The Merrill Counseling Series

2ND EDITION

40 TECHNIQUES EVERY COUNSELOR SHOULD KNOW

BRADLEY T. ERFORD

Second Edition

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This effort is dedicated to
The One: the Giver of energy, passion, and understanding;
Who makes life worth living and endeavors worth pursuing and accomplishing;
the Teacher of love and forgiveness.

INTRODUCTION

To some, a text specifically featuring counseling techniques is anathema, an abomination even. From their perspective, counseling is a process and an art. It should be a relationship built between client and professional counselor that is undergirded by the core conditions of genuineness, empathy, and respect as espoused by Carl Rogers; best conducted using effective communication skills, such as those delineated by Ivey and Ivey's Microskills approach; and facilitated using theoretical counseling processes, such as those championed by Glasser, Ellis, Adler, or Perls. I agree! Counselor education programs all over the world do an excellent job preparing counselors to do all of the above to a high degree of skill.

But what led to the composition of this text was the pragmatic realization that even professional counselors who are highly skilled communicators, grounded in a rich theoretical approach, and truly living the core facilitative conditions sometimes have difficulty moving the client toward the agreed-to objectives of the counseling experience. Counselors-in-training experience these difficulties very frequently and often desire specific, direct guidance on what to do in these situations to create movement. Specialized techniques, arising from important counseling theories, can provide this movement when they are judiciously applied.

This specific training need is the true motivation behind this text. While the techniques are presented one at a time in a deconstructed manner, each has a theoretical genesis and a rich, extant literature base that informs professional counselors about its appropriate and effective use. The techniques presented are clustered within the theoretical domain with which it is most closely associated (see Table I.1). I believe that all techniques are

TABLE I.1 The Techniques Described in This Text, Categorized by Primary Theoretical Approach

Theoretical Approach	Techniques
Section 1: Solution-focused brief counseling	Scaling; exceptions; problem-free talk; miracle question; flagging the minefield
Section 2: Adlerian or psychodynamic	I-messages; acting as if; spitting in the soup; mutual storytelling; paradoxical intention
Section 3: Gestalt and psychodrama	Empty chair; body movement and exaggeration; role reversal
Section 4: Mindfulness	Visual/guided imagery; deep breathing; progressive muscle relaxation training (PMRT)
Section 5: Humanistic-phenomenological	Self-disclosure; confrontation; motivational interviewing; strength bombardment
Section 6: Cognitive-behavioral	Self-talk; reframing; thought stopping; cognitive restructuring; rational-emotive behavior therapy (REBT); bibliotherapy; journaling; systematic desensitization; stress inoculation training
Section 7: Social learning	Modeling; behavioral rehearsal; role play
Section 8: Behavioral approaches using positive reinforcement	Premack principle; behavior chart; token economy; behavioral contract
Section 9: Behavioral approaches using punishment	Extinction; time out; response cost; overcorrection

integrative in nature and will eventually be categorized as such because the future of counseling will entail becoming more integrative. But for the time being, various theoretical camps claim certain procedures and techniques within their domains, and Table I.1 was constructed to demonstrate this artificial partitioning.

Each technique in this text will be presented in a standardized manner. First, the origins of the technique will be presented. Some have a rich history steeped in a single theoretical orientation. Others are more integrated or claimed by several theoretical approaches. Next, each chapter covers the basic steps or procedures for implementing each technique, followed by common variations of these procedures documented in the literature. To demonstrate real-life applications of how each technique can be used in counseling, case examples are presented. Most of the case examples include actual transcripts from an actual session. Yes, the transcripts were edited for brevity and clarity, and to remove those distracting affectations clients and professional counselors present in real life (e.g., um's, ah's, divergent thoughts, digressions)! Finally, each technique is evaluated for usefulness and effectiveness using sources from the extant literature. The literature provides a rich source of ideas regarding what each technique has been, or could be, used to address, and how effective it was in addressing those issues. This information allows the reader to make empirically based decisions to benefit clients and maximize client outcomes.

Each of the techniques in this text has been selected because of its usefulness and effectiveness in creating client movement toward agreed-upon objectives. Of course, writing a measurable behavioral objective is an important issue in itself and will be addressed here at the outset, in this Introduction.

COUNSELING OBJECTIVES

Erford (2010, 2015) provided an easy to implement, nuts-and-bolts procedure for writing measurable objectives using the ABCD model: (A) audience, (B) behavior, (C) conditions, and (D) description of the expected performance criterion. In individual counseling, audience (A) refers to the individual client. In other types of counseling, the audience could be a couple, family, group, or some other system or configuration. Behavior (B) usually refers to the changes that the client and counselor will observe as a result of the intervention, that is, the actual behaviors, thoughts, or feelings that one will observe to be altered. Conditions (C) refer to the specific contextual applications or actions that will occur. In counseling sessions, this usually refers to the intervention that will be implemented and the context or circumstances surrounding its implementation. The description of the expected performance criterion (D) is usually the quantitative portion of the objective: how much the behavior will increase or decrease.

Counseling goals are differentiated from counseling objectives by the degree of specificity and measurability. A counseling goal is broad and not amenable to direct measurement. A counseling objective, on the other hand, is both specific and measurable. A reasonable goal of counseling may be "to increase a client's ability to manage stress and anxiety." Notice how the wording of a goal is nebulous and not amenable to measurement as stated. In developing a counseling objective related to this goal, particular emphasis is given to specific actions that are measurable. For example, a possible objective stemming from this goal could be, "After learning thought stopping procedures, the client will experience a 50% reduction in episodes of obsessive thinking over a one-week period." Another possible objective might be, "After learning deep breathing procedures, the client will practice deep breathing for at least five minutes, three times a day, every day of the week." A third example might be, "After implementing time out with contingency delay procedures, the client's display of noncompliant behaviors will decrease from the current average of 25 episodes per week to no more than 5 episodes per week." Notice how the objectives designate the audience, the stated behavior, how the behavior will be addressed, and the level of expected performance (Erford, 2010, 2015).

Establishing counseling objectives early in a counseling relationship is important for at least five reasons. First, classic studies indicated, and there is an emerging consensus in the research literature, that about half of the progress in counseling occurs within the first eight sessions (Budman & Gurman, 1988; Howard, Kopta, Krause, & Orlinsky, 1986), and one of the best indicators of counseling outcome is whether the counselor and client were able to come to a quick agreement on counseling goals (Tracey, 1986), ordinarily defined as occurring during the first two sessions.

As one can easily see, establishing counseling objectives early in the counseling relationship is vital to successful client outcomes. This doesn't mean that clients will always immediately know or understand the true nature of the problems that bring them to counseling. But it does mean that those clients who can immediately establish counseling objectives are more likely to experience successful outcomes. By extension, it also means that professional counselors skilled at getting clients to develop counseling objectives quickly will be more successful in helping clients reach desired outcomes. It also does not assume that the "real problem" will be identified early in counseling. Many times, making progress toward obvious, surface-level problems will facilitate the client–counselor trust needed to tackle those deeper psychological issues that the client is less likely to reveal early in a counseling relationship.

Second, counseling objectives provide a concrete, operationalized target of where the counseling process is headed and how both the client and professional counselor will know that progress is being made. As such, objectives allow periodic updates of progress and concrete displays of whether the counseling interventions are having the desired outcomes. In program evaluation, we refer to this as formative evaluation because periodic checks reveal whether the professional counselor should stay the course and continue the current counseling approach or modify his or her approach to improve client outcomes.

Third, objectives present targets that initiate movement. Targets are essential in counseling because they motivate clients and thus create movement. Indeed, at its core, counseling is all about motivating clients to move in the direction of counseling goals and objectives in a way that empowers clients to be able to continue making progress toward life goals independently after counseling has ended.

Fourth, a well-crafted objective allows the professional counselor to glean effective approaches, interventions, and techniques from the extant counseling literature shown to be useful in helping the client. Counseling has a rich outcomes research literature, and this literature informs professional counselors of best practices for resolving client issues. Each chapter, each technique featured in this text, includes a section entitled "Usefulness and Evaluation of [the Technique]." This chapter section features outcome research from the counseling literature to guide professional counselors in the effective application of each technique, including the issues each technique has been demonstrated to address and its effectiveness in doing so. Such information informs professional counselors of the appropriate use of each counseling technique.

Finally, a measurable objective lets the client and professional counselor know when counseling has been successful, when new objectives can be crafted and pursued, or when counseling can be terminated. Objectives serve as the target for success in counseling. It is important to note that each of these five purposes for objectives serve to motivate both the client and counselor and to energize the counseling process. Having gained an understanding of the purpose of this text and having discussed the development and effective use of counseling objectives, readers are now ready to consider important multicultural applications.

MULTICULTURAL COUNSELING AND TECHNIQUES

It has been said that all counseling is multicultural counseling. Each client comes to a session with a unique worldview shaped by various cultural experiences, such as through race, ethnicity, gender, sexual orientation, socioeconomic status, age, and spirituality, among others. Such client worldviews will affect a client's receptiveness to certain theoretical approaches and the resulting techniques or interventions. Multiculturally competent counselors recognize that theories are used in counseling in order to answer *why* questions, for example: Why is the client seeking counseling? Why is the difficulty occurring? Why now? Interrelated with this realization, multiculturally competent counselors realize that, while the experience of a human being may have some finite limitations, the perceptions and interpretations of these experiences is infinite. Explained another way (Orr, 2014, p. 487), "There is a specific range of emotions that humans are capable of expressing; however, the meaning that is assigned to those emotions is dynamic and based on the ever-evolving variables of culture and context." Orr proposed that counselors must constantly strive to adapt counseling theory to meet the diverse client needs stemming from this dynamic interplay, all the while realizing that, where culture

is involved, within-group differences are almost always larger than between-group differences. Adapting theories to the individual client context allows counselors to frame client problems in unique ways, creating new challenges—and opportunities—for the application of techniques to problem resolution. In this way, counselors can choose to stay grounded in a primary theoretical orientation while simultaneously integrating techniques into the approach that helps to create movement for clients of diverse backgrounds.

So how does a multiculturally competent counselor adapt a theory to fit the unique worldview of a client? While the detailed answer to this question is rooted in the context of each client's dynamic situation, four general guidelines were offered by Orr (2014):

1. ***Illuminate assumptions:*** All theories are predicated on certain assumptions about mental health and worldview. Before using your chosen theory with any client, you need to familiarize yourself with the associated underlying assumptions.
2. ***Identify limitations:*** All theories do not fit all people, so explore the limitations of your chosen theory even before you begin working with clients. Pinpoint the gaps or gray areas in your theoretical orientation and strategize ways to compensate for them.
3. ***Simplify concepts:*** Theories are notorious contributors to jargon. Quite often various theories use multiple terms to refer to similar phenomena. Consider the concept of the therapeutic alliance as first described by Freud. Subsequent theorists have used any number of terms, such as partnering, rapport building, and so on, to describe the same process. Develop a layperson's explanation for your chosen theory that contains easily recognizable concepts in place of jargon.
4. ***Diversify interventions:*** Many theories are accompanied by a particular set of interventions. These interventions may be primary to the theory, but they are by no means the only way to apply that theory. Consider the commonly recognized empty chair technique, which involves clients imagining and role-playing a conversation with someone with whom they are in conflict as if that person were actually present. This technique is typically attributed to psychodrama and Gestalt theory, but it can be adapted for use with a wide range of theoretical orientations. This technique can be especially useful with clients who have a more collectivist worldview, regardless of counselors' primary theoretical orientation. In those situations, the empty chair can be occupied by imagined family or community members, elders, or other supporters who might be needed to endorse the particular treatment.

Now it is time to begin a whirlwind tour of *40 Techniques Every Counselor Should Know*! Enjoy!

NEW TO THIS EDITION

A number of features have been added to this second edition:

- A new section on mindfulness-based procedures was added to recognize the importance of this emerging approach to counseling.
- A new section on the humanistic-phenomenological approach to counseling was added to recognize the importance of person-centered and microskills techniques, as well as cross-cultural applications.
- A new chapter on journaling was added to the cognitive-behavioral section to recognize the contribution of this technique to bolster work between counseling sessions and focus on counseling objectives.
- A new chapter was added on Miller and Rollnick's (2002) motivational interviewing to address important motivational issues in counseling.
- New chapters were added on self-disclosure, empathic confrontation, and strength bombardment.
- A number of transcripts have been added, edited, or expanded to exemplify each chapter technique better.
- Sources were updated and added so that the second edition contains more than 20% of the references from 2010 or later and more than 57% from 2000 or later—yet it maintains the classic sources.

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He is the editor of numerous texts including: *Orientation to the Counseling Profession* (Pearson Merrill, 2010, 2014), *Crisis Intervention and Prevention* (Pearson Merrill, 2010, 2014), *Group Work in the Schools* (Pearson Merrill, 2010), *Group Work: Process and Applications* (Pearson Merrill, 2011), *Transforming the School Counseling Profession* (first, second, third, and fourth editions; Merrill/Prentice-Hall, 2003, 2007, 2011, and 2015), *Professional School Counseling: A Handbook of Principles, Programs, and Practices* (first, second, and third editions, Pro-Ed, 2004, 2010, 2016), *Crisis Assessment, Intervention, and Prevention* (first and second editions, Pearson Merrill, 2010, 2014), and *The Counselor's Guide to Clinical, Personality, and Behavioral Assessment* (Cengage, 2006); and author/co-author of six more books: *Assessment for Counselors* (first and second editions, Cengage, 2007, 2012), *Research and Evaluation in Counseling* (first and second editions, Cengage, 2008, 2014), *Mastering the NCE and CPCE* (Pearson Merrill, 2011, 2015), *40 Techniques Every Counselor Should Know* (Merrill/Prentice-Hall, 2010, 2015), *Educational Applications of the WISC-IV* (Western Psychological Services, 2006), and *Group Activities: Firing Up for Performance* (Pearson Merrill, 2007). He is also the General Editor of *The American Counseling Association Encyclopedia of Counseling* (ACA, 2009).

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BRIEF CONTENTS

CONTENTS

SECTION 1

Techniques Based on Solution-Focused Brief Counseling Approaches

Solution-focused brief counseling approaches have become increasingly popular since the 1980s due to managed care and other accountability initiatives, which place a premium on cost and time effectiveness. Solution-focused brief counseling approaches go by many names, but currently the most prominent orientation in counseling circles is called solution-focused brief counseling (SFBC). SFBC is a social constructivist model built on the observation that clients derive personal meaning from the events of their lives as explained through personal narratives. SFBC counselors value a therapeutic alliance that stresses empathy, collaboration, curiosity, and respectful understanding, but not expertness. Many pioneering authors and classic studies have made contributions to our understanding of the SFBC approach. de Shazer (1988, 1991) and O'Hanlon and Weiner-Davis (2004) are often credited as scholarly and theoretical forces behind the prominence of SFBC, which deemphasizes the traditional therapeutic focus on a client's problems and instead focuses on what works for the client (i.e., successes and solutions) and exceptions in the client's life during which the problems are not occurring. Berg and Miller (1992, p. 17) summed up the SFBC approach succinctly by proposing three basic rules on which SFBC counselors operate: (1) "If it ain't broke, don't fix it;" (2) "Once you know what works, do more of it;" and (3) "If it doesn't work, don't do it again." It is easy to see the basic appeal of this commonsense approach to counseling.

Walter and Peller (1992) proposed five underlying assumptions of SFBC that expand on these three basic rules: (1) Concentrating on successes leads to constructive change; (2) clients can realize that for every problem that exists, exceptions can be found during which the problem does not exist, effectively giving clients the solutions to their problems; (3) small, positive changes lead to bigger, positive changes; (4) all clients can solve their own problems by exposing, detailing, and replicating successes during exceptions; and (5) goals need to be stated in positive, measurable, active terms. Murphy (2008) and Sklare (2005) successfully applied SFBC to children and adolescents using the rules and assumptions above to focus on changing client actions rather than developing insights. Sklare concluded that insights do not lead to solutions; successful actions lead to solutions.

The five techniques covered in this section include scaling, exceptions, problem-free talk, miracle question, and flagging the minefield. Each is not exclusive to SFBC; indeed, all can be used in an integrative counseling approach (see Erford, 2014a). Scaling is a commonly used technique when counseling individuals of nearly any age and from any theoretical perspective. Basically, scaling presents clients with a 10-point (or 100-point) continuum

and asks them to rate where they currently are with regard to, for example, sadness (1) or happiness (10), calm (1) or extreme anger (10), hate (1) or love (10), totally unmotivated (1) or totally motivated (10). Scaling is helpful in gauging a client's current status on a wide range of issues. It is even more helpful when it is reused periodically to gauge the progress of a client. Scaling is a very quick and helpful assessment technique with wide applicability in counseling.

Exceptions are essential to the SFBC approach because exceptions provide the solutions to the client's "problems." Counselors probe and question the client's background for times when the problem wasn't a problem, determining exceptions and providing the client with alternative solutions to act on. Problem-free talk is the technique that allows the counselor to turn the counseling intervention from a problem-focused environment to a solution-focused environment. SFBC counselors hold the core belief that when clients focus on problems, they become discouraged and disempowered, and any insight they might gain into the origin and sustenance of the problem is not therapeutically valuable. A complementary belief is that finding exceptions and solutions to problematic circumstances encourages and empowers clients, leading to actions and successes. The miracle question helps to reconstruct the way a client perceives a problematic circumstance into a vision for success that motivates the client to pursue the actions that will lead to successes.

The final technique is a treatment adherence technique called flagging the minefield. Treatment adherence is critical in any field in which clients or patients seek and receive help. Many, even most, clients receive the help they seek but then do not follow the treatment regimen, for whatever reason, basically guaranteeing the treatment will not be effective over the long term. For example, a patient may go to a doctor to address a medical condition but then not follow the doctor's advice. If medication is prescribed, the patient may not have the prescription filled or may not take the medication according to the doctor's directions. Flagging the minefield is a technique ordinarily implemented during termination that facilitates clients' thinking about situations during which the positive outcomes and strategies learned during counseling may not work, and gets clients thinking ahead of time about what should be done in those circumstances to persevere and succeed. Treatment adherence is a critical issue in counseling; what good is all that hard work and effort to alter problematic thoughts, feelings, and behaviors if the client will return to problematic functioning shortly after counseling is terminated?

MULTICULTURAL IMPLICATIONS OF SOLUTION-FOCUSED BRIEF COUNSELING APPROACHES

SFBC is a culturally respectful approach to working with clients of diverse backgrounds because it discourages diagnoses, focuses on the client's personal frame of reference, and encourages clients to integrate and increase actions that have already been shown to be a successful fit for that personal frame of reference. The SFBC approach proposes that the client is the leading expert on what works for the client, and the counselor's role is to help the client recognize what already works for the client. The counselor then encourages the client to alter his or her actions and cheerleads the client's successes. SFBC approaches are particularly appreciated by clients who prefer action-oriented, directive interventions and concrete goals, for example, most men, Arab Americans, Asian Americans, and Latinos and Latinas (Hays & Erford, 2014). Meyer and Cottone (2013) also indicated that Native Americans respond well to solution-focused approaches and scaling questions. SFBC is one of the more effective cross-cultural approaches because it empowers clients' personal values, beliefs, and behaviors and does not try to dispute or alter these values, beliefs, and behaviors (Orr, 2014).

CHAPTER 1

Scaling

ORIGINS OF THE SCALING TECHNIQUE

Scaling is a technique that helps both counselors and clients make complex problems seem more concrete and tangible (Murphy, 2008). Scaling originated within behavioral approaches to counseling, and today is largely used in solution-focused brief counseling, which was started by de Shazer and arose out of Strategic Family Therapy (Lethem, 2002).

Because client thoughts, feelings, and behaviors are not always realistic or concrete, scaling questions provide a way to move from these more abstract concepts toward an achievable goal (Sklare, 2005). For instance, the counselor can say, "On a scale of 1 to 10, where 1 represents the worst that things could be and 10 represents the best that things could be, where are you today?" Scaling questions can also help clients to set tasks that will allow them to move to the next rank-order number. In this way, scaling can help measure client progress over time. Scaling techniques give clients a sense of control and responsibility over their counseling because scaling techniques help the clients specify goals for change as well as measure their progress toward accomplishing those goals.

HOW TO IMPLEMENT THE SCALING TECHNIQUE

Scaling questions usually involve asking the client to give a number between 1 and 10 that indicates where the client is at some specified point (Murphy, 2008). The counselor usually designates 10 as the more positive end of the scale (thus higher numbers equal a more positive outcome or experience). Scaling can be used to identify goals or to help the client progress toward an already established goal. Clients can identify goals by identifying specific behavioral indicators that signify they have reached a 10 on the scale.

Once a goal has been established, scaling techniques can be used to help the client move toward reaching the goal. After the client has identified where he is on the scale (with 10 meaning that he has reached the goal), the counselor can ask questions to discover what small steps the client could take to reach the next rank-order number (Corcoran, 1999). Questions include: What would you take as an indication that you have moved to a number 6? What would you be doing then? (Lethem, 2002). Scaling also provides an opportunity for counselors to compliment clients' progress by using questions such as, "How did you get from a 1 to a 5?"

VARIATIONS OF THE SCALING TECHNIQUE

Instead of using a scale of 1 to 10 for small children, scaling can be shown pictorially (Lethem, 2002). For instance, professional counselors can use a range of facial expressions, from frowning to smiling, or numbered steps leading to the desired change. When using scaling in a group, it is important to ask each person for a rating. Differences should be explored to discover the reasons behind the differences. In addition, relationship scaling questions can be used to help clients identify the perspectives of other people in their lives (Corcoran, 1999). Clients can be asked, "How do you think your parents (or teachers) would rank you?" These answers can then be compared to the client's self-rating,

which often forces clients to realize what actions they need to take in order to show others the improvements they've made (Corcoran, 1997).

EXAMPLES OF THE SCALING TECHNIQUE

Following are several short scenarios for which scaling would be appropriate and useful to assist both the client and professional counselor in viewing or assessing the problem in a more tangible way.

EXAMPLE 1: Scaling used to reduce catastrophic thinking

Maria (M): I'm completely panicked. Thinking about my first day of school, and not as a student, but actually as a teacher . . . me, a teacher . . . is sending me right over the edge.

Counselor (C): Right over the edge?

M: (Speaking rapidly) Right over the edge. Like, just thinking about it makes me want to throw up. I really don't think I can do it.

C: I can see how nervous you seem even now, just from talking about it.

M: I am! Thinking about it, talking about it . . . if I can't handle that, how am I going to handle it when I actually get to that moment? You know? I'm a basket case.

C: Okay. All right, I'd like you to close your eyes for a second and picture your first day of school, okay? You're in front of your class. (Pause) You're getting ready to teach a new lesson that you've never taught before. (Pause) Your new classroom is full of your new students. (Pause) They are sitting in their seats, looking at you. (Pause) Now, go ahead and feel the emotions that come up. Don't try to prevent them or hold them back. (Speaking very slowly) Feel the anxiety, and the fear, and the dread. Feel any emotion that may come up. Okay, now can you describe to me how you're feeling?

M: Um, I have this nauseous feeling in my stomach. Um, my palms are kind of sticky or sweaty or something. Um, I'm kind of concerned about the students and what they're thinking and making sure that, um, you know, they're gonna like my lesson. There's a lot of thoughts going through my head about what's gonna happen in the next few minutes or whenever I get started. I'm just really anxious . . . my feelings and thoughts.

C: Okay, on a scale from 1 to 10, with 10 being really, really extremely anxious—like you probably wouldn't even be able to stand up there—and 1 being very confident and comfortable, where do you think you'd be on that scale?

M: Um . . . I guess maybe like a 6.

C: Okay, so that doesn't sound quite so terrible. You could probably get through the lesson at a 6, yeah?

M: Yeah, I guess I could. It wouldn't be the most comfortable or enjoyable experience, but you're right, I could definitely get through it. It just feels so much worse sometimes though . . . like the dreading it is the worst part maybe.

C: Uh-huh. That could be true.

M: I just feel like something will go terribly wrong, and I get myself so worked up.

C: All right, then. Let's try this. Tell me, and I bet you've already thought about it, tell me what the worst thing is that could realistically happen on that first day of you being the teacher.

M: Hmm. (Laughs slightly) I have actually thought about it. . . . Sometimes I visualize that the students, just a few at first, lose interest in the lesson. More and more they become disinterested and a few of them begin talking to one another. Then more students begin to follow their lead, and they begin to giggle and talk louder so that it is very obvious they are not paying attention to me. Pretty soon, the entire class is chaotic and doing what they please and not one student is attending to the lesson.

C: Okay, so you have thought about that! On a scale of 1 to 10 again, with a 10 being a catastrophic, career-ending, mortifying event that you absolutely could not get through, and a 1 being no big deal at all, where would this scenario that you've visualized fall?

M: A 5.

C: Now, not to say that your anxiety is not justified, but to help you view it more objectively, let's scale it against another event. Okay, so thinking about the worst thing that could ever happen to you in life in general . . . the very worst thing in life . . . someone you love being murdered, your child being kidnapped, something that horrific . . . with that in mind, now rescale the visualized classroom event. With 10 being catastrophic and 1 being no big deal, where would you place the classroom event?

M: Like a 1 or 2. In the big scheme of things, it's not a big deal at all. It would be a little embarrassing if the other teachers saw I couldn't handle my own class, but other than that, really not that big a deal after all.

C: Okay. And if the worst-case scenario of that day is actually only a 1 or 2, then how will that change where your anxiety level would be on that scale of 1 to 10?

M: Way lower. Way, way lower. Really nothing beyond a few first day jitters.

EXAMPLE 2: Scaling used to assess motivation for change

Counselor (C): So Amy, so far Mollie has been sort of reporting on her progress and how she's doing in moving toward her goals . . . which is a necessary condition to her living with you . . . that she make movement toward her goals and keep her life, you know, going in a positive direction.

Amy (A): Yes, she is making some progress.

C: Okay. You know, to really make sure and to monitor your sister's progress, let's set up some kind of monitoring system to help you make sure that she's following through—that she wants to, so that your confidence will increase as well as your seeing her meet these goals.

A: Okay.

C: So thinking about your perception of Mollie's motivation to change and follow through with her goals, currently, in comparison to when you two first came in to see me, on a scale from 0 to 100, with 100 being extremely confident that Mollie is moving in a positive direction and definitely going to follow though with and accomplish her goals, and 0 meaning you have no confidence at all and see no real progress being made, or even any effort on her part—where do you think you lie on that scale?

A: Um . . . (Thinking). I would say probably about a 65.

C: Sixty-five?

A: Yeah.

C: Okay, well that's 35%, you know, 35 points to go before we get to 100. That's not bad at all! What is it that makes her progress a 65? Tell me a little bit about that 65.

A: Um, well, the reason I'm not higher than 65 is that she hasn't started saving any money for the courses that are starting really soon and I don't know that she's going to have much financial help so that kind of worries me. But at the same time, um, this past weekend she was studying for her GED. So I think she's serious about that. She's registered for her classes at this college so that's why it's a little bit higher, but the money thing kind of worries me.

C: Okay, so the 65 comes from the studying for the GED and the registering for classes. But the other 35 points comes from the lack of money or effort toward saving?

A: Yes. And I think that sounds fair (looking over at Mollie).

C: Mollie, what do you think about this 65? Is this where you would place your progress and motivation?

Mollie (M): Well, when you were first asking Amy that question, I was thinking around 80 or 85 even. But then listening to her explain how she came up with that number . . . well, I guess a 65 makes sense. (Thinking) I don't know, maybe a little higher than a 65 just

because I know my motivation for change is high, but I can't expect anybody else to know that because it's inside of me.

C: Yes. Everyone else can gauge your motivation only by looking at your actions.

EXAMPLE 3: Scaling in personal relationships

Counselor (C): Well, what I believe I'm hearing from both of you is that you "can't" talk to the other. Kevin, you said that Tamara "can't have a conversation without picking a fight" and, Tamara, you said that Kevin "ignores me and says almost nothing" when you try to talk to him. (Pauses) But you both feel that you are the better communicator in the relationship?

Kevin (K): Yes.

Tamara (T): I at least try. He doesn't even bother. And I don't see how we are going to get through some of our issues if we can't even communicate with each other about them.

C: I agree that communication is going to be very important to working through these other dilemmas and feelings. So perhaps we should focus some of our attention on improving communication. Kevin, what are your thoughts on this?

K: We've never been really good at talking things through. But everything just seemed to work itself out anyway—until now. So I'd love for you to help Tamara have a conversation without making it into something more.

C: Well, what I'd like to do is help you both improve *yourselves* and the way *you* communicate. Okay. Here is a sheet of paper for each of you. On the bottom half of the paper, I'd like you to give yourself a score from 1 to 10 based on how well you think you communicate, with 1 being a terrible communicator and 10 being a great communicator. (Both Kevin and Tamara were able to do this very quickly with little thought.) Now, on the other half of the paper, on the top half, I want you to each think for a moment about the way your partner communicates with you. After this, we will change the focus to yourselves, but for this last moment, you get to focus on your spouse and his or her shortcomings. All right, so for now, thinking about how your spouse communicates with you, I want you to give him or her a score from 1 to 10, with 1 being the worst communicator ever . . . everything he or she does leads to problems and miscommunications rather than effective communication. Now a 10 would indicate that you find your spouse to be a very effective communicator and find that the end result of a conversation is satisfying and the reason it was begun was accomplished. (Gives them both a few moments to write down a number) Okay, I would like to hear what each of you has.

T: I'll go first. Do you want to know what we put for ourselves or just for the other person?

C: Um, however you want to do it is fine.

T: Okay. Well, I gave myself an 8 because there are probably one or two minor things I could do a little better, but for the most part, I am an effective communicator, just based on what I do.

C: Uh-huh.

T: Okay, and so I gave Kevin a 4. . . .

K: (Interrupting) A 4?!

T: Yes, a 4, because if he's involved, it's just bound to go badly.

C: And what about you, Kevin, what did you write down?

K: Well, I gave myself a 9 because I'm not the problem here. And I gave Tamara a 6.

C: The great news is neither of you scored the other as a 1, so you both agree that the other does some things right with regard to communication. Okay. I want to ask you both if you would now be willing to completely scratch out the score you gave for yourself.

T: Why?

C: Well, if we assumed, Tamara, that you really were an 8 on a scale of 1 to 10, and you, Kevin,

really were a 9, we wouldn't have a lot to work on. You would both be nearly perfect communicators. Instead, I'd like to help you both to let go of your self-perceived communication skills and focus on how your partner perceives you. If we are going to improve, we have to really consider how our partner sees us. Tamara, the way Kevin perceives you is as important as the way you perceive him. And the same is true for you, Kevin. And as long as we feel we are near-perfect at this, we won't improve. So, if you're willing, I'd like for you to each scribble over the number you gave yourself and trade papers, and now let's operate from the assumption that you, Tamara, are a 6, and you, Kevin, are a 4.

T: I'll change his to a 5.

C: Okay, Kevin, you are a 5.

K: Can I change hers to a 5 so we're the same?

T: No! (Laughing somewhat)

K: (Laughs)

C: Now, with your new numbers, I'd like you to both consider what's keeping you from being a 10.

K: (After some thought) Well, I can be pretty defensive sometimes when she tries to talk to me, and I'm bad about tuning her out.

C: That's certainly a good start. Tamara? What about your new score? What do you suppose keeps it from being a 10?

T: Well, I suppose I don't always pick the best time to start a discussion and, um, I tend to dominate the conversation and get angry.

EXAMPLE 4: Scaling to recognize old baggage and personal reactions

D'Shawna (D): I just get so angry. I really lose my cool and I don't even know why I get that mad. She just makes me so . . . I could just . . . scream . . . well, I do, I mean, I do scream. Not at her, of course. But as soon as I hang up the phone, I just scream as loud as I can to get it all out. Like, the other day, she called to tell me happy birthday, and it wasn't my birthday, it was my sister's. And I just kidded with her about getting older and forgetful, but then I couldn't wait to get off the phone because I was just boiling inside. And as soon as I hung up, I screamed . . . and cried. I really don't get it . . . why I let her push my buttons like that . . . over something so silly that she probably really can't even help because she really is getting older.

Counselor (C): This phone call with your mother is a good example for us to work with to maybe help you gain some insight into your reactions.

D: Okay. How?

C: Your reaction the other day, after you hung up the phone, on a scale of 1 to 100, with 1 being no reaction at all, no emotional reaction whatsoever, and 100 being this huge, overwhelming, uncontrollable emotional reaction, what would you say your reaction the other day was on this scale?

D: (Looking down and fidgeting) Um, well, let's see . . . I guess it would have been about a 90. It felt very uncontrollable and overwhelming . . . it just swallowed me up.

C: Okay. Now, realistically, what your mom said on the phone, about the birthday when it wasn't your birthday, but your sister's, on a scale of 1 to 100, with 1 being no big deal and 100 being just this terrible thing for a person to do to you, what was your mother's comment?

D: Give her comment a number, too?

C: Yes, from 1 to 100 if you can.

D: Well, because I know she didn't do it intentionally, I would say like a 15, I guess.

C: Okay, D'Shawna. We have a comment at a 15 and a reaction at a 90.

D: Yeah, yeah, we, uh, we do, don't we? How does that happen? (Smiles)

C: Let's think for a moment about what 16 through 89 represent. Usually when we get a 15 and we react with a 90, there is much more there that accounts for our reaction.

What are all those other numbers about, do you suppose? What button did your mother's comment push?

D: (Thinks for a moment while still looking down and begins to cry) I feel so bad for even saying this, and I know I should be past it by now, and I try so hard to be grateful for her *pathetic* attempts at being a mother now, but she *still* can't get it right and I just want to *scream* because every time I talk to her it's this *ridiculous* reminder that she still sucks! (Crying harder) She walked out on us when we were kids because her boyfriend was more important and he didn't like kids, so she chose him over us and we didn't for the life of us understand why she had left us or what we had done wrong, and God that was so long ago and she's apologized a hundred times, but she still is not . . . she'll *never* be the mother I need her to be. I'll *never* get over what she did to us. (Angrily) We weren't important enough for her to stay with us then and we're not important enough for her to know when our damn birthdays are now!

EXAMPLE 5: Scaling in suicide assessments with an adolescent in a school setting

Counselor (C): So, Juan, your life right now, how you feel about your life, on a scale of 1 to 10, with a 1 being satisfied and happy and a 10 being unbearable, where would you say your life falls on this continuum?

Juan (J): Like a 9 or something.

C: Okay, and the likelihood of you harming yourself, even killing yourself, as you've been considering lately, on a scale of 1 to 10, with 1 being totally no intention to hurt yourself and a 10 being definitely going to commit suicide, where would you say you are right now?

J: Probably an 8 or maybe even 9 again.

C: (Pauses for a moment) Juan, I don't know if this is true for you, but I've noticed that when I've worked with other students who feel as you do at this moment, I've noticed something very interesting. I've noticed that almost always, they don't *really* want to die necessarily . . . they just don't want to keep living at a 9. (Pauses) Might that be true for you also, Juan?

J: I never thought about it like that. I mean, (Thinking out loud) "I don't really want to die, I just don't want to keep living at a 9." (Thinking again) You know, I can see where that fits . . . but if I don't know how *not* to live at a 9, then I feel like I only have one choice.

C: Yes, yes, I can see that. So if you'd be willing, I'd like for us to work together right now to consider how we can get you from a 9 to a . . . .

J: Anything would be better than a 9.

C: Okay, then, let's work together to see how we can get you to anything better than a 9. What are some things that you need to be different in order for life to be better than a 9? They could be things related to classes, personal relationships, parents . . . whatever you can think of.

USEFULNESS AND EVALUATION OF THE SCALING TECHNIQUE

Scaling techniques tend to measure progress toward concrete goals; consequently, they lend themselves to outcomes research (Lethem, 2002). Scaling can be used in a wide variety of situations. Some examples include assessment of progress toward a solution, confidence about finding a solution, motivation, severity of a problem, the likelihood of hurting oneself or others, and self-esteem (De Jong & Miller, 1995). Scaling has also been used with youth involved with the juvenile justice system and their families (Corcoran, 1997), as well as with families involved with child welfare services (Corcoran, 1999). Juveniles from multiproblem families, low socioeconomic status (SES), or diverse backgrounds improved on their treatment goals.

The scaling technique has been embedded in a comprehensive SFBC approach and used in at least three school-based outcome studies with middle

school students. Franklin, Biever, Moore, Demons, and Scamardo (2001) indicated that 71% of middle school student behavior cases improved when using scaling as part of a solution-focused approach in a middle school setting. In a study showing no difference due to treatment, Newsome (2004) used an SFBC groupwork model with at-risk junior high school students who showed no improvement in attendance or grade point average (GPA) when pretreatment GPA was used as a covariate. Finally, Springer, Lynch, and Rubin (2000) studied the effects of a solution-focused mutual aid group for Hispanic children of incarcerated parents that embedded scaling into a more comprehensive SFBC approach. Teachers reported that the middle school student participants reduced presenting concerns to below the clinical significance criterion for both internalizing (effect size [ES] = 1.40) and externalizing (ES = .61) difficulties. At the same time, the teenage participants' self-report resulted in an ES of .86 for externalizing problems, but no differences were noted in youth self-report for internalizing problems (ES = .08).

In studies of adults, Lindforss and Magnusson (1997) reported that Swedish criminals participating in an SFBC procedure that used scaling as one component experienced less recidivism and fewer serious crimes at 12- and 16-month follow-ups. Meyer and Cottone (2013) found that use of modifications of the scaling technique can be used effectively with Native Americans. And Lee (1997) reported that a solution-focused brief family therapy approach resulted in 65% of families successfully reaching diverse goals.