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INTEGRATING INDIVIDUAL AND SYSTEMS APPROACHES: STRATEGIC-BEHAVIORAL THERAPY

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The existing literature on the integration of family and individual approaches, largely analytic in orientation, consists of models which, for the most part, are not brief in application. An alternative, brief model is presented which integrates an individual, cognitive-behavioral approach with a strategic approach at both pragmatic and theoretical levels. The Strategic-Behavioral model justifies the selective use of behavioral frames in strategic therapy and offers guidelines for their selective application.

Interest in the possibilities and issues associated with eclecticism and integration (Dimond, Havens, & Jones, 1978; Garfield, 1980; Goldfried, 1980) is reflected in the literature addressing the integration of family therapy approaches (Colapinto, 1984; Duncan, 1984; Efron, 1986; Fraser, 1984, 1986; Sluzki, 1983). This interest has been accompanied by efforts to develop models which permit integration of individual and family approaches (Feldman, 1985; Feldman & Pinsof, 1982; Pearce & Friedman, 1980; Pinsof, 1983; Sugarman, 1986; Wachtel & Wachtel, 1986). To date, attempts to integrate individual and family approaches have primarily involved the combination of psychodynamic and nonstrategic family approaches. Largely analytic in orientation, much of the existing integration literature is not "brief" in application. Notable exceptions to these approaches are found in the behavioral literature. Barton and Alexander's (1981) functional family therapy offers both a conceptual and practical integration of systems theory and behaviorism. Systemic thinking and techniques have been integrated with operant learning and social exchange approaches in the marital therapy work of Birchler and Spinks (1980), Jacobson (1981), Jacobson and Margolin (1979) and Margolin (1981).

The present article offers, as an alternative, a brief model which integrates an individual, cognitive-behavior (hereafter called behavioral) approach with a Mental Research Institute (MRI) strategic approach. The Strategic-Behavioral Therapy (SBT) model (Duncan, Rock, & Parks, 1987) will be asserted to expand therapeutic options via the use of behavioral frames which serve systemic goals, yet do not elongate treatment. Two levels of conceptualization, pragmatic and theoretical, will support the integration model and guide the clinical application. The implications of utilizing individual therapy

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orientations to frame strategic interventions will be explored. A case example will illustrate the SBT model at both pragmatic and theoretical levels.

DEVELOPMENT OF THE MODEL

The SBT model was developed in response to the problem of "resistance" among clients in a behaviorally oriented stress-management program (see Duncan et al., 1987). The efficacy of behavioral interventions is often determined by the extent to which specific skills (e. g., relaxation, communication skills) are acquired. The assumption that all clients would readily comply with behavioral directives quickly proved unfounded. Subsequently, MRI interventions were introduced into the behavioral program for the specific purpose of enhancing compliance with behavioral directives. The combination of strategic and behavioral approaches proved most successful in terms of treatment outcome. Recognition of the pragmatic and theoretical complementarity of the two approaches permitted the development of the present model.

The Strategic Approach

To briefly summarize, the MRI approach holds that any given behavior in a system is understandable or explainable only in the context of its place in a wider, ongoing system of social interaction (Fisch, Weakland, & Segal, 1982). According to the MRI, problems generally develop in relation to ordinary life difficulties associated with transitions or unusual events. MRI's systems perspective is coupled with the view that problem formation results from solution attempts which are in some way mishandled (i. e., inappropriate). Fulfillment of two conditions, (a) the mishandling of the difficulty, and (b) applying more of the same when the original solution attempts fail, is all that is necessary for a difficulty to be transformed into a problem (Watzlawick, Weakland, & Fisch, 1974). The mishandled solution attempts exacerbate the difficulty into a problem/symptom through a positive feedback loop process (i. e., more of one leads to more of another, leads to more, etc.). Thus, the attempted solution becomes the problem (Watzlawick et al., 1974). The MRI identifies "resistance" as an interactional phenomenon of the therapist-client relationship. More so than any other individual or systemic school of therapy, the MRI has developed a specific style and methods to minimize or utilize resistance. Although other strengths of the MRI approach obviously exist, compliance enhancement can be argued to represent the MRI's "domain of expertise" (Pinsof, 1983).

The Behavioral Approach

Learning theory, upon which behavioral approaches to psychotherapy are based, explains a given behavior in terms of its relationship to ongoing sequences of antecedents and consequences (the interested reader is referred to Redd, Porterfield & Anderson [1979] for more detail concerning a behavioral approach). A behavioral approach to psychotherapy combines a general learning theory base with three assumptions regarding problem formation.

The first assumption is that, in the presence of a cuing stimulus, a deficit exists in the individual's behavioral repertoire (Paul & Bernstein, 1973). A person experiencing increased anxiety or panic attacks in response to a given situation exemplifies the first assumption. A deficit is said to exist because the person's range of possible solutions in response to the situation does not include a coping response that could effectively manage the situation.

The second assumption of a behavioral model is that an individual's interpretation of the cuing stimulus determines the nature and/or severity of the response (Meichenbaum, 1974). The person's beliefs, assumptions, and values regarding the cuing stimulus

(e. g., particular situation) affects the nature of the response as well as its intensity and duration.

The third assumption is that the consequences following the response affect the probability of its recurrence. Secondary gain reinforces a maladaptive response. Consider an individual experiencing anxiety in response to a given situation: Responding to the physiological discomfort, the individual may complain of being sick, leave the situation, and receive comfort from a spouse. The avoidance of the situation and the ensuing comfort/support (consequences or secondary gain) reinforce or increase the likelihood that the anxiety will recur.

Behavioral approaches are widely recognized for systematic methods of teaching specific skills to clients, thereby broadening the behavioral repertoire to include "coping" responses. Assertiveness training, relaxation training, sensate focus, communication training, and stress inoculation are but a few of the behavioral interventions which emphasize skill acquisition.

From a systemic perspective, it is worth considering the possibility that the behavioral, skill acquisition "frame" fits many clients' view of their problem, thus enabling responsiveness to behavioral interventions. Certainly, with specific problems, behavioral approaches have demonstrated more efficacy in the literature than have other individual or systemic approaches (Redd et al., 1979). Given the behavioral insistence upon empirical support for technique, skill acquisition can be argued to characterize the "domain of expertise" of the behavioral approach.

CONCEPTUAL FRAMEWORK FOR INTEGRATION

Two levels of conceptualization, pragmatic and theoretical, underlie the SBT model. On the pragmatic level, integration of the strategic and behavioral models is justified by: (a) the complementarity of the two approaches with regard to their domains of expertise; (b) the complementary emphasis of each approach on either Type I or Type II change; and (c) the process and conceptual similarities of the two approaches.

The theoretical level of conceptualization subsumes the pragmatic level. Duncan and Fraser's process-constructive model (Duncan, 1984; Duncan & Fraser, 1983, 1987; Fraser, 1984, 1986) combines Buckley's (1967) social systems process view with the constructivist view (cf. Watzlawick, 1984) from philosophy. The process-constructive model provides a conceptual framework which enables the selective integration of different approaches based upon the particulars of a given clinical situation (Duncan, 1984).

Pragmatic Level of Integration

Domain of expertise. The pragmatic advantage of pairing the two approaches is apparent when one compares their respective domains of expertise. The success of behavioral interventions involving skill acquisition can be enhanced if noncompliance is effectively addressed. As noted, methods for engendering compliance are a major strength of a strategic approach. Techniques which effectively minimize or utilize noncompliance such as go slow, dangers of improvement, taking-a-one-down position, qualifying language, and utilizing position (Fisch et al., 1982) can be easily incorporated into many approaches to therapy (Held, 1984).

The other side of the complementarity coin is that a behavioral approach provides for those instances in which the learning of a specific skill is deemed as appropriate by the therapist and the client. Skill acquisition, however, is not a concern of the MRI approach. As a general rule, the MRI tends to devalue skill acquisition. Like insight, it is seen as unnecessary for change to occur and serves to elongate therapy (Rohrbaugh & Eron, 1982). The principle of parsimony (i. e., the least intervention is the best

intervention) is highly valued in the MRI approach. The therapist's goal is to jam the problem cycle and terminate therapy before becoming entwined in the problem.

Unfortunately, adherence to the parsimony principle may interfere with positive treatment outcomes. Treatment options may be restricted when a skill acquisition frame fits the client's conceptualization or representation of the problem, as well as when such a frame is novel enough to provide useful dissonance to the client or family. It may also limit options when a skill deficit seems apparent, given the historical presentation of the client. The recognition that the major limitation of each approach (compliance and the behavioral approach, skill acquisition and the strategic approach) represents the domain of expertise of the other was critical to a practical integration of techniques. Each approach compensates for the weakness of the other in complementary fashion.

Type I and Type II change. The complementarity of the two approaches is further underscored in relationship to Type I or Type II change (Watzlawick et al., 1974). Briefly, Type I changes occur without a change in the basic rules or structure of a system. Frequently, Type I change is all that is necessary to achieve an interruption of the problem cycle. The behavioral skill acquisition model is a Type I change model, increasing the client's choice repertoire as well as the complexity of the range of possible solution alternatives. As such, a skill acquisition or Type I change model is a powerful change agent in and of itself. From a systemic perspective, a new skill provides an alternative to the current problem engendering solution attempts.

With the effective use of compliance-enhancing strategic interventions, skill acquisition (Type I change) can be effected with a minimal expenditure of time. At times, however, Type I changes may represent nothing more than "more of the same" solution strategies (e. g., the client whose solution strategies are characterized by trying too hard to resolve the problem and is likely to apply the newly acquired skills in a similar manner). In these situations, Type II change, which requires a change in the system's basic rules or structures, is necessary. Type II changes are, of course, the major goals of strategic interventions.

With respect to Types I and II change, the complementarity of the two approaches overlaps considerably. A sufficient increase in the level of acquired Type I skills could lead to a change in the rules of the system (Type II change). The acquisition of skills (Type I change) may alter the meaning or context of the problem. The rules governing the problem would, thus, be rendered irrelevant (Type II change). With the acquisition of a specific skill, a client may also acquire a sense of competence and control over the problem. The perception of control over the symptom, rather than a specific skill, has been suggested as the factor significant to successful outcome (Holroyd, Appel, & Andrasik, 1982). Symptom prescription interventions implicitly address the perception of control; if one can either evoke or worsen a problem, then one can probably make the problem better, as well.

The complementarity and overlap surrounding Types I and II change permits simultaneous application of interventions designed to produce specific levels of change. Both types of change may be addressed with a client in the same session; Type I and Type II change are not mutually exclusive. Such a combination potentially increases the likelihood that the problem-maintaining solution attempts of the client will be interrupted.

Similarities. The complementarity of the two approaches is further enhanced by the process and conceptual similarities between the approaches. These similarities are readily summarized: (a) both are symptom oriented; (b) conceptually and practically, both models focus on present patterns of observable behavior which precipitate and maintain problems; (c) intrapsychic variables and the role of the past are not important to problem resolution; (d) both models seek behavior change; insight is not viewed as necessary for problem resolution; (e) homework and behavioral assignments are utilized;

(f) concrete observable behavior and specificity of information from interview data are required for intervention; (g) both are directive, active approaches; (h) both are brief approaches utilizing focused interventions; (i) both share a constructivist bias in that they rely significantly on understanding and changing the client's construct of the situation; and (j) neither have a theoretical view of health or normality (Duncan et al., 1987).

The conceptual similarity of the strategic approach to the behavioral approach is probably best illustrated by the MRI statement that "all behavior . . . is continually being shaped and maintained or changed primarily by ongoing reinforcers. . . ." (Fisch et al., 1982, p. 12). Ongoing reinforcers establish a reciprocal reinforcement/positive feedback process. The circular causal systems perspective of the MRI is conceptually compatible with a behavioral model. The importance of positive feedback loops or vicious circle processes to problem formation and maintenance is recognized by behavioral clinicians (Beck, Emery, & Greenberg, 1985; Ullman & Krasner, 1975).

Overall, the assumptions underlying a behavioral approach are not incompatible with the MRI strategic model of problem formation. The behavioral assumption that secondary gain reinforces a maladaptive response fits directly with the MRI assumption of "feedback and reciprocal reinforcement" within a system (Fisch et al., 1982, p. 9).

The behavioral assumption regarding the significance of deficits in the response repertoire is also compatible with strategic theory. The strategic approach addresses repetitive applications of an ineffective solution, but not the behavioral repertoire from which the solution was selected. In some cases, it is at least possible that *nothing but* ineffective solutions exist in the client's repertoire. A skill acquisition approach would be compatible not only with a strategic approach, but would also be an important part of any intervention aimed at successfully interrupting the problem-enhancing cycle since all extant behavioral alternatives would be equally ineffective. In such cases, skill acquisition may be necessary for problem resolution to occur.

Skill acquisition does not *necessarily* lengthen the treatment process, as skill acquisition can occur concurrently with strategic interventions. A behavioral, skill acquisition approach is not only consonant with a brief approach, it actually facilitates brevity by providing a useful frame that enables clients to do something different about their problems.

Theoretical Level

Process. SBT is grounded theoretically in a process-constructive model (Duncan, 1984; Duncan & Fraser, 1983, 1987; Fraser, 1984, 1986) of selective integration. The "process" component of this model is derived from Buckley's (1967) hierarchical scheme of systems, which describes characteristics of systems according to the level of system under concern (cf. Duncan, 1984; Fraser 1984). Germane to the current discussion is Buckley's process/adaptive level of system description. This level, which subsumes all others, is characterized by ongoing process, fluid structure, morphostasis, and a *dependence* on change (variability) to remain viable. Sociocultural systems, like the family, exemplify this level.

When comparing strategic and structural views in relationship to Buckley's hierarchy, it was concluded that with one exception, all views appeared to be based upon the implicit homeostatic and structural assumptions of a biological level of system description (Duncan & Fraser, 1983). The MRI view, however, appeared to share more with the process-based, deviation amplifying assumptions of a social system (process) level of system description. As a process-based approach, the MRI view can be argued to subsume approaches based on lower levels of system description.

Duncan's (1984) strategic use of the functionality of symptoms demonstrates the selective use of a biological systemic construct (function) from an overriding process

level. Operating on the premises of ongoing process, fluid structure, and morphogenesis, frees a therapist to design interventions which match the client's world view and presentation of the problem.

Adopting the premises of the process level permits not only the use of lower level systemic constructs, but also enables the selective use of *any* construct or theoretical language to facilitate change. The process-based strategic approach furnishes the framework through which any specific content area (e. g., bulimia, gifted children, sexual difficulties, etc.), as well as any theoretical orientation (e. g., behavioral, existential, structural) may be employed to promote change in the problem cycle.

In a similar vein, Held (1986) asserts that the strategic model can subsume both individual and interpersonal levels of content since change is achieved via processes. In other words, a strategic approach posits no specific content (e. g., confused hierarchy, skill deficit, fixated psychosexual development, etc.) as the "true maintainer" of the problem; rather than one "true view," multiple views of reality prevail. Consequently, differing contents or language (views of reality) can be employed to construct frames and design interventions.

The process by which a therapist selects or constructs "reality" is entirely dependent upon the particular client and the specific clinical situation. The use of a specific content area in the construction of a frame is determined by client presentation (i. e., history, behavior constellations, etc.). For example, a mother presenting with concerns regarding her gifted child's school anxiety may respond to frames constructed around the content area of "gifted children."

Constructive. The constructive component of the model derives from constructivist philosophy (cf. Watzlawick, 1984). Simply stated, reality, like beauty, rests entirely in the eye of the beholder; there is no objective reality or truth inherent in a given situation. Reality, therefore, is constructed by each individual in each circumstance. The process of construction is based in complex sociocultural interaction between the everchanging larger society, the family, and the biologically/psychologically developing individual. The constructivist position is central to a selective integration model. In the absence of a specific view of reality, the therapist is free to entertain the "reality" of any content that seems applicable in a given clinical situation. Rather than imposing the therapist's theoretical reality on the client, a theoretical language or specific content is chosen because it best matches the client's conceptualization and presentation of the problem.

By the same token, if the client's presentation and conceptualization of the problem appears congruent with a particular theoretical orientation or language, the therapist may utilize that orientation in designing the intervention. Regardless of the content selected, the ultimate systemic goal remains that of interrupting the problem-containing process. For example, a client may present the problem as depression, and complain of malaise, feeling trapped, and overwhelmed by a sense of futility and meaninglessness. Utilizing this presentation, the therapist may draw from an existential therapy model to devise a frame. The symptoms may be normalized as a predictable response to the difficulty in finding meaning in a world that has no inherent meaning. Reframed as "existential anxiety," the depression may then become an existential dilemma to be contemplated and possibly not changed.

At times it is more helpful to construct a frame that may not appear to be directly related to the client's presentation of the problem. The purpose of such an intervention is to create dissonance and variability in the problem-containing system. Qualifying language such as, "some therapists might say. . .," allows the therapist to send out "trial balloons" for frames constructed from other theoretical orientations. The utility of the frame is, of course, determined by the reaction it elicits from the system (i. e., a change in the problem process).

Behavioral frames in strategic therapy. The use of behavioral frames exemplifies the relevancy of the process-constructive model to effective clinical work. In general, it is proposed that behavioral frames are widely applicable to a strategic perspective because of the previously described complementarities and similarities of the two approaches. Furthermore, behavioral interventions (frames) have established a well regarded and demonstrated efficacy with certain problems. To reiterate, one possible explanation of this success is that behavioral conceptualizations may sometimes conform to client perceptions, therefore facilitating change in the problem cycle. One may speculate that public familiarity with behavioral strategies (self-help books, behavior modification in schools, weight loss regimes, etc.) has encouraged acceptance of behavioral frames. Whatever the reason for the success of behavioral frames, the use of such frames seems not only reasonable but also indicated in certain instances. Integrating behavioral frames into strategic therapy broadens the range of possible interventions, enhancing therapeutic flexibility.

Certain kinds of problems seem especially appropriate for the SBT model. Problems that have an anxiety or sympathetic overarousal component such as panic attacks, phobias, or sexual dysfunctions, to mention a few, are particularly appropriate.

It is important to emphasize that the decision to integrate behavioral (content) frames is not contingent upon acceptance of a behavioral treatment philosophy. When working from a systems paradigm, behavioral frames, like other content frames, represent a means to the desired goal of interrupting the problem-maintaining process.

CASE EXAMPLE

The following case example and discussion will illustrate the SBT model:

Bob and Carol, a couple in their early 30's requested therapy after 3 years of marriage. The presenting complaints were marital quarrels, difficulty communicating about sexual matters, and sexual performance problems. The quarrels were described as unpredictable, but patterned. Bob would "blow up," criticizing Carol. A loud argument would ensue and Carol would withdraw in tears. Sexual intercourse was characterized by frequent erectile failure or premature ejaculation.

Carol was most upset by the harsh criticisms and expressed hope that communication would improve if the sexual difficulties were resolved. Bob expressed concern about his occassional blow-ups, and admitted that he was feeling increasing frustration about sexual problems. Bob acknowledged that Carol was the more sexually experienced of the two; in fact, Bob was without prior experience and had no history of successful sexual functioning (i. e., erection without premature ejaculation). Both clients expressed a commitment to the marriage and a desire to learn how to effectively cope with their problems.

In the first session, two simple interventions were delivered. Bob's blow-ups were framed as quite understandable given his frustrated sexual experiences. The therapist suggested that the blow-ups protected them both from further frustration experiences, since both were usually too hurt or angry to speak to one another afterwards, and expressed his admiration and respect for the couple's love and concern for one another. The couple was instructed to continue the blow-ups, but with a slight modification: Carol was to agree with and exaggerate Bob's criticisms, and to express her understanding of Bob's frustration and anger over the sexual problems. The couple was also given an instruction to "go slow" with supporting rationales for the directive.

The couple returned in 2 weeks, reporting that there had been no blow-ups and that, overall, they were getting along better. The sexual problems remained. The therapist expressed bewilderment and reemphasized the necessity for moving slowly, especially with sexual difficulties. The remainder of the second session was spent with Bob

normalizing his sexual difficulties and discussing the particulars of his problem. Bob reported feeling very anxious whenever intercourse was attempted. The anxiety progressively worsened as problems developed during attempts at intercourse.

He stated that he felt neither aroused nor attracted to Carol during those times; the therapist responded with "no wonder," and presented information on the inhibiting effects of anxiety on sexual functioning. Since Bob was somewhat naive about sexual functioning, time was spent discussing erectile difficulties and premature ejaculation in terms of anxiety interference and the sexual response cycle. This information was presented in a "one-down" and "qualified" manner. At the end of the session, the couple was directed to abstain from sexual contact; a relapse of the quarreling was predicted.

In session three, the couple reported they continued to get along better than they had for some time; the therapist responded by cautioning against rapid change and predicting a relapse. Using a one-down, "qualified" stance, the therapist taught Bob a relaxation exercise and suggested that he practice the exercise only as much as he felt comfortable to reduce his anxiety. An intervention design for the communication and sexual difficulties was then introduced. Sensate focus exercises were explained and prescribed in terms of enhancing communication skills. Sexual contact continued to be forbidden.

During the fourth session, Bob reported that the relaxation exercise helped with his insomnia (this was the first mention of that problem). Genital pleasuring was added to the sensate focus prescription. At the first hint of anxiety, Bob was directed to stop the pleasuring and practice his relaxation exercise. If an erection developed, Carol was instructed to discontinue the fondling until Bob became flaccid; the up-down procedure was to be repeated five times. Intercourse was prohibited.

In session five, Bob reported enjoying the exercise, as well as feeling very attracted to Carol. Although Bob had previously been reluctant to perform cunnilingus, they admitted to orally manipulating one another to orgasm. Both hoped that would be all right with the therapist's prior instructions. The therapist responded with a warning about rapid improvement and prescribed the insertion phase of the sensate focus exercise.

The couple reported they were ready to terminate in session six. Intercourse had been successfully accomplished and both were satisfied they could handle the remaining concerns. Although the premature ejaculation problem remained, both saw it as a problem they could successfully resolve on their own if the therapist could suggest some helpful exercises. The therapist agreed and presented the stop-start and squeeze techniques as possibly useful in developing control over Bob's orgasm. One final intervention was delivered. The therapist presented relapse as inevitable and suggested that Bob might want to intentionally lose his erection on occasion. This intentional failure would serve to remind Bob that all men experience at least some erectile difficulty from time to time.

Discussion

This case illustrates how skill acquisition (relaxation training, sensate focus) was combined with more general, compliance-enhancing interventions (go slow, qualifying language, one-down) and specific strategic interventions (symptom prescription, reframing) to address both Type I and Type II change. The couple left treatment with the presenting problems eliminated or improved; additionally, Bob acquired a coping strategy (relaxation) that he could generalize to a different problem (insomnia)

A behavioral skill acquisition frame was selected for two reasons. First, and most importantly, the frame was based on the client's presentation and conceptualization of their problem. They perceived themselves as experiencing communication problems; Bob perceived himself as suffering from anxiety when performing sexually. Thus, skill

acquisition frames (i. e., learning a new way to communicate their sexual needs; anxiety management) were consonant with their presentation. Behavioral frames were also selected on the basis of the type of problems that were presented. Behavioral approaches have been recognized for their efficacy with both sexual difficulties and anxiety (Redd et. al., 1979).

All of the behavioral frames were employed in service of the overriding systems goal: interruption of the process by which the clients' solution attempts maintained the problem. The behavioral frames created a new context for the sexual difficulties; the strategic intervention of symptom prescription, likewise, changed the context of the quarreling. While each avenue of intervention addresses a different level of change, both attempt to influence a change in behavior related to the presenting problem. A behavioral perspective provides an equally plausible rationale for the successful outcome. It could be argued that the acquisition of specific anxiety management and pleasuring skills were the factors significant in the outcome.

After the modified quarreling was prescribed, the arguments stopped. However, changing the quarreling did not change the sexual problems. Contrary to L'Abate's suggestion (1986), the notion of the ripple effect (the construct of "wholeness" in action) is seen as a very useful assumption that is, in some way, applicable to all cases. In clinical situations where a skill deficit is apparent, a positive ripple effect may not be sufficient to produce the desired change, but may set up or enhance subsequent interventions. The alleviation of the quarreling reduced tension and set the stage for interventions aimed at the sexual concerns.

The use of a purely strategic intervention (e. g., prescribing erectile failure) was not considered because of the specifics of the situation. Bob's sexual history strongly suggested that adequate coping skills were unlikely to be present in his sexual repertoire. A skill deficit assumption seemed more applicable in this case; it is unlikely that a strategic intervention directed at the erectile difficulty would have rippled to, and helped, the premature ejaculation difficulty, given Bob's history. Thus, the relaxation technique was taught so Bob could attenuate his sympathetic overarousal and the couple was instructed in the sensate focus technique.

It is worth noting that once the skill deficit was addressed, the ripple effect was powerful enough to impact the couple's perceived competence to address the premature ejaculation concern on their own terms. The behavioral approach dictated much of "what" was presented and the strategic dictated "how" the couple was approached.

CONCLUSION

The proposed SBT model is supported at two levels of conceptualization. The lower, pragmatic level of integration is enabled by the complementarity of the behavioral and strategic approaches with regard to their domains of expertise and emphasis on either Type I or Type II change. Additionally, the pragmatic level of integration is supported by the similarities shared by the two approaches.

An overriding process-constructive model of selective integration provides the theoretical justification for the SBT model. At the theoretical level, behavioral frames are no different than other frames selectively integrated into a process approach. Behavioral (or other) frames offer a content or theoretical language through which clients can be influenced to change. Behavioral frames were asserted to have wide applicability because of the established success of many behavioral interventions.

Whether one views the model as "Strategic-Behavioral Therapy" (the pragmatic level of integration) or as using behavioral frames in strategic therapy (the theoretical level), the proposed model may be helpful under several circumstances. First, an SBT approach is helpful when the client presents the problem in behavioral or skill acqui-

sition language. Comments such as, "I need to learn how to cope," "If I could only learn how to relax," "I wish I were more assertive," "I say too many 'shoulds'," etc., provide cues for developing behavioral frames which will promote the interruption of problem cycles.

SBT may be helpful when the historical evidence from the client seems to support a hypothesis of a skill deficit. While most clients possess the resources needed to make a particular behavioral change, it is at least possible that some do not. In such instances, a skill acquisition model can be utilized simultaneously with other interventions without lengthening the treatment process.

SBT may also be useful as a tool to introduce variability or dissonance into the problem system. If the frame is accepted by the client or family and promotes change, the therapist may choose to continue to frame the given situation in behavioral terms. If the frame is not useful, the therapist may select a different frame. Finally, SBT may be helpful for specific types of problems (e. g., anxiety), given the efficacy of certain behavioral interventions.

This paper has attempted to offer a specific rationale and method for integrating an individual orientation (content) with a strategic (process) approach (Held, 1986). It is hoped that as a result, some of the confusion and abstraction regarding the use of different orientations within the context of strategic therapy will be eliminated.

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