Journal of Marital and Family Therapy
1992, Vol. 18, No. 1, 17–24

STRATEGIC THERAPY, ECLECTICISM, AND THE THERAPEUTIC RELATIONSHIP

Barry L. Duncan
Dayton Institute for Family Therapy

Although profoundly influencing the family field by highlighting the deficiencies of pathology-based views, strategic therapy has come under fire in two general areas: (a) adherence to a "black box" philosophy that discounts the value of intrapersonal phenomena; and (b) interventions that appear exceedingly instrumental, manipulative, and based on a position of therapist power. This article will examine these criticisms in light of the rise of eclecticism and the resurgence of the primacy of the therapeutic relationship. It will be argued that if strategic therapy is to remain viable, it must evolve to include the contributions of other models and consider the relationship context from which intervention arises.

The strategic approach of the Mental Research Institute (MRI) (Fisch, Weakland, & Segal, 1982; Watzlawick, Weakland, & Fisch, 1974) has profoundly influenced the field of family therapy. Evolving from the double bind description of human problems as based in communicative interaction, the MRI proposed a model that freed the systems movement from the encumbrances of pathology-based views. Highlighting the excesses and deficiencies of individual and family approaches, the MRI interactional approach provides a normalizing view of the human experience of emotional and interpersonal difficulties. The significance of that singular point of departure can hardly be overstated.

Recently, the MRI view has come increasingly under fire. The limitations that have been articulated can be generalized as follows: (a) the MRI relies solely on interpersonal phenomena and adheres to a "black box" philosophy that discounts the value of intrapersonal variables and other traditional constructs; and (b) the MRI's interventions are exceedingly instrumental, manipulative, and based on a hierarchical position of therapist power (Duncan & Solovey, 1989; Heatherington, 1990; Hoffman, 1985). This article will discuss these criticisms and suggest that they may be understood in the context of a larger movement within the field of psychotherapy toward eclecticism and a reemphasis on relationship factors. This article will assert that if strategic therapy is to remain viable, it must evolve to include other models and consider the relationship context from which intervention arises. An eclectic expansion of the MRI model is presented that seeks direction for intervention from the client's frame of reference and enhances the change potential of the therapeutic alliance.

The author wishes to thank Steve Drewry for his invaluable input to this paper.

Barry L. Duncan, PsyD, is Director of the Dayton Institute for Family Therapy and Clinical Assistant Professor at Wright State University.

Requests for reprints should be addressed to Barry L. Duncan, PsyD, 65 W. Franklin Street, Centerville, OH 45459.

LIMITATIONS OF THE MRI

Many therapists discover the need to reassess what they are doing by intervening in people's lives after clinical experience has shattered the illusions provided by their chosen orientation. Consider the following vignettes.

Larry is a therapist in a community mental health center and is seeing Steve, a client suffering from seemingly inexplicable panic attacks and anxiety. Steve expresses a desire not only to diminish his anxiety, but also to understand why his panic exists and if it is related to his childhood. Given his strategic orientation, Larry investigates Steve's current solution attempts for addressing his anxiety. Larry normalizes the anxiety, given Steven's recent promotion and stressful schedule. A symptom prescription is employed to interrupt Steve's current solution patterns and help bring the involuntary panic episodes under voluntary control. The client's panic does not improve, and he reiterates his desire to explore why his anxiety exists. Larry does not believe in the importance of knowing why and views such archaeological explorations as unhelpful. Steve drops out of therapy.

Karen is a therapist in private practice and is seeing Alice, a woman in a battering relationship. Alice expresses a desire to leave her husband and reports that everyone has been urging her to do so for a long time. Karen discusses with Alice the dangers of leaving her husband and emphasizes all the valid reasons that have kept her in the relationship. After a couple of sessions discussing the dangers and resulting suggestions by the therapist to "go slow," Alice leaves her husband. Karen expresses surprise, inoculates her against possible pitfalls, and predicts that it will be very difficult, if not impossible, to stay away from her husband. Alice returns to her husband but also continues in therapy. After a few more sessions, Alice leaves again and files for divorce. Months later during a follow-up session, Karen asks Alice what was most helpful about therapy. Alice replied that it was just knowing that whatever she chose to do, Karen would accept her and understand why she did it.

Early on, therapists begin having cases that do not seem to fit their chosen model's assumptions. Steve wanted to know why his anxiety existed and whether it was related to his childhood; Larry's strategic perspective discounted such a pursuit. Alice indicated that she was helped by something quite foreign to a strategic explanation of what was therapeutic.

As therapists continue to work with clients who should get better according to their chosen model but don't, clients who get better for reasons the model doesn't explain, and clients who respond to methods that the model doesn't accommodate, it becomes evident that the models we hold so dear possess limitations and do not account for the diversity of human variation that a clinician encounters. The criticisms of the MRI discussed below seem reflective of a developmental process within a field that is recognizing the inherent limitations of *any* singular approach to therapy.

Limitation #1: The Black Box

The case of Steve illustrates the black box criticism often leveled at the MRI and strategic therapy in general. Attending solely to interpersonal variables (solution attempts) and discounting intrapersonal phenomena and other traditional constructs, the MRI typically views the search for the why of the presenting problem as an inherently self-defeating process that serves only to elongate therapy (Watzlawick et al., 1974). Larry investigated Steve's solution attempts and explored what others had suggested for him to do; Steve's desire to know why was acknowledged but not pursued. Because of Steve's idiosyncratic belief regarding the relationship between his childhood and his anxiety, holding an assumption that discounted intrapersonal descriptions was

itself inherently self-defeating. Pursuing why and exploring the "black box" is not only helpful, *but may be essential when the client believes it is important.*

Categorically dismissing the wide body of intrapersonal information available leaves unsampled the situational applicability of that information. Instead of discounting the contributions of other approaches as well as the client's request, Larry could have explored several descriptions of Steve's childhood with him. A meaningful exchange might have ensued that would have enabled Steve to revise the experiences that he found distressing, rather than leave therapy.

Perhaps more important than the pragmatic aspects of the black box criticism is the trend in the field which it illustrates. There appears to be a shift in family therapy away from the belief that systems theory is powerful enough to render all other knowledge bases superfluous toward a desire for a more integrative consideration of individual and family approaches (e.g., Sugarman, 1986; Wachtel & Wachtel, 1986). Such a shift may also represent the disappointing recognition that any model, be it strategic, intergenerational, or object relations, is limited in its applicability. Acknowledging the limitations of any single model is indicative of a large movement within the field of psychotherapy toward eclecticism (Garfield & Kurtz, 1977).

Early on, the attempted solution to the problem of limited applicability was the development of rival schools of psychotherapy, characterized by a unique theory or domain of practice specific to that particular point of view. Family therapy generally, and strategic therapy specifically, may be thought of as rival schools that evolved to address the limitations and excesses of psychoanalytic and Rogerian models of therapy. Over the course of the past 70 years, over 250 distinct systems of therapy have been identified (Corsini, 1981). All share a commonality: they have limited applicability, but under certain circumstances they are highly efficacious.

The acknowledgment of limited applicability, combined with the lure of increased efficacy, has fueled interest in the development of an eclectic model of practice. A variety of studies report that one third to one half of present day clinicians prefer to label themselves as eclectic (Norcross, 1986). Although lacking a precise definition, "eclectic" connotes a stated dislike for a single orientation, selection from two or more theories, and the belief that present theoretical formulations are inadequate to explain the diversity of human experience (Garfield & Kurtz, 1977).

Recent criticisms of a sole focus on interpersonal descriptions as practiced by the MRI can be viewed as not only valid at a pragmatic level, but also part of a larger movement within the field away from the inherent limitations of any singular school of thought. An implication for strategic therapy is that if it is to remain vibrant, it must allow for the situational applicability of constructs and techniques from other approaches.

Limitation #2: Power and Manipulation

The MRI has generally neglected the therapist-client relationship and eschewed its importance (Fisch et al., 1982). Perhaps because of this neglect, MRI interventions can sometimes appear to be power-oriented manipulations by a mastermind of covert influence. The case of Alice illustrates how such an appearance can occur. For example, the therapist employed the techniques of "go slow," "dangers of improvement," and "prediction of relapse" after investigating what others in the client's social system had suggested (Fisch et al., 1982). Alice's family and friends urged her to leave her abusive husband, so the therapist suggested the opposite, thereby reversing the solution attempts of others. When viewed in the context of suggesting the opposite, the techniques appear covertly directive and manipulative. The client, however, responded to the techniques in the context of the therapeutic relationship and hence did not perceive the therapist as manipulative. In the context of the relationship, "dangers of improvement"

aligned with and validated Alice's concerns about leaving her husband. "Go slow" and "predicting relapse" similarly validated the difficulty of her decision and allowed her to feel accepted, regardless of what she chose to do. The acceptance and validation that the techniques represented to Alice seemed the most important factor in enabling the conditions for Alice to arrive at a decision.

The criticism of the MRI's power-oriented tactics may similarly be viewed as part of a larger movement in the field toward an emphasis on the therapeutic relationship. Hoffman's (1985) call for a second-order view stressing collaboration with clients and a defocus on strategy and intervention is reflective of such a move in family therapy.

In the individual literature, recent attention to relationship factors and therapy outcome suggests that positive outcome is largely related to common factors (empathy, respect, genuineness) rather than specific techniques. Lambert's (1986) review identifies that as much as 30% of outcome variance is related to these common factors. This figure is consistent with the 25% to 40% figures that Patterson cites (1984). Lambert goes on to indicate that orientation-specific factors (techniques) have been found to be no more powerful than placebo effect, both of which account for approximately 15% of the positive outcome variance. Accounting for the remaining 40% of the variance are what Lambert identifies as spontaneous remission variables such as out-of-therapy events and other client-specific variables. This research certainly confronts our propensity to hold onto the specialness of our chosen model and essentially rubs our collective noses in the fact that theoretical orientations may be only as significant as placebo. In addition, and probably even more painful to realize, is that our specific theoretical frames of reference may be largely insignificant next to common factors and client variables. Recognition of the importance of these therapist variables to positive outcome undercuts the view of the therapist as the expert in methods and techniques of changing behaviors. Rather, this body of evidence suggests that the therapist's expertise lies in providing the conditions under which the client engages in behavioral or attitudinal change (Patterson, 1989).

Given this, strategic therapy, or other orientations that emphasize technique or seek to impose a particular therapist reality or theoretical frame of reference, may inadvertently undermine positive outcome. An implication for any therapeutic belief system that desires to enhance common factor effects is that technique and therapist ascriptions of meaning should emerge from and be demonstrative of therapist empathy, respect, and genuineness.

STRATEGIC THERAPY: A PROPOSED EVOLUTION

The criticisms of the MRI and the larger movements they represent suggest that strategic therapy must evolve to be inclusive of the situational applicability of any theoretical explanation and must emphasize the primacy of relationship factors. The eclectic selection of content from a variety of approaches is discussed elsewhere (Duncan, Parks, & Rusk, 1990); therefore, the discussion below will address a strategic perspective of enhancing common factor effects (Duncan, Solovey, & Rusk, in press; Duncan & Moynihan, 1991).

Operationalizing Common Factors

The notion of the therapeutic relationship is varied and complex. Empathy, respect, and genuineness are themselves a complex set of variables that need careful definition so that they may be operationalized more effectively (Patterson, 1989).

One way of more carefully defining aspects of therapist behavior that constitute the common factors is to extend the definition beyond the therapist's verbal contribution to include the client's interpretation of the therapist's behavior and the implicit and

explicit values and assumptions to which the therapist ascribes. Consider the therapist behavior of empathy and that fact that the client's rating of empathy is a powerful indicator of positive outcome (Gurman, 1977). However empathic a therapist may be in terms of his or her chosen theoretical orientation, the empathic response may have little or no positive impact on certain clients and may be interpreted by other clients as having negative impact. The therapist's reliance, in other words, on stand-by responses to convey empathy will not be equally productive in terms of the client's perception of being understood. The potential positive enhancement of common factors will then not occur in those situations in which the therapist's stand-by empathic response does not fit the empathic needs of the individual client.

A recent study conducted by Bachelor (1988) that examined received empathy provides similar conclusions. She found that 44% of the clients in the study perceived their therapist's empathy as cognitive, 30% as affective, 18% as sharing, and 7% as nurturant. Bachelor concludes that empathy has different *meanings* to different clients and should not be viewed or practiced as universal construct.

An approach more consistent with the client's experience would view empathy as a function of the client's unique perception or meaning system and therefore would respond flexibly to the client's empathic needs, determined by feedback from the client acquired during the interview process. The same therapist behavior may be interpreted very differently by different clients. When the therapist acts in a way that is consistent with the client's meaning system, or more specifically, with the client's experience of the concern that served as the impetus for therapy, then empathy may be perceived and may operationalize common factors beyond the therapist's global construct of the verbal expression of empathy.

Empathy is *not* a specific therapist behavior (e.g., reflection of feeling is inherently empathic); it is *not* a means to gain a relationship so that a switch can be made to promote a particular theoretical orientation or therapist personal value; and it surely is *not* a way of teaching clients what a relationship should be. Rather, empathy is therapist attitudes and behaviors that place the client's perceptions and experiences above theoretical content and personal values; empathy is operationalized by therapist attempts not only to accept the internal frame of reference of the client (Rogers, 1951), but more importantly to work within the expressed meaning system of the client (Duncan et al., in press). Although not as researched and related separately to outcome as empathy, the client's experience of therapist respect and genuineness can be similarly viewed as highly idiosyncratic and specific to the unique meaning system of the client.

From the strategic perspective presented here, operationalizing common factors suggests that for each client, the orientation adopted by the therapist is the client's unique meaning system rather than an invariant theoretical frame of reference. From that acceptance, the client's experience of the world becomes the guiding theory which dictates therapist actions/interventions.

Common factors may be further enhanced by validation, a therapist-initiated process in which the client's thoughts, feelings, and behaviors are accepted, believed, and considered completely understandable given the client's subjective experience of the world (Duncan et al., in press). Validation reflects an individualized combination of empathy, respect, and genuineness: the therapist genuinely accepts the client's presentation at face value, the therapist respects the client's experience of the problem by highlighting its importance, and the therapist empathically offers total justification of the client's experience. The therapist offers legitimacy to the client's meaning system and in the process may replace the invalidation that may have accompanied the client to therapy.

The growing evidence of the importance of the relationship may lead to the conclusion that intervention or technique is less important than the relationship aspects of

therapy. However, relationship and intervention factors are interdependent aspects of the same process. The actions or techniques that the therapist may use to intervene are intrinsically linked to the interpersonal context in which they occur (Butler & Strupp, 1986).

The interactional context that creates meaning for intervention is the characteristics, attitudes, and behaviors of the therapist that provide the common factors as perceived by the client. These core conditions are manifested by specific interventions that convey or implement the therapist's understanding and acceptance of the client's meaning system (recall Alice and the intervention of "dangers"). Intervention may be effective to the extent that it flows from a perspective that is empathic to and respectful of the client's meaning system. For example, consider the technique of symptom prescription. Asking a client to engage in the problem that brought him or her to therapy must emerge from meanings generated in the therapeutic interaction. The prescription may gain meaning following a mutual exploration of the complexities involved in the problem and an authentic desire by the therapist to learn more about the problem. To empower common factors, the prescription must also be perceived by the client as somehow validating his or her experience of the world. The prescription may validate the experience of the client who thinks that the problem has been trivialized by others and feels ashamed and incompetent because of the inability to control or handle the problem. If the technique is offered without meaning or validation, it is unlikely to be effective (e.g., the case of Steve).

The effectiveness of the intervention depends on the meaning the client ascribes to it, and that meaning is acquired in the interactional context of the therapist and client. Technique and relationship are completely interdependent and cannot be separated. Intervention therefore becomes the therapist's behavioral manifestation of the relationship. Intervention in the form of tasks or assignments extend the interpersonal context defined in session to the client's social environment (Duncan et al., in press; Duncan & Moynihan, 1991).

This proposal to operationalize common factors devalues the significance of specific technique in isolation and standby therapist responses that purportedly enhance the relationship. This proposal values specific technique only as it emerges from the interpersonal system of the therapist-client relationship; both technique and relationship interdependently provide a validation context, resting upon the meaning system of the client (Duncan et al., in press).

CONCLUSIONS

This article has addressed two major criticisms of the MRI model in light of the rise of eclecticism and the resurgence of the significance of the therapeutic relationship. To remain viable, strategic therapy must embrace its criticisms by an eclectic inclusion of the situational applicability of other models and a reconsideration of the relationship context from which intervention emerges.

Strategic therapy has enjoyed a long and rich history of innovation and contribution to the field. Evolving from the ground-breaking tradition of the double bind theory, strategic therapy has provided a creative force that has impacted both strategic and nonstrategic therapists with a wellspring of provocative perspectives and interventions. It is in the interest of the field that strategic therapy remain viable so that the wellspring does not run dry; the field needs the enthusiasm, creativity, and sometimes irreverence that, perhaps, only a strategic perspective can provide.

Another way to understand the criticisms of strategic therapy and address its future viability is through the evolving descriptions of how change occurs. One description views strategy as promoting an interruption of the behavioral interaction that consti-

tutes the problem cycle—in MRI terms, the interdiction of the repetitively misapplied solution attempts of the client and others with whom he or she interacts. This description sees strategy as attempts to influence the client simply to "do something different" regarding the problem so that the problem cycle is jammed and a new cycle of behavioral interaction can ensue.

Another description views strategy as promoting meaning revision, either in the interview process or in the client's interactive experience of the problem. Meaning revision in the interview process involves the conversational re-creation of the client's experience and the collaborative co-generation of new or altered meanings.

Still another description views strategy as an extension of the relationship context that enables client growth to occur. Interventions are explicit therapist behaviors that demonstrate empathy, respect, and genuineness and validate directly the client's meaning and experience regarding the concern under question. Change occurs as a result of interventions that are extensions of the alliance and that are congruent with the client's meaning system.

Whatever descriptive reality of change one chooses, what may matter the most is the therapist's ability to accommodate to a wide variety of client interpersonal styles and meaning systems through sensitivity to the client's perception of the common factors and a genuine acceptance of the client's meaning system. The thought of skillfully managing such a complex and difficult task is a very humbling experience.

REFERENCES

Bachelor, A. (1988). How clients perceive therapist empathy. *Psychotherapy, 25*, 227–240.

Butler, S. F., & Strupp, H. H. (1986). Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy, 23*, 30–40.

Corsini, R. J. (1981). *Handbook of innovative psychotherapies*. New York: John Wiley and Sons.

Duncan. B. L., & Moynihan, D. (1991). *Operationalizing common factors: A proposal*. Manuscript submitted for publication.

Duncan, B. L., Parks, M. B., & Rusk, G. S. (1990). Eclectic strategic practice: A process constructive perspective. *Journal of Marital and Family Therapy, 16*, 165–178.

Duncan, B. L., & Solovey, A. (1989). Strategic brief therapy: An insight-oriented approach? *Journal of Marital and Family Therapy, 15*, 1–9.

Duncan, B. L., Solovey, A., & Rusk, G. S. (in press). *Revisions: Creating opportunities for meaningful change*. New York: Guilford.

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

Garfield, S. L., & Kurtz, R. (1977). A study of eclectic views. *Journal of Consulting and Clinical Psychology, 45*, 78–83.

Gurman, A. S. (1977). Therapist and patient factors influencing the patient's perception of facilitative therapeutic conditions. *Psychiatry, 40*, 16–24.

Heatherington, L. (1990). Family therapy, control, and controllingness. *Journal of Family Psychology, 4*, 132–150.

Hoffman, L. (1985). Beyond power and control: Toward a second-order family systems therapy. *Family Systems Medicine, 3*, 381–396.

Lambert, M. (1986). Implications of psychotherapy outcome research for eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 436–462). New York: Brunner/Mazel.

Norcross, J. C. (1986). Eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 3–61). New York: Brunner/Mazel.

Patterson, C. H. (1984). Empathy, warmth, and genuineness in psychotherapy: A review of reviews. *Psychotherapy, 21*, 431–438.

Patterson, C. H. (1989). Foundations for a systematic eclectic psychotherapy. *Psychotherapy, 26*, 427–435.

Rogers, C. R. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.
Sugarman, S. (1986). *The interface of individual and family therapy.* Rockville, MD: Aspen.
Wachtel, E. F., & Wachtel, P. L. (1986). *Family dynamics in individual psychotherapy.* New York: Guilford.
Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York: W. W. Norton.

SALVADOR MINUCHIN: *"JMFT is recognized as **the** journal of the profession and is required reading for anyone serious about keeping abreast of developments in marriage and family therapy."*

JOURNAL of MARITAL and FAMILY THERAPY

Especially for Marital and Family Therapy Professionals

CLOE MADANES: *"Required reading for the abstracts and the book reviews alone!"*

WILLIAM DOHERTY: *"If I were heading for a desert island and could only take one family therapy journal, I'd take JMFT."*

Recent Articles Include:

- *The Relationship Among Selected Supervisor, Therapist, and Client Behaviors*
- *Cost Effective Research in Family Therapy*
- *Further Validation of the Family of Origin Scale: A Factor Analysis*
- *Family Goal Recording: An Adaptation of Goal Attainment Scaling for Enhancing Family Therapy Assessment*
- *Selecting a Family Therapy Model: The Role of Personality Attributes in Eclectic Practice*
- *The Borderline/Schizoid Marriage*
- *The "Incestuous Family" Revisited: ACritical Analysis of Family Therapy Myths*

1 year individual subscription: $45 • 1 year institutional: $75. Foreign orders: add $15/year.
Send name, address, phone #,and payment, Check or Credit Card
(MC/VISA ORders include Cardholder Name, Caro #, and Exp. date) to:
Subscriptions • AAMFT • 1100 Seventeenth St., NW • 10th Floor • Washington, DC 20036