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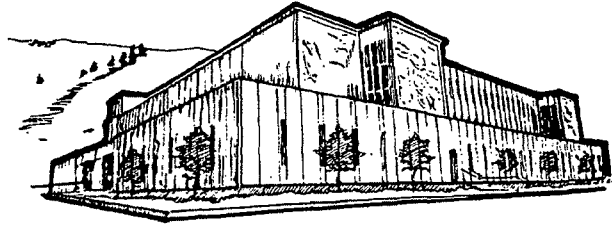
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EFFECTIVE COMMUNICATION STRATEGIES
UTILIZED TO FACILITATE CHANGE IN CLIENTS

by

Bobbin Field Maki, M Ed., LPC

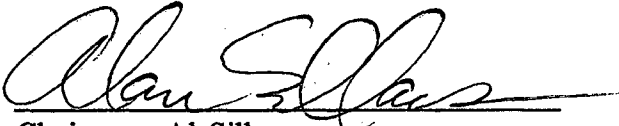
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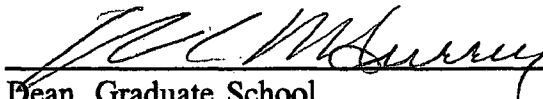
Master of Arts

University of Montana

1994

Approved by:


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Dean, Graduate School

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ABSTRACT

Bobbin (Field) Maki, M.A., October 1994

Effective Communication Strategies Utilized To Facilitate Change In Clients

Chairman: Al Sillars 

The research was conducted in an effort to determine which communication strategies are effective in producing change. Licensed therapists were the chosen study population because they work with change on a daily basis. Interactive interviews (10) were conducted in the subject's office by the researcher. Open-ended research questions were designed to collect a diversity of strategies from all psychological orientations. Analysis of the data produced 5 strategy themes: rapport building, confrontation, teaching, different perspectives, and insight/understanding.

Establishing rapport was found to be vital to the change process, however, the degree of importance rapport plays varied among therapists. Initially, rapport was viewed as essential in lowering client resistance. Resistance to change (dissonance) blocks clients from accepting alternate perspectives. Apathy and fear emanate from rigid thought patterns and deep attachments to a belief system. Once rapport is established and resistance lowered, and communication strategies of change are introduced. The strategy themes used most frequently and effectively were confronting problematical behaviors, teaching new skills, and introducing different perspectives.

Chosen strategies impact clients on 4 levels: behavioral, affective, cognitive, and insight. Clearly, strategies emanate from the therapist's theoretical orientation. The greater the education, both formal and experiential, the broader the strategy pool. Active therapists apply strategies directly; insight therapists reduce resistance with deep rapport and observe the client self apply the strategies internally.

Before any internal change transpires, strategies of change must alter the belief system. Lowered resistance permits newsuggestions and ideas to be incorporated. Once clients consider alternate possibilities, insights occur and produce a shift in understanding. Thereafter, former behavior emanating from an old belief system no longer makes sense. A new reality has formed. New understandings produce different feelings and behaviors.

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PURPOSE OF STUDY

Change becomes necessary when current behaviors and patterns of communication fail to produce desired results. Communication research, particularly in the field of persuasion, provides a foundation for the communication strategies that effectively facilitate change. Psychotherapy and counseling directly apply these strategies to human behavior in a clinical setting. The communication strategies observed to be most effective in facilitating change differ among psychological orientations. Initially, a therapist's preferred strategies are those learned in their theoretical and clinical training.

The goal of this study will be to gain greater understanding of the change process, first, through a study of the literature; secondly, by studying research data obtained from qualitative interviews. The focus will be to ascertain, "Which communication strategies are viewed by counselors and/or therapists as effective in facilitating human behavior change?" Self-reported strategies of change from working professionals will be studied. Questions will focus on the function of rapport, obstacles in therapy, and universality of strategies. The effect theoretical training has on a professional's choice of strategies will be assessed. The next section reviews the two types of change.

LITERATURE REVIEW

The Dynamics of the Change Process

In the classic text, Change by Watzlawick, Weakland and Fisch (1973), change is examined from two perspectives, the theoretical and the practical aspect.

From a theoretical aspect, change must always be discussed in reference to something else. Everything is relative to individual perception, so comparing or contrasting requires a reference point. For example, in a universe that is all blue, the concept of blueness cannot be differentiated. Blue compared to what? Similarly, the concept of peacefulness must be defined in relationship to turmoil, or quiet relative to noise.

Change of behavior may be viewed as important to an outsider but unnecessary to self. Misunderstandings and conflict can often be traced back to incongruent perceptions of acceptable or preferable behavior. Just as conflict occurs over the necessity of change, confusion exists in regard to the definition of change.

Theoretically, change occurs on two levels. First order change is best understood from the perspective of Group Theory, initially developed by the French mathematician Evariste Galois (Adler, 1927). He proposed that any grouping of "things" is the "most basic and necessary element of our perception and conception of reality" (Watzlawick et al., p. 4). An example of first order change is the internal interactions in a combustion engine. As the pistons move in response to released energy, change is continuously occurring within the engine. This first order change does not produce any mechanical changes outside of the system. Humans, after experiencing a time of continuous first order change in their lives, begin to resist

further changes. Exerting energy toward change while conditions essentially remain the same, is viewed as non-productive. This statement remains true as long as change is of the first order type.

The Theory of Logical Types (p. 6) provides a model for second order change. An essential axiom of logical types is that "whatever involves all of a collection (of members) must not be one of the collection" (Whitehead and Russell, 1910-1913). To return to the engine illustration, if we change the octane of the fuel, or replace the spark plugs, we make first order changes, and do not affect second order or real change. Second order change occurs when the system or engine is impacted by factors from outside the system, i.e. the operator shifts gears. This outside intervention introduces a change element which allows for a transfer of energy and real change to occur.

The principle of second order change applied to human behavior is the foundation of the dynamics of psychotherapy. The goal of therapy is to transform a client's perspective in a more functional direction, that is transcend a closed psychological system and shift a frame of reference. Change transpires when external intervention impacts the internal thought system in such a way that insight occurs. Cybernetics more fully illustrates this type of change.

The central theme of cybernetics is the process of output-feedback-adjustment, or the study of regulation and control systems. A simple switch control, such as a thermostat, is often used to illustrate first order change. As the temperature in a room drops below the thermostat setting, a switch responds to feedback from the sending

unit, causing ignition in the furnace, and heating continues until the thermostat "signals" another shut down.

Applying the previous example to family dynamics, outside feedback sends signals to the system to make adjustments. Positive feedback signals the member to maintain or increase present behaviors. Negative feedback sends the message to cut back or discontinue unacceptable behaviors. Unfortunately, complex human behavior does not respond as predictably as a thermostat, so changes take place more slowly.

At the complex sociological level cybernetic properties, help us to understand the central concept in systems theory. That is, (1) you cannot understand a part of the system unless you study the whole; (2) all parts of the system are interdependent and self-regulating; and (3) because the system interacts with the environment, behavior can be best understood in the context of feedback loops (Littlejohn, p. 34-36). The complexity is best understood when viewed from a system's perspective "... (that) what happens in a system is controlled by its aims, and the system regulates its behavior to achieve the aims. The parts of a system must behave in accordance with its rules ...and must adapt to the environment on the basis of feedback" (p. 31). Conflicting goals in tightly enmeshed family systems complicate simple changes. The tight, interdependence found in enmeshed families, produces strong resistance to change by all of the members.

In practice, a counselor using systems theory concepts would apply the above stated cybernetic principles in three ways: (1) a patient's behavior cannot be understood until you understand the nuclear family's interactions; (2) all family

members ascribe their behavior as a response to the other members's behavior; (3) interactions with the counselor will create "feedback effects" into the family. That is, any change in one member will create a need for readjustments from the others. A family's natural resistance (homeostasis) to interference from outside forces complicates the change process for the patient because the whole family system places pressure on the patient to maintain the status quo or system balance (Yerby, 1990).

Applying the theoretical principles of first and second order change is difficult on a daily basis. Expectations of solutions through change lead to discouragement when conditions or behavior remain unchanged or deteriorates. For example, in the recent world arms build-up between the United States and Russia, the fear policy of mutual deterrence provided an illustration of continuous internal change with expectations of a safer world (second order). The belief that a stronger arms build up would produce world peace justified the build up of destructive armament arsenals by both countries. Unfortunately, there were no provisions made to halt the policies, so the policy led both countries toward greater conflict. The constant increases in number of armaments and vast expenditures were changes of first order type, but did nothing to facilitate a shift toward cooperation and the ultimate goal of world peace.

True change demands external inputs, whether examining the armament policies of our strongest countries or working with client belief systems. For example, people often comply and stop drinking because of family or health reasons. However, when anxiety and fear override a resolution to quit drinking, relapse or substitution of other addictive behaviors is common (overeating, gambling or other mood altering

behaviors). The belief system does not change but compliance (first order change) may be interpreted as a shift in perspective or second order change. Continued relapse leads to discouragement, and the misconception, "Change didn't work, so why try?". Eventually, external suggestions are viewed as interference.

People resist changing core beliefs. Guidano and Liotti (1983) referred to the characteristics of second order change as confusion, cognitive disorientation, and loss of one's sense of identity. Resistance to change is understandable. Second order change "involves a readjustment of an individual's entire frame of reference" (Dowd, p. 256). The ability to incorporate internal assumptions (or schema) allows us to function in day to day situations rather than reanalyze every decision all day.

Conversely, this process often impedes consideration of alternative ways to function.

Resistance to change, a natural human behavior, becomes a problem when our everyday functioning ceases to be appropriate. Why do people prefer to remain with familiar, habitual behavior patterns? Fear of new behavior emanates from the way we make sense of our environment, or our cognitive data arrangement. Schemas are "cognitive structure that represents knowledge about a concept or type of stimulus" (Fiske & Taylor, p. 98). That is, prior knowledge creates a perceptual framework that forms today's reality. Schemas are important to stability as they "lend a sense of order, structure, and coherence to social stimuli that otherwise would be complex, unpredictable and overwhelming" (p. 150). Change occurs in therapy when clients embrace new concepts. Cognitive disorientation manifests resistance until understanding changes.

Previous documentation has indicated that opinions did not change unless new facts altered old belief systems in a convincing manner. Three models of understanding schematic change were proposed by Rothbart (1981). (1) The bookkeeping model suggests a process of gradual, incremental schema revision occurs as we are exposed to new information; (2) the conversion model finds that after resisting small changes for a time, a massive shift may occur when enough disconfirmation exists; (3) a subtyping model, "suggests that subcategories develop in response to isolated cases that disconfirm the schema" (p. 152). Research generally provides support for the subtyping model (Weber & Crocker, 1983; Deaux & Lewis, 1984; S.E. Taylor, 1981), that is, small pieces of schema are replaced at a time. This data supports the concept that change is an ongoing process.

In summary, there are two different types of change. First order change is an internal changing within the system that does not cause change to the system. Second order change occurs when an outside force disrupts and alters the system's structure and function. Second order change is change that provides positive resolution to problematic circumstances, and has been called change of change. The latter type is needed when present behavior is inappropriate or inadequate. Therapists essentially ask clients to accept a perspective which alters the interactions within the whole psychological framework. To patients or clients, these new concepts often appear illogical and resistance frequently occurs when alternative human behaviors are suggested.

Overcoming resistance becomes the challenge. Once new information is assimilated, a shift in perspective is expedited. How this shift occurs is not readily understood, but can be observed by a change in behavior. In literature, this change in understanding is referred to as illumination, insight, or an "Ah-Ha" experience.

Motivation to change may develop from new awareness brought on by pain, as a result of compelling outside forces, or insight gained from a single event. The role of the therapist is to function as an outside change agent. The therapist's job is to intervene with appropriate strategies at a critical time in a way that does not increase resistance.

Some of the questions this research will be asking are: "What are some intervention strategies that have proven to be effective in facilitating second order change?" "Which communication strategies are frequently chosen by counselors and/or therapists and do any consistently appear across the broad spectrum of theoretical approaches?" "Do therapists limit their choice of strategies to those acquired in their psychological training?" or, "Do they rely upon universally effective strategies?" Does a "thread of universality" exist with one or more strategies?

In the following section, the communication categories of persuasion, dissonance, and compliance will be examined in regard to change. Although the latter category of strategies does not usually produce second order change, an understanding of compliance is necessary to prevent misinterpretation of observable changes.

Communication Strategies

Communication may be viewed, most generally, as a process in which persons engage in direct or mediated symbolic interaction in order to create meanings (both individual interpretations and shared understandings) that satisfy multifarious personal needs and enable joint conduct (Siebold, Contrill & Meyers, 1985, p. 554).

When personal needs and joint conduct goals are no longer being satisfied, new solutions must be sought. Due to the complexity of communication, this study will focus primarily on the communication strategies of persuasion, and in particular, those strategies selected by therapists and/or counselors for the purpose of lowering resistance, altering perspectives, and facilitating change in clients.

History of Persuasion

In the beginning, persuasion research approached change as a "one-person-changes-another-person concept" (Littlejohn, p. 133). People were thought to be passive responders to life around them. Dysfunctional behavior was seen as an inner illness, rebellion, or sin. Selection of effective communication strategies often relied on intuition rather than understanding. A variety of strategies were developed to overcome resistance when changing to socially acceptable behavior was resisted. Theories of change developed from two backgrounds, the humanistic approach and behavioristic methods.

Humanistic theory of communication and persuasion began in Aristotelian rhetorical theory. Disciplines of both speech and psychological investigation date back to works by Aristotle. In his classical work, Rhetoric, he equated the success of public speaking's persuasive ability in the areas of ethos (ethical appeal), pathos (emotional appeal) and logos (logical appeal) (p. 134). Attempts to determine "...how we use language to change the perceptions, effect, cognitions, and behaviors of those with whom we interact" (Burgoon, 1990, p. 51) continue today.

The behavioral element was outlined by the Yale Communication and Attitude Change Program which laid the groundwork for a model of "antecedent, intermediate and outcome variables in the persuasion paradigm" (Littlejohn, p. 136). Although criticized for being essentially linear (source to receiver with little consideration for other interactions), the Yale studies expanded the understanding of persuasion. This model outlined how observable stimuli impact internal factors within the receiver; which interact with predispositional factors to involve the internal mediating processes (attention, comprehension or acceptance), and then exit in an observable change of attitude. This can be observed as a change in opinion, perception, attitude, or action (the complete model reprinted from Janis, 1959 by Littlejohn, p. 137).

Communication and psychology examine information from two different perspectives. While communication theory "asks what people do with information," psychology focuses "on how people are affected by information" (p. 136). This research is limited to identifying the communication strategies therapists report as effective in persuading clients to change.

Theories of Persuasion

The process of facilitating change is discussed in communication literature primarily under the persuasion theories information-processing, cognitive reorganization, and cognitive dissonance.

Information-processing Theories

Information-integration theory. This theory centers "on the ways people accumulate and organize information about some person, object, situation or idea to form attitudes toward that concept" (p. 141). Focusing on the process of attitude change, this theory identifies two variables which impact attitudes: valence and weight.

Valence has an assigned value determined by one's beliefs and attitudes. Information supporting one's beliefs is viewed as good; differing news is seen as bad. **Weight** is a reliability function. If viewed as "probably true", a higher weight will be arbitrarily assigned. "Valence affects how information influences attitudes; weight affects the degree to which it does so" (p. 141). Weight overrides valence, therefore, information deemed to be false loses its ability to affect attitude change. Attitudes change when new information is deemed valid and reliable. New concepts will be discounted or viewed as senseless if they differ greatly from present beliefs.

Theorist, Marten Fishbein, differentiates between beliefs and attitudes. Beliefs are statements of evaluation. Attitudes predispose people to act in specific ways toward objects, and are continuously changing with additional information. Attitudes are an accumulation of understanding. Attitudes are always interacting with belief

systems, weight, and valence. Integration theory views these interactions as an ongoing change process (p. 142).

Social judgement theory. A related theory, social judgement theory (Sherif & Hovland, 1961) has its roots in psychophysical research. Social judgement theory contends that individuals judge the quality of a message according to both the internal anchors and the amount of ego involvement.

Social judgement theory makes four predictions concerning attitude changes. (1) Supportive messages similar to an individual's beliefs facilitate change. (2) Messages similar to rejected information have little or no effect on attitude changes, and may even cause a reinforcing boomerang effect. (3) Messages that fall between discrepant and acceptance ranges produce the greatest attitude change. (4) the rejection latitude is larger and attitude change potential is diminished when ego involvement is high (Littlejohn, pp. 145-6). On an axis ranging from acceptance to rejection, the measure of attitude change would resemble a bell curve, where the apex of influence occurs at the highest point between the two extremes. Change will be resisted to an even greater degree when ego involvement is large. Since the 1960's, research on information processing has produced a large body of material on ego involvement and willingness to accept or reject new information.

A second theoretical approach, cognitive theories, views persuasion as a matter of cognitive reorganization. People change by reorganizing "their cognitions in the face of messages from others. Several factors enter the persuasion process. These include tension reduction, learning, social judgment, and interpersonal trust" (p. 158).

Cognitive Reorganization Theories

Social learning theory. Deterministic in nature, social learning theory (Bandura, 1977) presumes that behavior is shaped by environmental associations and reinforcement. Briefly summarized, this theory sees behavior as "shaped by interaction between external conditions and internal cognitive processes" (p. 147). As an example, to lose weight, plan the steps needed to accomplish the goal, i.e., join a weight loss clinic, stock up on low fat foods, purchase a smaller sized wardrobe, and visualize yourself at the beach next summer in your swimsuit. The anticipated compliments would be adequate motivation. Cognitive understanding of the consequences (positive or negative, external or internal) are seen as the motivational reinforcements of social learning theory.

Bandura shifted the focus from pure learning theory and reinforcement to focusing on "cognitive choice and internal reinforcement ...a teleological and actional set of assumptions" (p. 148). Social learning theory emphasizes the individual's responsibility for choices, but lends little to understanding the effect verbal communication has on attitudes, beliefs, and behavior. Appropriate strategy choice is based upon understanding resistance. Consistency theory provides the needed assumptions.

Consistency theory. Consistency theories have been developing for nearly 50 years. All begin with the premise, "People need to be consistent or at least see themselves as consistent" (p. 145). Research from this theoretical approach contributes considerable insight to the field of psychology, particularly, in the relationships

between persuasion, attitudes, and change. When inconsistencies in the cognitive system are encountered, the system seeks balance either through an action or internal adjustment in understanding. In systems language this is referred to as homeostasis (Watzlawick et al., 1973; Satir, 1967; Yerby, Buerkel-Rothfuss & Bochner, 1990).

Consistency theory is applied to the family in systems theory. The goal of family systems therapy is to move the whole system into a more functional pattern of interaction, and focus on behavior, structure, and texture of family relationships (Corsini, 1984, p. 471; Dowd, 1986 p. 247). Research has focused on relationship balance for the past 25 years.

Heider's (1946) early research work with "balance" in the 1940's was extended by Theodore Newcomb's (1953) work on interpersonal attraction. Osgood and Tannenbaum (congruity model) expanded consistency theory further by applying precise techniques of measurement in the hopes of predicting outcomes (Littlejohn, p. 148-149). More recently, Milton Rokeach's (1969) work enlarged consistency theory to include the cognitive elements (attitudes, perceptions, behaviors, and knowledge) and the interrelationship. He defined beliefs-about-oneself or one's self-concept as the purpose or center for functioning. Rokeach believes by understanding one's belief-attitude-value system we can understand human behavior. Balance occurs once self-concept inconsistencies are organized into a hierarchy of beliefs or a single value system. Resistance to change emanates from anticipation of an imbalance.

Tolerance for inconsistency is influenced by several factors. Serano (1968) found the highly ego-involved person is very resistant to changing attitudes about

issues in which strong identification exists. Reevaluation of the source will change before beliefs change. Some self-concepts have a lower tolerance for inconsistency. People who possess the 5 psychological variables, authoritarianism, dogmatism, anxiety, low self-esteem, and ego-involvement, experience greater amounts of dissonance, develop greater resistance to change, and use "black and white" thinking (King, 1975, p. 106). Miller and Rokeach (1968) stated:

Authoritarian and dogmatic persons should thus seek to structure situations in cognitively consistent and simple ways. Furthermore, inconsistent stimuli should be rejected, distorted, ignored, or denied. By contrast, equalitarian and low dogmatic individuals should be able to tolerate more cognitive inconsistency because of their greater ability to think complexly and in an integrated fashion (p. 626).

Cognitive Dissonance

Two elements, comfort and ego involvement, play a major role in cognitive dissonance theory. When a person experiences inconsistency, "he will generally choose the resolution mode that involves the least psychological effort" ... (and the one) that will require the least effort to maintain in the long run" (King, p. 106). For example, nicotine withdrawal can be easily avoided by rejecting the Surgeon General's edict on smoking.

Secondly, the mode of resolution that affects the cognition of lowest ego-involvement is preferred. The higher the attachment, the greater the resistance. For example, a low tar cigarette would be preferable to none.

Leon Festinger's (1957) original theory of cognitive dissonance contributed an important insight into human behavior. He proposed that the cognitive system is "empty" at birth, and progressively develops additional new elements of cognition. New elements consist of knowledge, opinions, or beliefs about the environment. Additions are not simply accumulated, but rather **integrated** into existing cognitions.

The dynamic relationship between cognitive elements is either consonant or dissonant. The relationship is dissonant if "disregarding the other cognitive elements, the one element does not, or would not be expected to, follow from the other" (Festinger, p. 15). Festinger proposed two dissonance constructs. The two overriding premises operate in such a way that, (1) dissonance produces stress which pressures the client to change in order to reduce the tension; and (2) the client will try to reduce dissonance by using avoidance. Therefore, dissonance therapies are most effective in restrictive settings where avoidance is not an option, such as, treatment hospitals or delinquent adolescent residential centers. Confrontive strategies are most utilized with the population most resistant to change, i.e., those displaying authoritarian, dogmatic, defensive and high ego involvement characteristics. Once change is viewed as the least objectionable option, outside tension serves as the change agent.

Festinger's cognitive dissonance theory predicts an inverse relationship between amount of reward and subsequent attitude change. "Incentive and reinforcement concepts are used together with the essential assumption of the change motivating intraattitudinal inconsistency caused by alterations in the cognitive attitude component" (Nuttin, 1975, p. 56). Put simply, one will continue to believe his own perspective

unless forced to accept a cognition that creates greater dissonance. This may appear either as a conflicting belief (constantly exceeding the speed limit is getting too costly), or as a reward (\$10.00 allowance if chores are done).

A desire to reduce tension is often the motivation for counseling. Tension may be reduced as new information provides a deeper understanding of another's behavior, or manifests the realization that an attitude is exaggerated. Change strategies serve to lower dissonance by modifying the cognitive framework. As clients modify pain-inducing perspectives, tension lowers. One method to modify cognitive framework is the paradoxical intervention.

Cognitively, therapists create a dissonance situation in the office by using paradoxical intervention, or "double bind" strategies. Doud writes, "A therapeutic double bind places the client in a no-lose situation" (p. 256) where choice is really just an illusion. Movement to another level of understanding is achieved primarily because cognitive reframing cannot be avoided. Double bind strategies introduce a new frame of reference which suddenly forces the client out of their present perspective (p. 145).

In summary, theories of persuasion fall into two categories: information-processing theory and cognitive reorganization theory. Two information processing theories are discussed, information-integration and social judgement theory.

Information-integration theory views attitude change as a shift in understanding based on integration of new information. The greater the identification with internal beliefs, the more likely integration will occur. Integration is influenced by both

weight and valence. Weight affects the degree of change and can override valence if the new information is too dissimilar. Social judgement theory finds dissimilar messages are rejected and may even reinforce original belief, while supportive messages are assimilated without producing change. Additionally, the greater the ego involvement invested in one's belief, the more likely the message will be rejected and the carrier discounted. Messages which produce the greatest changes are those which least threaten the receiver's pride, and fall somewhere between the two extremes of dissimilar and nearly identical.

Cognitive reorganization theories view behavior as a result of interaction between cognitive processing and external events. Social learning theory emphasizes behavior is shaped by external conditions and the way individual's process the stimuli. Consistency theory is based upon the premise that people need to see themselves as consistent and understand resistance to change as a need to remain in balance or maintain consistency. Consistency within the family system is evidenced by resistance (homeostasis). The more flexible the belief system, the greater the tolerance for change.

Cognitive dissonance functions as a change agent and figures prominently in the process of change. Dissonance is experienced internally in an individual's psychological system. Therapeutically, dissonance is used to produce stress on change-resistant people in a setting where avoidance is difficult. The desire to reduce tension and restore balance (lower dissonance) motivates individuals to seek alternative behaviors. Dissonance pressures people to choose a path of least resistance, either that

of avoidance, endurance, or transformation. Persuading people or families to make behavioral changes is even more difficult and complex. When present behavior produces intolerable pain, change becomes the path of least resistance. Therefore, the less attached the self-concept is to a belief system, the greater the tolerance for inconsistency. As balance is reached, a broader range of cognitive inputs are acceptable and new information can be integrated more rapidly. Once suggestions from outside the belief system are integrated, understanding shifts, tension is relieved, and real second order change occurs.

Persuasion Strategies

Functions of Persuasability

To better understand how beliefs change, functions of persuasability are next examined. The first theory of persuasability focuses on internal factors present in the receiver. The second theory concentrates on outside factors perceived in the sender and established in the process of communication.

Janis and Hovland (1959) developed a theory of persuasability hypothesizing that higher levels of understanding are gained when people remain consistent in their ability and level of motivation for processing messages. Internal process varies in the receptive ability in four areas: learning factors (attention and comprehension), and the acceptance factors (anticipation and evaluation).

Persuasability is higher when receivers pay attention and comprehend the speaker's message. Understanding increases as information is assimilated. The

acceptance factors of anticipation and evaluation modify the way a receiver responds to new information. The opportunity for belief modification increases when the receiver possesses the ability to place self in the position presented by the speaker (anticipation), and withholds internal criticism of the arguments presented (evaluation). "High abilities to attend, comprehend, and anticipate will promote persuasibility, but a high ability to evaluate will retard persuasibility" (Littlejohn, p. 138). In addition to internal persuasive factors, influenceability is dependent upon the perceived credibility of the sender.

Communication attempts at persuasion are further complicated by additional interactions between internal and external factors. In McGuire's (1969) examination of persuasibility, he defined five principles of influenceability: mediational, compensation, situational-weighting, confounding, and interaction.

The first principle, mediational, states the obvious: persuasion is a complex intervening of many variables. The interaction of variables modifies the original meaning as the receiver filters the message through expectations, emotional defensiveness, and varied degrees of attentiveness. This complexity contributes to misunderstandings, confusion in communication, and spawns conflict in relationships.

The second principle of influenceability, compensation, states that "various mediating factors will have opposing effects, thus tending to compensate or cancel out one another" (Littlejohn, p. 140). The concept of pure communication between sender and receiver is uncommon because persuasive communications are affected by conscious and subconscious factors.

The third principle, situational-weighting, states the more complex the message, the greater the likelihood of resulting resistance. Simple messages are easier to assimilate and produce less misunderstanding. Complex messages provide the opportunity for more cognitive inconsistency, therefore, assimilation requires cognitive effort. King (1975) found "people are more likely to accept an advocated premise if it is consistent with their present cognitive structure" (p. 101). The same principle is used to overcome resistance in anxiety-producing situations (Wolpe, 1958; Bandura, 1969) by introducing a series of very small changes over time (desensitization).

Principle four, confounding, states the greater the number of mediating variables within a person, the less one can conclude about specific effects from any one variable. Therefore, making absolute predictions about causation are foolish when working with complex internal human behavior.

The final principle, interaction, states change is complicated by interactions between individual characteristics and external communication variables. Understanding is influenced by perception, interpretation, relevance factors, and anticipated reactions from the sender, all before a receiver ascribes meaning to the message. Attributing behavior to a single cause, belief, or feeling, absurdly oversimplifies human functioning.

In summary, persuasibility is an internal process affected by our ability to pay attention, comprehend, and identify with the message being presented. The ability to change attitudes, beliefs, values, and overt behavior is influenced by a complex interaction of many factors. Change can be affected in three areas: behavioral,

cognitive, and psychological, and involves both internal and external variables.

Attempting to determine a "best way" to change attitudes and behavior is foolish. A more productive approach seems to be to gain an understanding of the change process, take into account the complexity of influenceability, and maintain the lowest level of resistance.

Influencing Factors

Persuasion strategies are influenced by many factors. On the following pages, sex, credibility, power, self-concept, assertiveness, ingratiation, rationality, coalitions and threats will be explored as factors of influence. Compliance-gaining strategies, when combined with confrontive strategies, produce second-order change.

Some strategies appear to be chosen for specific subjects. Results of studies indicate that choice of message strategies are linked to sex. Males used promises and threats (DeTurk & Miller, 1982), non-negotiation strategies with best friends (Fitzpatrick and Winke, 1979), and threats when influencing male friends (Luloff, 1982). Females rely on positive and negative expertise appeals (DeTurck and Miller, 1982), personal rejection and emotional appeals (Fitzpatrick and Winke, 1979), and negative self-feeling messages in their interactions (Luloff, 1982). Successful therapy may need to consider sexual response when strategy choice is made.

Strategies that create an image of credibility appear to be influential in persuasive attempts (Bettinghaus & Cody, 1987; Buller & Aune, 1988; Burgoon, Buller & Woodall, 1989). Research in the organizational field suggest that those

who are interpersonally influential use strategies such as obtaining valuable information, establishing favorable relationships with important people, being visible, building a credible and professional reputation, creating perceived dependence manipulating the environment, listening to and trying to understand subordinates, and judiciously applying reinforcements, among others. (Siebold, p. 580)

Establishing rapport, reflective listening, self disclosure and appropriate feedback are additional strategies used in persuasion.

In addition to sex and credibility, power has been shown to have the potential for influence (Manz & Gioia, 1983). In French and Raven's now classic study on power influence (1960), 5 bases of power were identified: reward, coercive, legitimate, expert, and referent power (Siebold, p. 578). Power factors have been shown to be more effective when the target cannot avoid the pressure exerted (dissonance).

In one study, managers were asked to provide written descriptions of the influencing strategies they used with superiors, peers and subordinates (Kipnis, Schmidt, & Wilkinson, 1980). Through factor analysis the 58 distinct influence strategies were grouped into 8 factors: assertiveness (ordering), ingratiation (humbling oneself), rationality (reasoning), sanctions (withholding salary increases), exchange of benefits (favor exchanging), upward appeal (increasing power from superiors), blocking (threats or stoppage), and coalitions (obtain coworkers's support). These persuasive strategies appeared to be effective in lowering external worker resistance.

The strategy one chooses may be highly tied to the therapist's own self-concept. Hunter and Boster (1987) attempt to identify the psychological process that takes place when a persuader decides whether or not to use a given persuasive message. In prior evaluation self asks, "Will the listener be pleased or hurt or enraged by the persuasive message in question?" (p. 2). The criteria that determines which strategies are deemed acceptable or unacceptable is referred to as their "empathy threshold."

To some degree it appears the persuader may evaluate how each message will be received before speaking. There is some support for the idea that a counselor's self-concept is highly involved with the strategy choice (Johnson, 1992, p. 55), although the degree of influence is not yet clear.

Compliance-gaining strategies.

These strategies refer to "phenomena that reside in dyadic message exchanges by which interactants reciprocally define the nature of their relationship as they interact and pursue identity, relational, and instrumental objectives" (Siebold et al., p. 588). How they interact in the change process is not clearly understood. To date, there is a lack of "theoretical development that incorporates compliance-gaining strategy use with a more comprehensive explanation of attitude-change processes" (Burgoon, p. 63). There is evidence that in order to achieve goals the sender will alter behavior and adapt to situational constraints when the situation demands (Cody & McLaughlin, 1980). Compliance is not second order change, however, behavioral adaptation can be misunderstood and thought to be a shift in perspective. These

behavioral changes are only a temporary action taken to lower dissonance. Care must be taken not to interpret compliance as permanent change.

Some of the important compliance-gaining strategies consistently identified in studies are establishing intimacy, acknowledging personal benefits, and pointing out relational consequences. These strategies are useful when combined with second order change-producing strategies. Outward changes in behavior (for compliance's sake) are visible to both sender and target.

Numerous attempts to create a taxonomy or category system of compliance gaining technique groups have been conducted (Marwell & Schmitt, 1967). Drawing upon social influence literature (such as French & Raven, 1960; Goffman, 1959; and Skinner, 1963), these techniques are used heavily in behavioral psychology (aversive stimulation, punishment, reward, etc.). Miller, Boster, Roloff, and Seibold (1977) extended these studies, and more than forty additional studies and convention papers have been published. Results of these studies show that "strategy selection was highly situation bound: and subjects generally preferred socially acceptable, reward-oriented strategies" (Seibold et al., p. 562). Cody, Woelfel and Jordan (1983) developed a six-factor solution that has become an "operational template for research aimed at specifying or manipulating situational variables" (Burgoon, 1990).

In summary, persuasion strategies vary with the specific situation, the desired outcome, and therapist's self-concept. Strategy choice is influenced by sex, sender credibility, and power. Strategies of influence included assertiveness, ingratiation, rationality, upward appeal, coalitions, and threats. Dissonance, or resistance to change,

is a major factor in restricting the change process. Compliance-gaining strategies are useful in building a working relationship, particularly when combined with cognitive restructuring strategies. Once rapport is established, explaining behavioral consequences or even applying force through domination has been found to produce change.

Psychotherapies

Definition

A universal definition for psychotherapy does not exist. The purpose of therapy, however, is to ameliorate a malfunction or combination of functions (reduction of psychological discordance or dissonance). Therapy transpires with one, two, or more parties and often involves exploring the client's past history and thought systems (Corsini, p. 1). Therapy ranges on a psychological-involvement continuum from supportive (through degrees of reeducation) to reconstructive, the latter involving work with unconscious conflicts and hopes (Burks & Steffle, 1979, p. 17). "The heart of therapy is change in behavior" (Corsini, p. 464).

Clarification of role between counselors and therapists is needed before proceeding. The difference is not so much in what they do (qualitative), but rather in the percent of time spent in each activity (quantitative). Burks & Steffle (1979) visualize therapists moving back and forth on a continuum responding to the needs of the client. For example, 60% of psychotherapists' time is spent listening, compared to 20% of counselors' time, but title does not preclude a counselor from listening 60% of the time in a particular session. Since all modes of facilitating change can be called psychotherapy, Corsini submits there is no need to differentiate between them (p. 2). Therefore, psychotherapist or counselor will be used interchangeably in this research.

Therapy begins by thoroughly investigating the client's conscious data, i.e., important influences, attitude, values, and ideas about self and relationships. As the therapist listens, a strategy of intervention is mentally constructed based on therapist

awareness of counterproductive thought patterns. Appropriate strategies of change are selected from a repertoire acquired in clinical training and through experience.

Modes of psychotherapy include cognition (learning), emotion (feelings) and behavior (action). Some theories concentrate on just one mode or a combination of two modes. Some approaches consciously involve all three: active body movements, emotional expression, and cognitive messages combine to impact the psyche, e.g., psychodrama.

History

In 1902, the Wednesday Psychological Society began meeting in Paris. From this group came the founding fathers of the three different branches of psychology: Freud, Adler and Jung. Sigmund Freud's beliefs were deterministic, influenced by his scientific training in the areas of biology and hydraulic elements. Alfred Adler's position was a common sense focus on what motivates people. Carl Jung, philosophically a mystical person, maintained a religious perspective. Because these three men approached the psyche from three different perspectives, their theories of personality "can be seen as direct extensions of their manifest personalities" (Corsini, p. 9). Hundreds of smaller theories in use today are considered to be deviations from Freud, while the latter two theories have remained relatively pure in their focus.

In 1940 a new approach to therapy was presented by Carl Rogers in a historic Psi Chi paper at the conference in Minnesota. He introduced the concept of empathetic understanding or "unconditional positive regard". This paradigm shift

expanded the therapeutic arena which provided the foundation for a variety of approaches in use today. Some 250 different approaches to psychotherapy have been identified (p. 7).

The next section provides a brief background of the major psychotherapeutic approaches. The preferred change strategies each psychotherapeutic approach utilizes most frequently are identified.

Therapeutic Approaches

Freudian

Early in the history of psychotherapy Sigmund Freud adopted the descriptive title of psychoanalysis. His clinical work was often referred to as the "talking cure" (Burks & Steffle, p. 125). Freud observed that patients felt much better after talking about their symptoms (catharsis), particularly, when they were allowed to express whatever thoughts came to mind (free association). He attributed the relief they experienced from their cathartic dumping to a release of internal conflict.

Conflicts or dialectics, derived from the biological principles, play a large part in Freudian concepts. Man's duality is observed in such conflicts as functioning as a biological animal or a social being, between the conscious and unconscious, or between love and self-destruction. Further, basic responses to stimuli are to seek pleasure or avoid pain. The child's psychological structure is shaped from early learned responses.

Freudian therapists believe the source of illness is outside of awareness (unconscious). Therapy is designed to show the patient how to "make rational choices

instead of responding automatically" ... and gain "freedom from neurotic inhibition and suffering" (Corsini, p. 15) and understand unknown driving forces. The goal in Freudian psychology is to reach self-actualization, a state of freedom and internal happiness which enables each person to contribute to the happiness of others.

Freudian analysts choose communication strategies that encourage cathartic expression. Therapy consists of the therapist listening for long periods of time to the client while painful suppressed memories are discharged. Clients are made to feel safe enough to explore internal conflicts while the therapist maintains a sympathetic and uncritical demeanor. Freudian therapists rely on reflective listening to identify understanding, and heavily utilize verbalization interpretation and feedback. Insight occurs as clients acquire a deeper understanding from the therapist's feedback. Old behavior discontinues once a new perspective is gained, better choices are made, and clients are more satisfied.

Criticism from within his field began during the period when interpretation became primarily focused on sexual inhibition and symbolic interpretation. Today the public generally associates Freud with sexual symbolism even though near the end of his career Freud reversed some of his thoughts regarding these most controversial concepts.

Rogerian

Carl Rogers developed a person-centered therapeutic or humanistic approach. The central hypothesis is "the growthful potential of any individual will tend to be released in a relationship in which the helping person experiences and communicates

realness, caring, and a deeply sensitive nonjudgmental understanding" (p. 142).

Rogers believed a condition of congruence existed and growthful change occurred within the client, as long as the therapist maintained an attitude of positive regard and empathetic understanding (Rogers, 1959). Man moves toward a state of self-actualization as this growth unfolds. For Rogers the purpose of psychotherapy is to release "an already existing capacity in a potentially competent individual" (Rogers, p. 221).

Rogersian therapy relies heavily on communication skills that are empathetic, so as to create a safe place for the client. Reflective listening and clarification are used throughout the whole treatment process to maintain a clear understanding of clients' perspectives. A state of congruence is achieved when therapists can be fully present with clients. Therapists must have no prior agenda in mind, and should assist clients by exhibiting complete acceptance. Trusting clients' inner wisdom to supply direction for needed change is a vital concept in Rogersian therapy.

Rogersian strategies are those associated with a nondirective approach. He believed negative confrontation was inappropriate. "Empathy, genuineness, and nonpossessive caring (is) causally related to many process variables, such as depth of self-exploration, and to successful outcomes" (in Burks & Steffle, p. 65).

In summary, Rogersian therapy utilizes empathetic and nondirective strategies to provide a warm and encouraging atmosphere. When an environment of total acceptance is provided, clients explore problem areas more fully, perspective changes, insights occur, and an increase in happiness is achieved.

Existentialism

Existential psychotherapy grew because of dissatisfaction with therapies existing in the 1940's and early 50's. Jung had a limited influence (May, Angel & Ellenberger, 1958, p. 4) however, existentialism was based mainly upon the writings of Jean-Paul Sartre, Nietzsche, and Albert Camus. Existentialism asks deep questions about the nature of man; anxiety, love, being, and in general, how can we understand the meaning of life? This approach falls near the humanistic end of the continuum. Today there are "few comprehensive training programs in existential therapy" (Corsini, p. 372), although Yalom's (1981) existential psychotherapy presents a comprehensive view of this approach. Existentialism is a way of viewing mankind rather than a method of treatment; a paradigm where clients' suffering is caused by the way anxiety is handled.

Anxiety is seen as underlying fears. The main therapeutic task is for clients to understand normal anxiety as part of life. Anxiety must be viewed as "proportionate to the situation", and "does not require repression ...(in fact) we can face eventual death ...(and) anxiety can be used creatively" (Corsini, p. 356). In short, as humans we must learn to transcend our present situations and understand that anxiety and guilt are created internally. Fears need not cripple individual personalities when viewed in the proper perspective.

Existentialist therapy strives toward establishing an **open, honest rapport** where therapists function almost like a midwife unfolding the client's potential existence. The therapist **listens carefully** to clients and assists in identifying problem

areas. Immediate **interruption and feedback** are appropriate as the therapist becomes aware of areas of client irresponsibility. A primary goal is to teach clients the importance of taking responsibility for feelings and conditions of existence rather than accepting a victim role. Change is sought by attempting to breakthrough emotional blocks constructed by clients. Existentialist therapists **flood** the client with intense feelings, a strategy used to facilitate new perspectives. Such confrontive techniques provide the client with an understanding of how their behavior impacts others. Perspectives shift once new insights are assimilated. New insights produce better behavioral responses. The primary difference between Rogerian and existentialism approaches is the latter confronts irresponsibility and avoidance behaviors.

Gestalt Therapy

Gestalt therapy, a form of phenomenological-existential therapy was founded by Fredrick and Laura Perls in the 1940's. Phenomenology is a "systematic exploration that takes as genuine knowledge only what is immediately given in the experience of the perceiver" (Corsini, p. 279). The methodology focuses on increasing awareness of present experiences. The goal of therapy is for the client to "become aware of what they are doing, how they are doing it and, at the same time, to learn to accept and esteem themselves" (p. 279). Reality is the experience of the moment. Gestalt therapy is frequently referred to as existential therapy (Burks & Stefflre, p. 256) because of an emphasis on awareness of the present.

Gestalt therapy views insight as an awareness about the patterning, the process and structure of the current situation. "A figure that has been organized meaningfully

out of a perceptual field is called a 'gestalt' " (p. 259). Individuals have a strong need to derive meaning and achieve closure about portions of the perceptual field. Insight is gained and the whole has meaning once all the parts are experienced together. There is no arriving, rather, people are always in the process of changing and experiencing new opportunities.

Gestalt therapists work with anything that makes "contact or withdrawal possible, including energy, body support, breathing, information, concern for others, and language" (Corsini, p. 281). Gestalt therapy has five characteristics: inclusion, presence, commitment to dialogue, absence of exploitation, and "dialogue that is lived".

Inclusion is "putting oneself as fully as possible into the experience of the other without judging, analyzing, or interpreting while simultaneously retaining a sense of one's separate, autonomous presence" (p. 281). Therapists must communicate an understanding of the client's perception while maintaining a sense of separateness.

Presence is experienced as therapists discriminately express feelings, personal experiences and thoughts to clients. Therapists become a part of the learning environment as trust and caring are shared and awareness is raised.

Commitment to dialogue is experienced as therapist and clients gain shared meanings, in contrast with following a controlled preset agenda.

No exploitation is valued and the therapist is careful not to influence the client's experience.

Dialogue is lived means to do the experience, rather than just talk about an idea. Nonverbal expression is used when possible and ethically allowed, such as, touching. For example, if clients lack an understanding of boundaries in relationships, therapists might move toward clients until knees were touching so as to create an experience of infringement.

Gestalt's theory of change is based upon the concept children absorb whole ideals about ineffective, but acceptable behavior. For example, the message, "children are not allowed to speak unless first spoken to" prevents natural expression of ideas and feelings. Habitual repetition of this message into adulthood produces psyche unable to develop functional conversation skills.

Gestalt therapy maintains that people have an innate drive toward healthy functioning. This awareness of what is, will automatically lead to change and result in new understanding. As a reorganization of the "field" occurs, a new gestalt (Ah-ha!) forms, and the goal of therapy, insight, is realized.

In summary, "Gestalt therapy works for understanding by using the active, healing presence of the therapist and the patient in a relationship based on true contact" (p. 282). Gestalt uses techniques which increase awareness, primarily, in presence tense experiential activities. The therapeutic direction must emerge out of the dialogue and experience to insure the greatest possible insight. Gestalt has been referred to as an insight therapy. Clients are directed toward taking responsibility for their own existence, and to look within for answers and understanding rather than toward the therapist. Communication techniques used are **empathic listening** (for

greater awareness), **clarifying** (so as to reach a congruent understanding of the client's reality), and **continuous regard** for the whole person in an effort to produce a shift in understanding (insight). The therapist uses **self disclosure** and a nondirective approach to help clients find answers.

Adlerian

The approach begun by Alfred Adler views man holistically and neurosis as a failure to learn. Children's self identity is formed from perceptions of significance within the nuclear family. These perceptions provide a framework whereby individuals can organize, understand, predict, and control life experiences. Achievement is cognitively limited by feelings of inferiority, so the goal is to enter the process of becoming complete. The therapeutic task is to "encourage the person to activate one's social interest, and to develop a new lifestyle through relationship, analysis and action methods" (p. 56).

Therapies have borrowed extensively from Adlerian social psychology concepts including Karen Horney (man can become good), Erick Fromm (love and productive work gives man a sense of belonging), and Harry Sullivan (individual's sense of security forms in childhood). Rational-emotive therapy (RET) draws heavily from Adlerian therapy and combines cognitive, emotional, and behavioral concepts.

Rationale-Emotive

RET, developed by Albert Ellis, is an outgrowth from the Adlerian school. RET is a broad cognitive theory which overlaps behavior modification,

phenomenologically-oriented therapies, Rogerian methods, and existentialist goals. Cognitive, behavioral, and emotional concepts are combined into a broad, overall theory of understanding human behavior (p. 200.)

Adler relied on cognitive strategies for facilitating change in the 40's. Ellis, his student and peer, found cognitive strategies used alone were inadequate. To rectify this deficiency, a highly active-directive form of therapy using a confrontational approach was developed. Psychoanalytical, Rogerian, and existential therapists of the day violently opposed these new techniques, however (Ellis in Burks & Steffle, p. 172).

Ellis was adamant, "Virtually all serious emotional problems directly stem from magical, empirically unvalidable thinking; and that if disturbance-creating ideas are vigorously disputed by logico-empirical thinking, they can be eliminated or minimized and will ultimately cease to reoccur" (Corsini, p. 198). RET therapists **confront** irrational or dysfunctional thought systems, **teach** new ways of process thinking, and **encourage** clients to assume responsibility for themselves as well as the society at large. Specifically, client belief systems are confronted by analyzing and attacking irrational thoughts. This type of dissonance intervention therapy is designed to be a brief therapy and is used extensively in alcohol treatment centers.

Therapists prefer to conduct therapy in an atmosphere of full acceptance (Rogerian). Therapists teach clients the following precepts:

- (1) blaming is the core of emotional disturbance;
- (2) that it leads to dreadful results;

- (3) that it is possible, although difficult, for humans to learn to avoid rating themselves even while continuing to rate their performances; and
- (4) that they can give up self-rating by challenging their self-evaluating assumptions. (p. 200)

RET therapists use techniques of persuasion, i.e., **humor, praise, honesty**, and resistance-lowering **personal disclosure** accounts. More often therapy consists of strategies used for the purpose of confronting dysfunctional behaviors and then, working cognitively toward replacing old beliefs with new ones.

At times RET overlaps phenomenologically oriented therapies. Clients are taught to be **fully present in the moment**, cultivate individuality, and accept their own experience as real and important. Strategies are often directive and at times include behavior modification procedures. However, RET cannot be classified as behavior modification. The primary goal is to change the client's thinking, elicit a change in feeling, and thereby, produce more rational behavior. (Behavior modification understands change to occur in the reverse order.)

RET uses activities to **teach** clients of the need to minimize the use of absolute expectations of self and others. Behaviors, i.e., perfectionism, grandiosity and intolerance are exposed as dysfunctional. The goal is to free clients from an illogical belief systems. The therapist selects cognitive, emotive, and behavioral techniques in order to help clients "to minimize their dictatorial, dogmatic, absolutistic core

philosophy" (Burks & Steffle, p. 191). Appropriate behaviors are **reinforced** with praise and encouragement.

Cognitive-persuasive aspects of RET are the most distinguishing characteristics. **Rapid-fire, active, persuasive techniques** are employed to identify and alter irrational thinking. Emotionally, clients are fully accepted, but their **belief system is dissected** and the **nonproductive ideas ridiculed**. Therefore, little time is spent in listening to stories of the past. These techniques would be used only briefly, if at all, in order to help clients see the irrationality of their belief systems. Feelings are seldom discussed. These activities are viewed as making clients feel better in the present, and may be seen as interfering in real change. Behaviorally, work **assignments** help clients identify how thoughts about life cause problems. **Assignments** might include facing fears in a group setting, using **desensitizing techniques and role playing** as practice in being more assertive, or **monitoring negative statements** for a period of time. **Confrontation** is used to help clients recognize their own irrational thinking, or as a **perception check**. The goal is permanent attitude changes (Corsini, p. 222).

In summary, RET is a comprehensive system of personality change that uses cognitive, emotive, and behavior therapy strategies to facilitate change. The techniques are hardheaded, empirically oriented, rational, and nonmagical... growth and happiness are the relevant core of a person's intrapersonal and interpersonal life. RET is designed

to enable people to observe, to understand, and persistently to attack their irrational, grandiose, perfectionistic shoulds, oughts, and musts.

It employs the logico-empirical method of science to surrender (the use of absolute demands) and practice the philosophy of desiring rather than demanding and of working at changing what they can change and gracefully lumping what they cannot. (p. 235)

RET assists people to discontinue conforming, complying or boring behaviors and begin to actualize, experience and enjoy the present. Eric Berne's transactional analysis (1961), and Joseph Wolpe's systematic desensitization (1958) are two methodologies that draw from RET and Adlerian concepts.

Reality Therapy

William Glasser formalized the central concepts of Reality Therapy in the early 60's with the help of G. L. Harrington (Burks & Steffle, p. 296; Corsini, p. 325). Glasser rebelled against psychoanalytic training after observing the techniques being taught were not being used in therapy and developed an approach of preventative methods. He realized patients must take responsibility and change internally rather than try to change external surroundings. He tested this theory while employed in an institution for delinquent girls. His success was phenomenal.

Reality therapy completely denies the precept that external events control either feeling or thought. "All behavior is generated within ourselves for the purpose of satisfying one or more basic need" (p. 323). We are cognitive in nature and the brain determines what we perceive as reality. Reality therapists view neurotic behavior as an attempt to control the world outside one's self so as to satisfy one's own needs.

Responsible people are considered to be those who meet needs without interfering with others. Disruptive people act out in an attempt to meet needs at the expense of intervening in another's process. The concept of mental illness is rejected. Neurotic behaviors are not seen as illness, but rather controlling behaviors. Some of the painful feeling behaviors that people use to control others are: acting depressed, feeling anxious, assuming guilt, blaming others, and creating tension that produces physical pain.

Therapy focuses on convincing clients to take responsibility for life, staying in the present moment, acknowledging how perceptions determine actions, and adopting behaviors which effectively meet needs. "When a man acts in such a way that he gives and receives love and feels worthwhile to himself and others, his behavior is right or moral" (Glasser, p. 69).

In the beginning, reality therapy relies on careful listening, empathy, and reflective listening in order to build rapport, but the primary strategies are confrontation and reframing. The goal is to help clients take more effective control of brain functions, control reality, and satisfy needs. Commitment, perseverance, and encouragement are vital because of a propensity for relapse with reality therapy's clientele.

Behavioral Therapy

In the late 1950's, behavior therapy (Skinner, 1953) developed from the "principles and procedures of classical and operant conditioning" (Corsini, p. 239). From the early beginnings (then referred to as modern learning theory), behavior

therapy has expanded until today it overlaps other psychotherapeutic approaches. Two major factors that differentiate behaviorism from other therapies are (1) human behavior is not viewed from the "traditional intrapsychic, psychodynamic, or quasi-disease model of mental illness; and (2) a commitment to the scientific method" (p. 240). Put simply, the behavior therapist uses a no-excuse approach and asks, "What is causing this person to behave in this way right now, and what can we do right now to change that behavior?" (p. 254).

The basic characteristics that distinguish this approach from nonbehavioral theories include: (a) applied behavior analysis; (b) a neo-behavioristic mediational stimulus-response model; (c) social learning theory; and (d) cognitive behavior modification (p. 239).

Applied behavior analysis evolved from Skinner's (1953) radical position adapted from operant conditioning. This mechanistic approach views present behavior a function of earlier behavioral consequences.

In the **stimulus-response model**, the use of laboratory techniques such as reinforcement, punishment, and stimulus control are considered the acceptable techniques for therapy. Cognitive processing is viewed as unsuitable for scientific analysis.

Social learning theory examines the "influence of environmental events on behavior (and) is largely determined by cognitive processes...". "Psychological functioning... involves a reciprocal interaction among three interlocking sets of

influences: behavior, cognitive processes and environmental factors" (p. 240).

Emphasis is on the individual's ability to direct self change.

The most identifiable technique used in cognitive behavior modification therapy is cognitive restructuring. Techniques, such as, persuasion, confrontation of irrational beliefs, and assigned tasks are used to teach and modify "faulty perceptions and interpretations of important life events" (p. 241). (Similar techniques are used in rational-emotive therapy which will be discussed later).

Behavior therapy asks clients to alter their behavior, e.g., monitor restless pacing or model appropriate behavior. The belief is that once the fear is acknowledged and faced, it will lose power. Therapy sessions work primarily on client's activities in the outside world, in contrast with psychoanalysis' probing of the past or the unconscious. Treatment techniques vary over a wide range and are selected primarily for each individual's unique problem. The therapist uses intuitive skill and draws upon past experience to know when and where to use techniques appropriately. One such group of imagery-based techniques is used in systematic desensitization. A hierarchy of stimulus ranging from mildly stressful to threatening are imagined while in a state of deep relaxation. As long as the client can proceed without anxiety in the mental imagery, movement toward a greater level of involvement continues. The imagery provides the safety factor needed to alter cognitive framework and overcome fear.

A second technique, cognitive restructuring, attempts to reframe the client's irrational belief system. Assertiveness and social skills training are taught cognitively

and phenomenologically, while the client observes modeling of appropriate behavior. As appropriate behavior is repeated (reinforced), alternate behavior is learned.

A system of reinforcement methods is frequently used in institutional settings where avoidance is more difficult. Appropriate behavior is rewarded with privileges or tokens which can be exchanged for desirable items. Inappropriate behaviors may cause a withdrawal of tokens, or at least non-issue of tokens. Additional communication strategies utilized include active listening, personal feedback from others, building trust and rapport through self-disclosure, self-monitoring, and verbal encouragement.

Bandura (1982) alleges a modification of the client's expectations of self (self-efficacy) creates beliefs enabling a client to cope with formerly feared situations. Sexual disorders appear to respond favorably to behavioral therapy, as well as depression (except for bipolar affective disorders, which result from a brain chemical deficiency). Until recently, psychotic disorders have been traditionally treated only with pharmacotherapy. In a comprehensive study conducted by Paul and Lentz (1977), a system of token reinforcement has been shown to be an effective treatment strategy in severely psychotic patients.

In summary, behavior therapy rejects the disease model of therapy and sees behavior as symptoms of unconscious anxiety and conflicts. Behavior therapy is based upon a learning model of human development. Present therapeutic approaches have greatly expanded the pure research model techniques and "often adopt(s) an informed trial-and-error approach to difficult...problems" (Corsini, p. 273).

In summary, each theoretical framework must continue to conduct research using quality methods and procedures before specific common principles of change can be established.

As the theoretical bases of behavior therapy are broadened, there will be renewed interest in identifying the commonalities among different therapies. (For the present therapists need to) devote their energies to developing replicable, testable, and effective methods of therapeutic change within the general social learning framework of behavior therapy and invite other theoretical orientations to do the same (Corsini, p. 273).

Conclusions

Resistance to change is seen as the primary cause of failure in therapy. Many clients are mistrustful, blame others for their problems, and are wary of close relationships. This inability to trust increases natural resistance. Therapy attempts to teach clients to take responsibility for their own behavior and the resulting consequences. Although resistance resides internally, it is experienced as refusal to change. Resistance from the family system reinforces the status quo and interferes in the change process. Establishing trust and respect in the client-therapist relationship is a vital component in the therapy process.

The following chart (page 46) graphically presents the communication strategies and psychotherapeutic approaches discussed in this research. These psychological approaches were chosen because of the major influence in the field both

Strategy Selection by Psychotherapeutic Approach

THERAPIST STRATEGIES	Rogerian	Gestalt	Freudian	Existen.	R.E.T.	Behav.	Reality
Rapport Building							
Empathy/Encourage	X	X	X	X	X	X	X
Careful Listening	X	X	X	X		X	
Reflective Listening	X	X	X			X	X
Self disclosure		X			X	X	
Cognitive Process							
Feed back	X	X	X	X		X	
Perception Checking				X			
Interpretation			X	X			
Reframing				X	X	X	X
Teaching, Assignment					X	X	X
Staying in the now		X		X	X	X	X
Behavioral Interventions							
Persuasion					X	X	X
Flooding				X			
Desensitization					X	X	
Reinforcement					X	X	X
Take responsibility					X	X	X
Confrontive (ridicule)					X	X	X
Punishment						X	

historically and currently. The communication strategies are presented (viewing the chart from top to bottom) from less to greater in degrees of producing dissonance. An "X" in the column beneath each therapy indicates frequent use of that strategy in the named approach.

Several factors are obvious. First, rapport building is considered necessary in all psychological approaches. Second, theories that are confrontive spend little time in "soft" strategies beyond initially establishing a desire to help. Third, the greater the emphasis on intervention with behavioral strategies, the greater the number of strategies are employed.

Viewing the chart on a scale from least-to-most confrontive (empathy to punishment), the strategies fall on a dissonance continuum. Clients needs may determine strategy choice. Personalities with self concepts that possess a lower tolerance for inconsistency (i.e., authoritarian, dogmatism, anxiety, low self-esteem, and ego involvement) resist change. An inflexible belief system allows little room for variance. For resistant clients an effective approach must include strategies that apply cognitive and emotional pressure, such as ridicule, anger, or threats to facilitate second order change.

The chart clearly reveals why such diversity in therapeutic approaches can be successful. The varied degrees of resistance inherent in human behavior have demanded the development of a wide continuum of strategies. Rogerian therapy provides sufficient strategies to override the relatively a small degree of resistance to change. Cognitive strategies are employed in order to "convince" or provide enough

valence and weight to cause a shift in perspective as the intensity of resistance and fear escalates. At the lower end of the dissonance continuum, Reality Therapy uses confrontive and dissonance producing strategies to apply pressure toward change. Strong confrontive therapy is needed to change behavior when clients have a low tolerance for inconsistency (high resistance). Confrontive strategies are more effective in residential setting where avoidance through flight is difficult (dissonance theory).

In summary, confrontive strategies are used when client resistance is greatest. Change is resisted as long as change is perceived as painful. Change usually occurs when present behavior becomes so painful, that a change in behavior is viewed as the path of least resistance. A variety of psychological approaches have evolved in an attempt to facilitate needed changes.

RESEARCH QUESTIONS

After examining the change process, exploring persuasive communication strategies, and identifying which strategies each psychotherapeutic approach utilizes, analysis will focus on these questions:

1. What do psychotherapists/counselors regard as change?
2. What is the effect of theoretical orientation on a therapist's perception of change?
3. Does the motivation and goal of counseling vary with orientation?
4. How do therapists view resistance in the change process?
5. How is a therapist's role interpretation influenced by theoretical orientation?
6. What communication strategy themes were utilized by the therapists to facilitate change in clients?
7. How does clinical training influence strategy choice?
8. Do therapists rely on strategies learned in clinical training?
9. What factors were found to influence strategy choice?
10. Were any observations made that deviated from a therapist's traditional approach?

METHOD

Subjects

Working therapists/counselors were chosen as the population for study since this occupation provides the opportunity to help facilitate change in clients on a daily basis. To obtain the sample, a letter requesting interviews (Appendix A) was mailed to every professional therapist (24) listed in the phone book in the Great Falls area. Within ten days after the mailing, each therapist was contacted by phone. All but two (one moved, one was retiring) expressed a willingness to participate in the research. A brief biography was obtained during this call for the purpose of narrowing the sample.

The following criteria were used to narrow the broad sample: age, sex, educational background, and type of clientele. Ten therapists, all licensed by the State of Montana, were selected for inclusion in the study. One, a licensed school counselor, was selected to broaden the work environment beyond the traditional clinical setting. Psychiatrists were not selected for the sample because their focus is on short-term treatment with medication followed by referral to a therapist for long-term therapy.

Background information obtained at the time of the interviews is graphically displayed in the chart on page 55. Ages ranged from 31 to 59. An attempt was made to select a balanced, broad based sample. The sample included six females and four males. The current minimum educational requirement for licensed therapists is a Master's Degree. Masters degrees in social work, psychology, pastoral and rehabilitation counseling, school counseling, and psychiatric nursing were represented.

In addition, one female is licensed in biofeedback and one male holds a doctorate of psychology. Clientele ranged from 4 year old children to mature adults. One therapist works predominantly with preadolescent; another treats primarily adolescent youth and their families. Half worked primarily with adults. Work environments include middle school, psychiatric inpatient hospital, and private practice settings. The commentary on therapist theoretical approaches and preferred choice of strategies will be considered further in the discussion of research questions section.

Interviews

Check lists were considered as a method of gathering data. However, the external validity of checklist questionnaires was challenged by Siebold & Thomas (p. 571). For checklists to be meaningful, a complex system of shared constructs must be assembled before messages can be communicated with any congruence of understanding. The time required to establish a shared understanding was deemed inappropriate by the researcher considering the one-hour format.

Research has shown that a greater variety of responses are obtained when strategies are volunteered rather than suggested. This "...methodological approach ...places no arbitrary limit on the types or quality of strategies produced, and directs attention to the strategies (which) subjects actually produce as opposed to those they think they might use" (O'Keefe, & Delia, 1979, p. 240). Asking subjects to create their own statements is preferable and more accurate than using check lists for these reasons: checklists may inadequately represent available strategic choices, differences

in understanding of strategies may produce inaccurate responses, and some strategies chosen by the researcher may not be viable to the respondent.

Person-centered strategies (listener-adapted model) describe the traditional psychotherapy session (Siebold, pp. 572-4). This model focuses on the speaker's message quality and allows for a variety of volunteered strategies. For these reasons, the interactive interview format was chosen.

The ten therapists were contacted by phone to arrange mutually convenient interview times. Materials used by the researcher included a cassette tape recorder and blank tape, table microphone, list of research questions, and an Informed Consent (Appendix B) to be read and signed by the subject. Interviews were conducted in the subject's office except for one which was completed in the researcher's office at the subject's request. The interview and questions (Appendix C) furnished a guideline for the 45 to 55 minute interviews. Interactive interviews cannot always adhere to a structured format, therefore, some of the questions were answered within other questions. The desired information was obtained within each interview, however.

All interviews were taped, transcribed, and printed to hard copy by the researcher within 3 days of taping. The final transcript included all ten interviews and covered 126 pages. The page numbers following quotations in the results section refer to the page numbers of this transcript. Subject identity was concealed by substituting fictitious names, either during the interview if a pseudonym was suggested, or at the time of transcription when one was assigned.

The portion of the interview which contained information regarding the therapist's psychological orientation and training was set aside until after the strategy analysis was completed in an effort to prevent bias in identifying communication strategies (chart on p. 55).

In general, as experience increases, so does the variety of strategies employed. Those utilizing the broadest variety of strategies work with children. The therapists with medical training continue to rely primarily on behavioral strategies. Continuing education requirements serve the function of expanding the choice of strategies. Several therapists expressed gratitude for ongoing opportunities to learn new techniques.

Analysis

Analysis followed the 8-step data analysis guidelines (Appendix D) outlined by Lindlof (in press). Each interview was analyzed before the next interview was read. The motivation for and goal of therapy was identified for each interview. In addition to strategy choice, the therapist's self-viewed role was derived.

In order to become thoroughly familiar with the transcript, five readings were completed before any notes were taken. After completing the 5th reading, broad communication strategy headings were developed, and recorded on a separate sheet of paper. From a 6th reading of the data, additional headings were added, and abbreviations assigned (i.e., RAP for rapport). On a separate sheet of paper, the individual communication strategies (i.e., reflective listening, confront denial, provide

assignments) were identified and recorded in a column in the left hand margin. The 7th time through, each strategy was listed under the appropriate heading or theme, (i.e., reflective listening under rapport, confront denial under confrontation, or provide feedback under teaching). Quotations which descriptively illustrated the strategies were also marked. On another sheet of paper, the page, paragraph and line of each quote was noted, and later these quotations were used to illustrate in the results section. To be included as a theme heading, examples had to appear in some form in all ten interviews. These themes or headings are discussed separately in the results section.

On the far right hand side a second column was created and strategies typical of each psychological approach were identified as they occurred in the transcript. These notes were helpful when developing the background chart on page 55.

Responses which did not fit into the format are discussed under question nine, other factors that appear to influence strategy choice.

THERAPIST BACKGROUND INFORMATION
Psychological Approaches Utilized

Name	Sex	Age	Education	Years	Work Place	Psyc Orientation	Clients	Approach Utilized
Jerry	M	40-50	Pastoral and Psyc Rehab Counseling	15	Inner City Psyc Unit, Private	BACI	Adoles. Boys Adults	Adlerian Gestalt Cognitive
Judy	F	40-50	Psyc Nursing Chem Dep.	20	Psyc Nur. Army, Private	Behavioral Cognitive	Adults	Behavioral Reality Family Sys.
Julia	F	50-60	Guidance & Counseling	30	School Counseling	Behavioral Cognitive	Middle School kids	Eclectic
Joyce	F	50-60	Social Work	20 10	Government Private	Psycho-analytical Cognitive	50/50 Adults Child	Eclectic
Jana	F	30-40	Social Work	3	Psyc in Hospital	Behavioral Emotive	Adoles. & Family	Psyc Drama Reality Family Sys. Behavioral
Jeanie	F	40-50	Reg. Nurse Biofeedback	20 8	Hospital Private	Behavioral Cognitive	Adults	Eclectic
Dick	M	30-40	School Counseling & Admin	6 6 4	School Adm. Government Private	Family Sys. Cognitive Behavior	Mainly Child	Cognitive Behavioral Rogerian
Dave	M	40-50	MA & PhD in Psychology	17	Private and Child	BACI	Adults	Eclectic
Hector	M	50-60	Social Work	4 7 8	Family Med Center Private	BACI	Adults Couples Adoles.	Rogerian Gestalt Cognitive Insight
Jody	F	40-50	School Psyc	5 2	School Psyc EAP Counselor	Cognitive Behavioral Rogerian	Mainly Adults	Eclectic

RESULTS

Part I of the results section addresses therapist's self-reported data in the following areas: perception of change, motivation and goal of counseling, resistance, and therapeutic role. Part II discusses the communication strategy themes which emerged from the data: Rapport, Confrontation, Different Perspectives, Teaching, and Insight/ Understanding. Part III examines effects on strategy choice of psychological orientation, clinical training, and other factors. Also, noted are deviations from normal therapy.

Except for the first question, most quotations and responses are presented under the therapist's four broad theoretical backgrounds, Behavioral (B), Affective (A), Cognitive (C), and Insight (I). When a quotation is used outside the this "B-A-C-I" format, the author is identified in this manner: the number assigned to that therapist (2) followed by the therapist's orientation (B), or (2/B). Theoretical background information is obtained from the intake questionnaires (summary chart on p. 54).

Three therapists were trained in a single approach. Numbers 2 and 6 were trained primarily from a behavioral perspective (B), and 4 in a psychoanalytic (C) model. Responses from therapists with combined orientations may appear under one or more headings, including those who view themselves as eclectic.

PART I - RESEARCH QUESTIONS

1. WHAT DO PSYCHOTHERAPISTS/COUNSELORS REGARD AS CHANGE?

All 10 therapists were cognizant of the two types of change as outlined in Change (Watzlawick, Weakland and Fisch, 1973). "First order change is an avoidance ...maybe a choice to do something differently rather than make a change to the whole system" (6/B, p. 78), a way to "relieve their anxiety" (4/C, p. 47), or "an avoidance of pain" (1/BI, p. 1). The transient nature of first order change is evidenced in these responses: a "predictable falling backwards" (8/BACI, p. 98), a temporary change and then "returning to old behaviors" (6/B, p. 74), or, a "crisis resolution" (3/BC, p. 29; 5/BACI, p. 55; 10/BAC, p. 117) and a return to former responses.

Therapist's understanding of second order change ranged from, "Well, I've been trying to figure that out" (2/B, p. 25) to, "...once a person has an insight, it's impossible to not have permanent change" (9/BACI, p. 107). Another stated, "Second order change requires a restructuring or modification" (6/B, p. 78), or, change is a process of "an increased awareness and understanding" (7/BC, p. 78), or, ...a shift in how the person sees themselves at a real core place (8/BACI, p. 93).

2. WHAT IS THE EFFECT OF THEORETICAL ORIENTATION ON A THERAPIST'S PERCEPTION OF CHANGE?

Behavioral

The responses from the two therapists with primarily behavioral backgrounds (2, 6) were: "I think that maybe sometimes (change) is just a matter of timing and

circumstances in their lives" (6, p. 80), or, "(the client) was motivated to change when he came in" (2, p. 24). "People change by learning; by being trained" (2, pg. 21). Behavioral therapists with combined theoretical orientations (1/BI, 3/BC, 5/BACI, 8/BACI, 9/BACI, and 10/BAC) spoke of needing behavioral changes in order to lessen pain (1), relieve a crisis (5), or take control of self (3). Clients change as they "learn new skills (through trial and error...and) integrate what works" (1, p. 5).

The therapeutic focus for number 9 has changed considerably. Well, initially I saw myself more as a behaviorist. ...you know working with a lot of the different behavior, changing people's behavior. ...Today I am much more involved in working with people in insight therapeutic understanding. (9, p. 136)

After 20 years of practice, he has recently acquired extensive insight training, and now views behavior as the outward expression of internal understanding. Because he uses predominantly insight strategies, hereafter, his responses always appear under the insight heading.

Affective

Both therapist's with training in affective strategies have multiple orientations (5/BACI and 8/BACI). Affective therapists frequently use emotive phrases and strategies to describe change, such as, "The more you empower (clients), the more they make the right decisions" (5, p. 65), or, "I ask my clients to experience their feelings around an event, rather than just talk about it" (8, p. 92). "Some stay with

(the change) just for the fact that, 'Oh, my life is easier.'" (5, p. 65), essentially, feels better.

Cognitive

Therapists trained in cognitive approaches (3/BACI, 4/C, 7/BC, 8/BACI and 10/BAC) perceive change occurring with, "an increased awareness and understanding" (7, p. 78), or, "(when clients) open up in terms of being able to see it differently" (7, p. 87). Change begins when (clients) finally understand they are not at the mercy of their emotions, and can "use their brains, their reasoning and their will power to change some things in their lives. (Just) ...make a decision they want to change, then do it. It's a step thing... " (4, p. 48). The biggest hurdle is for them "to see what's happening and their involvement in it... what control they have over the situation" (3, p. 30).

A variation in the "sequence of events" can provide a change in cognitive awareness (4, p. 48), for, "by changing some of their behavior, it changes some of the other things in their lives" (4, p. 48). Permanent changes occur through, "...practice in seeing that they are successful, that they have power back again, and basically getting a belief and trust in themselves (10, p. 117).

Insight

All 3 therapists with an insight orientation have a blended theoretical training: 1/BI, 8/BACI, or 9/BACI. These therapists understand that permanent change results from an internal shift in perspective, so they place little emphasis on outward

behaviors. "Well, the only thing I know that can make real permanent change is when it's their insight" (9, p. 106), "...you change the way you see your whole life.." (p. 110). "I know that there is a shift ...it's like they jump inside themselves and see themselves in a way that... they didn't see themselves before" (8, p. 97).

To summarize, the vocabulary and focal point to which therapists attend is created in training: the behaviorists discuss change as a result of being trained, chance timing, or through trial and error. Affective therapists concentrate on empowerment, invoking feelings, or experiencing the events. Cognitive therapists emphasize using reasoning, making decisions, seeing, or cognitive awareness. Insight therapists refer to change as coming through self-realization, a shift in the level of understanding, or "a completeness ...working at unity (of understanding) ... at the balance" (1, p. 7). The latter group choose strategies that focus on internal processes instead of the specific, concrete strategies chosen by behavioral, affective, or cognitive therapists.

3. DOES THE MOTIVATION AND GOAL OF COUNSELING VARY WITH ORIENTATION?

The previously stated goal of therapy is to alleviate a malfunction or combination of functions, or, as stated by one therapist, "enable each person to return to their highest degree of functioning" (6/B, p. 73). Corsini felt, "The heart of therapy is change in behavior" (p. 464), but what motivates people to change their behavior?

Responses indicate that progressively higher levels of discomfort are the motivation for counseling. When discomfort develops into worry, then anxiety, and

finally pain for clients or their family members (4/C, p. 41), "...they are more likely to make some changes because the pain is so unbearable" (p. 50).

Festinger's Theory of Cognitive Dissonance alleges that as pressure, either internal or external, exceeds the client's level of tolerance, people are motivated to seek solutions and change behavior. Pain is the pressure that motivates clients to seek counseling. Therapist's report this point-in-time may be a perception of hurting others by one's behavior (2/B), a crisis (5/BACI), excess concern from others (3/C), a lack of control in life (10/C), distress and suffering (8/BACI), or some form of fear (9/I). Following are some of the observations.

Behavioral

The motivation for change is problems and pain, so when "...they are having problems in their life... I can help them (2, p. 14). Behavioral methods confront ineffective behaviors (2), suggest alternate behaviors (2, 6), change old habits through reeducation, confrontation, and new understanding (6), and teach problem solving skills (2, 6). These strategies function to break through denial (2), produce relief (6), "eliminate baseline problems" (10, p. 117), and alter behaviors (2, 6).

Affective

Motivation for change can be a crisis (5) or relief from suffering (8). The corresponding goals are to learn to accept responsibility for one's actions (5) and understand their problem in a different way (8).

Cognitive

Motivation comes when clients experience hurt from a crisis (7), trouble or pressure from school (7, 3), frustration due to a lack of control (10), or, seek a way to diminish pain, anxiety and worry (4). The goal is to solve problems and relieve stress, increase awareness of internal processes (7), or, help them take control of their lives (3, p. 31).

Insight

People are motivated to change by fear (1, 9), pain (1), or suffering (8). The goal is to teach the client how to reduce that fear by accessing an "inner therapist" (1, p. 2), or, "(see) their health (or wisdom)" (9, p. 101), or understand (an event) in a different way" (8, p. 93).

Some of the ways suggested for the client to reduce pain or dissonance is to discontinue the habit of personalizing feedback, have clients examine and reduce their insecurities, or lower expectations of others (9, p. 107). When clients understand how a lack of knowledge produces insecurity and fear (1, p. 6), or, grasp a way to experience trauma differently (8, p. 93), insights change beliefs.

Regardless of orientation, motivation and goals focus on pain reduction, and restored healthy functioning. Variance occurs in the strategies selected to accomplish goals, e.g: confront behavior, learn new skills (B); accept responsibility/shift perspectives (A); solve problems, increase awareness (C); and examine your insecurities, or understand outside events differently (I).

4. HOW DO THERAPISTS VIEW RESISTANCE IN THE CHANGE PROCESS?

Resistance emanates from a combination of factors. People accumulate and organize information to form concepts (information-integration theory), and reject beliefs that are significantly dissimilar (social judgement theory) for people have a distinct need to see themselves as consistent (consistency theory). Resistance to change is even greater when ego attachment is high and beliefs are dogmatic (Miller and Rokeach, p. 626). Therefore, a new belief or behavior must be seen as somewhat congruent, or make sense to the client before it can be incorporated, for, "We don't do what doesn't make sense to us" (9/BACI, p. 103).

Defenses are viewed as blocks to change, "It is very difficult to lower your defenses to someone that you can't completely and totally trust... And when that is missing... the defenses, or friction, or something similar, causes a disruption of the therapy process" (8/BACI, p. 97). "Resistance...(I see as) just kind of a natural response to change... it's more a fear of change than it is resistance (1/BI, p. 3). Outward behaviors signal internal resistance, as, "I also think if they're that closed off in their communication, they're also resistant to change" (2/B, p. 18). Resistance blocks access to our wisdom, "... (for) our health is related to wisdom, and it's an innate, inborn, always available piece" (9/BACI, p, 107).

Initial resistance in varying degrees was anticipated by all 10 therapists, however, the employment assistant counselor did not perceive much resistance until she recommended additional counseling beyond the initial four 1-hour sessions (10/BAC). Resistance was attributed to financial and emotional costs. "They start

realizing, 'Yeah, I'm tired of this. This problem is really hurting me.'" (10, p. 116).

Therapists gave the following as blocks to change or resistance.

Behavior

Lack of trust (2, p. 20); rigid belief systems (6, p. 70); fear of hurting loved ones (2, p. 23) or (hurting) self (1/I, p. 19; 3/C, p. 35).

Affective

Fear of the unknown (5, p. 57); denial (5, p. 57; 10/C, p. 115); and fear of depression reoccurring (8/I, p. 98).

Cognitive

Lack of trust in others (7, p. 83); fear of being judged (4, p. 43); reverting to established patterns (7, p. 74), or old feelings (7, p. 91); a refusal to accept responsibility for actions (1/B, p. 2; 8/C, p. 96; 10/C, p. 115); a misunderstanding due to lack of communication skills (7, p. 84), and limited internal resources (7, p. 79).

Insight

Insecurity (1/B, p. 3), lack of value flexibility due to rigid belief systems (9, p. 104), reverting to "habits" (9, p. 104), and fear of judgement (9, p. 104).

To summarize, change requires a shift in attitudes or perceptions, but new levels of understanding cannot be reached when a client is resistant and "defending their truth" (7). The strategies utilized to overcome resistance will be discussed in more detail in the strategy section, however, those mentioned frequently were: many

varieties of rapport, humor, and teaching. Regardless of orientation, resistance to change was reported by all 10 therapists, evidenced by lack of flexibility (rigid beliefs), reoccurring feelings, and behaviors which produce fear and insecurity.

5. HOW IS A THERAPIST'S ROLE INTERPRETATION INFLUENCED BY THEORETICAL ORIENTATION?

Regardless of orientation, all 10 therapists were self-viewed as a listener, teacher, and confrontor, and their choice of strategies supports this viewpoint. However, therapists varied greatly in their degree of directiveness. Compare, "So then, I ask them, 'What did you do?' and I tell them why it didn't work" (2/B, p. 17) ..."I'm training them ... without them knowing" (p. 21), to the passive responsive, "No, (I teach little) because everybody ...has innately an ability to slow down (and teach themselves)" (9/BACI, p. 105). In addition to orientation, the degree of directness can be affected by both the type of clientele, "I can be more direct with (older people) (7/BC, p. 89), or, by the time available, "(Psychoanalysis) is just too slow, so we use perhaps more of the behaviorism mode (10/BAC, p. 121). Examples of role interpretation given by therapists grouped by category follows.

Behavioral

One of the behavioral therapists views her role is to first identify the cause of the problem (p. 15), next to confront, then be a teacher or trainer, and return to point out needed corrections (2). Another responded with, "(I)... begin teaching people some self-help skills" (6, p. 74), reeducate them (p. 75), and teach them "the mind

controls what occurs in their body, whether it's organic or whether its psychosomatic ... (pain) is (in your head) because that's where you perceive it" (p. 77). Although number 6 was originally trained in behavior modification (p. 133), today she views her role differently because of training received in other approaches, primarily through continuing education workshops (p. 71). A third therapist (10) answered with, "I see counseling as a problem solving place..." (p. 116).

Affective

The therapist (5) trained in affective or psychodynamic strategies, understands her role as trying to, "...get them to experience another perspective (p. 64). My approach has become more active, more involved.

I use to be more cognitive. Now I find I work more with feelings ...to experience their feelings around an event, rather than just talk about it.

(8, p 93)

Emotive and cognitive roles often combine to produce a perspective shift:

"I do a role play ...(then) people see the response" (5, p. 59).

Cognitive

Cognitively trained therapists use the teaching role and engage clients in talking about their problems.

I think part of it is teaching people a lot of (information) and then (they'll) all of a sudden see some sort of awareness... (so they learn to)

start chopping the problem up into little problems... (and) this sort of cognitive awareness (helps them) make a decision. (4, p. 48)

Providing feedback through reflection, asking questions, clarifying, and modeling to increase awareness are frequently chosen strategies (7, p. 89). "It becomes a matter of increasing awareness to be able to understand themselves" (7, p. 83), and "(it can) take a lot of effort working with (clients) to get them to the point where they have that awareness" (p. 87).

Insight

The insight therapist perceives his role as a deep listener, "When it works the best is when they tell themselves what they need to do, and if you're listening and the rapport is deep enough" (9, p. 102) they'll answer their own questions. "I think if I do anything that I could put a label on it, I genuinely, as much as possible, be interested in what the person is saying. Be interested in that human being" (p. 113).

To briefly summarize, therapists view their role as an always changing process. They must shift from being a good listener, then a teacher, sometimes a confrontor, or an encourager. Orientation appears to provide a list of appropriate strategies. With the exception of number 9, the wider the range of education, the greater the range of strategies utilized.

To summarize Part I, original theoretical orientation creates the mental skeleton of direction and strategies for a therapist to draw upon in the therapeutic process. Resistance blocks clients from incorporating new perspectives, and can take the form

of some type of fear, a rigid belief system, or a simple miscommunication. Change strategies are introduced once the therapist believes resistance is sufficiently reduced by rapport. When a client is open to new information, beliefs may be modified, and resulting second order changes transpire.

Strategy choice is influenced by psychological orientation. The behaviorist stresses confronting problem behaviors; affective strategies seek to shift perspectives; cognitive therapists increase awareness through teaching; and insight therapists create an environment of safety believing clients can best achieve their own insights.

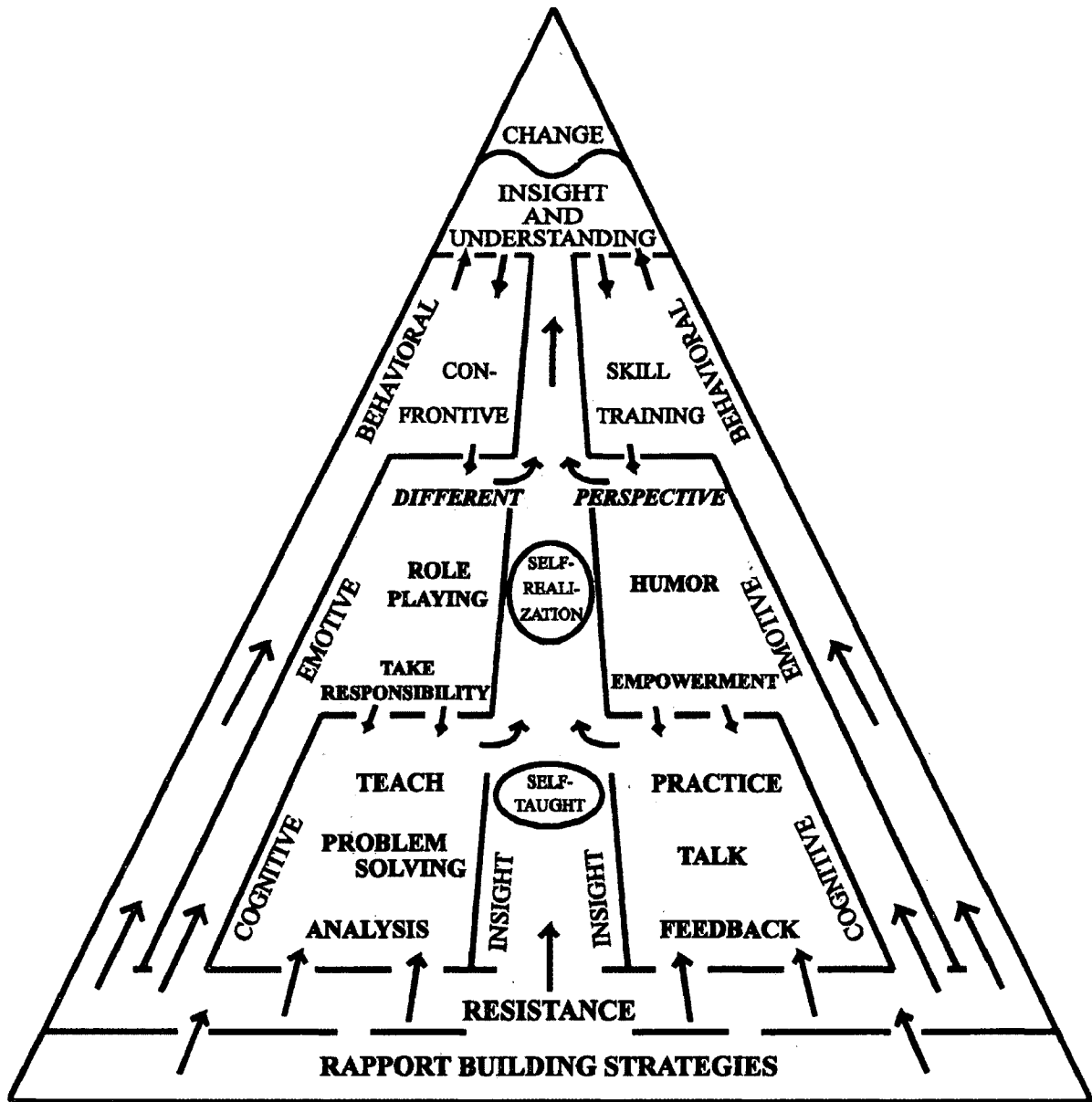
These strategies are used to relieve the pain or discomfort that originally motivated the client to seek help. As the role of the therapist fluctuates from listener to problem solver or teacher, the therapist selects the strategy ascertained to be most effective for the moment.

On page 70 the 4 psychological orientations and strategy themes (to be discussed in Part II) are presented in an upward flowing chart. Beginning at the bottom, rapport strategies are shown to break down initial resistance. Once resistance is perceived to be low enough to permit belief modification, the therapist selects strategies from their repertoire. The 4 psychological orientations, behavioral, affective, cognitive, and insight begin on the outer edge and appear in same order as they move toward the center. The horizontal "walls" dividing orientations are permeable (as indicated by the arrows-through-broken lines) because none of the therapists use strategies exclusive to one orientation. Theoretically, the chosen strategy will produce

an insight and a new idea will be integrated with a resulting change in understanding.
More likely, however, other strategies will continue to be tried until an insight occurs.

In Part II the strategy themes are discussed.

Change Therapy Flow Chart



PART II - RESEARCH QUESTIONS

6. WHAT COMMUNICATION STRATEGY THEMES WERE UTILIZED BY THE THERAPISTS TO FACILITATE CHANGE IN CLIENTS?

The communication strategies fell into five themes or groups: Rapport building, Confrontation, Different perspectives, Teaching, and Insight/Understanding. Strategies are discussed under the same "BACI" orientation format used in Part I.

Rapport Building Strategies

Good rapport is considered essential by all 10 therapists regardless of psychological orientation. The following examples illustrate what Carl Roger's referred to as "unconditional positive regard". "I really, really pay attention" (4/C, p. 43), or, "The way you project caring ... not only with what you say, but also with body language, facial expressions, things like that... (says) they felt like I really cared about them" (8/A, p. 93). "I just let the individual talk about what's important to them" (1/B, p. 1), or, "(I) try to make them feel comfortable ...listen ...reiterate" (5/A, p. 54) so they know somebody is listening. Therapists agreed unanimously -- the client must feel genuinely listened to before any change will occur.

Nobody is really going to be able to be psychological functional until that security level is established... and that comes out of rapport, out of safety... out of our ability to really pay attention to the client. (10/C, p. 101)

Strategies used to build rapport were consistent across orientation groups.

Behavioral

Listen, develop and maintain trust, feedback hope, encourage (2, 6); get their permission (6); and reassure client of confidentiality (6).

Affective

Listen, show caring, establish a sense of acceptance, reflect congruent verbal and nonverbal feedback (5, 8); use humor, be nonjudgmental (5); and show respect (8).

Cognitive

Listen, reflect, be nonjudgmental (3, 4, 7, 10); establish trust, show empathy or respect, (3, 7, 10); ask questions (3, 4); encourage (3, 7); avoid anxiety producing activities at first, occasionally share related personal experience (disclosure) (4).

Insight

Listen, show respect (1, 8, 9); congruent feedback, reflect, verbalize caring (8, 9); ask questions, sharing (1, 9); encourage (1, 8); maintain acceptance (8); use humor, and increase security level (9).

Nonverbal rapport strategies can function alone when the client perceives caring, as demonstrated in this example: One day when the therapist arrived at the apartment of an AIDS patient, he did not want to talk. Instead of leaving, she asked permission to remain and quietly do paperwork while he watched TV. As she prepared to leave, he expressed appreciation for "hanging out with me for an hour".

Even though he didn't need to talk, the fact she was there "if he wanted to talk ... was just as therapeutic for him" (p. 61).

Several therapists observed how rapport strategies produce internal change:

(a) "A lot of times even just being in a safe place to let out the feelings, and then ... most people will grasp that need to change themselves" (10/BAC, p. 120).

(b) "(The client)... must be involved at a feeling level, because sometimes the awareness and insights they reach, come when they are just in a caring environment" (8/BACI, p. 97).

(c) "(Until you) start to alleviate some of the fear ...they're not going to get much past the surface level (9/I, p. 100).

(d) "If the rapport is deep enough... (clients) will come all the way around a circle and they'll say, 'Gees, I answered that for myself, didn't I?' and that comes out of their own wisdom..." (9/I, p. 102).

To summarize rapport, therapists concurred unanimously, a climate of caring, safety and trust is necessary to facilitate change. Nonjudgmental feedback, a show of respect, or deep listening are interpreted by the client as caring. Once a client begins to feel safe, resistance to a change in beliefs lowers. Maintaining client-therapist rapport throughout the counseling period is vital to therapy for "...if a client perceives judgement, a challenge to their ideas, or a thrust to the beliefs to which they are attached, there is insufficient rapport for insight to occur" (9/I, p. 101). Although, therapists agree that rapport is vital to the therapeutic process, reliance on rapport strategies varies considerably.

Confrontation

The purpose of the second group of strategies, confrontation, is to persuade the client to question current behaviors and/or beliefs. Therapists' perceptions of confrontation varies from a soft asking, "How does that make sense to you?" (9/I p. 103), to the strong challenge to a client in denial, "Yea, then why are you here (in my office) if everything is going so good?" (2/B, p. 22). Following are some confrontive strategies applied to specific types of resistance.

Behavioral

(a) Describe present reality in a confrontive manner, a strategy used to break denial and force clients to experience the harsh behavioral consequences: "You tell the person that drinking hurts (others)... your drinking affected (our) lives" (2, p. 18).

(b) Startle a client by offering a baby bottle when (the therapist) observes excessive attachment to a belief (1, p. 10)

(c) Confront internally by discussing formative childhood memories and explore the attached feelings (6, pp. 78, 83).

(d) Verbally confront ineffective behavior and tell them, "That is not going to work... (and then) teach them skills" (2, p. 16).

Affective

(a) Confront blaming with direct questions, "There's a reason why (your child has) a temper. 'Which one of you has a temper?' ...I ask them point blank" (5, p. 58).

(b) Confront resistance and point out avoidance tactics, "So, if you really know that you're not going to try to work, that's fine" (5, p. 59), but, "When you're ready to come back and ... start working on some things, let me know. Here's my card" (p. 60).

Cognitive

(a) Provide feedback to a student to facilitate a realization that illogical beliefs cause problems, and that a more "rational interpretation instead of (the child's) irrational one" (3, p. 34) would work better.

(b) Suggest alternatives. "If it isn't working, could we do things that might work better for you? (or) ...if I don't feel that I am connecting after 5 or 6 sessions, I terminate it" (4, p. 46).

Insight

(a) "It's asking the question in such a way that... you're not saying it doesn't make sense, but that you're really interested in how they see it (9, p. 106), as, "How does that make sense to (you)?" (p. 104).

Strong, confrontive strategies were suggested by therapists who work primarily with two groups: either troubled, adolescent patients in a psychiatric hospital (5/BACI), or alcoholics and addictive clients in denial (2/B). Softer strategies, such as, verbalize caring (4/C), or treating a child with respect (7/BC) are utilized by therapists who work with younger children, and those who preferred rapport building

strategies over intrusive confrontation: avoid hurtful subjects (7), respond to suffering (8/BACI), or be genuinely interested (9/BACI).

Six of the 10 therapists (3, 4, 6, 7, 8, 9) prefer to increase rapport and establish a sense of safety and caring with the resistant client rather than use intrusive confrontation.

(a) "I don't think you can force anybody (to change)... you put it in front of them... but if they don't want to learn, then 6 horses are not going to make them learn" (4/C, p. 51).

(b) "(I) kind of let them examine that (response) ... rather than be right in the middle of it... I'm not a lecturer" (6/B, p. 75).

(c) "...people who are making changes ...I encourage" (7/BC, p. 87) them as they leave their comfort zone.

(d) If the "rapport is deep enough... they'll come all the way around a circle" (9/BACI, p. 102) and see for themselves.

Number 9 believes strongly that confronting behavior is counterproductive to therapy, "(because)... whatever they are doing makes sense to them at some level" and his job is to understand the belief manifesting their behavior, and help the client discover other alternatives.

Confrontation also varies in degrees of directness. For example, when asked about the use of confrontation, one therapist replied, "No I'm not very good at that... Even when I'm confrontive, I'm pretty gentle" (8/BACI, p. 96). He confronts clients in indirect and nonthreatening ways, i.e., make suggestions or give feedback. In

contrast, the therapist who frequently confronts clients directly ("I tell them that it's not going to work", 2/B, p. 16) views her style of confrontation as a 6 on a 1-10 scale.

In summary, all 10 therapists confront resistance, varying from a gentle asking for more understanding, to, "They don't start to say (they strike their kid) until you corner them" (5/BACI, p. 58). Six preferred to increase rapport strategies (reward side of dissonance theory) with the resistant client rather than use strong confrontive strategies. The stronger, more direct strategies are used with troubled teenagers in a confined environment (p. 57) or with clients in denial (2/B, p. 22).

Teaching Strategies

The third group of strategies, teaching, provides new information, suggests alternate actions (reeducation), or brings clients new awareness. The client's goal is to assimilate information, change belief systems, and demonstrate healthier behaviors.

Once the level of rapport is perceived as adequate, some therapists move to active teaching. Responses ranged from, "The more information you throw at 'em, the more is going to stick..." (2/B, p. 5), to the inactive role of being an interested listener, "...and they tell themselves what they need to do" (9/I, p. 102). Following are most of the specific teaching strategies that were used.

Behavioral

Identify problems, teach them communication skills, and give homework for practice (2), teach alternate routes, and life skills (1), teach self-help skills, and reeducate about effects of family influence or cause and effect (6).

Affective

Model behavior, use contracts or teach kids how to communicate (5), learn through role playing (5, 8), teach with suggestions, or, give advice and instruct new behaviors (8), as, "I encourage them ...they have the resources to do the steps they've learned" (p. 98).

Cognitive

Teach self control (3), rational interpretation (3, 10), new information (4, 10), how to manage stress (10), healthy behaviors (7), encourage practicing (7), problem solving skills (3, 4, 7, 10), and, "...looking at communication patterns ...or practicing communication between husband and wife" (10/BAC, p. 118).

Insight

People teach themselves... "It's an innate, an inborn, always available piece, and when we go to that innately, it will always tell us what we need to know" (9, p. 107).

Teaching strategies are used by all 10 therapists. As with confrontation, the meaning of teaching varies considerably, covering the broad spectrum from directive to passive. The directive role teaches an array of techniques (1/BI, 2/B, 3/BAC, 4/C, 10/BAC), problem solving steps (2, 3, 10), self-help skills (6/B), assertiveness skills (7/BC), and communication skills (2, 5/BACI, and 10).

The passive role is used predominantly by insight therapists where a deeper and deeper rapport is established to "...facilitate (the client) seeing their own health (or

wisdom)" (9/I, p. 101). These therapists perceive clients as self-taught through insights while attempting to communicate internal understanding to the therapist. "You know how to help them because they are telling you what they need ...they tell themselves what they need to do (9, p. 102), or "...they tell you where they need to go" (1/BI, p. 7).

Regardless of orientation, active teaching strategies are used by all therapists and include: provide feedback (verbal and nonverbal), ask questions and clarify responses, connect behavior to consequences, make suggestions, and provide alternative behaviors.

Different Perspectives

The fourth group of strategies centers around facilitating a shift in understanding, or helping clients gain a different perspective. Balance theory (Miller and Rokeach, 1968) suggests that the complex creation of a self-concept is an interweaving of one's attitudes, perceptions, behaviors and knowledge into a perspective. Before second-order or permanent change occurs, however, a shift in this understanding must occur. "(It's)... understanding (an event) in a different way... I think that balance between cognitive and affective, as well as insight" (8/BACI, p. 93). As long as people believe only one viewpoint is viable, change is difficult to facilitate. Strategies therapists utilized to alter understanding fell into four categories: empowerment, taking responsibility, role playing, and humor.

Empowerment

Empowering the client was a strategy mentioned directly by four therapists (3, 5, 6, 10), and implied by five others including: "point out strengths" (4), "encourage autonomy" (7), "see people in a positive way" (8), and "see their health" (9).

Sometimes they'll come back in and they'll say they have made a slight change and.. people are relating to them differently...(and) maybe change their perception of the past... they relate to people more, not in the victim role, but more in the power role. (10, p. 117)

Responses by orientation include the following statements.

Behavioral

(a) "(I recognize) how important it (is) to bond with the patient, and enhance them to help themselves become well" (6, p. 73).

(b) "My job is to get that person to his or her most empowered state" (6, p. 79).

Affective

(a) "(So I) ...help them experience control, kind of empower them.. some control over their life (5, p. 55).

(b) "(She told me) now she had the ability to be totally present, to show up for her life" (8, p. 97) because she had "been able to get rid of the (beliefs)" (p. 98) that were holding her back.

Cognitive

(a) "I think if a person starts seeing success, they are more apt to make that (behavior) a part of their permanent repertoire" (10, p. 120).

(b) "...try to empower (the child)... (tell them) you're the most important person (3, p. 37).

(c) "People often feel victimized ...and they don't realize they cannot change other people, that they can only change themselves... then you'll all of a sudden see some sort of awareness, like, 'Hey, I can do some things differently, and change some things!'" (4, p. 48).

Insight

(a) Answers are within: "Our health is an innate, an inborn, always available piece. It will always tell us what we need to know" (9, p. 107).

(b) " ... that's what understanding does... it changes the way you see something" (9, p. 108).

(c) "If they see something as normal, they can deal with it in a better way" (8, p. 98).

(d) "I use feedback to help clients understand that I see their resistance as fear of change, ...(they) are then willing to embrace and run the risk of seeing what is on the other side of the fence" (1, p. 3).

Empowering clients lowers the level of fear, the client sheds the victim role and considers alternative actions. If behavior changes produce positive feedback from

others, confidence builds. Successful interactions result in a willingness to take further risks.

Taking responsibility

As clients gain a sense of power, the therapist tries to move them toward taking responsibility for their own behavior, actions or situations. Responses occurred in all four groups.

Behavioral

(a) I have them step back and "...examine (their own behavior)... maybe from a little different perspective" (6, p. 75).

(b) An unwillingness to accept responsibility blocks changes, "(The client's) self-centered focus and propensity to blame others as being responsible for everything that happens, (they fail to escape from) obsessive behavior" (8, p. 96).

Affective

(a) "Half the battle" of change is getting clients to understand a present perspective is "one of many" (5, p. 60), and considering a different reality is possible.

(b) "... (Clients) are going to have to (accept responsibility); we can't go home with them at night!" (5, p. 67).

Cognitive

(a) "The main (problem) would be people who don't want to take responsibility for their own actions" (10, p. 115).

(b) I ask adults to take responsibility for their behavior by asking them to examine their self talk, "...their critical voice" (10, p. 125).

(c) I try to get them, "... to understand 'What is in my control; what isn't in my control?' ...(they need to focus) on their own responsibility, their own power" (10, p. 115).

(d) "It's giving them back the responsibility for themselves ...(when they) "take a risk... make a slight change and they realize people are relating to them differently... they change their perception ...they've changed the way they relate to other people" (10, p. 117).

Insight

(a) "I don't know how it happens exactly... there's a shift... the perspective that they have about their life is different" (8, p. 97).

(b) "That's what understanding does, it changes the way you see something" (9, p. 108).

(c) "They have more and more understanding, and they can see things from a clearer perspective" (9, p. 101).

In sum, therapists believe that once clients gain a sense of empowerment, they begin to take responsibility for their thoughts, feelings, and behavior. Positive feedback from others encourages them to repeat these new behaviors. Once they experience the feeling of having some control in life, vulnerability and fear is reduced. Taking responsibility for their own lives is then viewed as positive.

All of the therapists agree empowerment is necessary, however, they do vary in the proper approach. Behaviorists are more forceful in pointing out clients are behaving inappropriately; the cognitive approach frequently mentions an "unwillingness to change" (10); insight therapists ascertain the problem to be lack of clarity, a block in understanding. The latter believe clients automatically choose a more functional behavior once consequences are understood by the client as self-caused.

Role playing

The strategy of role playing is utilized by affective therapists to help clients emotionally experience a different perspective. In this example, a son imitates his mother in a therapy session. " 'Mom, you come in like this from work.. and throw your coat on the chair...' and Mom is thinking, 'I bet I do that! I bet I throw my coat there everyday' " (5/BACI, p. 63). As she watches her son's dramatic role play of her behavior, "...she gets insight just from seeing him do it" (p. 64). Observing dramas allow clients to feel a different perspective, rather than just hear one.

Metaphors are used as thought role plays. "What I'll do is kind of paint pictures.. or I'll ask them to tell me it in a different way... give me a metaphor ...(or I'll say), 'Does that make sense to you?' and they'll say, 'Yea, but it makes more sense (this way)'" (9/I, p. 112), and as they explain to me, they begin to see it differently. To illustrate his point, he used the metaphor of needing windshield wipers

in a rainstorm to provide a clearer perspective, "(it's like so many) things going on in my head, (I can't see clearly)" (p. 102).

A second therapist was challenged by a client who felt discouraged because people were saying her pain was "all in her head". To reduce the client's defensiveness, she used the analogy of a quadrapalegic who cannot feel trauma inflicted below the neck. Essentially, "Your friends are right, because (your head) is where (all) your awareness is" (6/B), p. 77). The clinicians reported that this type of strategy helps clients detach from ego involvement and defensiveness and gain a different understanding of the dynamics occurring. The shift in understanding permits new information to be incorporated into the belief system, and produces second-order change (integration theory).

Humor

Humor is used to build rapport, lower defensiveness, and facilitate open discussion of alternate solutions to problems. "I think appropriate humor is the most effective rapport builder there is..." (9/I, p. 111), and, "When I laugh, I feel more at ease, so when they laugh, they (feel) at ease and comfortable" (5/BACI, p. 60).

Functioning as a change catalyst, humor lowers defenses. "I use a lot of humor, a lot of smart comments that make them laugh, so they feel comfortable" (5, BACI, p. 60). When students were unable to provide solutions to a teacher problem, the school counselor suggested to the angry, "(Well, you could)... just take a gun and shoot that

teacher" (3, BAC, p. 32). After a good laugh, the student's perspectives opened up and more creative ideas were volunteered.

Insight and Understanding

Clearly, the suggested appropriate climate for the final group of strategies, insight and understanding, is one of lowered resistance, accomplished by deep listening (pp. 42, 54, 85, 93, 102, 112). Techniques don't produce insight, "...so you would have a really, really low batting average when applying techniques to get insight to happen... Insight comes out of a person's openness and level of understanding at any given moment" (9/I, p. 112). Responses describing insight follow.

Behavioral

(a) Insight and understanding seem to occur in sequential order, "...(once) understanding is gained, then insight occurs" (6, p. 75).

Affective

(a) "Some stay with (the changes) just for the fact that, 'Oh, my life is easier!'" (5, p. 65).

(b) "(When somebody) perceives and tries to understand where (others are) coming from, that's that insight, O.K... '(I don't agree with you, but now) I understand why you think (like you do)'" (5, p. 63).

Cognitive

(a) "So again, I try to get them to think ...to use their brain about what they might do differently"(4, p. 44).

(b) "(I believe) ...increased awareness and understanding is a key, basic consideration in the whole process (7, p. 87).

Insight

The majority of the information about insight and understanding came from the comments made by the insight oriented therapists.

(a) "So when you have insight, you change the way you've been thinking about something and it effects everything you do" (9, p. 107).

(b) "The more that we (work at communion or unity) ...you actually see people experience a Gestalt ...a wholeness (insight)" (1, pg. 7).

(c) "Insight comes out of a person's openness and level of understanding at any given moment" (p. 113).

(d) "Insight from another person sounds like a paragraph. Insight, when it goes off inside of yourself, sounds like a novel" (p. 106).

Therapists are not clear how insight occurs even though they understand insight is the core of belief changes. The more concrete the therapist, the greater the focus on methods or behavior changes, and the less mention of how change occurs. The affective therapist is more likely to observe the change after the fact; the cognitive approach sees change coming with more learning and better thinking. Few therapists tried to describe the way to facilitate insight.

Insight is a grasp of something we already know ...so when you have an insight, you change the way you've been thinking about something and ...it effects everything you do. (9, p. 107)

Insight and understanding were used interchangeably in this quote, "It's an understanding, an insight, a deeper understanding about ...the way they experience life" (p. 103). Other words used to describe this shift or change in understanding are inner therapist (1), innate wisdom (9), faith (9), or spirituality (8). Seeing an event from a different perspective, or with new understanding is the result; no one was sure just how that happens.

To summarize, changes in perspective requires a lowering of resistance. First, "In order for clients to see things from another perspective they must be open" (p. 11). Once openness is established with rapport, alternate perspectives are introduced. The strategies most frequently chosen by therapists to introduce different perspectives were: (a) Empower the client and explain how taking responsibility for their lives can open up different options. (b) Role playing and humor are used to raise understanding and assist the client in experiencing another perspective. Once beliefs change, behavior changes, because people do what makes sense (9, p. 103).

In summary, Part II addressed the five strategy themes utilized by therapists to facilitate change in clients. Rapport strategies were viewed by all 10 therapists as vital to change because establishing good rapport creates the climate of safety necessary to lower resistance. Confrontive strategies are used to break denial, challenge resistance, gain information, and provide feedback to clients, particularly

concerning behaviors considered unhealthy or inappropriate. A third groups of strategies, teaching, is used to present new skills or behaviors, and increase cognitive understanding. A fourth group of strategies is used to help clients see events from a different perspective by empowering clients so they take responsibility for their lives. In addition, the affective strategies of role playing and humor allow clients to experience a different perspective. The final group of strategies were those believed to produce insight/understanding, the foundation of change.

Part III will examine factors that influence strategy choice, examine reliance on original training, and discuss nontypical cases.

PART III - RESEARCH QUESTIONS

7. HOW DOES CLINICAL TRAINING INFLUENCE STRATEGY CHOICE?

Across the four orientations, actual rapport strategies utilized vary little. Psychological orientation does appear to affect the value or importance placed on rapport strategies, however. Insight therapists rely on rapport strategies more than any other orientation. Clinical training influences the frequency and variety of the strategies chosen.

Behavioral

Therapists with primarily behavioral training (2, 6) and those with combined behavioral training (1, 4, 5) frequently used confrontation and teaching strategies that varied from very soft to strongly direct. Strategies utilized include: challenge their behavior (1), teach and then confront their mistakes (2), have them question own behavior and teach problem solving skills (4), confrontation through warning (5), teach cause and effect (6), and, "...address the focus problem" (10, p. 116).

Affective

Therapists trained in affective strategies (5, 8), and those who have integrated emotive strategies into their practice (3, 10) utilize strategies that facilitate a shift in perspective through experience and feelings. Strategies are used to empower the client, such as, guided imagery (3), role playing (5), drawing pictures (8), having

clients take responsibility for feelings and behavior. The goal is to experience empowerment (10) and may be experienced by becoming more assertive (6).

Emotive and cognitive goals were often combined, i.e., "...encourage them to look at it as these feelings will come up, but that they have the resources to do the steps that they've learned (8, p. 98).

Cognitive

Therapists trained in a cognitive approach include 3, 4, 5, 7, 8, and 10. Cognitive strategies include teaching skills, such as "Stop, think, act and then evaluate" (3, p. 31), teaching, clarifying, and practicing new skills (7), re-parenting or teaching unlearned behaviors (8).

Insight

None of the 10 therapists were singly trained from an insight orientation. Spiritual orientations (1) and a balanced orientation of social work (5, 9) and psychology (8), all received insight training. Rogerian theory (mentioned by number 10) provides some background for insight strategies. Today a pure insight background would most likely be found in philosophy (i.e., existentialism). These strategies focus on gaining new understanding or different internal perspectives. They ask clients to:

(a) Search for deeper understanding, "There's something more (than we know)" (1, p. 4).

(b) In the therapist-client communication create a "sense of unity within, creating a sense of wholeness and serenity" (p. 7).

(c) Build a strong rapport, use metaphors and humor, reflect back to gain understanding, or reframe to obtain a different perspective (8, 9).

8. DO THERAPIST'S RELY ON STRATEGIES LEARNED IN CLINICAL TRAINING?

Eclectic Approach

Although theoretical training initially defines strategy choice, half of the counselors (3, 4, 6, 8, 10) stated they have developed an eclectic approach as a result of additional training and successful therapeutic experiences. These 5 eclectic therapist's and their strategy choices are examined separately.

Number 3 (30 years in counseling) works with middle school children, and uses "whatever works" (p. 39). She felt in the beginning she used only the strategies learned in training, "But I think it's probably been an evolution. "I really like ... getting further education, because I recognize where my limitations are and then try to remediate that (lack)" (p. 128). "I think you really have to use common sense, trust intuition, ...ask questions, (use) inspiration... whatever works!" (3, p. 39-40). Actual strategies volunteered verified her self view: 10 rapport, 5 confronting and feedback, 7 reframing including humor and guided imagery, 9 teaching, and 10 insight (or active listening).

Number 4 (29 years counseling) has "worked in so many programs, (I have) developed an eclectic approach" (p. 128). Approximately half of her clientele is

children. "I have a whole range of clients... (So, I) try to figure out what would (work) ...homework, ...analogies, ...books to read, ...play therapy, drawing, ...talk a little (p. 45-46).

I've had a great deal of experience by now and I've gone to a great many workshops in different techniques, and what happens after a while... you pick up a little bit here and a little bit there...I was not trained in behaviorism at all ...(but) I do now use some of the techniques. (4/C p. 49) In her interview she mentioned a balanced selection of strategies: 11 rapport, 5 confrontive, 8 emotive, 8 teaching and 8 active listening.

Number 6 (8 years counseling) saw her role change through exposure to a diversity of orientations and a wide range of clientele (age 7 to 65). She expressed gratitude for the effect continuing education requirements had in expanding her therapeutic approach, and felt a lack of available workshops in her area of training (nursing) has forced her to broaden her theoretical basis (p. 71). Consequently, she has "learned a lot more about human behavior" (p. 71) particularly in the area of marriage, relationship, and family systems. Although trained in a behavioral orientation, her response to the question on second order change, "...a restructuring or modification" of the belief system (p. 78), illustrates a shift in focus. Her strategy choices included: 8 rapport, 4 behavioral, 10 gaining different perspectives, 10 teaching, and 7 insight.

Number 8 (17 years counseling) received training in all four orientations including a Ph. D program in psychology. He used confrontation, although admittedly "soft" (B), gestalt strategies (A), historical influence and talk strategies (C), and viewed his therapeutic role as a combination of caring, involving feelings, teaching awareness, and producing insights (I) (p. 97). The strategy choices confirmed his eclectic self-perception: 11 rapport, 6 confrontive, 10 emotive, 7 teaching, and 8 insight.

Number 10 (7 years counseling) also was trained in all four orientations, including behavioral psychology, drama, speech communication, and rogerian strategies, (p. 136). This broad spectrum of training provides a wide range of strategies from which to choose, "I think I have a bag of tricks. I use everything" (p. 114). In addition to the 8 rapport strategies, she used:

(B) 9 confrontations, generally soft.

(A) 11, primarily focused on gaining a different perspective; also, feeling objects as, "...a fish tank for people who are anxious ...(and) my (eyeless) bear" (p. 114).

(C) 10 teaching, such as communication patterns, homework, "I" statements, brainstorming, and "practice, practice, practice" (p. 117).

(I) 6 to maintain rapport, such as, "They just need a place to unload, they need someone who is not judgmental to help them sort through... (p. 120).

Her job format limits the amount of time (4 sessions) she can spend with a client. Hence, a brief therapeutic approach including confrontation and taking responsibility for their own lives is frequently chosen (p. 122).

Combined Orientations

The remaining 5 therapists (1, 2, 5, 7 and 9) will be discussed in relationship to their theoretical orientations.

Number 1 felt his background was eclectic. His strategy choices demonstrate a preference for behavioral (direct confrontation and skill training) and cognitive strategies (educate, ask questions, teach). He also used affective methods (relaxation techniques, desensitization and role plays) to confront behaviors. Rapport strategies were mentioned the least often of the 10 interviewed. A reoccurring dialectic between learning new skills (B) or trusting that "inner therapist" (I) surfaced 5 different times. For example, he stated:

I believe that within each and everyone of us there exists an inner therapist... (and) once we can teach that therapist the proper skills... (that therapist) serves our own best interest... So my task in the long run as I view counseling is one of a teaching model, educational. (p. 2)

However, on the same page he says, "...teaching (that) their best therapist is really inside of them and it's not me".

This conflict between learning new skills and trusting the inner therapist was present even as he reminisced about his own training. He remembered how his "anxiety level was off the wall when I was on (the pediatric and geriatric) units" (p.

7), areas where he lacked experience and education. His consistent reliance on education and training contrasts sharply with his belief that one must trust and rely upon the "inner therapist", however, it is consistent with his dual psychological orientation, behavioral-insight.

Number 2 has remained with her original orientation more than any other therapist. The strategies mentioned are behavioral classics: ask questions and identify the problem ...create a plan ...give advice ...point out mistakes ...explore interactions ...teach skills ...practice, practice, practice ...give assignments ...analyze results ...make corrections, and confront denial, mistakes, or the pain they cause others (pp. 15-28). She viewed herself in an almost Pavlovian role, "I'm training them in a new way of doing something". She believes her original training prepared her, but "...sometimes I use some techniques that they haven't trained me to do" (p. 23).

The inpatient adolescent counselor (5) held degrees in early childhood and family development, teaching, and a Master's degree in social work. A recent graduate, her clinical training was divided between a mental hospital for the criminally and mentally insane, and an AIDS clinic. She felt "...behavior modification and a little psychodynamic" (p. 131) best described her approach. The therapeutic goal is to get patients to accept responsibility for their actions. Strategies were mainly behavioral and affective, "get right to the problem ...confront their behavior ...get them to question their behavior ...use humor and role playing to help them see a new

perspective ...give feedback ...help them re-frame ...empower them ...coach them" (pp. 55-68).

Number 7's orientation is in special education and school counseling a "cognitive-behavioral approach" (p. 133). He works primarily with children and their parents. Toys, paper activities and drawings are used to gather information from the very young. Strategies mentioned were, "...teaching ...reframing ...setting limits ...confronting ...questions ...clarifying ...reflect ...changing their awareness, and practice assertiveness skills" (pp. 81-90). He views himself as an active guide, a director, and a teacher. His strategy choices are consistent given his orientation. He has worked as a teacher, a school administrator, and a child counselor. He does not feel his approach has varied much from his early training. His strategies emanate from his training.

Number 9's educational background is in communication and social work (BACD). His clinical experience includes working as a probation officer in a family agency, a care coordinator in the dialysis unit of a medical center, and for the last 19 years a private practitioner. He has abandoned behavioral techniques for insight therapy. He relies primarily on rapport strategies with some affective methods. Those utilized were "pay attention ...really listen ...reflect back ...deep listening ...really hear clearly ...reframe their understanding ...use metaphors to gain a different perspective" (pp. 101-112). His stated goal is to help people reduce their fears and regain "their own innate mental health" (p. 107), a precept Rogers referred to as "an already existing capacity in a potentially competent individual" (Rogers, 1961, p. 221).

9. WHAT FACTORS WERE FOUND TO INFLUENCE STRATEGY CHOICE?

Besides orientation, three additional factors were mentioned as influencing strategy choice: time constraints, limited mental resources, and chronological maturity of the client.

Time Constraints

Three therapists mentioned time limits as affecting strategy choice: an employment assistance counselor (10) with four one-hour sessions; an inpatient psychiatric adolescent counselor (5) with a maximum of 2 weeks of influence; and a middle school counselor (3) with sporadic, brief sessions addressing specific problems.

1. The employee counselor (10/BAC) utilized brief therapy strategies that are "more directed and confrontational, thought confrontation" (p. 137). She used other brief therapy (crisis intervention) strategies such as setting boundaries and pointing out imminent consequences (reality therapy). She taught communication and problem solving skills, how to analyze self talk, and had clients practice stress relieving techniques (B).

2. The psychiatric hospital therapist (5/BACI) works with adolescents and views her role as "handling the crisis" (p. 56), or, "You go into what's happening right then and there" (p. 53). Once again the focus on brief therapy demands confrontive strategies. She believes strategies that involve emotions are most effective, "Kids need to express themselves in actions, because they can't verbally express themselves (5, p.

63) (and) "...it works. And in order for change to happen, you've got to act and you've got to get all of this energy... and be creative (p. 64). She observes people change when they take responsibility and ask themselves, "What am I doing wrong that's making all of this happen?" (p. 56).

3. A third counselor who mentioned time constraints works with 6th graders, is trained in school psychology, and also, perceives her role as one of crisis intervention (brief therapy). She seldom spent more than 30 minutes with a student. She stressed the importance of good rapport followed by a wide variety of behavioral, emotive, and cognitive strategies. "The biggest hurdle... is for them to see what's happening and their involvement in it" (p. 30), and that usually takes more time. She viewed second order change as when, "(they) change their irrational beliefs" (p. 33) (i.e., rational-emotive therapy, p. 37). Given her limited time, she did not feel she accomplished much second-order change.

In summary, intervention or brief strategies that address the immediate crisis are preferred by therapists when time is a limiting factor. These consisted of confrontation (verbal and emotive), setting boundaries, teaching problem solving and communication skills, and helping the client take responsibility for their behavior. All three refer clients with chronic behavioral problems to private practice therapists for long-term therapy.

A Lack of Life Skills

A second factor that influenced strategy choice is limited resources. One therapist finds the most difficult clients are those that have a self-centered focus and propensity to blame others, "such limited (inner) resources... to work on their own process ...in the sense of the holes in their parenting, thus the term re-parenting" (8/BACI, p. 96), or, "low in their cognitive abilities" (p. 95). According to the adolescent counselor (5/BACI), a lack of skills creates problems, "...because if (kids) can't communicate, how can (you) understand where they're coming from?" (p. 68). These clients require more patience and longer-term therapy to repair the gaps in their foundations.

Immaturity

Strategy choice is influenced by a third factor, chronological immaturity (age). Sometimes you need to "wait until that maturity does develop" (3/C, p. 31). The therapists who work with young children expressed the need to try everything:

(5) "Let them talk (p. 56), role plays (p. 58, 59, 64), listen and give feedback (p. 60), "go to Hardees, write some things down, or draw" (p. 61), modeling, humor (62), imitation (p. 63), reward systems (p. 65), or teach them how to control anger (p. 66).

(7) "We talk about things, ...(I) certainly incorporate activities with children, (p. 85) ...practice (p. 88), ..use reflection, ...modeling, assertiveness skills, and play the role of another person (p. 89).

Clearly, working with young children demands an increased variety of strategies. For this reason, several therapists preferred not to work with small children (1, 2, 5, 6).

10. WERE ANY OBSERVATIONS MADE THAT DEVIATED FROM A THERAPIST'S TRADITIONAL APPROACH?

The most traditional behavioral therapist (2) talked about an interesting case. Sexual offenders traditionally are resistant to counseling and behavior changes, however, this one was "doing really well" (2/B, p. 25). When questioned why this case was successful, she replied:

Well, I've been trying to figure that out! His job is to learn. I don't know what my role is in teaching that... 'I tried not to put any more guilt on him' (author's emphasis). I became like a friend that he could tell what was going on ...I go with my gut feelings usually... (I listen carefully because) you have to know what's going on. (p. 25-7)

She did not rely on a behavioral agenda, rather, refrained from confrontation, and used rapport strategies (listen, be a friend). In this case, reliance on rapport strategies proved to be effective, an approach more familiar to insight therapists.

The inpatient adolescent therapist views her role as non-directive and felt, "... (the client) needs to do all the talking in order to change" (5/BACI, p. 60). However, she frequently was quite directive, as, "And I just ask them point blank... very assertive, and in a very calm voice" (p. 58). This dual approach and apparent

conflict may emanate from two different orientations, the former position used to gain insight, the latter a confrontive strategy to break denial.

A therapist trained in the medical field made an interesting observation of her former colleagues (6). "(We) don't see many psychological referrals from the physician base" because the medical community have been "very comfortable in (their) power and have kind of disempowered the patients" (6, p. 72). Now she believes in "empowering her patients" or "enhance(ing) them to help themselves" (p. 73). This change in perspective was attributed to additional training (p. 71), or an understanding of the value of having some control of one's treatment.

A counselor (7/BC) who works predominantly with children viewed resistance as a diagnostic tool, a signal "that (the resisted subject) may become another issue that they're dealing with ... a pretty good indication of something (else to work on)" (p. 91). Follow-up on the resisted subject was done in a future session. Although not a deviation from his orientation, this viewpoint did stand out as a deviation from the normal perception of resistance.

SUMMARY AND CONCLUSIONS

The temporary nature of first-order change and permanence of second-order change is a shared understanding among all the therapists. Considerable variance did occur in describing the cause of change, as: a "matter of timing" (B), feeling another's perspective (A), seeing events from a new awareness (C), or an internal shift (I). These differences in perspective are expressed in terms of language and relevance to a therapist's psychological orientation with the exception motivation for change. As each area is summarized, the influence of orientation is addressed.

The motivation for seeking change was consistent across orientations, essentially some level of pressure or pain. Once change is sought, the goal is to reduce the client's discomfort. Therapists provide a wide variety of ways to achieve relief: skill training (B), experience a different perspective (A), think more clearly so as to understand events differently (C), and lower client resistance from fear so they can access their own wisdom (I).

Often change is viewed as pain producing, so therapists frequently encounter client resistance. Resistance is the visible behavior disguising a variety of fears: the unknown, failure, or judgement, just to name a few. The stronger the defense, the greater the need for rapport to create a climate of safety. Regardless of orientation, diffusing resistance is vital for change. Two diverse strategies are used to breach resistance: confrontation and deeper rapport.

The confrontive approach is used to break down denial and resistance. Dissonance theory suggests under the increased pain of confrontation, changing

becomes the path of least resistance, the lesser of two painful options. Examples of strong, directive strategies used to confront resistance are the avoidance tactics of blaming and denial.

Rogerian and insight therapies approach resistance from the opposite direction, that of creating a climate of safety and caring, something I will call the theory of attraction. This approach accepts the precepts from dissonance theory, however, it uses the reward route to change, rather than forcing the client out of present behavior. Initially, this alternate path of least resistance is introduced in the warmth and safety of the therapist's sessions. As fear of change is reduced, change becomes less threatening and more desirable.

The role the therapist plays is clearly, influenced by orientation. Behavioral therapists are more directive, therefore, use the more concrete, practice-type strategies congruent with a trainer. Affective strategies are selected for less cognitive clients and call for roles such as cheerleader, encourager, or coach (5, 8). Therapists with teaching backgrounds, primarily respond with cognitive strategies relying on thinking and understanding. Insight therapists prefer rapport strategies and view themselves as skilled listeners.

Interestingly, when time limitations are present, cognitive strategies are not effective because they work too slowly. It occurs to the author, perhaps the reason cognitive strategies are less effective in countering resistance is due to the fact resistance is cognitive in nature. Cognitive strategies can be opposed more effectively than can either affective or insight ones. Insight work occurs internally, therefore,

meets with little resistance. Insight therapists see themselves as midwives assisting in the delivery of a new perspective. Resistance to change lowers when the passive role consists of careful listening to "how it makes sense to them" (9, p. 104) and no directive pressure or attachment to an agenda. As the client relates their understanding to the therapist, they continue to gain more insight. Just as a tutor must create new perspectives while searching for alternate ways to explain calculus to a puzzled student, clients gain a deeper understanding of their belief system while trying to attain a shared meaning with the therapist.

Therapists who work with very resistant clients (2, 5) rely primarily on behavioral and confrontive strategies, where as those who work with a diverse population prefer the nonconfrontive approach. Unlike therapists with less resistant clients, they continue to rely on their "tried and true" strategies. This unwillingness to incorporate other strategies, may result from working constantly with resistant clients. The therapist may create a system of strategies to counter anticipated attacks, develop protective defenses, and thereby block incorporation of any new therapeutic strategies themselves.

Therapists continue to rely on strategies from their original psychological orientation with the exception of number 9. The latter, although trained in a broad-based orientation and with almost 20 years of experience, now utilizes primarily insight strategies. He sees the broad spectrum of strategies being utilized in therapy, but believes the client implements these strategies internally. "...They can see things from a clearer perspective" (p. 101), "they tell themselves" (102), or, "it's much better

if they got the (insight)...they can't explain what changed... but they know they've change" (p. 103). Since the goal is a shift in understanding or permanent change, he has found the briefest therapy is to lower resistance as quickly and fully as possible, and connect the client to their own innate mental health. Health is seen to surface in the absence of fear or resistance, therefore, greatest change occurs in a climate of rapport, safety and acceptance.

Insight therapists do not reject the strategies used in the other approaches, but see them operating on an internal level. For example, confrontation is self-applied by the client as they reflect on their own past behavior. Because they proceed at their own pace, resistance is minimal. Productive outside suggestions can be made, but only when the therapist is listening carefully enough to couch comments in such a way they are received as approval or confirmation. In this climate, clients are self-taught from their own "common sense", different perspectives are realized, and insights modify the belief system. In addition to rapport strategies, metaphors, analogies, and role plays are the preferred strategies used to assist in producing shifts in perception.

Strategy Overview

Change therapy proceeds in a fairly predictable manner, that is rapport is established, a level of confrontation is applied, teaching is initiated, and strategies are used to introduce a different perspective (cognitive and experiential). Rapport strategies play a key role in the change process for they reduce resistance in an

environment of caring and safety. As the belief system allows new information to be integrated into the belief system and a shift in understanding produces change.

Confrontation is used to mirror back one's behavior, in an effort to help them to see what others see. Ideally, the client will respond by accepting responsibility for consequences, alter behavior, and make healthier decisions. However, a majority of the therapists prefer soft confrontation (deeper rapport, inquiring questions, positive feedback) to facilitate self-confrontation within the client.

Teaching strategies present new information, and in and of themselves, do not produce change. Once the client is open to change, therapists use these strategies to provide a greater variety of available options and raise the probability of belief changes.

Resistance is evident in rigid, black and white beliefs or beliefs that allow only one viewpoint. Clients are exposed to a different perspective of an event in order to expand their understanding. For example, the abused woman who remains for years in an abusive relationship, must choose between two fears: (1) continued abuse from her partner if she stays, or (2) face the threats of being murdered if she tries to leave or get help (as well as the prospect of supporting her family alone). If she can believe, if only for a moment, that the legal system will empower her, she may glimpse the possibility of other options, and begin to make other choices. As long as she perceives her choices are to remain silent or be killed, the fearful victim resists change. Once empowerment begins and clients perceive some degree of control is available, taking

responsibility for their decisions allows them to maintain a lower level of protective defensiveness, thus a greater opportunity to experience change.

Role plays and metaphors are used to help the client feel different perspectives. In experiencing another's viewpoint, shifts in understanding come more quickly. These strategies also appear to bypass cognitive resistance when the client's guard is down, and an "ah-ha" or Gestalt experience results. Humor often functions in this same way.

All orientations understand real change occurs at the insight level and becomes visible via a change in behavior (chart, p. 70). A therapist's orientation determines at which point in the change process therapy will focus. Strategies are designed to impact the change process at different levels, all working toward the goal of insight. Once belief systems incorporate new information and shift understanding, new thought patterns manifest different feelings, and produce altered behavior. Therefore, whether you view the change at the behavioral, feeling, or cognitive level, evidence can exist to support the continued use of all strategies to facilitate change. By orientation the preferred strategy choice preferences are: confrontation and learning skills (B); role playing, metaphors and emotive techniques to change perspectives experientially (B); teaching, sharing ideas, and gaining new understanding through talking (C); and deep rapport, listening, reflecting, and reframing ideas that "just occur" in therapy.

Initially, therapists feel they do rely on strategies learned in training. Further training and positive feedback from their clients encourage them to broaden their repertoire. Evidence indicates strategy choice increases with additional training. The

five eclectic counselors have either many years of experience (30, 29 and 17), or a broad educational background. Non-directive, number 9 sees these strategies self-applied.

In summary, this research supports the tenets that rapport strategies are universally utilized to lower resistance to change. In the beginning, strategy choices are selected from a therapists initial training and expand with additional training or through both positive and negative feedback from clients. The broader the variety of clientele, the wider the range of strategies developed. Several other factors that particularly effect cognitive strategies are time restrictions and maturity levels. The least variety of strategies are used by therapists who work with strongly resistant clients. For this group, the strategies tend to center around either deep rapport (I) on one end of the continuum or direct confrontation of behavior on the other.

The key to brief therapy is to reduce resistance so the outside intervention necessary for second order change functions. Resistance, either in the client or the therapist, prevents integration of new information. Therapists find rapport strategies provide the most effective method for lowering resistance. Insight therapists contend deep rapport is sufficient to facilitate change in clients for clients "teach themselves". The briefest therapy occurs when client resistance is lowest.

Consensus is rapport strategies are vital to change. How great a role rapport plays in the change process varies among therapists. Outside strategies cannot be rated as more or less effective than others for the insight needed to produce change occurs within the client. Therefore, a variety of strategies will continue to be

implemented always in hopes of pressuring or attracting people toward a higher level of functioning.

Future Research

Ideas for several areas of future study emerged while completing this research. There is a need for research designed to determine ways to shorten the time required to effect the change process. Brief therapies currently claim to effectuate change more quickly than other strategies. Does research support this claim? Funding for such a study should interest insurance companies as rising therapy costs increase claims ratios.

A broad range of studies could be designed to examine the different levels of therapeutic approach (behavioral, emotional, cognitive or insight). The interconnectedness of strategy choice and therapeutic approach appear logical to this researcher, but may not be supported in other research.

Change theory is not closely defined or delineated. One reason more has not been done to integrate change theories resides in an attachment to the "best" theoretical approach. Strong attachment to one's perspective generates rejection of alternate theoretical tenets. Perhaps a greater understanding of the interdependence among all therapeutic strategies could help lower the resistance to doctrinal augmentation.

Theory begins by trying to find answers to questions. Each inquiry raises additional questions. Disconnected pieces of new information are either integrated or rejected. Eventually, fresh data begins to form a pattern, individual concepts begin

repeating, and a unified precept begins to reach cognitive awareness. People need to assimilate new awareness in a compatible manner. Research will continue as people try to understand the complexity of the change process.

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APPENDICES

APPENDIX A
A Sample Letter

APPENDIX A

November 14, 1993

Bobbin Maki
Crossroads Counseling Services, Inc.
410 Central, Suite #304
Great Falls, MT 59401

Dr. John D. Crowley, Adolescent Psyc Unit,
Montana Deaconess Medical Center
1101 25th Street S
Great Falls, MT 59405

Dear Dr. Crowley,

I am contacting you because your reputation as a counselor/ therapist in the Great Falls area is respected. Since I am currently compiling data for a Master's Thesis on the subject of, "Communication strategies used to facilitate change in the client", I would like to include your point of view in my study. Presently, I am compiling a list of professionals, from as many different theoretical perspectives as possible, in order to select a sample. In order to obtain this data, I will be conducting hour-long interviews in the Great Falls area in the forthcoming months at the convenience of you, the counselor.

Would you be willing to take out one hour of your time to share your ideas and thoughts on this subject with me?

Within the next week to 10 days I will be contacting you to determine whether you would be open to be included in my study. After the sample has been selected, I will recontact your office and arrange a meeting time that is convenient for you.

Confidentiality will be respected and a copy of the written report will be made available to you if you wish.

Thank you for assisting me in my research.

Sincerely,

Bobbin Maki, LPC

APPENDIX B

Interview Outline

APPENDIX B

INTERVIEW OUTLINE

INTRODUCTION:

Introduce myself and disclose appropriate information relating to the rationale for conducting the study. After describing the research, explain the format to be used. At this time I will offer to provide them with a copy of the results if they would so desire.

FORMAT:

Approximately one hour interviews, will be taped on cassette and transcribed at a later date. The following questions will be used for the interview. An attempt will be made to compile as full a body of information as possible from each therapist.

FOCUS:

What communication strategies are viewed by counselors and/or therapists as effective in facilitating human behavior change?

BACKGROUND INFORMATION FOR SAMPLE CRITERIA:

Assign fictitious name:

Marital Status:

Sex: Age: Family:

Degrees held:

Psychological orientation of training:

Type of clientele:

QUESTIONS

TRAINING ORIENTATION:

1. Describe your complete post high school education.
2. Describe work history (specific # of years in counseling).
3. Describe your present therapeutic orientation and setting.
4. Has your therapeutic approach changed over your years of practice? If so please describe.

THERAPEUTIC PROCESS:

1. What do you believe motivates people initially to come in for counseling?
2. Describe what things you feel are important to do at the beginning of the therapy process?
3. From your perspective, what is the goal of counseling?

NATURE OF CHANGE:

1. What kind of difficulties do you encounter when working with clients?
2. How do you overcome _____ ?
3. When, if ever, do you use nonempathetic methods?

TURNING POINTS:

1. Describe the type of client that exhibits the greatest difficulties in therapy?
2. In your opinion, what must happen before people begin to make permanent changes?
3. What do you see as fundamental or lasting change? (types of change)

MAINTENANCE:

1. After change has occurred, what kind of difficulties do clients encounter?
2. Summarize for me what communication strategies you feel are most effective for facilitating permanent change.
3. Do you have any questions?

SUPPLEMENTAL QUESTION (if not covered in interview):

There was one concept on my mind today that you did not mention, resistance. Could you comment on what you believe its place is in the change process?

APPENDIX C
Informed Consent

APPENDIX C

INFORMED CONSENT

This research will consist of hour-long interviews focused on self-reported change strategies that therapists use in a clinical setting. The interviews will be scheduled at your convenience. Your participation in this project is entirely voluntary. Your reading and signing the bottom of this page will serve as your informed acceptance of participation. You may refuse to answer any specific question and may terminate your participation at any time. Information collected and reported will be identified by an assumed name. In order to protect your identity, your actual name will not be connected to any responses you provide. If you would like a summary of the results of this study, check the appropriate box, and I will mail you a copy at the completion of the research.

In the event that you are physically injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such physical injury, further information may be obtained from University Legal Counsel.

Participant's Signature

Researcher's Signature

APPENDIX D
Data Analysis Guidelines

APPENDIX D

8 Steps for Data Analysis* presented by Martha Einerson

(NOTE) Do at least steps 1-4 in pencil.

1. Familiarize yourself with the data transcripts; read transcripts a minimum of 5 times without taking any notes.
2. On a separate sheet of paper, without referring to data, brainstorm broad subject headings. These may need revision.
3. Reread data once more; do not take notes.
4. Locate these subject headings (key words) on transcripts in the margin besides paragraphs, making even remote connections. Then, bracket, from the subject headings, looking for repeating patterns.
5. On a separate page identify subjects, or subheadings: i.e., Family = sibling talk, parental conflict. Note any interesting topic shifts, etc. Answer question? "What headings work?"
6. Separate subjects notated on data and assign codes, as Family Talk (FT). Focus on subject headings.
7. On a separate paper, pull out direct quotes (p. 16, 3rd P., L. 6.). Determine what quote is best to use in paper, i.e., clear, funny, succinct, etc.
8. Broaden back out to create and develop themes from both interviews. Make general categories or themes emerge from the materials. Find direct quotes to illustrate your conclusions.

*Based upon the Qualitative Research text (in print) by Thomas R. Lindlof, University of Kentucky.

APPENDIX E

**IRB Board Proposal
IRB Proposal for Thesis Project**

by

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Committee Chairman, Al Sillars

THESIS PROPOSAL

#1a. STATEMENT OF PURPOSE

The goal of this study is to gain a better understanding of the change process. Specifically, working therapists will be interviewed and their self-reported "strategies of change" will be identified. An attempt will be made to answer this question, "What communication strategies are viewed by therapists as most effective in facilitating human behavior changes?". Additionally, the question will be asked, Is there a "thread of universality" within the communication strategies that all therapists utilize?

RATIONALE AND SIGNIFICANCE

When current behaviors and communication patterns fail to produce the desired results and consistently leave one frustrated (or worse), change becomes necessary. Communication research, particularly in the field of persuasion, provides an understanding of the communication strategies that can be effectively used to facilitate the needed change. Psychotherapy and counseling directly apply these strategies in a clinical setting to assist people in lowering their level of discomfort. Literature reviews in the areas of Change, Persuasion, and Psychological theories provide the background for this study.

Much has been written about resistance to change and the role dissonance theory plays in human behavioral choices, but few studies exist that have identified effective communication strategies as they are self-chosen in the clinical setting. It seems logical to study the setting where theories are being applied and to qualitatively draw out support (or lack of) for dissonance theory and the process of change.

RESEARCH QUESTIONS

After examining the change process, exploring the persuasive communication strategies, and identifying which strategies each psychotherapeutic approach utilizes, the following questions are presented as the focus of this study:

1. What is the overall goal of counseling?
2. Do therapists regard rapport as vital to the change process? If so, why?
3. What obstacles to therapy do therapists view as problematical?
4. How are these difficulties overcome in therapy?
5. Which communication strategies do therapists view as effective for fundamental change?

#1b. METHODOLOGY

Data will be collected through hour-long, recorded interviews with working therapists and counselors. A series of open-ended questions will provide guidelines for the interview, but will not limit the discussion. These questions are written in a manner that will allow for a richness of thought and experience from the therapist. Discussion will be focused around the thesis question, "What communication strategies do you find effective in facilitating change in human behavior?"

#1c. PROTOCOL AND LOGISTICS

I. The parameters for selection of sample are:

- #4. a. Professional counselors - Solicit all known counselors in the Great Falls area (from the phone book, school directory, hospital personnel). Contact these first by letter (Appendix A). By nature of the professional**
- #5. educational requirements, all subjects will be over 24 years of age.**

- b. In a follow up phone call, the purpose of the study will be read to the therapist. If the therapist is willing to be interviewed, I will obtain the necessary information needed to narrow and balance the sample (Appendix B).**

- c. Narrow and balance the sample to a minimum of 10 interviews using the following criteria:**
 - 1) Type of clientele**
 - 2) Sex**
 - 3) Theoretical approach**
 - 4) Age**
 - 5) Educational background**

- #1d. d. Select counselors and arrange with an interview time and place at their convenience.**

#2. BENEFITS OF RESEARCH

The lay person who must make changes seldom understands resistance and dissonance theory. They experience resistance, but fail to understand the role it plays in change. Understanding how these strategies function could provide a heavy carryover value into society at large. Application of this understanding could be made

in the family, in the classroom, or at the city council meeting. Just seeing how effective learning how to use the "I feel" statement has been in producing better communication among college students demonstrates the need for better communication strategies and greater understanding of human behavior.

Our society is currently in a self-help frame of mind, that is, people are searching for ways to improve their quality of life. With exercise equipment sales up, new self-help books appearing on the shelves daily, and support groups continually forming, the signals are clearly, "How can we raise our awareness of how people function?"

This is a qualitative study of therapists and their self-reported strategies used for making changes. Providing a better understanding of the change process, and in turn applying this understanding in a practical manner to everyday life, would contribute to a higher quality of life.

#3. Subject use:

Conduct interviews with chosen counselors using interview questions created for the purpose of collecting data for study (Appendix B, page 2).

**#6. a. Have therapist read and sign a release of information
#8. (Appendix C).**

#7. b. Reassure subject confidentiality: data will be coded under an assumed name, and results will be written up in a manner so that no individual can be identified.

c. Tape record the complete interview.

d. Transcribe and print to hard copy.

#9. Not applicable.

#10. Type of analysis described below conceals any possible connection of data to the individual therapist.

ANALYSIS

- 1. Analyze data according to the guidelines outlined by Lindlof (with the assistance of Ms. Einerson.)**
- 2. Using the 8-step process of Data Analysis (Appendix C), compile a list of repeating patterns of communication strategies used by each counselor.**
- 3. From these subject headings, compare and contrast the similarities and differences between the interviews.**
- 4. After taking into account the biases in strategies that might be anticipated from that counselor's theoretical background, determine what other strategies have been used.**
- 5. Compare all the interviews to determine which communication strategies (if any) appear to be used by all counselors to effect change in their clients.**