CHAPTER ONE

INTRODUCTION: EMPIRICAL INFLUENCES

Our common struggle with therapeutic failures provided the impetus for an ongoing search of the literature for more satisfying descriptions of clinical practice. An exploration of the literature encouraged new ways of thinking and acting, validated our clinical experiences, and initiated an evolving set of values and therapeutic actions concerning the therapeutic relationship. We have been heavily influenced by three seemingly disparate sources. Eclecticism, common factors, and brief therapy provide an empirical context for the evolution of our thinking and a rationale for the approach which we propose.

ECLECTICISM

An historical review of the psychotherapy literature leads to the disappointing recognition that any given model which purports to explain, predict, and ameliorate human suffering is limited in its applicability. Early on, the response to the problem of inadequate models was the development of rival schools of psychotherapy, characterized by a theoretical content specific to that particular point of view. Thus, over the course of the past 70 years, psychotherapists have not suffered a dearth of models from which to order the therapeutic process; by one recent count (Corsini, 1981) over 250 distinct systems of psychotherapy have been identified. While the disparities in approach are legion, all share one common feature: limited applicability. The upside, of course, is that under certain circumstances a given approach may be highly efficacious. The lure of increasing the efficacy, applicability, and efficiency of psychotherapy through the selective application of disparate techniques and models has fueled interest in the development of eclectic, or integrative, strategies for practice.

While eclectic practice dates to the first half of the century (Patterson, 1989), it is only in the past 20 years that eclecticism has been identified as a clearly delineated area of interest (Norcross, 1986). A variety of studies report that one third to one half of present day clinicians prefer to label themselves as eclectic, disavowing affiliation with any particular therapeutic school (Garfield & Kurtz, 1977).

Although the term eclecticism lacks a singular precise definition, and has thus been inconsistently and indiscriminately applied, it does appear to retain several identifiable connotations: a stated dislike for a single orientation, selection from two or more theories, and the belief that present theoretical formulations are inadequate to explain or predict all observable behaviors (Garfield & Kurtz, 1977). These connotations were not only congruent with our clinical experiences, but also encouraged the pursuit of a flexible methodology for practice that could combine the best of what the individual psychotherapy and family therapy literature has to offer.

Eclecticism V. Integration V. Common Factors

Three main thrusts are evident in the modern movement to combine psychotherapy approaches (Saltzman & Norcross, 1990). Eclecticism in psychotherapy usually refers to the technical, largely atheoretical combination of clinical methods (Norcross, 1991). Technical eclecticism is empirical in the pragmatic selection of existing strategies based on demonstrated efficacy. Technical eclecticism, therefore, endorses the use of a variety of techniques within a preferred theory base, without the necessity of a connection between meta-beliefs and technique (Lazarus, 1967). A combination of approaches occurs at the level of specific procedure rather than at the level of theory. As exemplified by Lazarus (1981) and Beutler (1983), technical eclecticism strives to select the most useful procedures from the plethora of those available, irrespective of the theoretical underpinnings.

Another thrust, integration, denotes those efforts that seek the conceptual synthesis of varied psychotherapy theories (Saltzman & Norcross, 1990). The focus is more theoretical than empirical and the emphasis is on the development of superordinate or metatheoretical models of psychotherapy. Integration addresses the distance between approaches by building a bridge that unites them (Norcross, 1991). As exemplified by Prochaska and DiClemente (1984) and Wachtel (1977), integration reconceptualizes and recombines aspects of different approaches into new structure, at a higher order of synthesis, which shares some similarities to each approach, but possesses its own logic and coherence (Norcross, 1991).

Despite the emphasis on the differences among approaches, which at times overshadow and obscure commonalities, several writers recognize the significance of those elements common to diverse approaches. Common factor approaches, the third thrust, seek to determine the core ingredients across therapies with the goal of constructing more efficacious treatments based upon these commonalities (c.f., Frank, 1973; Garfield, 1986; Patterson, 1989). Common factor approaches strive to identify and operationalize those aspects of psychotherapy process that characterize successful approaches as a foundation for any treatment model.

The Thrust of This Book

This book presents an approach that incorporates aspects of all three thrusts to combine psychotherapy models. This approach seeks to: 1) direct the selective application of diverse techniques irrespective of their theoretical underpinnings; 2) promote an integration of different theories through the client's idiosyncratic synthesis of various views introduced by the therapist; and 3) operationalize those factors which cut across theories and account for successful outcome. Because we combine components from all three thrusts, without regard to their theoretical compatibility, we will hereafter refer to our approach as an eclecticism.

While the intellectual appeal of theoretical integration is compelling, fundamental philosophical and conceptual incompatibilities constitute a formidable obstacle to the development of a unified, integrated system of psychotherapy (Goldfried & Newman, 1986). The content differences among approaches may suggest that technical eclecticism may provide the least obstructed route to the flexible application of diverse methods. In many ways, efforts at theoretical integration, or the search for a unified system of psychotherapy, is reminiscent of our earlier pursuits of an inherently right way to practice.

Technical eclecticism, however, does not fully characterize our approach because conceptualizations derived from different theories, as well as specific techniques, are also included in the treatment process based on their situational applicability. Consequently, an integration or synthesis of disparate theories can be said to occur, but it occurs from the frame of reference of the client, rather than that of the therapist.

Restating the thrust of integration (see above) from the vantage point of the client: Clients reconceptualize problem experiences by combining aspects of their experience with alternative views introduced in therapy, creating new meaning structures, containing their own logic that may allow for problem resolution. Integration from this perspective is an idiosyncratic, process-determined synthesis of ideas formulated by the client, essentially a new theory that emerges with explanatory and predictive validity for the client's specific circumstance.

While embracing the philosophy and flexibility of technical eclecticism and promoting integration of theory from the vantage point of the client, the core element and primary emphasis of the approach of this book is the operationalization of the so-called common factors and the enhancement of other factors demonstrated of significance to successful outcome. The common factors literature presents a strong case for the assertion that the much sought after bridge among theories of psychotherapy may already indeed exist.

COMMON FACTORS

Patterson (1989) suggests that while most attempts at eclecticism focus on the inclusion of disparate methods and techniques, those factors which are common among therapies may provide a more useful foundation for an eclectic model. He makes a convincing argument that a systematic eclecticism must be based on those specific factors, common to all major theories, which have been supported by an ongoing and extensive body of research. Lending support to Patterson's argument, Goldfried and Safran (1986) similarly suggest that the integration of diverse approaches may be most fruitful when attempted at the "intermediate" level of abstraction, i.e., the level at which common principles of change operate. Likewise, Garfield (1986) calls for an eclecticism based in the common factors which characterize successful approaches to psychotherapy.

Supportive of these arguments is the outcome literature, much of which suggests that positive outcome is, in large part, related to "common factors" (empathy, warmth, acceptance, encouragement, etc.) rather than specific technique. Lambert's (1986) review identifies that as much as 30% of outcome variance is related to these common elements. This figure is

consistent with the 25% to 40% figures that Patterson cites (1984). Lambert goes on to indicate that orientation-specific factors (technique) have been found to be no more powerful than placebo effect, both of which account for approximately 15% of positive outcome variance. Accounting for the remaining 40% of the variance are what Lambert identifies as spontaneous remission variables such as out of therapy events, client ego strength, and other client-specific variables. This research certainly challenges the propensity to hold onto the inherent and invariant validity of a chosen model, especially since orientation/technique are only as significant as placebo. Even more disconcerting is the implication that our specific orientations are largely insignificant when compared to common factors and client variables.

Patterson (1959) suggests a classification system which permits closer examination of the potency of the so-called common or non-specific factors. Variables such as the therapist's authority, status, expertise, attractiveness, and credibility, as well as techniques such as persuasion, suggestion, encouragement, reassurance, and guidance are truly non-specific, and effectively constitute the placebo variables. While placebo has traditionally been ignored as a potent variable, Lambert's (1986) work suggests that placebo is at least as powerful a variable in positive outcome as is specific technique. Attempting to enhance placebo by design may as much as double the effectiveness of any intervention strategy. Recognizing and attending to client expectations and demand characteristics may secure, in part, the therapeutic alliance necessary for psychotherapy to proceed.

The second cluster of variables which Patterson identifies includes factors such as therapist acceptance, permissiveness, warmth, respect, non-judgementalism, honesty, genuineness, and empathic understanding. Patterson (1989) argues that these factors, which may be summarized as empathic understanding, respect, and therapeutic genuineness, are both specific and potent, providing at least the necessary basis for a facilitative interpersonal relationship. While disagreement exists regarding the extent to which these factors are sufficient for positive outcome, little disagreement exists among psychotherapists as to the importance and necessity of these qualities to the therapeutic process. Recognition of the importance of these

specific therapist variables to positive outcome undercuts the view that expertise in methods and techniques is the critical factor in achieving client change. Rather, this body of evidence suggests that the therapist's influence lies in providing the conditions under which the client engages in behavioral or attitudinal change (Patterson, 1989).

Operationalizing Common Factors

Given the robust nature of the outcome results related to common therapist factors, as well as the non-specific placebo variables, it would seem that any other elements incorporated into a systematic eclecticism should be consistent with and attempt to enhance those elements. Consistency with these elements would require that interventions be directed by the internal frame of reference of the client, rather than imposed by the therapist's theoretical frame of reference.

Understanding the client's subjective experience and phenomenological representation of the presenting complaint and placing that experience above the theoretical predilection of the therapist, is a concept which appears to be consistent with the notion of enhancing common factors, both specific and non-specific. The idea of operationalizing these factors provided a major thrust in the evolution of our thinking. The primacy of the client's experience and reality is the central organizing element of our work.

This book will propose a methodology for operationalizing common factors so that their effects may be enhanced and positive outcome encouraged. The proposal will: 1) expand the definitions of empathy, respect, and genuineness to enable therapist actions beyond stereotypical responses; 2) articulate the process of accepting the client's frame of reference as the therapist's theoretical orientation; 3) introduce a therapist behavior called "validation," that explicitly seeks to highlight, legitimize, and "validate" the client's subjective experience; and 4) challenge the distinction between relationship and technique by extending the common factors context of the therapeutic relationship to the client's social environment through the intervention process itself. This book will also present a perspective that not only recognizes and empowers spontaneous remission effects, but also attempts to create opportunities for such effects to occur.

BRIEF PSYCHOTHERAPY

During the past ten years, there has been a growing interest in time-limited or brief approaches to psychotherapy. While traditional models may favor long-term treatment as an ideal model, reviews of client expectations (Garfield, 1971) and treatment duration (Garfield, 1971, 1978; Langsley, 1978; Koss, 1979; Matarazzo, 1965) suggest that in actuality practice is time-limited rather than long-term. By and large, the literature indicates that most outpatient therapy is limited to fewer than ten sessions per case; Budman & Gurman (1988) argue that this has been the case for several decades, citing Rubenstein and Lorr's (1956) findings in that regard.

While long-term therapy may represent the ideal of many clinicians, therapists have been remarkably unsuccessful at convincing clients to commit to long-term psychotherapy. Recent changes in the health care delivery and insurance systems has increased the pressure on therapists and consumers alike to establish a treatment focus which expedites the resolution of psychological and familial problems and contains the costs associated with such treatment. Caps on outpatient mental health care benefits, cuts in government funding, and managed mental health care plans will continue to push for treatment options which are not only therapeutically effective but also cost effective. Like it or not, therapist behaviors are being affected by the pressures of the larger systems within which they operate.

Brief Therapy and Outcome Research

There is a growing body of evidence which appears to support the effectiveness of psychotherapy in general, and brief approaches (whether planned or unplanned) in particular. Given that most outcome research has involved therapy that has lasted for short periods by the standards of traditional psychotherapy, virtually every major review of the efficacy of various individual therapies (e.g., Bergin, 1971; Bergin & Lambert, 1978; Lambert, Shapiro, & Bergin, 1986; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Orlinsky & Howard, 1986) has been an unacknowledged review of unplanned brief therapy (Budman & Gurman, 1988). These studies offer impressive evidence supporting the general effectiveness of unplanned brief individual psychotherapy. Similarly, the research literature on the effectiveness of marital and family therapy has shown comparable findings (Gurman & Kniskern, 1978; Gurman, Kniskern, & Pinsoff, 1986).

Also supportive of brief therapy is the research suggesting a course of diminishing returns in psychotherapy with more and more effort required to achieve a noticeable difference in improvement (Orlinsky & Howard, 1986). Smith, Glass, and Miller (1980) similarly found the major impact of individual psychotherapy to occur in the first 6-8 sessions, followed by a continuing, but decreasing, positive impact for the next 10 sessions. In individual psychotherapy the largest proportion of positive change appears to occur in a time frame (6-8 sessions) that roughly parallels the amount of time most clients expect to stay in treatment (6-10 sessions; Garfield, 1971, 1978) and actually do stay in treatment (6-8 sessions; Garfield, 1978, 1986).

Compared to the enormous amount of research that exists on unplanned brief psychotherapy, outcome studies of planned brief therapy are few. The existing comparative studies of short term versus long term individual therapy show no reliable differences in effectiveness between the two (Butcher & Koss, 1978; Luborsky, Singer, & Luborsky, 1975; Koss & Butcher, 1986; Orlinsky & Howard, 1986). A parallel picture can be drawn from the existing studies of time-unlimited v. time-limited marital and family therapy (Gurman & Kniskern, 1978).

Brief Therapy V. Long Term Therapy

The brief therapy literature addressing the comparable outcome of short v. long-term therapy, the average length of treatment across treatment settings, client expectations concerning length of treatment, and the time frame in which the greatest proportion of change occurs is difficult to ignore. While the literature is convincing and it is evident that our philosophy, values, and methods are aligned with those of brief therapy, the framework that follows in no way demands an either/or, brief therapy/long term therapy allegiance. The design is to empower common factor effects, enhance flexibility, and expand the repertoire of intervention strategies within a coherent framework for practice. It is our hope that regardless of one's position related to long/short term therapy, the approach may be of value to any clinician who seeks these same goals.

This book, however, presents an approach that is usually brief - not because of a fixed a priori number of sessions determined by the therapist - but rather because the acceptance of the

client's frame of reference as the guiding theory for intervention necessarily shortens the treatment process most of the time. Brevity, therefore, is not advocated solely for the sake of being brief but rather is a consequence of thinking and acting in a particular way with clients. This book asserts a therapeutic position that enables the rapid resolution of problems, but that respects the client's right to determine length of treatment.

EVALUATING THIS BOOK

Three sources of influence were discussed that have set an empirical context for the approach that follows. The three sources also provide a way for the reader to evaluate the approach of this book. The eclecticism literature highlights the explanatory and predictive inadequacy of any one theoretical school and emphasizes the advantages of combining multiple models of therapy. Given the noted difficulties with the achievement of an actual theoretical integration, a technical eclecticism, expanded by the selective use of conceptualizations from different theories as well as techniques, may offer the most direct route to the consideration of multiple options for intervention. Such an eclecticism may be significantly strengthened if it also includes those elements that cut across approaches that contribute to successful outcome.

The eclecticism literature also suggests criteria for evaluation of the approach that follows. Goldfried and Newman (1986) identify five themes that warrant consideration in any eclecticism or integration effort: 1) the potential complementarity of divergent approaches to therapy; 2) the interactive significance of cognition, behavior, and affect; 3) the need for a common theoretical language; 4) the elucidation of universal, metatheoretical principles of human change; and 5) the desire for empirically based procedure. As you read this book, evaluate whether or not the approach adequately addresses these recurrent themes of eclecticism.

The common factors literature unequivocally supports the therapist variables of empathy, respect, and genuineness as a core foundation of any eclectic effort. Second only to client variables, these common factors account for much of positive outcome, and are far more important than technique. Empowering common factor effects through operationalizing

therapist variables of empathy, respect, and genuineness beyond standby reflections and into the intervention process constitutes a core element of this approach.

Our assertions regarding the operationalization of common factors can be easily evaluated by keeping two questions in mind: 1) Does this approach specify therapist behaviors and values that demonstrate empathy, respect, and genuineness beyond stereotypical therapist responses? and 2) Does this approach extend the common factors context of the therapeutic relationship into the intervention process itself?

The brief psychotherapy literature, especially the comparable outcome of short-term and long-term therapy and the mean number of sessions (ten) over the last three decades, provides a compelling argument for the clinician of any orientation to consider planning brief therapy rather than conducting brief therapy by default (Budman & Gurman, 1988). Brief therapy occurs as a frequent result of the therapist placing higher value on the client's frame of reference than any theoretical orientation; brief therapy emerges as a natural consequence from a rapid-change context set by the therapist's attitudes and behaviors regarding therapy, people, and the process of change.

The brief therapy literature also suggests criteria for evaluation of the approach in this book. Budman and Gurman (1988) summarize the value ideals of the brief therapist as: 1) the brief therapist begins treatment by using the least radical procedure; that is, therapy begins with the least costly, least complicated, and least invasive treatment; 2) the brief therapist views cure as inconceivable; 3) brief therapists view people as malleable and as constantly changing and developing; 4) the brief therapist, while maintaining an appreciation for the role of psychiatric diagnosis, has a health rather than an illness orientation; 5) the brief therapist takes the patient's presenting problem seriously and hopes to facilitate changes in some of the areas that the patient specifies or comes to clarify as important; 6) the brief therapist realizes that he or she may not be thanked for changes that have occurred after therapy, and may not, after relatively few visits, ever see the patient again; 7) the brief therapist assumes that psychotherapy may be "for better or for worse" and that not everyone who requests treatment needs or can benefit

from it; and 8) finally, and most importantly, being in the world is seen as far more important than being in therapy. As you experience this book, evaluate our approach in terms of its consistency with the value ideals.

The confluence of the three sources provided the impetus for the approach to eclecticism in the ensuing chapters. Chapter Two lays the groundwork and proposes a "process constructive" theory base for our eclecticism. Chapter Three will present three pragmatic assumptions derived from theoretical foundations discussed in this chapter. Chapter Four addresses the all-important first interview. Chapters Five and Six present intervention strategies that operationalize common factors, as well as enable the informed use of diverse theories and methods. Chapters Seven and Eight present full-length case studies. Ethical considerations and guidelines are presented in Chapter Nine, as well as a gender perspective of our approach. Chapter Ten will provide our analysis of the three proposed evaluation methods and will conclude with our perspective on the future of psychotherapy.

CHAPTER TWO

THEORETICAL FOUNDATIONS

The framework for eclectic practice presented in this book has evolved from the context described in Chapter One as well as earlier efforts to utilize and extend the strategic model of the Mental Research Institute (MRI) (Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fisch, 1974) to include the contributions of other approaches. In the early 1980s, the senior author investigated the possibilities of integrating the MRI strategic approach with other models of family therapy. Using the construct of the homeostatic or protective function of symptoms as an example, an integration was suggested that permitted the selection of constructs from a variety of models of family therapy as metaphors to design strategic intervention (Duncan, 1984). The selective integration of concepts from outside the realm of strategic therapy served as the trigger for an evolutionary process of seeking a method of combining the best of what the psychotherapy literature has to offer. Barbara Held was among the first to consider the advantages of combining an MRI approach with other models of psychotherapy. She proposed a "strategic eclecticism" (Held, 1984) and advocated the use of the MRI's resistance minimizing interventions to enhance compliance to therapeutic directives of other orientations.

Held's work was particularly helpful and influential to the senior author's work in a behaviorally oriented stress management program at a community mental health center. Held's strategic eclecticism provided a means to introduce strategic intervention into the stress management program and served as an impetus for a proposed integration between the MRI model and cognitive-behavioral approaches (Duncan, Rock, & Parks, 1987).

That early integration effort, which was referred to as "strategic-behavioral therapy," stressed the similarities between the two approaches. We became enamored of the idea that similarities between models could provide a crossover point that allowed conceptual and practical integration of diverse approaches. Exploration of the literature of many disparate models invariably yielded many crossover points of concept and action between strategic therapy and the model under scrutiny. Although the notion of integration through similarities ran into roadblocks, looking for commonalities served to encourage an openness to

ideas from the most antithetical of approaches.

Held (1986) expanded her proposal for a strategic eclecticism by suggesting that the MRI problem formation model is relatively void of specific theoretical content, thereby allowing the use of theoretical content from any approach in service of strategic goals. Held elaborated a process-content distinction that extended our earlier notion of selecting frames from other approaches as metaphors for intervention. Her distinction also enabled the recognition that the process-oriented strategic model could provide an organizing component for an eclectic approach that went beyond the confines of the strategic-behavioral pairing or the pairing of any two approaches (Duncan & Parks, 1988). The process-content distinction added both depth and support to the use of a constructivist rationale for selecting alternative meaning from various psychotherapy orientations.

In retrospect, a theme of simple flexibility emerged from a ten-year search for theoretical formulations that would expand the strategic model of MRI and permit an eclecticism. Constructivism provides a relative and contextual perspective of the therapeutic relationship that not only de-mystifies psychotherapy models as no more than views of reality that structure the therapist's reality, but more importantly also provides a strong rationale for the primacy of the client's view over the therapist's theoretical orientation. Buckley's (1967) description of sociocultural systems suggests a view of system interaction that emphasizes the flexibility of process and de-emphasizes the rigidity and restrictions of a purely homeostatic perspective of system operation. The MRI problem formation model eliminates the encumbrances of pathology-based explanatory schemes of client dilemmas, allowing for a more idiosyncratic and client-specific formulation of both the presenting complaint and the client's goal for change. Finally, Held's process-content distinction enables the consideration of multiple theoretical contents without the limitations inherent in the invariant application of any one theory.

CONSTRUCTIVISM

The philosophical position of constructivism and social construction theory from psychology (Gergen, 1985) both suggest that reality develops phenomenologically, emerging from the constructs of the observer-describer and his or her interaction with the environment. Reality is

therefore invented, not discovered (Watzlawick, 1984) and is evident only through the constructed meanings which shape and organize experience. People, as meaning generating systems, create meaning through a flowing interaction of ideas and correlated actions. The generation of meaning is an interactive and highly idiosyncratic process that emerges from the subjective phenomenology of the individual. These constructed realities organize perception and experience into rule-governed patterns or meaning systems through which individuals may describe, direct, and predict their lives (Duncan, Parks, & Rusk, 1990).

Meaning is created in two ways (Buckley, 1967). Meaning is neither inherent solely in external experience or the internal state of the individual, but rather is constructed during the ongoing interaction between the individual and the social environment. Varela (1989) describes this level of meaning creation as emerging as a result of effective action in the natural world.

The human capacities for symbol manipulation and self awareness enable another avenue of meaning construction. People can experience a transaction entirely at a covert or internal level which permits the continuous generation of meaning apart from the interpersonal experience. Accordingly, meaning systems may be generated through the transactional experience (the individual's interaction in the social environment), its covert rehearsal or internal processing, and the ordering and organizing of both ways. Through social interpretation and the intersubjective influence of language, family, and culture, an evolving set of meanings emerge unendingly from the interactions among people (Anderson & Goolishian, 1988).

Thinking of reality as meanings created in dynamic social exchange and communicative interaction can be both mind-boggling and disconcerting at the same time. Much confusion has arisen from esoteric descriptions of constructivism and the application of an anti-realist epistemology to psychotherapy. We would like to cut through the esoterica and bottom line the implications for eclectic practice.

Implications

Constructivism, not in the radical sense, but in the common sense variety applied to therapy, does not deny the existence of objects, events, or experiences, but rather provides a challenging

commentary on the relative and context-bound nature of meanings ascribed to those objects, events, and experiences by an observer. Understood in this way, constructivism elevates the client's view of reality, particularly the client's meaning system regarding the presenting problem, to paramount importance in the therapeutic process. Applying constructivism to therapy allows the client's meaning system to transcend to a hierarchically superior position to the therapist's theoretical orientation and/or personal beliefs. Constructivism, therefore, provides a strong rationale for respecting the preeminence of the client's world view. It suggests that the therapeutic process is best served by meeting clients within their idiosyncratic meaning systems regarding their problem experiences (Solovey & Duncan, in press).

From a constructivist vantage point, theoretical language and content conceptualizations may be viewed as somewhat arbitrary metaphorical representations which explain and organize the therapist's reality and may have little in common with the client's perception and interpretation of the presenting concern. The very content or theoretical orientation which the therapist selects to order the therapeutic reality necessarily limits the search for solutions. A constructivist position de-emphasizes the importance of the search for undeniable truths as well as the role of the therapist as the source of such truths. Constructivism, therefore, encourages more flexibility in the therapist reality and consequently facilitates an eclectic framework of intervention.

Constructivism also provides a different language of how change occurs. The language of meaning systems enables a respectful and noninterfering vocabulary for change that permits the therapist role to be essentially collaborative, and instrumental only in the sense of creating the conditions for change, not the actual change itself. A meaning systems perspective de-emphasizes therapist power, control, and a covertly directive or manipulative stance with clients. We will return to this implication of a constructivist stance in our discussion of pragmatic assumptions in Chapter Three, as well as in Chapter Nine in a discussion of ethics and strategic therapy.

PROCESS LEVEL SYSTEMS

Buckley, in a classic discussion (1967), categorized systems at three levels of description, each applicable to a specific domain. Buckley's scheme of systems is useful because it allows the

consideration of different ways of thinking about systems based in the particular kind of system under concern. It is Buckley's third level, the process/adaptive level (hereafter called process) that describes sociocultural systems such as families. At the social systems level, process or dynamic interaction between and among system members is primary. Structure is a fluid and ever-changing representation of an ongoing process, rather than a fixed, static entity. Structure is therefore no more than a snapshot of transactional process and continuously changing relationships. Unlike biological systems, which are characterized by fixed structures which perform recognizable and invariant functions across systems (e.g., the hypothalamus [structure] and temperature regulation [function]), social systems are possessed of no immediately identifiable fixed structures of invariant function (Buckley, 1967; Duncan & Fraser, 1987).

Inherent to process-level systems is the capacity for evolution and elaboration. These systems are not only sensitive to variation in the social environment but are also essentially dependent on change for continued viability. Unlike biological systems, which are characterized by mechanisms that reduce and eliminate variability, social systems rely on variation to stimulate interactional process, the construction of individual and shared meaning, as well as the continual movement toward complexity, flexibility, and differentiation. A sociocultural system, then, is a meaning-processing system of dynamic social exchange through which individuals accommodate or assimilate ongoing change (variation) in the internal and external social environment.

Implications

Buckley's process-level system represents a significant departure from the prevailing descriptions of family systems found in the literature. The majority of family therapy approaches are based in a biological level of system description and emphasize, to varying degrees, the concepts of structure, symptom function, and homeostasis. The process-level view provides a flexibility of thought and action that is not encumbered by a necessary and invariant search for homeostatic mechanisms and the like. Adopting a process view allows multiple courses of conceptualization and intervention that include consideration of homeostasis without the restriction of its sole reliance (Duncan, 1984; Fraser, 1984a, 1986). The process-level description of systems, therefore, provides a theory

base that enables an eclectic approach.

The emphasis on the interactional process surrounding variation and its importance to meaning construction is particularly relevant to psychotherapy. In general, the therapeutic goal is to promote conditions that increase choice and enhance possibilities for revisions of those meanings and/or experiences that the client views as problematic. In service of that goal and through the use of the therapeutic conversation and therapist's suggestions, variation is introduced to the system. Variation then stimulates interactional process and meaning construction, thereby encouraging client change and systemic growth.

While most of the systems literature can be argued to flow from a biological level of system description, the strategic approach of the MRI seems to align with the process-level description. It is particularly the MRI's interactional perspective of problem process that enables an eclecticism.

MENTAL RESEARCH INSTITUTE: A PROBLEM PROCESS MODEL

The strategic approach of the MRI is an outgrowth of the family systems movement and essentially evolved concurrently with many approaches to family therapy. At a time during which several independent groups were studying families containing a schizophrenic member, the Bateson project investigated the communication patterns in schizophrenic families. This research culminated in the double bind theory of schizophrenia (Bateson, Jackson, Haley, & Weakland, 1956). Until the double bind hypothesis, most other family-oriented descriptions of human behavior were mired in awkward transformations of psychodynamic theories. The double bind theory, based in communicative interaction, had the powerful capacity to describe human dilemmas as interactional in nature, and freed the emerging field from the constraints of the language of pathology (Anderson & Goolishian, 1988). Subsequently, Haley and Weakland, original members of the Bateson group, became interested in the work of Milton Erickson. After several years of studying Erickson's innovative methods, both Haley and Weakland went on to integrate Erickson's ideas with communication theory and cybernetics, forming the basis for what is now known as strategic therapy.

Main Principles

Weakland, Fisch, Watzlawick, and Bodin (1974) delineate the main principles of their work as: 1) the approach is symptom oriented, in a broad sense; 2) problems that bring people to psychotherapists are situational difficulties between people - problems of interaction; 3) problems are primarily an outcome of everyday difficulties, usually involving adaptation to some life change, that have been mishandled by the parties involved; 4) problems develop usually by overemphasis or underemphasis on difficulties in living; 5) once a difficulty begins to be seen as a "problem," the continuation and exacerbation of the problem results from the creation of a positive feedback loop, most often centering on those very behaviors of the individuals in the family that are intended to resolve the difficulty; 6) long-standing problems or symptoms are not viewed as "chronicity," but the persistence of a repetitively poorly handled difficulty; 7) resolutions of problems require a substitution of behavior patterns so as to interrupt the vicious, positive feedback circles; 8) means to such an interruption often may appear illogical or paradoxical; 9) accepting what the client offers and reversing usual treatment in a pragmatic fashion is the major focus of therapy; and 10) conceptions and interventions are based on direct observation of what is going on in systems of human interaction, how they continue to maintain the problem, and how they may be altered most effectively and efficiently.

In brief, The MRI holds that problems develop from chance or transitional circumstances encountered by individuals and families evolving through the life cycle. It
is when adjustment or adaptation to a variation is perceived as a difficulty that problems develop. The MRI simply and eloquently suggest two conditions as necessary for problem development: 1) the mishandling of the difficulty and 2) upon failure of the original solution attempt, more of the same is applied, resulting in a vicious cycle (Watzlawick et al., 1974). The inter/intrapersonal interaction which surrounds the difficulty, the process by which individual and shared meaning related to the difficulty is constructed, and the interplay of both are seen as significant to the problem process. Idiosyncratic interpretations and perceptions both influence and are influenced by the difficulty itself, creating a problem-oriented system (Goolishian & Anderson, 1987), or one in which interpersonal interactions and meaning construction are organized around the problem. While presenting complaints and concerns may be highly content- laden and idiosyncratic to the individual or the situation, the problem is defined in

terms of the interactive process.

Problems, then, occur as part of a vicious cycle of attempts to adjust or adapt to an internally or externally initiated variation. The variation, once perceived as a difficulty, becomes not only the original difficulty, but also all the meanings it has accumulated through the course of those interacting around it. Based on the individual and shared meanings about the problem or how to solve it, people will try variations on a theme of the same solution pattern over and over again. This usually occurs despite the best intentions of those involved and the fact that the solution attempts are recognized as not helping. The solution, in essence, becomes the problem (Watzlawick et al., 1974).

Implications

Given that the MRI emphasizes the process of interaction surrounding the problem, and in general views all behavior as explainable in terms of its place in a wider ongoing sequence of communicative transaction in a social system, a very different set of assumptions regarding problem etiology emerges. A major assumption is that regardless of basic origins or ties to historical or personality variables, problems persist only if they are maintained by ongoing current behavioral sequences between the client and others with whom he or she interacts. Since etiology resides in the interactive process, models of psychopathology, such as DSM III-R are viewed as no more than explanatory schemes which structure and organize behavior which appears irrational or self-defeating to an observer. The human experience of emotional and interpersonal difficulties is normalized in a model which requires no deficits of either character or family structure. This simple but elegant interactional view enables a contextual perspective of human behavior that de-pathologizes problems in living.

The significance of removing pathology explanations can hardly be overstated. All therapeutic intervention relies on the premises to which the helper subscribes. These premises structure the therapeutic intervention at every level. How the therapist interprets and conceptualizes the clinical situation influences not only the nature of the helping relationship, but also what data will require focus, who will be seen in treatment, what will be said, and how results will be evaluated. A process-based perspective, such as that of the MRI, shifts the focus from curing or

correcting character traits or deficiencies to empowering clients to utilize their existing resources to resolve problems.

Although the MRI does not present its model in terms of compatibility with other theoretical orientations, Held (1986) has argued that the MRI approach can subsume other individual and interpersonal models and therefore may be utilized as a basis for eclectic practice. Her argument rests in an important distinction between content and process elements within and across models of psychotherapy.

PROCESS V. CONTENT

Held (1986), building on the work of Prochaska and DiClemente (1982), defines process as the activities or behaviors the therapist engages in to promote change or develop coping solutions (i.e., methods, techniques, interventions, strategies). Process embodies one's theory of how change occurs (Held, 1991). Content is the object of the change involving the aspects of the client and his or her behavior which the therapist decides to focus his or her interventions (Held, 1991). Content is identified and defined at both Formal and Informal theoretical levels (Held, 1991). Formal Theory consists of either general notions regarding the cause of problems (e.g., symptoms are surface manifestations of intrapsychic conflict; symptoms are homeostatic mechanisms regulating a dysfunctional subsystem) or predetermined and specific explanatory schemes (e.g., fixated psychosexual development; triangulation) which must be addressed across cases to solve problems. Cause and effect are either specified or implied by way of the theoretical constructs of the formal theory. Those constructs provide the content, which become the invariant explanations of the problems that bring clients to therapy.

Models of Psychotherapy

While all models of psychotherapy are built on theoretical content, they vary in the degree to which content is emphasized and elaborated (Held, 1991). Despite the fact that variation exists in the extent to which the therapeutic process is ordered by a particular orientation's content, most therapies tend to fall to the content-oriented pole of the content-process continuum. The client or clients will present a complaint or set of complaints to the therapist and the therapist will overtly or covertly reinterpret the complaints within the language of the therapist's formal

theory or theoretical content. The therapist reformulation of the complaint into a specific preconceived theoretical content will enable treatment to proceed down a particular path flowing from the formal theory. Consider how a client complaint of panic attacks may be viewed in terms of many content-oriented models, and how the selected model suggests a particular content path to follow. A psychodynamic clinician may view the problem as a result of repressed ideas and/or wishes intruding into consciousness. The therapist may pursue information from the specific stage of psychosexual development deemed relevant and make interpretations to allow the client to integrate the unconscious material that is requiring the anxiety attacks as a defense.

A cognitive clinician may view the problem as a result of a set of irrational beliefs and/or cognitive distortions that the person has learned. The therapist may pursue the client's self-statements regarding the panic attacks and the situations in which the attacks occur, as well as the underlying beliefs and distortions that the self-statements represent. The therapist may attempt to replace self-defeating thoughts with self-enhancing ones.

A structural family therapist may view the panic attacks as serving a homeostatic function for the client's marriage, in that the marriage is protected from conflict due to the couple's focus on the attacks. The therapist may refocus the problem as between the client and spouse and address the trust and intimacy issues that underlie the panic attacks, thereby eliminating the need for the symptom as a homeostatic mechanism.

An MRI therapist may view the panic attacks as a vicious cycle of unsuccessful solution attempts that the client and others with whom he or she interacts have employed. The therapist may pursue an interruption of the problem maintaining process. The MRI is distinguished from the psychodynamic, cognitive, and structural approaches by an attention to the process surrounding the panic attacks and how that process may be interrupted. No particular or invariant content path to problem formation or maintenance is posited by the MRI.

Accordingly, the MRI model falls to the process-oriented pole of the content-process continuum. The MRI problem process model is a general and inclusive view of problem

formation and maintenance and posits no particular theoretical "true maintainer" or "real cause" of the presenting problem other than redundant solutions. The MRI- oriented therapist focuses on the vicious cycle of unsuccessful solution attempts. Unlike most therapies, which rely heavily on formal theoretical content to structure their understanding of the problem, the MRI position holds that the interactive process itself is the problem. The only goal which an MRI model dictates is that of changing the interactive process which constitutes and maintains the problem; the sole focus of therapy is on the problem process. As such, the content focus of psychotherapy can emerge from the informal theory of the client.

Informal Theory

Informal theory, which is evident at the client complaint level, involves the specific notions held by the client about the causes of their particular complaint. Revealed through statements such as "I guess I've always had really low self esteem," "I've never been able to trust anyone, it goes back to when I was a kid," "He doesn't really talk to me" as well as the elaboration of such statements, informal theory is highly idiosyncratic. At times, the match between the formal theory held by the therapist and the informal theory held by the client may seem serendipitously congruent (e.g., a client presenting to a cognitive therapist with a statement such as "Despite what everyone tells me, I just don't seem to like myself very well; I can't get past the feeling that there is something really wrong with me.") More often, the informal theory of the client will be overtly or covertly reinterpreted within the language of the therapist's formal theory before treatment proceeds (recall the example of panic attacks).

Implications

Held's general content/process delineation, coupled with her identification of the MRI as a process-based model, suggests an avenue for an eclectic approach which could utilize content as a vehicle for change. For a client to articulate a complaint requires that it be conceptualized in a content-rich meaning system (i.e., the informal theory); even the most general and non-specific of client-presented goals must be ordered by the content of the client's idiosyncratic meaning system. Client focus must necessarily be content-oriented and value-laden. In content-oriented approaches to psychotherapy, the formal theoretical reality of the therapist exists in a hierarchically superior position to the informal theory of the client. This formal theory

necessarily structures problem definition as well as outcome criteria. The more content oriented the approach, the more content-directed the goals become. The MRI change model shifts therapist focus from content-oriented goals (e.g., shifting coalitions, establishing a rational belief system, correcting learning deficits, etc.) to process-based goals and outcome criteria.

Given that the sole goal dictated by the MRI model is that of changing the problem maintaining interactive process, the content-structured goals associated with the client's informal theory may be actively utilized in service of the process-oriented goals of the therapist. Techniques, methods, and intervention strategies may be selected from any of the available models which, at the content level, are congruent with the informal theory of the client.

THEORETICAL ASSUMPTIONS, PSYCHOTHERAPY, AND SHAVING LEGS?

The combination of a process perspective of systems, a constructivist view of reality and meaning generation, an interactional model of problem formation, and the distinction between process and content approaches serves as a basis for an eclecticism which accepts the informal theory of the client as hierarchically superior to the formal theory of the therapist. This process-oriented approach, when considered in the context of the inherent values associated with common factors, brief therapy, and eclecticism, suggests several assumptions regarding people, problems, and the practice of psychotherapy.

Consider your own set of assumptions as you read the following example and think about what intervention options unfold based upon your assumptions. In the first interview with a 20-year-old man, he describes a feeling in his face that is directed by the curvature of his spine, which either curves to God or to the devil. He also notes that his hands are not there at times, and one of his legs is a woman's and one is a man's.

From just that opening statement, many assumptions may quickly emerge regarding what the problem is and how it may best be treated. Many professionals may interpret the client's statement as an indication of a mental illness. Such a view would conceptualize the statement as a somatic delusion that probably results from some psychotic process in the individual. A biochemical imbalance involving the neurotransmitter dopamine would be hypothesized as the

underlying mechanism of the behavior expressed in the session. This perspective may therefore suggest medical treatment (i.e., psychotropics, hospitalization, ECT, psychosurgery) perhaps combined with some form of psychosocial treatment to assist the individual and his family in managing the illness.

A more psychological view may conceptualize the client presentation as a fundamental deficit in the individual's ability to form relationships such that the client's behavior reflects a return to early childhood forms of communication His fragile ego, unable to handle the extreme stress of interpersonal challenges, has regressed. From this view, therapy would require the client to learn adult forms of communication and achieve insight into the role that the past has played. This process would occur very gradually, probably over a period of years.

A family systems view may conceptualize the client presentation as a reflection of dysfunction elsewhere in the client's family and as a homeostatic mechanism that detours conflict away from his parent's relationship. It is hypothesized that the young man may be protecting his parents and sacrificing his own development in service of detouring their conflict. From this view, family therapy would address the conflict between the parents, restructure the cross-generational coalition, and attempt to eliminate the need for the client to protect his parents through the symptom.

Obviously, such differences in conceptualization and treatment of the proposed clinical situation also make for some radical differences in prognosis as well as in ramifications for the client and his family. The formal theory of the therapist not only dictates what sort of therapy is selected, but also how drastic and lengthy it is expected to be. Furthermore, the evaluation of outcome will also depend on the therapist's original construction of the client's presentation. If that original construction or formal theory says "schizophrenia" and the problem is viewed as an inherent and fundamental defect or disease process, the client may be forever labeled a schizophrenic, even if the peculiar behavior ceases that led to the initial construction (i.e., in remission). From another point of view, however, a change may be interpreted as an indication that the problem no longer exists.

There are literally a hundred ways of conceptualizing the brief information given above, and the formal theories described, although presented in a grossly oversimplified fashion, have merit and warrant consideration. While they deserve consideration across cases, they do not merit invariant application across cases. The therapist who actually saw this client held a different set of assumptions about people, problems, and psychotherapy.

The therapist's process systemic view of the client's statement enables the therapeutic system (client and therapist) to be viewed as an ongoing exchange of meaning that continually shifts and changes as new information (variability) is added. The client statement was merely a snapshot of an ongoing transactional sequence that itself was in the process of change. The interaction between the therapist and client creates a context for meaning construction and meaning may be co-generated via the dynamic communicative exchange called psychotherapy.

The therapist's constructivist perspective suggests that the client had generated a meaning system that included a belief that God and the devil were within him and that he possessed characteristics of both males and females. The therapist accepted the statement at face value, believing that this client deserved no less acceptance and validation than any other client sharing concerns. The therapist placed the client's idiosyncratic meaning system above his own theoretical formulations.

The therapist's problem process assumption (from the MRI) viewed the ongoing interaction between the therapist and the client as significant to the client's expression of his dilemma. Although no one from the client's family was present, the therapist wondered how others have responded to the client and what solutions they have attempted to help him. A problem process perspective interpreted the client's presentation as a response to some developmental transition or incidental difficulty that the client and other's efforts at solving were probably exacerbating.

The process-content distinction allowed the therapist to utilize the client's informal theory (the client description of the complaint) as a content-oriented frame of reference for intervention. The informal theory took precedence over any formal theory notions the therapist was contemplating.

In response to the client's presentation, the therapist asked the client which leg was the woman's leg. After the client indicated it was his left leg, the therapist asked him if he had shaved his woman's leg yet. The client got a quizzical look on his face, blushed, and then laughed. He said that he wasn't going to shave his damn leg. The session proceeded to a conversation about the client's struggles in leaving home, which included a major confrontation with his parents and minister and living in an abandoned car for the past week. The young man did not make another "delusional" comment the rest of the session.

The therapist's formal theory creates a powerful context within which psychotherapy unfolds. We are arguing for a formal theory that provides maximum flexibility and that discounts the invariant application of any particular therapeutic reality. In the case example, we are not denying the possibility of brain dysfunction or biochemical imbalance. On the contrary, this particular client did in fact take an antipsychotic for a few months. Instead, we are suggesting that sole reliance on a biochemical view or any other theory severely limits intervention options and may preclude the therapist-client collaboration required for the co-construction of more helpful meanings.

In summary, this chapter has presented the formal theory of our proposed eclecticism: 1) Constructivism and Social Construction Theory; 2) Buckley's process level system description; 3) The MRI's problem process model; and 4) Held's process-content distinction. As illustrated in Figure 1, the empirical influences described in Chapter One and the theoretical foundation discussed in this chapter, form the segments that flow to the pragmatic assumptions of our approach. Chapter Three will set the stage for the clinical application to follow through a practical discussion of these assumptions