeutic encounters lead to life-enhancing outcomes for the clients. If this is the case, then it cannot be said that the principal vehicle of success was the treatment approach because there were ten different approaches. So it makes sense to ask: What do these successful helpers have in common? What root factors (basics) make for their success? Their ability to use their preferred model or approach to serve the needs of their clients is one of the basics, but just one. What are the other factors? Over the past ten years, a great deal of research has been done to identify them (Duncan, 2014; Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011; Wampold, 2010a, 2010b). Later in this chapter we will consider the role of treatment models. While research shows that the specific treatment model contributes relatively little to success in therapy, this does not mean that it does not serve an important purpose.

Different researchers have come up with different “packages” of common factors. There is also a great deal of both agreement and disagreement as to which package is “right.” See the Special Section: Common Factors in *Psychotherapy* (December, 2014, 467–524) for a bewildering array of opinions (most claiming to be “evidence-based”). Laska, Gurman, and Wampold (pp. 467–481) courageously wrote the main article (pp. 467–481) and, at the end (519–524), tried to make sense of it all, taking their own shots at the “empirically supported treatment” movement. This is how psychology works. Perhaps to avoid some of the unending controversy that plagues the helping profession, I prefer the term “key ingredients of successful helping.” My list is more or less in agreement with what researchers have discovered and is based on over forty years of practice and the training of hundreds of helpers (“practice-based evidence”). Therefore not everyone would agree that the list outlined here is the “right” list, developed in the “right” order, and supported by the “right” evidence. There is no such list. What Hubble, Duncan, Miller, and Wampold (2010) say of the common factors is true of the set of ingredients outlined here. That is, they are “not invariant, proportionally fixed, or neatly additive. Far from it, they are interdependent, fluid, and dynamic” (p. 34). Moreover, each ingredient has, like many things in psychology, its associated uncertainties. And so while it is important to name, describe, and illustrate each ingredient, the ingredients themselves are interactive and dynamic in actual helping encounters. In practice they overlap. The purpose of this book is to bring them alive through descriptions, examples, and discussions.

In this chapter we list the common factors, or ingredients, that we see as essential for competent helping. We also set out the reasoning behind my inclusions and let you and the helping profession itself be our judge. Discord in the helping industry should not surprise us. The social sciences deal with human behavior, which is often messy, disordered, and difficult to predict. Human behavior has a type of probability different from the probability associated with the so-called “hard sciences—physics, chemistry, biology, and cosmology (the STEM grouping: science, technology, engineering, and mathematics). Engineering a rocket to send a technology package to land on a fast-moving comet is one thing. Helping an addict “engineer” his or her behavior is another. And so debate, sometimes acrimonious, about psychological realities is part and parcel of the helping professions. There will always be a degree of uncertainty about the findings of the social sciences. Here is a list stated in terms of things you have to do:

1.Focus Primarily on the Client and the Contextual Factors of the Client’s Life

2.Define Success in Terms of Outcomes with Life-Enhancing Impact for the Client

3.Describe What an Effective Therapist Looks Like

4.Develop a Working Alliance with the Client

5.Acquire and Use the Communication Skills at the Heart of the Therapeutic Dialogue

6.Integrate the Basic Principles Related to Cognition, Behavior, and Emotions

7.Use Feedback to Improve the Effectiveness of the Helping Sessions and Clients’ Change Efforts

8.Come to Grips with the Role That Beliefs, Values, Norms, and Moral Principles Play in the Helping Process

9.Help Clients Redo Poor Decisions and Make and Execute Life-Enhancing Decisions

10.Adopt a Treatment Model Aligned with the Universal Problem-Management Process

The pages of this book are filled with examples of life-enhancing client outcomes. So we turn our attention to the ingredients that both individually and collectively lead to or produce outcomes with impact. Each ingredient together with some of the uncertainties associated with it are described here and then explored and illustrated throughout the book.

**1. Focus primarily on the Client and the Contextual Factors of the Client’s Life**

Let us call the person seeking or needing help a client rather than patient to avoid, at least for the time, the dispute about the use of the medical model in helping (Wampold, 2001, 2010). The client in his or her search for life-enhancing outcomes is the first and most important “ingredient” in the therapeutic process (Bohart & Tallman, 2010). However, much of therapy research has focused on the model or method of treatment. What clients themselves bring to the party, however substantial, has been shortchanged. This is odd because research shows that clients together with what they bring to therapy are responsible for most of the success or failure in the helping endeavor (Dunkin, 2010; Orlinsky, Rønnestad, & Willutzki, 2004).

Let us become more concrete. We will use cases to help bring the concepts discussed in this book to life. Here is the case of Karl and his helper Laura.

Karl was a veteran of two wars. His first stint was in Iraq, his second in Afghanistan. His tour in Afghanistan ended abruptly after his squad was ambushed near the Pakistani border. Two of his best friends were killed. Karl escaped with relatively minor injuries. Minor physical injuries, that is. When he first returned to base he seemed to be alright but about a month later the dam broke. Not only did the full range of posttraumatic stress disorder (PTSD) symptoms flood through him off and on— nightmares, flashbacks, bouts of anxiety and depression, irritability, insomnia, social avoidance, trouble concentrating, feeling emotionally numb—but he also began ruminating and agonizing over his pre-military life, especially poor decisions he had made. For instance, after high school he decided to join the army instead of going to college. During his first year in the army he broke up with his girlfriend, believing that “the military and deeper relationships did not mix.” He let himself “drift away from God.” It is not that he led an immoral life, rather his “beliefs became twisted.” This caused feelings of guilt. Early on he was told that all of this was probably only temporary. But that was not the case. He had his “good days,” but various PTSD symptoms kept popping up “for no reason at all.” He returned to the United States. But on a sick-leave furlough in his hometown, he found relationships with family and friends “difficult.” Army doctors decided that he was not fit to continue to serve in the army. An honorable discharge was arranged. Many of Karl’s symptoms persisted. Some grew worse. For instance, he began thinking that he could have done something to prevent the deaths of his friends and this increased the burden of guilt. While he did not entertain suicidal thoughts, he did wonder about servicemen who had taken their own lives. How bad could things get? He knew that he could never take his own life, but he began to understand why some people do. What he saw ahead of him was a life of misery. He resisted all but intermittent help—“I’m no psycho”—and, reluctantly and intermittently, took some medication for both anxiety and depression. Finally, at the urging of a VA Medical Center physician, he agreed to seek more substantial psychological help—“I’ll try anything.” Well, almost anything. Karl did not want to get involved with a VA therapist because he wanted to distance himself from the military—“I want to leave all that behind.” He believed that working in a VA setting would, for him, be part of the problem rather than part of the solution. So Karl and Laura, who works in a mental health clinic associated with a Christian hospital near where Karl lives, become client and helper. Because the hospital is near an army camp, Laura has seen a number of soldiers, but none “just like” Karl.

What do clients like Karl bring to the helping encounter? They arrive with their version of humanity in all its simplicity and all its complexity. Here are some of the things clients bring with them, in no particular order:

* The problem situations, issues, concerns, in various degrees of severity, for which they are seeking help.
* Successful or failed attempts to manage problem situations and/or exploit unused opportunities.
* The past to the degree that it is affecting them positively or negatively in the present.
* Their general life expectations and aspirations, however realistic or distorted, and associated disappointments.
* Their skills, strengths, and resources.
* Their general emotional state.
* Their hopes, fears, and expectations regarding therapy.
* Their degree of openness to and readiness for change.
* Their willingness to work at change.
* Whatever reluctance or resistance they feel.
* Their ability to engage in a collaborative relationship.
* Their sense of right and wrong, their personal ethics, their approach to morality.
* Their cultural beliefs, values, and norms of behavior, especially particular version of their dominant culture and its impact on their behavior.
* The entire range of their relationships together with all the associated ups and downs, especially the relationships related to their current problem situations.
* Their level of interpersonal communication skills.
* Their blind spots.
* External factors that stand in the way of progress.
* External factors that support constructive change.

This is just a partial list, but all of them are relevant to Karl’s situation. Since people are complex, it is important for helpers to identify factors that are key for each client. Or even better, it is important for clients, often with the help of a therapist, to discover the key factors that have an impact on their problem situations. In the end the quality of the client’s participation in the therapeutic endeavor is the major determinant of outcome. So Karl needs a therapist who can help him give his best to the therapeutic process. Clients are or should be in the driver’s seat with respect to managing problem situations in everyday life. It is essential that therapists help them get into the driver’s seat and stay there throughout the helping process. Therefore, for the reasons outlined by Duncan and Sparks (2010), if there are any heroes (an over-used and misused word) in the therapeutic endeavor, they are the clients themselves rather than the therapists. Karl is responsible for lifeenhancing change. His helper is a catalyst for that change.

There are client-associated uncertainties. Consider Karl. He, like the rest of us, is a complex human being and complexity breeds uncertainty. There are many issues that he could explore. Which factors from his past are having a negative impact in the present? Does he need to confront his problems head on or is it better to find ways to transcend them? What outcomes does he want beyond relief from both depressive moods and anxiety? To what degree are PTSD symptoms just that, symptoms, with other underlying issues as the main concern? But neither Karl nor Laura can afford to be overwhelmed by the natural complexity of human beings. With Laura’s help Karl must determine what the key issues are and what he is going to do about them.

***Determine why clients seek help*** To determine what helping is about, it is useful to consider (1) why people seek—or are sent to get—help in the first place and (2) what the principal goals of the helping process are. Many people become clients because, either in their own eyes or in the eyes of others, they are involved in problem situations that they are not handling well. Others seek help because they feel they are not living as fully as they might. Many come because of a mixture of both. Therefore clients with problem situations and unused opportunities constitute the starting point and the primary focus of the helping process.

*Problem Situations*. Clients come for help because they have crises, troubles, doubts, difficulties, frustrations, or concerns. Although the generic term “problems” is often used, these are not problems in a mathematical sense because they usually cause emotional turmoil and often have no clear-cut solutions. It is probably better to say that clients come not with problems but with problem situations—that is, with complex and messy problems in living that they are not handling well. These problem situations are often poorly defined. Or, if they are well defined, clients still do not know how to handle them. Or clients feel that they do not have the resources needed to cope with them adequately. If they have tried solutions, they have not worked.

All of us face problems in living. Problem situations arise as we interact with ourselves, with others, and with the social settings, organizations, and institutions of life. Clients—whether they are hounded by self-doubt; tortured by unreasonable fears; grappling with the stress that accompanies serious illness; addicted to alcohol or drugs; involved in failing marriages; fired from jobs because of personal behavior, office politics, or disruptions in the economy; confused or abused in their efforts to adapt to a new culture; returning from some battlefield with the psychological ravages associated with war; suffering from a catastrophic loss; jailed because of child abuse; struggling with a midlife crisis; lonely and out of community with no family or friends; battered by their spouses; or victimized by racism—all face problem situations that move them to seek help. In some cases, these problem situations move others—such as teachers, supervisors, and the courts—to refer people who are not managing their problems very well to helpers or even mandate that they seek help.

Even people with devastating problem situations can, with help, handle these situations more effectively. Consider the following example.

Martha S., age 58, suffered three devastating losses within six months. One of her four sons, who lived in a different city, died suddenly of a stroke. He was only 32-years-old. Shortly after his death, she lost her job in a downsizing move stemming from the merger of her employer with another company. Then, her husband, who had been ill for about two years, died of cancer. Though she was not destitute, her financial condition could not be called comfortable, at least not by middle class North American standards. Two of her surviving three sons were married with families of their own. One son lived in a distant suburb. The other son lived in a different city. The unmarried son was a sales representative for an international company who traveled abroad extensively.

After her husband’s death, she became agitated, confused, angry, and depressed. She also felt guilty. First, because she believed that she should have done “more” for her husband. Second, because she also felt strangely responsible for her son’s early death. Finally, she was deathly afraid of becoming a burden to her children. At first, retreating into herself, she refused help from anyone. But eventually she responded to the gentle persistence of her church minister. She began attending a support group at the church. A psychologist who worked at a local university provided some direction for the group. Helped by her interactions within the group, she slowly began to accept help from her sons. She began to realize that she was not the only one who was experiencing a sense of loss. Rather she was part of a “grieving family,” the members of which needed to help one another cope with the turmoil they were experiencing. She began relating with some of the members of the group outside the group sessions. This helped fill the social void she experienced when her company laid her off. She had an occasional informal chat with the psychologist who provided services for the group. Eventually, through contacts within the group she got another job. Gradually her depression eased and, despite some persistent anxieties, she found a sense of peace.

Note that help came from many quarters. Her newfound solidarity with her family, the church support group, the active concern of the minister, the informal chats with the psychologist, and upbeat interactions with her new friends helped Martha enormously. Furthermore, because she had always been a resourceful person, the help she received enabled her to tap into her own unused strengths.

It is important to note that none of this “solved” the losses she had experienced. Indeed, the goal of helping is not to “solve” problems but to help the troubled person manage them more effectively or even to transcend them by taking advantage of new possibilities in life. Problems have an upside. They are opportunities for learning.

*Missed Opportunities and Unused Potential*. Some clients come for help not because they are dogged by problems like those listed above but because they are not as effective as they would like to be. Therefore clients’ missed opportunities and unused potential constitute a second starting point for helping. Most clients, like the rest of us, have resources they are not using or opportunities they are not developing. People who feel locked in dead-end jobs or bland marriages, who are frustrated because they lack challenging life goals, who feel guilty because they are failing to live up to their own values and ideals, who want to do something more constructive with their lives, or who are disappointed with their uneventful interpersonal lives—such clients come to helpers not to manage their problems better but to live more fully.

It is not a question of what is going wrong but of what could be better. It has often been suggested that most of us use only a small fraction of our potential. Most of us are capable of dealing much more creatively with ourselves, with our relationships with others, with our work life, and, generally, with the ways in which we involve ourselves with the social settings of our lives. Consider the following case.

After 10 years as a helper in several mental health centers, Carol was experiencing burnout. In the opening interview with a counselor, she berated herself for not being dedicated enough. Asked when she felt best about herself, she said that it was on those relatively infrequent occasions when she was asked to help provide help for other mental health centers that were experiencing problems, having growing pains, or reorganizing. The counselor helped her explore her potential as a consultant to human-service organizations and make a career adjustment. She enrolled in an organization development program at a local university. In this program she learned not only a great deal about how organizations work (or fail to work) but also how to adapt her skills to organizational settings. Carol stayed in the helping field, but with a new focus and a new set of skills.

In this case, the counselor helped the client manage her problems (burnout, guilt) by helping her identify, explore, and develop an opportunity (a new career). The helper was a catalyst; Carol took the lead.

***Use positive psychology wisely to focus on unused opportunities*** Helping clients identify and develop unused potential and opportunities can be called a “**positive psychology**” goal. Seligman and Csikszentmihalyi (2000) called for a better balance of perspectives in the helping professions. In their minds, too much attention is focused on pathology and too little on what they call “positive psychology.” They propose, “Our message is to remind our field that psychology is not just the study of pathology, weakness, and damage; it is also the study of strength and virtue. Treatment is not just fixing what is broken; it is nurturing what is best” (p. 7). They and their fellow authors discuss such upbeat topics as: subjective well-being, happiness, hope, optimism, the capacity for love, forgiveness, civility, nurturance, altruism, an appreciation of beauty and art, responsibility, self-determination, courage, perseverance, moderation, future mindedness, originality, creativity, talent, a civic sense, spirituality, and wisdom. Traditionally, this has not been the ordinary language of the helping professions.

Seligman and Csikszentmihalyi’s challenge has stimulated a great deal of theory, research, debate, and practical programs for helping clients to identify and tap into unused resources and opportunities (Biswas-Diener & Dean, 2007; Carr, 2004; Diener & Biswas-Diener, 2008; Dykens, 2006; Ince, 2009; Peterson, 2006; Seligman, 2004; Seligman, Steen, Park, & Peterson, 2005; Siegel & Allison, 2009; Simonton & Baumeister, 2005; Snyder & Lopez, 2005, 2006). Helping is not just about “fixing,” but about enabling clients to design and redesign their lives. Ince (2009) in a Harvard Medical School Special Health Report refers to positive psychology as “the science of satisfaction” (p. 2). Obviously both fixing and redesigning have a place in helping and one often melds into the other. Effective counselors help clients choose the mix that is best for them. The “materials” of designing/redesigning are the often-overlooked resources within the client— strengths, values, beliefs, and pools of resilience that currently lie unnoticed. Sometimes it is better to help clients transcend problems than to work through them. Positive psychology suggests ways of doing just that. For instance, Olivia put a great deal of effort into developing a full life outside her workplace. She cultivated friendships, tutored disadvantaged kids in math, engaged in a reasonable but rigorous exercise regimen, and read extensively about current events in order to continuously enlarge what she calls her “sense of the world.” All of this made it much easier for her to put up with the petty politics that permeated her workplace. She would have put more energy into finding a better job, but the job market was very tight. When asked about life, she would say, “Life is good. I do what I can to make it that way.” Her positive-psychology approach helped her transcend the problems of her workplace.

You will find the positive psychology research and literature useful in striking a balance with your clients. But, because there is a human tendency to turn what is useful into a fad, a note of caution is appropriate. Positive psychology is not an “everything’s going to be all right” approach to life. Richard Lazarus (2000) put it well:

[It] might be worthwhile to note that the danger posed by accentuating the positive is that if a conditional and properly nuanced position is not adopted, positive psychology could remain at a Pollyanna level. Positive psychology could come to be characterized by simplistic, inspirational, and quasi-religious thinking and the message reduced to “positive affect is good and negative affect is bad.” I hope that this ambitious and tantalizing effort truly advances what is known about human adaptation, as it should, and that it will not be just another fad that quickly comes and goes. (p. 670)

Ongoing research (McNulty & Fincham, 2012) challenges the often-inflated claims made in the name of positive psychology. And this is only right. However, at its best, helping by whatever name (counseling, therapy, psychotherapy) engenders clients’ hope for a better life. Clients with hope are more likely to achieve lifeenhancing goals. We will discuss hope in more detail in Part III. Although this is not a book about positive psychology, the spirit of positive psychology permeates the approach to helping outlined and illustrated here.

**2. Define Success in Terms of Outcomes with Life-Enhancing Impact for the Client**

Success in helping consists of life-enhancing outcomes for clients (Goldberg, et al., 2016). A great deal of the helping literature focuses on the models, methods, and skills of helping. Less of this literature focuses on outcomes. This is a pity. Duncan, Miller, and their associates (2010), and a growing number of researchers and practitioners are working to introduce a better balance in the helping professions. They talk about “client-directed and outcome-informed” (CDOI) helping. As indicated above, the primary focus of helping is the client with unmanaged problem situations and/or unused resources, strengths, and opportunities. But because helpers do not solve or manage clients’ problems, it is essential to help clients become agents of change in their own lives. And change means life-enhancing outcomes in terms of problems managed and opportunities identified and developed.

Chad felt devastated. While he was taking a shower, his friend Gus, who was waiting for him to go to a meeting, tapped into Chad’s computer. The screen came to life with a full-color pornographic scene. When Chad finished his shower, Gus began kidding him about what he had found. “Gee, she doesn’t look like Erin” (Chad’s wife). Chad kept his cool and dismissed Gus’s remarks. But inside he was not cool at all. He and Erin had been married for about five years. They wanted kids, but “not now.” The initial ardor of their marriage had cooled, but neither had done much to deepen their relationship. They both worked and career demands always took precedence. Chad felt deeply ashamed, not because of Gus, but because he had been revealed to himself. He felt cheap. He had let pornography “supplement” and even take the place of a deeper social and sexual relationship with Erin. In fact, he was addicted.

The incident with Gus shocked Chad into taking a down-to-earth look at his relationship with himself and with his wife—in itself a positive outcome. Moreover, he hated the idea of being an addict—to anything. In a couple of sessions with a counselor, he realized more fully how he had been taking his marriage for granted and came to the conclusion that both he and Erin needed to be in “this counseling thing” together. They both quickly realized that they had to stop drifting. They found ways of “reinventing” their marriage in all its dimensions, including its sexual dimensions. Chad, despite a lapse or two, stopped substituting pornography for the “real thing.” Erin began to think of how she would eventually have to balance career and motherhood. But a “better marriage” was key to this balancing act. They began doing more things together and liked it.

Walters and Spengler (2016) review helper discomfort with certain topics, especially pornography, and discuss possible errors helpers may make because of this discomfort. In the above case, Chad’s counselor had a very negative view of pornography, but he kept his views to himself and helped Chad discover what he thought was best for himself.

As we have seen, clients come to helpers primarily because they want or need to manage specific problems situations more effectively and/or develop unused opportunities in order to live life more fully. This is the first goal of helping. But counseling, done right, can help them achieve two other goals. Let us take a brief look at all three. Read what follows and then return to Chad and Erin’s case and see if you can find elements of all three goals.

**Goal One: Life-Enhancing Outcomes.** Help clients manage their problems in living more effectively and develop unused or underused resources and opportunities more fully at the service of life-enhancing outcomes.

Helpers are successful to the degree to which their clients—through client–helper interactions—see the need to manage specific problem situations and develop specific unused resources and opportunities more effectively. Notice that I stop short of saying that clients actually end up managing problems and developing opportunities better. Although counselors help clients achieve valued outcomes, they do not control those outcomes directly. In the end, clients can choose to live more effectively or not.

Helping is an “-ing” word: It includes a series of activities in which helpers and clients engage. These activities, however, have value only to the degree that they lead to valued outcomes in clients’ lives. Ultimately, statements such as “We had a good session,” whether spoken by the helper or by the client, must translate into more effective living on the part of the client. If a helper and a client engage in a series of counseling sessions productively, something of value will emerge that makes the sessions worthwhile. Unreasonable fears will disappear or diminish to manageable levels, self-confidence will replace self-doubt, addictions will be conquered, an operation will be faced with a degree of equanimity, a better job will be found, a woman and a man will breathe new life into their marriage, a battered wife will find the courage to leave her husband, a man embittered by institutional racism will regain his self-respect and take his rightful place in the community.

Clients and people who interact with clients such as family, friends, peers, and co-workers can perceive the kind of results discussed in this book. Kazdin (2006), who works with families and children, emphasizes the importance of moving beyond change based on statistical significance and even clinically significant change-to-change that has palpable impact on clients’ daily lives. Kazdin, in an article on the importance of the behavioral indications of positive change in clients’ lives, cites an example of outcomes that make a difference in the everyday life of a child with “conduct disorder” and the lives of those who interact with him.

For example, one can see that the child no longer beats up a parent, teacher, or siblings; has stopped running away from home; does homework for the first time; no longer steals from neighbors; no longer brandishes a knife with younger siblings or peers; interacts appropriately with an infant sibling (e.g., talk, gentle play) rather than physically abusing him or her; and becomes only mildly upset during a tantrum at home without any of the usual property destruction. (p. 47)

The need for “palpable” results is not new. Effective helpers have realized this throughout the history of helping. Over thirty years ago Driscoll (1984) saw this clearly in his work with Andrea N., a battered woman.

The mistreatment had caused her to feel that she was worthless even as she developed a secret superiority to those who mistreated her. These attitudes contributed, in turn, to her continuing passivity and had to be challenged if she was to become assertive about her own rights. Through the helping interactions, she developed a sense of worth and self-confidence. This was the first outcome of the helping process. As she gained confidence, she became more assertive; she realized that she had the right to take stands, and she chose to challenge those who took advantage of her. She stopped merely resenting them and did something about it. The second outcome was a pattern of assertiveness, however tentative in the beginning that took the place of a pattern of passivity. When her assertive stands were successful, her rights became established, her social relationships improved, and her confidence in herself increased, thus further altering the original self-defeating pattern. This was a third set of outcomes. As she saw herself becoming more and more an “agent” rather than a “patient” in her everyday life, she found it easier to put aside her resentment and the self-limiting satisfactions of the passive-victim role and to continue asserting herself. This constituted a fourth set of outcomes. The activities in which she engaged, either within the helping sessions or in her day-to-day life, were valuable because they led to these valued outcomes. (1984, p. 64)

Andrea needed much more than “good sessions” with a helper. She needed to focus on and work toward outcomes that made a difference in her life.

**Goal Two: Learning How to Help Oneself.** Help clients become better at helping themselves in their everyday lives.

Clients often are poor problem solvers. Or whatever problem-solving ability they have tends to disappear in times of crisis or personal challenge. What G. A. Miller, Galanter, and Pribram (1960) said many years ago is, unfortunately, probably just as true today.

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 too many other things still to do. Then circumstances conspire against us and we find ourselves 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 or she has been specifically educated to do so. (pp. 171, 174).

Many people in our society are still not “educated to do so.” And if many clients are poor at managing problems in living, they are equally poor in identifying and developing opportunities and unused resources. We have yet to find ways of making sure our children develop what most consider to be essential “life skills” such as problem management, opportunity identification and development, sensible decision-making, and the skills of interpersonal relating.

It is no wonder, then, that clients—often poor problem solvers to begin with—often struggle when crises arise. If the second goal of the helping process is to be achieved—that is, if clients are to go away better able to manage their problems in living more effectively and develop opportunities on their own— then helpers need to impart the working knowledge and skills clients need to move forward. As Nelson-Jones (2005) puts it, “In the final analysis the purpose of using counseling skills is to enable clients to become more skilled in their own right…. Counselors are only skilled to the extent that they can be successful in skilling clients” (p. 14). That is, helping at its best provides clients with tools to become more effective self-helpers. Therefore, although this book is about a process that helpers can use to help clients, more fundamentally it is about a problem-management and opportunity-development process that clients can use to help themselves. This process can help clients become more effective problem situation managers and opportunity developers, better decision makers, and more responsible “agents of change” in their own lives.

**Goal Three: A Prevention Mentality.** Help clients develop an action-oriented prevention mentality in their lives.

Just as doctors want their patients to learn how to prevent illness through good nutrition and healthy activities, just as dentists want their patients to engage in effective prevention activities, so skilled helpers want to see their clients anticipate problem situations rather than merely manage them, however successfully, once they have arisen. In marriage and other relationships the economics of prevention are extraordinary. In health care every dollar spent in prevention saves, by some estimates, ten in cure. People who develop good nutrition and exercise habits not only avoid a host of physical complaints but also enjoy energy levels that can be poured into other life-enhancing activities. But prevention is fundamentally problematic. If we are good at it, bad things do not happen. If we get sick, we can see, touch, and sometimes literally taste, the cure. But the benefits of prevention are often invisible. The very materiality of cure makes it more attractive, or at least more noticeable, than prevention. While it is true that some people thoroughly enjoy a good workout and glory in making the USDA MyPlate guidelines to nutrition a centerpiece of their eating lives, many others do not. Prevention is invaluable, but we must help clients work at making it attractive for themselves.

Counseling at its best provides an opportunity for helping clients embark on the prevention path. Take the case of Ingrid and Carlos:

Four years into their marriage they found themselves sitting unhappily with a marriage counselor, pointing fingers at each other. With the help of the counselor they began, painfully, to come to grips with problems dealing with financial decisions, sexual relations, and child rearing (two children). The counselor pointed how, over the years, they both had experienced “pinches”—small annoyances—in their interactions. For instance, Ingrid noticed that Carlos was rather generous in buying small things for himself, but expressed mild resentment when she did the same. But she said nothing. On the other hand, Carlos thought that Ingrid at times was less spontaneous, less “into it,” in their sexual relations, but still resented it whenever she thought he was giving another woman a second glance. But he said nothing. The problem was that both of them “saved up” the pinches until they erupted, or even exploded, into “crunches”—major blowups in their relationship. And the number of crunches had begun to grow (the original pinch-crunch model is from Sherwood and Glidewell, 1973, but an Internet search will reveal a number of variations of this very useful prevention-focused conflict-management model).

The counselor helped Ingrid and Carlos do three things. First, he helped them diffuse and manage their most acute problem situation, which dealt with childcare. Second, he not only taught them the rudiments of the problem-management and opportunity-development approach to counseling he was using (the one that is described and illustrated in this book), but helped them use this process to manage some of the financial problems they faced. He pragmatically “walked them through” the model as a way of providing them with a set of skills they could use on their own in the future. They used the model to deal with financial problems. Third, from a prevention point of view, he helped them see that ignoring or “saving up” pinches almost inevitably led to crunches. In talking with them separately, he discovered that they both had a reasonably solid set of communication skills. But, strangely enough, they did not use these skills when talking with each other. He showed them how they could use their communication skills to defuse the pinches that creep into relationships. He made them aware that negotiating is not restricted to country-to-country relationships or to what Democrats and Republicans do as a last resort, if ever. Rather fair-minded negotiation is part of everyday communal living. The counselor introduced the clients to resources, which they then used.

**3. Describe What an Effective Helper Looks Like**

A great deal of research focuses on different kinds of client problems and different kinds of treatment for these problems. It is the stuff of abnormal psychology. But, strange to say, over the years relatively little research has been done on the key capabilities and characteristics of the therapist (Beutler et al., 2004). But we do know some key things. We know that the person of the therapist is more important than the method of treatment (Crits-Christoph et al., 1991; Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001; Wampold & Brown, 2005). We also know that some therapists are better than others (Castonguay & Hill, 2017; Okiishi, Lambert, Nielsen, & Ogles, 2003). But what makes some better than others? Wampold (2011), in a review of what research does say about therapists, comes up with a list of characteristics, which I have adapted. An effective therapist:

* Has a solid set of interpersonal skills and through them expresses acceptance, warmth, and empathy. These are discussed and illustrated in Part II.
* Acts in such a way as to build trust with clients. “This person understands me. I believe this person can help me.”
* Does his or her part to develop a collaborative working alliance with clients and come to an agreement with them on the goals of helping.
* Understands the client’s condition and can provide a plausible explanation for the source of the client’s distress.
* Understands both the client and the client’s problem situation in every relevant context—cultural, social, economic, political, and so forth.
* Has a flexible helping approach or treatment plan and communicates this approach clearly to the client.
* Is believable, persuasive, and convincing without robbing the client of his or her autonomy or dignity.
* Collaborates with clients in monitoring their progress and their views of the helping process.
* Establishes a formal or informal feedback system.
* Makes adjustments to the therapeutic process based on an evolving understanding of the client’s problem situation, formal or informal feedback, and signs of client reluctance or resistance.
* Helps clients, despite their difficulties, to develop a realistic sense of possibility, hope, and optimism.
* Does not avoid difficult issues related to the client’s problems or to the client-helper relationship, but handles them tactfully.
* Understands self, and injects self into the therapeutic dialogue only to the degree that this helps and does not distract the client.
* Knows the best research related to the client: the client’s personality, the client’s problems, the social context, and possible treatments for the client.
* Is committed to professional self-improvement. Understands the best the helping industry has to offer and makes it available to the client.
* Has a solid grasp of the key ingredients of successful therapy and, through collaboration with the client, knows how to tailor and orchestrate them at the service of client outcomes.

There are a lot of items on this list and there is no one right way of mixing and matching them to the client’s needs. A Special Section of seven highly academic articles on the assessment of helper competence fills most of the pages of an issue of *Professional Psychology: Research and Practice* (2007, 38, 441–537). In these articles the enormous ambition of setting up a professional “cradle to grave” assessment system covering all helping-related competencies, including “knowledge, skills, dispositions, self-perceptions, motives, and beliefs-attitudes” (Kaslow and associates, 2007, p. 443) is outlined. At times they present helping almost as an adjunct to the medical profession. But assessing the competence of a gall bladder surgeon is one thing; assessing the competence of a marriage counselor is quite a different thing. The 15 guiding principles for the assessment of competence are brutally thorough and highly academic. Lichtenberg and his associates (2007) outline some of the challenges to creating a picture of the competent helper and conclude that “achieving consensus within the [helping] profession and across its diversity of specialties, orientations, and models on the necessary competencies for professional practice is a critical first step” (p. 478). Professionally, it seems that we are still at the starting gate. Although there is some kind of broad consensus that helping in the main helps and that there is a set of “common factors” that contributes to successful helping, practitioners are divided as to just what competence is in helping relationships.

Because there is no “right” or “perfect” set of characteristics, let me take the role of client and answer that question for myself, that is, let me personalize the list. What kind of therapist would I want? For this exercise I have chosen Laura, a counselor I know. You ask “Why Laura?” Here is my response.

I have chosen Laura because she understands and can deal competently with all the factors being outlined and illustrated here as key ingredients in successful helping. However, she works with me in adapting these ingredients to my needs rather than to her theories. She has no preset formula. She is smart and she is competent, but she shoves neither her intelligence nor her competence down my throat. She is a pro but wears her professionalism lightly. Her professional skills are there to serve me. For her, helping is not just a job. I do not know whether she sees it as a vocation, but I do know that she is totally there all the time. She respects me and is street smart. I feel secure with her; I’m in good hands. She has excellent communication skills, including the ability to help me communicate when my own communication skills fail me. The values that drive her behavior emerge in the way she conducts herself, but she takes pains to understand my values and to help me see how they drive my behavior. She neither cudgels nor coddles me. But she does invite me to explore the unintended consequences of both my past decisions and the ones I am about to make. I like her invitational stance, knowing that I want a catalyst, not an advice-giver. The problem-management framework outlined in this book floats seamlessly in the background. It’s the geography of helping. We collaborate. We are a team, a unit. She is not afraid of work and assumes that I am willing to work at managing my problems. She is not a heroic figure. Sometimes she makes mistakes, but she readily admits them and works with me in reversing them. Right from the beginning she points out how important it is to establish a good working relationship. She explains the value of feedback. At the end of each session we evaluate what we have accomplished. What went right? What went wrong? How can we do better? At the beginning of each session we review what kind of progress I have made in managing my problem situation or some aspect of it. For us, feedback is a two-way street. The work we are engaged in is about life-enhancing outcomes. If I seem lax, she invites me to review my commitment. This is not her demand but rather my need. We explore the incentives I have for creating a better life for myself. We talk about obstacles that stand in the way of a better life or obstacles that I put in the way. We are honest with each other.

This is the kind of therapist I would like. Others would rather have a different mix of ingredients. For instance, in one study (Murphy, Cramer, & Lillie, 1984), clients who were mainly from the lower socioeconomic class wanted advice, signs of real interest in their problems, encouragement and reassurance, understanding, and the instillation of hope from their helpers. But the principle remains: within reason, work with the client to tailor the ingredients of therapy to his or her needs and preferences. As we shall see throughout this book, this does not mean indulging the client.

If you are interested in becoming a therapist, you may want to read Barry Duncan’s article (2011) entitled “What do therapists want?” He first answers this question by saying, “It’s certainly not money or fame!” That is interesting in a society whose media screams at us everyday that life is about money and fame. He cites a study (Orlinsky & Rønnestad, 2005) that provides some answers that are both sobering and uplifting: “Therapists stay in the profession, not because of material rewards or the prospect of professional advancement, but because— above all—they value connecting deeply with clients and helping them improve. On top of that the clinicians interviewed consistently reported a strong desire to continue learning about their profession …” (p. 40). They found satisfaction in deepening their sense of themselves, their clients, the profession, and the world. Therapists-to-be have much to mull over as they choose the helping professions.

Laura brings her own culture, personality, and approach to the helping process. She uses the cognitive-behavioral-social-emotional problem-management approach (outlined in this chapter and described in detail in Chapter 2) to organize her thinking about therapy and her interactions with her clients. She also uses this problem-management process as a kind of “browser” to explore other approaches and extract methods and skills that are useful for clients. She organizes them within the problem-management framework. So, like many therapists, she is eclectic in her approach but with an eclecticism that is organized, clientcentered, and outcome-oriented. The richness of her understanding of the helping process is a positive factor. But this richness involves complexity and therefore uncertainty. The uncertainty comes from the fact that methods and skills must be adapted to the needs of each client. She needs to understand Karl before enlisting his help to adapt any particular PTSD treatment program to his needs. PTSD is not a disease but a package of interrelated dysfunctional elements or symptoms. Karl is Karl, not his symptoms. She is competent, but her competence is not related to some kind of professional ideology. Rather it is related to meeting the needs of clients. She also knows that competence is a moving target. She has to keep at it throughout her career (Chow, Miller, Seidel, Kane, & Thornton, 2015). All in all, if you become competent in the basics outlined in this book, you will be well on your way of becoming one of the “better” therapists described and discussed in the helping literature. But remember, there is no one right way.

**4. Develop a Working Alliance with the Client**

According to the research, the second most important ingredient in helping (after client factors) is the quality of the relationship between client and helper (Muran & Barber, 2010; Norcross, 2011). Generally speaking, if client and helper are a collaborative team, the three goals or outcomes listed earlier in this chapter are more likely to be achieved. The therapist’s intelligence and competencies come alive and produce results only to the degree that they are channeled into the establishment and development of a collaborative client-helper relationship. Furthermore, while the therapist can do a great deal to see that this happens, it will not happen unless clients do their part. So it is up to the therapist and the client in their dialogue to orchestrate the mix of ingredients that best leads to targeted life-enhancing outcomes.

The American Psychological Association Interdivisional Task Force on Evidence- Based Therapy Relationships chaired by John C. Norcross (Norcross, 2010, 2011a, 2011b; Norcross & Wampold, 2011) came up with a range of conceptual conclusions regarding the client-helper relationship. Instead of a list of findings, here is how these findings might influence Laura directly and Karl indirectly. Laura says to herself:

Karl and I should make building and focusing our relationship a top priority. Focus means making sure that our emerging relationship is contributing to the main work at hand, namely Karl’s dealing with the problematic issues of his life. Our relationship will contribute more to Karl’s search for life-enhancing outcomes than any helping approach I take. I have to make sure that Karl understands the problemmanagement approach I will be taking. I have to do my best in helping him see its value and buy into it. I have to be open to adapting my approach to his needs and do so without compromising my professional standards. I don’t own the approach. Karl and I own it together. I have to make sure that Karl, if he so chooses, has a say in everything. Any therapeutic approach or program will lose its power if the relationship is poor. I will suggest programs or parts of programs that have been demonstrated to work with clients to, say, alleviate anxiety and/or depression, but Karl and I must be co-owners and collaborative implementers of these programs. We both need to understand, at some level of consciousness, that the relationship pervades every aspect of the treatment. My skills come to life only through the relationship. Karl is not an anaesthetized patient undergoing an appendectomy where skills and techniques are of paramount importance. I deliver my skills and techniques through the relationship. So I cannot take even a PTSD treatment program that has been demonstrated to be effective and apply it like a technician, even a skilled technician. So there are many things I need to do to make this relationship work, especially understanding Karl from his point of view, even when I think that he might profit from challenging his point of view. And there are things I must avoid such as hostile interchanges, critical comments, rejection, and blame. I must continually remind myself that no one formula fits every client. I have had some clients who felt short-changed when I failed to challenge them. Other clients have resented even tactful invitations on my part to self-challenge. Everything I do must help Karl become a partner.

The members of the Task Force also issued a caution. Given the complexity of and the moving parts in the helping process, their findings should be taken with a grain of salt: “Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the Task Force’s work.” Cautions like that could be issued for all the findings of the social sciences. So Laura needs to remain flexible and take her cues from Karl. Given its importance, the helping relationship is addressed in greater detail in Chapter 3.

All relationships have the potential for complexity and uncertainty. The helping relationship is a particular kind of relationship. It has to be established relatively quickly and must, from the beginning, be focused on client-enhancing outcomes. That said, it is always a work in progress. Collaboration is a two-way street. Karl and Laura keep adjusting to each other. Laura has entered into any number of these relationships, while, in a sense, everything is new to Karl. This makes things somewhat uncertain. Adding to the uncertainty is the fact that right now he is a person who is “out of community.” To what degree is he capable of establishing the kind of collaborative relationship needed in therapy? Therefore helping Karl get into the driver’s seat and helping him stay there could possibly breed more uncertainty.

**5. Acquire the Communication Skills Needed to Engage in the Therapeutic Dialogue**

Helping has been called a “talking cure.” Indeed, communication is at the heart of any relationship. Poor communication, however described, is often the bane of relationships. So helpers need a range of communication skills to become effective collaborators with their clients. In training helpers, I emphasize professional competence in basic communication skills. Not all training programs do. These skills are so important that Part II of this book is devoted to them. In Part II we outline and illustrate such skills as attending (professional presence), unbiased listening, working at understanding what clients are saying about themselves, responding to clients with understanding, helping clients explore their concerns more fully, helping them stay focused, and helping them develop new perspectives on their problem situations and unused opportunities. Conversations between helpers and their clients are or should be therapeutic or helping dialogues (Knapp, 2007; Paré & Lysack, 2004; Seikkula & Trimble, 2005). Interpersonal communication competence means not only being good at the individual communication skills but also marshaling them at the service of dialogue. Communication skills and elements of dialogue are addressed at length in Part II of this book.

It would be helpful if clients had the communication skills outlined in Part II and the ability to weave them into constructive dialogues with their helpers. This is often not the case. In fact, many clients get into trouble precisely because they do not know how to establish and maintain healthy interpersonal relationships, which are nourished by effective communication. We live in a society that does not take these skills seriously enough to incorporate them into its formal and informal curriculum. Research also shows that many, if not most people, believe that they are better at interpersonal communication than they really are. Becoming competent in dialogue is a life-long task.

What can helpers do when their clients are poor communicators? They use their own communication skills to help clients engage in dialogue. And they do this without becoming condescending. If Karl does not have all these skills, then Laura can use her skills to help him engage in a dialogue. Furthermore, uncertainty is part of the nature of dialogue. If either party knows the outcome of the conversation before the conversation starts, they may well have a conversation but it will not be a dialogue. Dialogue means that the parties involved “co-create” the outcomes. Laura is not treating Karl’s PTSD. The two of them are collaborating in an endeavor to make his life more livable.

**6. Integrate the Basic Principles Related to Cognition, Behavior, and Emotions into the Helping Process**

When clients talk, what do they talk about? They talk about their problem situations and their unused opportunities in terms of what they think, what they do, and how they feel all jumbled together. Some approaches to therapy emphasize cognition or what goes on in clients’ minds (Dobson, 2011; Galotti, 2013), others highlight human behavior (Antony & Roemer, 2011; Spiegler & Guevremont, 2015), and still others focus on emotion (Burns, 2012; Greenberg, 2015). In the end, however, every form of therapy deals with the interplay among what goes on in clients’ minds, their behavior, and their emotions (actions, thoughts, and feelings), especially in the social settings of life. In that sense every form of therapy is a cognitive-behavioral-social-emotional endeavor.

When it comes to these three dimensions of human life—the working of the human mind (cognition), what clients do or fail to do both within themselves and in their daily lives (behavior), and the feelings that drive, accompany, or result from thinking and doing (emotion)—psychological research has come to recognize patterns which have been codified into principles (sometimes called “laws” as in “the laws of human behavior”). Professional helpers use these basic principles to understand clients, help clients understand themselves, and collaborate with them in finding ways to manage problem situations and develop unused opportunities. Competence in these principles is essential (Ellis & Ellis, 2011; Watson & Tharp, 2013).

This book does not define and explore these principles, but training in them should be part of the curriculum of any helper preparation program. If your training program does not offer instruction in these key ingredients, then it is up to you to get it. For instance, Watson and Tharp’s book reviews these principles and their interplay and helps students apply them to their own lives. Charles Duhigg (2014) has written a very useful book on the power of habits, both good and bad. Habits play an important role in everyday behavior and are, therefore, the stuff of therapy. Habits and addictions are often closely related (Lewis, 2016). There are many different forms of addiction besides drug abuse that permeate our lives—for instance, digital (Kaminska, 2017; Lustig, 2017), pornography (Walters & Spengler, 2016), food (Lustig, 2014), falling in love, attachment to sports teams, sex, music we cannot live without, gambling, exercise regimens, work, preferred forms of daydreaming, TV programs, to name a few. Just as the sexual instinct can fasten on to almost anything, we can become addicted to almost anything. Given the many forms of addiction, it is understandable that failure to diagnose and treat addictions is a common helper problem (Liese & Reis, 2016). Some addictions such as exercise regimens enrich our lives, but even these can be pushed too far.

Even though medical treatments can help with some life-limiting addictions (Lyon, 2017), dealing with the psychological dynamics of addiction in terms of thoughts, actions emotions is essential (Kelly, 2016; Marlatt & Witkiewitz, 2009; Miller, P., 2013; Shaffer, 2012).

Understanding of motivation and its role in everyday life in terms of incentives, rewards, and punishment is a very important part of the thinking-doingfeeling triad (Pink, 2009; Thomas, 2000). Positive feelings and emotions motivate us, while negative ones can shut us down. Anxiety (Bourne, 2015; Bray, 2017) and depression (Mayo Clinic Health Letter, 2017; O’Connor, 1999; Pettit & Joiner, 2006) are so common in everyday life that it would make sense to train people at an early age in ways of managing them.

Although *The Skilled Helper* does not pretend to provide any in-depth training in these three sets of interacting principles (cognition, behavior, and emotion), it is filled with examples of clients who run afoul of these principles and of helpers who demonstrate competence in using them to help their clients.

**7. Use Feedback to Improve the Effectiveness of the Helping Sessions and Clients’ Change Efforts**

Tyler, Pargament, and Gatz (1983) moved a step beyond the consultant role in what they called the “resource collaborator role.” Seeing both helper and client as people with defects, they focused on the give-and-take that should characterize the helping process. In their view, either client or helper can approach the other to originate the helping process. The two have equal status in defining the terms of the relationship, in originating actions within it, and in evaluating both outcomes and the relationship itself. In the best case, positive change occurs in both parties.

So helping is a two-way street. Clients and therapists change one another in the helping process. Even a cursory glance at helping reveals that clients can affect helpers in many ways. For instance, Liang, a Chinese immigrant, has to correct Timothy, his counselor, a number of times when Timothy tries to share his understanding of what Liang has said. For instance, at one point, when Timothy says, “So you don’t like the way your father forces his opinions on you,” Liang replies, “No, my father is my father and I must always respect him. I need to listen to his wisdom.” The problem is that Timothy has been inadvertently basing some of his responses on his own cultural assumptions rather than on Liang’s. When Timothy finally realizes what he is doing, he says, “When I talk with you, I need to be more of a learner. I’m coming to realize that Chinese culture is quite different from mine. I need your help.”

Feedback is a critical, but too often overlooked, communication skill in the helping dialogue (McClintock et al., 2017; Miller, Duncan et al., 2006; Snyder & Aafjes-van Doorn, 2016). In therapy, two things need to be monitored carefully and continually—first, progress toward life-enhancing client outcomes and second the degree to which therapy sessions are contributing to these outcomes. As to the client’s progress in managing problem situations and developing opportunities, these are the kinds of questions that clients need to ask themselves. Overall, what does progress look like? What progress am I making in terms to getting to the heart of the problem situation? To what degree do I understand what the resolution of the problem situation should look like? What are my goals? How can I clarify these goals? What actions must I take to achieve these goals? How do I start moving in the right direction? What obstacles am I running into and how am I dealing with them? What do I need to do to persist in achieving the life-enhancing outcomes I say I want? Counselors can help clients ask themselves these questions. Prescott, Maeschalck, and Miller (2017), in an edited overview, show how useful feedback can be in a wide variety of helping settings, including private practice, clinics and agencies, child and family therapy, therapy with LGBTQ clients, and counseling in the criminal justice system.

As to the helping sessions themselves these are the kinds of questions that need to be asked. How are we doing? What is going right? What mistakes are we making? How can we make these sessions more productive? What do we need to do to improve our collaboration?

These two kinds of feedback have been studied thoroughly (Duncan, 2010; Lambert, 2010a, 2010b, 2012). Duncan and his colleagues have developed and researched a simple feedback system based on two brief surveys, one given at the beginning of each session and the other administered toward the end of each session. The first survey asks the clients to rate themselves in four broad categories— personal well-being, how things are going with family and other close relationships, how things are going with work, school, and other relationships such as friends, and an overall category called a general sense of well-being. The survey given at the beginning of the first session helps “jump start” the helping process and acts as a kind of baseline against which between-session progress is determined. The second survey, scored toward the end of each session, deals with within-session satisfaction. In this survey clients indicate what has gone right and what needs further attention in the session itself by rating four broad categories—degree of satisfaction with the helping relationship itself, the degree to which the session addressed the right topics and focused on the clients’ goals, how well the approach to treatment fits the clients’ needs, and overall satisfaction with the session. Ideally, the surveys stimulate collaborative dialogue, help keep the client in the driver’s seat, and make both the sessions and the client’s between-session behavior more productive in terms of problem-managing outcomes.

At one point during the first session Laura explains the importance of feedback to Karl and then goes on to describe the survey system outlined above and suggests that they use it. Karl looks at the forms and then dismisses them, saying “I don’t think so. It’s too much like playing games.” Laura does not try to convince Karl to use the forms, but decides to make feedback a more seamless part of the dialogue. About five minutes before the end of the session, she asks, “How do you think we’re doing?” Karl hesitates and then says pleasantly, “You’re the expert. How do you think we’re doing?” She realizes that Karl is not completely convinced that therapy is a good idea. So she shares what she thinks are the highlights of the session and does so in such a tentative way that Karl adds a few comments of his own. She ends by saying, “So I think we’re still feeling our way.” Karl hesitates again and then says, “That’s about right. We’re both feeling our way.” Laura believes that feedback is essential but is not going to shove a formal system down Karl’s throat. She does, however, make another suggestion, one that had proved useful in other cases. She suggests to Karl a “buddy” arrangement similar to those in some Twelve-Step Programs (such as Alcoholics Anonymous). Like Karl, he would be someone who has returned from the wars in Iraq and Afghanistan, who had many of the problems that Karl is facing, but who has come out “the other side” in pretty good shape. For Karl this would be another voice, another relationship that could well be, not therapy, but therapeutic. Karl says that he will think about it. But it remains an option.

At the beginning of each session Laura explores with Karl his sense of the progress toward problem-managing outcomes (or the lack thereof) he is making and what they both need to do to facilitate progress. At the end of each session she helps Karl review the session, what he has learned, and what he needs to do “out there.” Miller et al. (2010) see these two kinds of feedback as a way of saying, indirectly, to the client: “Your input is crucial; your participation matters. We invite you to be a partner in your care. We respect what you have to say, so much so that we will modify the treatment to see that you get what you want” (p. 424). In the fourth session Karl says, “You know, we’re not using the forms, but we are doing the feedback thing. It helps. So I don’t care whether we use the forms of not. It’s working for me.”

Most of the research on feedback deals with feedback provided by clients. What about feedback from the helper to the client? For instance, should helpers provide feedback to their clients with respect to the quality of their collaboration in the helping sessions or with respect to their between-session behavior? Feedback in this sense is a form of both encouragement and challenge to the client. Does such feedback take the client out of the “driver’s seat” or is it an invitation to clients to take the “wheel” more fully? Is challenge or even an invitation to self-challenge a form of criticism? I deal with challenge or invitations to selfchallenge more fully in Part II where I propose that helping is inescapably a form of social influence. It is a two-way social-influence endeavor that does not take the client out of the driver’s seat any more than it makes a helper the victim of a client’s whims. In my view, clients who are never invited to challenge themselves are being shortchanged.

**8. Come to Grips with the Role That Beliefs, Values, Norms, and Moral Principles Play in the Helping Process**

If helping is to be a social-civilizing and not just an individual-enhancement process, it must be value-driven and ethical. Therefore morality and ethics constitute one of the key ingredients of therapy. I have been criticized by some for not including a more extensive section on ethics in this book. My contention has been that ethics is so important that any kind of abbreviated overview would send the wrong message. I cannot imagine a helper training program that did not include a complete course on values and ethics. And beyond the bare bones of the ACA and APA codes, there are many excellent texts on ethics in the helping professions (Corey, Corey, Corey, & Callanan, 2015; Knapp, 2012; Knapp, Gottlieg, & Handelsman, 2015; Nagy, 2011; Welfel, 2013). So let me lay out the reasoning behind my decision.

The beliefs, values, norms, ethics, and morality package presents an intellectual challenge to the helping professions (Mikulincer & Shaver, 2012). While the helping professions are trying vigorously to demonstrate that they are driven by the rigorous methods of science, it is also true that beliefs, values, norms, ethics, and morality and the cultures in which they are embedded are not scientific terms. The social sciences can study these phenomena as forms of human behavior, but although science can demonstrate the societal usefulness of shared patterns of behavior, science cannot prove their “validity.” By definition science can neither prove nor disprove the existence of God together with the moral injunctions that stem from religious belief systems, but that does not stop both scientists and religion-minded people from trying (Aczel, 2014). I once watched a television debate between an internationally well-known scientist, a committed atheist, and an outspoken Christian apologist. At one point the atheist conceded, “Well, of course, everyone needs a moral compass” at which point social pragmatism entered the debate while science flew out the window.

The American Psychological Association wants psychological treatments to be based on science, but the Association also promotes a strict ethical code. For many people this is not an issue. They find the basis for ethics and morality in religion and culture. Judaism, Christianity, and Islam all have extensive moral codes. But these codes, while similar, do have differences. Injunctions such as “Do not kill” are found in all three, but there are variations. Others turn to cultures for moral codes. Culture can be defined as the interplay between shared beliefs and values that leads to shared norms of behavior that, in turn lead to shared patterns of behavior within members of the culture. But because cultures differ, there are differences in their respective moral codes. For instance, while one culture condemns revenge, another might, under certain circumstances, see it as a duty. There is no “scientific” answer to the question “Which beliefsvalues- norms package is the right one?” Others look beyond both religion and culture and see the emergence of morality among human beings as a bio-socialevolutionary phenomenon (Brooks, 2012; Churchland, 2011; Wilson, 1993).

Still others turn their back on all this theory and take an even more pragmatic approach. If the world’s increasingly growing population of seven plus billion people are to live in some kind of harmony and lead a decent life (however defined), common sense rules and regulations are needed. Many individuals will sense the need for such a pragmatic moral code and do their best to live up to it. And there are laws meting out punishments for those who violate the stated norms. So in many ways beliefs, values, norms, ethics, and principles of morality are not givens but choices. Pragmatists reach a common conclusion: Rules and regulations, whatever their source, are necessary to contain the “fallen angels” of our nature and make social life livable.

There is a way to transcend rather than manage or solve the issues outlined here, a way that avoids the negativity often associated with ethics and morality. Handelsman, Knapp, and Gottlieb (2009) review the work being done on “positive ethics.” They claim, “Positive ethics shifts the emphasis from following rules and avoiding discipline to encouraging psychologists to aspire to their highest ethical ideals” (p. 105). This, they contend, makes for better ethical decisionmaking. Moving beyond the “First, do no harm” approach, Corey (2008) makes a distinction between “mandatory” and “aspirational” ethics. Aspirational ethics focuses on doing what is in the best interests of clients, a sentiment in keeping with the radical client-centered nature of helping: “Ethics is a way of thinking about becoming the best practitioner possible” (p. 37). Grappling with ethical decision-making is part and parcel of life for both you and your clients. Beliefs, values, behavioral norms, ethics, and morality permeate the helping process. Positive ethics offers a way of grappling on higher ground.

In an American Psychologist article Rogerson and his associates (2011) add fuel to the fire. They discuss the role of “nonrational” processes in ethical decision- making. They take issue with current ethical decision-making models, seeing them as overly rational and based on faulty or inadequate assumptions. These models, they say, ignore nonrational factors such as context, the decision maker’s perceptions, relationships, and emotions. Ethics, they suggest, needs to be reconceptualized.

The “arationality” of beliefs and values is a theme that will not go away. An article in the *Economist* (July 10, 2017, p. 75) focuses on the work of economists Roland Benabou and his Nobel-prize winning colleague Jean Tirole (2016) who, as economists, see beliefs and values as “assets.” The *Economist* summarizes:

In many ways, beliefs are like other economic goods. People spend time and resources building them, and derive value from them. Some beliefs are like consumption goods: a passion for conservation can make its owner feel good, and is a public part of his identity…. Other beliefs provide value by shaping behavior … [R]eligious asceticism can help one avoid unhealthy habits.

Back to Karl and the decisions he must make based on the values he holds. The beliefs, values, norms, ethics, and morality package pervades all of Karl and Laura’s interactions. As to religion, Karl could be called a semi-lapsed fundamentalist. He is no longer a churchgoer, but aspects of the basic fundamentalist package clings to his psyche, if not his bones. They are part of the person he is. In one session, out of the blue as it were, Karl says, “You know, I pray sometimes. Especially if I get angry.” Laura sees this as a positive sign, recalling research on the value of prayer in controlling anger and aggression (Bremner, Koole, & Bushman, 2011). For her, the issue is not a belief system but what works.

Decisions tend to be driven by beliefs and values. Therefore, as decisions are being made, it is important that Karl and Laura focus on what underpins them. When Karl says that he was “perhaps too hasty” in turning his back on his family and pre-war friends, he may be saying he feels guilty. Laura realizes that he feels “out of community,” but it is not yet clear what he means by community.

Given all these variables, it is essential that Laura and Karl work together to determine and deal with key issues, which, when faced, explored, and changed, will make a substantive difference in Karl’s life. Helping is about managing problems in living and developing unused opportunities, not personality transformation. Karl is a lay expert in Karl, knowing himself, however incompletely, from the inside out. Like all of us he has blind spots which contribute to the complexity-uncertainty dyad, but he, rather than text books on abnormal psychology, is still the best source of knowledge about Karl. Laura, as an expert, has dealt with all these complexities before, but Karl is the decision maker. She can help Karl find his way through these inevitable uncertainties and not be paralyzed by them.

**9. Help Clients Redo Poor Decisions and Make and Execute Life-Enhancing Decisions**

Consider this case. You are the helper. Your client is a woman with breast cancer who has just been told that the drug she is taking to keep the cancer at bay is weakening her heart. This is a real case (Lagnado, June 5, 2017). What should she do? Should she make the decision? Should she be allowed to make the decision? Should the doctors make the decision? How can you help her?

Any number of popular and more academic books point out the ways in which decision-making defines our lives (Cooper, 2014; Craig, 2015; Hammond, Keeney, & Raiffa, 2015; Iyengar, 2010; Schwartz, 2009). While many dispute the findings of some of these authors, it is indisputable that decision-making is center stage in life and in therapy. If we review any given day of our lives, we realize that we make many decisions, most of them of small or intermediate importance—what to eat for breakfast, whether to return the call of an annoying relative, how to talk with a child who is having problems at school—the things of daily life. There are also big decisional moments. At age 80 which treatment, if any, should I choose for prostate cancer that has been described as “somewhat aggressive”? Shall I keep trying to get my spouse to stop smoking or will that make a somewhat troubled relationship even worse? Shall I convert to the religion of my fiancée? Shall I gather the courage to tell my boss that his style is belittling? Young adults face a whole range of important decisions. Should I move out of my parents’ home? Should I move back? Shall I go to college? Should I finish college when things go wrong? What kind of job do I want and what should my job search look like? Should I live with my girl/boyfriend? Should I get married? Should we have children? Should I go back to school?

As I was writing this chapter, a young woman, let’s call her Melinda, called me asking me for “advice.” I said to myself, “I don’t give advice, but I can help her grapple with the important decision she was making.” So I said, “Tell me what’s going on.” She was in the midst of a job search. Her current job was “OK” (meaning not OK), but it was headed nowhere. She wanted a job that fit her interests (she used the word “passion”) more closely. She had just received a call from a former mentor who knew her well. He offered her a senior position in his sales department. She had no real interests in sales, but the idea of getting a senior position with all its perks at an early age certainly had its allure. She also had a great deal of respect for her former mentor and did not want to disappoint him. Her younger brother had been urging her to take the position and deal with “other issues” down the road. We spent an hour talking through all the aspects of her decision-making challenge. At the end of the conversation she said, “Well I think I have made my decision. Thank you very much.” Later I found out that she had turned down the offer and had begun a more vigorous search for a job in computer technology and design, areas in which she was both very interested and very competent.

Melinda was not really looking for advice. Rather, it seemed to me, she had already made a tentative decision and wanted to run her thinking by someone she trusted. Decisions run along a continuum from the trivial to the life changing. We are all decision makers. So are our clients. Because decision-making is critical to everyday living, it is also critical in the helping process. When clients come to us, they often learn that they have to make some difficult decisions or that they have to deal with the fallout from poor past decisions. They come when they are afraid to decide at all.

***Therapy: a decision-rich process*** Problem management and opportunity development are inseparable from decision-making. They are often presented together (Adair, 2013; Kallet, 2014; Vaughn, 2007). Because both problem management and opportunity development deal with options, decision-making, that is, choosing from among options, is at the heart of helping for both helpers and clients.

***Client decision-making*** Clients have to decide many things: to come for help in the first place (unless mandated, say, by a court), to choose to talk about certain issues but not others, to determine what issue or set of issues they want to work on, to determine what a better future looks like, to choose the elements of this future to set goals for themselves, to make plans to achieve these goals, to find the strength, courage, and resources to implement these plans, to tell you when the helping process is working and when it is not, to persevere until they get what they have come for. Part of helping clients become better problem solvers is helping them become better decision makers (Dansereau, Knight, & Flynn, 2013). Clients come to therapy with a decision-making style. Understanding how they make decisions will help you become a catalyst for change. Effective helpers do not make decisions for clients, but they do help clients make decisions that lead to life-enhancing outcomes.

***Helper decision-making*** Counselors are in decision-making mode throughout the helping process (Gambrill, 2012; Goode, Tompkins, & Swift, 2016). Helpers choose an approach to therapy and then continually make decisions about how to tailor this approach to their clients during the therapeutic encounter. You as a helper will have many options in the way you interact with clients. Understanding what influences you in making these decisions is a key form of helper self-knowledge. While you want to avoid making decisions for your clients, you do want to help them make life-enhancing rather than life-limiting decisions. You want to help them face up to decisions they are trying to avoid. You want to help them explore the possible consequences—good or bad—of decisions they have made or that they are in the process of making. Wenzel (2013) highlights what she calls “strategic” decision-making on the part of the helper, “a flexible yet evidence-based approach to working through decision points in order to move treatment forward.” By “strategic” Wenzel means decisions that “(1) follow logically from the case conceptualization, (2) are arrived upon collaboratively between the therapist and patient, (3) allow the patient to leave the session with something new, and (4) are seen through in their entirety before their effectiveness is evaluated.” I would add that the “evidence” should often be practice-based rather than experimental-study-based. Some of the “decision points” she addresses include times when a specific intervention is not achieving its desired effect, when the patient does not understand or accept the rational for the helper’s intervention, or when some crisis calls for a shift in focus.

Helpers need to listen to or stay in touch with their own decision-making style. Responding to clients involves a whole series of decisions. Ongoing research on “naturalistic” or “adaptive” decision-making (Klein, 1998, 2008, 2011; Schraagen, Militello, Ormerod, & Lipshitz, 2008) shows that the kind of “fast” decisions experts such as firefighters and airline pilots make on the spot make sense under two conditions. First, they must be skilled and experienced. In the give-and-take of the helping process, counselors and therapists need to be skilled, experienced, and principled. Second, in the end, uncertainty will always haunt decision-making and helpers need to be prepared for the “complexity and ambiguity” Klein sees at the heart of important decisions.

***The bare essentials of direct decision-making*** What follows are the basics or bare essentials of what may be called the Newtonian, or rational, approach to decision-making (Baron, 2001; Galotti, 2002; Hammond, Keeney, & Raiffa, 2015; Harford, 2008; Harvard Business Essentials, 2006; Hastie & Dawes, 2001; Hoch & Kunreuther, 2004). But do not be fooled. Later on we will see that decisionmaking in everyday life and in helping can come closer to the complexity and messiness of relativity and quantum mechanics.

*Problem Identification and Information Gathering*. An issue, concern, or problem is at the starting point of therapy. The first rational task is to gather information related to the particular issue or concern. It is essential to describe or “frame” these issues accurately. A patient who learns that he has prostate cancer must understand the nature of the disease before he can decide what treatment to choose. What kind of cancer is it? How aggressive is it? What is the most likely progression of this particular type of cancer? What are the treatments like? What will they accomplish? What are the side effects? What are the consequences of doing nothing? What would another doctor say? How do I handle the shock of the diagnosis? And there many things he can do to get answers to these questions— Internet searches, books and articles, talking to doctors, and talking to patients who have undergone treatment or who have refused treatment. Many patients today routinely mount extensive Internet searches on their medical conditions in order to make better-informed decisions. This does not mean that the information they gather provides ready-made answers to emotion-laden questions.

Problem identification in therapy is different from problem identification in medicine and many other areas of life. The problems themselves are often murky. If applied to Karl, we have the following picture. Karl comes to realize that being a loner, being out of community, is an important part of the problem situation. So in his mind he gathers the information he needs to make a decision about what kind of social life he would like. Before he went into the army he was relatively gregarious. For the most part he enjoyed being with both family and friends. But at root he is a bit of an introvert. So he was not happy when he socialized too much. He said yes to too many invitations. He also realized that when he did socialize, he was relatively passive. But this meant that others would make the decisions in the social encounter—for instance, what to talk about, where to go, how long to stay together, and so forth. This did not sit well. In the army Karl had a few very good friends. They did things together. They counted on one another. They had common interests and talked about them when they got a chance to relax. Karl assembled a lot of information about his social life, including the fact that he did not like being a loner. Somewhat of an introvert— that was all right. But a loner—no.

*Analysis*. The next rational step is processing the information. This includes analyzing, thinking about, working with, discussing, meditating on, and immersing oneself in the information. Just as there are many ways of gathering information, so there are many ways of processing it. Effective information processing leads to a clarification and an understanding of the range of possible choices. “Now, let’s see, what are the advantages and disadvantages of each of these choices?” is one way of analyzing information. This approach assumes that the decision maker has criteria, whether objective or subjective, for comparing alternatives.

Karl analyzed the information he gathered. He took an upside-downside approach. For instance, the upside of being relatively passive in social situations meant that people did not “invade” his space, he felt free to leave if any given gathering was doing nothing for him because people were not counting on his contributions, and he could daydream at will. But as soon as he said these things to himself, he realized how self-centered this kind of “upside” was. He was more of a parasite than a contributor. Choosing to be passive was going beyond “being a bit of an introvert.” But was there an upside to being a bit of an introvert? Yes, he said to himself, “I can listen well, think about what’s being said, and then make some kind of intelligent contribution to the conversation.” He discusses the results of his analysis with Laura.

*Making a Choice*. Finally, decision makers need to make a choice—that is, commit themselves to some internal or external action that is based on the analysis: Anita, in the middle of a painful divorce, says, “After thinking about it, I have decided to sue for custody of the children.” And, as the fullness of the choice includes an action, she adds: “I had my lawyer file the custody papers this morning.”

There are rational “rules” that can be used to make a decision. For instance, one rule, stated as a question, deals with the consequences of the decision: “Will it get me everything I want or just part?” Values also enter the picture because, from one point of view, values are criteria and incentives for making decisions. “Should I do X or Y? Well, what are my values?” The woman suing for the custody of the children says to herself, at least implicitly, “I value fairness. I’m not going to try to extort a lot of money for childcare. I’ll make reasonable demands.”

In one session Karl says, “I’ve become a loner, but I can’t stay that way. It’s deadly. I wasn’t a loner in Afghanistan. It would have been deadly there. If my buddies could see me now they wouldn’t recognize me. But to tell the truth, I’ve become comfortable, not happy, but comfortable being an introvert. I bother no one. No one bothers me.” This is the beginning of a decision to get back into community even though he does not have a clear idea of what community would look like or how he would go about doing it. That is another phase of the problem-management process.

*Follow Through*. Effective decision-making ends in action. In therapy this means problem-managing and/or opportunity-developing action that leads to life-enhancing outcomes. Otherwise decision-making is just wishful thinking. The longer it takes to implement a decision (stopping smoking, keeping a marriage together), the higher the risk of doing nothing. Counselors can help clients talk through the risk of doing nothing or giving up (McGuire & Kable, 2012). As a first step Karl decides to take up an offer Laura had made early in therapy of talking with someone who has gone through the kinds of experiences he has had in Iraq and Afghanistan with the same crippling effects but who has come out the other side. At the time she made the offer, he said that he would “think about it.” When he thinks of getting back with family or friends, he realizes he does not want to get involved on a superficial level. Small talk and all that. Having some kind of “buddy” (he hated that word) had substance to it and fitted in with what he was trying to do. It could be the beginning of “normalization,” but his kind of normalization.

These, then, are the major steps in what Kay (2011) calls “direct” or rational decision-making. But he claims that most of the time in human affairs it is better to follow what he calls “indirect” (oblique) decision-making and the decisionheavy process we call problem management.

***The arationality of decision-making*** There are many different versions of the standard, rational decision-making process. However, decision-making, though on the surface a rational process of choosing between reasonably well-researched alternatives (Galotti, 2002), has many pitfalls (Ariely, 2010a, 2010b; Chabris & Chapman, 2010; Kahneman, 2012; Kahneman, Lovallo, & Sibony, 2011; March & Heath, 1994; Van Hecke, 2007; Watts, 2011). In the examples spread throughout this book you will see that the direct or rational process of decision-making described above is not necessarily the stuff of everyday life or of therapy. Socialemotional problem situations are often very complex and determining probabilities when it comes to human behavior is often difficult or even impossible.

The ground is continually shifting. Kay maintains that such situations call for oblique or “indirect” decision-making because of the uncertainties involved.

Oblique problem solvers do not evaluate all available alternatives; they make successive choices from a narrow range of options. Effective decision makers are distinguished not so much by the superior extent of their knowledge as by their being aware of its limitations. Problem solving is iterative and adaptive rather than direct. (p. 13)

Benabou and Tirole (2016), mentioned earlier, discuss the ways that beliefs and values can distort decision-making. Their findings are summarized in an Economist article (July 10, 2017, p. 75).

Because beliefs … are not simply tools for making good decisions, but are treasured in their own right, new information that challenges them is unwelcome…. “Strategic ignorance” is when a believer avoids information offering conflicting evidence. In “reality denial,” troubling evidence is rationalized away…. And lastly, in “self-signaling,” the believer creates his own tools to interpret the facts in the way he wants: an unhealthy person, for example, might decide that going for a daily run proves he is well.

You will see all of these possibilities in your interactions with clients. Helping them challenge their blind spots is, as we shall see in Chapter 7, one of the most important tasks in therapy.

Decision-making is not a straight line. Klein (2009) uses the term “adaptive” to describe the kind of pragmatic decision-making needed in real-life situations riddled with uncertainties.

Most of the research about thinking and decision-making takes place in bright and clear conditions. Most of the advice offered is about how to think and decide when the issues are straightforward. That is not what I am interested in. In this book I will explore how we think and decide in the world of shadows, the world of ambiguity. (p. 6)

Klein goes on to describe and then refute approximately ten commonly held ideas about decision-making. For instance, “The starting point for any project is to get a clear description of the goal.” I would answer “true” to such a statement. But as Klein points out its possible flaws, I move from “true” to “perhaps” or “sometimes.” It is not that this and the other statements are totally without merit.

The ten claims aren’t wrong. They work fine in well-structured situations. They even have some value in complex situations because any given situation has both ordered and complex aspects simultaneously. (p. 11)

Good decision makers tend to be “eclectic.” Decision-making in therapy is as much an art as an application of science. Eclectic decision makers do all the things that direct or rational decision makers do, but they do them differently and continually adapt the process to the context. This “adaptive decision-making” theme permeates this book. Like forecasting (Tetlock & Gardner, 2015) decision-making involves “gathering evidence from a variety of sources, thinking probabilistically, working in teams, keeping score, and being willing to admit error and change course.” In therapy the client and helper constitute the team. Gathering evidence includes exploring blind spots, seeing problems and opportunities contextually, and developing new perspectives. Keeping score means feedback regarding the process and outcomes of therapy. Probabilistic thinking involves creative thinking about both problem situations and life-enhancing outcomes. In their study Tetlock and Gardner trained participants in the basics of how to think about probabilities in an uncertain world. Within reason we can do the same with clients.

Even though totally rational decision-making in therapy looks more and more like an improbable event and that indirect (oblique, arational, feelingyour- way) decision-making is the norm and necessarily so, still both kinds of decision-making play a role in therapy. Decision-making tends to be a process that is direct and indirect, rational and arational, science and art with both dimensions intermingled like fudge-ripple ice cream. We work with clients to help them crawl out of the decisional pits into which they have fallen or to help them from falling into these pits in the first place. Karl admits that he made a mistake by cutting himself off from family and friends when he returned from Afghanistan. Therefore one of his goals is to get back into community. He has to reconstruct this part of his life. Wanting to get back into community is a decision in itself and the “how” of doing this requires any number of decisions. What kind of community of family and friends does he want? How should he go about reconnecting or making new connections? It will become evident that Karl (and clients in general) will not move in a linear fashion through the rational decision-making process outlined earlier. Problem management and decisionmaking are often, if not usually, circuitous journeys.

***Decision-making styles*** In his book, *Thinking, Fast and Slow*, Nobel Laureate Daniel Kahneman (2012) describes two systems people use to make decisions. System One is fast, intuitive, and emotional. He describes the capabilities, faults, and biases of fast thinking. People are strongly influenced by their intuitive impressions, so it is important to know when we can trust our intuitions. People brag about “following their gut” even though it is often the road to disaster. Karl followed his gut when he quickly decided to leave the army and this proved to be a life-enhancing decision. When he summarily dismissed Laura’s offer of a simple survey-driven feedback system, his fast thinking approach did him no favor. Although System Two, slow thinking, is more deliberative and logical, it can lead to life-enhancing decisions. However, if slow thinking is overused, problem-managing action can grind to a halt.

Assuming that all clients make decisions in the same way is, of course, unthinkable. Understanding different styles is essential to effective helpings. In a recent large study conducted by Teatro, a health-care data-analytics firm, and reported in the *Wall Street Journal* (September 22, 2015, D1–D2) researchers discovered that, generally speaking, women and men have different decisionmaking styles when trying to determine what to do once they have found out that they have cancer—women with breast cancer, men with prostate cancer. Men tended to be analytical, methodical, and data-driven in their search for treatment options. Women, on the other hand, tended to be more distrustful of assessment data and even of their physicians and went to the Internet not for scientific advice but for stories and advice from other women struggling with breast cancer. Reyna, Nelson, Han, and Pignone (2015) discuss in detail the process of patient decision-making in dealing with cancer. The point here is that both groups of people and individuals have decision-making styles. Effective helpers, armed with a good understanding of their own decision-making style, get a sense of the client’s style and the ways in which that style helps or hinders the management of problem situations. For instance, many clients go instinctively with their “gut” instead of their “head” even when their gut is leading them astray even when faced with important decision (Kahneman, 2012; Lehrer, 2009). Decisionmaking casts a large shadow and you will do well to understand what lies in that shadow. Both System One (fast, gut) and System Two (slow, head) are comprised of a continuum (somewhat fast, quite fast, very fast). Clients’ styles tend to be some kind of mixture of all decision-making factors.

What Karl is like as a decision maker is a key factor in this therapeutic endeavor. It seems that he too often gets caught up in the common irrationalities that plague decision-making. He seems to make decisions, even important ones, quickly with little internal debate or reflection. Is this a deep-seated pattern or is it temporary? To what degree might this interfere with the range of decisions, large and small, required by the problem management process? Laura believes that it would be quite useful to help Karl get in touch with and review what kind of decision maker he is. So she helps him explore his style. Both are surprised when he discovers that he sees his “fast” style as “more masculine.”

Even though clients and helpers have decision-making styles, any given decision is influenced by a wide variety of factors both within the client and the helper, in their relationship, and in the context in which the client is making the decisions. When we add the “influencers” described briefly here, the complexity of decision-making becomes obvious. No one escapes. In an edited book on clinical decision-making, Magnavita (2016) notes in his introduction that “even the most self-aware clinicians are susceptible to biases that can influence their decisions and can have a dramatic effect on treatment outcome.” Clients have their biases; we have ours.

In the following case we can ask ourselves: “What kind of influencers such as client or helper or third-party bias might affect Brinda’s decision making?” The core of the case is real even though much has been changed for the sake of privacy.

Brinda received a degree in design and Internet studies in the United Kingdom, Rohan a degree in business in Scandinavia. They met when they returned to their native country and decided to start a dress and accessories business. They ignored the fact that they were two very different people with very different styles. The first two years there were the usual start-up bumps, but the business did reasonably well. One day Brinda was shocked when Rohan accused her of mishandling funds, focusing too much on design, and failure to understand business realities, in effect blaming her for an undefined lack of progress. “We should be doing much better than we are.” She was so shocked that she did not even try to defend herself. In her view Rohan was the culprit. He was narrow minded, poor in relating to customers, suppliers, and employees, and unaware that his managerial style hindered rather than helped the business. She had been wishing that she had started the business on her own. But this was impossible because of financial realities. In the middle of all of this a sudden downturn in the economy made everything worse. Now it was a question of survival. Bankruptcy was around the corner. At her wits end, Brinda sought the help of a consultant-counselor.

Here, in no particular order, are some of the factors that could possibly affect, for better or worse, Brinda’s, Rohan’s, and the helper’s decision-making: contextual factors such as the economy, personal decision-making styles, complexity of problem situation, the importance of the issues to stakeholders, the cognitivebehavioral- social-emotional principles triad embedded in key players, perceptions of risks involved in making choices, beliefs and values, availability of options, differential understanding of problem situation, incentives for action, fear of downside in making choices, tendency toward procrastination, lost-opportunity costs, fear of unintended consequences, realization that “I am not in control,” perceived probability of success, perceived probability of failure, back-up plans or the lack thereof, lack of clarity of desired outcomes, time constraints—and the list goes on. If we pick just a few of these and apply them to the case of Brinda and Rohan, what might we have?

* *The Context*. What are the key contextual factors influencing Brinda’s decisionmaking as a whole and any given decision in particular? Brinda is currently providing financial support for her parents. Customers are beginning to drop by the wayside mainly because of Rohan’s behavior. Because of the economic downturn the bank is reluctant to loan the business any more money.
* *Values*. What values are driving Brinda’s decisions? Good working relationship with family, friends, and colleagues had always been a top priority for Brinda. She thinks that this should be a universal value even though she is smart enough to know it is not. Rohan is much more self-centered. He believes that people are out for themselves. Relationships are a means to an end, not an end in themselves. Money, success—these are among his top values. Brinda values “getting along,” while Rohan values “getting his way.”
* *The Cognitive-Behavioral-Social-Emotional Triad*. Consider the cognitivebehavioral- social-emotional triad considered earlier in this chapter. The mindsets of the players in this drama have a significant impact. Rohan sees himself as a “big, important” person. He wants to be known as a winner. Brinda, on the other hand, sees herself as a “steady, competent, focused” businessperson. Rohan has some destructive behavioral habits. He tends to take over conversations and crowd out the views of others, including those of Brinda, customers, and suppliers. Brinda spends time “cleaning up his mess.” Brinda is strong emotionally but she is beginning to see that she has limits. So she begins to realize that either she or Rohan has to leave the business. There is always a negative emotional edge to Rohan, but he is totally unaware of it. He does not see the end of the relationship coming.

As of this writing, this case has not yet been resolved. It is coming to an end, but it continues to be packed with a range of serious decisions.

**10. Adopt a Treatment Model Aligned with the Universal Problem-Management Process**

Helpers need to become competent in all the basic ingredients of successful therapy outlined here, but they must do more than that. They must use the right mixture of these basic ingredients, that is, they must organize them and tailor them to this client. This is the art of helping. That calls for a treatment model of or an approach to therapy that helps them both organize and tailor the basic ingredients to service clients’ needs. Therefore the treatment model is a key ingredient in therapy, not in itself but because of the role it can play. So it is helpful to determine whether all helping models have something in common that we have not yet reviewed that will help organize and give focus to the ingredients we have reviewed.

***Treatment models as organizers*** There are dozens (by some counts, hundreds) of different approaches to helping. Instead of asking, “Which approach to therapy is the most effective one?” it is better to ask, “How useful is the model in integrating the key ingredients outlined here at the service of clients?” All successful helpers have the ability to tailor the essential ingredients of successful therapy, including their preferred therapeutic model, to their clients and to work collaboratively with them.

Although the research says that it is not the treatment method that is the main driver of success (Wampold, 2010), this does not mean that it is not important. The chosen treatment model helps organize and give focus to both the client’s and the helper’s resources. Of course, the model or approach must have substance and face validity, that is, it must “make sense,” it must look like it might work. The therapist must believe in the model and be both skilled and comfortable in its use. The client in his or her own way must see the approach as reasonable and collaborate with the therapist in its execution. But execution involves all the ingredients of successful therapy.

Let’s return to Karl who is suffering from some form of PTSD. Studies on what researchers call “bona fide” psychotherapies for treating PTSD (Benish, Imel, & Wampold, 2007) show that even though each approach has merit, for any given client one approach may be better than others. Tailoring is essential because clients with PTSD symptoms are not homogeneous. Each client is different. Laura realizes that there are dozens, no hundreds, of different approaches to helping, all claiming to be effective. But, as mentioned earlier, she can use the problem-management framework to suggest methods and treatments drawn from a wide range of approaches. But in her practice this isn’t a “let’s-try-this-and-see-what-happens” approach. The fact that she knows many different evidence-based approaches does not clutter her mind because she uses the problem-management framework to organize them. And although she makes sure that Karl understands what is being offered, she makes sure that she does not dump any of this complexity on Karl.

***Problem management: human universal and key ingredient*** What treatment approach is highlighted in this book? The simple answer is: An approach that is embedded in every other approach. An approach with which clients are already familiar. An approach that can be used as a tool to borrow helpful treatments from any other approach. Sounds too good to be true? Let me explain.

This approach, which I call The Standard Problem-Management Process, poses four questions clients need to ask themselves in their search for life-enhancing outcomes:

* What’s going on? “What are the problems, issues, concerns, or undeveloped opportunities I should be working on?” This involves helping clients spell out her or his current picture.
* What does a better future look like? “What do I want my life to look like? What changes would help manage my problem situation and develop unused opportunities? What goals do I need to pursue to manage my problem situation?” This involves helping clients paint their preferred picture.
* How do I get there? “What do I need to do to make the preferred picture a reality? What plan will get me where I want to go? What actions will get me started on the right path?” The plan outlines the actions clients need to take to create a better future. This is the way forward.
* How do I make it all happen? “How do I turn planning and goal setting into the kind of action that leads to the solutions, results, outcomes, or accomplishments that have the impact I am looking for? How do I get going and persevere until I manage my problems and develop my unused opportunities?” The Action Arrow indicates the broad and specific actions clients must take to produce the changes they want. This is the ongoing challenge of implementation.

These questions are in a logical sequence, but do not let the logical sequence fool you. A logical sequence is not necessarily the way things happen in life or in therapy. Everything that has been said about indirect decision-making can be said of problem management. These four questions, turned into three logical “stages” and an “implementation arrow” in Figure 1.1 provide the basic framework for the helping process. But it is a framework, not a formula. The term “stage” is placed in quotation marks because it has sequential overtones that are misleading. In practice the three stages overlap and interact with one another as clients struggle to manage problems and develop opportunities.

*Embedded in People*. Around the world everyone faces problems in living and everyone has overlooked and unused life-enhancing opportunities. The advantage of a problem-management and opportunity-development approach to helping is that it is easily recognized across the world. That is, the standard problem-management process seems to be what McCrae and Costa (1997) call a “human universal” or what Norenzayan and Heine (2005), in a stimulating article, call a “psychological universal.” Its logic seems to be embedded in human beings. People do not so much learn the problem-management process as they recognize it. In essence it is already there. It is, to use Orlinsky and Howard’s (1987) term, a “generic” model or framework for helping. Sometimes, when I explain this approach, people say, “Oh, I know that!” Of course they know; it is a basic; its logic is wedded to their bones. The problem is that too many people who say they know it never really use it. It is not part of their lives.

**FIGURE 1.1** Key Problem-Management Questions

Many years ago, before presenting an earlier version of the helping process outlined in this book to some 300 college students and faculty members in Tanzania, I said, “All I can do is present to you the helping process I teach and use. You have to decide whether it makes sense in your own culture.” At the end of the three-day seminar they said two things. First, the communication skills used in the helping process would have to be modified somewhat to fit their culture. Second, the problem-management helping process itself was very useful.

Since then, this scene has been repeated—in conferences and training events many others and I have presented—over and over again on every continent. The approach, presented in detail in Chapter 2, spells out, in a flexible, step-by-step fashion, a common way human beings think about constructive change. This kind of cross-cultural validation is, as Norenzayan and Heine note, at the heart of universality: “A compelling case for universality can be made when a phenomenon is clearly identifiable in a large and diverse array of cultures” (2005, p. 769). Of course, the Standard Model as outlined here and explored in detail later has to be adapted both to different cultural settings and to different individuals within those settings.

*Embedded in Therapy*. While few models or approaches to helping talk explicitly about problem solving or problem management and the flipside, opportunity identification and development, all treatment approaches use problem-management concepts and language either directly or indirectly. That is, they talk about identifying and exploring problems or problem situations, they discuss the issue of unused strengths and other resources, they talk about goals and the action strategies or plans needed to achieve goals, they point out the difficulties inherent in carrying out plans and suggest ways of overcoming these difficulties. Therefore, in my thinking, the standard problem-management and opportunity-development process is one of the “common factors” in helping. That is, some form of it is found in all successful helping.

In this book I use this problem-management framework as the primary approach to treatment and as a way of organizing the key ingredients of successful therapy outlined in this chapter. Chapter 2 reviews in some detail my version of the Standard Problem-Management Framework. There are many different versions. Some, unfortunately, leave out the Stage-II question: “What kind of future do I want?” The shortened version—“What is my problem and what can I do about it?”—loses the richness of imagining a better future. This truncated version works if the problem is, let’s say, a broken refrigerator. The desired outcome is clear. Problems in human behavior are different. A couple in marriage therapy can spend time exploring their problems but ultimately need to ask themselves “If we want to be married, what kind of marriage do we want?” Then they can ask themselves, “Well, what do we have to do to create that kind of marriage?”

Even though most approaches to treatment use, directly or indirectly, problemmanagement language, the profession as a whole has not openly recognized its importance in therapy. You are more likely to find research in problem management and decision-making in business schools than in therapy training programs. The fact that Karl is in some way familiar with the problem-management process that Laura suggests they use helps cut down on complexity and uncertainty. The problem-management process provides a map, but of course the map is not the territory. Laura knows both the map and the territory well because of her experience. But now Karl and the context of his life constitute the territory. They have to chart a course together and agree on course changes as they move along. Even when a general direction is set, the journey itself will take twists and turns. The general direction of their journey together must be set by mutual agreement, but how to get there needs to be worked out. Sometimes the destination itself needs to be altered. There are starts and stops. A degree of uncertainty pervades the entire process. That’s why collaboration and mutual feedback are so important.

[Move from Smart to Wise by Managing the Shadow Side of Helping **LO 1.4**](https://jigsaw.vitalsource.com/books/9780357191538/epub/OEBPS/9781305865716_toc.xhtml#toc-ch1-4)

Let me add one more dimension of uncertainty to the helping process. More than intelligence is needed to establish a constructive client-helper relationship and use the problem-management framework and skills outlined in this book well—smart is not smart enough. The helper who understands and uses the framework together with the processes, skills, and techniques that make it work might well be smart, but he or she must also be wise. Effective helpers understand the limitations not only of helping theories, frameworks, and models but also of helpers, the helping profession, clients, and the environments that affect the helping process. It is one thing to understand and factor in the uncertainties or “known unknowns” described briefly in this chapter. It is another to understand and deal with the “unknown unknowns” that lurk in the background of all human endeavors, including helping. The latter unknowns constitute what I call the “shadow side” of life.

The shadow side of helping can be defined as follows:

*All those things that often adversely (and sometimes constructively) affect the helping relationship, process, and outcomes, in substantive ways but that are not identified and explored by helper or client or even the profession itself.*

This definition makes it clear that the shadow side is not the same thing as humanity’s dark side (Bohart, Held, Mendelowitz, & Schneider, 2013), which screams at us every day on our television screens. All human endeavors—social life, business, politics, on and on—have their shadow side. Companies and institutions are plagued with internal politics and are often guided by covert or vaguely understood beliefs, values, and norms that do not serve the best interests of the business, its customers, its employees, or its shareholders. The worldwide financial crisis brought to light a bewildering list of behaviors that were going on in the shadows of the financial industry for years before the blowup. New discoveries routinely fill the pages of the business press and financial institutions have already paid tens of billions of dollars in fines for illegal behavior. There are now excellent reviews of shadow-side factors that caused (and are still causing) troubles in finance (Kay, 2015).

The helping professions, too, have their shadow side. Consider the amount of disagreement on the nature of therapy, the failure to come to grips with the real differences between the social sciences and the STEM-related sciences, the implications of the fact that such realities as beliefs, values, and morality cannot be scientifically validated—the list goes on. The challenges to the helping professions outlined in Appendix 1 are often part of the shadow side. But shadow-side challenges, managed wisely, can provide benefits. Consider the following analogy. The shadow side of helping is a kind of “noise” in the system. Scientists have discovered that sometimes a small amount of noise in a system, called “stochastic resonance,” makes the system more sensitive and efficient. In the helping professions, noise in the guise of the debate around what makes helping both effective and efficient can ultimately benefit clients. In my thinking, the profession needs more noise related to the best way of rigorously studying human behavior, including therapy. There is some noise, but it is not yet loud enough.

What happened to learning from one another and integration? The search for the truth gives way at times to the need to be right. It is not always clear how all of this serves the needs of clients. Indeed, clients are often enough left out of the debate. Just as many businesses today are reinventing themselves by starting with their customers and markets, so the helping professions should continually reinvent themselves by looking at helping through the eyes of clients.

Wise helpers are idealistic without being naive. They also know the difference between realism and cynicism and opt for the former. If helpers do not know what is in the shadows, they are naïve. If they believe that shadow-side realities win out more often than not, they are cynical. Helpers should be neither naïve nor cynical about themselves, their clients, or their profession. I describe a cynic as someone who has given up but who, unfortunately, has not yet shut up. Wise helpers pursue a course of upbeat and compassionate realism. They see the journey “from smart to wise” as a never-ending one. And they do not neglect the “smart” part of helping or of everyday living. They continually get better at “separating sense from nonsense,” the subtitle of John Ruscio’s (2005) book *Critical Thinking in Psychology*, an excellent exploration of the value of critical thinking.

*The Skilled Helper* is by no means a treatise on the shadow side of helping. Rather the intent is to get helpers to begin to think about the shadow side of the profession and its professionals. There are signs that the helping professions are beginning to explore their shadow side. An example of that is the book *What Therapists Don’t Talk about and Why* (Pope, Sonne, & Greene, 2006). These authors explore myths and taboos that they see as standing in the way of effective helping. More recently, Chapman and Rosenthal (2016) review behaviors, either on the part of clients or therapists themselves or both, that interfere with the helping process. As they point out, such behaviors are often unintentional, automatic, or absent-minded. They operate in the shadows. Budge (2016) has edited a Special Issue in *Psychotherapy* on clinical errors. Many of these errors such as those in decision-making stem from shadow-side realities. Books and articles like these are a start. Of course, you may not agree with what these authors have to say (or what I say here), but they provide stimuli for deeper thinking about the helping professions and encourage debate. In my opinion the helping professions need to become, in a positive way, more self-critical. This means coming to terms with the shadow side. The shadow side of life is here to stay.

[Embrace Uncertainty **LO 1.5**](https://jigsaw.vitalsource.com/books/9780357191538/epub/OEBPS/9781305865716_toc.xhtml#toc-ch1-5)

At first glance it seems odd to use the word “**uncertainty**” when talking about the ingredients of successful therapy. Uncertainty is not in itself an ingredient. Rather uncertainty pervades all of the ingredients that have been mentioned so far. Helpers who understand the uncertainties associated with the helping professions and their processes are in a better position to help clients deal with the uncertainties of their lives. The social sciences want to be included in the STEM group—science, technology, engineering, and mathematics. Indeed the social sciences have elements of all four. In research they use the methodologies of the “hard” sciences to the degree that this is possible. They borrow and use various technologies such as video and the Internet in helping clients. Therapists, in some sense, help clients redesign or “reengineer” their lives. And mathematics and statistics have a large role in psychological research. None of this, however, changes the nature of human behavior. The social sciences, like economics or political science, study various forms of individual and group behavior, but the kind of probability associated with human behavior differs radically from the probability associated with the “hard” sciences. Research in counseling and psychotherapy draws its conclusions but these conclusions are permeated with different kinds of uncertainties. Researchers routinely outline these uncertainties or hesitations at the end of articles. So it is often difficult to translate their conclusions into methods practitioners can use. So some wonder whether expertise in psychotherapy can be nailed down or not. Is it an elusive goal? (Tracey, Wampold, Lichtenberg, & Goodyear, 2014).

However, let us end on a more upbeat note. Duncan (2010) highlights the upside of discord and uncertainty in therapy: “As frightening as it feels, uncertainty is the place of unlimited possibilities for change. It is this indeterminacy that gives therapy its texture and infuses it with the excitement of discovery. This allows for the ‘heretofore unsaid,’ the ‘aha moments,’ and all the spontaneous ideas, connections, conclusions, plans, insights, resolves, and new identities that emerge when you put two people together in a room and call it psychotherapy” (154–155). Orlinsky and Rønnestad (2005) show that the helper’s tolerance for complexity and uncertainty is a vital factor in therapy. Perhaps “tolerance” is the wrong word. Therapists and, at least eventually, clients need to befriend and embrace uncertainty, distill it, learn from it. The world of human behavior is full of uncertainties.