Self-management therapy had its beginning in an attempt to moderate the linear symptom-oriented approach to behavior therapy, by expanding both the theoretical base and the repertoire of strategies and procedures to include the cognitive and motivational domains as factors to be considered in the development of an individual treatment plan. Later, consideration of biological-emotional and socio-cultural factors were also added. They represent the most recent areas of interest and research in the field. They have not yet been fully integrated into a conceptual framework as the human system on which a comprehensive approach to therapy can be based, although considerable progress has already been made (e.g., Garber & Dodge, 1991; Greenberg, Rice & Elliott, 1993; Kanfer, 1992).

Some critical processes and domains form the core for therapy with most clients, strategies, timing, and priority of goals must be modified to meet the specific conditions of each case. While the basic task of most therapists is to help clients to alter their behaviors, emotions, thoughts and/or environmental settings, the specific goal state that is pursued will vary with the client’s developmental and biological history, her socio-cultural network and her own goals and values. In selecting treatment procedures from the vast resources provided by different theories and schools of therapy, the therapist must meet three criteria: (1) strategies and goals must match the individual client’s needs and abilities, (2) they must fit the institutional context in which the treatment occurs, and (3) they must suit the therapist’s own definition of her professional role and her personal convictions. Despite differences among schools of therapy, there are some assumptions about domains of psychological events and processes that are shared, albeit often expressed in different language, by most schools. These domains concern: 1) the client-therapist relationship; 2) the client’s motivational and emotional mechanisms; 3) the meta skills and skills of both client and therapists needed to move treatment toward a desired goal. In addition to these process-oriented domains attention must also be given to 4) the unique combination of experiences of the individual, the biological and socio-cultural status of the client, the context in which treatment occurs and the point in time that is most suited for various assessment and change processes. The idea has been summarized by the rule for clinicians: “Think globally, act locally.”

For each of the process-domains there are extensive literatures in psychology, psychiatry, and sociology that offer the basis for devising strategies and procedures to assist in the achievement of the subgoals both in the different domains and at various stages of change. These literatures not only provide suggestions for treatment procedures but may also help in the selection of realistic goals for clients with different histories, symptoms, motivations for therapy or socio-cultural contexts.

To be effective in each of these domains requires that the clinician be competent in three areas: first, knowledge of principles of change, strategies and methods; second, personal interactive skills; and third a sensitivity to the needs of the client and the context of his or her uniqueness and the current impact of the environment in which the client lives. This approach overlaps with the many characteristics defined as “prescriptive psychotherapies” (Beutler & Harwood, 1995). But there are practical limitations to the extent to which this idealized model can be applied. On the one hand, therapy should be designed for the individual client to maximize her potential and satisfactions, and must fit the therapist’s philosophy about the utility of therapy. On the other hand, technical or financial resource restrictions may force recourse to broad-spectrum, manualized treatment for specific pathophysiological behavior patterns, with a focus on rather modest immediate goals and with only the hope of eventual extension of treatment or self-guided psychological developments to reach more distal goals and to help the client to maintain a long-term, stable and effective living pattern.

In our approach, interventions in each of these domains are orchestrated to match two criteria: (1) they contribute toward progress on the general path of behavior change as prescribed by our self-regulation-based model for structuring therapy (Kanfer, Scheff, 1988; Kanfer Reinecker & Schmelzer, 1996), and (2) they fit the individual’s momentary status and long-term treatment objectives. In practical application, attention must be given to each domain to a different degree at various stages of treatment. Not only the client but also the clinician’s own history and perspective, shaped by training and/or adheren-
Difference schools of therapy will influence the extent to which each domain is emphasized. Because of space limitations, the following presentation will limit itself to describing general strategies with only few suggestions for specific methods. In most cases the step-by-step procedures can be found in the many texts and manuals on cognitive behavioral and interpersonal therapies. However it must be noted that our approach stresses a systems-orientation. This means that we assume that at each stage of treatment the selected strategies tend to interact with other factors. Therefore the outcome at each stage determines the choice for the next step. Nonlinearity, recursiveness, feedback and feedforward effects all characterize the structure of this dynamic approach to therapy.

Domain I: The Client-Therapist Relationship

Although recent technological advances in cyberspace are providing some therapeutic methods that do not involve direct contact with therapists, ultimately all treatments to date have taken place in the context of an interaction with a professional whose task it is to define the problem jointly with the client and to help her toward its resolution. A major problem in this domain often can be traced to both the therapist and the client’s difficulties in separating the specific roles designed for this interaction from roles, including emotions, reactions, and expectations, that have been experienced in previous extra-therapeutic relationships (Kanfer, 1994; Zimmer, 1983; Horvarth & Greenberg, 1994). Freud very perceptibly noted and named this phenomenon: transference and countertransference. Behavior therapists must also recognize the importance of generalizations from other human relationships into the therapy session for both the client and therapist. However, the issue on which behavior therapists differ from psychoanalysts is the extent and utility of this generalization for treatment. In self-management therapy much attention is given to this issue, from the therapist’s side during training to help trainees recognize the difference between the therapist’s professional role and personal contacts. In the former, the focus is primarily on assisting the client toward achieving a defined goal. But therapists also encounter patients who are similar in demographics, behaviors or emotional reactions to others with whom the therapist has had close contacts. This may tempt a therapist to forego the priorities defined by the therapeutic role and slip into the role of a friend, a parent, a judge or a teacher instead. Such temptation is even more difficult to resist when the client "sets up" the therapist for pursuing such a role. While deliberate and conscious uses of various interpersonal behavior patterns may represent part of a therapeutic strategy, they must never replace the therapist’s primary tasks as a "professional helper" who must not act for his own gratification but instead represents social, institutional and client interests aimed at ameliorating the client’s condition.

Across stages of treatment the main tasks in this domain are:

1. Develop trust and openness, show empathy, structure a communication system for a helping relationship, define roles and responsibilities with a unilateral focus on the client’s problems and difficulties. Inevitably, the client must also learn to alter her expectations of the therapist and recognize both the similarities and the differences of role-based expectations from extra-therapy relationships.

2. Utilize the relationship to assess the client’s interpersonal behavior patterns, attitudes and expectations outside therapy sessions by inference, and make some generalization of the client’s expectations and behaviors or from her outside experiences. On some occasions these tasks may also include redefining the therapeutic relationship for clients who have been in past unsuccessful treatment, have obtained distorted impressions of treatment relationships from reading or other sources of information. Failure in clear structuring of the relationship may result in blockage of therapy progress until the system is restructured. Only then can various therapy strategies be applied effectively.

3. Offer support, understanding and reinforcement but also attempt to alter client perceptions by presenting alternatives more adapted to the client’s socio-cultural setting and acceptable to the therapist as well. Combined with openness and empathy this task is sometimes implemented by variations of the socratic method, by mild provocations and many other communication techniques that guide the client toward cognitively restructuring interpretation of past experiences or current and further perspectives.

4. After establishing the necessary trust and free flow of communication the clinician’s task is to get the client to accept and act on jointly set goals.

5. As progress is made along the treatment path, the clinician gradually encourages the client to assume increasingly responsibility, reduces the “expert” image of the therapist, works toward reducing the client’s emotional ties to the therapist, encourages the building up of constructive outsider relationships, and reduces dependency or residual nonprofessional involvement with the therapist by strengthening the client’s autonomy and self-assuredness.

6. Helps the client resolve the bond and perceive the therapy relationship as a helpful but transitory experience.
Domain II: Motivation and Emotion

Unfortunately clinicians have taken over the use of the term "motivation" in a general and nonspecific way that has resulted in many misunderstandings and problems. Motivation is best defined by the person’s experience and disposition to direct actions toward a goal, to select such actions in competition with other tendencies and to sustain the orientation until the goal is obtained or abandoned. To understand therapy-relevant motivation therefore requires an analysis of the components that influence specific action tendencies, both momentary and enduring. We need to consider separately what moves the client to come for therapy sessions, what incentives are needed to change a long standing habit or to tolerate some anxiety associated with the change process, and to exert the efforts necessary to obtain specified goals. We must also ask whether conflicts exist between therapeutic goals and long-standing personal values. Unfortunately, even among professional clinicians the concept of motivation has been misunderstood. For example, we cannot speak of a non-motivated client since clients are always motivated for something. We must specifically ask sometimes what the client is motivated for and then attempt to relate such motivation to the changes associated with therapeutic success. Similarly, emotions have often been viewed as disorganizing, disruptive and incompatible with effective rational behavior. Although many clients must be helped to recognize the presence, nature and goal of their intense emotional reactions and the incentives and goals that motivate and direct their behaviors, it is not the elimination of emotional responding nor the rise in a presumed general level of motivation that is a task of therapy.

Across stages of treatment the main tasks in this domain are:

1. Assess degree of emotional control, including pervasiveness of intense emotional reactions or their absence, and the client’s capacity to monitor their feelings and emotions.
2. Assess concurrent, competing and hierarchically-structured motives.
3. Generate intentions (incentives), help clients to clarify goals implicit in their actions and expectations, and to verbalize their experienced emotions, moods and "urges". Help clients to acknowledge their presence and then use this information for action-planning.
4. Develop goal-states and consider paths to their attainment; differentiate proximal and distal goals.
5. Help the client to examine, clarify and evaluate her goals and long-enduring values and to consider their implication for required behavior changes.
6. Experiment with or sample goals states both in imagination and in a real context.
7. Support commitment to specified goals that are acceptable to both client and therapist by use of contracts and other means for commitment. Focus on anticipated gains and help clients solicit support for goal directed actions from persons in the social network and by structuring or seeking environments that provides such support.
8. Assist in reducing competing motives (e.g., fear of failure, abandonment of short-term satisfactions or other secondary gains through pathological behaviors or a patient role) and adjust the rate of change by small steps to result in the greatest self-efficacy and lowest cost to the client.
9. Anticipate early the need to develop procedures for maintaining the client’s motivation to continue newly acquired behaviors and for staying at the aspired goal level.
10. Integrate all of the above steps with the nature and intensity of the client-therapy relationship as one strong source of motivation for change.
11. Help client to acquire skills in recognizing and regulating both emotions and motives for long-term, post-therapy adjustment.

It should be noted that therapeutic improvement is dependent on changes in procedures and foci in the domain of motivation and emotion as the client moves across stages. For example, no motivation for change can be expected unless the client first develops some idea about desired goal-states and subsequently about some pathways to reach them. As stated in everyday language "you have to have a dream to make a dream come true". The dream must also be consistent with the person’s general values and past experiences. Only then the focus shifts to motivating the client toward enacting the plan. Further support is usually needed to maintain the changes in behaviors and cognitions necessary to carry out the therapeutic plan. These two separate stages have earlier been described by Heckhausen (1980) by separating the motivational process from the volitional process. In everyday terms, good intentions are important but not sufficient. The person must also be motivated to carry out the actions that lead to the goal.

Domain III: Metaskills and Skills

In contrast to the earliest behavioral approaches to therapy by conditioning methods, we assume that effective treatment helps the client to develop a series of metaskills that control a variety of psychological processes. They are designed to help him to modify current dysfunctions but also to become more effective in guiding his actions in the future. Thus the purpose of the treatment is not just...
a change in a specific response or symptom but the development of generalizable psychological skills that enhance the effectiveness of the client to direct and sustain his own cognitions and behaviors.

In our model, self-management and its components skills are essential for the client to initially work with the therapist. These include the client’s ability to assess his own behavior, assist in problem definition, develop and maintain new perceptions and actions and recognize the need for consistent evaluation and correction of one’s behaviors (Kanfer & Schefft, 1988). These self-regulatory skills, unfortunately, are usually not taught in schools and are acquired only experimentally over the person’s life. The basic self-management skills have been described in our previous work on the goal setting, self-monitoring and self-evaluative components of self-regulation (e.g., Kanfer, 1970; 1977; 1984; 1992).

Across stages of treatment the main tasks in this domain are:

1. Development of communication and interpersonal skills and sensitivities.

2. Self-management skills including:
   a. self-observation and self-focus;
   b. disruption of automatic processing;
   c. self-evaluation, with awareness of the importance of standard-selection; and
   d. self-reinforcement by use of appropriate emotional and mood-inducing cues.

3. “Aspirins” of therapy: symptom reduction by use of relaxation, skill training or anticipatory avoidance of anxiety-arousing cues and temporary removal from stressful situations are among the many possible skills that can be used early in treatment to help individuals find temporary relief and free them to actively engage in a change process.

4. Emotional regulation, for example by training clients to attend to and recognize danger signals and exercise anticipatory control strategies, by training them in post-awareness control of behavioral sequelae after emotional peaks, and by using mood control mechanisms such as deliberate training in “optimism”.

5. Use of imagination and role play for planning, problem solving and anxiety reduction and skill building by rehearsal.

6. Cognitive guides and restructuring by adopting a set of “think rules” (focus on specific behavior, on solutions, think positive and small steps, think flexible, and think future) (Kanfer & Schefft, 1988). Restructuring may also include training in “creativity” (openness and acceptance), risk-taking and experimental approaches to new ways of thinking and doing.

7. Enhance self-reliance with deliberate selection of supportive environments as needed, and train for relapse prevention.

In addition to the metaskills that may be useful for all clients, specific skills to remedy the client’s difficulties are trained by standardized procedures, for example by manualized procedures for assertiveness training and desensitization, among others. Individual skill-training can be added to supplement these standardized interventions.

I have described the main elements of most therapy procedures, aimed to enhance the patient’s capacities to use psychological processes and skills to alleviate complaints and optimize his effectiveness in daily living. The existing literature in psychology, psychiatry and biology offers innumerable resources for the adaptation of demonstrated relationships to clinical practice. Among these literatures are studies that increase our understanding of the functions and properties of emotions and motivation, their influence on the client’s change effort, the directive control of attention on behavior, the impact of social norms on goals and behaviors, the utility of reward-contingencies on learning new response, the differential effects of central and peripheral persuasion, the effects of mood on memory and many, many others. It is absolutely necessary that clinical training include awareness of these findings and prepare the clinician to apply such knowledge to optimize intervention procedures and their timing.

Domain IV: Individual History

In addition to improving the client’s capacity for enhanced self-regulation and training him in specific coping techniques that would anticipate and avoid future difficulties, the change process must also be embedded in the context of the individual’s history. Unlike the preceding process-defined areas this is the domain on which classical schools of therapy have based their theories, both for etiology and treatment of personality disorders. Childhood experiences, personal successes and failures, and other emotional events may certainly require analysis in order to understand their impact of the client’s strength and weaknesses or distortions in the other domains. However, we view these events not as directly and inevitable causal of current adjustment disturbances. In each case the nature and extent of their impact needs to be verified. And in each case the contents on which the preceding process domains are applied will differ; nevertheless, similar socio-cultural and biological contexts often lead to similar disturbances in relationship patterns, motivational direction and metaskills among individuals with similar experiences. For example, childhood abuse, different parent-child and sibling relationship patterns may result in the development of expectations and behavior patterns that may later be disadvantageous or pathological. In
each case, however, explicit demonstration of the connection is necessary before placing data from this domain at the top of the items requiring attention and resolution.

Across stages of treatment the following are some of the common themes and contents on which therapy centers across stages of treatment.

(1) Presenting complaints, reasons for coming now, why to this agency. History of previous therapy contacts, client’s expectations of treatment, client’s explanatory model of problem, client’s perceived and actual gains and losses associated with change.

(2) Familial, social, and vocational life context. Who are the client’s important heroes and models. What are her limitations in the biological, educational and socio-cultural areas, her special skills, talents and interests.

(3) Analysis of the client’s life sectors (work, intellectual, health, recreational, family, economic, sexual, social, self-care, personal achievement and social norms). Exploration of strengths and weaknesses in each area, extent of interference by client’s dysfunction in each sector.

(4) Plans, hopes and dreams of possible future states. Re-evaluation of various roles and relationships as the client changes; focus on session-to-session activities, experimentation with new behavior patterns and ideas, completion of task assignments.

(5) Planning for termination; relapse prevention. Anticipating future stresses and developing coping methods for them. Plans for maintaining improvement and enhancing future development.

It should be clear that the model described above is offered only as a resource for organizing therapeutic strategies for the individual case. It suggests some of the essential features in most treatments. The clinician’s perception of her role and her ethical responsibilities, the client’s cultural matrix and the institutional or treatment setting may restrict the number of features that have been listed here. It can also limit which components can be accommodated in the available time and result in greater focus on some components of our model than others.

If we highlight the absolute minimum requirement for a therapeutic intervention to be called effective and successful, it would be the joint setting of a goal that reduces the discrepancy between the client’s aspired and current state and satisfies to some extent the minimum requirements of what the client’s personal and social network demands of him. For some patients we may favor a focus mainly on symptom elimination, if it is believed that the client has the resources to make further progress later on his own and prevent relapse with minimal help. With others emphasis may be given to training metaskills or working through emotional and motivational components rather than focussing solely on behavior change. In all, rather than an offering highly structured and rigid step-by-step intervention program, we have presented a model that outlines what main components and in what sequence different therapy strategies need to be given attention.

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Literature


