Essential Motivational Skills For Therapists
How to work with unmotivated clients

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Introduction

Hi, I'm Paul Grantham, Consultant Clinical Psychologist and Director of SDS Seminars Ltd (www.skillsdevelopment.co.uk). I've put together this Learning Programme on Client Motivation For Therapists because I'm forever aware of the gap between the practitioner's needs on this topic and the wealth of little known material that provides answers to how to move forward on it.

The question of client motivation is one that frequently divides opinions amongst therapists of different modalities and approaches. Some argue that all clients are intrinsically motivated, others suggest that only motivated clients should be worked with, whilst others still have their own view as to why the client is "unable" or "not yet ready" to change.

The fact that you yourself have an interest in this question however suggests that you are curious as how you might increase the motivation of your clients and that their motivation (for whatever reason) is not ideal. Equally, you assume (quite rightly) that this is not a fixed state but one which might be alterable.

This programme is designed to provide you with ideas, strategies and techniques which you yourself can incorporate into your therapeutic work.

They are drawn from a number of sources – including:
- Motivational Interviewing (MI),
- Cognitive Behaviour Therapy (CBT),
- Solution Focused Brief Therapy (SFBT),
- Client Centred Therapy (CCT),
- and many others.
According to my calculation they represent a total of over 470 years of insightful experience in working with clients with psychological problems, from a range of different practitioners.

They are however, all research and evidence based - in other words they are not just someone's opinion - but their effectiveness has been demonstrated in published research studies.

Read, enjoy, inwardly digest and practice them!
One of the best ways to discover how to use motivational strategies with your clients is to use them with yourself first of all.

This book is about skills. It’s about the skills you need to develop in order to be able to motivate your clients more effectively.

The most effective way to develop any skill is to practise it. Actually, that’s not true. The only way to develop any skill is to practice it. Someone can give us an excellent description of how to ride a bicycle, but the only way we learn how to do it is to get on one ourselves and to start trying to use it.

The great thing about all the ideas in this programme is they are based on universal psychological principles – in other words they are as applicable to you and I as they are to the clients we work with.

That means you can start practising them on yourself immediately. Although this is unlikely to be sufficient in itself, it provides a great place to begin to develop your expertise.

As the author of this book it’s important to me personally as well. Let me share with you a worry that I have. It’s the worry that, despite finding this motivation programme interesting, you won’t actually put any of it into practice!

In fact, statistics suggest that less than only one in twenty of you will. Now I genuinely hope that you are one of the 5%, but it is a bit dispiriting to write this programme but be left wondering whether it will actually make any real difference to you.

Please prove me wrong!
So, before you read any further, please think about how, what and when you will begin to try these ideas out.

Write them down here. They will genuinely make a difference to whether this book influences your practice or not.

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Using things for yourself first also gives you a flavour of what things will be like for your clients. It will give you a sense of what their experience is like being at end of these strategies, the difficulties they experience and the benefits they get from them.

This is a good starting point for building rapport with your client and facilitating the transformation of theory into practice within your work.

Now… assuming you promise that you are committing yourself to doing this with this book, please read on and enjoy; safe in the knowledge that you’ve reassured me that my time’s not been wasted in writing this.
To motivate you have to engage and engagement often means starting with the client's own pressing agenda - not yours, your service's or even therapy's itself.

Some clients are easy to engage. You can start talking to them regarding a shared definition of the problem – especially when they have come to see you voluntarily. However, what do you do with clients who are mandated, have different priorities or are reticent to even talk to their therapist to the degree that’s necessary to engage them in any conversation and which can feel like pulling teeth!

Below are some suggestions on what to say after you say "Hello" to someone who, you know, has a propensity to simply grunt or answer all questions with "Dunno".

Firstly, identify your client's own current agenda as rapidly as possible. By "rapidly" I mean within the first few seconds of clasping eyes on them. How can we know this without even talking to them? Here are three simple options:

1. Observe what your client is DOING when you first see them and ensure this is what you first talk about. Are they playing with a mobile phone in a waiting room? Ask them which type? Are they watching "Daytime TV" when you visit them at home? Ask them where they think Jeremy Kyle gets his guests from.

2. Anticipate their "JOURNEY" to see you. This could either be their "bureaucratic journey" or physical journey. "Did you come here by tube? It's no fun at this time in the morning is it? Think of the poor folk who have to do this every day." If they've come to you from a
rural area and are reliant on public transport then you can be sure their ONLY thoughts are going to be about how long the appointment will be and how this ties in with bus timetables. Ask them about it. Their "bureaucratic journey" may mean that you are the fifth professional they are going to have to give personal details to. Acknowledge things, along with their probable annoyance.

3. Observe their "NON-VERBAL BEHAVIOUR" and ask them about that - especially if it is negative.
   "You look really fed about being here. Is that right?".
   "I don't think I've ever seen any one as bored looking as you do at the moment. Does this all seem like a waste of time to you?"

Craig sat down in front of Tina, his therapist and stared at the floor. Tina knew from his referral letter that he had been suffering from depression for nearly three months and had recently been signed off sick from work. "I guess it can't be easy coming here?" suggested Tina. "You're damn right about that," replied Craig. "It's crap!"
"I see from your referral letter that it's been just over twelve months since your mum died. That can't have been easy." Craig just shrugged.
The session continued in much the same vain until Craig left. On his departure, Tina wrote in his notes that his low mood made engagement difficult.
On his departure, Craig lit up a cigarette and thought to himself: "Why do those bastard health services make all their buildings no smoking. How do they expect you to relax and talk about things when you can't even have a smoke?"

Building on these ideas for initial engagement, it is also important to remember Motivational Interviewing's recommendation to avoid the danger of "the premature focus." This is the danger of assuming what the client's main concern is or assuming their desire or need to change. Of
course, at one level this is a product of a failure to listen, but at another
level it represents the common tendency of the therapist to impose their
own personal agenda on the client.

Identify ONE client that you work with who are difficult to engage
and use one of the three approaches above to indicate how you
would engage them
Being dissatisfied with things is essential for motivation

For anyone to change they have to be unhappy with their status quo in some way. Being unhappy with my current situation does not guarantee I will change, as I may feel unable to change or not know how to. However, without some sense of dis-ease no one has any desire to change.

Now, of course you may take this as a given. Why else would a client come to see a practitioner for help? In fact, clients come for all sorts of reasons apart from dissatisfaction. They may come under pressure from family members) or they may have been sent or even be mandated by agencies or other professionals.

Carl 45 yrs had been told by his GP that he was "grossly obese" and that he had "an eating disorder". His GP told him that the medication he was receiving for his cardiovascular problems was "a waste of time" unless he did something about his attitude to food. Carl's GP referred him to a therapist to address this. Carl resented the referral and saw no purpose to it. "I am happy the way I am. My heart problems are genetic." He said.

Additionally, clients may come dissatisfied with their current situation but not THAT dissatisfied. Indeed this is arguably the state that applies to the vast majority of clients that we see. There is some sense of dis-ease but that either it is counter balanced with the reasons for "no change" or that client doesn't know how to make the change.

In Tuesday's group therapy session the dialogue highlighted the different views of each participant. "I know living with my husband's a problem, but in honesty he's not really that bad". "I know" said another "mine's difficult but he can be so loving at times".
"I just don't know what to do," said Jane who was in tears. "I MUST leave mine. I just MUST. But every time I think about it, I just do nothing!" The therapist felt their distress. The domestic abuse group finished that day and participants returned home.
Your Client May Have a Different View of Their Dissatisfaction to You - Always Use Their View

In my experience, everyone we are likely to see as therapists is dissatisfied in some way with their status quo. It’s a myth that anyone is happy with the way things are in every single area of their life. However, it’s common for therapists to disagree with this and to talk about some clients being “unmotivated”, “happy as they are” or “not yet ready to change”. This belief is founded on a failure to recognise that clients often define their dissatisfaction in terms which are different from their therapist’s. Look at these examples below. They all highlight a client’s dissatisfaction with their status quo which is different from their therapist’s.

Charlie (47 yrs) had been referred for physical rehab following a fractured hip. He wasn’t interested in concentrating on the rehab programme he’d been given because he was so worried about how long the process would take and whether he’d still have a job.

Mary (19 yrs) had sought help because she was experiencing relationship problems with her partner. Her therapist spent a lot of time exploring her earlier relationship with her father whom she had lost contact with when he left home 10 years previously. Mary wasn’t interested in looking at this. Her therapist took her case along to supervision to talk about her problems engaging in therapy

Michael (35 yrs) had been referred as a perpetrator to domestic violence following an assault on his wife. He thought the whole process was psychobabble. As far as he was concerned, his biggest problems was getting his probation officer off his back and dealing with his nagging wife.
In all the examples above, the client is dissatisfied with their status quo but define it in ways that are different from their therapist.

What’s the solution? Therapists should ALWAYS at least start their engagement with clients by focusing on the client’s dissatisfaction. This is the case even when the therapist doesn’t see the dissatisfaction within their professional remit or when they do not agree with the client’s view of their dissatisfaction.

In a number of instances this is straight forward. The therapist simply switches focus – as long as they are willing to be client led. In other instances, the therapist needs to redefine what they are offering within the client’s existing framework. This is yet again an example of how the client’s agenda and language plays a paramount role in motivation.

Have a look at how therapists COULD approach the cases above:

Therapist: Charlie- could I just start off by asking you what you make of your hip fracture and this rehab programme you’ve been sent on?
Charlie: Well this is all very well, but what if it don’t work and I’m away from work for months on end. At my place they’re always looking for an excuse to sack people.
Therapist: So for you, it’s a real priority to get fit again as soon as possible and to get some security that you’re not going to be fired. This programme typically gets people up and running within a month and I’ll contact the social worker so she can tell you about your employment rights.

Therapist: So tell me Mary, what for you is the most important thing about dealing with your relationship problems with Mike?
Mary: I just want to understand why he never follows through anything he says
Therapist: If you did understand it, why would that be a good thing for you?
Mary: I think I could be more tolerant with him. I hate being snappy with him all the time

Therapist: Michael. How well are you managing your “nagging wife” at the moment and keeping your probation officer off your back?
Michael: What do you mean? Obviously things aren’t brilliant are they or else I wouldn’t have to be here.
Therapist: So if you got something from seeing me that both helped you to manage things better with your wife AND kept your probation officer happy, it would be worth doing?
Michael: I guess

Notice that the above examples keep open the possibility that the client’s definition of their dissatisfaction maybe be having to see you. As a result the aim of work together is to change that – in other words no longer having to do it.

It’s a myth that there are good and bad sources of motivation. The only definition of “good” in this context is a source of motivation that creates change.
Think of three clients who you work with and identify their sources of dissatisfaction along with how you would link this in with the work you are doing with them.

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Being dissatisfied comes either from wanting something I haven't got or getting away from something I don't like

So far, we’ve been assuming that client dissatisfaction with their status quo comes from the identification of something they would like to get rid of. This is often the case. However, it’s only half the story. Whenever motivation is an issue with clients it is fundamental that the practitioner understands the client's dis-ease from the perspective of both the desire for benefits (wanting something I haven't got because of their current situation) as well as the desire to avoid negative consequences (getting away from something I have that I wish I didn't have).

I’ve already suggested that there is no such thing as “good” or “bad motivation”, just motivation that “works”. It’s unfortunately often assumed however that the desire to avoid negative consequences is an inferior motivator to the desire for benefits. In practice however, one is NOT superior to the other (at least initially). Easily half of all human behaviour is motivated by the desire to avoid negative consequences and it works VERY well in many instances. It's often what gets us up in the morning (the avoidance of feeling guilty), what takes us off to work (the avoidance of not having enough money to pay the rent or mortgage) and what leads us into many of our relationships (the desire to avoid loneliness or isolation). Clients are exactly the same. However, whether its benefits or negative consequences (or a combination of both), that motivate an individual client, the practitioner needs discover which are important to the client sitting in front of them in order to proceed

How do you do this?

Firstly, you have to recognise that the client must inform you of these rather than the other way round.
Secondly, you need to ask as broad a based question as possible to capture the client's perspective on benefits and negative consequences.

Thirdly, you must listen and accept what the client has to say, and not try to "improve it" irrespective of what you think of it.

Below are some questions you might try out.

"How would you like life to be different from the way it is at the moment?"

"In what ways does the situation with [the issue] create a difficulty for you?"

"Take me through a typical day and tell me how this situation influences it?"

"What would have to happen here today, after seeing me, to make you think it was worthwhile coming?"

And what do you do with the answers? That's simple, you reflect them back!

"So, if I've understood you correctly, you want the current situation to change because…"
- you're fed up with being dissatisfied with your relationship…

- you're worried your cigarette smoking will stop you seeing your grandchildren growing up and that's really important to you…

- you want to live a life that's like everyone else's and don't want to feel a prisoner of your fears and phobias…

eetc..
What it is we selectively attend to amplifies in our perception

This is a well-established concept derived from the field of perceptual psychology and which (in various guises) has been adopted by modalities as diverse as CBT through to NLP.

As human beings we need to make sense of the world we experience in order to both make predictions within it and to ensure we don't get overwhelmed by the multitude of information that bombards us both internally and externally.

One way in which we do this is to selectively attend to what's around us. We either make our own decisions about what to selectively attend to on the basis of what we think is important or we follow the guidance of key others around us.

This is where you come in as a practitioner. Whatever modality you work with, you have an influence on how your client sees the world. One of the key ways in which you do this is through the questions you ask your client. This guides their attention. When you reflect back their answers it leads them to selectively attend to the same thing even more.

What happens when we ask clients to do this?

The brief answer is that the IMPORTANCE of the thing INCREASES in the client's perception and its EMOTIONAL SIGNIFICANCE also increases. This is quite logical. Why would we attend to anything in our world that DIDN'T have emotional significance for us.

Regarding motivation, one of the effects of this, is that the REASONS why a client says a change should occur, become more significant to the
client, as they are talked about.

Jean saw her therapist because she had gambling problems. She was buying around £60 worth of scratch cards a day. She felt stuck and demoralised. "Tell me" said her therapist, "How would you like things to be different from the way they are at the moment?"

"Well, that's obvious, isn't it" Jean replied, "I'd like not to be such a bad mother by frittering all this money away and denying my kids the fun they could be having."

"So" said her therapist, "For you, it's important to get to grips with your gambling because that way you'd feel better about yourself as a mum and would be able to give your kids more of what they deserve."

"Yeah." said Jean brightening up slightly. "My kids are really important to me and I want to do what's best for them."
You can amplify the significance of a motivational reason by asking the client why it is so significant!

Motivational reasons can seem like mere temporary sparks. Here now, gone a second later. However, one very useful way of "fanning" them so that they become more robust and grow into steady flames is to ask your client what their significance is. This often reveals much more powerful motives and helps the client to attend even further to the reasons given, ensuring their motivational power increases further.

The technique used for doing this is very simple. When a client identifies a benefit, you ask "Why is that a good thing for you?" and - when they identify a negative consequence - you ask "Why is that a bad thing for you?"

These questions can then be pushed two or three times before reflecting back the answers to clients in a summary format.

Derek was despondent about his drinking. It had been getting out of control for over a year now.

"What would have to happen here today, to make you think it was worthwhile coming?" asked his therapist.

"Well. You could stop me drinking! " replied Derek.

"And why would that be a good thing for you?" asked his therapist.

"Well. I wouldn't lose my job for a start", he replied.

"And why for you, would losing your job be a bad thing. I ask because people often have different thoughts on this don't they?"
"Well, I'd lose my house, and I want my son to grow up in at least a reasonable neighbourhood."

"And him growing up in such a neighbourhood is a good thing because?"

"Because I want him to have the best start in life, obviously."

"So, as far as I understand it", said the therapist, "You want to get to grips with your drinking because you don't want to lose your job and house as that would prevent your son getting the best start in life, which is what you want to give him. Is that right?"

"Damn right, it is!" Derek asserted.
Clients not only need reasons to be motivated to change. They need to hear those reasons from their own mouth - not ours!

One of the key lessons that Motivational Interviewing has taught practitioners over the last 20 years is that clients are more likely to be persuaded by and act on "motivational statements" that come out of their mouths, rather than the "motivational statements" that practitioners make.

In some contexts this is easy - especially when the options are not clear cut. However, it is often more difficult to do when the direction to go seems self-evident to the therapist.

Jessie swung into the therapist's room and plopped herself down on his chair.

"I dunno why you're seeing me!" she said, "It's them other kids you should be talking to. What do you expect me to do, if one of them kicks my shoe when they run past me? They need to learn not to be so disrespectful and clumsy."

The therapist was about to ask whether thumping a 13 yr old in the face in response, showed respect. However, he just about managed to bite his tongue.

For client centred non-directive therapists, however, this hardly seems news! Practitioners should never provide the client with reasons for doing something.

This does not mean that therapists should never be, or COULD ever be, non-directive. We influence whether we like it or not. For that reason, surely it would be better to influence in the direction of what helps the
client to make a change.

Hence we have a role in facilitating the client's expression of motivational statements through the way we ask our questions. And it is through the client's own words that they become motivated to act. If we facilitate the client to talk about their repeated failures or the impossibility or even unimportance of making a change, the process of selective attention will ensure the client remains "unmotivated" or "stuck".

To put it simply, our clients, like ourselves, are more likely to believe something and take action on it if they are allowed to convince themselves.

This doesn't just apply to the motivational reasons that already influence the client but also to additional reasons they may not have considered to date.

This has been powerfully illustrated in a research paper published in 2012 by Pablo Brinol and colleagues, from the University of Madrid who continues his extensive research at Ohio State University.

Together they outline how smokers who are asked to deliver a non-smoking message to others are more likely to give up smoking compared to those who hear a non-smoking message delivered to them by another. The same principle applies to internal states as well - such as self-confidence etc.

If our clients are asked to make an argument for why they are capable to doing something (even if they do not believe it) they are more likely to find it convincing and behave consistently with it.

From a personal point of view, I have found this technique useful not only
with a range of addictive behaviours and confidence issues but also with problems as wide ranging as OCD and depression.

If clients have difficulties, asking them to "give voice" from a third party perspective is often helpful. For instance, "If your mum was here today, what would she say were the reasons as to why you're going to get to grips with this problem?"

**Does this mean that information giving has no role in motivation? No! But how and what you give determines whether you motivate or demotivate your client**

Information giving often increases motivation. For example:

- Victims of domestic violence often become more motivated to leave abusing partners when they discover details of a secure refuge.

- Those with serious mental health problems can become motivated to change when they hear of the successes of others who share their problems.

- Anxious clients often become motivated to engage in a therapeutic programme when they hear that the dizziness (they fear) is made worse by deep breathing and that an alternative breathing method will reduce dizziness.

The examples are endless…

However, we also know that many clients become MORE resistant when given information rather than less. The classic example is the cigarette smoker who smokes more when his doctor tells him that his emphysema
is made worse by the amount he's smoking.

Now, it may be, that as you read this, you might be wary of the idea of motivation through information giving. However, there are lots of circumstances where we know that there are things which are either helpful or unhelpful for our clients to do and where we express this fact to clients - if not verbally then non-verbally.

Don't believe me? Have a look at some of the Gloria videos on YouTube and see how Carl Rogers himself non-verbally directs his client!

One major contribution made by Motivational Interviewing (MI) is to recognise that THE WAY information is communicated is as, if not more, important as the information itself. This is done through the concept of "Prefacing" within MI.

Prefacing is where information giving by the therapist is couched by them in a tone of "doubt". When such information is presented in this way we now know that the client is more likely to act on it rather than reject it.

So how do you "preface"?

There are a number of ways you can approach this. You could say: "You don't have to listen to what I'm about to say but...." OR "I don't know if this is for you, but a lot of folk in your position have found that..." OR "It's often been suggested that many people, in situations like yours find X makes things worse. What do you make of that?" This communication style emphasises the client's self-determination and reduces resistance to the message as a result.

Or you could be really radical and start off your interaction with your client by directly asking them what information they would find useful to know.
Using DARN-C to facilitate the client towards change

How the therapist facilitates what comes out of the client’s mouth regarding change is not just a principle of ethical practice, it also applies more broadly and has a strong research basis too.

Interestingly, we now know from MI research that the way the client talks increases motivation too. There is a strong relationship between a client’s "change talk" and how likely they are to make a change.

So what does "change talk" consist of and how can you, as a therapist, use it to increase their client motivation?

Both the type and hierarchy of "change talk" has been categorised within MI by the mnemonic "DARN-C".

**DARN-C stands for talk that reflects:**

- **Desire,**
- **Ability,**
- **Reason,**
- **Need,** and
- **Commitment (to change).**

- Desire statements relate to why I want to make a particular change.
- Ability statements relate to how I would do it if I decided to.
- Reason statements relate to the three best reasons I have for making the change.
- Need statements relate to how important it is for me to make a change and why.
Commitment statements relate to things I say that indicate my intention and readiness to make a change.

Questions that the therapist asks can help elicit such statements from the client and help increase their chances of making a change.

Below is a selection of questions that reflect this. Please note that there is a skill in spotting the transitions that clients make, which should guide which questions to ask at what point.

There is a hierarchy the client needs to move through that broadly follows a sequence of:

1) recognising the disadvantages of no-change,
2) recognising the advantages of change,
3) having some optimism about change,
4) intending to change,
5) making a commitment to change.

Try out some of the questions below:

- What concerns you about your current situation? (D)
- What makes you think you need to do something to change it? (D)
- What do you think might happen if your current situation is exactly the same as it is now, in five years from now? (D)

- What makes you think this is something you might be able to get to grips with, with help? (A)
- What other challenges have you dealt with before that make you think that you shouldn't give up on this situation yet? (A)
- If a good friend/partner was here now telling me why
they think you can get to grips with this problem.
What would they say? (A)

• How would things be different for you if you did get to grips with your problems? (R)
• If you woke up tomorrow and all these problems had disappeared, how would things be different for you? (R)

  • What makes you think you can't just leave this problem on the back burner and forget about dealing with it? (N)
  • I can see you are feeling stuck right now. What is going to have to change? (N)

• What would have to happen to make you think I have really got to do something about this now? (C)
• What do you think you might do after you leave here to move this situation forward a little? (C)
Clients will do what they describe themselves doing

Now you may be reading this and be feeling a little sceptical about some of the ideas contained here. Hopefully, you won’t be feeling too sceptical because you will have already tried some of them out and discovered that they work. However, if you haven’t, you may be wondering whether all this emphasis on what the client says ignores the fact that clients actually have to DO things in order to change. Is talk enough?

The brief answer is that it isn’t enough but it substantially shifts the balance. It also highlights one of the biggest traps we can inadvertently fall into if we use the principle incorrectly. And this isn’t just me saying this, one of the greatest neuropsychological researchers of the 20th and 21st centuries supports it too.

On 1 July 2011, at the age of 76, the great French neurophysiologist and psychologist Marc Jeannerod died. Jeannerod received numerous accolades within the academic establishment but his work is scarcely known outside of that despite being President Elect of the European Society for Philosophy and Psychology at the time of his death. His life's work examined the relationship between neural behavioural representations and motor behaviour.

The key practical implication of this was the discovery that "simulating a movement is the same as performing it, except that the execution is blocked" or to put it another way - when we describe ourselves doing a behaviour in detail we increase the chances of us engaging in that very behaviour.
This discovery has immense therapeutic implications. It means that when we facilitate our clients to describe to us changes in their own behaviour, we increase the chances of that client continuing the described behaviour.

Look at the two alternative case studies below and reflect on their implications.

Kim was a victim of domestic violence with low self-esteem and had been seeing her therapist Marie for a couple of months now.

**INTERACTION A:**

"So what's been happening, since I last saw you?" Marie asked.
"I keep on messing up," Kim replied.
"In what ways?" Marie continued.
"Well," said Kim. "Despite the fact my husband keeps running me down and shouting at me in front of the children, I keep silent and just skulk away into the kitchen and carry on making his dinner."

**INTERACTION B:**

"I know your husband keeps running you down Kim. I also know this situation is very difficult for you. Tell me, how you would LIKE to be behaving when he does this again in the future - even if you don't know whether you'd be able to"
"Well," replied Kim, "I suppose I'd tell him that he shouldn't say such things in front of the children for a start".
"What reasons would you give him Kim?"
"I'd say that running me down makes them respect both him and me less and causes some of the behaviour problems we see in them."
"What would you be doing whilst you told him this?" asked Marie. "I'd ask him to sit down with me because I had something important to tell him and I'd do it in the lounge when the kids were up in their bedrooms."

The key implication of this is that therapists can facilitate both client “success behaviour” as well as “failure behaviour”

Think of a client you work with and write down what you might say to them the next time you see them to facilitate their verbal description of “success behaviour”.

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The Use of Scaling To Increase Client Motivation

Asking clients to self-rate on a scale is a common strategy used in a variety of therapeutic modalities – from CBT to Solution Focused Therapy. If you want to learn more about the use of these in these modalities have a look at some of our training programmes that will teach you these at www.skillsdevelopment.co.uk

What you will learn here in this book are some of the key points to bear in mind when you are using scaling to help motivate your clients.

Make sure that the issue you ask a client to scale is of personal concern to them.

Before you ask your client to scale, identify an issue that is concern or interest to them. It can be any issue that the client wants to change but has difficulties with. However, it will not work if the issue has been externally imposed but has no value to the client.

Carl was running an "offending group" within one of the main UK prisons. The aim of the group was to reduce offending behaviour.

He asked Jake (an offender) to rate how confident he felt about reducing his offending behaviour. Jake said he wasn't interested doing anything about it.

"You've gotta eat to live," he said.

After exploring with Jake why returning to prison would be a bad thing for him, Carl rephrased the question. He asked Jake to rate how confident he felt about doing what was needed so he wasn’t separated from his family again.
This time Jake was more engaged.

The scale should be zero to ten with ten being good and zero being bad. And YOU should define zero and ten as extremes.

It's also useful to ask your client to rate their ABILITY or CONFIDENCE in managing the issue:

So what does this mean in practice?

It means you can ask your client to rate how well they are handling their depression at the moment but NOT how happy they are, or even how depressed they are.

You can ask your client to rate how able they feel to handle social situations but not how sociable they feel and certainly not how socially anxious they are.

Finally you can ask them to rate how well they're dealing with the sense of meaninglessness in their life, but not how meaningful (or meaningless) their life is at the moment. As mentioned, regarding the definitions of zero and ten, make sure you describe these as extremely as possible.

Wayne had OCD problems.

Jules asked Wayne to rate how well he was managing to resist checking the locks on the doors of his house "where ten was, I check them once when I leave the house and never give it a second thought" and "where zero would be I never ever leave the house because I am continuously checking 24/7 and worrying I can't remember the results from my last check."
Through scaling, build motivation by helping your client see what they are ALREADY doing to deal with the issue

So far, so good! Whatever number your client gives you, acknowledge its pessimism (or occasional optimism). Then ask why they didn't rate their management of the problem at zero.

This helps the client to identify resources and strengths they typically haven't acknowledged until now and raises mood and motivation.

There may well be a question on the tip of your tongue regarding all this which relates to the question of what do you do with the client who rates themselves at zero?

I'll let you into a secret. These numbers are not real. And that is an important point to remember because it allows you to recognise an important point with even your most unmotivated of clients – namely that whatever they are doing or not doing, they could always be doing worse. And yet they are not. So they must be doing something that's stopping them being in that position.

Bearing that principle in mind, have a look at the dialogues below and look at how the therapist addressed the “zero problem”, after the request to self-rate:

Diana: “Zero. It’s been a terrible week, I've binged eaten nearly every day and I haven't done that for years”

Therapist: “I’m really sorry to hear you’ve had a terrible week. That must be very disheartening. Yet I notice you didn’t rate yourself at minus 10,
you rated yourself at zero. And I’ve certainly come across some minus tens in my time. People who don’t just binge, but purge afterwards, who don’t even get out of bed for a week and who decide to miss their appointment with me. You’ve had a terrible week but you’ve not done that. What did you do to do that?"

You can built on your client’s answers by asking them what (NOT how) they do to manage that. This builds motivation further.

Does the above statement sounds a little confusing? Let's look at it in detail.

First of all, treat each positive (no matter how small) statement the client makes as "gold dust". Then ask the client what is it they DID in order to achieve that. Reflect these back as you go along and then at the end reflect ALL the reasons back as a summary statement.

Charlie was very depressed and said he was having real problems getting out of bed.

His therapist Jenny was very worried about him.

"How well would you rate your ability to get out of bed in the morning?" she asked, "Where ten would be - jumping out immediately on the alarm with a spring in your step; and zero would be - I can't move at all?"

"Two," replied Charlie.

"So clearly things are very difficult for you," replied Jenny. "But tell me this. Why did you say two but not zero. Why two but not zero?"
"Well," Charlie suggested, "I DO actually get up eventually."

"What do you do to do that Charlie? It can't be easy"

"Well, it gets boring in bed if you stay there all the time"

"So" said Jenny "Thinking about how boring it is in bed helps you to get up even when you don't feel like it?"

"Yeah… I guess it does," said Charlie thoughtfully.

**Asking your client about change elicits solutions that your client feels comfortable with and hence is more confident about using.**

Next, ask your client what would have to happen or what would they have to do to move up the scale by ONE only. Again, follow this up with asking the client what they'd have to do to achieve that and reflect back the answer at the end.

"So what would you have to do Charlie to help you move up from a two to a three?" Jenny asked.

"Dunno," replied Charlie.

"So there's nothing in the whole of the universe that would make any difference whatsoever?"

"Well, I do worry about my daughter seeing me like this"

"So, thinking more about the benefits for Kate of you getting out
of bed would make it slightly easier for you to do so."

"Mmmm… I guess it would," he replied.
"And what else?"
"I guess, KNOWING that I can do it would be a plus."

"So thinking about the benefits to your daughter and knowing you can actually do it would make it slightly easier."

"Yeah I guess they would. I never thought about it that way before," Charlie mused.

Try this out and let me know what happens.

The fact, that you're still reading this and, that you've hopefully begun to practice at least some of it, encourages me to think that you are part of the "one in twenty" practitioners who actually hope to make a difference to their practice rather than just thinking about it.

Just as our clients need to DO something in order to make a change, so do us as therapists.

Polina, our Administrator, here at SDS Seminars (www.skillsdevelopment.co.uk) has fielded a lot of questions that you have sent to me about rating scales and exercises discussed in the 1st edition of this book. These inevitably have ended in my Inbox. Although I will not be able to answer each of them individually here, bear in mind, that we pick up on many of these detailed questions in our training events on Solution Focused Brief Therapy.
However, I will address today one question that a number of you have raised and that seems to be a real sticking point for you:

What do you do with clients who rate themselves at 10 when in the opinion of the therapist they are at zero!?

The answer to this relies on exactly the same principles as those used to address the “zero problem”. The number is not real and there is ALWAYS something more the client could be doing that would improve their situation. What those things are and what they would have to do to do them is still a useful area to explore. It is not necessary for the client to “admit their incompetence” in order to identify what it is they would have to do to move themselves up to “eleven”.

Well, that brings us to the end of this Learning Programme on "Motivational Skills for Therapists". I hope you've found it useful and most importantly I hope you've put at least some of it into practice!

I also hope you recognise that we have barely touched the surface of this fascinating area.

This programme is not designed as a panacea to all client problems but rather a taster of what you can incorporate into your practice in order to increase your effectiveness, because I assume that, like me, you came into this business to do exactly that - to help people change in a way that is as effective as possible.

If you would like to explore this and many other interesting areas in training with myself or my extremely experienced and well-informed
colleagues – why not book onto one (or more!) of our many training courses?

Have a look at www.skillsdevelopment.co.uk for our open courses.

Have a look at http://www.sdsinhouse.co.uk/ if you are interested in us coming to your place of work for training

Our training courses are always very practical and (I hope) from following this programme you can see that the ideas and techniques that we offer actually work!

Thank you again for sharing this journey with me.

Take care and look forward to seeing you soon.

Paul Grantham
Consultant Clinical Psychologist
Director, SDS Seminars Ltd
Paul Grantham is a clinical psychologist with vast clinical and training experience. With degrees from Oxford University and the University of Sussex, Paul trained as a Clinical Psychologist at Liverpool University. He has worked extensively within the NHS for many years as a clinical psychologist within a wide variety of services and headed one of the first UK research projects designed to help clients withdraw from benzodiazepine addiction. He has subsequently worked in primary care, mental health, forensic, substance misuse and physical health as both a clinician and manager.

He has trained staff in health care, social services, local government and education around the UK and abroad. Over 110,000 professionals have worked directly with him. Paul has also designed and facilitated clinical supervision systems across a number of UK services. He has a wide range of current interests including: client resistance, resource based therapies and personality disorders. He has also presented and written on a range of psychological issues - from psychological interventions post-stroke to the application of solution focused work with complex clients.

Paul is a Chartered Clinical Psychologist, a Senior Associate of The Royal Society of Medicine and is an Accredited CBT Therapist. An extremely informed, clinically experienced and humorous speaker he is known for his emphasis on the practicalities rather than just the theory of client-based work. Paul was the Founder and First Chair of the BABCP Dialectical Behaviour Therapy Special Interest Group.

Paul is the founder and Director of SDS Seminars Ltd and one of the most popular and inspirational tutors in the field of psychological skills training.