Interventions and Strategies in Counseling and Psychotherapy

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CHAPTER 2

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Brief Therapy Strategies and Techniques

Over the past few decades, the movement toward more focused, directive, and change-oriented models of counseling—the brief therapies—has continued to develop rapidly. At this point, it is probably safe to say that brief therapy constitutes the state of the art regarding actual practice within the greater mental health field. Some counselors have embraced the new brief therapy paradigms and others have expressed a sense of validation as brief therapy more directly reflects the realities of their work settings. Still other counselors and therapists have fought and argued against the brief, time-limited approaches. However, no matter what a counselor's position regarding brief therapy, it seems irrefutable that the movement to time-limited, directive, change-focused models is a reality in the delivery of today's mental health services.

This movement toward brief therapy may be viewed as the logical result of a combination of factors affecting the mental health delivery system. Four factors appear particularly relevant. First, outcome research on the effectiveness of therapy has consistently shown brief therapy approaches to be at least equally effective as the long-term, time-unlimited therapies (Butcher & Koss, 1978; Koss & Shiang, 1994; Steenbarger, 1992). Reviews of the outcome research literature by Johnson and Gelso (1980) and Gelso and Johnson (1983) add an interesting dimension to the outcomes discussion. Their findings suggest that when therapy effectiveness is measured by therapist ratings, the bias is toward favoring long-term therapies. However, when effectiveness is measured by more objective measures—such as third-party observers, standardized measures, or even client self-ratings—the time-limited, brief therapies appear as effective as long-term models. With outcomes being comparable for the client, additional benefits realized by the economy of time and costs for the client would argue for using of a brief therapy approach.

Research on the process of change in counseling and therapy has also supported the move to the brief therapies. The research evidence to date has suggested that the greatest gains in treatment typically occur early in therapy (Howard, Kopta, Krause, &

Orlinsky, 1986). Garfield (1989), for example, found that most change appears to occur in the first eight sessions. Such evidence appears to support the use of brief, intermittent therapy. The counselor or therapist works with the client for relatively short durations of time and then interrupts, rather than terminating, treatment. This allows the client time to integrate changes into his or her life. Therapy may then be resumed later to work on other issues in a similar focused, time-limited manner.

Budman and Gurman's study (1988) added a further interesting dimension to the research support for brief therapy. Their meta-analytic review of therapy effectiveness found that the studied treatments ranged from 7 to 17 sessions per client. The outcome research in counseling and psychotherapy may therefore be regarded as consisting of comparisons between time–limited brief therapy and time–unlimited brief therapy.

A second factor driving the movement toward brief therapy paradigms stems from the research on client expectations of counseling and therapy. Research findings have increasingly suggested that clients come expecting an active, directive counselor who will structure the sessions and move them toward problem resolution (Budman & Gurman, 1988; Garfield, 1986; Shapiro & Budman, 1973). Despite therapist intent, it appears that most clients come to therapy for relatively few sessions. Phillips (1985) found the average number of therapeutic treatment sessions to be four, with a median of one session. Garfield's research indicated that up to 50% of clients do not return for the second session. This strongly suggests the need for therapists to structure even the initial session as if it were a one-session intervention. Haley (1990) suggested that this may reflect the changing nature of clients seeking counseling assistance. In the earlier years of counseling and psychotherapy (when most traditional, long-term, "depth" models were developed), clients largely elected to come for therapy voluntarily. Increasingly, however, clients today are being "sent" to counseling by a third party such as a parent, school staff, judge, and so forth. Mental health services are also more widely accepted and therefore sought by the general population. Many "higher functioning" clients come to counseling seeking help with a particular life situation, crisis, or problem area and are not inclined toward long-term analysis or therapeutic processes.

Thus, it appears that the movement to the brief therapies is an aligning of what the client seeks from counseling with the treatment the counselor is prepared to provide. From this perspective, brief therapy becomes a true "client-centered" approach in that the counselor provides the treatment sought by the client (i.e., direct and problem resolution focused) rather than the treatment advocated by a particular theory of counseling and therapy.

A third factor involved in the move to the brief therapy models is the problem of increased counseling caseloads without increases in funding to increase counseling staff to serve those caseloads. This is particularly true for many counselors working within educational and community agency settings. For example, school counselors are often expected to serve all the counseling and guidance needs for a caseload of 500 to 800, or more, students. Further compounding the problem is the reality that the school counselor's job description includes far more than only providing individual and group counseling, parent–family counseling, and teacher consultation services for these students. The nature of the position mandates that school counselors receive training in the more time-efficient models of brief counseling. Community agency counselors also commonly report large caseload problems. Such agencies frequently experience increasing demands for services without adequate financial support from funding sources. The problem of growing agency caseloads, combined with insufficient staffing, requires moving to more time- and cost-efficient treatment paradigms.

Finally, the fourth factor involved in the rapid movement to the briefer therapy models is the influence and policies of third-party insurance providers and the managed-care health provider industry. Such cost-conscious businesses often pay the counseling service fees and thus have the power to dictate what services they will cover. Increasingly, such providers have limited reimbursement for both outpatient and inpatient mental health treatment. In effect, such policies are tantamount to mandating time-limited, brief therapeutic interventions.

Some have attempted to argue that managed-care policies are the sole or primary reason for the move to brief therapy. This is simply not true. The issues of large caseloads, the research data as to what clients actually seek from counseling, and the outcome research literature are all much more compelling reasons for the move to brief, time-limited therapies. There are many legitimate problems with the third-party provider and managed-care approach to providing mental health services. Regarding the move to brief therapies, however, managed care has perhaps served as a catalyst forcing counselors to acknowledge the growing "cultural transition" within the field. The transition from time-unlimited, traditional therapies to the time-limited, directive, change-oriented treatment paradigms has been long evolving and is, perhaps, overdue in the field.

The move to more short-term, directive counseling models may be understood as the culmination of a long-evolving movement within the counseling and psychotherapy field. Its origins can be traced back at least some 80 years to the very origins of modern psychotherapeutic methods. The work of the Viennese psychiatrist Alfred Adler, in particular, can be viewed as seminal to the current brief therapy models. Adler's work stood in contrast to the intrapsychic-focused, "depth," or analytical models of Freud and Jung. Adler first advocated for a therapeutic paradigm focused not on intrapsychic conflicts but on how the individual attaches meaning to, and chooses to deal with, the social environment. Adler focused attention on how individuals interpret and interact with their social environment. He suggested that therapy must focus on assisting clients to alter mistaken or flawed assumptions about life and relationships and changing counterproductive interactions with the social environment.

Adler first suggested the emphasis in therapy turn more toward understanding the interpersonal nature of behavior and the facilitating of change processes rather than on analyzing intrapsychic processes. This alternate approach to psychotherapy eventually contributed to the famous split between Adler and Freud and the resultant two "camps" for psychotherapy: the long-term, analytical model of Freud's Psychoanalytic Society and the more directive, social context–oriented approach of Adler's Free Psychoanalytic Society. Over the course of the century, alternate paradigms focusing more on facilitating change through direct, brief, and resolution-oriented processes have served as perhaps the subplot in the history of psychology.

The more directive, briefer approach has been further advanced and developed by the work of Albert Ellis, William Glasser, Milton Erickson, Jay Haley, Gregory Bateson, and Michael White, to name but a few. Only during the past two decades, however, has this alternate, brief therapy paradigm finally emerged from the background and into the accepted mainstream of mental health services. Consequently, we have seen in recent years the emergence of many "new" models of counseling and psychotherapy advocating a shorter, more direct, empowering, and change-oriented approach. Most notable among these new brief therapy models would be the strategic, solution-focused, and narrative therapy models. The remaining sections of this chapter delineate an integrative framework based in Adlerian psychology and systems theory that enables counselors and therapists to use the strategies and techniques of all the brief therapies within

Characteristics of Brief Therapy

Five essential characteristics form the basis for an integrative framework for brief therapy: time limitation, focus, counselor directiveness, symptoms as solutions, and the assignment of behavioral tasks. For the most part, these essential characteristics are reflected in most models of brief therapy. Particular models may differ about which of the characteristics they most emphasize, but explicitly or implicitly they are, for the most part, integral aspects of effective brief therapy.

First, as in all brief therapy approaches, the counselor and client work within a time-limited context. Therapist and client essentially establish a contract during the first session regarding the number, frequency, and duration of therapy sessions. This therapeutic contract is subject to review and modification as therapy progresses. However, the beginning time limit on treatment serves two essential functions for therapy. First, it conveys an optimistic expectation that change, progress, and growth are possible, and in a brief amount of time. Second, the establishment of time limitations appears to serve the function of motivating both client and counselor to work more quickly and directly than when time is considered unlimited.

The issue of time limitations to therapy is often misunderstood. Although a time limit is set for therapy, it does not mean the counselor–client relationship ends at the final session. The counselor–client relationship is more analogous to that of the family practitioner in medicine. The counselor and client essentially agree to work intensively for a specific length of time around the current, presenting issue or symptoms. Then, once progress or growth is realized, active work in therapy ceases for an indefinite time period. Therapy is more interrupted than terminated at this point. In the future, the client may choose to return to therapy to work on further or new issues in his or her life. The client is thus provided with time to integrate and consolidate changes into his or her life before moving on to other areas of concern.

Brief therapy also allows the counselor to be flexible in using time. Counseling sessions do not need to be of the traditional 50-minute, once-per-week format. A longer initial session or two might be scheduled, followed by shorter (e.g., 30 minutes) follow-up sessions. Sessions may be scheduled weekly or semiweekly at first and then every other week or monthly depending on the issues and needs of the client.

The second primary characteristic of the brief therapies is that of focusing. Counselor and client agree to focus their work on a single, key area or issue of current concern in the client's interpersonal life. The idea of focusing therapy on a single issue of current concern is perhaps more important than time limitations in defining brief therapy. As noted by Wells and Phelps (1990), the key to successful brief therapy is therapeutic "focusing." Brief therapy is more about focus than it is about time. The counselor must strive to keep therapy focused to create change in a current area of concern in the client's life. Brief therapy does not address ancillary issues at this time. If explored at all, they are examined only in terms of how they relate to or affect the current focus issue. Therapeutic focusing involves the identification of one, central issue or concern to the client that will serve as the target of counseling intervention.

The third characteristic of the brief therapies involves the counselor–client relationship. Counselors take a direct and active role in therapy by structuring the session and working with clients as partners in understanding the dynamics of issues and creating change. The counselor further assumes an optimistic, empowering attitude regarding the client's capacity to change. Through a focus on the capabilities and strengths of the client, the counselor empowers the client by aligning with his or her

rather than by taking the position of focusing on problems, weaknesses, and inadequacies. Such practice serves largely a function of further discouraging the client and reinforcing defense mechanisms. Being pathology-focused may actually prolong treatment by increasing resistance.

A fourth characteristic of the brief therapies involves how the counselor views the client's presenting symptoms or problematic behaviors. The emphasis is placed on finding ways to resolve life concerns, not on trying to diagnose the etiological factors leading to the presenting symptoms. Brief therapy is about resolving, not identifying causes for, client concerns. Furthermore, presenting behavioral patterns of the client are understood not as problems per se, but instead as limited or counterproductive solutions to some underlying focus issue. The client's presenting behaviors are not the problem. These behaviors are viewed as solutions the client uses in an attempt to deal with an issue in his or her life. In essence, the client is seen as "stuck" using the same behavioral patterns to solve a problem without realizing that these patterns often serve to maintain the problem, avoid the problem, or, in many cases, exacerbate the problem.

Viewing presenting behavioral patterns not as problems but as the client's solution to the true problem is similar to the way in which medicine views presenting symptoms. Medical symptoms are the body's solutions to infection or disease processes. For example, coughing is not a problem but merely the body's way of solving the problem of an obstructed trachea. Similarly, a high fever is the solution used by the body to fight a bacterial or viral infection. So, too, in brief therapy we see presenting symptomatic behaviors of the clients as the methods they are currently using to address another underlying issue or concern.

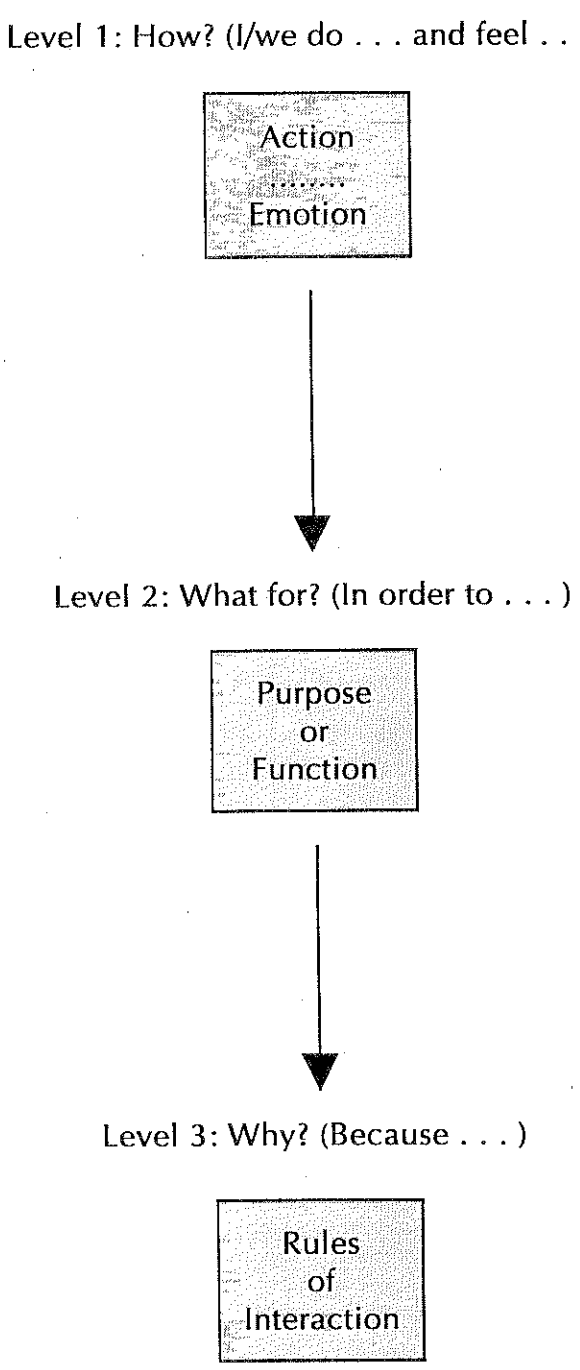
Finally, the fifth characteristic of the brief therapies is that clients are assigned behavioral tasks to do outside therapeutic sessions. Thus, activity and behavioral change, not passive suffering or emoting, is clearly established as the expectation for the client in therapy. Change takes place between counseling sessions, not within counseling sessions. The counselor and client use the sessions to gain a fuller understanding of the underlying issue and how it is manifested in the client's behavioral patterns. From there, they work toward seeking alternate behavioral solutions that will create growth and change rather than problem maintenance.

A Conceptual Framework for Brief Therapy

Every therapeutic approach has, at its foundation, some implicit or explicit assumptions about behavior that serve to guide the counselor in assessment and intervention. The integrative approach delineated in this chapter is primarily an integration of Adlerian psychology and systems theory. The model provides the counselor or therapist with a schema for understanding both client behavior and the process of brief therapy.

Behavior is understood as occurring on a three-tiered basis (see Figure 2.1). This three-tier model is applicable to understanding all systems, be they an individual, a family, a couple, a culture, or a business or organization. Brief therapists initially strive to understand their client's presenting concerns at all three levels.

The first level of assessment is that of identifying the client's precise actions and emotions and the social context in which they occur. This level of behavior assessment focuses on what the client does and how he or she feels as he or she engages in that behavior. The counselor works with the client to decide exactly [illegible]



circumstances the presenting issue occurs (and does not occur) and how the client is acting and feeling in relation to the presenting issue. Verbs that imply possession such as *to be* and *to have* are avoided in brief therapy. Such verbs serve the function of labeling clients and implicitly communicate to the client that he or she possesses some form of pathology, disease, or character flaw. Although such verbs are commonly used in the mental health diagnostic–assessment process, the implied message to the client is considered counterproductive for facilitating change and growth in brief therapy.

After determining the "how" of the client's behavior, the counselor probes deeper by addressing the second level of behavior; the function served by the client's actions. That is, to assess the "what-for" question of the presenting behavior. Consistent with Adler's pioneering work, causation (determinism) is rejected. Symptoms are assumed to serve a purpose or function for the client in some capacity. This purpose can often be discovered by placing the behavioral patterns in their social context and following the interaction patterns between the client and involved significant others or between the client and life expectations (career, marriage, social, etc.). As the sequence of interactions is followed, the function of the behavior is slowly revealed.

For example, a 10-year-old boy was referred for defiant, acting-out behaviors in his reading class. In the brief therapy process, it emerged that he used such behaviors to get out of his classroom. Through such defiant behavior he could leave with an image of power and strength among his peers. The alternative, from this boy's perspective, was to stay in the room and be exposed as a nonreader and face certain humiliation. His behavioral symptoms were his solution to a social threat created by his reading problem. Similarly, a female client used her depressing behaviors of withdrawal, inactivity, and sadness to mobilize first her parents—and then, later in life, her husband—to provide greater attention, assistance, and service. It is important to remember, however, that the client is not often consciously aware of the purpose or function of his or her behavior.

The third and deepest level of understanding behavior involves investigating the client's idiosyncratic rules of interaction. This level answers the third and final question of why the client handles life in this manner. *Why* refers here to the rationale or logic system underlying the presenting behavior patterns and not to causal factors. This concept, taken from general systems theory, refers to the idea that all systems function on the basis of a relatively small, yet highly salient set of systemic rules (or metarules) that govern all operations of the system.

With the individual, various theoretical models of counseling and therapy have referred to this idea using terms such as the client's basic assumptions, apperceptions, phenomenological perspective, private logic, belief systems, and so forth. The essential component driving all behavior is the client's idiosyncratic cognitive schema, a cognitive framework whereby he or she attaches meaning to life experiences and, therefore, chooses, consciously or unconsciously, behaviors. The rules-of-interaction concept is consistent with the theoretical principles of many leading cognitive therapies from Adler's individual psychology to constructivism.

The rules-of-interaction concept also holds in couples counseling where we strive to understand the couples' unique, unwritten "contract of expectations" (Hawes, 1989). All couples relate to one another based on a set of assumptions and expectations regarding their relationship, one another's roles, and the normative expectations for fulfilling those roles. So, too, in family counseling, most all approaches recognize the need to address the "family rule system" (Nichols & Schwartz, 1995), that is, the unique metarule system that organizes family interaction patterns and structures. The importance of those rules of interaction is even seen at the macrosystemic level when working

with organizations, businesses, and cultures. The focus is always on understanding the preconscious set of rules by which meaning is attached to events and on which behaviors are selected whether one chooses to call them organizational culture, business culture, or shared worldview. At the root of all human behavior (individual, familial, organizational, or cultural) lies this key concept of the rules of interaction.

Once these rules are recognized and understood, then all behavioral patterns become understandable and, to some extent, predictable. If one starts with an assumption (i.e., rule of interaction) that he or she is incapable of doing anything well or "well enough," then it is quite likely that he or she will seek to avoid tasks and responsibilities (purpose) that would predictably end in failure. Avoiding failure may be accomplished in a variety of ways. These include the demonstration of one's incompetence to others so that they will expect less or the charming of others into helping and doing things for oneself (including making decisions) or by developing symptoms (e.g., phobias) that excuse one from those aspects of life where one feels most susceptible to failure.

The key to brief therapy lies in obtaining an understanding of the client's behavior at all three levels and then focusing intervention at the third level—rules of interaction. Unless the client is helped to view or understand life from a different perspective, real change will not occur. Without a shift in perspective, one may observe short-term changes (more to please the counselor–therapist) or first-order behavioral changes (i.e., change without change) that are merely new ways of doing the same old thing.

These three interrelated levels of behavior might be viewed as analogous to the children's bop-bag or punching-bag toy. The first level, behavioral actions and emotions, would be the head of the toy. The second level, purpose or function of behavior, would be the body. The rules of interaction would then constitute the weighted bag at the bottom of the bop-bag. Thus, although one might temporarily move the location of the head (symptomatic behaviors) and even the body to some degree (function) through forceful intervention aimed at the head (symptom), eventually the bop-bag will return to its original position (i.e., homeostasis). Clients, like the bop-bag, will only maintain lasting change if intervention is focused on the third level, the rules of interaction (i.e., weighted base). Just as one must move the weighted base of the bop-bag if the head is to remain permanently in a new location, so too must counseling focus on shifting the client's rules of interaction for lasting behavioral change to occur.

Four Stages in Brief Therapy

The three levels of behavior can be translated into a four-stage schema for the brief therapy process. The four stages are identified with the acronym BURP: Behavioral description of the presenting problem, Underlying rules of interaction assessment, Reorientation of the client's rules of interaction, and Prescribing new behavioral rituals. This four-stage process is not necessarily followed in a simple, mechanistic manner. Instead, the brief therapist proceeds through each session following this general four-stage process more in terms of a structured flow than in a lock-stepped manner. Variations in the model are often necessary given the particular client and presenting issue. This four-stage process model merely provides the brief therapist with a structure for each session and to keep the client focused on moving toward change and growth.

Behavioral Assessment

In obtaining a description of the presenting issue, the therapist seeks a detailed behavioral description of how the problematic situation manifests in the client's daily life. At the beginning of brief therapy, the counselor must strive to have the client describe the presenting issue of concern in behavioral (i.e., actions and emotions) terminology. This requires the client to use action verbs (i.e., verbs ending in *ing*) when discussing the focus issue. The therapist gently directs the client away from using possession verbs such as *to be* and *to have*. Such verbs (e.g., *I am, I have,* or *I suffer from*), although commonly used by clients to describe the reason for coming to counseling, carry the implicit message that the client is somehow afflicted with a personality flaw, disorder, or disease that he or she has little or no power to change. Using terminology that implies the possession of pathology places the client in a double-bind situation. The therapist is left asking clients to change something over which they have no control or responsibility. For example, rather than allow a statement such as "I am depressed," the counselor might ask the client to describe specific times and situations in which he or she felt sad and depressed. Questioning at the assessment stage would focus on such things as "What did you do the last time this occurred?" "Who else was affected?" "What did they do?" and "How did you respond?"

Through such questioning, the counselor not only obtains a complete understanding of the presenting issue but simultaneously begins the reorientation process through a change in the language of therapy. The language of brief therapy avoids the implication of passive suffering by, or victimization of, the client due to processes beyond his or her control. Action-oriented terminology involves something similar to a hypnotic suggestion process through the implied message that one chooses to use certain behaviors and therefore always has the capacity to choose different ones. Without directly stating so, the therapist begins to shift the client's perspective from "What I suffer from" to "How I deal with"—in other words, a shift from an external locus of control to an internal locus of control.

Other useful phrases for the brief therapist to use in moving the client away from a passive, suffering perspective and toward an active, problem-resolution perspective include, "Tell me about the last time this occurred." Or "What happens when you are anxious (depressed, out of control, etc.)?" By attending to the client's responses, a therapist can begin to identify how the client acts and feels, under what situations the symptoms are most likely to occur, and what purpose may be served by such actions (symptoms).

The latter question, regarding under what situations the symptoms are most likely to occur, begins to move the therapist's understanding to the second level of behavior, the purpose or function of the symptoms. By identifying whom in the client's social environment is affected by or involved in the symptomatic behavior and the specific social situations where the problems occur, hypotheses can be developed as to the possible conscious or unconscious purpose of the client's symptoms. It is important, however, to recognize that although the client may be consciously aware of what he or she does, he or she is often less aware of his or her actual emotional responses. Furthermore, the purpose of the behavior (Level 2) and the rules of interaction underlying the behavior (Level 3) are usually outside the client's conscious awareness. It is the task of the brief therapist to discover the second and third levels of behavior in order to obtain a complete understanding of the dynamics behind the presenting issue.

Underlying Rules of Interaction

Careful attending to how the client describes the presenting issue, the situations where it occurs, and the behavioral sequences involved will provide the brief therapist with clues as to the possible purpose served (or intended to be served) by the client's problematic behaviors. It may also be helpful for the brief therapist to begin forming hypotheses as to possible underlying rules of interaction whereby the client perceives, attaches meaning to, and chooses behaviors in his or her life. The client, although not consciously aware of his or her underlying rules of interaction, will often act "as if" his or her perceptions were the correct and only possible perspective.

By placing oneself in the client's position and seeing the presenting situation from the client's perspective (i.e., rules of interaction), the client's behaviors (or symptoms) become completely understandable and logical to the therapist. This enables the brief therapist to strategically take the therapeutic position of aligning with (through understanding) the client's symptoms and thus to become an ally rather than an adversary. In this manner, resistance in therapy can be avoided or minimized. Only when the client first feels understood and accepted, rather than criticized and attacked, is he or she likely to be receptive to working with the counselor toward change.

There are numerous counseling techniques that can be used by a counselor to quickly gain an accurate understanding of the rules of interaction supporting and maintaining the presenting problem. It is not within the scope of this chapter to discuss these techniques in detail. However, a few techniques might be mentioned that are described more fully elsewhere. Early childhood recollections have been found useful when understood as metaphors for the client's current rules of interaction rather than as historical events (Mosak, 1972). Family stories and family genograms can help reveal rules of interaction derived from the client's family system (Nicoll & Hawes, 1984). The "magical question" ("How would your life change, be different if you did not suffer from these symptoms?") described by Dreikurs (1954) and later by proponents of solution-focused brief therapy can be useful for detecting possible rules that support the use of the symptom to avoid a perceived greater problem for the client (e.g., "if only I did not suffer from this depression, I could be successful in a job and live successfully on my own rather than be dependent on my mother for support").

I will illustrate the first two steps in the brief therapy process, the assessment stage, by identifying the dynamics of a presenting issue at all three levels for understanding behavior.

A 21-year-old man came to counseling because of recent problems he had experienced with panic attacks. These attacks suddenly began shortly after returning to campus for his third year of study. The problem had escalated to the point that he was initially hospitalized and then sent home for treatment. Since returning home, the attacks had significantly decreased, but he was concerned over possible recurrence of the anxiety problems.

When asked to describe one of his most recent panic attacks, the young man stated that they typically occurred in the evenings at his dormitory. He would awaken feeling very agitated, frightened, and sweating profusely to the point where he had difficulty breathing. His roommate had to call for emergency assistance from the campus medical center. Such attacks had never occurred in his first two years of study. However, during those years, his older brother had been a graduate student at the same school, graduating the previous spring semester. This was the client's first semester "out in the world" alone.

Further investigation into his underlying rules of interaction revealed a view of life as very dangerous and unpredictable and a view of himself as naive and vulnerable. For example, his early recollection focused on an incident at the age of 8 when he was in the kitchen with his alcoholic father.

> My father and I were laughing and joking about something when suddenly he turned around toward me and hit me in the mouth with his fist as hard as he could . . . . I bounced off the wall and fell to the floor. Never could figure out what I had said or what happened to cause him to hurt me like that.

Further, as the youngest of three boys with an explosive, alcoholic father, he had aligned closely with his oldest brother and his mother. "I was the type of kid always clinging to Mom's apron strings or tagging along with my older brother."

In this case, we see how the three levels of behavior can be quickly observed during the first two stages of brief therapy. Rather than viewing the client as "suffering from" panic attacks (a position of powerlessness and victimization), he could be seen as someone who, owing to early life experiences, has come to perceive the world as very dangerous and unpredictable, a place where one could be easily hurt (rule of interaction). Consequently, this young man had developed an approach to life whereby he sought safety and security by aligning with individuals he viewed as stronger, more capable, and protective of him (purpose). When placed in a situation without such supports, he resorted to unconsciously reminding himself of how dangerous his situation could be, and thus experienced panic attacks. Interestingly, the result was hospitalization and returning to live at home under the safety and protection of his mother. Thus, he had found safety and protection through the anxiety disorder symptoms. His presenting symptoms, anxiety, served as his "solution" to an unpredictable and dangerous world. They returned him to the protection of a safe environment.

Reorientation Process

Through careful exploration of the behavioral–emotional dimension of the presenting issue—including placing such behavior within a social context (i.e., where does it occur, who else is involved, and how do others respond?)—and exploring the client's underlying rules of interaction, a more precise picture can be obtained of the dynamics of the client's behavior. Now, the brief therapy process can be directed to the issue of facilitating change. However, it cannot be stated too strongly that the key to brief therapy—to initiating change processes—lies in careful attention to the assessment stages and accurately identifying the three levels of the client's behavior. The great paradox of brief therapy is that the key to successful brief interventions is to proceed slowly through the assessment stages.

The dynamics of change begin with the process of reorientation, that is, helping the client to view his or her behavior from a different perspective. Albert Einstein is credited with saying that one cannot solve a problem with the same thinking that created it. This is very much the essence of brief therapy. The therapist must assist the client in obtaining a new perspective, insight, or understanding of the presenting issue. Once the client changes his or her perspective, new behavioral options will be sought that are consistent with this new position.

For example, if the client's rules of interaction consist of themes that he or she is inept, incapable, and likely to fail at anything attempted, then he or she is highly unlikely to engage in any challenging task alone. Such an individual may instead develop a myriad of behaviors (symptoms) that all serve the function of protecting him or her from failure. Behaviors such as avoidance, procrastination, displays of incompetence, forgetfulness, excessive anxiety, and so forth may all be used as excuses for poor performance or to solicit others to step in and provide assistance. Without an alteration in this perspective, the client will engage in first-order change processes, at best. That is, he or she will create new ways of doing the same thing, avoiding the perceived certain failure. Tasks may be attempted halfheartedly or successes minimized or explained away in some way (e.g., "I was lucky," "The task was easy, anyone could do it").

True change involves second-order change processes—a fundamental or morphogenic shift in how the existing situation is understood and addressed. This is the challenge to the therapist in facilitating change through brief therapy. The process of reorientating the client's perspective takes place subtly throughout the session but quite directly at the third stage. Many techniques may be used in the reorientation process. Reframing, relabeling, humor, confrontation, metaphors, and language changes are just a few of the commonly used therapeutic intervention techniques that serve the purpose of reorienting the client's current perceptions.

The reorientation process can be illustrated in the example provided earlier regarding the young man suffering from panic attacks. Initially, reorientation is begun with the language change in the process of brief therapy. Rather than speaking of how he suffers from these sudden, unpredictable panic attacks, the language of therapy focuses on where he is when the attacks occur, what he does, and who steps in to assist. The language suggests an active, not passive, role for the client and further carries an implication or hypnotic suggestion that he could choose to act differently. Later, more direct reorientation strategies might involve reframing the issue from the medical model ("I suffer from this disorder") to a relationship model ("I scare myself to such a point that I am then placed in a safer, protected environment"). This latter position enables the client to start seeking alternate ways of handling his self-doubts and dealing with situations he finds potentially threatening. The reorientation involves a move away from looking at how the client passively suffers to seeing how he actively seeks safety. This constitutes a more empowering position for enabling change and growth by emphasizing competence and capability rather than pathology and incapability.

Prescribing New Behavioral Rituals

The final stage in the brief therapy process involves prescribing new behavioral rituals. Such rituals consist of new behavioral tasks for the client to perform outside therapy. Brief therapy, as stated previously, is based on the assumption that change occurs not within the therapy session but between therapy sessions. The client is not allowed to assume the role of passive sufferer but is instead expected to actively engage in the change process outside therapy.

Rituals can be defined as regular, repeated actions that serve the purpose, or function, within a system of reaffirming or maintaining underlying rules of interaction. Religious rituals, for example, are used to reaffirm a church's belief system. Ritual activities in the workplace usually reinforce the corporate culture and define and reaffirm what is deemed important or valued in the organization. Weekly posting of the top

salesperson, for example, is a ritual that serves the purpose of reminding all employees that competition for sales volume is what is most valued and rewarded.

Similarly, a client's symptoms might be viewed as ritualistic behaviors that serve the function of reaffirming for the client his or her underlying rules of interaction. As such, they often develop into self-fulfilling prophecies. Experiencing a panic attack, for example, might serve the function of avoiding a feared situation while simultaneously reaffirming the client's underlying rule of interaction that he or she is somehow flawed and incapable of coping with certain life situations effectively. Consequently, when the client is helped to view his or her symptoms and situation differently (i.e., through a reorientation process), he or she will need to learn new behavioral options (rituals) that will help deal with the presenting situation more effectively and reaffirm the new, healthier perspective regarding oneself, others, and life.

Rituals involve actions. This last step in the brief therapy process involves the prescribing of new behavioral patterns for the client to use when dealing with the presenting concern from the new perspective. Many types of rituals can be used depending on the client's needs. For example, new interaction steps might be introduced into a repetitive sequence between husband and wife for handling conflict (changing the choreography rituals). In addition, an individual might be taken out of, or placed into, an ongoing problem interaction to change the sequence (changing the actor's rituals). Other commonly prescribed rituals include restoring positive rituals, connecting rituals, desensitization rituals, and boundary-making rituals (Christensen, Bitter, Hawes, & Nicoll, 1997).

The prescribing of new behavioral rituals involves the client in actively making changes in his or her life outside the therapy session. However, it cannot be emphasized enough that the success of these prescriptions is based entirely on the extent to which the therapist can successfully create a shift, change, or reorientation in the client's original rules of interaction. The reorientation process is the key to change. It is the shifting of the bop-bag's base. Only when the client can view his or her symptoms from a new perspective will he or she be prepared to seek and then use alternate behavioral strategies. New behavioral rituals are directives given to the client for handling the presenting situation differently that will simultaneously serve the function of reaffirming this new perspective. The following case example illustrates the change process delineated by this integrative brief therapy framework.

☐ Case Example

A 45-year-old male client came to counseling due to feelings of distress and depression related to his second divorce that had occurred some 10 months earlier. He related lingering doubts about whether the divorce was a good decision, adding that he had a history of making bad decisions. Consequently, he now spent most of his time alone brooding over his situation, criticizing himself, and avoiding any situations outside his work setting that might lead to forming new social relationships.

After initially reframing by normalizing his "lingering doubts" regarding the wisdom of the divorce as normative in the first year postdivorce, the client was invited to explore the nature of his previous marital relationships. This was suggested as a way to gain a better understanding of how his relationships had failed so that he might avoid such problems in the future. He offered the explanation (rule of interaction) that

he was a nice, gentle man who seemed to always end up with very demanding and irrational women. This, he believed, resulted in inevitable problems as he was unable to tolerate their unpredictable and irrational complaints and demands. His typical manner of coping with these "irrational" complaints and demands in both marriages had been to stay longer at work, move out of the house for a week or more, or engage himself in another task and thus avoid these "unproductive confrontations." He reported often feeling "uptight and anxious" about going home or would get angry whenever a "trivial matter" was raised as a concern by his wife (i.e., Level 1, specific behaviors and emotions identified).

This initial investigation suggested that the client found confrontation and conflict particularly threatening and difficult and therefore sought always to avoid or distance himself from conflicts (Level 2, purpose of behavior). The early childhood recollections technique (Mosak, 1972) proved effective in obtaining a clearer understanding of the client's rules of interaction. He recalled a situation at about age 7 when he awoke late at night to the sound of his parents fighting and arguing loudly downstairs. After initially trying to block out the frightening sounds by hiding under his bed with a pillow over his ears, he climbed out the bedroom window and walked up to the top of a small hill across the road. There, he reported finding peace and tranquillity sitting under a tree, a full moon overhead. He could see his mother and father on the lawn but could no longer hear the troublesome sounds of their conflict. In this early childhood recollection, we observe a theme (rule of interaction) that conflict is uncontrollable, threatening, and to be avoided at all costs. His method for coping in life was to avoid or escape from any conflict or potential conflict situation. This strategy, however, only served to exacerbate the situation as problems remained unresolved in his marriages, further frustrating his spouses.

The therapist could now fully understand the client's symptoms based on the three levels of behavior. Viewing conflict as threatening and uncontrollable, he sought to avoid or distance himself from any conflict situation. Long work hours, moving out of the home for short periods, or engaging himself in other tasks and thus being "too busy" to discuss the matter were behaviors used for conflict avoidance. His current symptoms of depression, brooding, and self-criticism also served the function of avoiding further social relationships and thereby the potential for experiencing similar interpersonal conflicts. The therapist could now align with the client's symptoms as useful conflict avoidant strategies. At the same time, the therapist could reframe the client's symptoms and presenting issues not as suffering from mild depression and poor decision-making skills but rather as methods he used to avoid conflict. It could also be pointed out that the price he pays for avoiding conflict is that the conflict is never resolved, but further escalated, and true intimacy in a relationship is never realized.

As this client explored his relationships from this new perspective, he came to view himself not as a passive victim of his own inadequacies and the complaints of irrational wives, but instead as someone who tended to overimpress himself with the potential problems of conflicts. As such, he had perfected the fine art of conflict avoidance (i.e., reframing with a focus on competence rather than pathology). Consequently, the client was helped through role-playing exercises to learn new behavioral strategies for disclosing his difficulties with conflict situations and to ask for assistance from those close to him as he learned to use new strategies for resolving conflicts. Eventually, this led to the client choosing to reunite with his ex-spouse and working on the issues of their relationship directly.

This case study example illustrates the application of the integrative framework for brief therapy. Different clients and different presenting issues will require the use of

alternate strategies and techniques. However, the process of all brief therapy interventions follows a similar pattern of first identifying specific behaviors and emotions used by the client in relation to the presenting problematic life situation. Then the brief therapist uses appropriate techniques to obtain a better understanding of the client's underlying rules of interaction (i.e., the idiosyncratic cognitive schema the client uses to assign meaning to life situations). On the basis of this understanding, the therapist helps the client toward considering the presenting symptoms or issue from a new perspective (reorientation) and then assists the client in identifying new behavioral strategies (i.e., rituals) for resolving the presenting concern.

References

Budman, S. H., & Gurman, A. S. (1988). *Theory and practice of brief therapy*. New York: Guilford.

Butcher, J. N. & Koss, M. P. (1978). Research on brief and crisis-oriented psychotherapies. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed.; pp. 725–768). New York: Wiley.

Christensen, O., Bitter, J., Hawes, C., & Nicoll, W. G. (1997). *Strategies & techniques in brief therapy: Individuals, couples and families*. (Training manual available from the Adlerian Training Institute, P.O. Box 276358, Boca Raton, Fl. 33427).

Dreikurs, R. (1954). The psychological interview in medicine. *American Journal of Individual Psychology, 10*, 98–122.

Garfield, S. (1986). Research on client variables in psychotherapy. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.; pp. 213–256). New York: Wiley.

Garfield, S. L. (1989). *The practice of brief psychotherapy*. New York: Pergamon.

Gelso, C. J., & Johnson, D. H. (1983). *Explorations in time-limited counseling and psychotherapy*. New York: Teachers College Press.

Haley, J. (Speaker). (1990). *The first therapy session: How to interview clients and identify problems successfully* (cassette recording). San Francisco: Jossey-Bass Audio Programs.

Hawes, E. C. (1989). Therapeutic interventions in the marital relationship. In R. M. Kern, E. C. Hawes, & O. C. Christensen (Eds.), *Couples therapy: An Adlerian perspective* (pp. 77–114). Minneapolis, MN: Educational Media Corp.

Howard, K. I., Kopta, S. M., Krause, M. J., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41*, 159–164.

Johnson, D. H., & Gelso, C. J. (1980). The effectiveness of time limits in counseling and psychotherapy: A critical review. *Counseling Psychologist, 9*, 70–83.

Koss, M. P., & Shiang, J. (1994). Research on brief psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.; pp. 664–700). New York: Wiley.

Mosak, H. H. (1972). *Early recollections as a projective technique*. Chicago: Alfred Adler Institute.

Nichols, M. P., & Schwartz, R. C. (1995). *Family therapy: Concepts and methods* (3rd ed.). Boston: Allyn & Bacon.

Nicoll, W. G., & Hawes, E. C. (1984). Family lifestyle assessment: The role of family myths and values in the client's presenting issues. *Individual Psychology, 41*, 147–