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Family Consultation for Psychiatrically Complicated Health Problems

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Abstract

We describe a social cybernetic view of health behavior problems and a team-based family consultation (FAMCON) format for strategic intervention based on that view. This approach takes relationships rather than individuals as the primary unit of analysis and attaches more importance to problem maintenance than to etiology. Treatment aims to interrupt two types of interpersonal problem maintenance – ironic processes and symptom-system fit (conceptualized, respectively, as positive and negative feedback cycles) – and to mobilize communal coping as a relational resource for change. A case example features a depressed husband and bipolar wife complaining of severe communication difficulties related to the husband's kidney cancer and diabetes. Over 6 consultation sessions, strategic interventions focused on interrupting ironic interpersonal patterns resolved the presenting complaint. Although cost-effectiveness is an open question, FAMCON may offer a useful alternative to psychoeducational and cognitive-behavioral treatments in the framework of stepped care.

Key words: Family consultation, couple therapy, chronic illness, social cybernetics, psychotherapy

Family Consultation for Psychiatrically Complicated Health Problems

This article illustrates a social cybernetic view of health behavior problems and a team-based family consultation (FAMCON) intervention based on that view (Rohrbaugh & Shoham, 2011). We apply this approach in a stepped-care framework, after other more economical empirically supported treatments do not succeed. Although FAMCON is brief, the team format incurs increased expense via multiple professional participants and labor-intensive treatment planning; hence cost-effectiveness is a key consideration. For better or worse, the setting for our case illustration is a university training clinic, where cost was not a factor.

Family Consultation (FAMCON)

FAMCON is a format for resolving problems via *strategic pattern interruption* and *communal coping*. The format, spanning up to 10 sessions over 3-6 months, consists of a semi-structured assessment phase followed by a focused feedback (opinion) session and follow-up sessions to initiate, amplify, and solidify interpersonal change. Interventions focus on repeating case-specific sequences of interaction that maintain (as they are maintained by) the target symptom or complaint. These sequences involve positive and negative interpersonal feedback circuits, which respectively we call *ironic processes* (when attempted solutions maintain problems) and *symptom-system fit* (when problems stabilize relationships). Carefully planned strategic interventions aim to provoke change in ways that take into account clients' preferred views but do not depend upon education, skill acquisition, or even client understanding – and we assume pattern interruption is sufficient to alter problem trajectory and open the way to progressive therapeutic developments. Finally, the entire consultation emphasizes communal coping by the people involved (viewing problems as *ours* rather than *yours* or *mine* and taking collaborative action to solve them). To this end, the team aims to mobilize and/or create *we*-ness in a multi-person client system (whether a couple, a family, or some other configuration) as a relational resource for change.

Our most systematic clinical investigation of FAMCON to date focused on couples in which one partner continued to smoke cigarettes despite having heart or lung disease (Shoham, Rohrbaugh, Trost & Muramoto, 2006). However, we have also used this approach to help couples and families cope with problems ranging from heart disease, cancer, and chronic pain to alcoholism, anxiety, and depression. The case example here features an older couple coping with the husband's kidney cancer and diabetes. Following the husband's initial presentation of depression, an overriding couple complaint of rather severe communication difficulties related to the husband's health behavior (leading him to consider separation) emerged as the focus of FAMCON. The situation was complicated by other problems, because both partners carried long standing psychiatric diagnoses, took multiple medications, received disability income, and reported intractable conflicts with other family members.

Theory of Problems and Change

The social cybernetic framework resurrects ideas dating back at least 50 years to Bateson, Haley, Jackson, Weakland, and the beginnings of the family therapy movement

(Hoffman, 1981). The central idea is that problems of health and behavior do not occur in a vacuum; rather, they persist as an aspect of current close relationships in which causes and effects appear inextricably interwoven, with one person's behavior setting the stage for what another person does, and vice versa, in ongoing, circular sequences of interaction.

We call this approach *cybernetic* to highlight the circularity of interpersonal feedback systems in which the effect of some problem behavior operates to modify, control, or regulate that very same behavior. Although internal feedback loops are well known in clinical biology (e.g., physiological homeostasis), the transposition of this idea to systems of behavior outside the skin is less familiar – hence we add the modifier *social* to underscore the primacy of feedback-control circuits operating between people rather than within them. This social cybernetic view 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*, which refer to two corresponding patterns of social cybernetic problem maintenance: ironic processes and symptom-system fit. In technical terms, a positive feedback cycle denotes the enhancement or amplification of an effect by its own influence on the process that gives rise to it (e.g., an arms race, 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 hormone levels in the blood).

In the realm of behavior, ironic processes are deviation-amplifying positive feedback cycles that occur when well-intentioned, persistently applied solution attempts keep problem behavior going or make it worse. In couples, for example, urging one's spouse 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 may result in more despondency; or attempting to resolve a disagreement through frank and open discussion may serve only to intensify the conflict (a pattern we will see in the case example below). Although social psychologist Dan Wegner (1994) first coined the term *ironic process* to describe ironic effects of attempted thought suppression on mental control, the term captures a much broader range of intra- and interpersonal ironic phenomena introduced decades earlier by family therapists at Palo Alto's Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974).

Ironic processes persist precisely 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, formulations of ironic problem-solution loops provide a template for assessment and strategic treatment: They tell us where to look to understand what keeps a problem going (look for *more of the same* solution) and suggest what needs to happen for the problem to be resolved (someone must apply *less of the same* solution). If pattern

interruption happens even in a small way – as in the case we present here – virtuous cycles can develop, leading to further positive change (Rohrbaugh & Shoham, 2001).

A second pattern we call *symptom-system fit* refers to deviation-minimizing negative feedback cycles, where a problem or risk behavior appears to preserve some aspect of relational stability for the people involved. Emphasized in the writings of family therapists such as Jackson, Haley, and Minuchin, this form of maintenance 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. In other words, a problem may persist because it provides a basis for the restoration or preservation 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. Similarly, as in the case we present here, relational cohesion can depend on shared concerns about health.

Because one can only hypothesize about what interpersonal function a problem might serve, based on observing the interaction sequences in which it occurs, identifying symptom-system fit typically involves more inference than identifying an ironic process. 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., coaching a couple to disagree or stay connected without smoking, drinking, or focusing on health concerns).

Another clinical implication of social-cybernetic formulations is that patterns of problem maintenance – and the interventions we design to interrupt them – are inherently idiographic, or case specific. Because problem-maintaining interpersonal cycles can take different, even opposite forms across cases involving similar complaints (e.g., nagging vs. protecting a spouse who smokes, overeats, or shows distress), one-size-fits-all instructional methods are not usually well suited for pattern interruption.

Finally, the 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, cultivation of communal coping has a central place in the FAMCON format.

Supporting Research

Although FAMCON has not yet received attention in randomized clinical trials, a preliminary study found promising results with 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 advice to quit. In an open trial of up to 10 FAMCON sessions, primary smokers achieved a 50% rate of stable abstinence over at least 6 months, which compares favorably to cessation benchmarks of 25–30% in the literature (Shoham et

al., 2006). Although the sample was small (*N* = 20), cessation success tended to be best for health-compromised female smokers and smokers whose partner also smoked – two sub-groups at heightened risk for relapse.

A compelling illustration of the power of close relationships comes from our research on couples coping with 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). An important 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 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. We found also that increased *we*-talk by both partners during the course of couple-focused FAMCON for health-compromised smokers predicted stable cessation a year after the smoker had quit (Rohrbaugh, Mehl, Shoham, Reilly & Ewy, 2008).

In research related to ironic problem maintenance, we find diminished health outcomes and patient adherence associated with ironic demand-withdraw couple interaction in which 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.

Finally, our research highlights symptom-system fit associated with shared smoking and drinking. In a study of couples in which one or both partners smoked, the partners 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 while watching themselves on video. The ratings of participants in dual-smoker couples showed increased positive emotion and increased affective synchrony contingent upon lighting up, while in single-smoker couples both partners (non-smokers and smokers alike) showed decreases in these patterns (Shoham, Butler, Rohrbaugh & Trost, 2007).

Clinical Principles

FAMCON proceeds through a series of distinct phases: In a *preparation phase,* the team uses preliminary phone contacts to decide whom to see. In the *assessment phase*, usually consisting of 2–3 sessions about a week apart, the consultants conduct a systemic assessment of problem-maintaining interactional patterns (e.g., ironic problem-solution loops, problem-maintaining coalitions) via interview, direct observation, and daily diary reports. Based on this, the team offers feedback in a dramatic, carefully prepared opinion session (the *opinion phase*) designed to initiate pattern interruption either directly or indirectly and to mobilize communal resources for change. Finally, in the *follow-up phase*, where inter-session intervals are typically longer and depend on client response, the consultants adjust treatment strategies to address reluctance, amplify and solidify incipient

change, and prevent relapse. All sessions include multiple consultants, with some team members observing and phoning in suggestions from behind a one-way mirror.

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 addition to its overt aims, the assessment phase includes several forms of indirect intervention, for example, questions designed to stimulate and enhance communal coping, a solution-focused homework assignment at the end of Session 1, and daily-diary phone-ins requiring participants to monitor key problem and solution patterns.

Pattern interruption methods turn on identifying a problem-maintaining pattern and formulating strategic objectives that specify what behavior by whom in which situation(s) would suffice to break the pattern. To maximize the impact of pattern interruption, the team frames suggestions in terms consistent with clients' preferred views of the problem, themselves, and each other. Importantly, these 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 to direct and indirect suggestions, the opinion and follow-up phases sometimes incorporate *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 the couple approach or avoid (e.g., negotiating a conflict or talking intimately without smoking).

The last phase of FAMCON consists of amplifying and building upon small changes. The techniques for this are more strategic than educational. For example, we frame the meaning of changes to fit clients' preferred views and sometimes caution people against changing too fast. The team promotes communal coping throughout, and as the case of Emma and Mark will illustrate, even relapse prevention has a strong relational focus.

Case Illustration

Presenting Problem and Client Description

Mark (58) and Emma (54) came to our clinic for help with "communication difficulties" related to Mark's deteriorating health. Eight years earlier Mark had been diagnosed with kidney cancer, for which he received surgery, but during the past year a small malignancy had grown in size. Mark was also diabetic and not always fully adherent to his required regimen. Indeed, his erratic health behavior was a focus of considerable

concern for Emma, a former nurse. Two months before we saw the couple, Mark had sought individual psychotherapy at another clinic because he felt "depressed" and blamed himself for the painful and increasingly volatile arguments occurring between him and Emma. He said he could not handle the intensity of these exchanges and was considering separation. After 8 sessions of cognitive-behavior therapy (CBT), the therapist recommended working on the communication problems and referred Mark to our clinic.

Mark and Emma, both Caucasian, Jewish, and currently unemployed, had been married 15 years. This was Mark's third marriage and Emma's fourth, by far the longest and most successful romantic relationship either had ever experienced. The couple met in a psychiatric hospital just a few months before they married, when Emma carried a diagnosis of bipolar disorder (BD) and Mark was seriously depressed. Emma's hospitalization had followed a rather severe manic episode, whereas Mark's followed a suicide attempt and three previous hospitalizations during a 2-year period. They described their connection during the hospital stay as "intense" and "profound:" Emma described a kind of epiphany indicating she and Mark were meant to be together, and both agreed that Mark's calm, empathic provision of emotional support became a vital source of "ground control" for Emma. After discharge, both received more or less continuous outpatient treatments, mostly in public clinics, consisting of (multiple) medications and supportive counseling, and they typically transferred together from agency to agency. Over the years Emma and Mark had received a great deal of psychological therapy, including some couple counseling. Their favorite modality was CBT, and Emma showed us CBT flash cards with various affirmations and injunctions, which she carried in her purse.

Mark had given up his job as a clothing sales representative several years after the cancer diagnosis, and a short time later (four years before our consultation) Emma gave up the last of her nursing positions. Both eventually qualified for Social Security Disability Income (SSDI) status – his medical, hers psychiatric. In addition to BD, clinicians had told Emma she might have Obsessive-Compulsive Disorder (OCD), Attention Deficit Disorder, and most recently, Post Traumatic Stress Disorder (in the space of a year she had lost her mother, best friend, and a favorite pet, and had been in an automobile accident). Emma took the diagnoses seriously and became active in several advocacy groups concerned with these conditions. As a nurse, Emma also took Mark's health problems very seriously: She attended all his medical appointments, where she took extensive notes in order to help him remember the details of his medical regimen and advocate for better health care.

The incident that precipitated Mark's seeking therapy did not directly concern his health, but grew from an escalating conflict between Emma and Mark's sister Esther, who had long been critical of Emma's influence on her brother and reliance on SSDI. After an exchange of unpleasant emails and threatening phone messages, Emma (again with protective intentions) decided to drive past Esther's house late on the eve of Yom Kippur blowing the car's horn. Mark thought this was going too far, but when he tried to calm Emma by suggesting she "relax and be reasonable," Emma only became more agitated. Over several evenings this husband-wife cycle escalated to the point of Emma's shouting, "Get out of the house so I can commit suicide!" Mark eventually did go to a neighbor's house and, concerned about his wife's safety, was about to call 911 when he received an apologetic call from Emma asking him to come home.

In Session 1, our investigation of Mark and Emma's "communication difficulties" revealed similar ironic patterns centered squarely on matters of health. In a typical sequence, Emma responded to real or perceived signs of despondency, dietary indiscretion, or medical non-adherence from Mark by launching into questions, suppositions, and ultimately exhortations about what Mark should do (or let Emma do) to take better care of himself. Mark's initial response was usually mild verbal reassurance that he would be okay, coupled with suggestions that she relax and calm down. This rarely placated Emma, whose interruptions and exhortations became increasingly critical and hostile as Mark became more avoidant and withdrawn, eventually retreating to the bedroom or leaving the apartment.

Nevertheless, both partners believed talking about these difficulties would ultimately improve their communication. For this reason, Mark suggested they take brief "water breaks" every few hours when both were at home together (as they were a good part of each day) in order to "talk calmly and reasonably" by the water cooler about matters of mutual concern. The idea was to use *I* statements and other active listening techniques they had learned from previous therapists and self-help books. The water break plan had been in effect for over 3 months before we met the couple, and both partners agreed it had helped somewhat. At the same time, Mark expressed mild disappointment that Emma wanted more water breaks than he did, and both acknowledged a clear increase in out-of-control arguments, including one that had grown directly from a water break.

Several observations about couple strengths were also relevant to the case formulation and treatment plan: First, Emma and Mark had complementary and often effective ways of taking care of each other. For example, when Emma was "perseverating" or "going faster and faster" with activities like cleaning, organizing, and searching the Internet, Mark could redirect her by suggesting she do something else. He, on the other hand, found it helpful when Emma "pushes me to do things and gets me away from the TV." Second, Mark (but not Emma) had a daily routine of walking for exercise. In fact, Emma encouraged him in this because "Mark's having structure and space for exercise is good for his health."

Third, when we explored the partners' views of what was happening. Mark said Emma's rage was, for him, the most distressing part of their arguments, and both partners were interested in Emma's finding better ways to regulate the intensity of her emotional expression. They attributed the rage to Emma's noble intention, in particular to her impassioned advocacy for Mark, for them as a couple, and for worthy causes generally. Emma saw herself as an assertive problem solver and negotiator, committed to seeking justice and righting wrongs. Mark wanted people to see him as a thoughtful, mellow fellow, capable of compromise, with a good sense of humor.

Finally, when we asked what the couple's arguments would look like if someone recorded them on videotape, Emma said, "I'll show you" – at which point she waved her arms, slammed some papers on a table, shouted at Mark, and marched toward the consulting room door. As she did this, Mark first grimaced, then grinned and looked amused, remarking only that he appreciates Emma's sense of humor. This spontaneous

enactment revealed a potentially playful side of the couple's relationship, which we later used in the service of pattern interruption.

To investigate the broader context of the presenting complaints, the team conducted a brief genogram interview in Session 3, focusing in turn on Mark and Emma's respective extended families and their social network. From this we learned that family members on both sides had been skeptical of their union. In fact, some had actively discouraged them from marrying, and some (like Esther) had been openly critical of Emma's pursuing psychiatric disability from Social Security. There were many other notable dynamics in each partner's family of origin, but these had little bearing on the team's formulation and intervention.

Case Formulation

Central to the social-cybernetic formulation was a nexus of interwoven ironic feedback loops, through which each partner's well-intentioned attempts to influence the other partner's problematic behavior served to keep those behaviors going or make them worse. One strand of ironic problem maintenance had familiar elements of demand-withdraw couple interaction: For example, when Emma would interrogate and exhort Mark about his diet and diabetes regimen, his response was mild reassurance and progressive withdrawal, leading to intensified demands by Emma, and so on. Similarly, when Emma became agitated and emotional, Mark offered reassurance with injunctions to "calm down" and "relax," but this only pushed the cycle toward full-blown rage and Mark's eventual withdrawal. At the level of their communication difficulties, the main thrust of both partners' usual solution was to talk with each other about the problems that arose between them – and when that didn't work, they talked more.

To formulate strategic objectives, the FAMCOM team considered what less of these ironic solution patterns would look like. In other words, we asked what behavior(s) by whom in what situation(s) would suffice to interrupt the problem-exacerbating sequences? As a rule of thumb, strategic objectives that reverse a problem-maintaining solution pattern by 180 degrees (i.e., taking an opposite stance on some critical dimension of response) are ideal, but sometimes simply suspending a usual solution effort (e.g., by observing rather than reacting) works too. Here we hypothesized that key strategic objectives would entail (a) Emma's backing off from her direct, high-demand approach to influencing Mark's health behavior – or better, reversing this stance by encouraging autonomy instead; (b) Mark's helping Emma regulate her rage by taking charge rather than withdrawing and encouraging expression and catharsis rather than telling her to relax and calm down; and (c) both partners' finding ways to communicate and resolve their differences nonverbally, especially in the face of distress, rather than continuing in unproductive, often escalating verbal discussion. The challenge, of course, was how to persuade or arrange for Emma and Mark to make these small but potentially radical modifications in their usual ways of dealing with each other, when doing more of the same made perfectly good sense to them.

Symptom-system fit for this couple was pervasive. Rather than some single complaint or shared risk behavior preserving relational stability, Mark and Emma's entire relationship appeared predicated on their shared psychiatric history and how they had

pulled together to cope with health challenges. This had happened despite (or perhaps because of) persistent skepticism and discouragement from important extended family members. An implication of this apparent higher-order ironic process between family members and the couple was that our team should in no way recapitulate the family's direct attempts to dissuade Emma and Mark from their psychiatric preoccupations. At the same time, we thought more participation by Mark and Emma in day-to-day activities and social relationships not mediated by their psychiatric role(s) would signify therapeutic gain, 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 Mark and Emma, as a couple, had good potential for communal coping. Indeed, their shared history included many successful instances of collaborative problem solving, which we took as a favorable prognostic sign.

Course of Treatment

After the initial phone contacts, FAMCON treatment consisted of 6 consultation sessions over a period of four months, plus three follow-up phone contacts over the next year. The consultation team consisted of an experienced leader (MJR) and four advanced doctoral students. We conducted the consultation sessions in a one-way mirror suite, where two team members typically worked with the clients directly in the therapy room while observing team members could call in suggestions from behind the mirror. In keeping with our usual practice, Mark and Emma's first consultation session lasted a full 2 hours, while subsequent sessions were 60-90 minutes. To plan, the team met for 20–30 minutes immediately before and after each session, and took breaks during the sessions themselves for brief strategy meetings behind the mirror. There was also an extended team meeting after Session 1 to construct daily diary items and another meeting before Session 4 to outline the team's opinion and strategy for intervention.

The main clinical goal in the assessment phase (Sessions 1–3) was to develop a clear behavioral picture of the presenting complaint(s) and a formulation of interpersonal (social cybernetic) problem maintenance, which led us to generate the specific strategic objectives outlined above. Along the way the team took careful note of the partners' preferred views and explanations for what they were doing. These views (noted above) were not targets for intervention, as they might be in CBT, but rather suggested useful frames for pattern interruption. The team also had brief, separate meetings with Mark and Emma in Session 2 to evaluate commitment to the relationship and identify other concerns (including potential violence) that may not have come up in the conjoint sessions.

The assessment phase also included several forms of indirect intervention. To promote communal coping, the consultants asked about and reinforced Mark and Emma's recollections of how they had successfully resolved difficulties together in the past. The team also framed questions in terms of their implications for "you as a couple" and created externalizing frames to accentuate how the couple had worked together to ward off various "invaders" of their relationship (e.g., the "fog of mental illness," the relatives who doubted the marriage could succeed). Similarly, a solution-focused homework assignment at the end of Session 1 asked the partners to notice things about themselves, each other, and

especially their relationship that they wanted to continue and preserve – in other words, what did they not want to change? (Emma came back with 7 pages of notes about this.)

Another form of indirect intervention was the daily diary Mark and Emma began shortly after Session 1 and continued for 3 weeks. Based on a preliminary formulation of problem maintenance, the team developed parallel sets of 15 questions for Mark and Emma, each answerable on a 0–10 scale. We asked the partners to leave responses on the clinic voice mail every morning before 9 AM and not to share their answers with each other. Some of the diary questions concerned problem status (e.g., "How well did Mark follow his diabetes regimen yesterday?" "To what extent did Emma become emotional?"), some concerned attempted solution patterns ("How much did you and [partner] talk about issues in your relationship?"), and some concerned partners' well-being and the state of their relationship (e.g., "How close and connected did you feel to [partner] yesterday?"). We were able to identify several clinically meaningful patterns of statistical co-variation among the diary items (see below), and incorporating this material in the opinion session seemed to increase the credibility of the team's observations and recommendations. Although difficult to document, we suspect the most powerful indirect impact of the diary exercise was to promote self-monitoring of the very behaviors we wanted to help Mark and Emma change.

The centerpiece of FAMCON is the opinion session. We built expectations about this special session from the outset, billing it as a time for the team to "tell you what we think" and "offer recommendations about ways to improve your situation." Accordingly, the team had avoided giving any direct suggestions in Sessions 1 – 3, and several times deferred requests for advice to the upcoming feedback session. To maximize gravitas, the team leader conveyed most of the opinion from a written outline, receiving support from another team member in the room and from several planned phone-ins, punctuating key points, by members behind the mirror.

The opinion itself unfolded in four parts: To open, we complimented Mark and Emma on their obvious strength as a couple, noting not only our own observations but also daily diary patterns indicating high levels of connectedness and agreement about their day-to-day experiences (suggesting they are in tune with each other). Other diary findings served to highlight points the team planned to emphasize in framing later interventions: On days when the couple talked more about their problems, things tended to go poorly for the partners and their relationship. Although Mark engaged in healthy routines more often than Emma did, the data suggested that Emma felt better about herself and closer to Mark on days when she herself adopted healthy routines. Finally, responses to questions about caretaking suggested that Emma took care of Mark more than vice versa, but caretaking by Mark was associated with increased well-being and relationship quality from Emma's perspective.

The second and most elaborate part of the opinion aimed to interrupt problem-maintaining patterns related to Emma's emotional intensity, Mark's withdrawal, and the couple's escalating arguments. We began by recalling the couple's wish to learn better ways to communicate about their differences, as well as their shared concern about Emma's albeit justified rage: If the team had ideas about alternative communication strategies, or

about effective rage management techniques, would the couple want to know about them? With strong client affirmation, the consultants elaborated a rationale for why nonverbal modes of communication could be especially useful in Mark and Emma's situation. In particular, it would be helpful to have a way to signal each other when someone feels a situation is becoming potentially volatile (e.g., when Emma begins pushing Mark to talk about something, or Mark wants to tell Emma to calm down). Then, rather than going to the water cooler to talk, each person goes to a quiet place in the apartment to sit and reflect (or meditate, as Emma had said she wanted to learn to do) for at least 10 minutes. After this time out period, the partners should check in with each other, but again do this non-verbally, with touches, facial expressions, or even a hug. In discussing these suggestions, Mark and Emma enthusiastically identified a time out hand signal they could use and said they would give this a try. The consultants advised caution: This is a difficult task, not for everyone, but a couple as in tune as Emma and Mark might have a chance of pulling it off.

The team also predicted that, despite the couple's best efforts, there would inevitably be times when Emma lapsed into rage, and when that happened, Mark's taking charge would be crucial. We then presented the couple with a foam encounter bat and instructed Mark on how to help Emma express and ventilate (rather than suppress) her rage by pounding the bat on an inanimate object such as a chair, or even the floor. It was especially important for Mark to prescribe the dosage (number) of hits and supervise the entire therapeutic process. To reinforce this prescription, we invited Mark and Emma to practice the sequence in the session, and after several enactments they felt ready to proceed at home.

The third piece of the opinion essentially predicted that Emma's finding healthful routines for herself, while continuing to encourage Mark's autonomous walks, would confer benefits on both partners and the relationship. Although the team had no specific recommendations about the form such routines would take, we suggested Emma might have an epiphany about this sometime soon, perhaps while Mark was on one of his walks.

The final part of the opinion, offered very tentatively, was a restraining intervention intended to open the possibility of Emma's and Mark's moving away from their identity as psychiatric patients. We introduced this by opining that a special challenge would be for the partners to find better, more balanced ways of taking care of each other, perhaps in ways less dependent on having problems, crises, and psychiatric diagnoses. The consultants hastened to add, however, that moving in this direction could have unforeseen negative consequences. For example, developing additional activities and relationships outside the mental health system might undermine their uniqueness as a couple or disappoint the expectations of professional helpers and family members used to relating to them as psychiatric patients. These and other vague cautions, although nonsensical on close examination, avoided the critical, problem-maintaining stance of key relatives and gently challenged the couple to be normal.

When Emma and Mark returned 2 weeks later for Session 5, they reported doing much better. They had managed two timeouts, which involved more talking than the team considered ideal, but playful gesturing (especially by Mark) appeared to have prevented the usual sequences from spiraling out of control. Emma had used the encounter bat just

once, but did this at her own initiative, asking Mark to bring it out when she returned from a support group meeting feeling frustrated by a woman who had dominated the conversation. After hearing the details of what transpired, the team gently chastised Mark for abdicating his managerial caretaking responsibilities and asked him to guide Emma through another rehearsal in the session. We also recommended that Mark initiate at least one prophylactic rage management session in the coming weeks if there was no opportunity to do this remedially. Although Emma denied having any epiphany about routines, she mentioned several recent "awarenesses" that life had been better for her and Mark when she was working; that, as a nurse, she should not express anger in ways that hurt people (even Esther); and that it would be nice to take just one pill a day (preferably the Lithium) rather than the 8 or 9 she takes now. Emma had also joined Mark on some of his daily walks, which he said he welcomed.

At the final FAMCON session, 6 weeks after Session 5, the couple reported "much improved communication and no more bad fights." Mark had brought out the "heavy artillery" encounter bat only once, but for a purpose unrelated to Emma's rage: When Emma told Mark she worried about her OCD symptoms returning (e.g., intrusive thoughts, compulsions to Google things on the Internet), he suggested she "beat down those thoughts with the bat!" When she tentatively began to comply, he shouted, "There's one getting away across the carpet!" and the complaint dissolved from there.

A final, relapse prevention intervention involved asking the couple if they would know how to make things worse. More specifically, if they wanted to go back to the rages and unbearable fights of 4–5 months ago – and we certainly hoped they wouldn't do that – what could each of them do to help that happen? The pre-emptive strategic aim of these questions was to highlight each partner's specific behavioral contributions to problem-exacerbating patterns and, by implication, to define any recurrence as willful sabotage.

Outcome and Prognosis

Follow-up phone contacts with Mark and Emma 1, 4, and 12 months after the final FAMCON session revealed that their situation remained stable, at least with regard to the presenting complaints: There had been no more bad fights or uncontrolled rage, both partners expressed pride in their more nuanced approaches to communication, and Emma's OCD symptoms were no longer a pressing concern. Talking too much was still a rough spot, especially for Emma, but Mark described her as noticeably less pushy than before, and Emma said Mark was doing a better job taking care of his health (e.g., he was exercising more, eating healthier foods, and had lost almost 10 pounds). In the symptom-system fit arena, it was less clear how much Emma and Mark had done to alter the place of psychiatry in their relationship. A positive sign was that both had become active in a synagogue group and related volunteer activities, but both also continued to take multiple psychotropic medications, and Emma continued her involvement with mental health advocacy groups.

Sadly, in the last follow-up call, the couple reported that Mark's kidney cancer might be taking a turn for the worse, in that the doctors were now talking about more aggressive treatments. They conveyed this news calmly, with Emma adding a communal coda: "No matter what happens, we're in this together." Mark agreed.

Clinical Practices and Summary

The case of Mark and Emma illustrates a focused approach to couple intervention based on interrupting current patterns of problem-maintaining interaction. The methods were strategic rather than instructive and sufficed to resolve the main presenting complaint. Although Mark's aberrant health behavior (of concern to Emma more than Mark) was not an explicit target of treatment, this too improved during the course of family consultation. Less clear was whether the FAMCON process helped the couple move away from their shared identity as psychiatric patients, but this was our goal more than theirs.

Although Mark and Emma's case was in some ways difficult, it was in other ways relatively easy or at least not typical of what we encounter in FAMCON practice. First, the clients were cooperative and tended to comply with the team's therapeutic suggestions. We do not know if this was in their nature or a product of clever framing, but such cooperation is as much the exception as the rule. Even well framed interventions meet resistance, and when this happens we resort to strategic devices such as a reflecting team (where consultants discuss client behavior with family members behind the mirror) or more muscular enactment modules, which require bringing problem patterns into the therapy room and challenging them directly. Second, the interventions with Emma and Mark gained traction fairly quickly, and nurturing incipient change was relatively straightforward. This is not always so, and sometimes we try several approaches to pattern interruption before a wedge takes hold.

Third, what to call intervention was not an issue here. Although Mark and Emma were comfortable with receiving *counseling* or *therapy*, we find the label *consultation* better suited to health complaints. It is rarely a good idea to push people toward acknowledging relationship problems in the context of helping them cope with a physical illness, even when such problems may be obvious to an observer. A better approach is to frame the clinical encounter as an in-depth consultation about how to handle the complaint, where several heads are better than one, and a communal orientation by the people involved will increase the likelihood of success (Rohrbaugh & Shoham, 2011).

This approach is open to many criticisms. Some will see the social cybernetic theory as superficial and oversimplified, viewing pattern interruption as insufficient to prevent people from getting stuck in the same old ways. This makes sense from other (e.g., psychodynamic or social learning) perspectives, but our view is that iceberg assumptions about what lies beneath or antecedent to a couple's complaint serve mainly to complicate the clinician's task and make change more difficult to achieve.

Another criticism is that this approach discounts individual determinants of behavior. Indeed, identifying social cybernetic sequences requires deliberately setting aside more familiar and convenient individualistic schemas, which is not easy. Although individual factors such as partners' preferred views *do* play an important role in FAMCON, this role is secondary: We prefer to accept and use a particular view to frame suggestions for pattern interruption rather than taking the view itself (even if it appears problematic) as a target for change.

One could also fault social cybernetic intervention for not providing clients with generalizable skills and insights. Indeed, this approach makes no assumption that skill acquisition, client understanding, or corrective emotional experiences are necessary for sustainable behavior change. As Mark demonstrates, pattern interruption can be sufficient.

Similarly, because the FAMCON therapist/consultant is not always explicit with clients about the rationale for strategic intervention, this approach may seem unnecessarily manipulative. In our view, the strategic stance is most indicated when clinical problems or the relationship patterns supporting them do not change in response to straightforward evidence-based intervention: If Emma and Mark had benefitted sufficiently from the communication training they received in previous therapies, the strategic tact we took with them would not have been necessary.

Finally, because FAMCON is a time-intensive, team-based treatment, so far implemented only in university training clinics, this approach may have limited applicability to real world community settings, even in the framework of stepped care. Much work remains to determine if FAMCON can claim the status of a disseminable, cost-effective, experimentally supported treatment.

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