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ECLECTIC STRATEGIC PRACTICE: A PROCESS CONSTRUCTIVE PERSPECTIVE

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The development of an integrative individual and family therapy approach has been hampered by fundamental differences in philosophy and theoretical conceptualization among approaches. Given these largely irreconcilable differences, a systemic framework for a technical eclecticism may represent a logical step toward a more flexible consideration of both individual and family approaches. This article will describe an extension of the strategic therapy model that enables and encourages the selective application of content and techniques from individual and family approaches. Three case examples will illustrate a process-oriented, constructivist rationale for eclectic strategic practice as well as a more collaborative and relationship-oriented perspective of strategic therapy.

The fundamental differences in philosophy, theoretical conceptualization, and treatment goals which distinguish the multiple models of individual and family therapy constitute a formidable obstacle to the development of an integrated psychotherapy model (Goldfried & Newman, 1986). Given these largely irreconcilable differences, an eclectic, rather than integrative, effort may provide a more pragmatic direction for the systems-oriented clinician desiring to utilize individual approaches. Technical eclecticism endorses the use of a variety of techniques within a preferred theory; a connection between metabeliefs and techniques is not necessary (Lazarus, 1967; Norcross, 1986). A systemic framework for such an eclecticism may represent a logical step toward a more flexible consideration of both individual and family approaches.

While the Mental Research Institute's (MRI) brief interactional therapy (Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fisch, 1974) is not presented as an eclectic model of therapy, others have suggested that the MRI approach may provide

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a basis for the use of a variety of therapy views and techniques. It has been argued that an MRI view is a process/adaptive systems perspective (Buckley, 1967) that subsumes homeostatic systemic views and, therefore, can use homeostatic family therapy approaches as metaphors for intervention (Duncan, 1984; Fraser, 1986). Held (1984, 1986) asserts that the MRI approach is relatively void of a specific theoretical content, thereby enabling a flexible use of theoretical content from any approach. Finally, Duncan and Parks (1988) present an example of an MRI-based strategic eclecticism in which behavioral therapy content and technique are employed within an overarching systemic framework.

The present article will describe an extension of the MRI brief therapy model that enables and encourages the selective application of content and techniques from both individual and family approaches. A process-oriented, constructivist rationale for eclectic strategic practice will be presented, not only as a theory base for technical eclecticism, but also as an updated and more collaborative description of the practice of modern strategic therapy. The theoretical and pragmatic assumptions which underlie a process-constructive perspective will be discussed and eclectic strategic practice will be illustrated via clinical examples.

A PROCESS CONSTRUCTIVE DESCRIPTION OF ECLECTIC STRATEGIC PRACTICE

The proposed theoretical foundation for eclectic strategic practice is drawn from two primary sources, constructivism and systems theory. The first theoretical component, constructivism, posits that reality does not exist as a phenomenon separate from the constructs of the observer-describer (von Foerster, 1981; Watzlawick, 1984). The second element, a systems view of "process," is described at three levels: (a) Buckley's (1967) process/adaptive level of system description; (b) the MRI's problem formation model (Watzlawick et al., 1974); and (c) Held's (1986) process/content schema for psychotherapy models.

Constructivism

The constructivist position holds that individuals do not discover "reality," rather, they invent it (Watzlawick, 1984). Experience orders and organizes the environment; it does not directly reflect it. Reality develops phenomenologically, emerging from the individual's interaction with the environment.

Reality is evident only through the constructed meanings which shape and organize experience; simply put, meaning *is* reality. Meaning is inherent in neither the external experience nor the internal state, but, rather, in the interaction and relationship between the two (Buckley, 1967). The construction of reality/meaning by individuals is a highly creative process which is limited somewhat by prevailing sociocultural limits and expectations. The creation of meaning frames and organizes perception and experience into rule-governed patterns through which individuals may predict, describe, and direct their lives.

Two levels of meaning construction are posited by Buckley (1967). Initially, meaning is created during the ongoing interaction between an individual and the social environment. The human capacities for symbol manipulation and self-awareness enable a second level of meaning construction. Humans can continue to experience a transaction entirely at a covert level, permitting the continuous generation of meaning and meaningful behavior apart from the actual transaction(s). Therefore, a meaning system can be said to be generated by the actual transactional experience, its covert rehearsal or repetition, and the meaning constructed to organize both (Buckley, 1967).

The constructivist paradigm bears implications for a flexible, eclectic strategic practice. Therapists, like clients, are engaged in the struggle to create a predictable,

structured reality. Models of psychotherapy and individual/family development serve to assist clinicians in the struggle to order their own perception and experience regarding the client's presenting problem. In addition, theory functions to structure the assumptions and goals of the interactive process which is designated "psychotherapy" (Beutler, 1983). Paradoxically, the structure which the therapist selects also limits the search for solutions. From a constructivist vantage point, theoretical language and content conceptualizations may be viewed as metaphorical representations which explain and organize the therapist's reality. The theoretical language and content of Buckley's process model may provide a flexible metaphor for organizing a systemic framework for eclecticism.

Buckley's Process Model of Systems

Buckley (1967) classifies systems at three levels, each applicable to a specific domain: (a) mechanical/equilibrial (inorganic, chemical, and mechanical systems): (b) organismic/homeostatic (biological systems); and (c) process/adaptive (social systems). Germane to this discussion is the third level, the process adaptive, which is characterized by a dependence on variability and an implied capacity for growth or change.

This level has three characteristics: (a) fluid structure, ongoing process; (b) nonpurpose; and (c) evolution and elaboration. In social systems, the process is primary; it is the actions and interactions among members of the system which creates structure. This ongoing process involves not only the actions and interactions among system members, but, also, their everchanging, everdeveloping relationships. Because form is fluid, structure in social systems is but a temporary accommodating representation of a process which is continuous.

Unlike biological systems which are characterized by fixed structures (e.g., the hypothalamus) which perform recognizable and invariant functions across systems (e.g., temperature regulation), social systems are characterized by no immediately identifiable structures of invariant function. Purpose does not exist in process-level systems; like structure, it is an attribution of the observer. The aggregation of individuals in a system represents a level of abstraction and complexity that precludes a determination of inherent systemic purpose. At the social system level, only individuals act with purpose; systems do not.

Inherent to process-level systems is a capacity for evolution and elaboration; these systems are not only sensitive to change (variability), but are essentially dependent upon change to exist or remain viable. System interactions are precipitated by small changes or variations in the internal or external environments. Variation may result from a developmental or transitional change, or simply through chance. The variation or perturbation provides the system with information, which may or may not signify difference or importance. The system members interact to assimilate the new information/variation into ongoing patterns or accommodate the patterns to the variation. Individual and shared meanings constructed through the interaction surrounding the variation both guide, and are shaped by, the ongoing interactional process. Variation, then, is the stimulus for interactional process, constructed meaning, and the continual movement toward greater complexity, flexibility, and differentiation.

Problem Process

Problems develop when the system attempts to adjust or adapt to variation. This variation, once perceived as a difficulty, will influence individual and shared constructs of the system. The problem consists of not only the original perceived difficulty, but, also, the meanings that system members assign to the difficulty. The MRI proposes that only two conditions are necessary for a "difficulty" to become a problem: (a) the

mishandling of the difficulty; and (b) when the original solution attempt fails, more of the same is applied (Watzlawick et al., 1974). It is the problem process, per se, that is of interest and importance: i.e., the process of inter-/intra personal interaction surrounding the problem, the process of individual and shared meaning construction, and the interplay of both. Based on individual and shared meanings regarding the problem or possible solutions, people repeatedly will try variations on the theme of a particular solution pattern. This may occur even though the solution pattern itself worsens, rather than improves, the difficulty, thereby creating a vicious cycle.

The meanings constructed by those involved both influence and are influenced by the problem, itself. This reciprocal process creates a problem-oriented system (Goolishian & Anderson, 1987), i.e., a system in which interpersonal interaction and meaning construction are organized around the problem.

Process versus Content

Although the MRI does not present their approach as compatible with other theoretical orientations, Held (1986) argues that the MRI approach can subsume other individual and interpersonal models. The MRI holds that problems develop from chance or transitional circumstances encountered by individuals and families evolving through the life cycle. Significant etiology resides in the process itself, rather than in factors such as personality or history. Change, according to the MRI, is achieved by changing the interactive process which supports the problem.

Held (1986), building upon the work of Prochaska and DiClemente (1982), argues that the MRI problem process model is a general and inclusive view of problem formation and maintenance; it posits no particular theoretical "true maintainer" or "real cause" of the presenting problem (e.g., fixated psychosexual development, confused hierarchy, existential anxiety, irrational beliefs, etc.) other than redundant solutions. While all models of psychotherapy contain theoretical content, they vary in the degree to which content is emphasized and elaborated (Held, 1988). Although variation exists in the extent to which the therapeutic process is ordered by any particular theoretical "reality," most therapies fall to the content-oriented pole of the content-process continuum.

For example, a psychodynamic therapist may view the presenting problem as a result of fixated psychosexual development. The therapist may pursue information from the specific stage of development under question and make interpretations to allow the client to integrate unconscious material. A structural therapist may view a child problem as related to the marital relationship and, therefore, act to remove the child from the marital conflict and refocus the problem as trust and intimacy issues between the parents. An MRI therapist may view the presenting problem as a vicious cycle of unsuccessful solution attempts by the client and others attempting resolution. The therapist may pursue an interruption of the problem-maintaining process. While the psychodynamic and structural approaches posit particular content paths (i.e., psychosexual fixation, child diverting conflict), the MRI focuses on the process surrounding the problem. Accordingly, Held (1986) has identified the MRI's approach as process oriented, rather than content oriented.

Held's process/content distinction bears implications related to decisions regarding treatment goals. The theoretical reality of the therapist orders the goals (both overt and covert) and outcome criteria; the more content oriented the approach, the more content defined are the goals. An MRI change model shifts therapist focus from theoretically ordered content goals to process-based goals and outcome criteria. The only goal which this model dictates is that of changing the interactional process which permits the problem.

From a process-constructive perspective, the significant content is that which the client presents; for a client to articulate a concern requires that it be framed in a content-rich meaning system. A process-oriented approach such as the MRI's may provide a

basis for technical eclecticism in which the content-structured goals of the client are facilitated by the process-structured goals of the therapist.

PRAGMATIC ASSUMPTIONS AND CLINICAL INTERVENTIONS

The foundations provided by the MRI, constructivism, Buckley, and Held suggest several assumptions regarding people, problems, and intervention strategies. Three case examples have been selected to illustrate the pragmatic assumptions and clinical application of eclectic strategic practice.

Case Examples

Case l. An intact family of three sought therapy for "school phobia." Sam, the 10-year-old son, had not attended school more than once weekly in the prior month. With a hint of anger in her voice, Mother (Peg) reported that each day she arose before the others, completed leftover chores, prepared the family's breakfast, and prepared Sam for school. Mother then departed for work, leaving Sam alone to wait a half hour for the bus. Within the half hour, Sam would phone mother at work, complaining of nausea. Mother would return home, to minister to Sam, who, on occasion would vomit.

Case 2. Joe, a 19-year-old college student, became increasingly preoccupied with religion, the preoccupation culminating in an announcement to his family that he was a messenger from God. Parental attempts to calmly reason with Joe evoked accusations that his parents were "disciples of the devil." When Joe began pounding on doors at all hours, attempting to spread the Word, he was taken into custody. The parents were very invested in avoiding a hospitalization due to the father's very negative experience with a psychiatric hospital many years before.

Case 3. Andy, a 41-year-old executive, presented with complaints of anxiety and periodic panic attacks. Explaining his problem in detail, he was unable to identify any precipitating event or speculate upon any cause for the anxiety; in fact, he reported that everything in his life was going well. He clearly stated that his goal was to identify options which might permit understanding and control of his anxiety. He would then evaluate their merits and choose an action plan to implement. The client was somewhat familiar with different treatment modalities as a result of a class he had taken.

Pragmatic Assumptions

Assumption #1: The therapist's role is consultative; the therapeutic relationship is collaborative and cooperative. To the extent that it emphasizes the primacy of the client's subjective reality, a process-constructive approach is phenomenological and client centered. Understanding and respecting the client's meaning system is the basis for both the therapeutic relationship and the intervention process. Emotion, a significant component of the meaning system, is attended to through an explicitly empathic therapeutic stance. Explicit empathy validates and normalizes the client's experience of the problem and may enable a shift in the frame around experience. Attending to the emotional context of the presenting complaint also provides the therapist with invaluable information for intervention.

In each case, the therapist established a collaborative and cooperative relationship by respectfully incorporating the client's view of the problem as well as client feedback to the therapist. The resentment and anger that Sam's mother (Case #1) felt were acknowledged, validated, and incorporated into the intervention. Joe's desire to spread God's word (Case #2) was neither discounted nor pathologized; empathy for the difficulties encountered by one in Joe's position provided the basis for a somewhat unorthodox, but effective, intervention. Andy's desire to understand his anxiety (Case #3) and his cursory familiarity with treatment options were respected, and were seen as of paramount importance to the development of an effective intervention.

This is not to say that the therapist may *never* adopt a less collaborative stance; on the contrary, some clients may expect, and, thus, respond well to a more authoritative or expert position. In any event, the client presentation dictates such therapeutic choices and it is the therapist who must flexibly select the best fit for the client. Most clinical situations seem more amenable to change when a collaborative stance is assumed.

Assumption #2: The client presentation, rather than the therapist's orientation, determines the content of the therapeutic conversation and intervention. Constructivism suggests that reality exists only as a construct of each party to the problem process. In a second-order view, the reality of the client interacts with the therapist's reality as individual and consensual realities related to the problem emerge. Like the client, the therapist is also involved in a struggle to order and organize the problem-focused system. The content orientation to which the therapist subscribes both enables and restricts intervention options. Therapists continually struggle to achieve balance between the flexibility and uncertainty of process and the directionality and limitations of content (Held, 1986). For the therapist who subscribes to the constructivist view, the realities of the client and therapist are equally true and real; the therapist's reality does not automatically supercede that of the client.

The potential advantage of the constructivist position is the freedom it offers to the therapeutic endeavor. Once the content/process distinction is appreciated, it becomes feasible for the client's unique presentation to direct the content of the therapeutic conversation.

Content may be selected from four sources: (a) *generic response patterns* associated with incidental and developmental crises (e.g., grief, rape, midlife crisis); (b) *specific clinical content areas* (e.g., gifted children, AIDS, anxiety disorders); (c) *problem-specific intervention techniques or conceptualizations* (e.g., relaxation training, sensate focus); and (d) *specific theoretical formulations* (e.g., psychoanalytic, structural).

The case of Andy (#3) illustrates content selected from all four sources. The clinical content area of "anxiety" was the obvious choice, given Andy's presenting complaints. This content area provided a conceptual framework which was consistent with Andy's view of the problem situation. Recall Andy's initial expressed desire to explore several possible causes and solutions to his complaint. In service of that desire, the therapist presented psychoanalytic, behavioral, existential, family therapy, and developmental explanations for the anxiety. Client response to a particular content area indicates the fit, or lack thereof, with the client's meaning system. The extent to which fit occurs, directs the pursuit of any given content area in the therapeutic conversation.

In Sam's case (#1), the content and language of a particular approach (Madanes, 1981) was utilized because of the therapist's perception of Mother's anger and the inequality of responsibility that seemed apparent. The selection of this content was predicated by the client presentation, rather than the belief in the inherent truth of the Madanes model.

In the case of Joe (#2) the therapeutic conversation was directed by the client presentation and the information provided by the parents regarding Joe's behavior. The therapist acknowledged Joe's belief that he had been called by God as a messenger. The problems related to drawing people to the Message were explored. It was tentatively suggested to Joe that the power of God's message might appear frightening, confusing, and overwhelming to the unenlightened, thus leading many to discount and retreat from Joe's efforts to share the Word. Joe's response to this hypothesis shaped the intervention plan.

Content is only the vehicle through which the problem process is influenced. The overriding goal is to alter the meaning or context of the problem process in the direction of improvement. Content matches client circumstances, rather than tailoring client circumstances to the therapist's orientation.

The specific grounds on which the content-matching decision is made is not determined by diagnostic nomenclature. Clinical diagnoses seem too broad and nonspecific to dictate a specific course of treatment (Beutler, 1986). In a similar vein, while the content-matching decision is not determined by specific client qualities such as symptom complexity, client coping style, reactance level (Beutler, 1986), or any other theory or content-based rationale, intervention may incorporate any or all of these factors. The matching decision is based entirely in the content-laden description of the presenting concern offered by the client. The specific client quality, therefore, could consist of any quality that the client offers as relevant to the presenting problem; the matching decision is directed by the content focus of the client.

Assumption #3: Problems and their solutions are embedded in the interactive process. Regardless of its relationship to the past or individual factors, all behavior is continually being influenced by ongoing interaction in the social system (Watzlawick et al., 1974). Problems occur as a result of the interaction of the biopsychosocial unit with the environment and its construction of the environment; they are maintained or exacerbated by a vicious cycle of attempts to adjust or adapt to a difficulty in living.

In Joe's case (#2), regardless of possible brain dysfunction/biochemical imbalance, there existed an interactional process around the problem which enabled therapeutic participation in problem definition and problem solution. This is not to suggest that biochemical imbalances do not exist or do not merit consideration. However, sole reliance on such a view may restrict intervention options and preclude therapist collaboration in the construction of a more helpful, problem-solving meaning.

Since therapy focuses on interactive and process variables, individual or systemic pathology is not emphasized nor are symptoms seen as necessarily functional to the individual or interpersonal system (Duncan, 1984). This is a nonperjorative and nonjudgemental view of people and problems; attributions of pathology are viewed as generally unhelpful and potentially harmful. While ascriptions of functionality may be utilized, investment in the concept of functionality may limit therapeutic options. In Sam's case (#1), the parents were not viewed as overinvolved/peripheral nor was the marital dyad judged as "dysfunctional" and dependent upon the problem to maintain stability; such attributions implicitly connote fault. In a similar vein, diagnostic labels which construct the situation as either unchangeable or bearing a poor prognosis are avoided. This is not to say that the information that a diagnosis may yield should be ignored, but, rather, that such information may not be necessarily helpful in the design of interventions.

Aligning with a process-level model, an eclectic strategic perspective expects that growth and change will occur. This resource-based perspective encourages the creation of a change-enhancing therapeutic context, given the therapist's construction of the inevitability of change.

Assumption #4: The client's meaning system and view of reality is primary to the problem-oriented system. It is the client's construction of meaning related to the presenting concern that is important to the problem process. The client's presentation of the problem offers the entry point through which changes may be effected. Joe (#2) believed he was a messenger from God; attempts to dissuade him from his holy mission were viewed as inspired by the enemy (the devil). Andy (#3) expressed a willingness to consider multiple conceptualizations for his problem; as a successful executive, he valued his ability to investigate and weigh options and take decisive action based on information.

Presentation involves not only the client's description of and beliefs about the presenting concern and its meaning, but, also, the associated affective experience. Recall Peg, Sam's mother (case #1). Her presentation of the problem situation was accompanied by a controlled, veiled anger and acknowledged frustration with the situation. Joe (#2)

became defensive and suspicious when his view was questioned; Joe's dad was frightened and uncomfortable with the possibility of a psychiatric hospitalization. Through the entry point of the client's emotional experience, a context for the construction of a differing meaning system may be created.

The presenting complaint is what the client says it is, be it discrete, concrete, or specific (e.g., panic attacks, avoiding hospitalization, "school phobia") or global, abstract, or esoteric (e.g., spreading God's message). Regardless of the client's agenda, the therapist respectfully incorporates the client's view into the therapy.

Reiterating, this is not to say that the therapist may not conceptualize the "problem" as schizophrenia, pedophelia, or any other diagnostic category, or that such a classification is not useful or even imperative to consider or incorporate. Rather, it is the clients' description of the problem, their particular complaint, that warrants special attention with regard to the intervention selected.

Assumption #5: Problem improvement occurs by influencing the context of the problem via the actual interaction and/or its acquired meaning system. Change occurs at either of two meaning levels (see Buckley, 1967). At Level I, interaction generates meaning that organizes perception, further directing and influencing interactions that constitute the problem cycle. Influence at this level entails changing the interactional context, thereby challenging the limits of the client's constructed meanings. Placing clients and the problem process in a different context enables new meanings to be ascribed; changing the context, therefore, generates new meaning (Erickson, 1980).

Level I interventions seek to influence the actual interaction that maintains the problem and involve either *prescribing different behaviors based on an accepted client meaning, or prescribing tasks and current behaviors.*

Due to the individual's ability to recall and review interaction following its termination, the acquired meaning system can also be influenced apart from the actual transaction. Direct exploration of the problem-oriented reality may promote alternative ascriptions of meaning by the therapist or client. Level II interventions involve either *empowering client ascribed meaning* or *ascribing a different meaning to the problem situation.* Excerpts from the three cases will illustrate the clinical application of the two levels of intervention:

Case 1 (Sam)

T: There are certainly a lot of ways to look at a problem like this. Some therapists might say, and this may sound a bit crazy so please bear with me, that Sam's school phobia problem, his getting sick to his stomach in the morning, is a metaphorical expression of unexpressed anger between the parents.

P: What do you mean? *[Looking interested.]*

T: Well, again, this is just one way of looking at this problem—that Sam gets sick in the morning preventing him from going to school, is a metaphorical expression of Mom being *sick* and tired of carrying the whole load. After all, both of your jobs are equally important, yet, it is always Mom who must interrupt her work routine and come home, while Dad is able to work and not be bothered. Not to mention that it is Mom who must also be responsible for keeping the house, fixing the meals, etc. In essence, then, and this may seem far-fetched, when Sam throws up, he's doing it more for Mom than for himself.

P: That's great! *[Laughing for a while.]* You know, I haven't told Dan about my resentment for all this.

D: What should we do?

T: To let Sam see that he is no longer needed to express Mom's unexpressed resentment, it may be helpful for you, Dan, to help a bit more around the house—but, more importantly, it may more strongly convey the message to Sam if you are the one that he calls in the morning when he is sick. Are you willing to try that?

D: Of course, anything that will help.

Case 2 (Joe).

C: I know you won't believe this, but I'm a messenger from God and I have a mission to spread His word to everyone on earth. Are you religious? Do you believe in God? Do you believe me—that I'm a messenger from God?

T: I believe you and yes, I am religious. I can tell by the glow on your face that you've been touched by God and you are truly a messenger from Him. I feel honored to be talking with you, but I'm concerned that no one will hear your very important message.

C: I think I see what you're getting at. You mean that they won't believe me.

T: Yes, and, also, that this kind of message is so powerful and divine that it is probably just plain overwhelming to most people who are unenlightened and have not received divine inspiration as you have. I'm afraid that given this, they can't possibly understand the beauty and glory of your message from Him. What scares me is that they will become frightened and confused and will discount the message of love that you're trying to deliver. What do you think?

C: Well, I think you're right.

T: I wonder how else you can spread God's word in more subtle, yet powerful, ways that mere mortals can understand and accept. One thing that occurs to me is that you could possibly share the Word and accomplish your mission on earth by giving God's love to people a little at a time. You could smile His holy smile and greet people with His love and demonstrate His word by your deeds, rather than your words.

Case 3 (Andy).

T: There are many options with regard to understanding this problem of yours, as well as controlling it, but I'm not convinced of the validity of any of the options—so I need your help to figure out the best plan of attack.

C: Sure—what are the options?

T: Well, again, none of these options I'm about to say are the truth, with a capital T, but are, rather, a few of the many different ways that the various schools of therapy might suggest. A psychoanalytic therapist may suggest that your anxiety problem is a surface manifestation of an underlying, unresolved conflict, and represents a defense against this conflict coming to your conscious mind. The unresolved conflict could probably be best understood by the exploration of your childhood and your relationship with your parents. A behavioral therapist may suggest that your anxiety is a learned physiological response to certain situational events that is somehow being reinforced or rewarded in the environment. A behavioral therapist would advocate the learning of a relaxation technique so that you can have a coping response to respond to those situations instead of your current response of anxiety and panic attacks. An existential therapist may suggest that your anxiety represents a message to you that you have lost meaning, or a sense of purpose in your life—that things that contained meaning for you no longer serve as motivating factors or are things that give you fulfillment. This existential dilemma is basically a struggle that we all must face—attempting to find meaning in a world with no apparent meaning. The treatment would consist of an exploration of your inner self and the consideration of the issues of freedom, responsibility, and your authorship of your own destiny. A family therapist might say that your anxiety is, in some way, perhaps protective to your marriage and is a nonverbal message of some sort that you are attempting to convey to your wife about some aspect of your relationship. In other words, it may be stabilizing your marriage and defining or redefining the basic nature of your relationship. A family therapist might suggest that your anxiety may be best addressed through marital therapy. Perhaps another way of understanding your anxiety is that it is part of a midlife crisis of sorts, i.e., struggling with the idea that the years you have left are less than the years you have been here—essentially facing your own mortality, and engaging in an agonizing reappraisal of how you have spent your time here on earth and whether or not you are going to continue in the same vein.

C: A lot of very interesting ideas—but, what am I to do about them and how can I decide which is for me?

T: That's where I need your help. So that we can weigh the merits of each view, I would like to ask you to consider doing an exercise to further both of our understanding

of your anxiety. What I'm suggesting is that you consider spending 15–30 minutes on two occasions making yourself feel as anxious as you can—and closely monitor your thoughts and feelings and see if any of what we've discussed makes sense in the context of your life during the actual anxiety experience.

Prescribing Different Behaviors Based Upon an Accepted Client Meaning

To varying degrees, clients hold to firm meaning systems which must somehow be altered if change is to occur. Rather than challenging the system by direct confrontation and risking further entrenchment into the problem-maintaining process, the therapist may prescribe different behaviors based in the existing meaning system. Utilizing the existing meaning system to generate new and competing behaviors is seen as a more useful, as well as more respectful, stance.

The case of Joe (#2), offers a dramatic illustration of this intervention. The therapist accepted the client's meaning system, although "delusional," and suggested different behaviors based in his meaning system. The different behaviors (i.e., greeting, smiling, nonverbal conveyance of the message) thereby changed how the client interacted with the social environment and vice versa. A change in the actual interaction can result in a change in the contingencies surrounding the problem, thereby allowing for new meanings to be constructed. Over time, Joe constructed a new meaning concerning his religious preoccupation that did not include his insistence that he was a messenger from God. Instead, he returned to college two quarters later and pursued a major in religion.

The intervention with Joe may raise some ethical concerns. Joe was quite intense in his presentation (almost glowing) and was insistent and somewhat demanding in his request to know whether the therapist believed him. It was also apparent that an expression of doubt by the therapist may have alienated the client. That context, combined with the therapist's belief that the client's reality was truly as valid as the therapist's, enabled the therapist to accept the client's meaning system and believe him. The therapist did not feel ingenuine or deceptive when responding to the client's question of his belief.

Prescribing Tasks and Current Behaviors

Prescribing tasks and current behaviors provides a new experience or context that competes behaviorally, affectively, or cognitively with the problem-oriented system, thus permitting the construction of a different meaning. Prescriptions enable clients to confront the limitations of their ascribed meanings, thus allowing consideration of different interpretations of themselves or their problem. Prescriptions encourage clients to explore alternative solutions on their own.

In the case of Andy (#3), the prescription of anxiety following a smorgasbord of explanations enabled the client to challenge his operative meaning system which restricted possible solutions. The client believed there to be no reason for the anxiety and, therefore, attempted to discount it or will it away. In the next session, Andy reported that he had attempted the exercise and was unable to make himself very anxious, his anxiety had diminished, and he had experienced no panic attacks. He added that he had figured out what the anxiety was about, which permitted him to take different action. After much consideration during his attempts to follow the prescription and, subsequently, he concluded that the anxiety was related to the boredom of his job and the lack of romance in his marriage. The client then contacted an employment recruiter as well as discussed the lack of romance in his marriage with his wife, who was relieved to finally address a heretofore unspoken issue.

The prescription seemed to allow the client to explore different, more helpful meanings to his problem, which, in turn, enabled him to implement solutions of his own choice. The prescription was not suggested so that the client would do the opposite or

resist the therapist, nor was the prescription viewed as "paradoxical" or intended to trick or manipulate the client out of the anxiety problem. Rather, the therapist wanted the client to follow the prescription in order to set up a competing experience that would allow a change in the behavioral, affective, or cognitive component of the anxiety, and thereby enable a new meaning to be ascribed. The prescription was designed to present a context for change to empower the client to search for his own solutions. A process-constructive perspective of eclectic strategic practice devalues the old power and resistance explanations of so-called paradoxical interventions, viewing such explanations as hierarchical and unhelpful, if not harmful.

Empowering Client-Ascribed Meaning

Since prescriptions are designed in large part to encourage reconstruction of meaning, clients often report new perceptions regarding themselves or the problem as a result of their attempts to follow a homework assignment. This meaning, which is client-, rather than therapist-, generated (Duncan & Solovey, 1989), reinforces or empowers continued change, and vice versa.

The task of the therapist in such a situation is to punctuate the change that has occurred, through questions which encourage the client to articulate and embellish the reasons behind the change in the problem. Further change is empowered through the client's own positive ascriptions, without the therapist taking responsibility for the change or assuming the cheerleader role.

After Andy (Case 3) reported the change in his anxiety, as well as the steps he had taken to help himself in his job and marriage, the therapist facilitated a discussion of the client's newly acquired meaning by asking questions encouraging the detailed articulation of how and why the change came about. Andy reported that, for too long, he had resigned himself to the fact that his life was dull and somewhat pointless. He also commented that he had accepted that his relationship with his wife was little more than that of "friendly roommates."

Encouraged by his wife's response and his own initiative regarding his job, Andy concluded by asserting that he felt relieved to be back in control and pleased that he was able to overcome his resignation to an unfulfilling life. Empowering client-ascribed meaning is fundamentally a growth-enhancing intervention that enables clients to creatively solve their own dilemmas.

Ascribing Different Meanings to Problem Situations

The therapist's ascriptions of different meanings to problem situations is a somewhat extended version of reframing (Watzlawick et al., 1974). The therapist and client collaboratively ascribe an alternative meaning to the problem, solutions, or circumstances related to the problem in the hope of influencing the meaning system around the problem and, thereby, stimulating different action regarding the presenting problem (Duncan & Solovey, 1989). The ascribed meaning is collaborative in the sense that it emerges from the interaction between the therapist and client.

Unlike interpretation, which flows from a particular orientation and seeks to offer a particular, and perhaps inherently better view of the problem, therapist-ascribed meaning is intended to present alternative ways of viewing the client's concerns. The meaning ascribed is dependent upon clients' own observations about themselves and their problems, as well as the specific clinical situation and its historical presentation. Since no particular theoretical or content path must be followed, meaning may be ascribed from any content area, so long as it seems consistent with the emergent reality that is constructed in the therapeutic conversation.

In the case of Sam (Case 1), it was the mother's affect or emotional experience surrounding the presenting problem (i.e., anger) as well as the specific circumstances

of the occurrence of the problem (i.e., inequitable home and parental responsibility) that became salient in the selection of the ascribed meaning. The different meaning was selected, not because the therapist believed it to be a necessarily true or better meaning, but, rather, in an attempt to offer different information to encourage the client construction of a more helpful meaning system; i.e., one in which problem improvement can occur. Likewise, the Madanes conceptualization was selected because it seemed to best fit the presentation of the family and their feedback in response to it. After delivering the suggestion that Sam call Dad instead of Mom, Sam replied, "I guess I won't be staying home any more." At follow-up this, indeed, was the case.

DISCUSSION

This article has presented a technical eclecticism which extends an MRI-oriented strategic approach to include diverse clinical and theoretical contents. A process-constructive perspective of eclectic strategic practice was described as a derivation of Buckley's schema of systems and constructivist philosophy.

A process-constructive view of strategic therapy addresses many of the criticisms and limitations of the MRI brief therapy model. Held has criticized the MRI's sole reliance on interpersonal phenomena, and many have noted and discredited the MRI's "black box" philosophy of intrapersonal variables.

An updated strategic view does not discount or ignore the contribution of intrapsychic and personality variables or the role of insight. The knowledge of intrapsychic development from a variety of theories can be selectively utilized for the content of the therapeutic conversation. Knowledge of intrapsychic or personality development is not only useful, but, at times, essential to the consideration and design of effective intervention. It is the goal of eclectic strategic practice to enable the informed and pragmatic use of historical, diagnostic, and personality knowledge bases without the restrictions of their sole reliance.

Some approaches may more easily be incorporated or utilized within an MRI-oriented technical eclecticism than others. Because many conceptual and process similarities exist between a cognitive behavioral and MRI strategic approach, a foundation for their combination may easily be conceptualized (Duncan & Parks, 1988). Although there is obviously more consonance between strategic and behavioral views than strategic and psychodynamic or humanistic approaches, this is not to say that there are no commonalities, or that all, or even many, aspects are necessarily antithetical.

While not critical to a technical eclecticism, per se (because theoretical compatibility is not required), the opening of the black box and the re-emphasis on the therapeutic relationship may provide the opportunity for many similarities between strategic and other views. It is the attention to individual psychological and personality developmental variables and their potential use in constructing interventions that distinguishes eclectic strategic practice from an MRI perspective.

Another criticism often leveled at the MRI concerns its covertly directive, instrumental, and, perhaps, even deceptive approach (Doherty, 1989; Hoffman, 1985). A process-constructive perspective of strategic therapy strives for a more collaborative interaction with clients by not conceptualizing interventions or therapist action in terms of power, resistance, paradox, or double binds. Such explanations perpetuate and perhaps justify the views of strategic therapy as manipulative and deceptive. From a process-constructive vantage point, suggestions made by the therapist are intended to be followed and are delivered with this intention.

Eclectic strategic practice emphasizes setting a context for change and empowering clients to challenge their meaning systems, thereby allowing the discovery of alternatives, independently. The therapist deliberately attempts to set the stage for change by

attending to and utilizing the client's content-rich description of the presenting complaint. From that description, and in the context of a collaborative therapeutic relationship, the therapist and client may construct a more helpful meaning system.

An extension and expansion of a strategic view seems desirable, given the current movement within the family field toward a reconsideration of the self in the system. Inattention to the black box and the multitude of meanings provided by individual models of psychotherapy leaves valuable sources unsampled as to their situational applicability and, therefore, may be strategically disadvantageous. By the same token, further condemnation of a strategic view as manipulative and deceptive may, likewise, limit therapeutic flexibility. Rather, it would seem that the maturity of the profession warrants a move beyond polemical stances and consideration of the advantages of collaboration.

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