ABSTRACT
Optimizing emotion and relationship management, Strategic Brief Therapy (SBT) focuses on the core mechanisms for human experience and behavior on the one hand and on the use of personal resources and skills on the other. The result is (a) the trichotomy of symptom-directed therapy, skills training, and personality or identity development; and (b) the emergence of SBT’s sixteen therapeutic steps ((1) assessment; (2) behavior and context analysis of symptom development; (3) biography and family; (4) needs, personality, survival strategy; (5) resource and goal analysis; (6) symptom-directed therapy; (7) affective therapy; (8) cognitive therapy; (9) coping with fear, need, anger; (10) coping with social situations; (11) letting go of old issues and coping with fear of change and failure; (12) personal values; (13) development as therapy; (14) automatization, generalization, self-management; (15) dissolving the therapeutic relationship; (16) relapse prevention, planning for the future). These steps in turn contain aspects of mindfulness, acceptance, exposure, and self-reinforcement as process components.

Keywords: Strategic Brief Therapy, mindfulness, acceptance, resources, affective therapy, survival strategy, identity development, symptom reduction

A. Introduction
Having applied a cognitive-affective developmental and systems-theoretical model to mental disorders (for more details, see Sulz, 1994; Sulz, this issue) and consequently derived theoretical implications for therapy (Sulz, 1996), clinical evidence now supports the corresponding cognitive-behavioral therapy approach, which will be described below.

The therapy assumes that the personality of an individual is a result of the interactions between a child with his or her inherent dispositions and the parents with their acutely traumatic or chronically frustrating parenting styles (Lewis & Miller, 1990; Sulz & Tins, 2000). The child’s

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1 The word “parent” is used throughout the translation to mean any man or woman who assumes parental responsibility toward a child (e.g., a grandparent, stepparent, adoptive parent, etc.).
still immature mind (Kegan, 1986; Piaget & Inhelder, 1981) is not able to respond to these threats and frustrations with already developed behavioral repertoires. Anxiety results and is alleviated by an array of avoidance responses. If avoidant behavioral patterns successfully reduce anxiety, they are learned; if they are unsuccessful, they extinguish; and if they increase anxiety, they are suppressed (cf. Reinecker, 1994). If need fulfillment corresponding to the child’s respective age and developmental level is lacking, the child expends extraordinary effort to satisfy the currently pressing needs. Most of his or her efforts are frustrated. A few, mostly child-inappropriate or – conversely – regressive behavioral patterns lead to success. These behavioral patterns move the parents to gratify the child’s need, and the behavior is reinforced (see also Petersmann, 1997). Even in adulthood, this need will be maintained as a primary reinforcer within the hierarchy of the motivational system. To understand the person’s subsequent responses, or to comprehend why he or she does or does not engage in particular behaviors, familiarity with the significance of the concrete situation as well as the reinforcer hierarchy is necessary (Bloschl, 1986; Ullrich & Ullrich, 1980). The sum total of these mostly trans-situational experiential and behavioral tendencies may be termed “personality” (Mischel, Shoda, & Smith, 2003). To the extent to which behavioral patterns correlate more strongly with the person than with any particular situation, one may term them “behavioral stereotyped” (Sulz, 2001). If these behavioral stereotypes produce considerable disadvantages for a person in the medium or long-term, then they are dysfunctional (Beck, 1979).

For our consideration, the distinction of conditioned behavior, which is accounted for by the psychology of learning, and rule-governed behavior is of major significance (Hayes, 1989; Hayes & Hayes, 1989; Hayes, Brownstein, Haas, & Greenway, 1996; Hayes, Strosahl, & Wilson, 2004). The latter suggests that not only dichotomous information processes such as “reinforced/non-reinforced” or “punished/non-punished” govern human behavior but that the mind integrates these learning experiences, e.g., into basic assumptions about the self and the world, and then derives general and situation-specific behavioral plans (Grawe, 1998). Both, i.e., Beck’s fundamental assumptions and Grawe’s behavioral plans, may be incorporated into a cognitive statement about the homeostatic regulation of the human mind: the survival strategy (Sulz, 1994; 1996). An interpretation in the context of self-regulation enables a categorization of Beck’s and Grawe’s views with Kanfer’s self-regulation approach (Kanfer, Reinecker, & Schmelzer, 1995).

Any human behavior that is observable in principle (i.e., ideally everything a person does, thinks, feels, or perceives) may be reduced to the homeostatic regulation described by the survival strategy. It is as important to determine what a person does not do, does not think, does not feel, does not perceive, when compared to many or a few other people in similar situations. According to our conceptualization, the avoidance and suppression of opportunities for experience and behavior following the traumatic or frustrating experiences described above are significant. In any given situation one must ask: What doesn’t this person perceive? What
doesn’t he or she think? What doesn’t he or she feel? What doesn’t he or she do?  
Acculturation and socialization processes require lasting inhibition and suppression of impulses that could potentially harm the self or the community. Among other things, this ability to inhibit characterizes a healthy human being. However, the ability to inhibit can only be developed once a certain developmental level has been reached (Kegan, 1986; Piaget & Inhelder, 1981). If this demand is placed on a child prematurely (i.e., the child is younger than three years of age), then he or she is able to meet this demand only via fear conditioning and the establishment of avoidance patterns that are relatively resistant to extinction. These learned patterns strongly determine the child’s later personality. In principle, an individual may deem the suppression of any kind of impulses and emotions necessary, joy as well as grief, love as well as hatred, liking as well as aversion. The suppression of tendencies for anger and attack are central, however. The stronger my anger, the more harm it may cause; the less developed my self-regulation skills, the more likely it is that anger, left unrestrained, may lead to harmful behavior. The less my self-image and worldview have been shaped by experiences indicating that the greatest anger still does not have to turn into a behavioral impulse, that I can keep my anger to myself, or that even intensive expressions of my anger do not cause harm in the world, the more credibility I will attribute to my fear that my anger will cause great harm. Thus, I must suppress this feeling and these impulses even more rigorously.

Our therapeutic assessment should capture the nature and the degree of suppressed anger and tendencies to attack as well as the nature, the flexibility or rigidity, the degree of maturity, and the effectiveness or the side effects of habitual inhibitory or suppressive patterns related to primary impulses. Together, the actual and the suppressed or avoided behavior give a complete picture of the individual. These assessments enable a categorization of behavior into dimensions of psychosocial effectiveness or ineffectiveness. As a matter of principle, we are able to explain situational failures prospectively and retrospectively in this fashion. If the dysfunctional proportion of these behavioral stereotypies dominates, then pathogenic life and relationship styles result and lead to symptom formation when specific triggering situations pose challenges that overwhelm the homeostatic system. The survival strategy’s rigidity prohibits the person’s adaptation to the situational tasks at hand and so necessitates symptom maintenance. The symptom or the symptomatic behavior is reinforced when with its help problematic life situations or constellations are overcome without having to alter the time-tested homeostatic mental system. Any disadvantages brought about by the symptom are more than outweighed by the advantages of maintaining intra-mental stability. The latter appears as the greatest good, as the fundamental guarantee for emotional survival.

An example may illustrate homeostatic self-regulation (Figure 1): A person’s self-conscious and dependent behavior serves to generate a rather self-confident vantage in others, from which they respond benevolently and acceptingly. In turn, the person’s fear of rejection and loss is reduced, and his or her need for affection and security is met.
If these individuals cease to respond in a fear-reducing or need-gratifying manner, or if a novel need comes to the fore, e.g., for autonomy and self-determination, then the probability of non-self-conscious behavior increases drastically and jeopardizes the survival strategy, such that symptom formation is the last resort and functions as a virtual "emergency break." Depressed or anxious behavior, or low back pain, forces these novel behavioral trends into the background. Interacting with people in the familiar self-conscious manner becomes possible again. The psychosocial homeostasis has been preserved.

A polarization of the initially introduced roles occurs over time as people tend to respond to any disruption in the homeostatic process according to the principle, "more of the same old," i.e., influencing the reduced benevolence of others by engaging in even more self-conscious and dependent behavior. Ultimately, this process will reach a point at which the costs greatly exceed the benefits of self-regulation as effected so far. Referring to the example described above, the maintenance of a sufficient sense of self-esteem or the suppression of the growing anger induced by constant frustration will become impossible at last. Finally, the homeostatic process will fail, and only symptom formation will be able to halt this escalation.

In the example, my partner needs me less, and I have become progressively unattractive in his or her eyes. There only appear to be two ways in which I may be able to preserve my sense of self-esteem: To leave him or her and then feel lost, or to express the full range of my anger and then feel culpable and lose all affection. I would not be able to emotionally survive either. The symptom frees me from the pressure to choose; it renders me, as the patient, unable to act and to decide. My environment is forced to acknowledge my symptom, and this initially occurs in a caring and affectionate manner. Now I am receiving differential treatment without having to change anything or myself. Some tasks are removed and novel entitlements without strings come my way. My self-regulation has regenerated an advantageous situation.

Nevertheless, I rightfully fear that I will have to forego these advantages again if my symptom disappears. And this I cannot afford.
The symptom and its immediate negative consequences considerably narrow the individual's mental functioning, often to an extent to which they make the psychotherapeutic process impossible. For this reason, symptom management is a required first step: Learning to cope with the symptom such that its negative effects are reduced to a point at which the psychotherapeutic process may occur. These considerations suggest that any intervention must occur at three levels (Figure 2):

**Figure 2. The trichotomous strategy of SBT**

1. Learning to cope with the symptom;
2. Establishing interpersonal skills that facilitate the building and maintenance of fulfilling relationships;
3. Personality development.

People who develop mental and somatic symptoms generally lack interpersonal competence. Even if excellent skills seem to be present at times, these skills are not available at the right moment; individuals are unable to apply them to the critical relationship. Because of this circumstance, it is worthwhile to analyze these deficits and practice the corresponding skills as soon as the intervention for symptom reduction permits additional time. Simplified, the questions are:
What does he/she do? What doesn’t he/she do? Avoidance.
What is he/she able to do? What is he/she unable to do? Skill deficits.

The main interest is in the interpersonal situation that led to symptom formation. Which concrete behavior would have been required to master this situation? What other situations are experienced as difficult, or as a setting for failure? What relationships are experienced as difficult? Which dysfunctional interpersonal and relationship patterns go unnoticed by the patient (and are only indirectly deducible from the patient’s reports)? Based upon Kanfer’s (1998) self-regulation model, we may distinguish three areas of interpersonal competence:
1. Observation of self and others (perceptual regulation)
2. Evaluation of self and others (behavioral and cognitive regulation)
3. Reinforcement by self and others (motivational and emotional regulation)

“Observation of self and others” implies the realistic perception of my own and others’ needs, fears, and emotions. “Evaluation of self and others” comprises the social and cognitive judgment of interpersonal processes as well as the situational appropriateness of my or others’ needs, fears, and behavior, but also the trans-situational internal establishment of my attachment figure as an invariant component of our lasting relationship. Reinforcement by self and others entails the effectiveness of my behavior, such as my ability to
• express feelings directly;
• behave in accordance with my affect;
• assert myself and to say, “no,”
• influence the behavior of my vis-à-vis;
• consider the needs, fears, and emotions of my vis-à-vis;
• argue;
• lose/fail;
• generate a balance between self and relationship-directed behavior;
• care for my relationships with an eye to the future and to enter lasting commitments;
• mourn a loss or a separation.

After the individual deficits and avoidance patterns have been assessed, the building of interpersonal skills may begin. Table 1 provides suggestions for this progress. The respective situation is practiced with role plays in session and as daily homework out of session. The practice is identical for deficits and avoidance patterns. On the one hand, practice reduces situational fears and avoidances; on the other hand it leads to the acquisition of new skills.
B. Strategic Brief Therapy (SBT): Planning content and designing individual sessions

**SBT: Outline of therapy progression**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
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<tbody>
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<td>1</td>
<td>Intake, assessment, diagnosis</td>
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<td>2</td>
<td>Behavior and context analysis concerning symptom development</td>
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<td>3</td>
<td>Organismic variable – history: Biography and family</td>
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<td>4</td>
<td>Organismic variable – current: Needs, personality, and survival strategy</td>
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<td>5</td>
<td>Analysis of resources, targets; therapeutic plan and contract</td>
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<td>6</td>
<td>Intervention for symptom reduction (mindfulness, acceptance, willingness, exposure)</td>
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<td>7</td>
<td>Affective intervention (deep emotional experience; affective coping)</td>
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<td>8</td>
<td>Cognitive intervention (modification, survival strategy; reevaluation)</td>
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<tr>
<td>9</td>
<td>Behavior change I: Novel management of anger, need, and fear</td>
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<td>Behavior change II: Novel management of social situations</td>
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<td>11</td>
<td>Resistance: Letting go, fear of change and failure</td>
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<tr>
<td>15</td>
<td>Dissolving the therapeutic relationship</td>
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<tr>
<td>16</td>
<td>Relapse prevention, planning for the future</td>
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**Table 1: Interpersonal Skills Training Practice**

<table>
<thead>
<tr>
<th>Problem situation</th>
<th>Significant person</th>
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<tbody>
<tr>
<td>His or her concern</td>
<td>His or her behavior</td>
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<tr>
<td>My interpretation of his/her behavior</td>
<td>My response so far</td>
</tr>
<tr>
<td>My deficit or avoidant behavior</td>
<td>What exactly will I practice (novel skills, now permissible behavior)?</td>
</tr>
<tr>
<td>How will I practice?</td>
<td>Where will I practice?</td>
</tr>
<tr>
<td>When will I practice?</td>
<td>How often will I practice?</td>
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<tr>
<td>Practice results:</td>
<td></td>
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The following sections detailing each topic are organized by topic number (in parentheses).

**SBT: Required duration of therapy**

On the average, five assessment (diagnostic) sessions plus 25 therapeutic sessions for a total of 30 sessions are necessary. Some topics (3-10, 13) require 100 minutes. While some therapists complete therapy in 40 sessions, others conduct 60 sessions, i.e., therapy is brief in the most optimal case, it is long in the most difficult case.

1. **Intake, assessment, diagnosis**
   - 20 minutes: The patient freely voices his or her concerns, to reveal him or herself in this way, as a human being with difficulties, his or her psychosocial problem and the symptom-evoking living situation.
   - The therapist does not ask any hypothetico-deductive questions.
   - 20 minutes: Mental and somatic assessment (possibly according to BDS14) (Sulz, 1999a).
   - 10 minutes: Diagnosis and differential diagnosis according to ICD-10.
   - Patient has completed BDS90 (symptom checklist) and BDS30 (personality scale)

2. **Behavior and context analysis concerning symptom development**
   a) Exploring the client’s living situation, including relevant relationships, at the time of symptom development (macro level)
   b) Exploring the client’s response chain (primary emotions → primary behavioral impulse → anticipation of consequences → secondary emotions → avoidant behavior → symptom → short-term consequence (micro level, see also Figure 3)
   c) Exploring the consequences of symptom formation on the macro level: What would mastery look like, what life event did the symptom prevent?
   (Proceed according to BDS21 (behavioral analytic interview) or *.ppt file2”analysis of symptom.”

3. **Organismic variable – history: Biography and family**
   The patient has brought the completed assessment questionnaire BDS1 to session, and the therapist has read it before session.
   - Vivid memories of the parents and their frustrating parenting behavior (possibly role-play)
   - Deep emotional experiences in childhood (frequently deep pain, anger, grief)
   - Promoting acceptance that I (after these experiences) have become the person I am today
   - Introducing the worksheets SBT06 and 07
   - If possible, maintaining a prolonged focus on and elaboration of the topic by assigning completion of the worksheet SBT20 (writing one’s life history) for homework

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2 These files may be ordered in *pdf format via email: SergeSulz@aol.com
Figure 3. Behavioral analysis (micro-level) example: Depression as avoidance behavior.

(4) Organismic variable – present: Needs, personality, and survival strategy
The patient has brought the completed worksheets SBT9, 11a, 11b, 13 and 18 to session. The therapist has copied them.

- Imagination: How does a lack of basic need gratification feel? In what context?
  - Generate a deep emotional experience in the subsequent processing period.
- Exploration: How have I coped with my need so far? What has the outcome been? How would I like to change this? What would I like to be able to do, achieve?
- An analogous procedure is applied to core fears, core anger, and the most important personality traits
- Summarizing the survival strategy
- My survival strategy: Its costs (what opportunities are lost?) – generate a deep emotional experience.
- How would I like to change this? What would I like to be able to do, achieve?

(5) Analysis of resources, targets; therapy plan and contract
The patient has brought the completed resource questionnaire BDS26 to session; the therapist has copied it. The patient has read the therapeutic contract and may have proposed changes (see Figure 4).

- What are the most powerful resources?
- Imagination: Being able to use these resources, associated emotions?
- Exploration: How may I use these resources, take them into difficult situations?
- Imagination: What is my life’s desire, my goal?
- Noticing somatic markers associated with wish fulfillment
- Outlining effective action toward goals (according to M. STORCH, 2004)
- Establishing a concrete plan for future resource utilization (what resources facilitate which goal?)
- Formalizing the therapeutic contract

![Figure 4. The cycle of motivation: From wishes and desires as central themes to need gratification.](image)

(6) Symptom reduction (mindfulness, acceptance, willingness, exposure, self-reinforcement)

First, it is determined whether routine behavior therapy has to be applied using a disorder-specific manual, or whether an intervention for non-specific symptoms is appropriate:

(i) Mindfulness: Noticing early signs of the symptom in a non-evaluative manner
(ii) Acceptance: Accepting the symptom and making space for it
(iii) Willingness: Choosing to stay in the situation, in the encounter with the symptom
(iv) Exposure: Feeling and tolerating the symptom and all associated emotions, the progressively increasing intensity, the long duration, and the slow reduction
(v) Self-reinforcement: I have managed to confront my symptom; even if I had difficulties, I am content with my achievement

(7a) Affective intervention

Strategies:
- Mindfulness and acceptance
- Exposure
Interventions:
• Microtracking: Deep emotional experience\(^3\)
• Coping with inappropriate emotions – not doing what the emotion wants
• Coping with appropriate emotions – behaving effectively\(^4\)

(7b) **Affective therapy (deep emotional experience)**
(i) The patient reports his or her currently most troubling difficulty
(ii) A **contract** is agreed upon that stipulates the patient’s tasks within the conversation:
   a) The patient will return to his or her painful emotions and images repeatedly.
   b) The patient is committed to engage in emotion work to bring about a good solution/perspective
   c) The therapist will accompany and follow the patient’s lead in the process

(7c) **Affective therapy (procedure – see also *.ppt file “Emotion work in VT”)**
• Noticing emotions
• Acknowledging the emotion-evoking context
• Understanding the relationships within which events evoke emotions
• Defining **cognitions** as mere thoughts
• Hearing cognitions as non-self-generated statements and as the internalized messages of significant others
• Expressing affect upon the articulation of these internalized messages
• Noticing **needs**
• Noticing who is responsible for satisfying the need
• Noticing the **frustration** associated with ungratified needs
• Remembering the learning history of these frustrations
• What was needed back then, and from whom?
• What would need-gratification have felt like?
• Visualizing wish fulfillment and remembering it as a vision
• Articulating goals that might lead to an approximation of this vision
• Planning steps toward change that facilitates the partial achievement of the goal

(7d) **Coping with inappropriate affect (mindfulness, acceptance, willingness, exposure, and self-reinforcement)**
The patient has brought the completed SBT-worksheet 13 to session.
• Imagination: A situation is chosen that evokes emotions which are subjectively interpreted as being too intensive.
   (i) Mindfulness: Noticing early signs of the feeling in a non-evaluative manner
   (ii) Acceptance: Accepting the feeling and making room for it
   (iii) Willingness: Choosing to stay in the situation, in the encounter with the feeling

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\(^{3}\) According to Pesso (2005)
\(^{4}\) According to Linehan (1996)
(iv) Exposure: Feeling and tolerating the emotion, the progressively increasing intensity, the long duration, and the slow reduction (without doing what the emotion suggests)

(v) Self-reinforcement: I have managed to confront my feeling; even if I had difficulties, I am content with my achievement

(7e) Coping with appropriate affect (mindfulness, acceptance, willingness, exposure, behavior, and self-reinforcement)

The patient has brought the completed SBT-worksheet 13 to session.

• Imagination: A situation is chosen that evokes emotions which are subjectively interpreted as being too intensive (anger, fear, grief)

(i) Mindfulness: Noticing early signs of the feeling in a non-evaluative manner
(ii) Acceptance: Accepting the feeling and making room for it
(iii) Willingness: Choosing to stay in the situation, in the encounter with the feeling
(iv) Exposure: Feeling and tolerating the emotion, noticing the impulse to act and making such action appropriate

(v) Effective action: Communicating emotional experience and its context as well as my concerns (demand or saying "no"); persisting until the other person is responsive

(vi) Self-reinforcement: I have managed to make use of my feeling; I have achieved a good result with which I am content

(8a) Cognitive intervention (reevaluation of self and world; modification of the survival strategy)

Strategies and interventions:
• Articulating the old self-image and worldview
• Formulating the survival strategy
• Enabling a wish for change
• Generating emotional distance from the old perspective
• Modification of the survival strategy or discovering a new survival strategy

(8b) Cognitive analysis (self-image and worldview, dysfunctional survival strategy)

The patient has brought the completed worksheets SBT16a and 16b to session. The therapist has made a copy.

• Once again, the patient is directed to notice the emotional significance of his or her core need and fear.
• He or she feels the imperative force of the proscription, "Only if I always…" and his or her prohibition, “and if I never …,” implied by the survival strategy
• Collaboratively, therapist and patient articulate the dysfunctional survival strategy in its final form.
• How well has it guided the patient in his or her life so far?
• What kind of life has been denied due to the survival strategy? (Enable feelings of longing and sadness!)
• Does the patient want to free him or herself from this shackle? May he or she choose to do so?
(8c) **Cognitive therapy (Reevaluation of self and world; modification of survival strategy)**

- Mindfulness: Non-evaluative attention
- Acceptance: I accept myself and others
- Resource orientation: I am present with my powerful resources (…)
- New self-image and worldview:
  - I can/have ….
  - You are …
- My new survival strategy is:
  - I trust myself and others and do not have to behave ______ in the future anymore;
  - I may have ______ feelings and will still be able to satisfy my core needs (…) without being delivered to my core fears/threats (…).

(9) **Behavior change I: General**

- Engaging in mindfulness
- Accepting that I used to behave in a ____________ way
- Change target (what?)
- Commitment to change
- Planning change (how, when, where, with whom?)
- Practicing change (role-play, mental training)
- Imagining success (positive somatic markers)
- Implementing the change (what was good, what could I still change and how?)
- Self-reinforcement

(9b) **Behavior change I: Learning to manage core fears**

- Engaging in mindfulness
- I accept that I am scared of … (core fear)
- I accept that I have managed my fear by (…) so far, even if I knew it was an irrational fear
- From now on, I will cope with my core fear differently by (…)
- Imagining the new management of core fear, the distancing of the feared event, and the perception of safety in the here and now.
- Noticing and remembering the positive somatic marker while imagining safety in the here and now.
- Implementation, evaluation of the result, and self-reinforcement

(9c) **Behavior change I: Learning to manage basic needs**

- Engaging in mindfulness
- I accept that I need … (basic need).
- I accept that I have managed my need by (…) so far.
- From now on, I will cope with my need differently (…).
- Imagining the new management of the need and the successful gratification of this need.
- Noticing and remembering the positive somatic marker while imagining
- Implementation, evaluation of the result, and self-reinforcement
(9d) Behavior change I: Learning to manage core anger

• Engaging in mindfulness
• I accept that I have the impulse to … (core anger) because of my anger.
• I accept that I have managed my core anger by (…) so far, even if I knew that this behavior was ineffective.
• From now on, I will cope with my core anger differently by (…).
• Imagining the new management of the core anger and the positive effect on me and my relationships.
• Noticing and remembering the positive somatic marker while imagining the positive effect
• Implementation, evaluation of the result, and self-reinforcement

(10) Behavior change II: Learning to manage social situations (relationship competence)

• Engaging in mindfulness
• I accept that I have interpreted situations as if (…) so far and because of this I have engaged in (…)
• From now on, I will interpret situations differently (…) and thus I will be able to engage in different behavior such as (…).
• Other people as well as I give me the right to act in this (…) way.
• Other people as well as I understand that I still need to practice the new behavior (make mistakes).
• Imagining the novel behavior and its positive effect.
• Noticing and remembering the positive somatic marker while imagining
• Implementation, evaluation of the result, and self-reinforcement

(11a) Resistance: Letting go and farewell, fear of change, coping with failure

Any resistance to novel behaviors is due to
a) failure to let go of old issues;
b) fear of change; and
  c) discouragement as a function of unexpected failures.

(11b) Resistance: Letting go and farewell

• Engaging in mindfulness
• I accept that resistance is occurring.
• What are the (actual) disadvantages of my novel behavior and its effects?
• What do I have to surrender, give up, let go in order to free myself for the path toward my goal?
• Imagining mourning for (…) (Worksheet SBT26)
• Accepting my grief for the loss of …
• Accepting life without …
• Remembering the positive somatic marker while viewing a life without …
(11c) Resistance: Discouraging failures

- Engaging in mindfulness
- Learning from mistakes: Did I evaluate the situation incorrectly? …
  Did I respond incorrectly? …
  Was my behavior clear enough? …
  What should I do differently next time and how? …
- Acceptance of the current failure
- Imagining novel behavior, failure and coping with failure (reevaluation, acceptance) (worksheet SBT31)
- Remembering the positive somatic marker while imagining the positive outcomes of my novel ability to cope with failure

(12a) Personal values: From need to value-directed behavior

- A need-directed person is subconsciously governed by his or her needs throughout life. He or she has only a few degrees of freedom in choosing a lifestyle and thus is frequently helpless in the face of failure
- Mindfulness and acceptance facilitate active coping with needs and fears. This generates energy and the freedom to build a life according to one’s own values.
- If a need is important to me, it becomes a personal value. However, I also derive values from my experience in the world. If I am able to manage my values in a directive manner and if my values constitute guiding principles for my behavior, then I am a value-directed person. I attempt to fulfill my life’s values and, within this context, I am free to choose a path of action.
- Values provide a future-oriented perspective, meaning, and fulfillment in my life. As values specify only a direction but no destination that I could ever reach in my lifetime, I can never lose my values.
- A mindfully performed value analysis (BDS33) may assist in the discovery of values and their examination as to balance, lopsidedness, or overemphasis.
- New behavioral goals that effect positive change in life and in important relationships emerge from values.

(12b) Personal values: From need to value-directed behavior

The patient has brought the completed BDS33-Value Analysis to session. The therapist has made a copy (see also Figure 5).

- Engaging in mindfulness
- Exploring and enhancing the personal significance of important values
- Accepting my values and my management thereof so far
- Imaging the fulfillment of important values (vision). Noticing the associated positive somatic markers
  - Which behavior patterns contribute to the fulfillment of these values?
  - Imagining value-directed behavior. Noticing the somatic markers associated with the
behavior. Maintaining the image until partial value fulfillment occurs in the short or medium term. Concluding the exercise with the initial imagination of fulfillment of my important values. Noticing and remembering the associated somatic markers.

- **Behavioral plan**: What will I do (including when and how) in a value-directed fashion?
- **Mental training**: Daily imagination of value-directed behavior, including noticing the positive somatic markers
- **Daily mindfulness** while observing one’s behavioral patterns
- **Daily recollection** of the value-directed behavior emitted during the day. Imagining the contribution to value fulfillment. Working with the experimental booklet SBT34
- **Perceiving feelings** of satisfaction and associated somatic markers

![Figure 5. The value cycle: Assigning individual priority to human values](image)

(12c) **Personal values**: Value balance

- Engaging in mindfulness
- **Filling in personal values** into the cycle of values
- Which poles of the value structure are well represented? How does this affect my life and my relationships?
- Which poles of the value structure are hardly represented? How does this affect my life and my relationships?
- **Accepting** my values so far
- **Exploring** the heretofore uncharted continents of my values. What attracts me, what frightens me, what leaves me indifferent?
• **Imagination**: If I had a magic wand and these values could be fulfilled without encountering anything frightful, then … Perceiving the associated positive somatic markers.

• Is there an opportunity to gain entry to novel value domains in a non-threatening way (concrete situation)? Am I tempted enough to give it a try?

• **Behavior plan**: What will I do when and how in a value-directed manner?

• **Mental training**: Daily imagination of novel value-directed behavior, including noticing the positive somatic markers

• Implementing new value-directed behavioral patterns

• Evaluation of these behavioral patterns and self-reinforcement

(13) **Development as therapy**

Behavior is not only conditioned: It also develops. It is not possible to modify an undeveloped behavior via conditioning or to cognitively regulate the behavior. Thus, therapy may have the additional task to facilitate the development of yet undeveloped experience and behavior. People who enter therapy frequently display insufficiently developed emotion regulation, cognitive self-regulation and behavioral repertoires as well as an underdeveloped relationship style and values system. The determination of therapy targets must consider whether these targets are attainable and functional at all, given the patient’s current developmental level (as if a person were asked to climb from the basement to a non-existing first floor while the stairs from the basement to the ground floor are also nonexistent).

For this reason, the developmental assessment (BDS31) should precede the setting of therapy targets. The introduction occurs with worksheet SBT22. Our approach is based upon KEGAN’S (1986) neo-Piagetian cognitive developmental model.

(13b) **Procedure: Development as therapy** (see also *.ppt file “Development”)

To transition from my developmental level number … (………………………) to the next higher level number … (………………………) (see Figure 6), I must learn to

• be able to: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

• not need anymore: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

• not fear anymore: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I will practice this in the following situation: . . . . . . . . . . . . . . . . . . . . . . . . . .

and with the following person: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I will behave and will be able to: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I will not need from the person: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

I will not fear with regard to the person: . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .
(14) Automatization, generalization, and self-management of novel experience and behavior

**Automatizing the novel behavior and experience**
- through practice and habit-building
- through reduction of competing behavioral patterns in the respective situations

**Generalization of novel behavior and experience**
- through transfer of responding to similar situations
- through definition of a class of situations for which this behavior is appropriate and success is probable
- through flexible variability in the behavior according to the differences inherent in appropriate situations

**Self-management of behavior and experience**
- by fading therapeutic support
- by the patient’s responsibly taking on decisions for change
- by self-evaluation and self-reinforcement

(15) **Dissolving the therapeutic relationship**

The termination of the therapeutic relationship already begins with the transition from external to self-management of the therapeutic process and the fading of therapeutic initiatives and activities.

**Farewell, grief, and separation**
- Feeling the emotional significance of the therapeutic relationship
- Mourning the loss associated with the end of therapy and the end of this relationship
- Deciding to dissolve the bond
• Maintaining the connectedness and availability in times of crises
• Engaging in an emotional farewell ritual
• Continuously noticing the many attempts to avoid the associated emotions
• Both patient as well as therapist engaging in this process

(16) Relapse prevention, planning for the future

Relapse prevention
• Which situation could trigger a relapse? ...........................................
• What do these situations have in common? .................................
• How can I cope with these situations? ............................... ..................................
• What responses signal a beginning relapse? ............................... ..................................
• What do these responses have in common? ................................. ..................................
• How can I cope with these responses? ............................... ..................................
• Mindfulness, acceptance, emergency kit, asking for help

Subsequent to therapy
• Discovering the therapist within
• Expanding the achievements rather than letting them fade away
• Transferring some of the qualities of the therapeutic relationship to a significant other person

Worksheets selected from Sulz’s (2002) Therapy Manual:

06 Parents
07 Frustrating parenting styles
20 Writing the life story
09 Core needs
11a Core fears
11b Core anger
18 substitute BDS30, possibly already in the diagnostic phase
13 My emotions
16a Survival strategy to date
16b Novel survival strategy
26 Letting go, mourning
27 Fear of change
31 Failures
34 Experimental workbook (including value-directed behavior)
22 Development
Additional SBT Scripts (*.ppt files, see also Sulz, 2001)

- Analysis of symptom
- Emotion work
- Resource utilization
- Development

Suggested questionnaires and interview schedules from the BDS-System (Sulz, 1999a; 1999b; 2005)

- BDS1 . . . . . . . . . . . . . . . . Assessment (history – life and presenting problem)
- BDS90 . . . . . . . . . . . . . . . . Symptom checklist
- BDS30 . . . . . . . . . . . . . . . . Personality scales
- BDS14 . . . . . . . . . . . . . . . . Diagnostic interview schedule
- BDS21 . . . . . . . . . . . . . . . . Behavior analytic interview schedule
- BDS26 . . . . . . . . . . . . . . . . Analysis of resources
- BDS31 . . . . . . . . . . . . . . . . Analysis of development (substitute SBT22)
- QMP04 . . . . . . . . . . . . . . . . Session feedback questionnaire (completed by patient)
- QMT04 . . . . . . . . . . . . . . . . Session rating (completed by therapist)
- QMT06 . . . . . . . . . . . . . . . . Relationship rating (completed by therapist)

In addition to these non-specific opportunities to change and develop the personality through training, more specific and individualized demands emerge from the concrete work with the patient during skills training. Thus, SBT maintains a balance of acceptance and change on the one hand as well as of emotional exposure and skills building on the other. Learning processes are facilitated while developmental steps are promoted. The development of self and relationships progresses. This psychoeducational approach may be applied in individual as well as in group settings. A combination of individual with group therapy is ideal, as the psychoeducational elements and the skills training are shifted to the group environment which provides additional opportunities for social learning and for the development of relationships. If different therapists conduct the group versus individual sessions, the patient is asked to brief the therapist in individual sessions on the results of each intermediate group session. Accordingly, a release for the exchange of information between individual and group therapists is obtained. Even without the use of these particular worksheets and questionnaires SBT may be conducted. In this case, the therapist is required to apply the planned therapy strategy within the context of the current therapeutic relationship and the interpersonal events in session. To this end, the complex structure of the patient’s mind must be actively and consciously available to the therapist. This availability develops with experience but is initially overwhelming. For this reason, the reader who is unfamiliar with SBT was provided with the psychoeducational version only, for which in-session written work is not necessary.
C. Recommended Literature

Therapy:

Assessment

D. References


• Sulz, S. (1999a). Verhaltensdiagnostiksystem (VDS) Materialmappe (VDS1-VDS17) [Behavioral diagnostic system (BDS) materials (BDS1-BDS17)].

• Sulz, S. (1999b). Therapieplanungsmaterialien (VDS20-VDS47) [Therapy planning materials Behavioral diagnostic system (BDS20-BDS47)].


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