

# Brief Interventions and Brief Therapies for Substance Abuse

*Treatment Improvement Protocol (TIP) Series*

# 34



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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# 5 Brief Strategic/Interactional Therapies

Strategic/interactional therapies attempt to identify the client's strengths and actively create personal and environmental situations where success can be achieved. In these therapies, the focus is on the individual's strengths rather than on pathology, the relationship to the therapist is essential, and interventions are based on client self-determination with the community serving as a resource rather than an obstacle. This model has been widely used and successfully tested on persons with serious and persistent mental illnesses (Rapp and Wintersteen, 1989; Saleebey, 1996; Solomon, 1992). It has also been used with persons who have problems related to substance abuse (Juhnke and Coker, 1997; Miller and Berg, 1991; Ratner and Yandoli, 1996; Watzlawick et al., 1967). Although the research to date on these therapies (using nonexperimental designs) has not focused exclusively on substance abuse disorders, the use of these therapies in treating substance abuse disorders is growing.

Many different theoretical approaches have strategic or interactional roots. They can be distinguished from each other primarily by the different emphasis and value they place on components of the change process. Therapists rarely follow a single theoretical approach strictly; therapists today influence and learn from each other, incorporating what they find useful into their own work.

All of these models stem in part from the work of Milton Erikson. He coined the term *strategic therapy* to describe an approach in which the therapist takes responsibility for finding new and effective strategies to help clients in distress. Jay Haley, John Weakland, and other theorists of the Mental Research Institute (MRI) consulted with Erikson as they expanded on his theoretical approach.

More recently, Steve De Shazer and his colleagues, who were influenced by the MRI approach, shifted the focus of treatment from problems to solutions, calling their modality *solution-focused therapy*. Their approach, originally developed to work in brief marriage and family therapy, has since been used in a variety of situations for a variety of presenting problems, including substance abuse disorders. (See Chapter 8 for more information on the application of all these therapies to the treatment of families.)

*Interactional therapy* is based on the assumption that problems can best be understood by examining clients' (often dysfunctional) interactions with others and their resulting problems. Strategic therapy is a form of interactional therapy because it does not focus on the root causes of the client's problems but instead tries to increase competency and develop problem-solving skills that will help the client in her interactions with others. For the



purpose of this discussion, however, the combined term *strategic/interactional therapy* is used. This broader term allows solution-focused therapy, which is certainly interactional, to be included in this section. Although it has a strong kinship with strategic approaches, not all practitioners consider solution-focused therapy to be “strategic.”

The significance of these different approaches can be found in their presentation of an alternative approach to understanding how substance abuse disorders evolve and how new innovative solutions could be generated to assist with the resolution of these problems.

The Consensus Panel believes that these therapeutic approaches are potentially useful for clients with substance abuse disorders and should be introduced to offer new knowledge and techniques for treatment providers to consider. This chapter presents one strategic/interactional approach, solution-focused therapy, which has been used in substance abuse treatment. Information on when to use solution-focused brief therapy with substance abuse clients, a case study using strategic/interactional approaches with a substance-abusing client, and the general theories that provide the basis for strategic/interactional therapies are discussed below.

## **Solution-Focused Therapy for Substance Abuse**

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While this chapter covers several strategic and interactional theories and practices, most of the work currently being done on substance abuse treatment uses a solution-focused approach. Solution-focused therapy is always brief, and to date there has not been a great deal of research comparing it to other models.

Research by Iguchi and colleagues supports some of the theoretical claims made by solution-

focused therapists (Iguchi et al., 1997). The solution-focused therapist believes that helping clients with substance abuse disorders to address any life problems they find significant will help them to reduce their substance use. What is important is finding a solution to the problems the client identifies as significant, then reinforcing the client’s success in solving those problems. This procedure helps the client to recognize her own ability to solve her problems. The study by Iguchi and colleagues compared the role of urine testing, traditional substance abuse counseling services, and the reinforcement of nonsubstance-use-related positive life changes and found that the latter resulted in the most significant reduction in substance use even after reinforcement contingencies ended.

The solution-focused therapy model has been used to respond to a range of problems and complaints. Researchers Berg and Miller were the first to apply the model specifically to the treatment of alcohol-related problems, but others also have used these techniques for treating substance abuse disorders (Berg, 1995; Berg and Miller, 1992; Berg and Reuss, 1998; Ratner and Yandoli, 1996). This treatment model is not necessarily a useful treatment strategy for all clients with substance abuse disorders; no one model is. However, this model is a “complex and varied package of strategies that can be applied in an individualized, eclectic fashion to those seeking treatment” for a multifaceted and complex problem (Berg and Miller, 1992, p. xix). Berg and Reuss delve into greater detail regarding the applications of solution-focused brief therapy to the treatment of substance abuse disorders (Berg and Reuss, 1998).

One technique of solution-focused therapy is to focus on the exceptions to the client’s problems. For example, in providing solution-focused brief therapy for a client with a substance abuse disorder, the therapist should

direct the client's attention to periods when he was substance free. To identify these periods, the therapist must listen carefully to the client's responses, then ask the client to discuss those periods. The purpose is to help the client realize that he can maintain sobriety and has, in fact, done so in the past. The idea of focusing on the exception to any presenting problem is an aspect of strategic therapy that has particular relevance to the substance abuser because, as Berg notes, almost every substance abuser has had some period of abstinence—in many cases this period may have lasted months or years (Berg, 1995).

Exceptions to presenting problems may fall into two categories, *deliberate exceptions* and *random exceptions* (see Figure 5-1 for definitions). The more deliberate the behavior on the part of the client, the easier it will be for her to repeat it. But even substance-free periods that seemed to result from outside influences (i.e., random exceptions) can be used to help the client realize her own ability to stay sober.

As discussed above, a therapist using a solution-focused approach works closely with the client to understand the client's own perspective on her problems. By focusing on those areas the client considers significant (e.g., relationships, work, financial security), the therapist assists the client in understanding how

her substance abuse affects those significant areas of concern. The therapist helps the client solve those significant problems while strongly reinforcing the client's success. After the initial session, the therapist keeps the client focused on how her situation is improving by asking, "What's better this time?"

## Compatibility of Strategic/Interactional Therapies and 12-Step Programs

Strategic/interactional approaches can be used in conjunction with other treatments, even those that require a longer term commitment.

Strategic/interactional therapies are guided by an intent to generate a unique set of techniques, approaches, or modalities that are effective for a particular client. For some clients, a combination of brief therapy with longer term participation in another treatment program, such as a self-help group, will be most effective.

In spite of some theoretical differences, strategic/interactional approaches can be used successfully in conjunction with 12-Step programs. These approaches, especially identifying triggers that can lead to relapse or

Figure 5-1

### Deliberate and Random Exceptions to Substance Abuse Behaviors

*Deliberate exceptions* are situations in which a client has intentionally maintained a period of sobriety or reduced use for whatever reason. For example, a client who did not use substances for a month in order to pass a drug test for a new job has made a deliberate exception to his typical pattern of daily substance use. If he is reminded that he did do this in the past it will demonstrate that he can repeat the behavior.

*Random exceptions* are occasions when a client reduces use or abstains because of circumstances that are apparently beyond her control. The client may say, for example, that she was just "feeling good" and did not feel the urge to use at a particular time but cannot point to any intentional behaviors on her part that enabled her to stay sober. This type of exception is more difficult for the therapist to work with but can also be used to help the client perceive her own efficacy. In such instances the therapist can ask the client to try to predict when such a period of "feeling good" might occur again, which will force her to begin thinking about the behaviors that may have had an effect on creating the random exception.

exploring barriers that can prevent the client from going to Alcoholics Anonymous (AA) meetings or calling his sponsor, can be applied to critical points in maintaining sobriety. For example, the therapist can help the client identify the “payoff” for not attending the meeting and the key players in the system that maintains the client’s substance abuse. Even a client who feels he is powerless over substance abuse without the help of a higher power can recognize he has some control over the choices that lead to substance abuse.

Some therapists familiar with 12-Step programs may be concerned that the strategic/interactional approach is opposed to viewing addiction as a disease. The focus on empowering the client may seem incompatible with the first step (i.e., “we admitted we were powerless over...”). However, the key to therapeutic success with this approach is the ability to work within a client’s frame of reference. Therapists can acknowledge that addiction is a disease but still use the strategic/interactional approach to enhance clients’ coping skills and help them to control the use-related behaviors that clients may believe are random and spontaneous. Strategic therapists who do not accept a disease model may tell a client, “You have a disorder of the pleasure centers in your brain,” and work with the client to find healthier ways to activate those “pleasure centers.”

## When To Use Strategic/Interactional Therapies

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No matter which type of strategic/interactional therapy is used, this approach can help to

- Define the situations that contribute to substance abuse in terms meaningful to the client
- Identify steps needed to control or end substance use

- Heal the family system so it can better support change
- Maintain behaviors that will help control substance use
- Respond to situations in which the client has returned to substance use after a period of abstinence

More specifically, strategic/interactional approaches are useful in

- Learning how the client’s relationships deter or contribute to substance abuse
- Shifting power relationships
- Addressing fears

Most strategic/interactional therapies ask a client to consider the question, “How do you understand your using?” (Solution-focused therapy is an exception because it concentrates instead on improving the situation.) Often, as the therapist and client explore the client’s understanding of the abuse, critical relationship issues surface—even when the client appears to be isolated from family and friends. Even if a client seems to have no existing family connections, the family sometimes plays a role in her substance abuse. Her family, or her reaction to it, may have influenced her decision to begin using or her decision to stop. Messages from the family (internalized or actual) can also play an ongoing role in the client’s choice to continue using.

One therapist treated a woman whose entire family appeared to have alcohol-related problems and who believed that everyone drank, but at different levels. For this client, a strategic/interactional approach helped her become aware of new possibilities, develop social skills, and identify sober activities. She learned to see the world as a richer place with many options. The therapist in this case chose to be directive and showed the client the possibilities for change that exist. To many clients who are trying to change their behavior, it is reassuring to believe that “there is someone

who knows the way.” The therapist using this strategic/interactional approach should convey a sense of hope that bridges the chasm between what is and what could be and support the client through the change process with respect.

The strategic/interactional approach can also help break through a stalemate in a relationship that blocks healing, particularly if there has been a power struggle that has left both parties exhausted and with an apparently restricted range of options. In a power struggle, each person says she is right and the other is wrong; one of them must give in. When the strategic/interactional approach is applied to power struggles it can help to “open up the system,” working to change the clients’ perceptions of each other and their relationship and enable them to see a broad range of options. Both parties are assisted in seeing themselves as strong, capable, and in control. Because the substance abuser typically feels helpless, inadequate, and condescended toward, the therapist often has to rebalance the power structure to promote more effective interactions.

For example, in a situation where one partner pushes the other to stop drinking, the partner who has been drinking may feel controlled and demeaned and therefore may withdraw in a passive manner or react with an explosive temper. He then gets drunk to further express his anger or to get even. The partners’ respective behaviors maintain the problem. The therapist works to help each partner perceive the other more positively. As this is accomplished, each person becomes more receptive to new solutions. The therapist then helps the partners identify specific changes they can make, thus dismantling the old system and laying the foundation for a new one that can support different behavioral choices.

The strategic/interactional approach is also an appropriate way to address a client’s fear of change. Often, clients feel that “something worse” may happen when they quit using. In

the Eriksonian model, a therapist might ask the client to project herself into the future and describe what it will be like when the changes just discussed have been made, or talk about a “future self” who has resolved current problems and for whom current fears are no longer an issue. Such strategies are useful in confronting common fears and helping clients see beyond them.

## **Duration of Therapy and Frequency of Sessions**

Most forms of strategic/interactional therapies are brief by the definition used in this TIP. Strategic/interactional therapies normally require 6 to 10 sessions, with 6 considered typical. Sessions are usually weekly, and it is not advisable to have more than two sessions per week. This type of therapy often involves assigning “homework” for the client to observe how specific changes in behavior affect the problem, and time is needed to determine how a new strategy is working and see how the system is affected by the change.

In solution-focused brief therapy, the client is encouraged to determine the length of time needed between sessions. This approach helps the client take ownership of the process and recognize his power to control change (realizing that one has the power to choose often is the solution itself).

## **Applicability to Different Types of Clients**

In strategic/interactional approaches, clients are traditionally defined as customers, complainers, or visitors. Customers are clients who state that they have a problem, they can not cope with the problem on their own, and they need the therapist’s help. Strategic/interactional approaches are particularly helpful for the latter two types of clients—those who think someone else should change to resolve the presenting problem (complainers) and those who see their



presence in treatment as involuntary (visitors). Strategic/interactional therapies offer these kinds of clients a way to make effective changes within their own frames of reference.

For example, consider a client who feels her boss overreacted to her substance abuse and believes she should not have been forced to enter treatment to retain her job. Instead of working to try to convince the client she really does have a problem, the therapist can make progress working within her view of the situation, perhaps by saying, “So your boss thinks you have a problem. What would it take to get him off your back?” The assumption that the client wants to be free of the problems caused by this other person gives the therapist something to focus on without challenging the client’s view of the situation.

Most clients with substance abuse disorders can be viewed as “hidden customers” who desire some sort of change in their behavior, even if they are not willing to articulate that fact (Berg, 1995). Given that, the therapist’s task is to make the “complaininer” or “visitor” aware that he is in fact a “customer” of the therapist’s services.

### **When Might a Strategic/Interactional Approach *Not* Be the Best?**

Eriksonian approaches may be contraindicated for clients with severe disorders. Clients who have personality disorders (Axis II) may jump quickly from one suggestion to another without a clear sense of how to make use of therapeutic suggestions. Because they feel a need to stay in therapy they may resist solutions that would bring an end (albeit a successful one) to their relationship with the therapist. Clients with impaired brain function as a result of substance abuse may not be good candidates for this approach either. (For these clients, a more directive approach is helpful.) However, even

when it is difficult to use this approach directly with the client, it may still be an effective modality to use with family members to help them change behaviors that support the client’s substance abuse (Fisch et al., 1982).

For other populations, the approach may have to be adapted to work effectively. The therapist may have to use supportive props such as handouts of the agreed-upon plan of action and a list of goals to help keep the client on track. Strategic/interactional strategies can be simplified for people who have a cognitive impairment. Because this approach works with the client’s language and functional level, a client with a cognitive disability may be able to identify and meet goals appropriate to her skills and abilities. Many therapists believe that the solution-focused approach is useful with clients who have schizophrenia, and research supports its effectiveness with some clients who have serious mental illnesses (Saleebey, 1996; Solomon, 1992).

## **Case Study**

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Figure 5-2 presents a portion of a dialog between a counselor and a client, a 45-year-old real estate agent who was treated 4 years ago in an inpatient treatment program and thereafter attended a 12-Step group to help him stop his polysubstance abuse (cocaine and alcohol). After experiencing 3 clean and sober years, he began to use again. The client started gambling, then using cocaine and alcohol while gambling. His real estate license is now in jeopardy because of customer complaints and reports to the State Licensing Board. He was recently convicted for a second time for driving under the influence (DUI), and his wife and family moved out. The client tells the therapist that his renewed abuse of substances was the result of the gambling. Unlike the negative feedback from family, colleagues, and other professionals,

**Figure 5-2**  
**Strategic/Interactional Therapy in Practice: A Case Study**

Conversation	Observations
<p><i>Client:</i> Things were going great. I was going to a lot of meetings. I felt life was getting better. I was getting along with my kids. Getting in touch with the spiritual part of the problem. I don't know what happened.</p> <p><i>Therapist:</i> What led you to go gambling?</p> <p><i>Client:</i> I guess I'd been gambling for a few months before I got high. I was bored.</p> <p><i>Therapist:</i> What is the experience of gambling like?</p> <p><i>Client:</i> I really feel alive.</p> <p><i>Therapist:</i> When did you first use again?</p> <p><i>Client:</i> I spent too much money on gambling, and my wife yelled at me the same way she used to when I got high on cocaine. I won a whole lot, really. It wasn't fair.</p> <p><i>Therapist:</i> What do you do when your wife gets angry at you for spending money?</p> <p><i>Client:</i> I just say, "Yeah, you're right." And then I go away. Then she hassles me some more. There are times I blow up, but normally I just try to let it go by.</p> <p><i>Therapist:</i> Sounds like when you were gambling, you were excited. So I don't get it – what went wrong? Why did you need the cocaine, too? Is it possible gambling wasn't enough?</p> <p><i>Client:</i> I guess I just needed more of the high, you know. My wife and I were fighting more. The pressure was getting to me. I guess that's when I started on the cocaine.</p> <p><i>Therapist:</i> How did that cocaine work for you?</p>	<p><i>The first trigger (boredom) has been identified; this will have to be reframed as treatment progresses.</i></p> <p><i>An important interactional element surfaces. Sometimes the things that spouses or significant others do or say can either reinforce the client's substance abuse or help him out of the problem.</i></p> <p><i>Nonjudgmental language is used to enter the client's frame of reference/world-view. It is best if the client is able to define the substance abuse as a problem he wants to overcome rather than have the therapist define this for the client.</i></p>

**Figure 5-2 (continued)**  
**Strategic/Interactional Therapy in Practice: A Case Study**

<i>Conversation</i>	<i>Observations</i>
<p><i>Client:</i> I was excited. I felt really powerful.</p> <p><i>Therapist:</i> What went wrong? What led you start using alcohol, too?</p> <p><i>Client:</i> I got scared. I was up for 3 days. The alcohol helped me come down and sleep.</p> <p><i>Therapist:</i> Sounds scary to me. How did you get through that scared period? You tolerated it somehow for 3 days.</p> <p><i>Client:</i> It was kind of a blank, mostly. I felt I had to fix it somehow. That's when I started drinking.</p> <p><i>Therapist:</i> How did you know alcohol would work?</p> <p><i>Client:</i> I've used it to bring me down before.</p> <p><i>Therapist:</i> I hear that you realized something needed to be done, and you knew you needed something to slow you down, and you took action.</p> <p><i>Therapist:</i> So how is this a problem for you now?</p> <p><i>Client:</i> Well, I lost my family, almost lost my business, and I'm facing another DUI.</p>	<p><i>Here the therapist gets some understanding of the sequence of the client's substance abuse.</i></p> <p><i>The therapist validates the client's experience, rather than criticizing the client's behavior.</i></p> <p><i>The therapist is pointing out that the client's action was an attempt at regulation, though not a long-term solution. The statement reminds the client that he is in control and making choices. It reaffirms the client's strength and coping skills – the client made an adaptive response to a difficult situation and may make a different choice next time.</i></p> <p><i>This question brings the client back to defining the problem for himself, rather than letting the therapist or someone else (spouse, boss, probation officer, etc.) define it for him.</i></p> <p><i>This “hopeless and helpless” stance should be shifted. Solution-focused and MRI approaches would try to promote effective strategies and eliminate ineffective ones. An Eriksonian might challenge the client to compare his positive and negative self-image (i.e., the way it feels to go to AA and stay sober versus how it feels after getting high).</i></p>

**Figure 5-2 (continued)**  
**Strategic/Interactional Therapy in Practice: A Case Study**

<i>Conversation</i>	<i>Observations</i>
<p><i>Therapist:</i> So where do you want to go now? Why are you here?</p> <p><i>Client:</i> I want to get sober again. I went back to AA, but now I can't stay sober more than a day.</p> <p><i>Therapist:</i> When you were determined to stay sober, you were successful. What's different about the way you're trying to do this now?</p> <p><i>Client:</i> Well, now, I'll leave the meeting and go get high.</p> <p><i>Therapist:</i> And how is that working for you?</p> <p><i>Client:</i> It's not working! I just start feeling worse about myself. I've been through so much already. I really just need to stop.</p> <p><i>Therapist:</i> It sounds to me like you have incredible inner strength. What keeps you going?</p> <p><i>Client:</i> I don't want to die.</p> <p><i>Therapist:</i> It sounds like you have a very strong, competent side that wants the best for you and wants to live. Let's use that competent part of you to get back on track and rebuild your life. What do you think?</p> <p><i>Client:</i> I would like that.</p> <p><i>Therapist:</i> Let's begin by figuring out where you are now. On a scale of 1 to 10, on which "1" is the worst you could feel and "10" is "clean, sober, and successful," where are you now?</p>	<p><i>This therapist is using a strategic approach to shift the client off helplessness to a self-motivational statement: "I really need to change my life."</i></p> <p><i>Here is a "make it or break it" point in treatment. The therapist is seeking a key that will move the client to action (e.g., his love of his children, his desire to get his wife back, his concern about his job). In this case, the therapist has just learned that the client fears he will die as a result of his use.</i></p> <p><i>Some therapists would call the competent self the "recovery self."</i></p> <p><i>The "readiness ruler" is an effective way to determine the client's readiness to change and identify next steps. The therapist is using this technique to identify a baseline to measure progress and focus the client in the direction of change and progress.</i></p>



**Figure 5-2 (continued)**  
**Strategic/Interactional Therapy in Practice: A Case Study**

<i>Conversation</i>	<i>Observations</i>
<p><i>Client:</i> Well, now I feel like an “8,” but I know it’s temporary. When I go back home, I’ll probably get back to a “2” right away.</p> <p><i>Therapist:</i> That’s good because slow change is more important than fast change. You really can’t count on fast change to last. So if you did slip back to a “2,” what would it take to move you to a “3”?</p> <p><i>Client:</i> I guess more of what I know works or what used to work, anyway. Going to meetings or calling my sponsor. That kind of thing.</p> <p><i>Therapist:</i> Sounds good. You said now you go to AA meetings and get high afterward. What did you do afterwards when you didn’t do that, when you stayed sober?</p> <p><i>Client:</i> Went home. Watched TV. Had fun with my wife; sometimes we made love. Now that she’s not there, I really dread the evenings. They are so empty. I just go back and stare at the ceiling.</p> <p><i>Therapist:</i> So when you don’t have things to do, you get antsy.</p> <p><i>Client:</i> Yeah. I guess so. I get lonesome.</p> <p><i>Therapist:</i> Yes, it is difficult to go home to an empty place. But it sounds like you have not given up on people. People are still important to you. You want human contact—to care about people and have them care about you.</p> <p><i>Client:</i> If nobody’s around, I feel empty. I get bored. Then I want to use. I want to make something happen.</p>	<p><i>At this point, the therapist is ready to define some kind of action and seek commitment to change. The response is also intended to encourage the client by identifying small, feasible steps</i></p> <p><i>The therapist is looking for exceptions: times when something the client did worked and he experienced success.</i></p> <p><i>The therapist is reframing the problem to open the door to a solution.</i></p> <p><i>The therapist is acknowledging the difficulty, but also pointing out the positive direction implicit in the client’s statement. The therapist empathizes with the client, validating his experiences and feelings, but also pointing out the positive direction implicit in the client’s statement.</i></p>

**Figure 5-2 (continued)**  
**Strategic/Interactional Therapy in Practice: A Case Study**

<i>Conversation</i>	<i>Observations</i>
<p><i>Therapist:</i> Are you bored now?</p> <p><i>Client:</i> Sort of. Not really here all the way, you know what I mean? Sort of empty.</p>	<p><i>This question gives the therapist information on how the client feels and acts when bored and can help the therapist recognize signals of boredom in the future. Sometimes the therapist will have great participation, and the client will still describe himself as bored. It is also important to ascertain whether the boredom results from depression or a sense of emptiness. A better understanding of what “bored” means will enable the therapist to help the client figure out “what’s different” and find a solution.</i></p>
<p><i>Therapist:</i> That’s interesting. Despite the fact that you feel empty, you can still function. I think there is something internally powerful in you that has not come out. For some reason, it has been suppressed. My guess is that the boredom comes when you suppress that side of you.</p>	<p><i>The therapist is framing the client’s self-image positively, suggesting a change in the way the client now sees himself.</i></p>
<p><i>Client:</i> You keep talking about this powerful side. I don’t get it. I lost everything. Where’s this great power I’m supposed to have?</p>	<p><i>A natural response from a client who is mostly focusing on negative perceptions and experiences. The therapist’s focus continues to be on shifting the client’s perception to positive strengths and constructive action.</i></p>
<p><i>Therapist:</i> I think it’s right here—let’s see if we can bring it out a bit. Tell me about a time when you felt tremendous pleasure and control, but you were sober.</p>	
<p><i>Client:</i> Well, I have to go pretty far back. When I was ten, though, I remember playing baseball and hitting this home run. I really hit that ball.</p>	
<p><i>Therapist:</i> Some time this week if you’re willing to try something, and only if you’re willing, try to bring back that experience. Take note of what it was like and how difficult it was to get there.</p>	<p><i>At this point, the therapist might encourage the client to feel that vibration and run across the bases in his mind or ask whether the activity mentioned is one the client could do in his present life. The therapist could suggest here that a local recreation center, or another way of being physically active, would be an option for restoring the sense of power and control as well as connecting with people.</i></p>
<p><i>Client:</i> Okay. Maybe I’ll try that.</p>	

Figure 5-2 (continued)

Strategic/Interactional Therapy in Practice: A Case Study

*Therapist:* I'm sure there have been a number of things in your life that you've done right, otherwise you wouldn't have survived all of the difficulties you've had. It would help if you could think about those successful or effective behaviors.

*Client:* I can try.

*Therapist:* Now that we've identified that you have all this strength inside of you—and you still do—how do we use it?

*Client:* I guess if I could go to AA and stay sober when I get home, that would at least be a start.

*Therapist:* What do you think is going to happen at AA?

*Client:* It's going to be good to sit there and know I'm not hiding.

*The therapist should make the client work here. If the client is blank, he could be asked to free associate. In a group setting, others could give suggestions.*

*Part of what's happening is that the external and internal pressure resulting from the shame is being reduced; consequently, the feeling about going is changing.*

the therapist, using strategic/interactional approaches, praises the client for coming back to treatment: “Look at what you have done! You’re in this chair instead of still out there.” The therapist assures the client that relapse is part of the recovery process and suggests that the experience can be seen as educational. In contrast to emphasizing the client’s failure, the therapist sends the message, “You’re a survivor, not a victim.” The therapist affirms the client’s ability to stay sober and begins to seek ways to emphasize and draw on the client’s strengths. The therapist seeks to understand the events that led up to renewed use but also searches for the behaviors that previously helped the client stay abstinent for 3 years.

This case study is an example of how a brief strategic/interactional therapist might work with a client who has previously been successful at controlling his substance abuse problem but has relapsed. The approach described is a generic strategic/interactional approach and does not represent a pure model of any one type of strategic/interactional therapy. Because the client has relapsed, an important guiding principal is to discover what has caused him to deviate from those behaviors, thoughts, and activities that had previously been effective in controlling his substance abuse. The therapist must then assist the client either to return to those things that have been working before or to add or replace them with strategies that are more effective.

## Strategic/Interactional Therapies

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The primary strength of strategic/interactional approaches is that they shift the focus from the client's weaknesses to the client's strengths. The therapist's task is to help the client identify, recognize, and use these strengths to make the changes the client sees as beneficial.

Strategic/interactional therapies are based on three primary theoretical assumptions:

1. These therapies take a *constructivist* view of reality. They assert that reality is determined by individual perceptions, which are influenced by cultural, sociopolitical, and psychological factors.
2. These therapies stress the importance of attribution of meaning. According to this theoretical approach, it is the meaning we attribute to situations that determines whether a problem exists. In this model, an important therapeutic goal is to understand the meanings that clients attribute to events—often referred to as the client's "frame of reference"—and to use this knowledge to promote constructive change. This can involve helping clients to construct a different meaning that is more useful to them in the recovery process.
3. These therapies focus on human interactions and the problems that evolve from ineffective ways of coping with situations. There is always some element of social interaction in the development, maintenance, and change process for any problem. By taking these interactions into account, the therapist can better support the client through the change process.

A basic tenet of this approach is the assertion that human problems can be understood by applying the principles of human systems. Problems do not exist in a vacuum; they exist because of relationships with others. The

strategic therapist believes that a positive change to one part of a system will positively affect the rest of the system. This approach is distinct from a structural view of systems, however; whereas the structuralist sees the need to consider and try to change dysfunctional aspects of the larger family structure, the strategic therapist does not necessarily posit a systemwide dysfunction—only the existence of *ineffective interactions* within the system.

A strategic approach accepts the fact that clients may not always provide accurate information about the real nature of their problems. It is possible to work with the client's view of what is happening and make progress, even if that view is only partially "correct." For example, consider a client who enters therapy complaining, "My boss drives me to drink." In a cognitive or confrontational approach, the therapist might strive to change this way of looking at reality. The therapist using a form of strategic/interactional therapy might say that this approach represents the client's view of the world and, rather than correcting or altering it in some way, the therapist can make more progress by working within that frame of reference to accomplish strategic objectives. The therapist might ask, "If your boss is driving you to drink, how does that happen and what can you do about that?" The therapist implies that the client must be more effective in interactions with his boss, and this becomes a treatment issue. By working within the client's frame of reference, the therapist can define what the client might do to change key interactions that contribute to substance abuse, *without* buying into the premise that it is only his boss' behavior that must change.

### Initial Session

The first question that a therapist using a strategic/interactional approach should ask is, "Why are you here?" The first session should be spent trying to understand the client's problem.

However, different models (discussed later in this section) use different tactics to explore the nature of the problem, as follows:

- The therapist using *Eriksonian therapy* seeks to define the client's problem in the client's terms and probe the way she understands the problem (i.e., the "frame"). Compared to other strategic interactional models, the Eriksonian approach moves more quickly to action, seeks to effect change more quickly, and places greater emphasis on the unconscious processes underlying change.
- The therapist using *solution-focused brief therapy* spends most of the first session defining goals. Throughout the session, the word "problem" is avoided.
- The therapist using the *MRI model* seeks to define the problem in the client's terms and understand the "frame" in a manner similar to the Eriksonian approach. However, this modality focuses on modifying ineffective solutions that have been previously attempted.
- The therapist using *Haley's problem-solving therapy* pays special attention to gaining an understanding of power issues in relationship to the problem (e.g., who controls key decisions).

## Later Sessions

Once the therapist has encouraged a person with a substance abuse disorder to take further steps toward change, the subsequent sessions will focus on identifying and supporting additional steps in the same direction. The following are examples of techniques that might be used in the remaining sessions with the client in this case study.

- Set up a termination point. The therapist could ask the client to describe the signs that things are getting better for him, or ask, "What things will you be doing differently?"
- The therapist could continue to develop effective strategies and increase their use. She could use affirmations, continue to use scaling questions, and "join" with the client by acknowledging how difficult it is to change and rebuild his life.
- The therapist should also be aware of the client's motivation to change and continue to ask the client what he thinks will happen if changes take place. This technique demonstrates respect for the client's values.
- The therapist could continue to gather information about the stressors that trigger the client's substance abuse and help him to determine how he can handle them differently. The therapist should ask the client about ways he has successfully handled stressors in the past and expand on those successes.
- The therapist could use images and symbols to help the client see the problem in a helpful way. For example, the client might find a new job and throw himself completely into it. The therapist could tell him that he is a shining star: "You're shining bright right now. What can you do to keep shining?" This starts a discussion about how to last longer, work smarter, achieve more, and use restraint.
- The therapist might also focus on assisting the client to improve other aspects of his life.
- The client's continued belief in his own strength and basic goodness should be supported. The therapist should help him see himself as an individual who wants what's best for both himself and his family.
- One effective strategy is to encourage the client to adopt a "helper" role in some area of his life. This shifts the focus further from his view of himself as a helpless, incompetent addict to a strong, caring, competent person who can help others. This client's



participation in AA might give him the opportunity to help others in this manner.

As the end of the therapeutic process nears, the therapist helps the client prepare for the future. Following are suggestions for how the therapist can do this.

- *Prepare the client to maintain positive change through difficult times.* It is useful to convey the idea that the learning curve is never a straight slope; rather, it is a curvy line, with peaks and dips. There will be slips. It is unrealistic to expect perfection. Life will continuously have “ups and downs” — the goal is not to make things even but to cope effectively with these ups and downs.
- *Identify what the potential next stressors and challenges will be.* Work through the following question with the client: “Given what we’ve learned, how would you cope with the next stressor/challenge?”
- *Devote some time to preparing the client for changes to the environment.* For example, how will significant people in his life react to his change in behavior?
- *Ask the client to look into the future at the end of the treatment period and tell the therapist where he intends to be at a certain time (this is an Eriksonian approach).* The therapist could ask for a specific date when the client expects to get there and ask the client to call the therapist on that date. This process sets up an expectation of progress and accountability.

## Ericksonian Therapy

All forms of strategic/interactional therapies have their roots in the work of Milton Erickson, an innovative psychotherapist who was one of the first theorists to suggest the importance of working within the client’s “frame.” With his unique use of hypnotherapy he fostered rapid changes in his clients, often in an indirect fashion. Through this work he came to

emphasize unconscious factors in change and the importance of indirect ways to shift meanings and behavior. His approach is active, building on clients’ resources to help them attain their goals. The therapist and client cooperate in building an awareness of the client’s *experience* and an understanding of its *meaning*. Together, they build a context for change.

Erikson’s interventions emphasize the following:

- *Suggestion* as a means of bypassing an impasse, reframing the problem, and taking a first step toward solving it
- *Metaphor* as indirect intervention — a way to help the client retrieve resources and create a unique response that builds a bridge for learning; the therapist uses the client’s metaphors (e.g., if the client sees recovery as a road, then the therapist can speak of bridges or of smoothing the way, thus activating the client’s imagination in the service of the change process)
- The *symptom* as a communication that conveys information about developmental needs
- *An orientation toward the future* (e.g., depression is seen as the result of focusing on past associations; as the client works toward change and begins to accomplish goals, she lets go of depression)
- Acquiring new *skills* to meet the requirements of new situations (such as the different ways of socializing associated with abstinence) and to handle developmental tasks
- The *cure* conceptualized as the loss of the symptom and as the development of new relational patterns that allow a creative response to the environment

While Erickson was able to work with virtually all clients using these techniques, his work has been especially useful in helping people let go of trauma, break through a

resistance to change, and alter obsessive-compulsive, phobic, or addictive behavior.

## **Solution-Focused Brief Therapy**

Solution-focused brief therapy was developed by Steve De Shazer and his colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin. In solution-focused brief therapy, the emphasis is placed on building exceptions to the presenting problem and making rapid transitions to identifying and developing solutions intrinsic to the client or problem (Cooper, 1995). Basic tenets of this approach include the following:

- Focusing on competence rather than pathology
- Finding a unique solution for each person
- Using exceptions to the problem to open the door to optimism
- Using past successes to foster confidence
- Looking to the client as the expert
- Using goal-setting to chart a path toward change
- Sharing the responsibility for change with the client

The basic tenets of the solution-focused model are fairly simple; they are the same when used for treating substance abuse disorders as they are for treating other mental health concerns. A therapist uses these same principles for an individual client, family, or group. The therapist emphasizes finding solutions to a problem, not on discovering the cause or origins of the problem. According to Giorlando and Schilling,

The innovative perspective of solution-focused therapy shifts the emphasis from problems to solutions, empowering the client to access her internal resources, strengths, and past successes, with therapist and client working collaboratively to achieve change in a shorter time than that required by traditional schools of psychotherapy (Giorlando and Schilling, 1996).

Berg and Miller relate the “central philosophy” of solution-focused therapy in the following three rules (Berg and Miller 1992, p. 17):

1. “If it ain’t broke, don’t fix it!”
2. Once you know what works, do more of it!
3. If it doesn’t work, then don’t do it again—do something different!

Solution-focused interviewing strategies include the following (based on Giorlando and Schilling, 1996), presented in a typical sequence. These strategies can be applied at different points in the therapeutic process as appropriate.

- Ask the “miracle question” (i.e., “If a miracle happened and [your condition] were suddenly not a problem for you, how would your life be different?”).
- Ask about exceptions (e.g., “Are there ever times you see pieces of the miracle?”).
- Explore differences between current status and the desired problem-free state (e.g., “What is the difference between the times when you can see pieces of the miracle and the times when you can see only the problem?”).
- Use scaling to determine how well the client thinks things are going, how willing she is to work toward the “miracle,” her confidence in her ability to change, and the steps needed to improve the situation from one rating on the scale to the next highest.
- Try taking “time-outs” and suggest to the client “While I step out, I want you to think of the next smallest step you could take that would bring you to the next number on the scale.”
- Affirm client competencies (e.g., tell the client, “I am impressed you are sitting in that chair again after what you just went through”). Many of these clients have never had this success acknowledged before.

- Suggest tasks that the client can perform to improve her situation (e.g., ask her to do something achievable that would provide useful information or move her closer to the “miracle” she has chosen).

## The MRI Therapeutic Model

The Mental Research Institute’s brief therapy model is based on the belief that problems develop from, and are maintained by, the way that normal life difficulties are perceived and handled (Fisch et al., 1982). Normal difficulties become problems when an individual continually mishandles a situation, using the same ineffective approach each time. A client’s belief system can cause him to develop ineffective approaches to problems that result in maintaining or even exacerbating the difficulty. The more the client uses an ineffective solution to solve a problem, the more the problem is reinforced and maintained. The solution lies in helping the client change his perception of the problem, then either modify the attempted solution so it has a greater chance of success or devise a more effective solution. These new solutions (generally referred to as *second order change*) work best if they are sufficiently different from the ineffective, previously attempted solutions.

In each session, practitioners using the MRI brief therapy model should try to do the following:

- *Define the problem in behavioral terms.* For example, a client may say, “I feel compelled to join the others at work in drinking, although as a result I have such a ‘short fuse’ that I get in fights and even hurt my wife.”
- *Determine how the client understands the problem.* What is her “frame of reference” or “position”? It is important to understand how the client views her problem and what attitudes she has toward the problem. For example, a client might insist that her substance abuse is the result of pressures at work. However, the therapist notes that she began using after the death of her spouse and therefore hypothesizes that the substance abuse is related to her deep grief. The challenge for the therapist is to work with the client’s position in a way that allows for a more useful understanding of the problem, and therefore for new, more effective solutions.
- *State goals.* What behaviors are to be changed and what would be the signs of change?
- *Review attempted solutions.* What has the client done to try to solve the problem? What has worked, and what has not worked?
- *Reframe the situation.* Help the client change his perception of himself, others involved, or the problem situation so that new options can appear.
- *Develop second order change.* Help the client generate more effective solutions that lead in a different direction from the ineffective ones—either by modifying attempted solutions or by developing new ones. In the case of a client who has tried to control her drinking by obsessing over her need to stop drinking, the therapist might perceive that every time she thinks about controlling her drinking she activates her fears that she is weak and out of control. The more she obsesses over controlling her drinking the more overwhelmed she becomes about the impossibility of the task. The therapist would try to help this client to stop obsessing over this task and instead view the situation as manageable and changeable in a step-wise fashion. The therapist would help her see that she has been strong and capable in other aspects of her life and that she can make use of these strengths and competencies to handle his drinking problem.
- *Plan for maintenance of the new behaviors.* Support continued improvement by preparing the client to meet future challenges and crises.



The speed with which a therapist is able to move through these steps will depend on the client's particular problem, overall development, cognitive capacities, and his stage of readiness to change.

### **Haley's Problem-Solving Therapy**

Jay Haley wrote that "therapy can be called strategic if the therapist initiates what happens during the therapy and designs a particular approach for each problem" (Haley, 1973, p. 17). To do this the therapist will have to identify solvable problems, design interventions to resolve them, correct those interventions based on responses from the client, and evaluate the effectiveness of the therapy.

Haley's problem-solving therapy emphasizes obtaining a clear statement of the problem and an accurate picture of the interactional sequences that maintain it. Moreover, symptoms (i.e., presenting dysfunctions) or problem behaviors serve a function in families and carry metaphorical information about hierarchical dysfunction (Haley, 1987). Through observing the client's symptomatic behavior, the therapist can often understand the underlying problem metaphorically. For example, if a child runs away it can indicate that the family is "running away" from confronting an issue. This behavior often signals a solution as well, calling attention to what needs to be changed.

To map out a family's organization, the therapist should observe communication

sequences—who talks to whom, and in what order. The therapist should try to answer questions such as, "What function does the symptom serve in stabilizing the family?" and, "What is the central theme around which the problem is organized?"

Haley's approach assumes that substance abuse by a family member is a symptom of a family's desire to avoid confronting dysfunctional family dynamics. The individual is not necessarily responsible for having created the symptom (which would fit in well with a disease concept addiction). According to Haley's model, a wife may drink to avoid expressing her rage at her husband for having an affair. The husband implicitly understands that by confronting his wife's drinking, a confrontation might ensue over his infidelity and that could destroy the marriage. This approach recommends negotiating a path to change by changing the family pattern that militates against it. The therapist could work with the family to set goals and design a strategic series of directives to meet these goals, usually involving a change in the sequences of interaction that maintain the problem. In the above example, the wife's drinking serves to stabilize the family and avoid the real issues of the wife's anger and the husband's infidelity. The therapist would work with the wife to express her anger in a way other than drinking, and define the issue as one of trust in the marriage.

# Appendix A

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