

Rohrbaugh, M.J., & Shoham, V. (2015). Brief strategic couple therapy: Toward a family consultation approach. In A.S. Gurman, D.K. Snyder & J. Lebow (Eds.), *Clinical handbook of couple therapy* (5th edition), pp. 335-357. New York: Guilford Publications.

CHAPTER 10

Brief Strategic Couple Therapy

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In this chapter we describe applications and extensions to couples of the “brief problem--focused therapy” developed over 30 years ago by Richard Fisch, John Weakland, Paul Watzlawick, and their colleagues at the Mental Research Institute (MRI) in Palo Alto (Weakland, Fisch, Watzlawick, & Bodin, 1974; Weakland & Fisch, 1992; Watzlawick, Weakland, & Fisch, 1974; Fisch, Weakland, & Segal, 1982). This parsimonious therapy approach is based on identifying and interrupting *ironic processes* that occur when repeated attempts to solve a problem keep the problem going or make it worse. Although Fisch, Weakland, and associates did not themselves use the term “ironic process,” it captures well their central assertion that problems persist as a function of people’s well--intentioned attempts to solve them, and that focused interruption of these solution efforts is sufficient to resolve most problems (Shoham & Rohrbaugh, 1997; Rohrbaugh, Kogan & Shoham, 2012; Rohrbaugh & Shoham, 2001, 2011).¹

The hallmark of this approach, sometimes referred to as the Palo Alto model or the MRI model, is conceptual and technical parsimony. The aim of therapy is simply to resolve the presenting complaint as quickly and efficiently as possible, so clients can get on with life: Goals such as promoting personal growth, working through underlying emotional issues, or teaching couples better problem--solving and communication skills are not emphasized. Theory is minimal and non--normative, guiding therapists to focus narrowly on the presenting complaint and relevant solutions, with no attempt to specify what constitutes a normal or dysfunctional marriage. Because the “reality” of problems and change is constructed more than discovered, the therapist attends not only to what clients *do* but also to how they *view* the problem, themselves, and each other. Especially relevant is clients’ “customership” for change and the possibility that therapy itself may play a role in maintaining (rather than resolving) problems. Finally, in contrast to most other treatments, therapists working in this tradition often see the partners individually in the context of couple therapy, even when the focus of intervention is a complaint about the marriage itself.

This model is sometimes called “strategic” because the therapist intervenes to interrupt ironic processes deliberately, on the basis of a case--specific plan that sometimes includes counterintuitive suggestions (e.g., to “go slow” or engage in behavior a couple wants to eliminate). Calling this approach “strategic therapy” alone, however, risks confusing it with a related but substantially different approach to treating couples and families developed by Jay Haley (who coined the term “strategic therapy”; 1980, 1987) and his associate Cloé Madanes (1981, 1991).² More importantly, the “strategic” label gives undue emphasis to intervention style and detracts attention from the more fundamental principle of ironic problem maintenance on which this brief therapy is based. Although Haley and Madanes sometimes used interventions similar to those practiced by the MRI group (which should not be surprising given that Haley was an early member of the MRI Brief Therapy Center), their strategic therapy makes assumptions about relational structure and the adaptive (protective) function of symptoms that the Palo Alto group deemphasized (Weakland, 1992). Useful descriptions of strategic marital therapy drawing on the Haley--Mades model can be found in Keim (1999), Cheung (2005), and Mitrani and Perez (2003), as well as in Todd’s (1986) chapter from the first edition of this *Handbook*.

Our chapter deals primarily with applications of this brief problem--focused therapy to *couple* complaints, but this is a somewhat arbitrary delimitation. As a general model of problem resolution, this therapy approaches couple problems in essentially the same way it does other complaints. Furthermore, because practitioners of this

therapy are inevitably concerned with social interaction, they often focus on couple interaction when working with “individual” problems such as depression (Watzlawick & Coyne, 1976; Coyne, 1986a), anxiety (Rohrbaugh & Shean, 1988), addictions (Fisch, 1986; Rohrbaugh, Shoham, Spungen, & Steinglass, 1995; Rohrbaugh, Shoham, et al., 2001; Shoham, Rohrbaugh, Trost, & Muramoto, 2006), and various health complaints (Rohrbaugh et al., 2012; Rohrbaugh & Shoham, 2011). For tactical reasons we may avoid calling this “couple therapy,” especially when clients present health complaints (Rohrbaugh & Shoham, 2011). This and the predilection of strategic therapists to treat couple problems nonconjointly (by seeing individuals), make it difficult to distinguish between what is and is not “couple” therapy.

BACKGROUND

Couple therapy based on interrupting ironic processes is a pragmatic embodiment of an “interactional view” (Watzlawick & Weakland, 1978) that explains behavior—especially problem behavior—in terms of what happens between people rather than within them. The interactional view grew from attempts by members of Bateson’s research group (which included Weakland, Haley, and MRI founder Don D. Jackson) to apply ideas from cybernetics and systems theory to the study of communication. After the Bateson project ended, Watzlawick, Beavin, and Jackson (1967) brought many of these ideas together in *Pragmatics of Human Communication*. Around the same time, Fisch, Weakland, Watzlawick, and others formed the Brief Therapy Center at MRI to study ways of doing therapy briefly. Their endeavors were also influenced by the “uncommon” therapeutic techniques of Arizona psychiatrist Milton Erickson, whom Haley and Weakland visited many times during the Bateson project (Haley, 1967). In retrospect, it is striking how discordant this early work on brief therapy was with the psychodynamic *zeitgeist* of the late 1960s and early 1970s, when therapies were rarely designed with brevity in mind. As Gurman (2001) pointed out, most brief therapies represent abbreviated versions of longer therapies—and most family therapies are brief by default. In its commitment to parsimony, the Palo Alto group was probably the first to develop a family--oriented therapy that was brief by design.

Beginning in 1966, the MRI’s Brief Therapy Center followed a consistent format in treating over 500 cases. Under Fisch’s leadership, the staff met weekly as a team to treat unselected cases, representing a broad range of clinical problems, for a maximum of 10 sessions. One member of the team served as a primary therapist, while others consulted from behind a one-way mirror. After treatment (at roughly 3 and 12 months following termination), another team member conducted a telephone follow-up interview with the client(s) to evaluate change in the original presenting problem and to determine whether clients had developed additional problems or sought further treatment elsewhere. The center’s pattern of practice remained remarkably consistent, with the three core members (Fisch, Weakland, and Watzlawick) all participating regularly, until Weakland’s death in 1995.³ (Watzlawick died in 2007 and Fisch in 2011.)

From the work of the Palo Alto Brief Therapy Center emerged a model of therapy that focuses on observable interaction in the present, makes no assumptions about normality or pathology, and remains as close as possible to practice. The first formal statement of this model appeared in a 1974 *Family Process* paper by Weakland et al., “Brief Therapy: Focused Problem Resolution.” At about the same time, Watzlawick et al. (1974) also published *Change: Principles of Problem Formation and Problem Resolution*, a more theoretical work that distinguished between first- and second-order change,

and provided many illustrations of ironic processes. Eight years later, Fisch et al. (1982) offered *The Tactics of Change: Doing Therapy Briefly*, essentially a how-to-treatment manual that remains the most comprehensive and explicit statement to date of the Brief Therapy Center's clinical method. In 1992, Weakland and Fisch presented a concise description of the model in a book chapter, and Fisch and Schlanger (1999) later provided another concise outline of the model, along with illustrative clinical material, in *Brief Therapy with Intimidating Cases: Changing the Unchangeable*. Although these sources do not deal with marital therapy per se, couple complaints figure prominently in the clinical principles and examples. Other applications to couples, especially when one of the partners is depressed, can be found in the work of former MRI affiliate James Coyne (1986a, 1986b, 1988). Coyne's work highlights the significance of the interview in strategic marital therapy, particularly how the therapist works to (re)frame the couple's definition of the problem in a way that sets the stage for later interventions.⁴

In addition to the ironic process model's historical connection to the strategic family therapy of Haley (1980, 1987) and Madanes (1981), we should mention its sometimes confusing connection to the *solution--focused therapy* pioneered by the late Steve deShazer and Insoo Berg (Berg & Miller, 1992; de Shazer, 1991; de Shazer et al., 1986). Inspired by the Palo Alto group, de Shazer et al. initially took Weakland et al.'s (1974) "focused problem resolution" as a starting point for a complementary form of brief therapy emphasizing "focused solution development." Subsequently, however, solution--focused therapy underwent progressive revision (de Shazer, 1991; Miller & de Shazer, 2000) and now has a substantially different emphasis than the parent model (for a detailed comparison, see Shoham, Rohrbaugh, & Patterson, 1995). One of the main points of disconnection is that de Shazer et al. (1986) tried to avoid characterizing their therapy as "strategic," preferring instead to describe it as collaborative, co--constructivist, and (by implication) not so manipulative. This (re)characterization aligns solution--focused therapy with the narrative, postmodern tradition that rejects the model of therapist-as-expert-strategist in favor of therapist-as-collaborative--partner (Nichols & Schwartz, 2000). We suspect that this distinction may be more semantic than substantive. In any case, because the idea of deliberate influence runs counter to many therapists' preferred views, calling one's therapy "strategic" is probably not a very strategic thing to do.

Although research at the MRI has been mainly qualitative, it is noteworthy that the original description of brief, problem--focused therapy by Weakland et al. (1974) included tentative 1-year outcome percentages for the first 97 cases seen at the Brief Therapy Center. In 1992, in collaboration with the Brief Therapy Center's staff member Karin Schlanger, we updated the archival tabulation of outcomes for cases seen through 1991 and attempted to identify correlates of success (Rohrbaugh, Shoham, & Schlanger, 1992). For 285 cases with interpretable follow-up data, problem resolution rates of 44, 24, and 32% for success, partial success, and failure, respectively, were very similar to the figures reported by Weakland et al. (1974) more than 15 years earlier. Thus, at least two--thirds of the cases reportedly improved, and the average length of therapy was six sessions. To investigate correlates of outcome more closely, we identified subgroups of "clear success" cases ($n = 39$) and "clear failure" cases ($n = 33$) for which 1-year follow-up data were complete and unambiguous. Then, after coding clinical, demographic, and treatment variables from each case folder, we compared the success and failure groups and found surprisingly few predictors of outcome. Interestingly, however, it appears that about 40% of the early cases seen at the Brief Therapy Center involved some form of marital or couple complaint, and we touch on some findings from the ar-

chive study in sections to follow.

Today, apart from our own work and that of several direct descendants of the MRI brief therapy team (e.g., Ray & Sutton, 2011), pure form applications of brief strategic couple therapy based on interrupting ironic processes appear relatively rare. On the other hand, principles and practices from this approach have a central role in several integrative models (e.g., Eron & Lund, 1998; Fraser & Solovey, 2007; Scheinkman & Fishbane, 2004) and have certainly influenced systems therapies more generally.

A NON-NORMATIVE VIEW OF COUPLE FUNCTIONING

Couple therapy based on interrupting ironic processes makes no assumptions about healthy or pathological functioning. In this sense, the theory is non--normative and complaint-based: In fact, if no one registers a complaint, there is no problem (Fisch & Schlanger, 1999). At the relationship level, this means that patterns such as quiet detachment or volatile engagement might be dysfunctional for some couples but adaptive for others. What matters is the extent to which interaction patterns based on attempted solutions keep a complaint going or make it worse—and the topography of relevant problem--solution loops can vary widely from couple to couple.

At the heart of brief problem--focused therapy are two interlocking assumptions about problems and change:

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. (Weakland et al., 1974, p. 144)

These assumptions imply that how a problem persists is much more relevant to therapy than how the problem originated, and that problem persistence depends mainly on social interaction, with the behavior of one person both stimulated and shaped by the response of others (Weakland & Fisch, 1992). Moreover—and this is the central observation of the Palo Alto group—the continuation of a problem revolves precisely around what people currently and persistently do (or do not do) to control, prevent, or eliminate their complaint; that is, how people go about trying to solve a problem usually plays a crucial role in perpetuating it.

A problem, then, consists of a vicious cycle involving a positive feedback loop between some behavior someone considers undesirable (the complaint) and some other behavior(s) intended to modify or eliminate it (the attempted solution). Given that problems persist because of people's current attempts to solve them, therapy need consist only of identifying and deliberately interdicting these well--intentioned yet ironic "solutions," thereby breaking the vicious cycles (positive feedback loops) that maintain the impasse. If these solutions can be interrupted, even in a small way, then virtuous cycles may develop, in which less of the solution leads to less of the problem, leading to less of the solution, and so on (Fisch et al., 1982).

Such an ironic feedback loop can be seen in the following passage from *Pragmatics of Human Communication* (Watzlawick et al., 1967), which highlights the familiar demand--withdraw cycle common to many marital complaints:

Suppose a couple have a marital problem to which he contributes passive withdrawal while her 50% is nagging and criticism. In explaining their frustrations, the husband will state that withdrawal is his only *defense against* her nagging, while she will label this explanation gross and willful distortion of what “really” happens in their marriage: namely, that she is critical of him *because* of his passivity. Stripped of all ephemeral and fortuitous elements, their fights consist in a monotonous exchange of the messages, “I will withdraw because you nag” and “I nag because you withdraw.” (p. 56)

Watzlawick et al. (1974) elaborate a similar pattern in *Change*:

In marriage therapy, one can frequently see both spouses engaging in behaviors which they individually consider the most appropriate reaction to something wrong that the other is doing. That is, in the eyes of each of them the particular corrective behavior of the other is seen as that behavior which needs correction. For instance, a wife may have the impression that her husband is not open enough for her to know where she stands with him, what is going on in his head, what he is doing when he is away from home, etc. Quite naturally, she will therefore attempt to get the needed information by asking him questions, watching his behavior, and checking on him in a variety of other ways. If he considers her behavior as too intrusive, he is likely to withhold from her information which in and by itself would be quite harmless and irrelevant to disclose—“just to teach her that she need not know everything.” Far from making her back down, this attempted solution not only does not bring about the desired change in her behavior but provides further fuel for her worries and her distrust—“if he does not even talk to me about these little things, there *must* be something the matter.” The less information he gives her, the more persistently she will seek it, and the more she seeks it, the less he will give her. By the time they see a psychiatrist, it will be tempting to diagnose her behavior as pathological jealousy—provided that no attention is paid to their pattern of interaction and their attempted solutions, which *are* the problem. (pp. 35–36)

The “solutions” of demand and withdrawal in these examples make perfectly good sense to the participants, yet their interactional consequences serve only to confirm each partner’s unsatisfactory reality. How such a cycle began is likely to remain obscure, and what causes what is a matter of more or less arbitrary punctuation: From this perspective, the problem--maintaining system of interaction is its own explanation.

THE PRACTICE OF BRIEF STRATEGIC COUPLE THERAPY

The Structure of Therapy

The basic template for brief therapy based on interrupting ironic processes involves the following steps: (1) Define the complaint in specific behavioral terms; (2) set minimum goals for change; (3) investigate solutions to the complaint; (4) formulate ironic problem--solution loops (how more-of-the-same solution leads to more of the complaint, etc.); (5) specify what less-of-the-same will look like in particular situations (the strategic objectives); (6) understand clients’ preferred views of themselves, the problem, and each other; (7) use these views to frame suggestions for less-of-the-same solution behavior; and (8) nurture and solidify incipient change (Rohrbaugh & Shoham, 2001). Sessions are not necessarily scheduled on a weekly basis, but allocated in a manner intended to maximize the likelihood that change will be durable. Thus, when the treat-

ment setting formally imposes a session limit (e.g., both the MRI's Brief Therapy Center and our own clinics limited treatment to 10 sessions), the meetings may be spread over months or even a year. A typical pattern is for the first few sessions to be at regular (weekly) intervals and for later meetings to be less frequent once change begins to take hold. Therapy ends when the treatment goals have been attained and change seems reasonably stable. Termination usually occurs without celebration or fanfare, and sometimes clients retain "sessions in the bank," if they are apprehensive about discontinuing contact.

Although two (co)therapists are rarely in the room together, practitioners of this approach usually prefer to work as a team. At the Brief Therapy Center and in most of our own work, a primary therapist sees the clients, with other team members observing (and participating) from behind a one-way mirror. Team members typically phone in suggestions to the therapist during the session, and the therapist sometimes leaves the room to consult briefly with the team. A typical time for such a meeting is late in the session, when the team can help the therapist plan the particulars of a homework assignment or framing intervention.

The team format also opens the possibility of clients' having contact with more than one therapist. As if to downplay the sanctity of "therapeutic relationship factors," the original Palo Alto group (Fisch, Weakland, Watzlawick et al.) had no reservations about one therapist substituting for another who could not be present—and in fact, about 25% of cases in the first 3 years of the Brief Therapy Center did see more than one therapist, but this proportion fell to 11% in the early 1970s, and to under 5% by the late 1980s (Rohrbaugh et al., 1992). In our own manual--guided treatments for couples who face drinking or smoking problems in one or both members, we routinely hold brief individual meetings with the partners in the second session and, whenever possible, use different members of the team to do this (Rohrbaugh et al., 1995, 2001).

As a treatment for couples, this approach differs from most others in that the therapist is willing, and sometimes prefers, to see one or both partners individually. The choice of individual versus conjoint sessions is based on three main considerations: customership, maneuverability, and adequate assessment. First, a brief strategic therapist would rather address a marital complaint by seeing a motivated partner alone than by struggling to engage a partner who is not a "customer" for change. In theory, this practice should not decrease the possibility of successful outcome, since the interactional systems view assumes that problem resolution can follow from a change by any participant in the relevant interactional system (Hoebel, 1976; Weakland & Fisch, 1992). A second reason to see partners separately, even when both are customers, is to preserve maneuverability. If the partners have sharply different views of their situation, for example, separate sessions give the therapist more flexibility in accepting each viewpoint and framing suggestions one way for her and another way for him. The split format also helps the therapist avoid being drawn into the position of referee or possible ally. The goal, however, remains to promote change in what happens between the partners.

A third reason for interviewing spouses separately is to facilitate assessment. For example, strategic therapists often make a point of seeing the partners alone at least once to inquire about their commitment to the relationship and assess the possibility of spousal abuse or intimidation (Coyne, 1988; Rohrbaugh et al., 1995). This assessment is especially important in cases where there is domestic violence but the abused partner

is too intimidated to introduce this violence as a complaint in the conjoint interview.

In our study of the Brief Therapy Center's archives (Rohrbaugh et al., 1992), cases with marital or couple complaints were more likely to be successful when at least two people (the two partners) participated in treatment. This finding would not seem to fit well with the MRI view that marital complaints can be treated effectively by intervening through one partner. On the other hand, we did not evaluate the potentially confounding role of customership in these cases, or the possibility that the absent partners were as uncommitted to the relationship as they apparently were to therapy. In any case, the Center's own data do little to undermine Gurman, Kniskern, and Pinsof's (1986) empirical generalization that "...when both spouses are involved in therapy conjointly for marital problems, there is a greater chance of positive outcome than when only one spouse is treated" (p. 572).

Role of the Therapist

The essential role of the therapist, as explained earlier, is to persuade at least one participant in the couple (or most relevant interactional system) to do less-of-the-same solution that keeps the complaint going. This essential role does not require educating clients, helping them resolve emotional issues, or even working with both members of a couple. It does, however, require that the therapist *work with the customer and preserve maneuverability*. The customership principle means simply that the therapist works with the person or persons most concerned about the problem (the "sweater" or sweaters). Preserving maneuverability means that the therapist aims to maximize possibilities for therapeutic influence, which in this model is his or her main responsibility. In *The Tactics of Change*, Fisch et al. (1982) outline tactics for gaining (and regaining) control, even in initial phone contacts, since "treatment is likely to go awry if the therapist is not in control of it" (p. xii). Preserving maneuverability also means that the therapist avoids taking a firm position or making a premature commitment to what clients should do, so that later, if they *do not* do what is requested, alternate strategies for achieving less-of-the same will still be accessible.

Despite this preoccupation with controlling the course of therapy, good strategic therapists rarely exert control directly in the sense of offering authoritative prescriptions or assuming the role of an expert. Much more characteristic of this approach is what Fisch et al. (1982) call "taking a one-down position." Early in therapy, for example, a Columbo-like stance of empathic curiosity might be used to track behavioral sequences around the complaint (e.g., "I'm a little slow on the uptake here, so could you help me understand again what it is you *do* when John raises his voice that way?"); later, when intervening to promote "less of the same," a therapist might soft-sell a specific suggestion by saying something like, "I don't know if doing this when he walks through the door will make much difference, but if you could try it once or twice this week, at least we'll have an idea what we're up against." One purpose of these tactics is to promote client cooperation and avoid the common counter-therapeutic effects of overly direct or prescriptive interventions.⁵

Empathic restraint, exemplified by the *go slow* messages discussed later in the Techniques section, is a related stance strategic therapists use to neutralize apprehension and/or resistance to change. For example, once change begins, continued gentle restraint helps the therapist respect the clients' pace and avoid pushing for more change than they can handle. A typical response to clear progress would be for the therapist to compliment clients on what they have done, yet caution them against

premature celebration and suggest again that a prudent course might be to “go slow.” Similarly, when clients fail to follow a suggestion, a common response is for the therapist to take the blame on him- or herself (e.g., “I think I suggested that prematurely”) and seek alternative routes to the same strategic objective, often within the framework of further restraint.

Although the writings of the Palo Alto group attach little importance to the therapeutic relationship, this does not mean that strategic therapists come across as cold, manipulative, or uncaring. On the contrary, most therapists we have known and seen working this way would likely receive high ratings on client rapport and “therapeutic alliance.” A reason may be that practicing this approach requires very close attention to clients’ unique language, metaphors, worldviews—and that communicating effectively within the framework of someone else’s construct system (if only to frame an intervention) usually entails a good deal of empathy.

Assessment

The main goals of assessment are to (1) define a resolvable complaint; (2) identify solution patterns (problem--solution loops) that 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, whereas the third goal is relevant to *how* to intervene.

The therapist’s first task is to get a very specific, behavioral picture of the complaint and assess who sees it as a problem, and why it is a problem now. Because the problem is not assumed to be the tip of a psychological or relational iceberg, the aim of assessment is simply to gain a clear understanding of who is doing what. A useful guideline for this phase is for the therapist to have enough details to answer the question, “If we had a video of this, what would I see?” Later the therapist also tries to get 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 into the behaviors most closely related to the problem, namely, what the clients (and any other people concerned about it) are doing to handle, prevent, or resolve the complaint, and what happens after these attempted solutions. From this step emerges a formulation of a problem--solution loop, and particularly of the specific solution behaviors that will be the focus of intervention. The therapist (or team) can then develop a picture of what “less of the same” will look like—that is, what behavior, by whom, in what situation, will suffice to reverse the problem--maintaining solution. Ideally this strategic objective constitutes a 180 degree reversal of what the clients have been doing. Although interventions typically involve prescribing some alternative behavior, the key element is stopping the performance of the attempted solution (Weakland & Fisch, 1992). Understanding problem--maintaining solution patterns also helps the therapist be clear about what positions and suggestions to avoid—what Weakland and colleagues called the “mine field.” Thus, if a husband has been persistently exhorting a wife to eat or spend less, the therapist would not want to make any direct suggestions that the wife change in these ways, so as not perpetuate “more of the same” problem--maintaining solution. A more helpful less-of-the-same stance might entail wondering with the wife about reasons why she *should not* change, at least in the present circumstances, and about how she will know whether, or when, these changes are actually worth making.

The most relevant problem--maintaining solutions are current ones (what one or both partners continue to do about the complaint *now*), but the therapist investigates solutions tried and discarded in the past as well, because these 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 hard-line 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.

Along these lines, we have found it useful to distinguish ironic solution patterns that involve action (commission) from those that involve inaction (omission). The solution of pressuring one's partner to change, as in the demand--withdraw cycle described earlier, exemplifies a commission pattern, whereas the indirect stance of the alcoholic's wife in the case just mentioned illustrates problem maintenance based on omission. Although commission patterns are more salient, ironic solutions of omission are surprisingly common, especially among couples coping with health problems, addictions, or both. One such pattern involves *protective buffering*, in which one partner's attempts to avoid upsetting a physically ill spouse sometimes inadvertently lead to more distress (Coyne & Smith, 1991; Rohrbaugh & Shoham, 2011).

The distinction between these two types of ironic processes again underscores the principle that no given solution pattern can be uniformly functional or dysfunctional: What works for one couple may be precisely what keeps things going badly for another—and a therapist's strategy for promoting less-of-the-same should respect this heterogeneity.

The final assessment goal—grasping clients' unique views, or what Fisch et al. (1982) call the "patient 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? (Eron & Lund, 1998). At some point, the therapist 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. We also find it helpful to understand how partners view themselves as a couple, 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 relationship—its values, flavor and unique style?"

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

Goal Setting

Goal setting in this approach serves several key functions. First, having a clear behavioral picture of what clients will accept as a sign of improvement helps to bring the complaint itself into focus. Without a clear complaint it is difficult to have a coherent formulation of problem maintenance (or, for that matter, a coherent therapy). Second, setting a *minimum* goal for outcome supports the therapist's tactical aim of introducing a small but strategic change in the problem--solution patterns, which can then initiate a ripple or domino effect leading to further positive developments. In this sense, the model emphasizes what some clinicians would call intermediate or mediating goals rather than ultimate outcomes. For some couples, a spin-off benefit of this strategy may be the implicit message that even difficult problems can show some improvement in a relatively short period of time.

Before setting specific goals, it is usually necessary to inquire in detail about the clients' complaint(s) and, if there are multiple complaints, establish which are most pressing. As the complaint focus becomes clear, the therapist at some point asks questions such as the following:

"How will you know the situation is improving?"

"What kinds of change will you settle for? What will need to happen (or not happen) to let you know that, even if you're not out of the woods entirely, you're at least on the right path?"

"What will each of you settle for?"

As clients grapple with these questions, the therapist presses for specific signs of improvement (e.g., having a family meal together without someone getting upset and leaving the table; a spouse showing affection without it seeming like an obligation). It is easy in such a discussion to confuse means with ends, and the therapist aims to keep clients focused on the latter (what they hope to achieve) rather than how to pursue them. Important assessment information does come from queries about what partners think they should do to make things better, but this is much more relevant to formulating problem--solution loops than to goal setting.

Techniques

The Palo Alto group distinguishes *specific* interventions, designed to interdict ironic, case--specific problem--solution loops, from *general* interventions that tend to be applicable across most cases (Fisch et al., 1982). Most of this section is devoted to illustrating specific interventions for common couple complaints. We focus especially on interventions designed to interrupt demand--withdraw interaction, a common couple pattern associated with not only marital distress but also many health complaints and addictions. First, however, we comment briefly on more general aspects of this therapy.

Because interrupting an ironic problem--solution loop usually requires persuading clients either to do less or the opposite of what they have been committed to doing, it is crucial to frame suggestions in terms compatible with clients' own language or worldview—especially with how they prefer to see themselves. Indeed, grasping and using clients' views—what Fisch et al. (1982) call "patient position"—is almost as fundamental to this form of brief therapy as the behavioral prescriptions that interdict problem--maintaining solutions. Some partners, for example, will be attracted to the

idea of making a loving sacrifice, but others may want to teach their mates a lesson. Strategic therapists are careful to speak the clients' language, use their metaphors, and avoid argumentation. These therapists not only elicit but also shape and structure clients' beliefs to set the stage for later interventions. For example, a therapist might accept a wife's view that her husband is uncommunicative and unemotional, then extend this view to suggest that his defensiveness indicates vulnerability. The extension paves the way for suggesting a different way of dealing with a husband who is vulnerable, rather than simply withholding (Coyne, 1988). A less direct way to break an ironic pattern is to redefine what one partner is doing in a way that stops short of prescribing change, yet makes it difficult for him or her to continue (e.g., "I've noticed that your reminding him and telling him what you think seems to give him an excuse to keep doing what he's doing without feeling guilty. He can justify it to himself simply by blaming you").

In addition to interventions that target specific problem--solution loops, the model uses several "general interventions" that are applicable to a broad range of problems and to promoting change in all stages of therapy. General interventions include telling clients to go slow, cautioning them about dangers of improvement, making a U-turn, and giving instructions about how to make the problem worse (Fisch et al., 1982). Most of these tactics are variations of therapeutic restraint, as described in the previous section. The most common is the injunction to "go slow," given with a credible rationale, such as "change occurring slowly and step by step makes for a more solid change than change which occurs too suddenly" (Fisch et al., 1982, p. 159). This tactic is used to prepare clients for change, to convey acceptance of reluctance to change, and to solidify change once it begins to occur. Fisch et al. suggest two reasons why "go slow" messages work: They make clients more likely to cooperate with therapeutic suggestions, and they relax the sense of urgency that often fuels clients' problem--maintaining solution efforts.

Coyne (1988) described several other general interventions that he uses in the first or second session with couples. One intervention involves asking the couple to collaborate in performing the problem pattern (e.g., an argument) deliberately, for the ostensible purpose of helping the therapist better understand how they get involved in such a no-win encounter, and specifically, how each partner is able to get the other to be less reasonable than he or she would be normally. This task is more than diagnostic, however, because it undercuts negative spontaneity, creates an incentive for each partner to resist provocation, and sometimes introduces a shift in the usual problem--solution pattern.

In terms of Bateson's (1958) distinction between complementary and symmetrical interaction patterns⁶ (cf. Watzlawick et al., 1967), some of the most common foci for specific interdiction of ironic problem--solution loops involve complementary patterns such as the familiar demand--withdraw sequence described earlier. For example, one partner may press for change in some way, while the other withdraws or refuses to respond; one partner may attempt to initiate discussion of some problem, while the other avoids discussion; one partner may criticize what the other does, while the other defends his or her actions; or one may accuse the other of thinking or doing something that the other denies (Christensen & Heavey, 1993). Each of these variations—demand--refuse, discuss--avoid, criticize--defend, accuse--deny—fits the problem--solution loop formula, because more demand leads to more withdrawal, which leads to more demand, and so on. Although the brief strategic model avoids (normative) a priori as-

sumptions about adaptive or maladaptive family relations, the clinical relevance of demand--withdraw interaction appears well established by research indicating that this pattern is substantially more prevalent in divorcing couples and clinic couples than in nondistressed couples (Christensen & Schenk, 1991), and that couples embroiled in more intense demand--withdraw interaction patterns are less ready for change (Shoham, Rohrbaugh, Stickle, & Jacob, 1998). Interestingly, many authors have described the demand--withdraw pattern and speculated about its underlying dynamics (e.g., Napier, 1978; Wile, 1981), but few have been as concerned as the MRI group with practical ways to change it.

To the extent that the partner on the demand side of the sequence is the main customer for change, intervention focuses on encouraging that person to do less of the same. In the demand--refuse cycle, one spouse may press for change by exhorting, reasoning, arguing, lecturing, and so on—a solution pattern that Fisch et al. (1982, pp. 139–152) call “seeking accord through opposition.” If the demand-side partner is the main complainant,⁷ achieving less of the same usually depends on helping him or her suspend overt attempts to influence the husband—for example, by declaring helplessness or in some other specific way taking a one-down position, or by performing an observational--diagnostic task to find out “what he’ll do on his own” or “what we’re really up against.” How the therapist frames specific suggestions depends on what rationale the customer will buy. An extremely religious wife, for example, might be amenable to the suggestion that she silently pray for her husband instead of exhorting him. Successful solution interdiction in several cases seen at the Brief Therapy Center (Watzlawick & Coyne, 1976; Fisch et al., 1982) followed from developing the frame that the behavior one partner saw as stubbornness was actually motivated by the other’s pride. Because proud people need to discover and do things on their own, without feeling pressed or that they are giving in, it makes sense to encourage such a person’s partner by discouraging (restraining) him or her. A demand-side partner who follows suggestions for doing this will effectively reverse his or her former solution to the stubborn behavior.

For some couples, the demand--withdraw cycle involves one partner’s attempt to initiate discussion (to get the other to open up, be more expressive, etc.) while the other avoids it. One of us (Shoham) had the experience of being the primary therapist for one such couple during her training at MRI. The wife, herself a therapist and the main complainant, would repeatedly encourage her inexpressive husband to get his feelings out, especially when he came home from work “looking miserable.” When the husband responded to this encouragement with distraught silence, the wife would urge him to talk about his feelings toward her and the marriage (thinking that this topic would bring out positive associations on his part and combat his apparent misery). In a typical sequence, the husband would then begin to get angry and tell the wife to back off. She, however, encouraged by his expressiveness, would continue to push for meaningful discussion, in response to which—on more than one occasion—the husband stormed out of the house and disappeared overnight. The intervention that eventually broke the cycle in this case came from Fisch, who entered the therapy room with a suggestion: In the next week, at least once, the husband was to come home, sit at the kitchen table, and pretend to look miserable. The wife’s task, when she saw this look, was to go to the kitchen, prepare chicken soup, and serve it to him *silently*, with a worried look on her face. The couple came to the next session looking anything but miserable. They reported that their attempt to carry out the assignment had failed because she—and then he—could not keep a straight face, yet they were delighted that the humor so charac-

teristic of the early days of their relationship had “resurfaced.” Whereas the intervention served to interdict the wife’s attempted solution of pursuing discussion, it also interrupted the heaviness and deadly seriousness in the couple’s relationship.⁸

When the demand--withdraw pattern involves criticism and defense, both partners are more likely to be customers for change; in these cases, change can be introduced through either or both partners. One strategy, noted earlier, is to develop a rationale for the criticizing partner to observe the behavior he or she is criticizing without commenting on it. Another is to get the defending partner to do something other than to defend—for example, by simply agreeing with the criticism or helping the criticizer “lighten up” by not taking the criticism seriously (“I guess you’re probably right. Therapy is helping me see I’m not much fun and probably too old to change,” or “You’re right. I don’t know if I inherited this problem from my parents or our kids”). In *Change*, Watzlawick et al. (1974) also describe a more indirect interdiction of a wife’s attempts to avoid marital fights by defending herself. As homework, the therapist asked the combative husband to pick a fight deliberately with someone outside the marriage. In the next session, the husband recounted in detail how his attempts to do this had failed, because he had not been able to get the other person to lose his temper. In the authors’ view, hearing this “made the wife more aware of her contribution to the problem than any insight--oriented explanation or intervention could have done” (p. 120).

Another approach to interdicting accusation--denial cycles is an intervention the MRI group calls “jamming” (Fisch et al., 1982). When one partner accuses the other of something that both agree is wrong (e.g., dishonesty, infidelity, insensitivity), and the other partner’s denial seems only to confirm the accuser’s suspicions, leading to more accusations and more denials, the jamming intervention aims to promote less of the same by both parties. After disavowing any ability to determine who is right or wrong in the situation, the therapist proposes to help the couple improve their communication (which obviously has broken down), particularly the accuser’s perceptiveness about the problem. Achieving this, the therapist continues (in a conjoint session), will require that the defender deliberately randomize the behavior of which he or she is accused (e.g., sometimes acting “as if” she is attracted to other people and sometimes not), while the accuser tests his or her perceptiveness about what the defender is “really” doing. Both partners should keep a record of what they did or observed, they are told in a conjoint session, but they must not discuss the experiment or compare notes until the next session. The effect of such a prescription is to free the defender from (consistently) defending and the accuser from accusing; thus, the circuit is “jammed,” because verbal exchanges (accusations and denial) now have less information value.

Sometimes a problem cycle is characterized by indirect demands related to the paradoxical form of communication Fisch et al. (1982) called “seeking compliance through voluntarism.” For instance, a wife may complain that her husband not only ignores her needs but that he also should know what to do without her having to tell him, as he would otherwise be doing it only because she asked him and not because he really wanted to. Or a husband may be reluctant to ask his wife to do something because he thinks she may not really want to do it. The brief therapy strategy for these situations is to get the person who is asking for something to do so directly, even if arbitrarily. If clients want to appear benevolent, the therapist can use this position by defining their indirection as unwittingly destructive; for example, “a husband’s reticence to ask favors of his wife can be redefined as an ‘unwitting deprivation of the one thing she needs most from you, a sense of your willingness to take leadership’” (Fisch et al., 1982,

p. 155). Intervening through the nonrequesting partner might also be possible, if that person can be persuaded to take the edge off the paradoxical “Be spontaneous” demand by saying something like, “I’m willing to do it and I will, but let’s face it, I don’t enjoy cleaning up.”

In other complaint--maintaining complementary exchanges, one partner may be domineering or explosive and the other placating or submissive. Here, less of the same usually requires getting the submissive, placating partner to take some assertive action.

Symmetrical patterns of problem--maintaining behavior are less common but often offer more possibilities for intervention because customership, too, is balanced. For combative couples embroiled in symmetrically escalating arguments, the strategy could be to get at least one partner to take a one-down position, or to prescribe the argument under conditions likely to undermine it (Coyne, 1988). Another symmetrical solution pattern stems from miscarriage of the (usually sensible) belief that problems are best solved by talking them through. Yet some couples—including some whose members are very psychologically minded—manage to perpetuate relationship difficulties simply by trying to talk about them. In a case treated at MRI, for example, a couple’s problem--solving “talks” about issues in their relationship usually escalated into full-blown arguments. Therapy led them to a different, more workable solution: When either partner felt the need to talk about their relationship, they would first go bowling (Fisch, April, 1992, personal communication).

Interestingly, despite their emphasis on interaction, the MRI group acknowledges a “self--referential” aspect of complaints, such as anxiety states, insomnia, obsessional thinking, sexual dysfunction, and other problems with “being spontaneous.” These complaints “can arise and be maintained without help from anyone else. This does not mean that others do not aid in maintaining such problems; often they do. We simply mean that these kinds of problems do not need such “help” in order to occur and persist” (Fisch et al., 1982, pp. 136–137).

Treatment of such problems in a couple context may involve simultaneous interdiction of both interactional and self--referential problem--solution loops. For example, with a woman who experienced difficulty reaching orgasm, the Brief Therapy Center’s team targeted two problem--solution loops: one self--referential (the harder she tried, the more she failed) and the other interactional (the more the husband inquired about how aroused she was and whether she had had an orgasm, the harder she tried to perform). One strand of the intervention was a prescription that, for the wife to become more aware of her feelings during intercourse, she should “notice her bodily sensations, *regardless of how much or how little* pleasure she may experience” (Fisch et al., 1982, p. 158, emphasis in original). The second (interactional) strand was a version of jamming: In the wife’s presence, the therapist asked the husband not to interfere with this process by checking her arousal—but if he did, the wife was simply to say, “I didn’t feel a thing.” Other strategies aimed at combined interdiction of interactional and self--referential solution patterns have been applied in the treatment of “individual” complaints, such as depression (Coyne, 1986a, 1988) and anxiety (Rohrbaugh & Shean, 1988).

Interventions for marital complaints usually focus on one or both members of the couple, yet there are circumstances in which other people—relatives, friends, or even another helper—figure prominently in this approach to couple therapy, especially when the third party is a key customer for change. For example, a mother, understand-

ably concerned about her daughter's marital difficulties, may counsel or console the daughter in a way that unwittingly amplifies the problem or makes the young husband and wife less likely to deal with their differences directly. In this case, brief therapy might focus first on helping the mother—an important complainant—reverse her own solution efforts, and take up later (if at all) the interaction between the young spouses, which is likely to change when the mother becomes less involved. Brief therapists have also found ways to involve third parties who may *not* be customers for change, particularly for problems related to marital infidelity (Teismann, 1979; Green & Bobele, 1988).

Finally, for a small subset of marital complaints, the goal of brief therapy is to help couples reevaluate their problem as “no problem,” or as a problem they can live with; strategies for achieving this goal typically involve some sort of reframing. Indeed, marriage is fertile ground for what Watzlawick et al. (1974) call the “utopia syndrome”:

Quite obviously, few—if any—marriages live up to the ideals contained in some of the classic marriage manuals or popular mythology. Those who accept these ideas about what a marital relationship should “really” be are likely to see their marriage as problematic and to start working toward its solution until divorce do them part. Their concrete problem is not their marriage, but their attempts at finding the solution to a problem which in the first place is not a problem, and which, even if it were one, could not be solved on the level on which they attempt to change it. (p. 57)

Published case reports notwithstanding, the outcome of brief therapy rarely turns on a single intervention. Much depends on how the therapist nurtures incipient change and manages termination. When a small change occurs, the therapist acknowledges and emphasizes the clients' part in making it happen but avoids encouraging further change directly. The most common stance in responding to change consists of gentle restraint (e.g., “Go slow”) and continuation of the interdiction strategy that produced it. Special tactics may be used with clients who are overly optimistic or overly anxious (e.g., predicting or prescribing a relapse), or who minimize change or relapse (e.g., exploring “dangers of improvement”). Termination occurs without celebration or fanfare. If change is solid, the therapist acknowledges progress, inquires about what the clients are doing differently, suggests that they anticipate other problems, and implies they will be able to cope with whatever problems do arise. Otherwise various restraining methods may be used. If clients ask to work on other problems, the therapist suggests taking time out to adapt to change and offers to reassess the other problems later (Fisch et al., 1982; Rosenthal & Bergman, 1986).

Before concluding the section on technique, we should note that critics sometimes regard this approach as “manipulative,” because the therapist does not usually make explicit to clients the rationale for particular interventions (Wendorf & Wendorf, 1985) and may say things he or she does not truly believe to achieve an effective framing (Solovey & Duncan, 1992). Proponents of strategic therapy counter that responsible therapy is inherently manipulative (Fisch, 1990), that therapeutic candor can be disrespectful (Haley, 1987), and that good therapy shows profound respect for clients' subjective truths (Cade & O'Hanlon, 1993).

CURATIVE FACTORS/MECHANISMS OF CHANGE

The central curative factor in this approach is interruption of ironic processes. As we have emphasized, this interruption depends on (1) accurate identification of the partic-

ular solution efforts that maintain or exacerbate the problem, (2) specifying what less of those same solution behaviors might look like, and (3) designing an intervention that will persuade at least one of the people involved to do less or the opposite of what he or she has been doing. To demonstrate such a process empirically, it is not enough to document changes in the target complaint. One needs to show that changes in attempted--solution behavior precede and actually relate to changes in the complaint. Evidence of such sequential dependencies in couples is at this point limited to case reports, though we are optimistic that quantitative methods can illuminate these processes as well.

A closely related curative factor is avoidance of ironic *therapy* processes—as can occur, for example, when “working through” a couple complaint in supportive individual therapy makes it possible for partners to avoid resolving the problem directly, or when pushing a spouse to change recapitulates a problem--maintaining solution applied by the clients themselves. The latter pattern is illustrated by our study comparing two treatments for couples in which the husband abused alcohol (Shoham et al., 1998). The two treatments—cognitive--behavioral therapy (CBT) and family systems therapy (FST)—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, whereas CBT took a firm stance about expected abstinence from alcohol, using adjunctive Breathalyzer tests to ensure compliance, FST employed less direct strategies to work with clients’ resistance. Before treatment began, we obtained observational measures of how much each couple engaged in demand--withdraw interaction, focusing on the pattern of wife’s demands and husband’s withdrawal during a discussion of the husband’s drinking. The retention and abstinence results 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 ironically have provided “more of the same” ineffective solution: The alcoholic husbands appeared to resist a demanding therapist in the same way they resisted their demanding wives.⁹

A similar concern with avoiding ironic therapy processes has influenced the framing of our manualized couple therapies for substance abuse and health problems as “family consultation” (Rohrbaugh et al., 1995, 2001, 2011; Shoham et al., 2006). By connoting collaboration and choice, the term “consultation” arouses less resistance than “treatment” and underscores our assumption that people come to therapy because they are stuck—not sick, dysfunctional, or in need of an emotional overhaul.

Although ironic processes remain primary, more recent applications of the family consultation (FAMCON) approach to health and behavior problems include a second social-cybernetic pattern of problem maintenance we call *symptom-system fit* (Rohrbaugh & Shoham, 2011), referring to deviation-minimizing negative feedback cycles in which some problem or risk behavior appears to preserve relational stability (e.g., when shared smoking or drinking maintains couple cohesion). In another departure from the pure MRI model, the FAMCON approach also aims to mobilize and/or create communal coping (*we-ness*) by the people involved as a resource for change (Rohrbaugh et al., 2012).

For better or worse, brief strategic couple therapy attaches little importance to the curative factors, such as alliance, understanding, skills acquisition, and emotional ca-

tharsis, that are central to other therapies. The focus is entirely on interrupting ironic processes in the present, with no assumption that insight or understanding is necessary for such interruption to happen. History may be relevant to clients' views, which in turn are relevant to how a therapist encourages less-of-the-same solution behavior, but interpretations (or frames) offered in this context are pragmatic tools for effecting change, not attempts to illuminate psychological reality.

A common criticism is that this approach to therapy oversimplifies—either by making unrealistic assumptions about how people change or by ignoring aspects of the clinical situation that may be crucial to appropriate intervention. Some critics find implausible the rolling--snowball idea that a few well--targeted interventions producing small changes in clients' cognitions or behavior can kick off a process that will lead to significant shifts in the problem pattern; others grant that brief interventions sometimes produce dramatic changes, but doubt that those changes last. Not surprisingly, therapists of competing theoretical persuasions object to the fact that these brief therapies pointedly ignore personality and relationship dynamics that, from other perspectives, may be fundamental to the problems couples bring to therapists. For example, Gurman (quoted by Wylie, 1990) suggested that “doing no more than interrupting the sequence of behaviors in marital conflict may solve the problem, but not if one spouse begins fights in order to maintain distance because of a lifelong fear of intimacy” (p. 31). Defenders of this approach to therapy reply that such “iceberg” assumptions about what lies beneath a couple's complaint serve only to complicate the therapist's task and make meaningful change more difficult to achieve. Unfortunately, it is unlikely that research evidence will soon resolve these arguments one way or the other.

APPLICABILITY

In principle, this brief strategic therapy model is applicable to any couple that presents a clear complaint and at least one customer for change. In practice, however, this approach may be particularly relevant for couples and clients who seem *resistant* to change. For example, the team-based family consultation for couples coping with health problems we outline below is indicated in the framework of stepped care, when other, more economical or straightforward approaches have not been successful (Rohrbaugh et al., 2012; Rohrbaugh & Shoham, 2011; Shoham et al., 2006). Published case reports in the broader literature similarly suggest that strategic therapy is most useful for difficult cases (Fisch & Schlanger, 1999). Even advocates of other treatment methods have recommended using this model's principles and techniques at points of impasse—either sequentially, when other methods fail (e.g., O'Hanlon & Weiner-Davis, 1989; Stanton, 1981), or as a therapeutic detour to take before resuming an original treatment plan (Spinks & Birchler, 1982). In addition, controlled studies of both individual problems (Shoham, Bootzin, Rohrbaugh, & Urry, 1996; Shoham--Salomon, Avner, & Neeman, 1989; Shoham--Salomon & Jancourt, 1985) and couple problems (Goldman & Greenberg, 1992) suggest that strategic interventions are more effective than straightforward emotion- or skill--focused interventions when clients are more rather than less resistant to change.

Of particular note is Goldman and Greenberg's (1992) study of couple therapy that compared a systemic treatment to Greenberg's own emotion--focused couple therapy and a waiting-list control condition. The systemic treatment employed a team format, with a one-way mirror, and “focused almost exclusively on changing current interactions, [positively] reframing patterns of behavior, and prescribing symptoms” (p. 967).

Both of the active treatments were superior to the control condition at termination, but at 4-month follow-up, the couples who had received the systemic therapy reported better marital quality and more change in their target complaint than those who had received emotion--focused therapy. This finding, coupled with their clinical observations, led the authors to conclude that the strategic approach may be well suited for change--resistant couples with rigidly entrenched interaction patterns. Goldman and Greenberg's conclusion fits well with the results of our alcohol treatment study, described earlier, in which couples embroiled in demand--withdraw interaction appeared to do better with a therapy focused on interrupting ironic processes than with CBT (Shoham et al., 1998).¹⁰

Brief strategic therapy is probably *least* applicable to couples whose concern is relationship enhancement, prevention of marital distress, or personal growth, because therapy requires a complaint and would rarely continue more than a few sessions without one. Sometimes a discussion of growth--oriented goals such as improved communication leads to specification of a workable complaint, but short of this, the therapist would *not* want to suggest or imply that clients could benefit from therapy. In fact, the ironic process idea sensitizes us to therapeutic excess and the possibility of therapy itself becoming a problem--maintaining solution. In this framework, intervention should be proportionate to the complaint—and as a general rule, less is best.

At the same time, because this approach is so complaint--focused, critics have pointed out that therapists may ignore problems, such as spousal abuse and substance abuse, if clients do not present them as overt complaints in the first session (Wylie, 1990). Although couple therapists working in this tradition explore complaint patterns in great detail, and some (like us) routinely meet with partners separately to allow an intimidated spouse to raise a complaint, the focus of intervention remains almost exclusively on what clients say they want to change. The non--normative, constructivist premise of brief therapy, which rejects the idea of objective standards for what is normal or abnormal, or good or bad behavior, may too easily excuse the therapist from attempting to discover conditions such as alcoholism or spousal abuse. According to Fisch (as cited by Wylie, 1990), Brief Therapy Center's therapists would inquire about suspected wife beating only if it were in some way alluded to in the interview. Thus, although brief therapists no doubt respect statutory obligations to report certain kinds of suspected abuse and warn potential victims of violence, they clearly distinguish between therapy and social control, and reserve the former for customers with explicit complaints.

Other ethical dilemmas in couple therapy concern dealing with the (often conflicting) agendas of two adults rather than one. In this particular approach to couple therapy, a further complication arises when a therapist intervenes through only one member of a couple, with the implicit or explicit goal of changing the behavior of not only the motivated client but also that of the nonparticipating spouse (Watzlawick & Coyne, 1976; Hoebel, 1976): What responsibility, if any, does the therapist have to obtain informed consent from other people likely to be affected by an intervention? Such questions have no easy answers.

Application: A Family Consultation Approach

Much of our own brief strategic therapy work applies a team-based family consultation (FAMCON) format to help couples and families cope with difficult health problems and addictions, and we do this in the framework of stepped care, after other interventions

do not succeed (Rohrbaugh et al., 2012; Rohrbaugh & Shoham, 2011). The FAMCON format, which typically spans 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 case-specific, often ironic interaction sequences that maintain (as they are maintained by) the target symptom or complaint and simultaneously aim to build or reinforce communal (*we-focused*) coping by the people involved. Procedurally, the FAMCON team first uses preliminary phone contacts to decide whom to see in what format (*preparation phase*) and conducts a systemic assessment of problem-maintaining interaction circuits (e.g., ironic problem-solution loops, relationship-stabilizing consequences of symptoms) via interview, direct observation, and daily diary reports (*assessment phase*). The team then offers feedback in a dramatic, carefully prepared “opinion” session designed to initiate pattern interruption either directly or indirectly and to mobilize communal resources for change (*opinion phase*); and adjusts interventions strategies to address reluctance and amplify incipient change (*follow-up phase*). Some FAMCON principles of strategic intervention are as follows: (1) call encounters “consultation,” not “therapy;” (2) formulate strategic objectives specifying what behavior by whom in which situation(s) would suffice to interrupt a particular problem-maintaining interpersonal pattern; (3) learn and use patients’ language and preferred views rather than teaching them your own; (4) avoid imparting insight or awareness, allowing cognitive change to follow successful pattern interruption as clients construct new meanings for their changed behavior; (5) use therapeutic restraint to manage reluctance; and (6) when stuck, add people – both conceptually and in the consulting room.

Our most systematic investigations of FAMCON to date have focused on couples in which one partner continued to smoke cigarettes despite having heart or lung disease (Shoham et al., 2006). However, we have also used this approach to help couples and families cope with problems ranging from heart disease, cancer, chronic pain, and pediatric obesity to alcoholism, anxiety and depression. A recent case report, for example, features an older couple with severe communication difficulties coping with the husband’s kidney cancer and diabetes (Rohrbaugh et al., 2012).

The following vignettes from our work with change--resistant smokers illustrate couple-level ironic patterns:

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 of the FAMCON intervention is to identify and interrupt ironic processes such as these. As it turns out, most ironic patterns tend to involve either doing too much, as in the first example, or doing too little, as in the second. They may also bear on smoking either directly (e.g., nagging to quit) or indirectly (e.g., pushing exercise or a particular quit strategy). Accordingly, the FAMCON therapist--consultant attends closely to ironic interpersonal cycles fueled by well--intentioned attempts to control or protect a smoker, as well as to the role smoking appears to play in the couple's relationship (e.g., promoting cohesion when both partners smoke, preserving distance when only one does). Thus, to interrupt an ironic pattern in which one partner persistently attempts (without success) to control the other partner's smoking directly, the consultant would look for ways to help the spouse back off—for example, by declaring helplessness, demonstrating acceptance, or simply observing the smoker's habits. On the other hand, when an ironic interpersonal pattern involves *avoiding* the issue of smoking, we encourage a more direct course of action (e.g., taking a stand). Compared to the alcohol--involved couples we saw earlier, our sample of health--compromised smokers tended to show ironic patterns centered more on avoidance and protection than on direct influence. Consequently, our interventions aimed more often to *increase* partner influence attempts than to decrease them.

Beyond such case--specific formulations, the FAMCON approach to smoking cessation takes great pains to avoid the kinds of ironic therapy processes that can occur when a counselor's demand for change intensifies client resistance, or when a therapist aligns with failed solutions attempted by others in the smoker's family. Not surprisingly, in the terms of psychological reactance theory (Brehm, 1966; Shoham, Trost, & Rohrbaugh, 2004), many of the smokers we see appear highly motivated to restore "threatened behavioral freedoms"—especially their freedom to smoke. For this reason, an important overarching guideline is to maximize the smoker's *choice* about various facets of the FAMCON process. We also believe that presenting FAMCON as "consultation," a term that connotes collaboration and choice, arouses less reactance than calling it "treatment" (Wynne, McDaniel, & Weber, 1987).

Ideally, FAMCON for change--resistant smokers proceeds through three sequential phases—the preparation phase, the quit phase, and the consolidation phase—that together encompass up to 10 sessions over 3–6 months. The preparation phase includes two assessment sessions, scheduled about a week apart, in which the consultant works to identify ironic couple interaction patterns that may play a role in the persistence of smoking. In the third (intervention) session, the consultant presents a carefully tailored "team opinion," in which he or she provides specific feedback based on information gathered during the first and second sessions. The opinion includes observations about how smoking fits the couple's relationship and why quitting may be difficult, as well as couple--specific reasons to be optimistic about success and issues for the couple to consider in developing a quit plan. The consultant couches the opinion in terms consistent with the clients' preferred views of themselves and their situation, and concludes the session with an invitation for the couple to consider setting a quit date. In addition to helping the partners cope cooperatively with the threat smoking poses to their health and relationship, a key consideration in the quit phase is to encourage quit strategies that interrupt or avoid ironic processes and neutralize any relationship difficulties that could arise in a smoke-free system. When smokers show signs of "cold feet," the consultant may join them with a "go slow" intervention; and when they do quit, the consultant conveys "cautious optimism" and refrains from premature celebration of change. Finally, during the consolidation phase, the consultant adjusts therapeutic sug-

gestions according to the clients' responses to previous interventions.

In addition to basic information from clinical interviews, the preparation/assessment phase draws upon quantitative daily diary data that the two partners provide independently. Specifically, the clients call our voice mail (answering machine) 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 and relationship quality (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 the questions are answered quantitatively, most on a 0- to 10-point scale, it is possible to identify couple--specific trends over time, such as the extent to which what one person does (e.g., frequency of smoking) correlates from day to day with what the other partner does (e.g., intensity of influence attempts). In addition to using this data in research, we find that presenting selected daily diary results in the feedback/opinion session enhances the credibility of the consultant's observations and therapeutic recommendations. Most couples also do a shortened version of the daily call-ins again later, for at least a week before and after their planned quit date, and this provides a basis for regular contact during the critical transition to not smoking.

The smoking cessation outcomes for couples who went through the FAMCON treatment--development project compare very favorably to benchmarks in the literature (Shoham et al., 2006). For example, the 50% rate of stable abstinence achieved by our health--compromised smokers at a 6-month follow-up is approximately twice that found in a meta--analysis of other intensive interventions with mostly shorter follow-ups (Fiore et al., 2000). Moreover, in an area where relapse rates often exceeds 50% (Stevens & Hollis, 1989), it was encouraging to see that only three smokers who quit for at least 2 days relapsed during the next year. It is also encouraging that the FAMCON intervention appeared well--suited to female smokers and to smokers whose partner also smoked—two subgroups at increased risk for relapse (Homish & Leonard, 2005; Wetter et al., 1998). Still, in the absence of a randomized clinical trial, we cannot conclude with certainty that FAMCON is superior to other cessation treatments.

CASE ILLUSTRATION

The following case, seen in a university psychology clinic and supervised by Rohrbaugh, illustrates essential elements of the MRI approach to couple problems: (1) specification of a complaint and minimum acceptable change goals; (2) formulation of an ironic problem--solution loop, including what *less* of the same solution would look like behaviorally; (3) focused interruption of the ironic loop in a specific situation; and (4) use of the client's own views and experiences to frame, or sell, the suggestion for less of the same. Because the therapist saw only the female member of the couple, this case also illustrates the brief strategic therapist's willingness to intervene in a relational system unilaterally, without conjoint sessions. [The man in the couple felt he had good reasons for not coming to the clinic, and we respected this; he did, however, give consent for therapy to address his *partner's* difficulties, including her concerns about the relationship, and he was ultimately pleased by the results.] The case may also be of interest because of what the therapist did *not* do in terms of exploring or dealing with bread-and--butter issues of other therapies.¹¹

Maria, a 26-year-old graduate student in biology, came to the clinic for "personal

counseling.” When initially asked about the problem, Maria said, “I just don’t feel good about myself, especially the way I am with men.” She went on to talk at length about her contributions to the demise of two earlier relationships, including one in which she had been engaged, and worried that she might soon spoil a third, with Harold, whom she lived with and cared for very much. Maria saw herself following a pattern with these men, one she did not like much, because it was reminiscent of how her mother had been with her father: She simply could not succeed in pleasing or sustaining intimacy with a man she loved, no matter what or how hard she tried. At the same time she resented feeling like she *should* please a man and very much wanted to avoid the kind of traditional, subservient relationship her mother had with her Mexican American father. Despite feminist sympathies, Maria felt that “old tapes from childhood” about woman–man relationships had contributed to her difficulties with men. Later in the session, she contrasted her failures in love with successes in other parts of her life: Not only was she beginning to publish in her chosen academic specialty, she felt “less anxious” and “more grounded psychologically” than she had several years earlier, when she entered graduate school. Maria attributed this mainly to her practice of “mindfulness meditation,” which she had taken up during her first year in graduate school, shortly after breaking off a brief engagement to Carlos (whom she felt was becoming emotionally abusive), and about 6 months before she became seriously involved with Harold. At the time of the first interview, Maria and Harold had been romantically involved for nearly a year and had lived together (in his house) for 5 months. They did not discuss long-term plans, and Maria’s earlier hopes that marriage would be in the offing were beginning to dim.

After listening attentively to Maria’s historical account of problems with men, the therapist asked how these difficulties were showing themselves *currently* in her relationship with Harold. To this the client said, “Well, I just seem to bring out the worst in him,” then went on to explain how Harold, a 36-year old faculty member in another department, was a very kind, loving, and sensitive man who, unlike the younger, more *machista* Carlos, could appreciate and respect a competent woman. Nevertheless, Harold was sometimes sensitive to the point of insecurity: He had some “jealousy issues,” which the couple attributed to “traumatic residue” from his ex-wife’s affairs some years earlier. Try as she might, Maria had not been able to provide the reassurance Harold seemed to need. In fact, their attempts to discuss the jealousy issue sometimes led to “really bad arguments, like the one last week before I called the Clinic”—hence, the fear about “bringing out the worst.”

Seeking a more behavioral complaint description, the therapist at this point asked Maria to describe what typically happened when she and Harold tried to discuss the jealousy issue, perhaps using the previous week’s incident as an example: “How does the issue come up? Who says or does what? What happens then? If we recorded your interaction on video, what would I see?” From questions along this line emerged the outline of a problem–solution loop: When Harold expresses concern about whether Maria finds him sexually attractive, Maria typically explains (patiently at first) that yes, she does find him attractive, and in fact has never loved a man the way she loves him. Apparently unconvinced, Harold then asks further questions, either about the details of her past sexual experiences (especially with Carlos) or about men she finds sexually attractive now. For her part, Maria responds to this by denying other interests, offering further reassurances that Harold really has nothing to worry about, and expressing her growing frustration with Harold’s inability to trust her. Once, in response to persistent questioning, Maria had actually tried to describe her lovemaking with Carlos, calling it

“vigorous, at least on his part,” but “unsatisfying for me, because I felt used.” To Maria’s dismay, Harold questioned her about “vigorous orgasms” in a later dispute, and the accuse–deny sequence between them had several times escalated to the point of yelling and name–calling. On one such occasion she stormed out of the house, and on another, Harold threw a book, accidentally breaking a lamp. These “blow-ups” were invariably followed by periods of remorse, in which both partners (but especially Maria) would try to take responsibility for what happened and resolve not to let it happen again. While allowing that Harold’s fits of jealousy were often “unreasonable,” Maria clearly regarded them as anomalous to his otherwise pleasing personality and felt that the blow-ups mainly reflected her inability to meet his needs. Despite these complications, Maria confided that she and Harold really did have good sex, especially when they had not tried beforehand to talk about it, which was all the more reason to save the relationship.

Toward the end of the first session, the therapist asked what Maria hoped to gain from coming to the Clinic, and what she would take as a tangible sign that the situation with Harold was improving. She said she most wanted to understand *why* she was unsuccessful with men, because this might help her save the relationship with Harold. The therapist did not challenge this, but pressed instead for a minimum change goal: “What, when it happens, will let you know that you and Harold are getting a handle on the jealousy problem? Or that even though he might not have proposed marriage, your relationship is at least heading in the right direction?” Maria said she just did not want him to be jealous, and eventually she agreed that not having arguments about sexual matters, even if Harold brought it up, would be a significant indication that things were improving. After consulting with the team behind the one-way mirror, the therapist closed the session by suggesting that Maria tell Harold at least about her first goal (to understand *her* contribution to problems in important relationships), and to ask whether he might be willing to help with this later, particularly since he knows her so well—assuming that we (the team) could think of something he could do. [The rationale here was to open the door for Harold’s possible participation in the therapy, yet to do so in a way that respected Maria’s—and perhaps also Harold’s view—that the problem was *hers* rather than his or even theirs. [In retrospect, it would probably have been better to ask Maria’s permission to call Harold directly, so that we could better assess his customership and control the message. Later, after the next session, the therapist in fact did this.]

Maria opened the second session by announcing that her homework assignment had not gone well. Although Harold had known about the counseling appointment and felt OK about Maria getting help, he had not expected (she said) that so much time would be spent talking about *him*. Furthermore, as for helping with the therapy, there was no way that he, a tenured professor at the university, could be comfortable with the videotaping and observation room setup, or with talking about personal matters to graduate students and faculty from another department. When asked why she thought Harold reacted this way, and how she handled it, Maria said she thought he might have been embarrassed. She had tried to reassure him that she was really coming to work on her own problems, not to complain about him, but this did not work, so rather than risk another argument, she decided to apologize quietly and drop the subject. After a phone-in from the team, the therapist conveyed to Maria the team’s apology for putting her in this awkward position and asked permission for us to call Harold and apologize to him as well. Maria was initially reluctant, but agreed to the call, adding that she would probably warn Harold what was coming.

The rest of the second session was devoted to further investigation of the problem--solution pattern identified in the first session to develop a clearer picture of what less of the same (the strategic objective) might look like on Maria's side. Although characteristic "solutions" such as explaining, reassuring, and denying were already in focus, it was not clear in what situation(s) the escalating interaction sequence most typically occurred. Questions about this yielded few specific answers: In fact, Maria found it disconcerting that she could not predict *when* Harold would ask her a "sexual attraction" question, because if she could, she might better prepare for it: "It can just come out of the blue, like when he's reflecting on things—even good things." Another useful piece of information came from questioning Maria about solutions that did work for her, at least with other problems. Here we were particularly interested in how she used mindfulness meditation, and what this meant to her. Maria did meditation exercises every morning and preferred to do them when Harold was not in the house, so as not to disturb or distract him. She also said that meditations—and more generally, the Eastern idea of "yielding"—had helped her cope with interpersonal stresses, particularly after problems with Harold. When feeling stressed in this way, Maria would try to "yield" by taking a "miniretreat," which amounted to a brief period of private meditation, again away from Harold. These miniretreats were inevitably "healing, at least temporarily," but they were not always possible to arrange. A final line of questions concerned the views and possible solution efforts of people beyond the couple, such as relatives, friends, and colleagues. Here we learned that Maria spoke several times weekly on the phone with her mother, whose opinion was that the relationship with Harold was unlikely to succeed, in part because he was from a different cultural and religious background. Maria did not argue with her mother about this, but at the same time she stiffened her resolve to succeed in love, as well as work. After all, her mother had at first been skeptical about her career plans, too.

The therapist called Harold several days after the second session as agreed, and found him symmetrically apologetic about the misunderstandings surrounding Maria's therapy. Harold said he hoped the counseling could help Maria, who he felt was often "too hard on herself," and maybe if that happened, there would be some indirect benefits for the relationship. He hoped the therapist would understand, however, why he did not want to come in himself. Sensing that this was not a matter for negotiation, the therapist said she did understand and that we, too, wished the best for his and Maria's relationship. Although careful not to comment or ask questions about any particulars of the relationship, the therapist did ask Harold if she might call him again "sometime down the road" to consult, if she and Maria thought that might be helpful. After a brief hesitation, he agreed to this request.

At a staff meeting a few days later, the team reviewed the accumulated information about the case, sharpened its formulation of problem maintenance, and planned the particulars of an intervention for the third session. Focusing on the jealousy sequence, it was clear that the main thrust of Maria's solution effort involved *talking* with Harold about his fears and concerns, notably, explaining and reasoning with him, offering reassurances, and denying that she was sexually attracted to other men. It was equally clear that less of this solution—the strategic objective that, if accomplished, would suffice to break the cycle—should involve *not* trying to talk Harold out of his concerns or, perhaps better, not talking in the face of accusations at all. [The team briefly considered ways Maria might reverse her usual stance (e.g., by agreeing with Harold and amplifying his concerns), but this seemed provocative and much too risky.] Because it is usually easier in such a context for clients to do something than not to do something, the

team considered what the therapist could ask Maria to do that would effectively block her usual solution efforts. After some discussion, it was decided that the simple act of meditation, if done at the right time in Harold's presence, could serve this purpose nicely. An advantage was that the behavior of sitting quietly, breathing evenly, and focusing inwardly, with her eyes closed, was familiar to Maria and a proven way of coping with stress. On the other hand, because Maria preferred to meditate alone, so she would not distract or disturb him, it might be difficult to persuade her to do this with Harold not only present but also actively attempting to engage her in conversation. A final consideration was that the target sequence often came "out of the blue," with no predictable onset. This meant that Maria's strategic meditation would need to occur contingently, and that when to attempt this should be spelled out clearly in the intervention.

As the team pondered how to frame the meditation intervention in a way that Maria would accept, several aspects of her preferred views, or "position," seemed especially relevant: First, saving the relationship and being helpful to Harold were high on Maria's list of concerns. Second, she understood that mindfulness meditation and knowing when to yield can help people cope with stressful situations, so perhaps this idea could be extended to include possible future benefits for Harold and the relationship, as well as for her. Second, because Maria believed that self-understanding was the preferred path to personal growth and change, it might be advisable to frame the meditation task as something likely to provoke unforeseen insights, primarily for her, but perhaps (eventually) for Harold too. Another aspect of client position that the team considered was Maria's resolve not to be constrained by her mother's expectations, but because this did not seem applicable to framing the meditation intervention, it was held in reserve for possible use later in the therapy.

Session 3 began with a report on Harold's reactions to the therapist's phone call, which Maria characterized as more thoughtful and considerate than she had expected. Although the couple had had a good week, with no jealousy or sexual-attraction disputes, Maria was not optimistic that this state of affairs would continue. The therapist agreed with her assessment, adding that the team had given some thought to Maria's situation and had come up with some ideas that might help in her self-analysis. When Maria said she would like to hear about those ideas, the therapist proceeded to frame the intervention: First, she said, it might be helpful if Maria had a way to cope with the jealousy situation on the spot, so it would be less likely to get out of hand. Second, it might be possible to do this in a way that helps us understand more about *why* Maria behaves as she does, at least with Harold, which in turn could give clues about how to change. Finally, though the team was not sure, what they had in mind might also help Harold with the stress he must be experiencing, and perhaps even help him take stock of what he could do to make the relationship better. [Through all of this, both the therapist and team behind the one-way mirror carefully watched Maria's nonverbal expression, particularly her head nods, to see whether she seemed to be accepting the frame. Only the part about Harold taking stock of his own contributions seemed to evoke skepticism, and the therapist quickly downplayed this as "a pretty unlikely possibility."] Taking a position of mild restraint, the therapist then said that although she knew of several small but specific steps Maria could take to accomplish these things, those steps could be difficult, and she (the therapist) was reluctant to add to Maria's burden. After Maria responded by affirming her commitment to "doing whatever is necessary," the therapist, with an air of caution, proceeded to lay out the strategic meditation idea and its rationale.

The key to doing the meditation successfully, the therapist explained, would be for Maria to pay close attention to her own reactions. When she was sure she felt like defending herself or reasoning with Harold about sexual matters, she should do the following: (1) Look toward the ceiling and politely say, "Excuse me, Harold"; (2) ceremoniously assume a comfortable meditation position on the floor; (3) close her eyes; and (4) begin meditating. If Harold attempted to interrupt this or draw her into conversation, she should simply say, without opening her eyes, "The counselor suggested I do this when I feel stressed. I'll be available again in about 15 minutes." If Harold became upset or tried to roust her from meditation, she would simply remain silent and yield, Gandhi style, no matter what the provocation. Afterwards, she might do whatever felt natural, either with Harold or without him. The therapist went on to underscore the potential enlightenment value of this exercise, pointing out that the team was reasonably confident that should Maria have opportunity to do this a few times, some insights would emerge to shed light on either her habitual difficulties with men or what the future might hold for herself and Harold. The team did not know what form these insights might take, what they might mean, or how soon they would emerge after a meditation session, but the therapist expressed confidence that she and Maria would know how to handle them when the time came. The session closed with Maria reassuring the therapist that the meditation experiment would not be too burdensome for her. Maria also noted that, in her experience, important awarenesses usually occurred well after a mindfulness meditation, for example, while taking a hike. The therapist was unsure what Maria meant by this, but she did not explore it further.

When Maria returned for Session 4, two weeks later, she reported there had been no occasions to try the meditation experiment. Although she had considered doing it several times when she was beginning to feel irritated with Harold, these situations were not really related to the jealousy issue, so she held back. Actually, Maria said, knowing what she would do if/when a difficult situation came up had made her feel more confident, and she wondered whether she might have behaved a little differently around Harold because of this. The therapist complimented her on feeling confident, but suggested that she "go slow" with behaving differently around Harold due to uncertainties about how he (and they) might handle it. The therapist also expressed mild chagrin that Harold had not provided Maria with the learning opportunity she had anticipated. After a period of general discussion about parity in man-woman relationships, the therapist returned to the "missed opportunity" problem and suggested the possibility of delaying the next session until Harold had "misbehaved" to the point of allowing Maria to try the meditation experiment. Maria at first seemed puzzled by this, because she thought talking things out would continue to help her, but she agreed to call in a month for another appointment, or possibly sooner, if she had the fortunate (?) opportunity to meditate in front of Harold.

Roughly a month after Session 4, the therapist received a phone message from Maria announcing: "Big news! Harold proposed!!!" And in a session a few days later, she explained what had happened. One evening not long after the last session, Harold had again tried to draw Maria into a discussion of Carlos's sexual prowess, and after only a minute of this, she had invoked the meditation routine. After she began, he had said, "What the hell?" With eyes closed, Maria repeated the brief explanation about feeling stressed. As best she could tell, Harold left the room a minute or so later, then left the house. He came back fairly late, after Maria had gone to bed, but the next morning before she finished her shower he had prepared pancakes (something he had not done since early in the courtship). At breakfast, after a period of silence, Harold proffered an

awkward apology for his insensitivity over the past few months, then asked whether Maria might teach him how to meditate. This was something she had urged him to try a number of times in the past, but he had shown little interest, and she had thought better of pursuing it further. In any case, Maria and Harold had good sex that evening; afterwards, she instructed him in mindfulness meditation. Much to her delight, they had meditated together every morning since then, except for a few days when Harold went to a meeting out of town. There had been two potential recurrences of the jealousy sequences, but Maria had nipped each of these in the bud—the first by looking at the ceiling and closing her eyes, and the second by playfully saying “Meditation time.” As for “insight and awareness,” Maria said that once she and Harold began meditating together, she realized how “enabling” she had been by preventing him from taking a full share of responsibility for the success of their relationship. Again, however, the team was not entirely sure what to make of this realization, so the therapist respectfully validated it without much elaboration.

Finally, when asked why she decided to come back to the clinic, Maria said she had thought about calling to schedule an appointment earlier, around the time of the first potential jealousy recurrence, but she decided not to risk spoiling her success (and upsetting Harold) by doing that. In fact, she would probably not have called when she did except that, this time, Harold had suggested it. Therapy terminated at this point, amid messages that both congratulated Maria (and, through her, Harold) on what they had accomplished and cautioned her against thinking the road ahead would be trouble free. The therapist would be available over the next few months in case she (or they) wanted to visit the clinic again, and Maria could count on a routine follow-up call from the clinic in 6–12 months. A few days later, the therapist received a personal note from Harold, expressing his sincere thanks for “helping Maria come to terms with the stress in her life.” Harold felt that this had helped him, too. In the follow-up contact 9 months later, Maria reported no further recurrences of the jealousy complaint. In addition, she was married and pregnant.

ACKNOWLEDGMENTS

This work was partially supported by Grant Nos. R21-DA13121, R01 DA17539, and U10 DA15815 from the National Institute on Drug Abuse.

SUGGESTIONS FOR FURTHER STUDY

Fisch, R., Weakland, J. H., & Segal, L. (1982). *The tactics of change*. San Francisco: Jossey-Bass.

Rohrbaugh, M.J., Kogan, A.P., & Shoham, V. (2012) Family consultation for psychiatrically complicated health problems. *Journal of Clinical Psychology, 68*, 570-580.

Rohrbaugh, M. J., & Shoham, V. (2001). Brief therapy based on interrupting ironic processes: The Palo Alto model. *Clinical Psychology: Science and Practice, 8*, 66–81.

Rohrbaugh, M. J., & Shoham, V. (2011). Family consultation for couples coping with health problems: A social-cybernetic approach. In H.S. Friedman (Ed.), *Oxford handbook of health psychology*, pp. 480-501. New York: Oxford University Press.

REFERENCES

- Bateson, G. (1958). *Naven* (2nd ed.). Stanford, CA: Stanford University Press.
- Baucom, D. H., Shoham, V., Meuser, K. T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. *Journal of Consulting and Clinical Psychology, 65*, 53–88.
- Berg, I. K., & Miller, S. D. (1992). *Working with the problem drinker: A solution--focused approach*. New York: Norton.
- Brehm, J. W. (1966). *A theory of psychological reactance*. New York: Academic Press.
- Cade, B., & O'Hanlon, W. H. (1993). *A brief guide to brief therapy*. New York: Norton.
- Cheung, S. (2005). Strategic and solution-focused couple therapy. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 194-210). Hoboken, NJ: John Wiley & Sons.
- Christensen, A., & Heavey, C. L. (1993). Gender differences in marital conflict: The demand/withdraw interaction pattern. In S. Oskamp & M. Costanzo (Eds.), *Gender issues in contemporary society* (pp. 113–141). Newbury Park, CA: Sage.
- Christensen, A., & Schenk, J. L. (1991). Communication, conflict, and psychological distance in nondistressed, clinic, and divorcing couples. *Journal of Consulting and Clinical Psychology, 59*, 458–463.
- Coyne, J. C. (1986a). Strategic marital therapy for depression. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy*. New York: Guilford Press.
- Coyne, J. C. (1986b). Evoked emotion in marital therapy: Necessary or even useful? *Journal of Marital and Family Therapy, 12*, 11–14.
- Coyne, J. C. (1988). Strategic therapy. In J. Clarkin, G. Haas, & I. Glick (Eds.), *Affective disorders: Family assessment and treatment* (pp. 89–113). New York: Guilford Press.
- Coyne, J. C., & Smith, D. A. (1991). Couples coping with a myocardial infraction: Contextual perspective on wife's distress. *Journal of Personality and Social Psychology, 61*, 404–412.
- de Shazer, S. (1991). *Putting differences to work*. New York: Norton.
- de Shazer, S., Berg, I., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., et al. (1986). Brief therapy: Focused solution development. *Family Process, 25*, 207–222.
- Eron, J.B., & Lund, T.W. (1998). Narrative solutions couple therapy. In M.F. Datillio (Ed.), *Case studies in couple and family therapy*. New York: Guilford Publications.
- Fiore, M. C., Bailey, W. C., Cohen, S. J., Dorfman, S. F., Goldstein, M. G., Gritz, E. R., et al. (2000). *Treating tobacco use and dependence. Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Fisch, R. (1986). The brief treatment of alcoholism. *Journal of Strategic and Systemic Therapies, 5*, 40–49.
- Fisch, R. (1990). "To thine own self be true . . .": Ethical issues in strategic therapy. In J. Zeig (Ed.), *Brief therapy: Myths, methods, and metaphors* (pp. 429–436). New York:

Brunner/Mazel.

- Fisch, R., & Schlanger, K. (1999). *Brief therapy with intimidating cases: Changing the unchangeable*. San Francisco: Jossey-Bass.
- Fisch, R., Weakland, J. H., & Segal, L. (1982). *The tactics of change: Doing therapy briefly*. San Francisco: Jossey-Bass.
- Fraser, J.S., & Solovey, A.D. (2007). Second-order change in psychotherapy: The golden thread that unifies effective therapies. Washington, DC: APA Books.
- Goldman, A., & Greenberg, L. (1992). Comparison of integrated systemic and emotionally focused approaches to couples therapy. *Journal of Consulting and Clinical Psychology, 60*, 962–969.
- Green, S., & Bobele, M. (1988). An interactional approach to marital infidelity. *Journal of Strategic and Systemic Therapies, 7*, 35–47.
- Gurman, A. S. (2001). Brief therapy and family--couple therapy: An essential redundancy. *Clinical Psychology: Science and Practice, 8*, 51–65.
- Gurman, A. S., Kniskern, D. P., & Pinsof, W. (1986). Research on the process and outcome of marital and family therapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 565–624). New York: Wiley.
- Haley, J. (1967). *Advanced techniques of hypnosis and therapy: Selected papers of Milton H. Erickson, M.D.* New York: Grune & Stratton.
- Haley, J. (1980). *Leaving home*. New York: McGraw-Hill.
- Haley, J. (1987). *Problem--solving therapy: New strategies for effective family therapy* (2nd ed.). San Francisco: Jossey-Bass.
- Hoebel, F. C. (1976). Brief family--interactional therapy in the management of cardiac-related high-risk behaviors. *Journal of Family Practice, 3*, 613–618.
- Homish, G. G., & Leonard, K. E. (2005). Spousal influence on smoking behaviors in a U.S. community sample of newly married couples. *Social Science and Medicine, 61*, 2557–2567.
- Keim, J. (1999). Brief strategic marital therapy. In J. M. Donovan (Ed.), *Short-term couple therapy* (pp. 265–290). New York: Guilford Press.
- Klinetob, N. A., & Smith, D. A. (1996). Demand--withdraw communication in marital interaction: Test of interspousal contingency and gender role hypotheses. *Journal of Marriage and the Family, 58*, 945–957.
- Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.
- Madanes, C. (1991). Strategic family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 2, pp. 396–416). New York: Brunner/Mazel.
- Miller, G., & de Shazer, S. (2000). Emotions in solution--focused therapy: A re--examination. *Family Process, 39*, 5–23.
- Mitrani, V.B., & Perez, M.A. (2003). Structural-strategic approaches to couple and family

- therapy. In T.L. Sexton, G.R. Weeks, & M.S. Robbins (Eds.), *Handbook of family therapy* (pp. 177-200). New York: Brunner-Routledge.
- Napier, A. Y. (1978). The rejection--intrusion pattern: A central family dynamic. *Journal of Marriage and Family Counseling*, 4, 5-12.
- Nichols, M. P., & Schwartz, R. C. (2000). *Family therapy: Concepts and methods*. Boston: Allyn & Bacon.
- O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. New York: Norton.
- Rohrbaugh, M. J., & Shean, G. (1988). Anxiety disorders: An interactional view of agoraphobia. In F. Walsh & C. Anderson (Eds.), *Chronic illness and the family* (pp. 65-85). New York: Brunner/Mazel.
- Rohrbaugh, M.J., Kogan, A.P., & Shoham, V. (2012) Family consultation for psychiatrically complicated health problems. *Journal of Clinical Psychology*, 68, 570-580.
- Rohrbaugh, M. J., & Shoham, V. (2001). Brief therapy based on interrupting ironic processes: The Palo Alto model. *Clinical Psychology: Science and Practice*, 8, 66-81.
- Rohrbaugh, M. J., & Shoham, V. (2002). Family systems therapy for alcohol abuse. In S. Hofmann & M. C. Tompson (Eds.), *Handbook of psychosocial treatments for severe mental disorders* (pp. 277-295). New York: Guilford Press.
- Rohrbaugh, M. J., & Shoham, V. (2011). Family consultation for couples coping with health problems: A social-cybernetic approach. In H.S. Friedman (Ed.), *Oxford handbook of health psychology*, pp. 480-501. New York: Oxford University Press.
- Rohrbaugh, M. J., Shoham, V., & Schlanger, K. (1992). *In the brief therapy archives: A progress report*. Un-published manuscript, University of Arizona, Tucson.
- Rohrbaugh, M.J., Shoham, V., Skoyen, J.A., Jensen, M., & Mehl, M.R. (2012). We-talk, communal coping, and cessation success in couples with a health-compromised smoker. *Family Process*, 51, 107-121.
- Rohrbaugh, M. J., Shoham, V., Spungen, C., & Steinglass, P. (1995). Family systems therapy in practice: A systemic couples therapy for problem drinking. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 228-253). New York: Oxford University Press.
- Rohrbaugh, M. J., Shoham, V., Trost, S., Muramoto, M., Cate, R., & Leischow, S. (2001). Couple--dynamics of change resistant smoking: Toward a family--consultation model. *Family Process*, 40, 15-31.
- Rosenthal, M. K., & Bergman, Z. (1986). A flow-chart presenting the decision--making process of the MRI Brief Therapy Center. *Journal of Strategic and Systemic Therapies*, 5, 1-6.
- Scheinkman, M., & Fishbane, M.D. (2004). The vulnerability cycle: Working with impasses in couple therapy. *Family Process*, 43, 279-299.
- Shoham, V., Bootzin, R. R., Rohrbaugh, M. J., & Urry, H. (1996). Paradoxical versus relaxation treatment for insomnia: The moderating role of reactance. *Sleep Research*, 24a,

365.

- Shoham, V., & Rohrbaugh, M. J. (1997). Interrupting ironic processes. *Psychological Science, 8*, 151–153.
- Shoham, V., Rohrbaugh, M. J., & Patterson, J. (1995). Problem- and solution--focused couple therapies: The MRI and Milwaukee models. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 142–163). New York: Guilford Press.
- Shoham, V., Rohrbaugh, M. J., Stickle, T. R., & Jacob, T. (1998). Demand--withdraw couple interaction moderates retention in cognitive--behavioral vs. family--systems treatments for alcoholism. *Journal of Family Psychology, 12*, 557–577.
- Shoham, V., Rohrbaugh, M. J., Trost, S., & Muramoto, M. (2006). A family consultation intervention for health-compromised smokers. *Journal of Substance Abuse Treatment, 31*, 395–402.
- Shoham, V., Trost, S. E., & Rohrbaugh, M. J. (2004). From state to trait and back again: Reactance theory goes clinical. In R. A. Wright, J. Greenberg, & S. S. Brehm (Eds.), *Motivation and emotion in social contexts* (pp. 167–186). Mahwah, NJ: Erlbaum.
- Shoham--Salomon, V., Avner, R., & Neeman, R. (1989). You are changed if you do and changed if you don't: Mechanisms underlying paradoxical interventions. *Journal of Consulting and Clinical Psychology, 57*, 590–598.
- Shoham--Salomon, V., & Jancourt, A. (1985). Differential effectiveness of paradoxical interventions for more versus less stress-prone individuals. *Journal of Counseling Psychology, 32*, 443–447.
- Solovey, A., & Duncan, B. L. (1992). Ethics and strategic therapy: A proposed ethical direction. *Journal of Marital and Family Therapy, 18*, 53–61.
- Spinks, S. H., & Birchler, G. R. (1982). Behavioral--systems marital therapy: Dealing with resistance. *Family Process, 21*, 169–185.
- Stanton, M. D. (1981). An integrated structural/strategic approach to family therapy. *Journal of Marital and Family Therapy, 7*, 427–440.
- Stevens, V. J., & Hollis, J. F. (1989). Preventing smoking relapse using an individually tailored skills--training technique. *Journal of Consulting and Clinical Psychology, 57*, 420–424.
- Teismann, M. (1979). Jealousy: Systematic, problem--solving therapy with couples. *Family Process, 18*, 151–160.
- Todd, T. C. (1986). Structural--strategic marital therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy*. New York: Guilford Press.
- Watzlawick, P. (1978). *The language of change*. New York: Basic Books.
- Watzlawick, P., Beavin, J., & Jackson, D. D. (1967). *Pragmatics of human communication*. New York: Norton.
- Watzlawick, P., & Coyne, J. C. (1976). Depression following stroke: Brief, problem--focused treatment. *Family Process, 19*, 13–18.

- Watzlawick, P., & Weakland, J. H. (Eds.). (1978). *The interactional view*. New York: Norton.
- Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.
- Weakland, J. H. (1992). Conversation—But what kind? In S. Gilligan & M. Price (Eds.), *Therapeutic conversations* (pp. 136–145). New York: Norton.
- Weakland, J. H., & Fisch, R. (1992). Brief therapy—MRI style. In S. H. Budman, M. F. Hoyt, & S. Friedman (Eds.), *The first session in brief therapy* (pp. 306–323). New York: Guilford Press.
- Weakland, J. H., Fisch, R., Watzlawick, P., & Bodin, A. (1974). Brief therapy: Focused problem resolution. *Family Process, 13*, 141–168.
- Wegner, D. M. (1994). Ironic processes of mental control. *Psychological Review, 101*, 34–52.
- Wendorf, D. J., & Wendorf, R. J. (1985). A systemic view of family therapy ethics. *Family Process, 24*, 443–460.
- Wetter, D. W., Fiore, M. C., Gritz, E. R., Lando, H. A., Stitzer, M. L., Hasselblad, V., et al. (1998). The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline: Findings and implications for psychologists. *American Psychologist, 53*, 657–669.
- Wile, D. B. (1981). *Couples therapy: A non--traditional approach*. New York: Wiley.
- Wylie, M. S. (1990). Brief therapy on the couch. *Family Therapy Networker, 14*, 26–35, 66.
- Wynne, L. C., McDaniel, S. H., & Weber, T. T. (1987). *Systems consultation: A new perspective for family therapy*. New York: Guilford Press.