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The Therapeutic Alliance in Brief Strategic Therapy

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> We . . . see our work as very strategic. This is not in the military sense, since we view treatment as a cooperative endeavor, not an adversarial one. But the broader dictionary definition refers to strategy as "a careful plan or method," which certainly proposes forethought, judgment, and deliberate choices of one's actions.
>
> WEAKLAND, 1992, p. 142

As a discussion of the therapeutic alliance in strategic therapy written by authors including a former member of the Mental Research Institute (MRI) Brief Therapy Center staff, this chapter represents a first of sorts. In their writings, strategic therapists have emphasized *techniques* to the exclusion of *relationship*. To readers familiar with the approach, a discussion of the therapeutic alliance in strategic therapy might seem as odd as discussions of the therapeutic alliance in behavior therapy would have been in the early 1970s, prior to Goldfried and Davison's (1976) seminal chapter on the topic. We will start by arguing that the reluctance of strategic therapists to discuss their approach in terms of a therapeutic alliance has been principled, but that it has had some unfortunate consequences. We next provide an overview of the basic assumptions and conduct of strategic therapy. We then proceed to a strategic perspective on the therapeutic alliance more generally, and specifically, on what occurs in strategic therapy itself.

The Therapeutic Alliance in Strategic Therapy: An Oxymoron?

Writings concerning the strategic therapy developed by the MRI (Coyne, 1989; Coyne & Segal, 1982; Fisch, Weakland, & Segal, 1982; Watzlawick & Coyne, 1980; Watzlawick, Weakland, & Fisch, 1974; Weakland, Fisch, Watzlawick, & Bodin, 1974) have been curiously silent about the nature of the therapeutic alliance in this form of brief therapy (Duncan, 1992). The term *strategic* was chosen for this approach because of its emphasis on therapists accepting responsibility for their role in the change process by making deliberate choices about which strategies and tactics to adopt in assisting clients (Haley, 1973; Weakland, 1992). Considerable attention has been paid to specific therapist behaviors and broader strategies such as therapists preserving their maneuverability by adopting a *one-down position*, that is, taking steps to diminish the implied distance from clients and conveying a sense that strategic therapists themselves are modest people with insecurities and shortcomings of their own. Strategic therapy also involves the prescription of distinctive therapeutic assignments to clients, assignments often of a paradoxical nature. It would seem that an understanding of how to select and implement such interventions would require a focus on the therapeutic relationship within which they occur. Yet there is a consistent lack of discussion of the therapeutic alliance as an interpersonal relationship throughout the writings of the MRI group (for one brief exception, see Coyne, 1986).

This omission is particularly striking, given the strong Sullivanian roots of strategic therapy (Coyne & Segal, 1982). The interpersonal theory of Harry Stack Sullivan involved a key shift from viewing the individual in isolation as the focus of study and treatment to the patterning of interpersonal relationships. The founder of MRI, Don Jackson, was directly supervised by Harry Stack Sullivan. Richard Fisch, who joined the group later and who was instrumental in forming the MRI Brief Therapy Center, was also a Sullivanian by training. In the early 1960s, the MRI group began exploring how they could intervene directly in clients' lives to modify the interpersonal contexts, complex feedback processes, and characteristic responses of others that were maintaining clients in their predicaments. This was something Sullivan himself was reluctant to do (Wachtel, 1977). The MRI group's experimentation grew into strategic therapy as we now know it. Yet the Sullivanian emphasis on the interpersonal relationship as the irreducible unit of study was not extended to therapy itself.

The MRI group's eschewal of any discussion of therapy as an interpersonal relationship was a part of a deliberate effort to refocus attention on the interface between therapy and the everyday lives of clients rather than on therapy as an autonomous system of communication separate from this life. The MRI approach construes therapy as a brief series of consultations with the purpose of providing clients with a staging area to plan and begin to implement changes in their everyday lives. Strategic therapists assist clients in reframing their coping tasks so that their existing values and orientation can lead to new behaviors. Yet, therapists are skeptical of apparent change that is discussed in the therapy session, unless there is evidence that these changes have been implemented in the everyday contexts where clients' problems have been occurring. This is one of the reasons for their emphasis on therapeutic homework assignments to be completed between sessions.

The MRI group was also eager to distance themselves from the ways in which the therapeutic relationship had been construed in more conventional approaches to therapy. Both psychodynamic and humanistic therapy have tended to view the quality of the therapeutic alliance as more important than what the therapist specifically does or what is occurring in clients' lives between sessions (Bordin, 1982). One derivative of strategic therapy, solution-focused therapy, has reverted to such an exclusive focus. It analyzes what goes on between the therapist and the client. Thus, de Shazer (1993) stated:

> There are no wet beds, no voices without people, no depression. There is only talk about wet beds, talk about voices without people, talk about depression. . . . There is nothing outside of the therapy session that can help us understand what is going on in the session. (p. 89)

Yet, it is precisely this position that the MRI group rejects because of concerns that such a conceptualization reduces therapy to mere conversation, rather than a basis for clients' developing plans and making a commitment to action. Furthermore, this view of therapy excludes the actual changes relative to wet beds, voices without people, and depression that strategic therapists and their clients view as the goals of therapy.

It may well be that the same qualities of the therapeutic relationship determine a major portion of the variation in outcome across diverse therapeutic orientations (Horvath & Symonds, 1991). Surely, some basic level of trust and therapist credibility is required by all forms of therapy. There is some evidence that in strategic therapy, as in other therapies, client ratings of therapist warmth predict subsequent improvement (Green & Herget, 1991). Yet from a strategic perspective, too exclusive a focus on such ratings would leave some key

questions unanswered. First, what are strategic therapists actually doing that is reflected in client ratings of the therapeutic relationship, and how might this differ from what is done by therapists of other orientations? Second, how are these qualities of the therapeutic relationship related to what clients are able to achieve in their everyday lives, and how, in turn, do events in clients' lives determine the kind of therapeutic relationship that can be achieved?

Another reason strategic therapists have avoided much discussion of the therapeutic relationship is that traditional writings on the topic have often been associated with the assumption that therapy is, of necessity, a long-term process. The gradual development of the therapeutic relationship is assumed to be a precondition for the therapist's breaching of sensitive topics and the client's responding in a nondefensive manner. In contrast, strategic therapists immediately take steps with clients to decrease some of the social distance. With humor, irony, and calculated irreverence, they encourage clients to join with them in acknowledging what might otherwise remain obvious, but unspoken. As early as the first session, homework assignments may be negotiated as a way of gathering information, defining the nature of the therapeutic contract, or simply beginning the process of change.

Strategic therapists' reluctance to discuss the therapeutic alliance in traditional terms has been principled and defensible. Yet, such a position has distinct disadvantages when it becomes a barrier to teaching and refining strategic therapy. It is difficult to evaluate and generalize from strategic therapists' provocative case vignettes when no sense is provided of the therapeutic context in which interventions were developed, implemented, and followed up. Open-minded, but skeptical readers are left wondering how a strategic therapist could possibly have come up with an intervention in a particular situation and why the client accepted it. Obviously, the nature and effectiveness of such interventions are inextricably intertwined with the kind of relationship within which they are formulated and delivered. It is known from studies of therapists of other orientations that poorly timed and otherwise inappropriate interventions may damage the therapeutic alliance (Piper, Azrin, Joyce, & McCallum, 1991), and the influence of the quality of the alliance on the appropriateness of intervention is undoubtedly reciprocal. Moreover, when its proponents remain silent on the quality of the therapeutic relationship in which strategic interventions are delivered, the approach becomes vulnerable to caricature and distortion by critics who claim that it is manipulative and noncollaborative (see, for instance, Goolishian & Anderson, 1992). More than therapists of most orientations, strategic therapists have exposed their actual sessions with clients to scrutiny in transcripts (Fisch et al., 1982), videotapes, and observation through one-

way mirrors. Nonetheless, misperception and misinterpretation have been fostered by written presentations of their interventions in brief vignettes that grant little acknowledgment of how the therapists and clients collaborated in reaching the point of intervention and in its follow-up.

Another disadvantage of strategic therapists' reluctance to discuss the nature of the therapeutic relationship is that it has prevented others from appreciating the potential contribution of this approach to more eclectic and integrative models of therapy. As we argue in this chapter, strategic therapists sometimes simply use different terms to describe what they do in therapy; yet in other ways, they do indeed operate with some assumptions that differ from those guiding traditional forms of therapy. In some instances, strategic therapists are best seen as utilizing alternative means to achieve goals that are shared with other approaches. In other instances, strategic therapists are operating in ways that truly challenge traditional assumptions. Regardless, one cannot adequately explore such similarities and differences unless there is first greater acknowledgment of the nature of the therapeutic relationship in strategic therapy.

Some Basic Assumptions of Strategic Therapy

Strategic therapy is a pragmatic, goal-oriented, short-term approach that focuses on how clients' miscarried coping efforts are perpetuating their problems and how these efforts can be redirected. The aim of therapy is to resolve clients' presenting complaints as briefly and efficiently as possible so that the clients can get on with their lives. Yet, the focus of case formulations and therapy more generally is typically not on the presenting complaint, but rather on what clients are doing about it. Thus, the focus with a depressed client is not likely to be depression per se, but rather what the client has been attempting to do to feel better. This could be, for instance, efforts to renegotiate an unsatisfactory intimate relationship by alternately futilely arguing with the partner and then avoiding any direct expression of discontent because it only leads to futile arguing.

The assumption is that if these ineffective means of coping—these *attempted solutions* or *problem-maintaining solutions*—are redirected, then the clinical problem will resolve itself. A further assumption is made that clients persist in these ways of coping because they have become involved in the situation in a way that validates for them that this is the only or the best way they can cope. It is not assumed that they lack

the requisite skills for more effective problem solving, but rather that they fail to see the relevance of their existing skills or fail to appreciate that they are entitled to respond differently in the situation. Thus, upon careful inquiry, it might be established that a depressed woman is quite nurturant of her friends, deeply empathizes with them, and would take offense if they were to tolerate mistreatment in a close relationship. Confronted with a friend remaining in a verbally abusive relationship, the woman would undoubtedly protest that the friend should look after herself and not accept such mistreatment. Yet, the depressed woman might be in such a predicament herself because she does not similarly feel entitled to look after herself and instead accepts abusive and exploitative behavior from a partner.

Working goals are typically specific small changes in behavior, but these strategic changes are intended to instigate change of a more general nature (i.e., a fundamental shift in clients' attempted solutions). Exploring the role of the past, working through emotional issues, and teaching problem-solving or communication skills are not emphasized (Shoham, Rohrbaugh, & Patterson, 1995). Insight, increased self-awareness and emotional release may accompany change in strategic therapy, but they are not considered necessary. They often prove insufficient, and pursuit of them as ends in themselves may distract the therapists from their fundamental task: to redirect clients' miscarried efforts to cope with their problems. Clients may ultimately feel they have gained insight from therapy, but the insight is more likely the result of having effectively dealt with their situation, rather than the trigger for a behavior change.

A wide variety of interventions are used, and, most distinctively, some of them are paradoxical in nature (see Fisch et al., 1982, for actual transcripts of sessions). A key element of many of these interventions is *reframing* (Coyne, 1985; Watzlawick et al., 1974). This involves the therapist's grasping the client's interpretation of the problematic situation, actively acknowledging an acceptance of this view, and then introducing some new element into this view that leads to very different behavior. Thus, in the example of the depressed woman just presented, reframing might begin with the therapist eliciting reports of how she looks after friends, praising this virtue, and then lamenting that the woman does not have a friend immediately available to look after her in the same way. The crucial element that would be added is the suggestion that when dealing with her partner, the woman should step back, adopt the role of a friend, and follow the friend's advice. In subsequent sessions, the therapist might revert to a query such as "What would a friend say?" when the client voiced discontent about her treatment by her partner. The therapist would also assist the client in identifying instances in which she had adopted such

a perspective herself. Taken literally, such reframes may seem to request little or no change in behavior; yet, when such reframes are successful, clients are likely to give a markedly different answer to the question "What is going on here?" and their experience of the predicament and their tendencies to behave in particular ways are likely to change significantly (Coyne, 1985).

This approach assumes that clients persist in ineffectual attempted solutions because they have become committed to a particular perspective on their predicament. This perspective or framing of their situation is both the basis for the persistence of their problem and the basis of engaging them in the process of therapeutic change:

> [Clients'] existing framing of their situations reflects some mixture of what their situation affords; socioculturally provided, commonsense understanding; and the validation available in their interaction with others. Their existing frames maintain their problems, but are also the means for communicating with them and finding new solutions. Thus, in order to provide viable frames, the therapist must acknowledge some key aspects of [clients'] existing frames and link reframes to it. For reframes to endure, they must be proposed in such a manner that they validate [clients'] interactions with their everyday environments. (Coyne, 1985, p. 343)

For our present purpose of understanding the therapeutic alliance in strategic therapy, some points deserve emphasizing. Therapeutic change involves what is at least a covert challenge or unsettling of clients' existing perspective. Whatever else strategic therapists do, they try to persuade clients to take action or to adopt views that will advance the clients' interests. Therapy is inherently rhetorical, and to draw on a classic rhetoric text,

> You persuade a man only so far as you can talk his language by speech, gesture, tonality, order, image, attitude, idea, *identifying your ways with his*. . . . True, the rhetorician may have to change an audience's opinion in one respect, but he can succeed only insofar as he yields to that audience's opinions in other respects. Some of their opinions are needed to support the fulcrum by which he would move other opinions. (Burke, 1950, pp. 55–56)

Although strategic therapists strive to modify or transpose key elements in clients' understanding of their situation ("I will be a friend to myself and do what that friend suggests, rather than what I would otherwise be inclined to do"), they can succeed only if they accept key aspects of clients' own interpretations and actively communicate this acceptance. Unfortunately, writings on strategic therapy have sometimes exaggerated therapists' cleverness in formulating reframes and have downplayed the role of careful information gathering, clarification, negotiation, shaping of clients' willingness to accept interven-

tion, and timing. Furthermore, the outcome of a case is rarely set with the client's acceptance of a single reframe or assignment. Much depends on how the therapist subsequently nurtures incipient change, negotiates the client's interpretation of resultant new experiences, and manages termination (Shoham et al., 1995).

The Conduct of Strategic Therapy

Strategic therapy sessions are relatively low-key, with the therapist taking an active role in obtaining the particulars of the client's everyday life, highlighting the specific exchanges that are seen as problematic, and identifying the client's problem-maintaining solutions. An effort is made to move from abstract definitions of the problem such as the client feeling depressed or not being able to communicate with an intimate partner to specific incidents that illustrate these problems, exactly how they are distressing, and what the client has tried to remedy the situation. What is first sought is a concrete, action level of description, essentially an elaborated answer to the question, "*Who* is doing *what* that presents a problem, to *whom*, and *how* does such behavior constitute a problem?" (Fisch et al., 1982, p. 70). Additionally, the client needs to be committed to a workable goal, and an explanation is sought for why the client is seeking change now rather than previously or putting the matter off until some future time.

The therapist guides this process by requesting examples, indicating confusion when complaints are left abstract, or suggesting that therapy would proceed better if the therapist could visualize the occurrence of a problematic situation. The emphasis is on what is occurring currently in the client's life, rather than in the distant past. The most relevant situations and problem-maintaining solutions are current ones, but the therapist is also likely to at least touch upon solutions that have been tried and discarded, as well as touch upon how analogous situations have been successfully handled in the past. The intent is to reveal resources and past achievements that are relevant, but are unnoticed by the client.

Clients define their problems, even though therapists may take a key role in clarifying just what behavior is involved and in identifying what is most important to the client but initially expressed in a vague or confused manner. Ultimately, "the client is the expert on and basic determiner of the *ends* of treatment" (Weakland, 1992, p. 144). However, strategic therapists are sensitive to the possibility that in exploring precisely how a particular problem is troubling to a client, it may be revealed that the client is personally not particularly troubled

at all, but coming for therapy only because of pressure from others. The ability to define behavior as problematic and people as troubled and in need of therapy is not necessarily evenly or fairly distributed in social systems (Lakoff & Coyne, 1992). If in a particular case the therapist and client jointly conclude that a problem is mainly a problem for others, therapy may become refocused on solving the problem of the client feeling harassed, coerced, or simply misunderstood by others. Strategic therapy is decidedly nonnormative and nonjudgmental in the definition of clinical problems. The radical acceptance of the client's perspective is often subtle, but pervasive. Occasionally, this attitude on the part of strategic therapists becomes explicit. When a client opens with "I think I am kinda weird," the therapist might counter with "I have come to think we all probably are. Are you 'weird' in a way that is interesting or in a way that is troubling to you?"

As the problem becomes defined, an attempt is also made to formulate some concrete, minimal goal for treatment with answers to the question, "What would it take to indicate to you that you were on the right path, even if you were not out of the woods?" Alternatively, it might be suggested that "There is a lot of difficulty and uncertainty in your life, and we cannot expect to take care of it all. Is there one problem such that if we were able to make some small progress in dealing with it, you would feel a bit more able to cope with everything else?" When clients are facing situations that appear largely intractable to their efforts, the question of goals may be a matter of "What would it take to allow you to feel that you were handling this situation as well as you could?" In the initial interview, a therapist may realize that a pessimistic stance better matches client expectations than to propose goals that hint of an optimistic prospect. Being flexible, a strategic therapist might shift to

> It doesn't look like things will ever be the way you want them to be again. What's your bottom line? What could you live with if you really have to? (Efron & Veenendaal, 1993, p. 16)

From the start, the therapist calls attention to the time-limited nature of therapy. This brief nature of therapy can be structured in a number of different ways. At the MRI Brief Therapy Center, clients are offered 10 sessions with an understanding that they can complete therapy in fewer sessions and leave the rest "in the bank." Clients seem to find security in leaving some sessions in the bank. Even when not actually drawing on these sessions, clients' merely knowing that they are available seems to give a sense that they are not alone and that they can proceed with the assurance that they have this resource. This may give them a greater confidence in their own efficacy. Furthermore, they may sense that whatever they do is in a context of a continued rela-

tionship with the therapist, and this relationship serves as a reference point, where the therapist becomes a significant other. Clients' coping efforts may be positively affected by how they would potentially explain themselves to the therapist, and this possibility is heightened by their having the option of returning to claim their sessions in the bank. Often, when clients do eventually use their remaining sessions, they report having resolved problems in the interim in which they engaged in imagined dialogues with the therapist.

An alternative to a limited number of sessions is an agreement that therapy will proceed in short blocks, perhaps of three or five sessions, and that continuation will be based on making progress. The therapist may then make repeated reference to the time-limited nature of therapy and use this to prompt clients to think in terms of small, observable changes and to share in the responsibility for demonstrating that therapy is not a waste of time:

> I would like to think that what we are going to do here will make a difference, but we can not be sure. I don't want it to be a waste of your time, and so maybe we should plan to assess our efforts in five sessions and decide whether we have got enough evidence that we are getting somewhere to justify continuing. What would be a sign to you that we were getting somewhere? (Coyne, 1988)

The sign that is negotiated may be a goal of therapy or simply an identifiable step toward it. What is important is that continuation of therapy be justified by progress, not the lack of it. With a positive assessment of progress, a new target can be identified for the next block of sessions.

Strategic therapists proceed with an acute sense that they are not simply eliciting an account of the clients' beliefs in an interview, but also are actively shaping clients' formulation of those beliefs. In an important sense, therapists and clients are together *creating* what clients experience as a *reporting* of their beliefs. The particular questions therapists ask focus clients' attention on specific details, while distracting them from others, and a line of questioning implicitly challenges some assumptions that have been taken for granted, while leaving others unexamined. Likewise, therapists' selective responses and choices of whether to accept clients' language or introduce new language of their own shape not only the course of the discussion that follows, but also clients' understanding of themselves. Thus, in gathering information, therapists are simultaneously structuring clients' *framing* or definition of the problems, preparing them for reframes, and defining the nature of the therapeutic relationship. The interventions that can be designed by therapists and the extent to which they

can be made palatable to clients depend upon how these intermediate steps are accomplished.

In the course of the interview, strategic therapists are sensitive to the nuances of clients' choice of words. They are alert for language that reveals clients' key values and commitments in a situation—their position (Watzlawick et al., 1974)—and other language that can be adapted to their purposes. Thus, a client's presenting complaint of chronic fatigue was not ostensibly related to her divorce from a domineering ex-husband 2 years earlier. However, in a digression, she spontaneously mentioned the difficulty she had faced in convincing her ex-husband that the relationship was over, even after the divorce was final. Asked how she finally succeeded, she described a telephone conversation: "I just refused, again and again, I just refused to see him." At the end of the session, the therapist commented that she was not sure how the client would unleash the relevant resources to reclaim some of her life from the dominance of her fatigue, but that in dealing with her husband, she had shown that she had what it took. Undoubtedly, her resistance to being dominated by the fatigue would start with a defiant "I refuse." The client was then encouraged to practice saying that phrase until it no longer stuck in her throat and to notice what initiatives occurred over the next week.

Strategic therapists do not take for granted that they have achieved a sufficient understanding of clients' existing framing of their predicaments or that they have adequately communicated an acceptance of it. Instead, in the course of questioning and making interpretations, they are constantly checking and refining this understanding, adjusting to the nuances of clients' responses. In the course of the interview, strategic therapists also deliberately introduce particular language and test and shape its acceptability so that it can become the basis for subsequent intervention. For example, a depressed client had frustrated all efforts by the therapist to activate him, despite that being his stated goal. Straightforward homework assignments to increase pleasurable activities had been readily accepted, but then routinely forgotten or thwarted in the course of the time between sessions. Finally the therapist observed, "You seem to be a man who doesn't like to be pushed around by others." His stubbornness was reframed as determination, a refuge for his self-respect in the face of health problems he could not control. The therapist then asked, "In fact, if someone told you to breathe, would you be inclined to hold your breath just to spite him?" The client quickly agreed with this depiction of himself, thereby setting the stage for paradoxical intervention. At the end of the session, the client was instructed in a mock authoritarian manner to go home and, "Do nothing, rest yourself, don't give into

the urge to do something until it becomes absolutely irresistible." The following week this client reported numerous activities that had been attempted in spite of the therapist's admonition to do nothing and that he had some success. The therapist immediately backed down from his previous authoritarian stance, apologized for giving such bad advice, and pointed out that the client clearly already knew what he needed to do.

Reports of strategic interventions are easily misunderstood, particularly if they are taken as literal requests. It may seem as if clients are being instructed to do homework assignments that are bizarre and even counterproductive. Thus, a single mother complained that her 8-year-old son was demanding and disrespectful, particularly in the morning when she tried to get him ready for school. She was instructed that when the child's morning temper tantrums upset her, she should quietly make a peanut butter and tuna fish sandwich for his lunch. When the child came home and complained about his lunch, she was to apologize and state that she was so upset by the child's behavior that she must have gotten distracted and put peanut butter and tuna fish together, rather than peanut butter and jelly or tuna fish and mayonnaise. The therapist added that the woman would be doing her future daughter-in-law a favor in teaching her son now that if he mistreats women, they become less responsive to his needs. The goal was to empower the mother to take control of the situation. Although it would not have been a problem if the woman had actually made such a sandwich, doing this was considered unlikely. The expected outcome in such situation is that she would realize she has both the responsibility and the ability to regain control of a child's behavior. She would be more likely to exercise the existing option of intervening early and directly if he began misbehaving, even if she had previously denied that this was possible. Such assignments make explicit the mother's tendency to avoid conflict, even at her own expense. By giving her permission to confront the situation, even in an outlandish manner, the therapist is also implicitly communicating that she is responsible for her own behavior.

Strategic therapists are careful to follow up such therapeutic tasks in the next session with direct inquiries as to how clients interpreted them and what happened if they attempted to implement them. Yet, it is not assumed that literal interpretation and completion of such tasks as they have been prescribed are necessary or that a client's failure to complete these tasks represents sabotage or resistance. Strategic therapists are likely to react to such outcomes praising clients' assertion of their autonomy or creative reinterpretation of what has been asked of them. The therapist might even take a one-down position by apologizing for having been overcome with "therapeutic enthusiasm"

in assuming that what had worked for others fit a particular client's needs. What is important with many assignments is that they commit clients to particular perspectives and plans of action, even if this is not manifested in completion of the assignment. Thus, an ex-Catholic man was asked to tackle his excessive scrupulosity and mildly compulsive behavior with a newspaper-buying ritual. On Mondays, he was to pay for two newspapers, but only take one from a machine; however, on Tuesdays, he should pay for one and take two. Wednesdays were labeled as the most difficult day of the week: He was to take two papers, pay for one, and hope that he did not die and go to hell before he could make up the difference on Thursday. What is important in his acceptance of this assignment is that he distance himself from his guilt and accept a certain amount of discomfort as part of the process of change, not that he pay for and retrieve newspapers in a particular order.

A Strategic Perspective on the Therapeutic Alliance

As we emphasized at the outset of this chapter, one would be hard pressed to find much in the way of explicit reference to the therapeutic alliance in existing writings on strategic therapy—unless we look for discussions of technique as therapeutic relationship. Yet, that is not to say that there is not much of relevance in these writings and in clinical materials such as videotapes. In the remainder of the chapter, we will discuss the therapeutic alliance from a strategic perspective. Some points apply more generally, across orientations, whereas others are particular to the strategic approach. However, in discussing the strategic perspective, we often had to go from descriptions of specific strategies and tactics by therapists to inferences about the kind of alliance in which these arise and which they foster. In doing so, we try to make explicit what is usually only implied in writings about strategic therapy. Strategic therapists sometimes seemingly make odd requests of clients, yet this is generally done without clients defecting from therapy. Clients often do not complete therapeutic tasks as they have literally been assigned; and not only is this not typically a source of a rupture in the therapeutic alliance, it may be met with praise and enthusiasm from strategic therapists. Strategic therapy is not typically characterized by any struggle between therapist and client, and traditional conceptions of client "resistance" are absent from key writings, except as a notion to be rejected. All of this assumes a well-developed, even if quickly developed, and sometimes unusual therapeutic alliance.

Perhaps the first step in understanding the nature of the therapeutic alliance in strategic therapy is to recognize that unless there is compelling evidence to the contrary, it is not assumed that the clients are fragile. Despite any distress, impairment, or self-derogation clients may present, there are nonetheless strengths, accomplishments, and competencies in who they are and what they have made of their experiences. Strategic therapists are careful to identify and cultivate these resources, paying more attention to the positive than the negative, and they attempt to engage clients as strong, accomplished, and resourceful. Strategic therapists are explicitly committed to persuading clients to undertake changes in behavior, but they are careful to recognize the limits of their influence and acknowledge their dependence on the cooperation of clients. They are careful not to replicate what has not worked in others' efforts to influence clients. Strategic therapists also strive to avoid seeming more powerful than they are or as if they are more committed to clients achieving particular goals than to the clients themselves. They are respectful of clients' ambivalence about proceeding and acutely sensitive to the possibility that clients have appeared to fail in previous efforts to attain their goals because the clients have mouthed conventional values without actually embracing them. Strategic therapists may introduce irreverence and paradox into clients' problem-solving efforts, but if so, these inteventions are often grounded in a shared sense that conventional values and ways of dealing with the client's predicament have paradoxically not worked.

AVOIDING OTHERS' PROBLEM-MAINTAINING SOLUTIONS

Strategic therapists' assumption that clients' attempted solutions are perpetuating their problems has an important corollary. Namely, if clients have persisted in their problem-maintaining solutions, it is because they have been unsuccessful in engaging others in ways that have freed them from their ineffective approach. Clients' self-defeating strategies may even be maintained and aggravated by others' responses. It becomes important, therefore, for strategic therapists to recognize what others have tried and to avoid replicating their unsuccessful efforts. Significant others may be hostile or adversarial, but it is also possible that their efforts have been normative, kind, and reasonable, at least at the outset, but ineffective in resolving clients' predicaments.

A specific patterning of client behavior and response from others has been spelled out for depression (Coyne, 1976), but it may have broader generality for situations in which one person attempts to relieve the distress of another. The obvious distress of depressed per-

sons is compelling and invites efforts to soothe them and cheer them up. Similarly, their harsh denigration of themselves invites rebuttal: "You are not that bad of a person . . ." Their disclosure of ineptness invites constructive feedback and advice: "Why don't you . . ." Finally, their reports of victimization invite judgment about persons who are significant in their lives: "Your husband is an awful person. Why don't you . . ." Under some circumstances, these responses from others might do much to resolve transient distress. Yet, if these responses had proven sufficient, the client would not be presenting with depression. Such responses are likely to make them feel even more badly about themselves. As Watzlawick, Weakland, and Fisch (1974) have noted:

> What [others'] help amounts to is a demand that the client have certain feelings (joy, optimism, etc.) and not others (sadness, pessimism, etc.). As a result, what for the [patient] might originally only have been a temporary sadness now becomes infused with feelings of failure, badness, and ingratitude toward those who love him so much and are trying so hard to help him. (p. 34)

Like others in clients' lives, therapists are vulnerable to falling into these patterns of response. Therapists may find themselves slipping into countering depressed clients' negativity with phony reassurance and then getting into a dispute in which the depressed person gets more committed to justifying their negative view of themselves. Therapists may take the side of depressed persons in their disputes with others, only to have these depressed persons defend the people allegedly victimizing them. Finally, active, directive therapists may get more committed to plans of action than the depressed persons are, even while depending on the depressed persons to implement them. There can be a decay of helping so that therapists become frustrated, personalize depressed clients' difficulties, and ultimately become critical and rejecting (Coyne, Wortman, & Lehman, 1988).

The psychoanalysts Nacht and Racamier (1960) have unwittingly revealed taking this position with depressed clients:

> We wish to insist . . . that the depressed person . . . is always truly aggressive toward others through the very medium of the manifestations of his depression. His suffering is an accusation. His sense of incurableness is a reproach. His demands are perhaps humble, but devastating. His depression is tyrannical. He wallows in suffering, whilst trying to enmesh his object in it as well. (p 486)

Regardless of orientation, however, all therapists are potentially vulnerable to replicating these patterns. One important function for a theoretical framework for doing therapy is that it gives therapists a structure and focus to their relationships with clients so that they are

buffered from falling into the compelling, but unhelpful response that may have characterized others. At the same time, however, they also need to avoid being perceived as aloof, indifferent, cold, or rejecting.

In strategic therapy, direct inquiry about others' past efforts to assist clients, including any recent psychotherapy, is an important part of the therapists' efforts to recognize and avoid becoming involved in unhelpful or miscarried helping. Other distinctive features of the therapists' contribution to the therapeutic alliance in strategic therapy serving this purpose include therapists taking a one-down position and maintaining a sense of irony and paradox.

TAKING A ONE-DOWN POSITION

Strategic therapists have some clear advantages over their clients. If they are justified in receiving a fee for their services, they presumably have some expertise. Clients seek help from them because they have decided that their own views have proved inadequate or inappropriate to resolve their problems. Perhaps most important, strategic therapists have the advantage of only empathically hearing about clients' problems, rather than having to live them out and be worn down by them. There is an inherent power imbalance in the client–therapist relationship, but anything that therapists do to aggravate this imbalance may reduce the client resources within which therapists must work. Strategic therapists, therefore, strive to create a relationship that clients experience as low-key and free of coercion. They assume that clients are cooperative and motivated to be relieved from their distress and that their task is to avoid interfering with this. Some clients prefer an authoritative, overtly directive approach, and strategic therapists are prepared to adapt to this. However, the working assumption is that clients will be more resourceful if they do not feel they are being pressured or simply following orders. Moreover, even if the goal is to shift clients' existing framing of their predicament, care is taken to avoid embarrassing or intimidating them or otherwise making them defensive.

From the perspective of other theoretical orientations, strategic therapists may seem to be overly respectful of clients' defensiveness and seem to encourage externalization of problems. To paraphrase Robert Frost, strategic therapists believe that good defenses make good clients. Thus, if a client tends to blame a spouse for all of the problems in the relationship, a strategic therapist is unlikely to challenge this directly. Instead, the therapist may acknowledge that the spouse sounds difficult or even impossible and then inquire how the client intends to deal with this. Without being required to take responsibil-

ity for the problem, the client is shifted into considering how to take responsibility for his or her own behavior in response to it.

Strategic therapists also operate on the assumption that clients will be more resourceful and accepting of what is asked of them in therapeutic tasks if the tasks are presented in a way that emphasizes both clients' choice in whether to accept them and the sacrifice involved in doing so. Thus, having gotten an agreement from the wife of a stroke victim that she would shift from her previous efforts to activate him with criticism and coercion, the therapist then immediately asked:

> I'm wondering . . . are we being carried away by therapeutic enthusiasm? Are we . . . demanding something that is so contrary to your outlook on how to help your poor husband that you will listen to us here but by the time you walk out of the building . . . your mind would have changed. . . . Think for a moment, how difficult this is going to be for you. (Fisch et al., 1982, p. 272)

If there are any doubts about the acceptability of a task, strategic therapists are inclined to express doubts about the suitability of it in a way that invites clients to offer reassurance that it is acceptable and that they are prepared to carry it out. Thus, in the above example, the woman's reply, "No, listen, I would be delighted to try anything you suggest . . ." (Fisch et al., 1982, p. 272), indicating that her commitment had been secured. The answer to the question "How do strategic therapists get clients to accept outlandish intepretations and assignments?" varies. First, they very often explicitly inquire whether clients are willing to accept a particular assignment and are prepared to clarify or retract the assignment if clients have any misgiving. Second, the offering of the assignment is likely to have been prepared in the exploration and rejection of more straightforward ways of tackling the problem.

In an important sense, the notion that clients are cooperative and that what appears to be resistance is a reflection of therapists' failure to engage them properly is not a readily falsifiable proposition, but a presumption in strategic therapy. It is the responsibility of the therapist to elicit and nurture this cooperativeness. What is paramount, however, is that the therapist avoid getting into struggles with clients and appear to pressure or criticize them. It may be seen as a first-order accomplishment that they avoid such traps, but a second-order accomplishment that they succeed in getting clients to demand a chance to attempt a task or to argue that they are responsible for their behavior in the face of therapists' polite suggestions to the contrary.

Protecting the clients' dignity and sense of cooperativeness is a working goal of strategic therapists, and task assignments reflect this.

When clients have ostensibly failed to undertake a task assignment, strategic therapists are likely in some way to avow responsibility for this; cite evidence that clients were actually being reasonable, creative, and cooperative in not completing the task; or simply retract the assignment as having been inappropriate. Assignments often have provisions built into them for making any response from the client a form of cooperation. Thus, a woman had returned to graduate school after having negotiated her husband's assumption of child rearing and household tasks that had previously been exclusively her responsibility. She felt she was not performing well enough in her studies to justify this and that she was also responsible for her husband's ineptness in looking after the family. Further, she felt that she was now neglecting both her studies and her family, basically retreating to bed. The therapist at first suggested that she make a choice and take a few days concentrating on either the family or the studies, but not both. However, when it could not be established that the client experienced this as permission to do what she wanted, rather than an additional burden, the therapist added what was meant to be face-saving for the client:

> And maybe you need a third choice. If you find that the next session is impending and you have not exercised either of your other options, you should come back and tell me that "No, I did not focus on my family or my schoolwork. I did a bit of both, or I just looked after myself." Maybe the issue is that you are inhibited from getting anything done because you are not listening to yourself and feeling free to make choices for yourself. Maybe the first step is to decide not to be pushed around by anyone including me, and you will figure this out by the end of the week.

IRONY AND PARADOX: THERAPY AS DEAD-SERIOUS PLAY

A strategic conception of clinical problems and their treatment involves a number ironies or formal paradoxes (Coyne, 1987; Watzlawick, 1978; Watzlawick et al., 1974). Clients' problems and the associated distress are persisting because of what they (Wegner, 1997) and others (Shoham & Rohrbaugh, 1997) are doing to try to solve these problems. Clients present complaints that they cannot on their own change their behavior, and yet attempt to enlist the aid of therapists who can only work through clients' own behavior. It is assumed that clients have the resources to solve their problems, but they are either misapplying or failing to recognize these resources or not feeling entitled to use them. Yet, therapists' direct comments to clients about how their attempted solutions are perpetuating their

problems can prove counterproductive. Such comments risk alienating or further demoralizing the client, aggravating their predicament and making it less likely they will be resourceful. Strategic therapists are more likely to focus on how the particulars of a given client's circumstances reveal resources and ironies that are useful in tackling the client's problems. A woman whose husband has abruptly left her for another woman may be distressed about having suddenly become a lonely single parent. However, it could be the case that her husband's lack of involvement had functionally made her an effective single parent long before his departure, and she was now free to claim a right of an "official" single parent: She no longer has to have sex with a man she detests.

All of this gives rise to the ironies and counterparadoxes that characterize strategic therapy. Many reframes and task assignments allow clients to recognize features of their behavior and circumstances that cannot readily be commented on directly. There is often a collusive quality to therapists' delivery of task assignments that goes beyond the subtle testing and negotiation that lead up to them. Far from being tricked, clients frequently nod approvingly or smile when given assignments. They are well aware of the absurdity of their having been trapped in ineffective problem-solving strategies and perceive how they are being given a way out. However, it is usually unwise for therapists to comment on this.

Strategic therapists are not averse to taking a stand and providing direct feedback when the feedback appears likely to be accepted, but they are sensitive to the risk of increasing clients' defensiveness. Even in the first session, strategic therapists begin to expand the bounds of what can be discussed with irreverence and a calculated unconventional sentimentality (Lakoff & Coyne, 1992). Thus, a woman was upset that her manipulative and hypochondriacal mother had scheduled a minor elective surgical procedure on the same day the daughter was planning to leave the country on a long-anticipated vacation. The daughter felt tremendous guilt that she would not be able to help her mother following the surgery and had even considered changing her vacation plans. The strategic therapist responded, with feigned indignation, "How could you leave your poor, sick mother in her time of need? How terrible!" The woman at first appeared shocked, but then laughed heartily and launched into a discussion of how angry she felt with herself for being so easily manipulated.

Strategic therapists may take increasing liberties, verbalizing what is obvious, but previously taboo for discussion. Thus, in a first session, a strategic therapist pushed the limits with a woman who had seemed to be indicating that she would be upset if her boyfriend was unfaithful, but that she would nonetheless tolerate his unfaithfulness:

THERAPIST. I know it would not be right, but could he get away with it?

CLIENT. Possibly, maybe once. You can forgive and forget one time, but not a second.

THERAPIST. You mean like . . . What do you think if I told [the live-in boyfriend] "you have this deal that you are not going to believe. You have a free one coming, but only one and so it better be good . . ."

The discussion then turned to how the woman might make it convenient for the man to have his fling discretely. Her complicity became explicit enough for her to realize that she really was not prepared to accept this behavior from him and that she should stop tacitly encouraging the man to believe otherwise.

Strategic therapists are aware that praise and other positive comments are as risky as criticism in terms of leaving clients feeling defensive or misunderstood. As with criticism, therapists will not refrain from praise if they believe that what they say will be credible and well-received by clients. However, they tend to be sparing in their complimenting of clients and careful not to disrupt clients' budding efforts by premature or overly generous praise. Therapists will, however, look for opportunities to elicit material from clients that is not controversial in its praiseworthiness:

THERAPIST. What is of interest to me is how, given all that has gone wrong . . . why you are not more laid low than you are?

CLIENT. Because I decided not to be . . . The same way I decided having my father molest me wasn't going to ruin the rest of my life. . . . I don't mean that I don't get pissed off as hell sometimes, just like I get pissed off that my father molested me. And there are times when it really does affect me, but . . . what I strive for is to be able to be depressed without being suicidal.

THERAPIST. . . . Sure . . . I wish I could bottle whatever you've got. I am sure that there would be a real demand for it. . . . How about your husband, how is he dealing with things?

Notice how the therapist avoided engaging the client in a discussion of her childhood sexual abuse. His intent was to elicit material from her in order to compliment her on being a survivor, not to explore the history or details of the abuse. Notice also that this valued attribute was never named, and so the compliment was less vulnerable to being dismissed, but more easily generalized to other situations.

Conclusion

> We are bound to influence our clients, and they are bound to influence us. The only choice is between doing so without reflection, or even with attempted denial, and doing so deliberately and responsibly. Clients come seeking change which they could not achieve on their own; expertise in influencing them to change usefully seems to us the essence of the therapist's job. (Weakland, 1992, p. 142)

Strategic therapists assume that clients are in therapy because they seek to be influenced in a way that reduces their distress and resolves their complaints. Clients' accomplishing these goals is facilitated by therapists being persuasive. Furthermore, therapeutic tasks are an important aid in ensuring that discussions in the therapeutic session lead to viable change in clients' everyday environment where their problems have been occurring. Being able to design, convey, and follow up on such therapeutic task assignments are important skills for the strategic therapist, and it is the development of these skills that writings on strategic therapy have emphasized. Yet, even if typically left implicit, much is being assumed about the resourcefulness of clients and the necessity of therapists engaging and recognizing this resourcefulness. In this chapter, we have tried to bring to the forefront of the discussion how this is done and the kind of therapeutic alliance it requires. Undoubtedly, much of what we have presented can be understood procedurally, in terms of the therapeutic alliance as a set of techniques. Yet, we hope we have also conveyed a sense of the attitudes and commitments that strategic therapists must bring to the relationship if they are to maximize their effectiveness. We are skeptical about the possibility of reducing these attitudes and commitments to a set of procedures. Effectiveness may depend upon them being held as core beliefs about people and therapy.

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