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PART 1
DESCRIBING BEHAVIOR

Chapter 1. Topographical Aspects of Behavior

The task of clinical behavior analysis is to formulate the problem in a way that increases the possibility for change. The individuals who seek our help usually show up with their own idea or conceptualization of the problem, for example:

- Marie wants help to overcome her “lack of self-confidence.”
- The staff finds Jenny troublesome because she is so “self-destructive and manipulative.”
- Peter and Anna want counseling for their “hopeless marriage.”
- Leonard is referred to a therapist for treatment of his “persistent depression.”

Formulating the Problem

All of the statements above contain a problem-formulation—the kinds of formulations we use in everyday language. Professional language is often quite similar to this, even if different words are used. Let’s start by looking at Marie. What is she describing when she uses the expression “lack of self-confidence”?

> *I guess I’ve never been one of those who love speaking in front of a group. But it has gotten so much worse in the last few years. Now I can hardly sit down and have a cup of coffee with a colleague. It’s even hard to go out if I know that I’m about to see someone. The worst part about it is that I never know what they’re thinking. They must think that I’m kind of strange or something like that.*

Marie describes a number of behaviors:

- She avoids situations where she has to speak in public.
- She avoids having a cup of coffee with colleagues.
- She thinks twice about going out if she is going to meet people.
- She worries over what other people might think about her.
- She thinks that others might find her strange.

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To Marie's description, we could also add observations made by the therapist: while talking, Marie rarely makes eye contact and she tends to sit slightly turned away from the therapist. We now have started to formulate her problems in terms of observable behavior. It should be noted that most of these observations are not made by the therapist. They are made by Marie herself. The therapist has never seen her avoid speaking in public or having a cup of coffee. Neither has she seen Marie hesitating to go out. But we could assume that if the therapist were present in these everyday situations, these behaviors would be observable by the therapist. Marie, on the other hand, has made direct observations. It is her behavior. To call something *observable behavior* means that someone can actually observe the behavior in question. In a therapeutic context, this someone will most often be the client. This underlines the notion of therapy as a -collaborative task, where the therapist largely depends on clients' observations of their own behavior.

However, it is not the case that Marie comes to therapy with a list of observable behaviors that she considers the problem. Her definition of the problem is that she lacks self-confidence. When asked about her withdrawn and avoidant lifestyle, she explains, "It surely must be that I lack self-confidence somewhere deep inside." To her, the lack of self-confidence becomes a cause of her behavior.

Let's consider how we might detect this problem with self-confidence. How could we observe it? We can observe Marie's avoidance, her hesitance, her behavior in social situations. The more we observe, the more behaviors we will detect. But we will never actually see any "self-confidence."

We easily end up in circular reasoning when lack of self-confidence is treated as a cause of her behavior. How can we conclude that she lacks self-confidence? The only thing we can do is to return to what we can observe: her behavior!

But what about Marie herself? Can she observe her lack of self-confidence? The answer is the same—she can only observe her behavior. She probably will be able to observe some of the events accessible to an outside observer: that she lowers her gaze, that she avoids meeting other people, and so on. But she will also be able to observe events that are inaccessible to an outside observer: that she is thinking about things, that she is remembering things, that she is feeling something in a certain situation. But in those cases still, it is what she is doing that is being observed.

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The "self-confidence" that we so often refer to in everyday language is not there to be observed as a thing in itself, let alone a thing that one could have too little or have too much of. Instead we are referring to a label that may conveniently summarize a number of behavioral events. It is like a name. This name works in about the same way as when we use the word "bouquet" to denote a bunch of flowers that are put together in an arrangement. If we remove the flowers, the bouquet no longer exists. The bouquet was nothing in itself, but merely a convenient term to summarize what we could observe. It is important to note, however, that arguing that the bouquet does not exist as a thing is not the same as saying the word "bouquet" is meaningless. On the contrary, labels or words like "bouquet" allow us to conveniently talk about these flowers without referring to every single one of them as separate objects. Thus, this way of talking makes communication easier. However, just as a bouquet itself does not gather together a number of flowers, a lack of self-confidence does not set in motion a series of observable behaviors. This kind of reasoning, where we apply illusory explanations by simply naming phenomena, occurs frequently in everyday language. It should be noted, however, that it is also commonplace in psychological and psychiatric conceptual systems. Now let's take a look at Leonard's situation:

Leonard hasn't been outside his apartment for the last two days. He spends most of the time on his couch in front of the TV, flipping between the afternoon shows. He goes to the store only after running out of food or cigarettes. But he hasn't been eating well for the last few weeks. He spends most of the time ruminating over his divorce, thinking about what went so wrong between him and Tina. He told his brother that life feels so meaningless. If it wasn't for his kids, he'd probably just kill himself.

Again we have a description of a number of behavioral events. In this case, these behaviors are characteristic of Leonard's life at the moment:

- He rarely leaves the apartment.
- He spends time on the couch in front of the TV.
- He eats irregularly.
- He ruminates.
- He experiences lack of meaning in his life.
- He thinks about suicide and at the same time about his children.

So, we ask ourselves, why is he behaving like this? Because he's depressed. But how do we know he's depressed? Because he's … And again we come back to descriptions of behavior.

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Basically this follows the same logic as Marie's lack of self-confidence. We attach a label to a number of behavioral events and then come to see the label as the cause of those events.

Naming Is Not Explaining

Does this mean that a functional perspective is incompatible with using diagnoses in clinical case conceptualizations? Absolutely not. As previously stated, these labels are convenient terms and can be useful as such. It simplifies communication if we label Marie's difficulties as "social phobia" and Leonard's as "depression" instead of using a detailed list of observable behaviors when describing them. This, of course, assumes that we share a mutual understanding of these concepts with the listener. In the same way, it is easier for Marie to explain to a friend that she lacks self-confidence rather than stating all the behavioral events this term refers to. The problem that lurks among these abstractions is when they acquire a character as if they were something that Marie *is* or *has*, as if there were a property or thing inside her that could be treated as an entity separate from her behavior. It becomes even more problematic when this hypothetical entity is treated as an agent that is capable of governing the individual's behavior. Labels like these conveniently summarize, but they are not explanations.

Labels or concepts like these are useful because they can influence our behavior in a general way. If we are told that the person we will meet "suffers from depression" or "lacks self-confidence," this will probably influence how we act toward that person when we meet him or her. Although these general concepts speed up communication, they do so at the expense of individuality and detailed description. The word "bouquet" can correctly be applied to an armful of luscious red roses or a meager bunch of half-faded dandelions. If you want a bouquet to express your appreciation to someone dear, you'd be ill-advised to choose the latter even though you could, by indisputable logic, argue that they qualify as the same general concept as the roses: a bouquet. The problem with labels is that they may contribute to less effective action.

In psychotherapeutic settings, generally speaking, it is far from self-evident that these labels lead us to effective interventions. We do not know where the self-confidence is situated, and even less how to fix it when there is a "lack" of it. This puts us very much in the same position as Marie. Her self-confidence becomes a mysterious inner entity that needs to be repaired. But if we instead look to the list of observable behaviors, it becomes easier to identify strategies for change.

Covert or Overt: Is It Just Behavior?

It is common to think that focusing on behavior means that private events, such as thoughts and feelings, are rendered unimportant. This is definitely not the case, and we would like to expand a bit further on this. In the observations we have gathered from Marie and Leonard, we mention behaviors like worrying, thinking, and feeling. These are phenomena that are located inside the skin of these individuals. From a functional perspective, these phenomena are not special, that is, they are not uniquely different from other kinds of behavior. They are, just like the other observations, something that these individuals do. They are examples of *covert behavior*.

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The difference is that these private events do not lend themselves to direct observation by an independent observer. They are only accessible to direct observation by the person who is doing the behaving. To the rest of us, the private events can only become indirectly accessible when the person tells us about them or in some other way expresses what is going on beneath the skin. This does not render these observations less important. The difference lies in how easily they can be verified. Most of the time, it is easy to agree on whether a person cries or not, or if a person screams. But how can we agree on whether that person is mourning or feeling pain? We are still referring to something the person is doing, but this “doing” is not accessible to verification by an outside observer in the same way as the person’s *overt behavior*. If we, as outside observers, are to gain meaningful access to these inner observations, we must share the same verbal “code” as the direct observer. For example, when I feel anxiety, do I refer to the same inner sensation as you do when you say you feel anxiety? And how do I know that I am hungry in the same way as you are?

Now sticking to observable behaviors alone can feel incomplete. It is as if you miss something genuinely human that is inherent in the expression “self-confidence” or the graveness in “depression.” And, indeed, the phenomena we are referring to are not easily expressed in a few words depicting the person’s behavior. We can be sure that the more we pay attention, listen to, and talk with our client, the more we will be able to observe; a richer and more complex picture evolves. However, it is not a picture of some other kind of material. It is just behavior, but it is more behavior!

The Medical Model

Let’s consider the physician who has met a patient who complains about his throat aching when he talks. By our definition, the observation “experiencing pain while talking” would qualify as a behavioral event. In this scenario, the physician will probably look down the patient’s throat to see what it looks like. In clinical psychology, we have grown used to a similar practice in a metaphorical sense. Human problems are to be understood by looking into the individual in the search for an underlying pathological element. But when we do this in psychology, we tend merely to formulate hypothetical constructs—constructs that do not contain any further observations of what the person is doing or under what circumstances. The medical model (see fig. 1.1) rests on a rather straightforward logic, and this relatively simple model is considered integral to the success of Western medicine (Sturmey, 1996).

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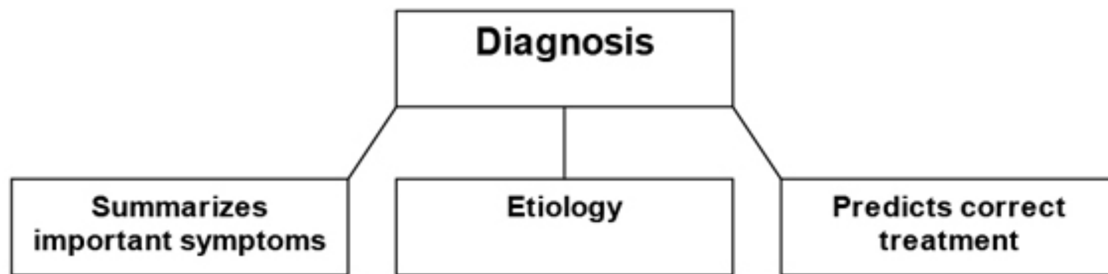
Figure 1.1 The Medical Model



The physician does his observations by noting symptoms (which may well be behavioral data). The patient tells him about his sore throat, and this could be supplemented by confirming redness and a whitish fur on the palate (symptoms). He assumes that this could be a case of tonsillitis, since all the symptoms seem to point in that direction. It would then be reasonable to conclude that the cause of this is the presence of streptococci (etiology). This could easily be verified by taking a throat culture. This additional information is, however, not behavioral data. What has been identified is instead something that could be regarded as circumstances under which the problem is likely to occur. The conclusion is that, to cure the infection, treatment with antibiotics would be a proper intervention. The medical model works in an impeccable fashion in this case. But what if Marie tells us about her feelings of insecurity in the presence of others, how she finds it difficult to express herself when she gets nervous, and how she dare not approach her colleagues during lunch breaks (symptoms). If we were to obtain further information about her fears and avoidance, we would be able to conclude that she suffers from social phobia (diagnosis). But what can we say about etiology? Our present knowledge might point in the direction of inheritance or learning factors, that is, her personal history or special circumstances in that history. But there is no objective indicator or special test to confirm that it was her lack of self-confidence or that she had a disordered self-image somewhere inside. When searching for this, we are, at best, just observing more behavior. At worst, we are just inventing new words.

From the general diagnosis, there are a multitude of possible therapeutic strategies. Even if we can give an authoritative recommendation on treatment of choice for social phobia, the diagnosis does not tell us a great deal of what the treatment will be specifically directed at in Marie's case. As you may notice, the medical model does not work as well in this instance. This has also been found to be the case with lifestyle disorders such as hypertension, obesity, cardiovascular disease, and so on (Sturmey, 1996). In spite of this, the medical model has had a huge impact on the field of psychological treatments across a range of theoretical orientations.

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This is true even among approaches that share few other common assumptions. In a functional model, we do not gather behavioral observations primarily for the purpose of classification. We do it for the purpose of understanding the nature of the relationship between the individual and the environment and through this understanding to better equip ourselves to contribute to a process of change. The topographical description of behavior will serve as a starting point for this.

And Thy Name Shall Be …

We tend to see the process of naming, or attaching the proper label to, human misery as a matter of great importance. This can easily acquire an almost magical property of being able to capture the essence or truth that lies hidden inside. We see evidence of this in Jenny's case.

> *At Jenny's ward, there has been a divisive argument over whether her "lack of impulse control" is a sign of a "borderline personality disorder" or if she is acting out in a "histrionically manipulative" fashion. Others insist that her problems are really a "prolonged adaptation disorder with narcissistic features." It seems almost as if it is impossible to agree because of professional differences.*

Whether Jenny cuts her wrists, yells at the staff, or collects the pills that are in her cupboard is not debated. These events are not only observable, they can also be agreed upon by independent observers. What is not hidden from the eyes is more easily agreed upon. Whether Jenny actually is sad when she says so is a question that can evoke many answers. The staff cannot, of course, see her "sadness." Jenny is the sole observer of her sense of sadness. The essential descriptive task in a clinical situation like this is not to decide what she is or has but rather to describe what she does.

Observing and Categorizing Behavioral Excesses and Deficits

To continue with our task, we need a way to organize the observations we make when we work on a viable problem-formulation. We make a basic distinction between behaviors that occur too frequently (excesses) and those that don't occur frequently enough (deficits) (Kanfer & Saslow, 1969). This distinction provides, at least at first glance, a relatively easy way of categorizing behavior.

Behavioral excess may be defined as a behavior or class of behaviors that can be considered problematic due to excess in frequency, intensity, duration, or to their occurrence in inappropriate situations. Here are some examples:___________

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- Hand washing twenty-five times a day (frequency)
- Hand washing with steel wool and detergents (intensity)
- Hand washing thirty minutes at a stretch (duration)
- Interrupting a conversation to go to wash one's hands because the topic could be considered "dirty" (occurrence in inappropriate situation)

A *behavioral deficit* is a behavior or class of behaviors that can be considered problematic due to deficits in frequency, intensity, duration, or their lack of occurrence in situations where they would be beneficial for the individual. Here are some examples:

- Washing hands once a week (frequency)
- Washing dirty hands without using soap or any cleansing product (intensity)
- Washing dirty hands for just a few seconds so they will not be clean (duration)
- Without washing visible dirt from hands, being seated at a formal dinner (lack of occurrence when it would be beneficial)

Thus, it is not the behavior of "washing hands" in itself that is the basis for categorization: it is the inappropriateness of the behavior in a given situation. In the previous examples, it is obvious that it is "too much" when we use the term "excess" and "too little" when we use the term "deficit." But does this mean that we have identified a norm for adaptive hand washing? How often do people wash their hands? Twice a day or five times a day? How long do they wash their hands? And what should be a normal cleansing product? Actually, we do not know of any data that could, in an objective way, tell us what the behavioral norm for all people should be. It is probably safe to assume that there would be substantial variation in what would be considered "normal." The examples above depart in an obvious way from what most of us would consider normal behavior, and that makes them easy to categorize as excesses or deficits, especially since these behaviors would have adverse consequences for one's skin, way of life, and social functioning.

An Excess—of What?

But where is the cutoff for an excess behavior, and where does a deficit begin? Can excesses and deficits occur together? Let's consider some examples. Jenny is cutting her wrists, which can cause a serious threat to her health. This is a behavioral event that is excessive as soon as it occurs. Once is enough to be considered too much. We would not consider wrist cutting in terms

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of relative variations in the population. It is not an act that, in principle, every person is expected to perform under certain circumstances and thus a problem only when it exceeds a certain frequency. Also, in clinical settings we are bound to consider it as behavioral excess due to its potential harmfulness in the same way that we are bound to consider drug abuse or physically abusive behavior as excesses. The laws and ethical guidelines we follow as clinicians lead us to define such behaviors as excesses regardless of circumstances.

Let's return to the problems of Anna and Peter and try working on a useful formulation of the problem. Their own formulation is that they have a "hopeless marriage." Here we immediately run the risk of perceiving their marriage as if it was a thing that had acquired a quality of hopelessness. You probably will not be very surprised when we advocate that a more viable avenue is considering what behaviors are getting in the way of them living happily together. The primary task will be to observe what they are doing. The available observations come from two perspectives: Anna's and Peter's. A third perspective can be added: observations made by the therapist.

When this couple is encouraged to define their relationship problems in terms of observable behaviors, Peter puts forth their frequent arguing (excess) that is followed by long periods of silence (here defined as excess, but it could equally well be understood in terms of deficit). He is sad that Anna does not want to have sex with him (deficit), and he does not think she shows him the respect he is entitled to (deficit). Instead, she continuously makes unreasonable demands of him (excess).

Anna, too, says that the worst part is the frequent arguing (excess) and the silence that follows. She says that she does not get any appreciation from Peter for what she does (deficit) and that he does not spend time with their daughter (deficit). Anna describes how she has to put up with him constantly working long hours (excess), and lately she has become really worried about his drinking habits (excess).

We have now taken a substantial step forward toward reaching a more viable formulation of the problem than their initial description of "hopeless marriage." But it is also an improvement over the label "relationship problem" that might be the label we would prefer as clinicians.

Another observation is made by the therapist. Both Anna and Peter's descriptions of problems include behaviors that the other person does, or they both do together. Neither identifies behaviors they do alone that could be causing problems. That is a deficit in both of their repertoires, noted by the therapist.

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When the couple is invited to comment on the other's description, they note that they agree on two things: the excessive arguing and the silence that follows. However, Anna says, "I just don't get why you have to bring that sex issue up when our relationship is the way it is. Sure, I respect that your work is important, but it is always given priority over us." And Peter comments, "Okay, I've been drinking too much lately, but the pressure has just been too much for me these past few months. But how can I spend more time with our daughter? As soon as I have a day off, you take Lisa and go over to your sister's place!"

Clearly they will also have comments on these comments and so on. We will, however, stop at this point and, like the therapist, note a behavioral excess for both of them: finding arguments in how the other's behavior causes problems in their relationship.

The issue of Peter's consumption of alcohol has also been raised, and it would be difficult to ignore this. So for a moment we put our analysis of the other problematic behaviors aside and focus on this. Anna says, "I think he's turning into an alcoholic." This is a profound concern for her, especially when taking Lisa into consideration. Now we are not primarily interested in what to call Peter but rather in what he does. In this case, what he does is drink alcohol. How do we assess what is "too much" in this case? Peter's drinking habits could be related to existing knowledge about average consumption levels in the population and to the existing knowledge of the risk for long-term adverse health consequences due to excessive alcohol consumption. From a functional perspective, yet another aspect becomes important. Both Peter and Anna define their quarrels as an excess that is definitely unwanted. These quarrels tend to occur more often in association with discussions connected to Peter's drinking: both discussions about his drinking and discussions that take place when Peter is under the influence of alcohol. Peter himself says he likes "to have a drink and relax," but when the actual consequences are examined, you will see that this is rarely the case. Drinks tend to be followed by fighting more often than relaxation. It could thus be argued that his behavior does not really work very well in regard to its desired effects. Neither does it work well in regard to other important objectives in his life. At this point, our topographical analysis has led us to functional aspects, and these aspects provide a further basis for categorizing Peter's drinking as a behavioral excess.

CATEGORIZING BEHAVIORAL EXCESS

We have now identified a number of grounds for categorizing behavior as an excess:

- It departs substantially from a generally agreed upon norm.
- It is associated with suffering and impairment of daily functioning.

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- It is associated with known health-related risks.
- It is a behavior that is attached to certain legal and ethical issues.
- It is a behavior that is incompatible with important values for the person.

This might give the impression that working with this kind of categorization results in well-founded and logically impeccable judgments, but this is hardly the case. If we meet a person who spends two hours a day showering, this is an obvious excess (given that the person does not have a very convincing explanation for this). If we, on the other hand, meet a person who showers for fifteen minutes every other week, we would probably agree that it is a deficit. But what's the normal rate? Well, we guess that most people would say once a day. Do we need to do this for our survival and to abstain from becoming socially repulsive? We doubt it! Is this a rate that is vital to our physical health? Hardly! But still, we tend to perceive this as a normal rate. This is worth considering since sooner or later we will run into this question: Who decides what is an excess and what is a deficit? Most often the answer will be that you do, together with your social group. Consider what is normal regarding the following:

- The frequency of intercourse with people other than one's spouse
- The amount of time a toddler's parent spends at work
- The duration of mourning after a broken relationship
- The extent to which deeply personal topics should be discussed in public

But if this kind of categorization is to a large degree subjective, should we even do it? The answer has to be yes, basically because it is not possible to avoid categorization. As humans, we assess, make judgments, and categorize. It is as though this is a fundamental part of being human. For clinical practice, it is important to do this in a way that it is open for discussion and criticism, and in a way that helps clients clarify what they are doing and what they want and need to change.

A Deficit—of What?

We can observe an individual's behavior and sense that something is missing. Take, for example, the depressed person's lack of activity, the shy person's short and quiet answers that make it hard to hear what he says, or the person who does not show up for scheduled appointments. Similar to the categorizations described above, we could take the same stance in regard to deficits. The individual does not perform or too infrequently performs behaviors that

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would be beneficial for health or social adaptation or that would be functional in the service of personal values. But would we be able to observe a behavioral deficit? It could be difficult, given it would require that we possess a thorough knowledge of exactly what behaviors should exist in an ordinary repertoire. What we can do, in collaboration with the client, is to state behaviors that would be functional in regard to desirable life changes. What are identified as behavioral deficits could actually be seen as ideas for behavior change.

Excess or Deficit—What Is It?

The distinction between excesses and deficits may seem straightforward and obvious. As we will see, however, making the distinction involves several decisions. The first decision is choosing one's perspective. Let's look at this in Alice's case.

> *Alice is in one of her "periods" when she avoids almost everything. "Nothing's working anymore," she says. For several months, she's had no problems going to work. But then all of a sudden she just feels unable to manage these trips, and when her fiancé doesn't give her a ride, she stays home. She says she has turned "antisocial" again. By this, she refers to the fact that she avoids being around people, even if these are coworkers or friends. She says that she doesn't want to have to explain to others "why I am like this."*

Let's go back to the task of observing. What does Alice do? Let's focus on two observations:

- She avoids traveling to work by herself.
- She avoids situations where there are plenty of people.

When confronted with the task of categorizing these and similar behaviors, the question arises: Are these excesses or deficits? She avoids too much, but that implies that she does not do certain things enough. This question is interesting because it turns our attention to the function of the descriptive analysis.

If, in Alice's behavioral repertoire, we identify a class of behavior that reasonably could be labeled "avoidance" and if these behaviors occur with a frequency that somehow is associated with impairment, they will fall in the category "excess." Our analysis will then focus on these and put them in a theoretical context where we can explain the function of these behaviors.

From a pragmatic point of view, however, in therapy it could be reasonable to talk of the same phenomena as "deficits." Alice rarely travels alone and rarely allows herself to be in social

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situations. By defining these as deficits, they are indirectly understood as behaviors where an increase in frequency could be assumed to be beneficial. So, in order to facilitate life changes, it seems more straightforward to do more of these deficit behaviors than to do less of the more abstract "avoiding." The categorization of deficit is also intuitively closer to Alice's own definition: "Nothing works anymore." Theoretically, though, we will be interested in understanding the class of "avoidance." Seeing this as an excess also guides the clinician toward the observation that "avoid" and "can't do" do not necessarily imply an absence of behavior. "Doing nothing" is often an extensive activity.

The Relation Between Excess and Deficit

Jenny's behavior is seen as very worrisome at the ward. Apart from cutting her wrists with whatever sharp objects she can find, she yells abusively at the staff and causes disruption by repeatedly requesting to leave the ward on her own. However, when these behaviors are not occurring, the staff describes her as "fairly invisible." She spends most of her time by herself but does very few activities. She seems to find it difficult to ask for things, whether it is ordinary things such as unlocking the kitchen or talking to a staff member when she doesn't feel good.

The behavioral excesses are obvious because they constitute a serious threat to her well-being and they are aversive to the people around her. In these cases, interventions are often directed at the excesses—interventions aimed at making her stop. But parallel to this, several deficits can be observed (see fig. 1.2).

Figure 1.2 Excesses and Deficits: Jenny

Excesses	Deficits
■ *Cutting herself* ■ *Yelling obscenities* ■ *Nagging*	■ *Spending time with others* ■ *Taking initiative to do things on her own* ■ *Asking for things*

Drastic excesses are always a reason for considering deficits in the behavioral repertoire. The connection between them also provides a ground for raising hypotheses about the function of these excesses. In the same vein, watching Alice, we can see the interdependence between excesses and deficits (see fig. 1.3). When one class of behaviors increases in frequency, it

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corresponds to decreases in another. This furthers the analysis by providing a basis for establishing their functional relationship to each other.

Figure 1.3 Excesses and Deficits: Alice

Excesses	Deficits
▪ *Worrying about her health* ▪ *Worrying about how other people might evaluate her*	▪ *Managing to get to her job on her own* ▪ *Being in social situations when there are plenty of people around*

Observing Emotions: How Does It Feel?

It might be worth taking a moment to consider what to do with the observation of emotions. We have gotten to know Marie who has defined her problem in terms of "lack of self-confidence." She also tells us that she "feels a lot of anxiety." This obviously sounds like an excess, though a covert one. But what is Marie observing? She senses something on the inside that her *verbal surroundings* (that is, the cultural context that uses a certain language) have taught her to label "anxiety." When does this become an "excess"? Well, we are now entering an area with a complete lack of normative data and explicit guidelines. How is life supposed to feel? Can we be sure that it really is anxiety she is feeling? The key here is that Marie describes her suffering, and this suffering poses an obstacle to the life she wishes to live. These are the kinds of things that bring people to seek therapy: the feeling is too much, too little, or maybe not there at all. We are constantly facing the questions of what is too little, too much, or if clients' emotions correspond with what they say they feel.

It could hardly be considered meaningful to try to settle these questions in an absolute sense. The client's report could in principle be regarded as valid. We would have a difficult time finding arguments to invalidate it. On the other hand, we should keep in mind the fact that what we label anxiety is simply one aspect of the problem-formulation, and it should by no means be regarded as the most central part. And it is important to note that when the intensity of feeling states is considered the problem, an intuitively tempting solution seems to follow, as we see in these examples:

- "If I only could get rid of this anxiety, I would be free from my problems."
- "If I only could feel motivated, I would get on with my life."

In reality, however, these intuitive solutions may be a part of the problem.

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How Much Detail Do We Need?

How detailed should an adequate description of behavior be? We said that Marie is isolating herself and suggested that this involves several behavioral events:

- She is most frightened of the informal meetings and lunch breaks at work.
- She always brings her own food to have an excuse to eat alone.
- She plans activities to keep herself busy so she has excuses for not going out after work.
- She stays away from situations where she thinks that her colleagues may bring up ideas about social activities.

We now have a more detailed picture than the description of "isolating herself." The isolating is not an event that is observable in itself but rather is a description that refers to a consequence (becoming isolated) of the behaviors above. Of course, it would be possible to go into more detail about how she prepares and eats the lunch she has brought with her and how she plans her activities. If we wanted to go into extreme detail, everything could be expressed as muscular movements. But there would be nothing gained at that level of detail. We need to be detailed enough only to get our analysis working, which means understanding what happens in a way that allows us to influence it.

However, we should be alert to the kind of abstractions that we get so used to that we tend to perceive them as if they were observable events: "acting out," "fulfilling needs," "forming attachment." Do we know what the person is doing when we use these phrases? We cannot teach clients to "fulfill" their "needs." We can, however, teach them a number of skills that would increase the likelihood of getting what they consider, or what is considered, to be needed. These skills need to be specified to the extent that we can perceive them as functional units at a level where they can be learned. Thus, the level of detail is governed by pragmatic considerations.

Hypothetical Constructs, or What About the Self-Confidence?

Nowhere in our descriptive analysis have we found that the client shows a deficit in "self-confidence" or an excess in, using rather circular logic, a "lack" of self-confidence. It is important to be alert to hypothetical constructs that do not add further observations. It is so easily said that the passive person has a deficit in "motivation," the anxiously withdrawn person has a deficit in "courage," and the person behaving angrily has an excess of "aggressiveness." But this restating is just another version of "naming," and, as we said earlier, naming is not explaining. A good rule of thumb is to search for verbs instead of nouns. Ask clients what they are *doing* rather than what they *are* or *have.*

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Functional for Life

In the process of clinical problem-formulation, we are moving from a diffuse and commonsense description of problems to a description expressed in terms of observable behavioral events in order to get a clearer picture of what the person is doing. But in order to decide whether these behavioral events are problematic or not, we need to consider what is beneficial for the person. Problem behaviors are behaviors that are dysfunctional in relation to living consistently with one' s own values and goals. Ultimately we want to promote behaviors that are functional in that sense. Functionality is not inherent in a behavioral event; it exists only in relation to something. We could assume that all behaviors are functional in relation to something, or else they would not be there. We are searching, however, for behaviors that could be functional for clients, in getting to the life they seek.

- *Marie would like help to overcome her lack of self-confidence. She thinks this would enable her to seek a new job. And she is so tired of feeling lonely and isolated on weekends.*
- *The staff is really worried that Jenny might seriously hurt herself. They've seen too many young girls develop cutting habits and wish that they could help her. Jenny herself wants to be discharged from the ward.*
- *Alice wants to be the way she was before she became so "anxious."*
- *Peter and Anna are not really sure what they want, basically because they thought the therapist's question "What do you really want?" was a prompt to come up with a solution to their problems. They agree, though, that if they didn't have the problems they have, they would like to be a family.*

At this point, we do not have exact and well-defined goals to govern the process of change. The formulation and mutual agreement on the goals for the therapeutic work is a later part of the clinical process. What we do have are rather vague formulations of a direction in which to go as we pursue our analysis. We need to clarify these formulations, and we learn more about how to do that in chapter 10. Let's now move on to the topic of how the temporal and situational variations can be used in the process of gaining knowledge of behavior.

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