Psychotherapy Volume 24/Summer 1987/Number 2

STRATEGIC-BEHAVIORAL THERAPY: A PRACTICAL ALTERNATIVE

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Eclecticism may be criticized for a lack of clarity of theory and a nonspecificity of application of technique. This article narrows the focus of broad-based eclecticism to a specific integration between strategic and behavioral approaches, as implemented in a stress management program.

The psychological literature has increasingly addressed the possibility of integrating different psychotherapeutic approaches to maximize efficacy. *Eclectic* has become a popular self-description for many clinicians, and the notion of eclecticism in individual treatment has become the impetus for many publications, both pro (Dimond & Havens, 1975; Garfield, 1980; Goldfried, 1980; Lazarus, 1967), and con (Loew, 1975; Maultsby, 1968; Simon, 1974).

This article narrows the focus of prescriptive eclecticism to a specific integration between a cognitive-behavioral (hereafter called behavioral) and strategic therapy approach. The strategic-behavioral therapy approach emerged from the clinical practice of two of the authors (B. D. and J. R.), who collaborated to modify an established stress management program at a community mental health center. Based on the recognition that each approach was characterized by a specific (and complementary) domain of expertise (Pinsof, 1983), a practical and conceptual integration model was developed and implemented.

The major thesis of this article is that integration of behavioral and strategic views is both desirable and acceptable at practical and conceptual levels. The similarities between the two approaches enable a conceptual/theoretical integration that can effectively guide practice, thereby preserving the important link between theory and practice (Maultsby, 1968; Simon, 1974).

The Stress Management Program

The South Community, Inc. stress management program is a brief (8–12 sessions) program of individual psychotherapy for stress-induced or stress-exacerbated emotional and physical problems.

A cognitive-behavioral model assists clients in conceptualizing the experience of stress. Phase 1 involves the occurrence of a stressor, by nature either internal (memories, thoughts) or external (events, interpersonal interactions). Phase 2 identifies the individual's interpretation of that stressor, focusing on examining related client beliefs, perceptions, attitudes, and self-statements. Maladaptive stress responses characterize Phase 3, and involve physical, emotional, behavioral, and cognitive responses to stressors and their interpretations. The therapeutic goal is development of adaptive, coping response(s), to replace the maladaptive response(s) to stressors.

Behavioral interventions utilized with Phase 1 factors include problem solving, time management, decision making, and assertiveness training. For Phase 2 difficulties, cognitive psychotherapy (e.g., RET or stress inoculation) is utilized. Methods

We gratefully acknowledge the influence of J. Scott Fraser, whose tutelage of the authors in strategic theory has proven invaluable.

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for effective management of physiological aspects of the stress response (e.g., relaxation training, aerobic conditioning, weight control, dietary and nutritional changes) are taught to help attenuate the maladaptive stress responses at Phase 3.

The client's inability to cope effectively with certain stressful situations is assumed to be related to skill deficits at one or more phases of the stress experience. Consequently, the program is characterized by a holistic, directive, and often didactic approach which relies heavily on cognitive-behavioral interventions.

It is important to emphasize that although the primary theoretical orientation of the stress management program was cognitive-behavioral, many of the interventions utilized did not naturally flow from that model (e.g., time management, problem solving). Within the realm of the behavioral model employed, a technical eclecticism already existed.

Motivation for Attempted Integration

Shortly after the program's introduction, the anticipated problem of client resistance or noncompliance surfaced. Many interventions (e.g., relaxation training, time management) require home practice or other homework assignments. Skill acquisition and implementation are crucial to success; failure to follow through with between-session assignments is particularly interruptive to the treatment process.

Several direct approaches for addressing this problem were utilized. The first approach was to ensure client understanding of the intervention; its execution; and its place/rationale in the individual's program. A second approach involved teaching operant self-control strategies to clients experiencing difficulty in home follow-through with stress management techniques. Cognitive psychotherapeutic interventions to manage attitudinal and value conflicts which interfered with compliance constituted a third approach. The use of these three strategies effectively addressed resistance in the majority of clients. Nevertheless, there remained a group of clients whom those strategies did not help, and another group of clients who, despite prior stress management training, did not improve.

Munjack & Oziel's (1978) categorization of resistance into five types proved helpful in selecting appropriate tactics to counter client resistance. Those clients exhibiting a lack of understanding of interventions (Type I) or skill deficits (Type II) were seen as highly likely to respond to the direct resistance-reducing strategies. Clients exhibiting guilt about previous behaviors or anxiety about discussing certain issues or the therapeutic relationship (Type IV) only sometimes responded to the direct resistance-reduction tactics. The direct strategies, however, impacted minimally on clients exhibiting low motivation or expectations for change (Type III), or significant secondary gain from symptoms (Type V). The possibility of utilizing an approach that was not a direct outgrowth of the program's behavioral assumptions and therapeutic biases was explored to address the needs of these last two groups.

The Strategic Approach of the Mental Research Institute

The limitations of the behavioral approach in countering resistance led to an interweaving of the strategic MRI approach into the stress management program. As the utility of the strategic approach became apparent, it was more fully integrated into the program. Of the many different schools of strategic therapy (e.g., Haley, 1980; Hoffman, 1981; Madanes, 1984; Papp, 1983), the MRI approach was viewed as more adaptable to individual work. The MRI's systemic interventions are routinely utilized with individuals as well as couples and families (Fisch et al., 1982). More important, the MRI model offers specific methods of minimizing and utilizing resistance that may be incorporated into any approach, regardless of orientation (Held, 1984).

Assumptions of the Approach

The MRI strategic approach is a cybernetic (systems) viewpoint, based on "the understanding and explanation of any selected bit of behavior in terms of its place in a wider, ongoing, organized system of behavior, involving feedback and reciprocal reinforcement throughout" (Fisch et al., 1982, p. 9). The MRI's systems perspective is coupled with the view that problem formation occurs as a result of solution attempts that are mishandled (i.e., inappropriate at a given level). According to Fisch et al. (1982), problems generally develop in relation to ordinary life difficulties associated with unusual events or transitions. Fulfillment of two conditions, 1) the mishandling of the difficulty, and 2) when the original solution attempt fails, more of the same is applied, is all that is necessary for a difficulty to be transformed into a problem. From a strategic perspective, the mishandled solution attempts exacerbate a diffi-

culty into a problem or symptom through a positive-feedback-loop process (i.e., more of one leads to more of the other, etc.). Thus, the attempted solution becomes the problem (Watzlawick et al., 1974).

Resistance and the MRI

The MRI views resistance as an expected phenomenon, guaranteed to occur in the therapeutic context; it is not interpreted as a negative client attribute, a roadblock to change, or a justification for therapeutic failure. Rather, resistance is viewed as a useful tool that leads to therapeutic success (Fisch et al., 1982). This view of resistance as a naturally occurring process variable of psychotherapy which paves the way for therapeutic change is a radical departure from the traditional perspective. Resistance is generally seen as a counterproductive phenomenom for which a clinician has little or no useful management tools to overcome. In this regard Jahn & Lichstein (1980) state:

> Resistance in psychotherapy has been recognized, described, and theoretically explained for decades, but research into techniques for the management and resolution of resistance has been woefully lacking. (p. 303)

The MRI's clear delineation of specific interventions to minimize or utilize resistance is a notable exception to the previous statement. Their approach has been utilized with much apparent success with a broad array of presenting problems (Held, 1984; Watzlawick et al., 1974). The MRI's conceptualization of and interventions with resistance represent their major strength and domain of expertise. Recognition of this major strength led to the addition of the strategic techniques to manage Types III (low motivation/expectation), IV (anxiety/guilt), and V (secondary gain) resistance (Munjack & Oziel, 1978).

Strategic Interventions with Resistance

Go Slowly (Types III and V Resistance)

Accompanied by a supportive rationale, the injunction to *go slowly*, is often a useful first-session intervention. It is particularly helpful for clients who present as trying too hard to resolve their problems. The utility of *go slowly* may be related to its portrayal of the therapist as uncommitted to changing the client, thus exerting subtle pressure on the client to follow any suggestions made by the therapist. The client's sense of urgency, which perhaps has helped maintain the problem, is directly addressed. If told that satisfactory resolution depends on proceeding slowly, the client is either more likely to relax the problem-maintaining efforts or resist the directive and improve rapidly despite the therapist's warnings.

Dangers of Improvement (Types III and V Resistance)

This intervention encourages the client to recognize the dangers inherent in resolving the problem, thus opening discussion to the possibility of secondary gain. Usually, the client will initially deny the possibility of negative outcome; the therapist then helps the client identify possible drawbacks to improvement at both the individual and systemic levels. This intervention can be used to extend the *go slowly* position to further discourage change. The client may then resist and further improve. Finally, *dangers of improvement* places subtle pressure on the client to comply with subsequent assignments after initial noncompliance.

Utilizing Position (Types III and V Resistance)

Position is defined as those strongly held beliefs, values, and priorities that influence the client's behavior in relation to the symptom (Fisch et al., 1982). To utilize position, a therapist must accept the client's statements, recognize the values they represent, and avoid making inflammatory or noncredible comments. Successful execution of this technique requires overcoming the temptation to confront, reason, or argue with the client. The impulse to help by direct educative methods may only serve to intensify the resistance by creating an unnecessary values conflict between the therapist and the client.

Taking a One-Down (Types III and IV Resistance)

One-downmanship and the use of qualifying language are interventions that rest in the subtle but powerful utilization of the therapist's personal style as a tool to facilitate cooperation. From a strategic perspective, a one-up, authority, or power position by the therapist can inhibit expression and intimidate or embarass clients. It may engender resistance, which the MRI views as a common response to authority. It is often useful for clients to see the therapist as an imperfect colleague rather than an expert, so that change might occur more readily and be more easily attributed to the client's efforts. The one-down therapist presents sugges-

tions as experiments or as possibly not helpful or important.

Using Qualifying Language (Type III Resistance)

Using qualifying language when presenting an intervention protects the therapist from possible negative effects related to taking a definitive stand (e.g., suggestions, redefinitions of the problem, assignments) before enough information has been gathered to fully evaluate its appropriateness and timing. The qualifications (words like may, depends upon, seems, etc.) imply that the suggestion is appropriate but the outcome depends on the client's efforts, thus protecting therapist credibility.

Case Illustration

S, a 23-year-old grocery clerk and part-time student, was referred to the stress management program by his physician. S had begun missing work and had dropped out of school because of anxiety attacks. The anxiety, which at times escalated into attacks, had originated at work and generalized to other situations. Excerpts from this typical stress management case illustrate the practical integration of behavioral and strategic approaches to client resistance.

In session one, S presented his problem pessimistically, expressing his doubts about the benefits of seeing a psychologist despite his doctor's strong recommendation. He added that despite his skepticism, he was hopeful that his anxiety problems could be eliminated. The therapist countered the client's pessimistic position with pessimism, employing the go-slowly intervention:

"I can understand your hope that I will be of some help, but it would be best if you approached this treatment with skepticism. After all, your family doctor couldn't help, and you've tried several things on your own. It may be more realistic for us to focus and work on your acceptance of this problem. Besides, given your score on the Schedule of Recent Experience, I am not surprised that you are experiencing anxiety attacks. In fact, I'm amazed that you are still able to work as much as you are. All this is to say that even if you could change your anxiety levels, it may not be a good idea. The last thing we want is to add another rapid change to your already long list. We need to be cautious and proceed slowly in attacking this problem of yours. Therefore, for the next week I think that you should do nothing to solve this problem, but only monitor your anxiety."

The client returned for session two and was compliant with the monitoring assignment. The therapist countered his report of a reduction in anxiety with concerns that the client was moving too quickly. The therapist then decided to proceed with relaxation training intentionally couched in qualifying language:

"The Benson relaxation response may or may not help your anxiety problem. Its success will depend on your ability to recognize when it may be of benefit and your readiness to take a risky step toward improvement. It, of course, also depends on your creativity in arranging your schedule to practice it."

In session three, it was clear that the client had not been compliant. Although reporting a significant reduction in arousal and seeing an increase in peripheral temperature during the session, he had not practiced the relaxation response at all. He also reported an increase in general levels of anxiety as well as two attacks at work. The therapist intervened with dangers of improvement from a one-down position:

"Please don't apologize for not practicing the relaxation exercise. I was probably on the wrong track and undoubtedly trying to move you too fast before considering all the implications. It may be that your unconscious is telling us something. Can you see any dangers in getting over your anxiety problem? . . . I see. Well, this is a different way of thinking about problems, but it seems that almost always there are some disadvantages or dangers associated with resolving a problem—like a whole new set of things to handle. Hmm—one danger may be that if you reduce your anxiety levels you will think that you have to return to school right away. I don't need to tell you about all the hassles of being in college like boredom, pressure, deadlines, unreasonable proofs, and so on. This anxiety may be protecting you from that, and also from the possible outcome of not quite cutting it in your classes, which I'm reasonably sure would be a big fall for you to take. Do you see where I'm coming from? Can you see any other dangers?"

In subsequent sessions, cognitive strategies were also utilized and presented to the client in a similar strategic fashion. The dangers of improvement intervention seemed to facilitate cooperation with this client which allowed him to learn adaptive coping alternatives for his anxiety.

The Limitations of Parsimony

While offering a systematic and comprehensive approach to the management of resistance in psychotherapy, the MRI approach is open to criticism regarding its strong emphasis on the principle of parsimony. The MRI view of therapy and change holds that, as a general rule, the least intervention is the best intervention. The goal is to jam the problem cycle and terminate therapy before becoming part of the problem. From a strategic perspective, achieving insight or acquiring skills are seen as unnecessary to problem resolution and serve to elongate therapy (Rohrbaugh & Eron, 1982). From a behavioral perspective, the strategic approach is seriously limited. Clients leave therapy without any acquired coping skills/strategies that will help them prevent or adaptively handle future problems. A strategic approach may ameliorate a presenting problem of anxiety attacks by interrupting the problem-maintaining solution attempts of the client. However, it does not address skill deficits which may interfere with a client's ability to control the physiological and cognitive components of sympathetic overarousal. The implicit assumption is that coping skills are present in the client's repertoire. That assumption is often un-

founded. Additionally, many clients who exhibit a coping-skills repertoire may benefit from training in their systematic application. This limitation of the strategic approach, that is, the parsimony principle which dictates a neglect of skill acquisition is, of course, the major strength or domain of expertise of a behavioral approach.

Similarities of the Two Approaches: A Basis for Conceptual Integration

The recognition that the major limitation of each approach (resistance 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. The similarities between the two approaches permitted the more important conceptual integration that could guide broad clinical application.

The similarities between the approaches are readily summarized: 1) both are symptom oriented; 2) conceptually and practically, both models focus on present patterns of observable behavior which precipitate and maintain problems; 3) intrapsychic variables and the role of the past are not important to problem resolution; 4) both models seek behavior change; insight is not viewed as necessary for problem resolution; 5) homework and behavioral assignments are utilized; 6) concrete observable behavior and specificity of information from interview data are required for intervention; 7) both are directive, active approaches; 8) both are brief approaches utilizing focused interventions; 9) both share a constructionist bias in that they rely significantly on understanding and changing the client's construct of the situation; and 10) neither have a theoretical view of health or normalcy.

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 not conceptually incompatible with a behavioral model. The importance of positive feedback loops or vicious circle processes to problem formation and maintenance is recognized by behavioral clinicians. Ullman & Krasner (1975) describe a vicious circle process in the etiology of schizophrenic symptoms. Although they emphasize extinction as the initial impetus to development of deviant behaviors, the exacerbation of these behaviors into schizophrenia is explained via a deviation amplification or vicious-circle process.

Furthermore, the MRI concept of a positive feedback loop is paralleled in the three-phase behavioral stress management model outlined previously. Selecting one occurrence in the stressor-interpretation-stress response cycle involves taking an arbitrary temporal cross section for the purpose of explanatory and conceptual simplification. If one looks beyond a single stress cycle, it becomes possible for the awareness of a stress response (e.g, increased heart rate), to become a stressor in a subsequent cycle. Beck's discussion of the significance of the vicious cycle to the development of anxiety (Beck et al., 1985) is strikingly similar to the MRI model. In Beck's model, the initial anxiety itself may be appraised as a threat in and of itself. "As the sense of danger increases, more primal responses are activated, and these in turn may present further handicaps and threats" (p. 46). Thus, through a feedback process the initially adaptive response becomes the problem.

Overall, the assumptions underlying a behavioral approach are not incompatible with the MRI strategic model of problem formation. The general behavioral assumptions regarding problem formation are: 1) a deficit exists in the behavioral repertoire in the presence of the cueing stimulus (stressor); and/or 2) one's interpretation of a stressor can exacerbate or ameliorate the severity of the stress response; and/or 3) the consequences following the stress response affect the probability of its recurrence (secondary gain reinforces a maladaptive stress response). The latter assumption fits directly with the MRI assumption of "feedback and reciprocal reinforcement" within a system (Fisch et al., 1982, p. 9).

The first behavioral assumption is compatible with strategic theory, but on a different explanatory level. 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 distinctly possible that *nothing but* ineffective solutions exist in the client's repertoire. In such cases, the behavioral assumption is accurate. A coping-skills approach would not only be compatible 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.

Additionally, the general assumption of cognitive interventions (behavioral assumption 2) is compatible with a strategic approach. Situational reinterpretation is a key aspect, explicitly or implicitly, in strategic interventions such as go slowly, dangers of improvement, and utilizing position. Furthermore, assumptions underlying cognitive interventions are consonant with a circular causal, positive-feedback-loop perspective of problem formation and maintenance. Rational-Emotive Therapy (RET) proponents discuss situations in which the symptom (the C in ABC model) becomes the activating event (the A), resulting in the exacerbation of the original symptom, as well as the addition of new ones (Whalen et al., 1980). The similarity to the circularity of the vicious cycle is apparent.

Finally, Beck discusses a reciprocal interaction model in the cognitive theories of depression (Beck et al., 1979) and anxiety (Beck et al., 1985). Beck et al. (1979) describe a vicious cycle process involving depression→rejection→criticism by significant others→increasing self-rejection/criticism→withdrawal→depression, escalating the depression to a point at which the depressed individual is impervious to attempts of help from significant others.

Given the conceptual and process similarities, clinicians need not abandon or compromise their current theoretical orientations. The two approaches can be integrated in a simple additive fashion based on their respective domains of expertise. The behavioral approach is seen as having much to say about *what* is learned; the strategic model about *how* the client is approached to facilitate that learning. Each approach effectively compensates for the weaknesses of the other. Pairing the behavioral approach (skills acquisition) with the strategic approach (effective utilization of resistance) produces a more powerful therapeutic approach than does either in isolation.

The strategic-behavioral therapy model may have application in any setting where cognitive-behavioral theory and techniques are utilized. Research evaluation of comparative outcomes among strategic, behavioral, and strategic-behavioral approaches is, of course, needed to support the assertion that an integrated approach constitutes a more effective intervention strategy than either in isolation.

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