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Family Consultation for Change-Resistant Health and Behavior Problems: A Systemic-Strategic Approach

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Summary

This chapter describes a systemic-strategic approach to change-resistant health and behavior problems that evolved from a couple-focused treatment for alcohol problems (Rohrbaugh, Shoham, Spungen, & Steinglass, 1995) we outlined in the first edition of the *Comprehensive Textbook of Psychotherapy*. Subsequently simplified and adapted to help couples and families cope with problems ranging from nicotine addiction, anxiety, and depression to heart disease, cancer, and dementia, this "family consultation" (FAMCON) approach now offers a conceptual and procedural framework for addressing a variety of individual and relational complaints that do not respond to first-line interventions.

FAMCON embodies a systemic (social-cybernetic) view of clinical problems and a team-based format for brief intervention based on that view. Case formulations take relationships rather than individuals as the primary unit of analysis and attach more importance to problem maintenance than to etiology. Interventions aim to interrupt two types of repeating interpersonal feedback circuits – *ironic processes* (when attempted solutions maintain problems) and *symptom-system fit* (when problems stabilize relationships) – as well as to mobilize *communal coping* by the people involved (when we-ness promotes change). The entire intervention format usually spans no more than 10 sessions over 2-5 months and consists of a semi-structured assessment phase, a focused feedback (opinion) session, and follow-up sessions designed to initiate, amplify, and solidify interpersonal change. Because the FAMCON approach requires multiple professional participants and labor-intensive treatment planning, cost-effectiveness is a key consideration. Indeed, most applications of FAMCON to date have occurred in university or medical school training clinics where cost was not an overriding factor.

Keywords: Family Consultation, Systemic-Strategic Family Therapy, Ironic Processes, Symptom-System Fit, Communal Coping

Historical Background and Evolution

The conceptual underpinnings of FAMCON date back more than 50 years to the beginnings of the family therapy movement (Hoffman, 1981). Borrowing ideas from cybernetics and systems theory, pioneers such as Bateson, Jackson, Weakland, and Haley observed that problems of health and behavior rarely occur in a vacuum, but persist as a function of ongoing close relationships, where causes and effects appear inextricably interwoven. In the 1960s, '70s, and '80s, groups of clinician investigators working independently in Palo Alto (Weakland, Fisch, Watzlawick et al.); Philadelphia (Haley, Minuchin); Italy (Selvini-Palazzoli et al.); and elsewhere systematized these ideas into distinct but interrelated models of therapy. Today the common elements of these pragmatic approaches continue to embody a relatively pure-form systemic paradigm defined by the core themes of *context*, *circularity*, and *pattern interruption* (Rohrbaugh, 2014). The *context* theme means that, to understand a problem, we first look around it, to the social processes that keep the problem going; and when stuck, we add people – both conceptually and in the consulting room. *Circularity* refers to the assumption that a problem or symptom both maintains, and is maintained by, the sequence(s) of interpersonal behavior in which it occurs. When one person has (or better, *does*) a problem, how do others respond – and how does this feedback help keep the problem going? The third core theme, *pattern interruption*, represents a necessary and sufficient condition for clinical change. Because patterns of social interaction maintain problems, identifying and interrupting those patterns should be sufficient to initiate change by altering the problem cycle and opening the way to progressive therapeutic developments. In contrast to most other therapy models, there is no assumption that pattern interruption requires insight, skill acquisition, or corrective emotional experience.

Taken together, these core themes imply that how problems *persist* – their maintenance and course – is more relevant to case formulation and intervention than is etiology or antecedent cause. Another implication is that what people *do* with each other is more relevant to therapy than internal processes such as what they think and feel. For example, internal or dispositional constructs like attachment style, biological temperament, trauma residue, or even social learning history do not fit well with this paradigm because they risk drawing the clinician's attention into the individual or back to the past.

A Systemic Couple Therapy for Problem Drinkers

In the early 1990s, for a research project comparing family-systems and cognitive-behavioral treatments for alcoholism, we attempted to integrate key ideas and techniques from then leading family therapy approaches to alcohol problems. Thus, from Steinglass et al.'s alcoholic family model we drew the concepts of family-level detoxification, couple identity, and alcohol as an external invader of family life; from Fisch, Weakland, et al.'s brief strategic therapy came an emphasis on interrupting ironic problem-solution loops and framing suggestions in terms consistent with clients own preferred views; and from the solution-focused therapy of DeShazer, Berg, Miller, et al. we adapted techniques to identify and reinforce client strengths. As if this were not enough, the resulting systemic treatment manual also incorporated therapeutic neutrality, circular questioning, a brief family genogram, externalization tactics to build couple collaboration against alcohol, and structural/strategic family therapy techniques to counter resistance and restabilize the family system later in therapy (Rohrbaugh et al., 1995).

Ideally, this therapy occurs in three phases: In an initial *consultation phase* (sessions 1-6), the therapist conducts a systemic assessment, begins to intervene indirectly using circular- and solution-focused questioning, and in a carefully prepared feedback (opinion) session offers the couple "treatment" while remaining neutral about whether they should choose it. If both spouses accept, the *treatment phase* consists of "family detoxification" and therapist-initiated intervention to alter couple interaction patterns that help to maintain drinking. The final, *restabilization phase* aims to restabilize the family system without alcohol and prevent relapse. Throughout therapy, a key principle is to avoid confronting resistance or denial directly. Thus, if resistance arises during the treatment phase – or if the couple does not choose treatment in the first place – intervention shifts to strategic and structural tactics (framed as *continuing consultation*) such as prescribing a controlled drinking experiment, intensifying the restraint-from-change stance, seeing the spouse alone, or involving other family members or friends. The main goal of these tactics is to lead couples back to family detoxification, or failing that, to provoke change directly.

In retrospect, the implementation of this integrative treatment package was only partially successful, but lessons learned proved crucial to the evolution and broadened application of FAMCON (Rohrbaugh & Shoham, 2002). Although more than half of the 39 male-alcoholic couples who entered the systemic treatment completed the full 20-session regimen with at least moderately positive drinking and relationship outcomes, the fidelity of implementation by the master's level clinicians we had trained proved quite uneven. For example, therapists implemented some components of the integrative model more effectively than others, and the accessibility of familiar and/or well specified procedures (e.g., doing a genogram or contracting for family detoxification) sometimes seemed to undermine effective implementation of other, more central or exacting components (e.g., tracking and interrupting ironic problem-solution loops). In any case, analyses of case records and videotaped therapy sessions indicated that therapists' adherence to the manual and successful implementation of its main components predicted successful outcomes.

Fidelity difficulties also highlighted limitations of our integrative approach to treatment development. For example, because the models we drew upon call attention to different clinical phenomena (e.g., hypotheses about adaptive consequences of drinking vs. descriptions of problem-solution loops) and prescribe starkly different therapeutic actions (e.g., neutrality, advocacy of family detoxification, strategic restraint from change) depending on the clinical situation, our manual-based rules governing which concepts and techniques to invoke in which circumstances were difficult for therapists to understand and apply. For subsequent applications of FAMCON, it therefore seemed imperative to simplify both the conceptual framework for understanding systemic problem maintenance and the associated clinical guidelines for promoting pattern interruption.

A final lesson was that developing a viable formulation of problem maintenance and using this to plan a successful feedback/opinion session and pattern interruption strategy proved very difficult for therapists to do independently. In almost all cases this required some degree of supervisory input, and the most compelling instances of feedback and treatment planning seemed to emerge from group brainstorming by multiple project therapists and at least one supervisor. We subsequently came to regard FAMCON as an inherently multi-headed clinical endeavor, discouraging attempts to implement the entire package on a solo basis. In addition to generating more coherent case planning, the team approach presents avenues for strategic management of

resistance to change (e.g., reflecting team interventions, split opinions about the possibility or advisability of change), as case material below should illustrate.

FAMCON for Other Health Problems

Later in the '90s, and into the new millennium, we experimented with using FAMCON teams to address a variety of other problems, most of which referring clinicians considered "difficult" by virtue of not responding to other, often individually focused interventions. The organizational context for this was the University of Arizona's Psychology Department Clinic, where doctoral students and faculty could work together in a live-supervision (one-way mirror) set-up with selected cases.

One particularly formative project involved a series of cases we saw in a Family Neuropsychological Consultation Clinic, where complaints concerned adjustment to neurological problems such as Parkinson's disease, Alzheimer's disease, traumatic brain injury, and surgical intervention for brain cancer. The complaints themselves ranged from aberrant patient behavior to relationship conflict and debilitating caregiver distress. The teams for these cases included two neuropsychologists, two family psychologists (MR and VS), and several neuropsychology graduate students interested in broadening their intervention skills. After conducting conjoint and sometimes individual interviews with relevant members of the client system, the team would construct and deliver a carefully prepared expert "opinion," with suggestions designed to interrupt or reverse some specific sequences of interaction we thought helped to maintain the complaint behavior. Case formulations typically centered on interpersonal *ironic processes*, which we identified by investigating family members' well-intentioned, repeated, but ultimately unsuccessful "solutions" to whatever the problem was (e.g., trying to reason with a demented loved one, over- [or under-] controlling the patient's living environment or daily activities, over-functioning as a caregiver at the expense of self-care). An important piece of each opinion involved framing suggestions for change in a manner consistent with observations about indications and functional limitations imposed by the patient's neurological condition, as well as with family members' preferred views of themselves and the problem for which they sought consultation. Although opinion/feedback sessions were rarely sufficient in and of themselves to instigate "less of the same" solution behavior (and thus break the problem cycle), the usual result was at least some perturbation of problem maintaining interaction patterns, which the team could then use to adjust intervention strategies and amplify incipient change over a limited number of follow-up sessions. Of the 10 cases we saw in this format, virtually all evinced at least modest improvement in the presenting complaint.

Unfortunately, due to competing commitments, the neuropsychology consultation project did not continue beyond the 1998-99 academic year, but later in 1999 we began a NIDA-funded treatment development study of FAMCON for health-compromised smokers (Shoham, Rohrbaugh, Trost, & Muramoto, 2006). This open trial ultimately provided the most systematic data we were able to obtain on the process and preliminary outcomes of the FAMCON intervention. Later, when the smoking project was complete, we returned to investigating FAMCON with a variety of other problems, albeit in a less systematic way (Rohrbaugh, Kogan, & Shoham, 2012).

FAMCON for Health-Compromised Smokers

The background for our interest in smoking was that evidence-based interventions for this pressing health problem, while only modestly successful, focused almost exclusively on the individual smoker, even though a substantial body of research indicated that social support from significant others, especially spouses, strongly predicts whether smokers will be able to quit and stay abstinent. Interestingly, however, clinical trials of behaviorally informed “social support” interventions based on teaching partners better support skills have yielded consistently disappointing results (Park, Tudiver, Schultz, & Campbell, 2004; Rohrbaugh et al., 2001), apparently leading the Public Health Service (PHS) Clinical Practice Guideline panel to exclude relationship-focused interventions from their best practice recommendations (Fiore et al., 2008).

From a systemic viewpoint, the failure of one-size-fits all skill training or problem solving is not surprising and should not deter efforts to develop effective couple-and family-level interventions for change resistant smoking. The main limitation is that these interventions did not typically address couple-specific relationship patterns that facilitate or hinder stable cessation (Shoham et al., 2006). For example, teaching skills and problem solving strategies in group formats can easily detract attention from how particular support behaviors function in a particular couple: Thus, in one couple, a spouse’s persistent positive encouragement to quit might provoke resistance, while in another a spouse’s refusal to allow smoking in the house (counted as “negative” support in some studies) could actually function to help a smoker stay abstinent. In addition, some of the psycho-educational social support programs mixed dual- and single-smoker couples in the same treatment group, while others made little distinction between committed partners and other relatives or acquaintances.

Taking couple relationships as the primary focus of intervention – and drawing on accumulated experience with prior FAMCON projects – we proceeded to develop and pilot test a FAMCON intervention for couples in which one partner (the primary smoker) continued to smoke despite having or being at significant risk for heart or lung disease, and despite receiving repeated medical advice to quit. Based on social-cybernetic and family systems principles, the FAMCON approach to smoking cessation is substantially different in concept, format, and technique from the social support interventions that had been tested in the past. The preliminary results were promising in that 50% of the primary smokers achieved stable abstinence over at least 6 months, a rate that compares favorably to cessation benchmarks in the literature, especially for smokers initially unmotivated to quit. The results also suggested that FAMCON may be particularly well suited for female smokers and patients in dual-smoker couples, two groups at high risk for relapse (Shoham et al., 2006).

Principles of Case Conceptualization and Change

As noted above, principles of case conceptualization follow from systemic and cybernetic assumptions about problem maintenance and change. Weakland, Fisch, Watzlawick, and Bodin (1974) stated the core assumption as follows:

> *Regardless of their origins and etiology—if, indeed, these can ever be reliably determined—the problems people bring to psychotherapists persist only if they are maintained by ongoing current behavior of the client and others with whom he interacts. Correspondingly, if such problem-maintaining behavior is appropriately changed or eliminated, the problem will be resolved or vanish, regardless of its nature, or origin, or duration.* (p. 144)

In other words, following our definition of “systemic” above, problems of health and behavior do not occur in a vacuum (context theme) but persist as an aspect of current close relationships in which causes and effects appear inextricably interwoven (circularity theme), with one person's behavior setting the stage for what another person does, and vice versa, in ongoing, circular sequences of interaction. It follows, therefore, that simply breaking these interactional circuits (pattern interruption theme) should be sufficient to change the problem.

The term *cybernetic* highlights the circularity of interpersonal systems in which the social effects of some problem behavior feedback to modify, control, or regulate that very same behavior. Because behavioral feedback circuits outside the skin are less familiar than internal, physiological ones (like homeostasis in clinical biology), we add the modifier *social* to underscore the primacy of feedback-control circuits operating between people rather than within them. A *social cybernetic* view thus takes relationships rather than individuals as a unit of analysis and attaches much more importance to problem maintenance than to etiology. Note, too, that this view departs from the familiar stress-vulnerability model by downplaying linear causality and blurring the conceptual boundary between an individual patient and factors such as stress or support in his or her social environment.

A key distinction in the cybernetic framework is between *positive and negative feedback* circuits, which in the clinical realm embody two patterns of problem maintenance we call *ironic processes* and *symptom-system fit*, respectively. In technical terms, a positive feedback cycle denotes enhancement or amplification of an effect by its own influence on the process that gives rise to it (e.g., an arms race, or amplifier gain in electronics), whereas negative feedback refers to the dampening or counteraction of such an effect (e.g., the operation of a simple thermostat, inhibition of hormone secretion by high levels of other chemicals in the blood). Importantly, cybernetic usage of the term negative feedback has little to do with giving or receiving criticism, and positive feedback relates only tangentially to reinforcement or praise. On the other hand, positive close relationships do matter: In fact, a crucial flip side of social-cybernetic problem maintenance is that positive, collaborative relationships not only confer health benefits but also provide a powerful resource for change. For this reason, in addition to pattern interruption, the FAMCON approach places special emphasis on cultivating *communal coping* by the people involved.

Ironic Processes

Ironic processes are deviation-amplifying positive feedback cycles that occur when well-intentioned, persistently applied solution attempts keep problems going or make them worse. Although social psychologist Dan Wegner first used the term “ironic process” to describe ironic *intra*personal effects of attempted thought suppression on mental control, this idea captures a much broader range of clinical phenomena, including interpersonal ones, described decades earlier by family therapists at Palo Alto’s Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974) – and from a systemic perspective, ironic processes occurring between people have greater clinical significance than those occurring within people (Shoham & Rohrbaugh, 1997). In couples, for example, urging one’s partner to eat, drink, or smoke less may lead him or her to do it more; protective attempts to avoid conflict or hide negative feelings may lead to more partner distress; encouraging a depressed partner to cheer up can inadvertently promote more despondency; or attempting to resolve a disagreement through frank and open discussion may serve only to intensify conflict.

Ironic processes persist because problem and attempted solution become intertwined in a vicious cycle, or positive-feedback loop, in which more of the solution leads to more of the problem, leading to more of the same solution, and so on. Most important, specific formulations of ironic problem-solution loops provide a useful template for assessment and strategic intervention: They tell us where to look to understand what keeps a problem going (look for *more of the same* solution) as well as what needs to happen for the problem to be resolved (someone must apply *less of the same* solution). When pattern interruption happens, even in a small way, more virtuous cycles can begin to develop, leading to further positive change (Rohrbaugh & Shoham, 2001).

Interestingly, certain paradoxical interventions – injunctions in apparent opposition to therapeutic goals yet actually designed to achieve them – can help to interrupt persistent problem-maintaining solutions and cut ironic processes at their joint (Shoham & Rohrbaugh, 1997). Unfortunately, although featured in our earlier work, we came to view the term "paradoxical intervention" as problematic because it lumps together interventions based on different rationales (e.g., compliance and defiance), elevates technique over formulation, and tends to privilege processes occurring *within* people over what happens *between* them. The *ironic process* rubric is more compelling, both conceptually and pragmatically.

The following vignettes illustrate how ironic positive-feedback loops can help to maintain change-resistant smoking:

- *A husband (H) smokes in the presence of his non-smoking wife (W), who comments how bad it smells and frequently waves her hand to fan away the smoke. H, who had two heart attacks, shows no inclination to be influenced by this and says, "The more she pushes me the more I'll smoke!" Although W tries not to nag, she finds it difficult not to urge H to "give quitting a try." (She did this when he had bronchitis, and he promptly resumed smoking.) Previously H recovered from alcoholism, but only after W stopped saying, "If you loved me enough, you'd quit": When she said instead, "I don't care what you do," he enrolled in a treatment program.*
- *H, who values greatly his 30-year "conflict-free" relationship with W, avoids expressing directly his wish for W to quit smoking. Although smoke aggravates H's asthma, he fears that showing disapproval would upset W and create stress in their relationship. W confides that she sometimes finds H's indirect (nonverbal) messages disturbing, though she too avoids expressing this directly – and when he does this she feels more like smoking* (Rohrbaugh et al., 2001, p. 20).

A central aim in FAMCON is to identify and interrupt ironic positive-feedback circuits such as these. To do this, the therapist-consultant must (a) accurately identify particular solution efforts that maintain or exacerbate the problem (here smoking), (b) specify what less of those same solution behaviors might look like (the strategic objective), and (c) persuade at least one of the people involved to do less or the opposite of what they have been doing (Fisch, Weakland, & Segal, 1982; Rohrbaugh & Shoham, 2001). As it turns out, most ironic patterns tend to involve either doing too much (commission), as in the first example above, or doing too little (omission), as in the second. Thus, if the main thrust of a spouse's solution effort is to push directly or indirectly for change – and this has the ironic effect of making change less likely – doing less of the same might entail declaring helplessness, demonstrating acceptance, or simply observing. In

contrast, if the spouse's main solution is to *avoid* dealing with the smoking, the consulting team will encourage more direct courses of action, such as gently taking a stand. Interestingly, compared to the alcohol-involved couples we studied earlier, our sample of couples with a health-compromised smoker tended to show more ironic patterns centered on avoidance and protection than on direct influence. Consequently, interventions with smoking couples more often aimed to *increase* partner influence attempts than to decrease them.

Symptom-System Fit

The second social-cybernetic pattern, *symptom-system fit,* refers to deviation-minimizing negative feedback cycles, where enactment of a symptom or problem appears to preserve some aspect of relational stability for the people involved. This form of problem maintenance, emphasized by family therapists such as Jackson, Haley, and Minuchin, relates to the interpersonal functions a problem may serve, not for the problem bearer as an individual, but for the current close relationships in which he or she participates. For example, a problem may persist because it provides a basis for the short-term preservation or restoration of some vital relationship parameter (e.g., marital cohesion, conflict reduction, engagement of a disengaged family member) in a kind of interpersonal homeostasis. Thus, in couples where both partners smoke, drink, or overeat, shared indulgences might create a context for mutually supportive interactions or help partners remain connected, even when they disagree – or cohesion in other relationships may depend on sharing concerns about health. Alternatively, a young person's somatic symptoms (or misbehavior) could provide a focus for detouring parental conflict, activating a depressed caretaker, or justifying a grandparent's involvement. In each of these examples symptoms serve to regulate relationship patterns, and vice versa.

These vignettes illustrate symptom-system fit in couples where both partners smoke:

- *H and W have an early morning ritual of smoking together in their garage on favorite lawn chairs. W says smoking together is the only thing H will let her initiate: "If we didn't smoke in the garage I doubt we'd talk much – and he wouldn't even miss me". When the couple does talk, W feels that H calms her down – and they mostly talk when they smoke. W had quit smoking some years previously but resumed "because I felt such a distance between us."*
- *H and W have mostly non-smoking friends but say, "We enjoy our forbidden pleasure together. We like being outside the mainstream." W says, "If one of us quits and the other doesn't, I think our relationship would change – and probably not for the better."* (Rohrbaugh et al., 2001, p. 22)

The aim of addressing symptom-system fit in FAMCON is to help couple and family members realign their relationship in ways not organized around the symptom. For example, if partners anticipate relational difficulties will accompany giving up cigarettes (as above), they can practice exposing themselves to such situations before attempting to quit, or work toward establishing substitute rituals and activities that do not involve smoking. In this way, they begin to make nonsmoking fit the system – a collaborative strategy that often pays special dividends in managing symptoms of nicotine withdrawal.

In general, however, patterns of symptom-system tend to be more difficult to conceptualize, operationalize, and target for intervention than ironic processes. This is because

identifying a symptom's presumed homeostatic "function" (maintaining cohesion, reducing conflict, etc.) requires more inference than simply describing the behavioral components of an ironic problem-solution cycle. Formulations of symptom-system fit are nonetheless useful because they suggest approaches to pattern interruption that target this aspect of problem maintenance directly (e.g., by helping a couple to disagree or stay connected without smoking, drinking, or focusing on health concerns). These formulations often translate into graded relationship-level exposure interventions, through which the team helps clients experience approximations of whatever a symptom such as substance use, overeating, or anxiety helps them avoid as a couple or family, but without engaging in the symptom.

Communal Coping

FAMCON's third central construct is *communal coping*, which involves encouraging partners or family members to view a health problem as 'ours' rather than 'yours' or 'mine' and take cooperative action to deal with it (Lyons, Mickelson, Sullivan, & Coyne, 1998). This idea of building *we-ness* has been around a long time, and in fact was an important component in our preliminary FAMCON treatment for couples coping with alcohol problems. For example, by defining alcohol as an external invader of the couple's relationship, we aimed to help partners develop a more collaborative approach to family detoxification and change. In current practice we routinely aim to promote communal coping both indirectly (e.g., by attending to and reinforcing partners' recollections of how they have successfully resolved difficulties together in the past) and directly (e.g., by requesting partner agreement and framing suggestions in terms of benefiting "you as a couple"). Although communal coping is not a particularly systemic or cybernetic idea – it actually comes from interdependence theory (Lewis et al., 2007) with individualistic trappings – we think it adds an important dimension to relationship-focused intervention. In fact, by mobilizing collaborative resources for change, it sometimes seems to provide an indispensable complement to social-cybernetic pattern interruption.

Research on Effectiveness and Mechanisms

Although FAMCON has not yet received attention in randomized clinical trials, preliminary results from the Shoham et al. (2006) open trial with health-compromised smokers show some promise. In that study, FAMCON was tested with 20 couples in which one partner (the patient) continued to smoke with heart or lung disease, and in 8 of these couples the other partner smoked as well (18 couples were heterosexual and 2 couples were homosexual). On average, couples participated in 8 FAMCON sessions and had quit rates approximately twice those of comparably intensive interventions: For the entire sample of 28 smokers, stable co-verified cessation rates were 54% and 46% over 6 and 12 months, respectively. The results were especially encouraging for female smokers and patients whose partners also smoked. Although *n*s were small, virtually all cessation, health, and client satisfaction indices were in the direction of better outcomes for women than men (perhaps because FAMCON explicitly takes relationship dynamics into account). Similarly, dual-smoker couples were at least as successful as single-smoker couples, suggesting that FAMCON's emphasis on relational functions of smoking (symptom-system fit) may have helped to neutralize the powerful risk factor of spousal smoking status.

While it was not possible to document rigorously *how* FAMCON helped smokers quit and maintain cessation, our clinical observations were consistent with the family systems principles on which the intervention is based. For example, cessation was most successful when

partners accepted the communal-coping frame and worked together in choosing and preparing for a quit date, not to mention finding satisfactory ways to protect their relationship after one or both had quit. It was also apparent that rather different patterns of couple interaction served to maintain smoking in different ways for different couples, and that correspondingly different intervention strategies (e.g., encouraging a spouse to back off vs. take a stand) helped to facilitate constructive change.

A broader base of research supports the relevance of FAMCON's three central constructs. *Communal coping* first caught our attention in a longitudinal study of couples coping with congestive heart failure, a chronic condition that makes complex demands on patients and their families. In an 8-year prospective study, dyadic measures of marital quality predicted how long the patient lived, regardless of baseline illness severity (Rohrbaugh, Shoham, & Coyne, 2006). The most predictive component of marital quality, related to communal coping, was the reported frequency of a couple's useful discussions about the patient's illness. Consistent with this, a follow-up study found that communal coping, measured unobtrusively by automatic text analysis of a spouse's first-person-plural pronoun use (*we*-talk) during a conjoint coping interview, predicted a favorable course of heart failure symptoms over the next 6 months (Rohrbaugh & Shoham, 2011).

Extrapolating this finding to intervention, we performed similar analyses of pronoun use by health-compromised smokers and their partners before and during the FAMCON treatment development study to determine whether *we*-talk during the course of treatment would predict clinical outcomes. To check this, we examined cessation outcome in relation to partners' *we*-talk during FAMCON session 4 (immediately following the opinion/intervention) and the final session, using word counts from a pre-treatment marital interaction task as a baseline covariate. Similar to the heart failure results, *we*-talk by the patient's spouse at baseline predicted the patient's cessation success a year later. Even more striking was that *both* partners' *we*-talk in the later couple sessions predicted cessation success as well, after controlling for *we*-talk levels at baseline. This latter finding raises the possibility that communal coping marked by *we*-talk might function as a "common factor" change mechanism across some forms of couple-focused intervention (Rohrbaugh, 2014; Rohrbaugh & Shoham, 2011).

To investigate another FAMCON construct, *symptom-system fit*, we used a stimulated recall procedure with a larger sample of 25 couples in which one or both partners smoked. As noted above, symptom-system fit occurs when a problem such as smoking or drinking appears to have adaptive consequences for a relationship, at least in the short run. Thus, in couples where both partners smoke, shared smoking might create a context for mutually supportive interactions by helping partners stay positive, even when they disagree. In a laboratory demonstration of this phenomenon, dual- and single-smoker couples discussed a health-related disagreement before and during a period of actual smoking. Immediately afterwards, the partners used independent joysticks to recall their continuous emotional experience during the interaction (from highly positive to highly negative) while watching themselves on video. Participants in dual-smoker couples reported increased positive emotion contingent upon lighting up, while in single-smoker couples both partners (non-smokers and smokers alike) reported the opposite. Strikingly, changes in individuals' emotional experience from baseline to smoking depended almost entirely on a couple-level variable (one vs. two smokers), with no apparent contribution from individual characteristics such as a participant's gender or psychological distress.

Still, this result left open the possibility that the reports of dual-smoker couples amounted simply to a surge of positive emotion in each individual partner, rather than something inherent in what the partners experienced *together* as a couple played a role as well. To examine more directly the couple as a dynamic, interacting unit, we re-analyzed the same data to determine if the coordination or *synchrony* of partners' moment-to-moment emotional experience also changed coincident with active smoking. The results showed that a couple-level index of *affective synchrony*, operationalized as correlated moment-to-moment change in partners' reported emotional experience, in fact increased during smoking for dual-smoker couples and decreased for single-smoker couples – and this was independent of the parallel mean-level changes in emotional valence we found earlier. Thus, emotional correlates and consequences of change-resistant smoking appear to have an important social dimension, depending not only on biological or psychological characteristics of the individual smoker, but also on the specific relational context in which smoking occurs (Rohrbaugh, 2014; Rohrbaugh & Shoham, 2011).

We have used a wider variety of self-report and observational methods to investigate *ironic processes* in couples coping with various health problems and addictions. Across the board, measures of the ironic process construct show strong concurrent and prospective associations with health outcomes and patient adherence to medical regimen. Many of these studies focus on ironic patterns of attempted influence, including variants of demand-withdraw couple interaction, where one partner criticizes, complains, and pressures for change, while the other resists, avoids, and withdraws. Another ironic pattern, common in chronic illness, occurs when one partner tries to protect the other from distress by hiding negative emotions and avoiding potentially upsetting topics. Studies of protective buffering in couples coping with heart disease and cancer suggest ironic associations with increased distress, not only for the person who tries to protect but also for the medically ill spouse. In fact, a daily-process analysis of co-variation between protection and distress in heart failure couples found asymmetrical partner effects, where protection by the spouse predicted the patient's daily distress more than patient protection predicted spouse distress. Overall, our results in this arena have been consistent with a broader literature linking gender, relationships, and health – specifically, with evidence that women are generally more oriented to relationships than men, and that associations between relationship quality and health tend to be stronger for women than for men (Kiecolt-Glaser & Newton, 2001; Rohrbaugh, 2014).

Lastly, an analysis of demand-withdraw couple interaction in the early 1990s alcohol project illustrates how well intentioned *therapeutic* efforts can have ironic consequences as well. The two treatments in that study (Rohrbaugh et al., 1995), cognitive-behavioral therapy (CBT) and family-systems therapy (FST – a preliminary prototype of FAMCON), differed substantially in the level of demand they placed on the drinker for abstinence and change. Although drinking was a primary target for change in both approaches, CBT took a firm stance about expected abstinence from alcohol (e.g., using adjunctive breathalyzer tests to ensure compliance), while FST employed more permissive, indirect strategies to work with clients' resistance. Before treatment began, we had obtained observational measures of how much each couple engaged in demand-withdraw interaction, focusing on the pattern of wife's demand and husband's withdrawal during a discussion of the husband's drinking. Association with later retention and abstinence were striking: When couples high in this particular demand-withdraw pattern received CBT, they attended fewer sessions and tended to have poorer drinking outcomes – whereas for FST, levels of this pattern made little difference. Thus, for high-demand couples, CBT may have

ironically provided "more of the same" ineffective solution: The alcoholic husbands appeared to resist a demanding therapy in the same way they resisted their demanding wives (Shoham, Rohrbaugh, Stickle, & Jacob, 1998). Similar results emerged in a recent study of family therapy for adolescent drug abuse, where pre-treatment parent-demand/adolescent-withdraw moderated the relationship between observed therapist demand and clinical outcome (Rynes, Rohrbaugh, Lebensohn-Chialvo, & Shoham, 2014).

Assessment and Selection of Patients

The first phase of FAMCON, beginning with preliminary phone contacts and continuing until the opinion/feedback session, is primarily about assessment, but includes some preliminary indirect intervention as well (see Treatment below). This typically happens in 2-5 sessions, most more than an hour in duration. The format is mainly conjoint (seeing partners or family members together) but often includes individual meetings as well. With couples, for example, we routinely see clients separately (though briefly) to assess partner commitment, possible violence, or other concerns they may be reluctant to express in each other's presence. Similarly, when complaints occur in multi-generational configurations, we might meet with parents or caregivers alone and/or with children or the identified patient alone.

In general, the main goals of assessment are to (1) define a resolvable complaint; (2) identify ironic processes (problem–solution loops) and patterns of symptom-system fit that may help to maintain the complaint; and (3) understand clients' unique language and preferred views of the problem, themselves, and each other. The first two goals provide a template for *where* to intervene, while the third informs *how* to intervene.

The first assessment task is to obtain a very specific, behavioral picture of the complaint, including who sees it as a problem, and why it is a problem now. A useful guideline is having enough details to answer the question, "If we had a video of this, what would I see?" Later the consultant also solicits a clear behavioral picture of what the clients will accept as a minimum change goal. For example, "What would he (or she, or the two of you) be doing differently that will let you know this problem is taking a turn for the better?"

The next step requires an equally specific inquiry about the behaviors most closely related to the problem, especially what happens immediately *after* problem behavior occurs. Of particular interest is what the clients and other concerned people are doing to handle, prevent, or resolve the complaint, as well as what happens in response to these attempted solutions. From this begins to emerge a formulation of ironic problem maintenance – and perhaps of the specific solution behaviors that will be the focus of strategic intervention. Also of interest are shifts in relationship patterns that follow performance of the complaint (e.g., increased closeness or involvement, reduced conflict, more competent functioning by another family member), as this may provide clues about symptom-system fit and possible paths to neutralizing it.

The most relevant problem maintaining patterns are current ones (how people organize around or attempt to manage the complaint *now*), but solutions tried and discarded in the past may also give hints about what has worked before – and may work again. In one of our alcohol treatment cases (Rohrbaugh et al., 1995), a wife, who in the past had taken a hard line with her husband about not drinking at the dinner table, later reversed this stance because she did not want to be controlling. As his drinking problem worsened, he further withdrew from the family, and she dealt with it less and less directly by busying herself in other activities or retreating to

her study to meditate. Careful inquiry revealed that the former hardline approach, though distasteful, had actually worked: When the wife had set limits, the husband had controlled his drinking. By relabeling her former, more assertive stance as caring and reassuring to the husband, the therapist was later able to help the wife reverse her stance in a way that broke the problem cycle.

The final assessment goal – grasping clients' unique views or "position" – is crucial to the later task of framing suggestions in ways clients will accept. Assessing these views depends mainly on paying careful attention to what people say. For example, how do they see themselves and want to be seen by others? What do they hold near and dear? When are they at their best, and what do others notice at those times? We also find it helpful to understand how people view themselves as a couple or family, and typically ask questions, such as "If people who know you well were describing you two as a couple, what would they say?" or "What words or phrases capture the strength of your family (or relationship) – its values, flavor, and unique style?" And at some point, the consultant will usually also ask for their best guess as to *why* a particular problem is happening – and why they handle it the way they do.

Other important client views concern customership and readiness for change. Although much will be evident from how people initially present themselves, direct questions such as "Whose idea was it to come?, Yours equally?, Why now?, and Who is most optimistic that this consultation will help?" often make this crucial aspect of client position clearer. It is also useful to understand how clients sought help for the complaint in the past, what they found helpful or unhelpful, how the helper(s) viewed their problems, and how the therapy or consultation ended.

Finally, regarding patient selection and applicability, there are several circumstances in which we think the FAMCON approach is not ideal. First, in keeping with the social-cybernetic emphasis on interrupting patterns of problem maintenance, FAMCON is most suited to stable, persistent problems, where clients or clinicians in some way feel stuck; this approach is probably *least* applicable to crisis situations, health transitions (e.g., adapting to a cancer diagnosis), or prevention aims – although other forms of consultation or psych-education based on non-systemic (e.g., social learning or bio-medical) assumptions might well be useful in those contexts. Second, because communal coping is often a key change mechanism, FAMCON seems to work best when there are stable, committed relationships on which to build: Having to re-build such commitment or repair relationship estrangements before addressing the central complaint can overload the clinical agenda. Third, we find FAMCON most helpful in the framework of stepped care, and not ideal as a first line treatment: If other, more economical interventions work – even those focused on individuals – that should be sufficient.

Treatment

FAMCON typically proceeds through a series of distinct phases: Preparation, assessment, feedback (the opinion session), and follow-up. In the *preparation phase,* the team uses preliminary phone contacts to decide whom to see in what format. Whom to see initially depends on the team's preliminary assessment and hypotheses (based on phone contacts with more than one member of the client system) about likely patterns of problem maintenance and possibilities for productive communal coping. For adult problems this is usually (but not always) a couple, and who participates may change during the course of FAMCON. When stuck, we add people – both conceptually and in the consulting room – and this adds leverage for therapeutic change.

In the *assessment phase*, usually consisting of 2–4 sessions over several weeks, the consultants conduct a systemic assessment of problem-maintaining interactional patterns (e.g., ironic problem-solution loops, relationship-stabilizing consequences of symptoms, problem-maintaining coalitions) via interview, direct observation, and optional daily diary phone-ins. In addition to its overt aims, the assessment phase includes several forms of indirect intervention, including circular questions about possible implications of change; questions designed to stimulate and enhance communal coping, via inquiries about how partners or family members have managed difficulties together in the past; and a solution-focused homework assignment at the end of Session 1, where the consultant asks clients to make notes on aspects of their relationship (and each other) they would like to preserve, or *not* change.

With some cases – usually involving couples – we also employ a daily-diary procedure in which clients independently leave messages in our voice mail every morning for at least 14 consecutive days to answer a series of questions about the preceding day. The questions concern specific problem and solution patterns relevant to the case, as well as mood, relationship quality, and communal coping (e.g., How many cigarettes did you smoke yesterday? How much did you try to discourage your partner from smoking? How close and connected did you feel?). Because clients answer each question on a quantitative (0- to 10-point) scale, it is possible to identify couple-specific trends over time, including the extent to which what one person does (e.g., frequency of smoking) correlates from day to day with what one's partner does (e.g., intensity of influence attempts) as well with other aspects of the respondent's own experience (e.g., mood-activity correlations). In addition to illuminating key dynamics, we find that presenting selected daily diary results in the feedback/opinion session enhances the credibility of the consultant's observations and therapeutic recommendations. In applications to smoking or substance use cessation, most couples also do a shortened version of the daily call-ins again later, for a week before and after their planned quit date, which provides a basis for regular contact with the team during the difficult transition.

For the pivotal *opinion/feedback* session, the team prepares and presents a carefully scripted message that (a) compliments couple/family strengths and acknowledges clients' noble intentions; (b) frames change as difficult but possible, if family members work together; (c) presents selected data from the daily diary exercise (if applicable) to highlight relevant patterns; (d) offers direct or indirect suggestions for less-of-the-same solution behavior (beginning interruption of ironic processes); (e) directly or indirectly challenges couple or family patterns that the problem may help to maintain (beginning neutralization of symptom-system fit); (f) encourages communal problem solving and decision making by "you as a couple" or "you as a family"; and (g) invites couple or family-level commitment to some specific behavior change. When the target complaint does not involve substance use, the invitation to consider a specific behavior change (offered at the end of the opinion session) is more likely to focus on interrupting some specific aspect of problem maintenance than on initiating change in the problem itself by setting a quit date. The presenter of the opinion is usually a relatively high-status member of the team, who follows prepared notes, and we sometimes give a written outline to family members as well.

In the *follow-up phase*, where inter-session intervals are typically longer and depend on client response, the consultants amplify and build upon small changes, adjust treatment strategies to address reluctance, and prevent relapse. This phase comprises all contacts after the opinion/feedback session, employing techniques that are more strategic than educational. For

example, we frame the meaning of changes to fit clients' preferred views, caution people against changing too fast, and sometimes respond to intractable reluctance with strategic reflection. As before, all sessions include multiple consultants, with at least one team member observing and phoning in suggestions from behind a one-way mirror. An exception is strategic reflection, where clients themselves go behind the mirror to observe team members empathically discussing the pros and cons of changing their situation.

In addition to direct and indirect suggestions, the follow-up phase sometimes incorporates *enactment modules* designed to bring problem-maintaining interaction sequences into the consulting room, where we try to interrupt them directly. For example, a consultant might first invite a couple to enact a sequence where the spouse exhorts the patient to change some health behavior, then encourage them to try a less-of-the-same approach (again via enactment) to the problem at hand. Similarly, for symptom-system fit, the consultant might promote enactment-based exposure to whatever the symptom helps clients approach or avoid (e.g., negotiating a conflict or talking intimately without smoking). For couples in which one partner has an anxiety disorder such as PTSD, an interesting variation of this strategy is to involve both partners – not just the patient – in graded real-life exposure to situations they have avoided *together* (e.g., noisy social gatherings), all within a communal coping frame. This of course entails extra-session homework rather than in-session enactment.

Most fundamentally, FAMCON pattern interruption turns on identifying problem-maintaining interaction sequences and formulating strategic objectives that specify what behavior by whom in which situation(s) would suffice to break the pattern. To optimize pattern interruption, the team frames suggestions for change in terms consistent with clients' preferred views of the problem, themselves, and each other. Importantly, these interventions do not depend on client understanding or awareness: The idea is simply to interrupt entrenched sequences of behavior, from which we assume cognitive change will follow as clients construct new meanings for their changed behavior. In addition, because change requires interrupting what people habitually do with each other, the path to new (less-of-the-same) behavior can appear bumpy and discontinuous, with starts and stops and even minor crises occurring before new interaction patterns replace old ones.

Compared to other approaches, FAMCON makes more use of indirect, strategic tactics such as tailored reframing, metaphor, restraint from change, strategic reflection, or even prescribing the very experiences clients aim to avoid. These methods tend not to be a first line of approach, but are often helpful when problem maintaining interaction patterns are highly entrenched. Another key guideline is "when stuck, add people" – both conceptually and in the consulting room.

A non-trivial semantic (and strategic) consideration is what to call this approach when presenting it to clients. In general, we find the term "consultation" preferable to "therapy" and especially "*family* therapy." This is particularly so with health complaints, where pushing people to acknowledge or address relationship problems in the context of coping with physical illness can easily have ironic consequences, even when those problems may seem obvious to an observer. For example, implying that patients might benefit from couple or family therapy can arouse resistance when partners or family members avoid overt conflict with each other (a common relational correlate of chronic somatic complaints), or when one client system favors a "therapy" solution while others do not. On the other hand, offering in-depth "consultation" helps

to frame the clinical encounter as an endeavor in which several “heads” are better than one and a communal orientation by the people involved will increase the likelihood of success.

Another semantic distinction, useful for clinicians (rather than clients) in understanding problem maintenance and planning interventions, involves investigating what people *do* rather than what they *have*. Thus, rather than attempting to identify or diagnose some particular psychological disorder (what people *have*), it is more useful to explicate how they *do* whatever symptoms may be involved. For example, asking how people show a problem like anxiety, pain, or depression leads naturally to questions about what other people do in response – and what happens next. From this, circular sequences of interaction begin to emerge, helping clinicians more easily shift the conceptual locus of problem maintenance from inside to outside the “skin” (see above).

Finally, we will briefly note some common criticisms of the FAMCON approach. One is that the social-cybernetic framework is superficial and oversimplified – that mere pattern interruption will not prevent people from getting stuck in the same old ways. While this makes good sense from psychodynamic and other perspectives, our view is that assumptions about underlying cause unnecessarily complicate the clinician’s task and make change more difficult to achieve. A second criticism is that a purely systemic approach discounts individual determinants of behavior (e.g., personality traits, internal conflicts, enduring mental representations) and does not provide clients with generalizable skills or insights. Indeed, setting aside familiar psychological and dispositional constructs in favor of interpersonal feedback circuits goes against common intellectual wisdom. Although clients’ individual views do play a key role in FAMCON, that role is secondary: We prefer to accept and use a client’s idiosyncratic view to promote pattern interruption rather than taking the view itself (even if it appears dysfunctional) as a target for change. Third, because FAMCON consultants are not always explicit with clients about their rationale for specific interventions, the approach may seem unnecessarily manipulative. As noted above, we see the strategic stance as most indicated when problem-maintaining patterns appear highly entrenched or do not respond to more straightforward intervention. Last, because FAMCON requires multiple clinicians and time-intensive planning, its application in many real-world community settings may not be practical, even in the framework of stepped care. Indeed, whether this approach can claim the status of a disseminable, cost-effective, evidence-based treatment remains to be seen.

Diversity

FAMCON places great emphasis on understanding, validating, and working within client meaning systems related to all dimensions of diversity. The approach is fundamentally non-normative, with no guiding assumptions about what constitutes health or pathology and no specific guidelines for addressing matters related to age, race, gender identity, sexual orientation, culture, socio-economic status, and so on. On the other hand, we do often address such matters indirectly in selecting members of the clinical team. While an ideal team includes, at minimum, a skilled family systems consultant and a health professional (e.g., a medical doctor or a registered nurse) with both general and complaint-specific expertise, we also find it helpful to have a member whose life experience or background is relevant to members of the client system. One example of this – in addition to diversity consideration – is including a professional or paraprofessional fellow traveler with direct experience regarding the problem at hand (e.g., a cancer survivor, former smoker, combat veteran, or parent of a diabetic child).

Clinical Illustration

The following case, described at greater length by Rohrbaugh, Kogan, and Shoham (2012), features a depressed husband and bipolar wife complaining of severe communication difficulties related to the husband's kidney cancer and diabetes. Over 6 FAMCON sessions, strategic interventions focused mainly on interrupting ironic interpersonal processes helped to resolve the presenting complaint. Interventions addressing symptom-system fit and communal coping were present as well but played a secondary role in this case.

Mark (58) and Emma (54) sought help for "communication difficulties" related to Mark's deteriorating health. Mark faced an apparent recurrence of kidney cancer, for which he had surgery 8 years earlier; he was also diabetic and not fully adherent to medical regimen. In fact, his erratic health behavior was a major focus of concern for Emma, a former nurse, and the couple had increasingly volatile arguments about this, marked by Emma's "rage" and Mark's withdrawal. Feeling "depressed" and considering separation, Mark had recently sought individual (cognitive-behavioral) therapy, but after 8 sessions, the CBT therapist recommended working on "communication problems" and referred him to our family consultation clinic for help with this.

Mark and Emma – white, Jewish, childless, and unemployed – had been married 15 years (his third marriage, her fourth). The couple met in a psychiatric hospital where Emma carried a diagnosis of bi-polar disorder and Mark was seriously depressed following a suicide attempt. They experienced an intense emotional connection as fellow inpatients and married two months after discharge. Since then, both had received more or less continuous outpatient treatment (including multiple medications and supportive counseling), with no further hospitalizations. Both had also given up their jobs and qualified for Social Security Disability income (his medical, hers psychiatric) 3-4 years before their consultation with us.

Clinical observations during the FAMCON assessment phase revealed ironic interaction patterns centered mainly on matters of health. In a typical sequence, Emma responded to perceived signs of Mark's despondence, dietary indiscretion, or medical compliance with questions and exhortations about what he should do (or let Emma do) to take better care of himself. Mark's usual response was mild verbal reassurance that he would be OK and suggestions that Emma calm down, but this prompted more intense criticism, anger, and demands. As the cycle escalated, Mark would become more avoidant and withdrawn, eventually retreating to the bedroom or leaving the apartment. Nevertheless, both partners believed that talking about their difficulties was the best way to resolve them, and at Mark's suggestion had initiated a ritual of taking brief "water breaks" every few hours when they were at home together (as they were most of each day) to discuss matters of concern, using *I*-statements and other active listening techniques they had learned from previous therapists and self-help books. Although both felt the water breaks were useful, Emma wanted more of them than Mark did, and both acknowledged a recent increase in out-of-control arguments, including one that immediately followed a water break.

Several couple strengths were also relevant to case formulation and treatment planning: One was that Mark and Emma's complementary ways of caring for each other sometimes worked. For example, Mark was able to redirect Emma from "perseverating" and "going faster and faster" by suggesting other things for her to do, and he appreciated Emma pushing him to take daily walks and "get away from the TV" (which she did because "Mark's having structure and space for exercise is good for his health"). Another was the couple's sense of humor, which they demonstrated when we asked what their arguments would look like if someone recorded them on videotape: Emma said, "I'll show you," then slammed a book on the table and marched toward the consulting room door. Mark first grimaced, then smiled and looked amused, saying only that he appreciates her sense of humor.

In session 3, when the team conducted a brief genogram interview, we learned that family members on both sides had discouraged them from marrying and some, like Mark's sister, had been openly critical of Emma pursuing psychiatric SSDI status. There were many other notable dynamics in each partner's family of origin, but these had little bearing on our central formulation and intervention. Finally, in response to inquiries about signs the communication difficulties were improving, both cited Emma's "rage" as especially distressing and were interested in finding better ways to regulate the intensity of her emotional expression. The team accepted, and later validated, their attribution of the rage to Emma's passionate advocacy for Mark's wellbeing, for them as a couple, and for worthy causes more generally.

In developing its case formulation, the team focused on a nexus of interwoven ironic processes, through which each partner's well-intentioned solutions fed back to keep the communication difficulties going or make them worse. One strand had familiar elements of a demand-withdraw pattern, where Emma's interrogation and exhortations about Mark's diet and diabetes regimen led to progressive withdrawal, more demands, and so on. Another ironic circuit involved Mark's attempts to calm Emma when she became upset, and yet another was the couple's attempts to resolve their communication difficulties by persistently talking about them. The team's strategic objectives included (a) Emma reversing or reducing her high-demand approach to influencing Mark's health behavior and encouraging autonomy instead; (b) Mark helping Emma regulate her rage by taking charge, rather than withdrawing, and by encouraging catharsis and expression, rather than telling her to relax and calm down; and (c) the couple finding ways to communicate and resolve their differences nonverbally, rather than pursuing verbal discussion. The challenge, of course, was how to persuade or arrange for the partners to make these small but potentially drastic changes when doing more of the same made such good sense to them.

Also relevant to the formulation were symptom-system fit and communal coping. The former appeared pervasive in the couple's relationship, owing to their shared identity as psychiatric patients who organized their lives around meeting medical and mental health challenges. Because this had evolved in the face of persistent skepticism and discouragement from family members, the team was careful to avoid replicating this apparent ironic pattern. At the same time, however, we thought more day-to-day activities and relationships not organized around their role(s) as psychiatric patients would signify

positive change, and several indirect interventions aimed to open the possibility of their moving in this direction. A fortuitous flip side of this symptom-system fit was that communal coping came easily for Mark and Emma, and we reinforced this throughout the consultation process.

Intervention followed the usual FAMCON format, with 6 consultation sessions over four months, plus three telephone follow-up contacts over the next year. After three assessment meetings, the team presented a carefully prepared "opinion" that (a) reinforced couple strengths, using data from a daily diary exercise to supplement our observations and seed pattern interruption (e.g., on days when they talked more, communication and well-being appeared to deteriorate); (b) recommended Emma promote Mark's health by encouraging even more exercise autonomy; (c) prescribed a non-verbal "rage reduction" ritual, to be initiated and administered by Mark if/when Emma's anger exceeded a discomfort threshold; and (d) advised the couple to go slow in developing additional activities and relationships outside the mental health system because this could undermine their identity as psychiatric patients and upset the expectations of important others (e.g., Mark's sister) who have come to see them in this way. The most impactful component appeared to have been the rage reduction ritual, which required that Mark coach Emma on how to hit the floor, and subsequently a chair, with a foam encounter bat. After rehearsing this several times in the session – first seriously and then with some humor – both partners agreed they would use the bat at home if the need were to arise.

Two weeks later the couple reported doing much better. Emma had used the bat only once, but at her own initiative (after a frustrating support group meeting). The team gently chastised Mark for abandoning his managerial caretaking responsibilities, guided him through another rehearsal, and recommended he initiate at least one prophylactic rage management session in the coming weeks if there was no opportunity to do this remedially. At the final FAMCON session 6 weeks later, the couple reported much improved communication and no more bad fights, and the team implemented a relapse prevention intervention by asking if they would know how to make things worse again (thus highlighting each partner's specific behavioral contributions to problem-exacerbating patterns).

Follow-up phone contacts with Emma and Mark over the next year indicated that their situation remained stable, at least in regard to the presenting complaints: There had been no more bad fights or uncontrolled rage, Mark's health habits had improved (he was exercising more and had lost 10 pounds), and both partners expressed pride in their more nuanced approach to communication. Change in symptom-system fit was less clear: Although both had become involved in a synagogue group and related volunteer activities, they continued taking multiple psychiatric medications, and Emma continued her intensive involvement with mental health advocacy groups. Sadly, in the 12-month follow-up call, the couple reported that Mark's kidney cancer had taken a turn for the worse and might require more aggressive treatments. They conveyed this news calmly, with Emma adding a communal coda: "No matter what happens, we're in this together."

Conclusions/Key Points

1. FAMCON embodies a systemic (social-cybernetic) view of health behavior problems and a team-based format for brief intervention based on that view.
2. Case formulations take relationships rather than individuals as the primary unit of analysis and attach more importance to problem maintenance than to etiology.
3. Interventions aim to interrupt two types of repeating interpersonal feedback circuits – *ironic processes* (when attempted solutions maintain problems) and *symptom-system fit* (when problems stabilize relationships) – as well as to mobilize *communal coping* by the people involved (when we-ness promotes change).
4. The intervention format, usually spanning no more than 10 sessions over 2-5 months, consists of a semi-structured preparation/assessment phase, a focused feedback (opinion) session, and follow-up sessions designed to initiate, amplify, and solidify interpersonal change.
5. FAMCON pattern interruption turns on identifying problem-maintaining interaction sequences and formulating strategic objectives that specify what behavior by whom in which situation(s) would suffice to break the pattern.
6. To interrupt entrenched sequences of behavior, consultants optimize pattern frame suggestions for change in terms consistent with clients' preferred views of the problem, themselves, and each other.
7. Change does not depend on insight, awareness, skill development, or emotional processing.
8. Although FAMCON has not yet received attention in randomized clinical trials, an open trial with health-compromised smokers showed promising results. Other research documents the likely importance of putative mechanisms –ironic processes, symptom-system fit, and communal coping.
9. In addition to smoking, we have successfully applied FAMCON with complaints related to health conditions ranging from heart disease, cancer, chronic pain, and dementia to alcoholism, anxiety, and depression.
10. Because the FAMCON approach requires multiple professional participants and labor-intensive treatment planning, cost-effectiveness is a key consideration. This approach is probably most applicable in the framework of stepped care, after first-line interventions have not been successful.

Review Questions

1. What basic assumptions guide the FAMCON social-cybernetic approach?
2. What does it mean to think "systemically" and to intervene "strategically"?
3. What essential clinical procedures comprise the FAMCON approach?
4. What are the putative mechanisms of change in this approach?
5. What are some limitations and criticisms of the FAMCON social-cybernetic approach?

Resources

American Association for Marriage and Family Therapy (AAMFT) (www.aamft.org)

American Family Therapy Academy (AFTA) (www.afta.org)

Family Process: The Journal. Description available from www.familyprocess.org/about-us/fpjournal; published by Wiley-Blackwell.

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