of mastery in working with narcissistic clients and will continue to expand their knowledge and technical expertise.

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Systemic Therapy: A New Brief Intervention Model

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A brief psychotherapy model based on systems theory is presented. The model emphasizes the interactional context of clients' problems and represents an efficient intervention paradigm.

Available literature on the duration of counseling suggests that the average therapist or counselor has only a limited number of sessions within which to intervene. Fiester and Rudestam (1975), in a study of three large, urban community mental health centers, found that approximately 45% of adult outpatients terminated psychotherapy before the third session. Lacy, Frank, and Kirk (1976) found that the modal number of sessions at a large university counseling center for vocational concerns was three, while the majority of clients seeking assistance for personal problems attended fewer than six sessions. In a review of studies covering a range of psychotherapy and counseling settings, Garfield (1978) concluded that the median number of sessions was between five and six. In addition, there is evidence that those who leave therapy early rarely go on to seek therapy elsewhere (Riess & Brandt, 1965).

Despite this reality, however, the majority of the intervention strategies used are derived from models that emphasize numerous hours of client–therapist contact (Corsini, 1979). Therefore, the figures presented above suggest that most mental health clients receive an abbreviated form of treatment.

In recent years there has been a growing interest in short-term psychotherapy (Budman, 1981; Butcher & Koss, 1978). But the majority of these brief therapies are essentially scaled-down versions of traditional long-term intervention models (i.e., "less of something"). They are typically viewed as conventional psychotherapy delivered in less than optimal form. These short-term treatments carry with them the implication of being expedients such as in crisis intervention (Aguilera & Messick, 1978), as something to do in the face of shortages (personnel, client resources, time), or as a preliminary step toward resolving deeper problems (Weakland, 1982).

The purpose of this article is to describe a newly developing mode of brief, problem-oriented therapy. In contrast to the traditional psychodynamic, cognitive-behavioral, or client-centered paradigms in which brief interventions are viewed as short-cuts, a paradigmatic assumption of this new model is that complete, optimal, and effective treatment is of short duration. This alternative model, which we shall call *systemic therapy,* is derived from a substantially different set of epistemological assumptions.

Historically, systemic therapy originated with Bateson, Jack-

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son, Haley, and Weakland's (1956) classic article, "Toward a Theory of Schizophrenia," which described human problems as arising out of confused patterns of communication rather than through intrapsychic conflicts or the learning of inappropriate stimulus-response contingencies. Over the past 2 decades, this group of theorists and researchers has directed its efforts toward examining the interaction patterns within human beings' primary social network, the family. The therapeutic techniques developed from this still-evolving paradigm—reframing (Watzlawick, Weakland, & Fisch, 1974), strategic directives (Haley, 1976), and paradoxical messages (Palazolli, Boscolo, Cecchin, & Prata, 1978)—obtain their effectiveness as a result of the interactional context from which they were derived.

Therapists who adopted these methods frequently saw substantial changes in their clients in relatively short periods of time, often in less than 10 sessions. Gurman and Kniskern (1978) have concluded that systems-oriented family therapy is the treatment of choice for a number of different types of mental health problems. Based on a thorough review of research, Strong and Claiborn (1982) have stated that for a large number of mental health problems, systems-based approaches emerge as clearly superior to traditional interventions.

Recently, a growing number of family-systems theorists have been edging toward a conceptual model of human problems and their treatment that is free-standing and not based on the kinship network of the family. This shift has not been formally acknowledged by the major theorists, but has been the result of a very gradual process. Recent literature and conference presentations have included examples in which the same principles used for diagnosing and treating family dysfunction have been applied to clients whose difficulties do not explicitly arise from family discord (Fisch, Weakland, & Segal, 1982; Haley, 1982). Instead of treating clients within the context of the family network, several theorists are beginning to use systems concepts in a more generic manner. For example, Watzlawick (1982), commenting on the work of Milton Erickson, used the term "interactional therapy" to describe a treatment modality founded upon the assumption that "[personal] dysfunction arises from contemporary social contexts rather than from inferred intrapsychic processes" (p. 183).

In our work in a college counseling center, we too have found ourselves using systems concepts and techniques to work with problems not related directly to dysfunctional patterns of family interaction. The process by which we began using systemic interventions with nonfamily problems was a gradual one that followed the historical trend described above: We began to apply systems concepts in a generic manner to our assessment and intervention efforts without formally acknowledging this transition. The remainder of this article is an attempt to formalize the assumptions and intervention strategies associated with this shift. In the following discussion we will try to explicate the central tenets of systemic therapy.

Our conceptualization of the etiology of problems presented by our clients is highly compatible with Keeney's (1979) model of "ecosystemic diagnosis." Disturbed or deviant behavior is viewed as a social phenomenon (Weakland, Fisch, Watzlawick, & Bodin, 1974). The symptoms exhibited by an individual client are assumed to be an expression of a dysfunctional relationship pattern.

For example, young adults often present observable symptoms such as academic underachievement, anxiety, or depression. By looking at a wider frame of reference than the client, we frequently find that the client's difficulties are the observable part of a "sick" social network. This network can be a family who is having difficulty traversing a stage in the family life-cycle (Carter & McGoldrick, 1980), but can also be a secretary in a business that is undergoing a stressful period of reorganization or a college dormitory resident representing a conflict among the members of his or her floor. If counselors neglect to take this social context into account in working with clients, they are severely handicapped when it comes time to develop interventions. Although behavior therapy does emphasize environmental factors when assessing clients' difficulties, behavioral theory continues to be person-centered rather than truly contextual. We feel that is it essential not to view clients as isolated cases, but instead as integral parts of a larger social body.

Traditional modes of counseling and psychotherapy continue to reflect the medical model's view of the role of client and therapist. In this traditional paradigm, the client is viewed as an external object that is operated upon by a counselor using therapeutic techniques as instruments of change. An implicit assumption of this model is the separateness of counselor and client. Counselor and counselee represent distinct and frequently opposed systems. This assumption violates one of the fundamental postulates of modern systemic epistemology: When left together for any period of time, two systems will become structurally coupled (Marturana, 1980). Bateson (1979) described the coherence patterns that developed between his dog and pet gibbon as a result of sustained interaction. The separate systems represented by the two organisms evolved into an integrated and consistent "whole" that included both animals (Dell, 1982a). The traditional medical model, upon which most counseling and psychotherapy continues to be based, does not acknowledge this process by which the therapist and client come together to create a new ecosystem.

In contrast, systemic theory emphasizes the context created by the patterns of interaction between client and therapist. Systemic therapists have heeded the findings of Rosenthal (1966), Capra (1977), and other scientists who have recognized the impossibility of separating the observer from the phenomenon being observed.

As DeShazer (1982) has noted, traditional views of client-as-a-system and therapist-as-another-system result in the creation of an artificial boundary. Rather than acknowledging that psychotherapist and client create a new, unique system (which contains elements of both subsystems and unique properties arising from their interaction), traditional views create an unnecessary dichotomy between therapist and client subsystems. This traditional view "breaks up the [natural] ecology" (Bateson, 1979) and denies the relationship between energy and information by splitting wholes (ecosystems) into supposedly independent "things" (Wilden, 1980). Instead, systemic therapy emphasizes the emergent interactional pattern that is created when the therapeutic process is alternatively punctuated as a unitary ecosystem.

A particularly unfortunate byproduct of the traditional client–therapist dichotomy that emerges from the creation of an artificial opposition is the notion of "resistance" (DeShazer, 1982). The term *resistance* is a conceptual artifact that has become reified in traditional psychotherapy as a wall between the client and the counselor. The traditional view holds that this barrier needs to be broken down in order for change to occur. Resistance is a logical outgrowth of a linear model of therapy featuring a duel between two opposing forces. In contrast, systemic therapy, because it emphasizes the unity of the newly created counselor–client ecosystem and the nonlinear, self-reflexive feedback loops by which this system is maintained, does not contain the concept of resistance as part of its epistemology.

Erickson (1967) has described resistance as a stance taken by a therapist in which the client is allowed to have certain symptoms but not others (obnoxiousness, uncooperativeness). In traditional models of counseling and psychotherapy, resistance is seen as something located within the client; resistant behavior is described as emanating from the client rather than being a product of client–therapist interaction (DeShazer, 1982).

Recently, Dell (1982a) questioned the epistemological correctness of the resistance concept. Dell noted that resistance is used as an explanatory device to account for a situation in which the client does not respond to therapeutic interventions in the manner predicted by the therapist. Resistance is an attribution made by the therapist to account for "difficulties" in the therapist–client system. In addition to not being therapeutically helpful, the concept of resistance has been described as an epistemological error: "People and systems do not resist; they simply are what they are (Dell, 1982a).

As strategic therapists have noted, resistant clients undergo change when the therapist "goes with reality"; the therapist accepts the client's construction of the world as it is and works within it. When one considers the time expended in traditional therapy in breaking down resistances (6 to 12 months in long-term, dynamic psychotherapy), the epistemological assumptions contained in systemic therapy promise substantially greater efficiency.

From our systemic perspective, we conceptualize problem development and resolution within a matrix anchored by three dimensions: language, perception, and behavior. These three dimensions summarize the important content of human interaction. Rather than having any type of linear, cause-effect relationship, these dimensions are conceptualized as three relatively distinct subparts that mutually interact.

Intervention efforts can be directed toward any one of these three components. We, however, are in agreement with Watzlawick (1978, 1982) and Weakland (1982) that the linguistic component is the most malleable of the three. It is generally easier to induce change at the other two nodal points through a relatively minor alteration in communication patterns. Our world is the self-generated product of language. Dell (1982b) elaborated this point:

> We think we are interacting with the various objects in the world, but are instead interacting with our distinctions. We think we are perceiving (*per capiens*—through capturing) or discovering objects, when, in fact, our concepts are constructing those "objects" via creative acts of distinction. We think we live in a world of real, absolutely objective objects, when we really live in a self-constructed world of language. We think that language is a tool for describing the world in which we live, when, in fact, the world in which we live is language. (p. 5)

Behavior and perception are in turn based on the linguistic definitions that we ascribe to situations and events (Watzlawick et al., 1974). The therapist can best understand a client's own construction of the world (which includes the client's current difficulties) through careful attention to the client's use of language. Does the client describe a problem as internally caused, externally created, a chronic personality defect, or a situational "problem in living"? As counselors, we do not see a client's construction of a problem as right or wrong or as correct or incorrect; it simply *is* (Dell, 1982a). The client's language tells us how the problem is disturbing the client's world.

In contrast to most traditional models of psychotherapy, we do not attempt to teach the client a language and metatheory of personality dynamics or behavior change. Instead, we attempt to restructure elements of the client's reality and create a different "script" (Andolfi, Angelo, Menghi, & Nicolo-Corigliano, 1983). In this process the counselor emphasizes certain nodal elements of the client's reality that were previously deemphasized, and relegates other aspects to the background. Within the context of the newly created client–therapist system, the client's cognitive-perceptual map of the world becomes altered. This new map will lead to behavioral changes compatible with the client's new reality. Essentially, the therapist and client create a world less painful and less conflict-ridden.

Although there is evidence that language and perception can be changed through a focus on changing overt behavior (Highlen & Voight, 1978; Lefcourt, Hogg, Struthers, & Holmes, 1975), we have found that this is usually not the most productive route for intervention efforts. As suggested above, behavior therapies tend to ignore the interactional context of the symptom. Behavioral interventions operate through principles of first-order change (Watzlawick et al., 1974) because they focus on altering symptomatic behavior rather than the contextual frame (meaning) within which the symptom is based. In contrast, systemic interventions focus on changing the context of the client's problem. This redefinition of the client's problem is the essence of second-order change (Watzlawick et al., 1974), which is frequently more efficient than direct attempts at changing overt behavior.

There are several other advantages of emphasizing changes in communication patterns as the basis for therapeutic intervention. Given the temporal and spatial constraints of the counseling process, changing linguistic frames is usually more efficient than attempting to change problem behaviors, many of which are not directly observable in the counseling session. In addition, many of the problems brought to counselors and therapists have no clear behavioral referent. In working with college undergraduates, we typically hear concerns such as "I don't know who I am" or "I just don't feel motivated to do my school work." We have found that if we try to pin these students down to describing their problems with clear behavioral referents, they often become frustrated and let us know that we do not understand the abstract complexity of their concerns. By looking at the students' social network and determining their definitional frames, we can participate with the client and facilitate a reduction in discomfort.

The content of therapy consists of altering the context that surrounds a group of facts (DeShazer, 1982). The counselor helps clients to change their frames in a gradual fashion. This process, called reframing, has been defined as follows:

> [Changing] the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning. (Watzlawick et al., 1974, p. 95)

The art and skill of reframing is to develop an initial frame close enough in meaning to that of the client so that a new, better fitting frame can be meaningfully associated to the one held by the client. The result of the client–counselor interaction is often that the client leaves with a blended frame consisting of the client's old frame, the counselor's frame, and a "bonus" in the form of the unique perspective resulting from the melding of two distinct views (DeShazer, 1982). Once things are seen differently, behavioral change follows, which in turn allows for the creation of additional new subjective experiences.

As we noted in the introductory paragraphs, one of the hallmarks of the systemic model is its efficiency. By focusing on the interactional context within which symptoms arise and by creating second-order changes, a seemingly small intervention will often produce a "ripple effect" that changes other parts of the system (Keeney, 1979). Bateson's (1979) "self-healing tautology" asserts that if any aspect of a system is changed, the whole organization of the system is changed; each aspect of the system implies the remainder of the system. Thus, a small change can be the trigger for the major reorganization of a complex interactional network.

DeShazer (1982) suggested that this process is similar to the results of a key change for a musical composition. By altering the key (frame), the entire sound of the melody is changed, both in how it is played and in its sound. The key change itself

is a minor change; however, the resulting musical meaning is altered dramatically. In the case of human difficulties, a relatively minor change in the definitional frame of a problem can result in changes in clients' perceptions of themselves and in their pattern of interaction with others.

Drawing on the notion of the key change in a musical composition and similar analogies, two cases that attempt to illustrate an interactional approach to counseling will now be presented.

A third-year student presented himself as having concerns about poor grades and feelings of discouragement. He was frightened by a recent increased use of marijuana, and described himself further as feeling guilty and low in motivation. His self-description was focused typically on intrapsychic issues. Western culture generally places great emphasis on individual responsibility, with a vocabulary ranging from resistance to sinfulness, which connotes psychic processes.

Several interventions were offered to the student, with the objective being to change his relationship to his environment. At the end of the first session he was asked to return to the dorm and thank fellow smokers for a chance to get high with them. He reported that this was uncomfortable, but that he had complied. This was the beginning of transforming marijuana smoking from a spontaneous response to stress into a clear choice.

The second session dealt mainly with understanding the client's relationship to his family, who lived hundreds of miles away. Information about how the client interacted with parents and handled challenges was deemed necessary to help predict current responses to the pressure for readjustment.

The third session was arranged to include his closest marijuana smoking friend. Though the usual assurances that all was well and that the drug use was well-controlled were given by both, the real objective was not to elicit promises of change. The discussion centered on the ecology of marijuana smoking, with a very detailed examination of where, when, and with whom the act took place. Lighting, music, and other supportive facets were looked at in a very matter-of-fact spirit.

The goal was to provide a whole new perspective on the activity. Henceforth, the client would never again be able to slide from supper or studies to a bout of drug use without knowing every step of the way that he was violating a standard he himself set by coming into therapy. Some of the fun was taken from the activity by the microscopic examination that took place. The two young men became more like allies than co-conspirators. Later meetings showed a marked improvement in grades and a decrease in drug use.

It is, of course, very difficult to cull out what the key ingredients of change are, but within the paradigm of systemic therapy the above case highlights the "key change." The sound of impulsive laughter around a daring, illicit act was changed to a very heavy, ritualized march. In this movement is believed to be the essence of the behavior change.

The second case involved a clergyman who complained of feeling overwhelmed by a busy schedule and anxious about his performance of duties, which showed up in physical ailments. The fear of failing against the vague but insistent internal standard of selfless service was prevalent in the discussions.

It was decided immediately that invitations to slow down or set limits would be fruitless because it would grate against his conscience and also cause him to risk the admiration of those around him. The desire to admire is strong, and members of his congregation gave mixed messages that advised him to slow down, while applauding his overwork at the same time.

The client's frame of reference around the ideal of service required change, and symptom prescription (Watzlawick et al., 1974) was the tool chosen. He was sent away and asked to try harder still to please his constituency, the rationale being that if he simply worked harder he would in fact be able to both help and please everyone. It was suggested that only more work could lead to inner peace.

The third session began with his announcement that he would no longer be nice to everyone. He would simply do his best and if this did not please everyone he need no longer feel guilty. He was pleased with himself and said so, but the therapist expressed surprise and scant confidence that this was the type of behavior that could or should be continued. The client went on to list other areas where he felt he had reached his limit and would no longer carry on. He was dismissed with the therapist announcing confusion.

He returned for the fourth meeting rattling off six definite stances he had taken to reduce his feeling of being overwhelmed: (a) he complained directly during a sermon, for which he received rave reviews from the congregation; (b) he fired a lazy janitor and felt a sense of justice and satisfaction; (c) he spoke twice with superiors to clarify his areas of responsibility; (d) he met with teachers (he was a school principal) to establish better billing procedures; (e) the office workers were told that he was the supervisor and that they served as consultants and not peers; and (f) he sought assistance on management techniques from a parishoner who worked at a plant nearby as a supervisor.

The client was dismissed at the conclusion of the fourth meeting with an expression of some concern by the therapist, but with the invitation to recontact at his convenience later if he felt the need.

The key to change was entering a situation where someone had been encouraged by significant figures for years to slow down and take it easy while simultaneously being congratulated implicitly for pleasing everyone by overworking and backing down. He came for help because he sensed through allergies and stomach pains that he was losing control.

His pattern was not "confronted," but rather encouraged in a way that turned the emotional setting from righteous self-pity to one of determination. It fit the facts equally well, and allowed the client to generate a series of responses that extricated him for a pattern of compliance and overwork.

Research indicates that clients devote a limited amount of time to therapy. What systemically focused therapy offers is a perspective that enlivens clients through bypassing the intrapsychic concerns that are the domain of parents, friends, and colleagues. The therapist does not become caught in the tangle of discussing motives from the past or encouraging the client to simply stop doing what he or she already knows should be stopped.

In a word, systemic approaches are less culture-bound. They offer greater probability of actually catching the client's attention because they may not fit his or her accustomed perspectives or reasoning. In addition, the systems view can be just as congruent with the person's experience as intrapsychic terminology. They present an array of approaches to problem solving that demonstrate great promise.

Minuchin points out that this perspective requires a "quantum jump" to viewing dependency, aggression, and various attachments as interactions in the present rather than internal psychic phenomena (Minuchin, Rosman, & Baker, 1978). The point of intervention is no longer the individual, but the individual in his or her significant social contexts.

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Peer Attributions and Action Plans for Underachievement: Implications for Peer Counseling

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Students playing the role of peer counselors blamed failing students for their poor performances by attributing them to internal, controllable factors.

The attributions college students make for other students' academic failures have a variety of important consequences. A peer's perception of the causes of another student's failure may determine what advice he or she gives, how he or she perceives the ability of the other student, and how the other student experiences the failure (Frieze, 1980). Peers may also influence the causal attributions of other students both by their verbalizations and by the emotions they display (Weiner, 1980a,b; Weiner, Russell, & Lerman, 1979). When peers serve as peer counselors the attributions they make and action plans they suggest to other students are especially important (Alley, 1981; Durlak, 1979; Hinrichsen & Zwibelman, 1979). Peer advisors have been equated to faculty advisors and professional counselors in terms of their effectiveness as helping agents (Barrow & Hetherington, 1981; Brown & Myers, 1975; Durlak, 1979; Murry, 1972; Zultowski & Caltron, 1976). They often do academic counseling and work with underachievers (Andrews, 1981; Fineman, 1981; Moore & Delworth, 1976; Reinharz, 1979).

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