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AUTHOR Brown, George S.; Brown, Joanne L.
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ABSTRACT

This paper describes a set of therapeutic tactics employed in the treatment of court-ordered spouse abusers at a community-based counseling center. The introduction states that the term therapeutic tactics was chosen to describe a class of interventions which are closer in nature to strategic ploys used in a contest rather than collaborative techniques traditionally employed by psychotherapists. A program description includes discussions of referral sources, treatment modalities, treatment goals, and a description of clients. The therapeutic tactics used (which are also known as paradoxical, strategic, or therapeutic double binds) are described in detail in these sections: (1) opening game; (2) establishing the parameters of treatment; (3) redirecting the client's energy; (4) protecting the client's self-esteem; (5) middle game; (6) fostering closeness and intimacy; (7) minimizing the demoralizing aspects of recurring conflict; (8) introducing new skills and behaviors; (9) minimizing the fear of failure; and (10) end game. It is stated in conclusion that these tactics are only one aspect of a treatment program that employs a variety of more traditional techniques and that these tactics enhance the effects of other interventions. (ABL)

Therapeutic Tactics in the Treatment of Marital Violence

George S. Brown, Ph.D.
Center for Family Development
3366 South 900 East
Salt Lake City, Utah 84106
(801) 466-8353

Joanne L. Brown, Ph.D.
Department of Psychiatry
University of Utah
Salt Lake City, Utah 84112
(801) 581-5111

INTRODUCTION

The purpose of this paper is to discuss specific treatment tactics which have been profitably employed in the treatment of court ordered spouse abusers at a community based counseling center*. The term therapeutic tactics was chosen to describe a class of interventions which are closer in nature to strategic ploys used in a contest rather than collaborative techniques traditionally employed by psychotherapists. Traditional psychotherapy assumes there exists a working alliance between the therapist and the client and a strong motivation on the part of the client to change. While we assume that the clients discussed in this paper are motivated to change, we recognize that they possess considerable ambivalence if not outright hostility regarding the idea of psychotherapy. Such clients are likely to strongly resist attempts on the part of the therapist to influence their behavior.

The tactics described in this paper have in recent years become more accepted by the mainstream of psychotherapeutic practice, especially among those clinicians working from a family systems perspective. The variety of interventions available and their theoretical underpinnings have been adequately discussed elsewhere (Ericson & Rossi, 1975; Haley, 1976, 1976; Madanes, 1981; Minuchin & Fishman, 1981: Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978; Watzlawick, Beavin, & Jackson, 1967; Weeks & L'Abate, 1982) and our purpose is not to re-state what has been better expressed by others. Rather, we wish to describe

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* The Community Counseling Center, 355 South 600 East, Salt Lake City, Utah, 18102; Bob Terragno, Executive Director

the adaptation of this therapeutic modality to our specific treatment problem, namely marital violence. The tactics described herein are not employed independent of other therapeutic approaches and are carefully integrated into the structure of a treatment program that: (a) offers individual, couple, family and group counseling; (b) places heavy emphasis on the acquisition of specific skills to control anger, manage stress, and improve communication; and (c) encourages clients to understand their behavior in terms of earlier experiences in their families of origin.

Although we assume a systems perspective, (i.e., that the behavior of each member of an interpersonal system is at least partially determined by the behavior of every other member of the system), we communicate to our client that each individual is responsible for his or her own behavior. Specifically, where the issue of violence is concerned, we stress that we do not see violence as an acceptable or viable behavior in marital relationships, that no one "makes" another person violent, and that it is the violent partner's responsibility to stop the violence.

At the same time, we as therapists covertly assume considerable responsibility for creating a context in which violence is most likely to stop and in which the couple is able to begin to experience increased positive interactions. Much of what we do is not made explicit to the client, hence the term tactics. These tactics will be discussed in detail and case examples will be provided. First, in order to put the tactics in their proper context, a description of the program will be presented.

PROGRAM DESCRIPTION

The marital violence treatment program was begun in cooperation with the police department in one of Salt Lake county's municipalities. The program was initatiated as a pilot project, and after some experimentation during the first year, the program assumed the following form.

Referral Sources

Police policies and procedures were altered, giving officers the option, when confronted with a case of marital violence, to charge the offending partner with spouse abuse. At that time the offender is given a leaflet which explains that he/she has been cited with spouse abuse, describes the treatment program, and explains that if he/she pleads guilty, he/she will probably be referred to the program for counseling.

It is the officer who presses the charges and ,therefore, the victim does not have the option of dropping the charges as often occurs in marital violence cases. This procedure also tends to focus the abuser's anger on the police rather than on the abused spouse.

In the large majority of cases it is the male who is charged as the abuser. For this reason we will employ masculine pronouns when referring to the abuser. We wish to stress that in our experience, however, it is not at all rare for the wives to have also been violent on one or more occasions. In fact in some cases the wife may be the more dangerous partner.

Treatment Modalities

Clients are seen in individual, couples, family, and group

counseling, with the largest percentage of treatment time occurring in groups. Each modality offers advantages and the mix of modalities is adjusted to fit the needs of each individual or couple.

Treatment Goals

The goals of the program are relatively limited and modest. The primary goal is to bring about an immediate cessation of the violence and to give participants adequate skills so that the violence will not reoccur. The program does not endeavor to produce "character change". Treatment is viewed as relatively short term (average of six months), but some couples have chosen to remain in treatment for a year or longer. Treatment focuses on the the client's behavior in the context of a relationship. Some time may be spent on individual symptoms such as anxiety or depression, but this is not the focus of the program. Clients who experience severe symptoms which may not be directly related to the relationship are referred elsewhere for treatment.

Clients are also informed that they are expected to control their intake of alcohol and drugs, especially if substance use is related to the violence. Clients who are clearly alcohol or drug dependent are referred to programs which work primarily with substance abuse. At such time as the substance abuse problem is resolved they may then be re-admitted into the program.

Description of Clients

The majority of clients admitted into the program are male. Females are admitted if they present themselves as being violent or if they accompany a violent male. Women who present alone as non-violent victims are referred to other programs that offer

counseling for battered women.

The violent males generally present themselves as defensive and mildly hostile. They tend to minimize the severity of the offense and argue that their marital relationship has improved and that counseling is not necessary. They generally appear passive, lacking in self-esteem, and remarkably dependent upon their wives. Despite the aggression they exhibit toward their partner, they usually become depressed and frightened if she threatens divorce. In general the men do not have a history of legal difficulties; however a minority have prior arrests for alcohol related offenses.

The women likewise present themselves as passive and lacking in self-esteem. They demonstrate low ego strength and oftentimes a sense of futility about life in general and their marriage in particular.

THERAPEUTIC TACTICS

Overview

The tactics described in the following sections have been referred to as paradoxical, strategic, or therapeutic double binds. The reader is referred to Weeks and L`Abate (1982) for a comprehensive discussion of the use of these techniques, their theoretical underpinnings, and empirical support for their efficacy.

Approximately 70 percent of the male clients are court ordered to the program as a result of a conviction for spouse abuse. At intake most of these clients can safely be described as overtly hostile to the idea of treatment. Once a therapist

accepts the idea of conducting involuntary therapy, it can be useful to conceptualize the task as a contest between therapist and client, in which the therapist attempts to influence the client`s behavior and the client resists these attempts. The therapist "wins" if the client changes. It is necessary, however, for the therapist to firmly believe that they both lose if the client continues to be violent.

The reader is referred to Saposnek (1980) for a charming paper comparing therapy to the martial art of Aikido, in which the practitioner gracefully utilizes the attackers energy and momentum to neutralize the attack.

Tactics can be divided into opening, mid-game, and end-game moves. The following sections describe maneuvers suitable for various stages of the contest. Broad themes are outlined and basic moves are made explicit. The possibilities for variations and nuances are infinite and the reader is invited to enjoy the contest and welcome the challenge to his creative inventiveness.

Opening Game

The client´s opening challenge can take a variety of forms, of which a few examples are:

"I don´t want to be here and you can´t help me."

"I don´t have a problem" (and the problem is obvious).

"I´ve been to several therapists already and none have helped me."

"I´ve had this problem for a long time and don´t believe it can be changed."

"I´m not responsible (someone, something) makes me do it."

"I want you to help me, but I´m not willing to change (some behavior)."

The therapist's opening moves need to accomplish four tasks: (1) establish the parameters of treatment; (2) If possible, involve the non-offending spouse in treatment; (3) redirect the client's energy toward desired behavior change; (4) protect the client's self-esteem.

Establishing the paramaters of treatment. The first contact with the client begins the process of defining the rules and limits of treatment. Our expectations about the length of treatment are conveyed to the client, fees are negotiated, and the client is informed that continued violence will disqualify him from the program and that he will be referred back to his probation officer.

As part of limit setting, we teach the use of time out as a valuable skill to decrease conflict. A time out is a mini separation following an agreed upon signal. Generally, couples employ the T-sign formed with the hands close to the chest. Either member may give the signal if he or she fears that violence might occur if the the interaction continues. Both members then separate until they have calmed down. After explaining the technique, some time is spent discussing how one or another member may sabotage its use. This can be done with some humor.

A brief explanation of the treatment rationale is also given, which stresses that violence is a learned behavior, that it is often a response to stress, and that we will teach the violent member specific techniques to control anger. Generally, clients don't chose to argue at this point, but if they do, we don't accept the invitation to fight.

Involving the Non-offending Spouse in Treatment. Involving

wife of a court ordered offender in the treatment process can be a considerable challenge. If she does not spontaneously accompany her husband to the first session, we find that she is usually still angry with him and is conveying the message that he is "sick" and that the problem is all his. Most of the husbands whose wives do not initially enter treatment, express a desire to have their wives involved and pessimism that she can be induced to do so. In our experience it is not realistic in many cases to expect the husband to successfully persuade his wife to accompany him.

A tactic we have found useful in these instances is to ask the husband if he really wants his wife to join him. If he insists that he does, we tell him that we have an idea that might work, but that may be very difficult for him to agree to. We then ask if he would be willing to have us call his wife and invite her to help with his therapy. We tell him that, of course, this would require him to swallow some pride, and we would certainly understand if he found this to difficult to do. In a surprising number of cases the husband will agree to this strategy and it becomes an invitation that the wife will almost always accept. After she has joined her husband in a session it is usually possible to engage her in the treatment process and gradually lead her to look at her own issues.

Redirecting the Client's Energy. Immediately after establishing the parameters of treatment, it is important to change tactics and begin to redirect the client's attention and energy towards the desired behavior change. At this point the client is still usually in an oppositional mindset and for this reason it

is useful to give the client something to resist, which by resisting he can move in a direction that furthers treatment. A few examples include:

> "Of course, I expect that the timeout will be difficult for you to use at first, given your problems with anger."
>
> "I expect the violence to stop, but I would caution you not to try to improve your relationship too quickly as this might be unsettling.
>
> "My experience is that clients like yourself have a very difficult time sitting down and discussing problems openly so I don't expect you to really discuss much now. I'll do most of the talking."

Protecting the Client's Self Esteem. The clients referred to our program have a fragile sense of self-esteem which predisposes them to be sensitive to issues of status and power. The client will protect his self-worth by resisting the therapist, and getting one-up by proving that the therapist is powerless to help him change. It is useful, therefore, for the therapist to contrive to assume a one-down position that allows the client to remain one-up and to change without the therapist's "help" or at a faster rate than the therapist believed possible or wise. Assuming a plodding or bumbling style as therapist can accomplish this goal. For example, an interpretation offered in a tentative manner gives the client an opportunity to prove to the therapist that he understands himself with more clarity than does the therapist.

> "You know, some therapists are really good at figuring out what's going on with a client right away. I wish I were one of these, but I'm not. Now I've got some thoughts about the two of you, but I'm not really sure if I'm right. Please think about this carefully before you accept it."

With other clients an alternative tact is to emphasize therapist expertise in an attempt to create a situation for the

client to resist. For example:

> "In my experience, someone like yourself usually has a very difficult time letting his wife know when he feels hurt. It is much safer to get angry. I think that we can begin to discuss this, but I advise against you showing the side of you that can be easily hurt. I believe that this would be too threatening for you just yet."

In this case the client's self-esteem is protected while he changes by proving the therapist wrong.

It is difficult to stress too much the importance of allowing the client to remain one-up. Even after treatment has progressed and a more cooperative working relationship may have evolved between the therapist and the client, it is wise for the therapist to remain sensitive to status and power issues.

Middle Game

The middle-game of therapy is that broad, nebulous period that may begin during the first session and extend to the last, during which the bulk of the work is accomplished. Traditional therapists emphasize the process of acquiring insight or awareness and of "working through" the problem. The approach that we have taken, while respecting the role of insight, emphasizes acquiring skills and new behaviors,regardless of whether or not insight occurs.

The following sections describe various therapeutic goals and maneuvers which may be employed. The goals include: (a) fostering and prolonging periods of closeness and harmony between spouses; (b) minimizing the demoralizing aspects of recurring conflict; (c) introducing new skills and behaviors; and (d) minimizing the fear of failure.

During this phase of treatment, the clients tend to become

more cooperative and engaged in the process. We rely less on strategic tactics and make more use of traditional approaches such as offering interpretations, teaching skills, providing reassurance, etc. Even with our most cooperative and motivated clients, however, we find it useful to have these tactics at our disposal in the event the treatment process becomes bogged down.

The following sections are organized by therapeutic goals, with discussions of maneuvers available to achieve the respective goals. The reader will begin to recognize the structural and thematic similarities between tactics. Recognition of the basic patterns greatly simplifies the task of constructing interventions with specific clients.

Fostering closeness and intimacy. The first obvious goal, the cessation of violence, is almost always achieved by the second session. The combination of consequences imposed by the court and the use of time out provides the abuser with both the motivation and the tools to control violent outbursts. The next task is to take advantage of the lull in fighting to attempt to foster opportunities for the couple to experience closeness and intimacy.

While violence in a marital relationship may have any number of determinants, including faulty learning, poor impulse control, and external stressors, we find it tactfully useful to emphasize that it results from a conflict between a wish for intimacy and a fear of the same. The ambivalent feelings are assumed to exist roughly equally in each partner, though the husband employs the more obvious tactics to mask this conflict. With impressive consistency we find that as the more violent partner decreases

his aggression, the victim tends to escalate her level of aggression, usually verbal, but not uncommonly physical. We interpret this as evidence of the couples' mutual need to regulate intimacy and their lack of non-violent means to achieve this.

Within the first few sessions we begin to make explicit our belief regarding their fear of closeness. As a rule, we will introduce this notion by warning against becoming too close quickly. This warning may be worded in any number of different ways and the rationale varied to suit the style of the clients. Below are two examples:

> "I think we need to be cautious about making changes too quickly, especially trying to get along too well. In my experience, couples with your problems are consciously or unconsciously afraid to get close to somebody. Maybe it's because they grew up in a kind of crazy family where it was dangerous to get close to people. Anyway, I'm worried that if you started to get along too well, one or the other of you would start a really big argument just to keep from getting too close and scared. I think it would be better to have a lot of little arguments."

> "Something I've learned about couples like you is that sometimes if they get close too quickly, they get scared and someone starts a big fight. I guess if you haven't had much practice at being close, it can be kind of uncomfortable. Anyway, I think that it's really important that you have a number of small arguments this week. This will keep you from getting too close and will also give us something to work on in therapy. Of course, I don't want you to get violent, but I think some small arguments would really be the best idea."

The above moves accomplish two purposes. One, the couple is given a golden opportunity to prove the therapist wrong by getting along and second, it introduces the notion of fear of closeness and reframes arguing in a more positive light. This tactic is very successful in initiating a "honeymoon phase" in which the couple feels more positive about their relationship and optimistic about the future.

The honeymoon phase can generally be maintained for four to twelve weeks. The therapist may take a stance of being surprised that the calm has lasted this long, but that he is afraid that they have gotten too close too quickly and that this is dangerous. He can renew his instructions to have some arguments. With some clients this can be done humorously, with others dead seriousness is required.

As the honeymoon continues over several weeks (and the couple beams with pride) the therapist can compliment them on their impressive progress and inquire as to how they achieved this. It is a good idea for the therapist to explicitly reject any credit for himself.

> "I have to admit that I am impressed at how the two of you seem to be getting along so well and are able to be more open with each other. I'd really like to take credit for this, but to tell you the truth, I'm not really sure how you have done it. Could you tell me? I'm really curious to know. I do need to tell you, however, that I have some concerns that this may be too much too fast. I would feel much better of you were having a few arguments. I think that it is important that you have some arguments so that we can get on with the therapy."

Minimizing the Demoralizing Aspects of Recurring Conflict. At some point the couple will in fact need to have arguments in order to explore new ways to handle conflict. The tension within the relationship will inevitably build until open conflict emerges. This fighting rarely reaches the point of interpersonal violence, but some doors may be slammed or objects thrown. About half the time it appears that the woman is the more angry or aggressive spouse.

When the conflict does re-emerge, the therapist can minimize the couple's discouragement by complimenting them for being

willing to move on in treatment. He may even thank the more aggressive spouse for being willing to let the therapist see just how unpleasant their fighting can be. "This is really commendable openness."

This response by the therapist has the effect of reassuring the couple. By this point the couple has hopefully begun to trust the therapist and will welcome the opportunity to discuss their problems. The prior honeymoon experience has given them a sense of pride and pleasure at having initially done well without the therapist's help, and will predispose them now to feel more positively towards the therapist.

During the next few weeks or months, the couple will tend to go through cycles of conflict and closeness of varying intensity. Each cycle of conflict is an opportunity to explore dynamics and experiment with alternative behaviors.

Introducing new Skills and Behaviors. An essential aspect of our treatment is the teaching of skills and alternative ways to cope with stress. While some clients are open to direct suggestions and instruction, most of our clients tend to resist them, even after they have been in treatment for several months and have made satisfactory progress. It is helpful to introduce new behaviors in a way that allows the client to adopt the behaviors without unquestionably accepting the therapist's advice. This is best accomplished in a group setting, in which anger control, stress management, and communication skills are introduced in a class like format. This structure provides an opportunity for the client to pick and choose from a variety of alternatives and to try new behaviors in secret. If he succeeds,

he can return to the group and relate his success. Sometime this creates an atmosphere in which clients appear to one-up each other with success stories. The therapist may be tempted to confront their competition issues, but this is best postponed until group members have achieved a relatively high degree of trust. Boasting about success is also an indirect way for group members to discuss their problems. In a short period of time they may spontaneously begin to be more open about their pain and fears and begin to exchange support.

Another tactic available to the therapist introducing new behaviors is to describe a new behavior in some detail and then discourage the client from attempting it just yet.

> "As we talk, I'm beginning to understand that when you get angry, it's usually because you feel hurt or scared. Now one option you might have is to say something like, 'when you do/say _____, I feel hurt'. However, this would involve some risk, because you'd be making yourself more vulnerable than you probably feel safe doing just yet. You might get scared and then get even more angry. I think that we should discuss this some more, but I'd suggest not changing the way you handle this yet. It's best to be cautious in this respect."

Minimizing the Fear of Failure. The client may be willing during this phase of treatment to specify a behavior that he wishes to change. As the therapist begins to develop a strategy for altering the behavior, however, the client often becomes reluctant to implement the strategy. In some instances this is due to a fear of failure. The client may even argue persuasively that every thing he has previously tried has failed and that this time will be no different. If the client brings to treatment an impressive history of failure, the therapist may likewise become pessimistic.

The best tactic in these cases is to construct an intervention in which "failure" becomes part of the treatment plan. These interventions are referred to a therapeutic double binds, in that the client is expected to succeed by failing.

Warning the client against too rapid change is one simple means of constructing such a double bind. This can be taken one step further by instructing the client at all cost not to change the behavior at this time and even to make it worse for the purposes of better understanding the problem.

> "As we talk about your anger, I am becoming even more convinced that we need to proceed slowly. As I mentioned earlier, I am generally of the opinion that change should be done slowly and carefully, and in your case this is especially true because of the complexity of the problem. Your anger has been useful in many ways and it's important that we understand this. It's also important that we understand just how you become angry. I've found that in cases like yours a lengthy period of gathering information about anger is generally time well spent. During this next week I suggest that you look for opportunities to feel and show anger. As you do this pay attention to all the details of how this happens, the thoughts you have, the sensations, any images, etc. In fact, it would be particularly useful if you could feel a little more angry than usual, without hurting anyone of course. Here is a form we use to record experiences. Whenever you are able to feel angry, take a few minutes to write down the details of the experience. If you wish, I'll write a note to your wife explaining this assignment. I really think that it is terribly important that we gather this information."

After using the above intervention with one client who had suicidal feelings because of constant feelings of anger which plagued him, the therapist was interrupted during a session two days after with a "crisis" call from the client. Concerned, the therapist excused himself to take the call. The crisis, as it turned out, was that the client had been unable to feel angry for two days and had not been able to record any experiences. The therapist reiterated the importance of feeling angry in order to

collect this data and urged the client to continue trying to feel angry. The client responded that perhaps he would be able to at least feel some "irritation".

Another variation on this tactic is to insist on a double bind contract before agreeing to work on the problem. The contract is that the client must promise to not give up the behavior all together and to not change it too quickly. This contract allows the therapist to redefine any client response as adherence to the treatment plan.

This contract was used with a woman who complained that every time she became upset, she began to scream. This problem plagued her since childhood and, although she had tried for years to control her screaming, all attempts had failed. The woman had an IQ in the borderline retarded range and a history of school and job failures. She was very skeptical about whether or not she would be able to learn to control her yelling but was willing to try.

The therapist stated strongly in front of the entire family that he could help her with this problem if she promised to abide by the contract. He particularly stressed that she not change her yelling too quickly because this would be too big of a shock to her family and to her conscious and unconscious mind. After she solemnly promised to abide by the contract, the therapist spent the rest of the session developing a strategy using cue controlled relaxation, self talk, imagery rehearsal, and repeated suggestions to use a "soft, strong voice". Again, he stressed not to make big changes and to certainly yell some during the week, because sometimes yelling was necessary and he was afraid

she might give this up altogether.

At the following session she proudly reported that on several occasions she had been able to speak in a soft, strong voice without yelling. On other occasions she had raised her voice, but in relating this, added with a smile "You made me promise not to change too quickly". Several weeks later her husband joked that he wished she would yell more often because he couldn't ignore her soft,strong voice like he could her yelling.

END GAME

The goal of the final stage of treatment is for the therapist to extradite himself from the couple's system while ensuring that the changes made are stable or that the couple will continue to improve their relationship outside of treatment.

Some court ordered clients are eager enough to leave treatment as soon as possible. Whenever possible, we try to schedule a follow-up contact to deal with how the couple is fairing. We express that we expect that there will be a period of non-violent conflict and that we will discuss this at the follow-up appointment.

With clients who have been particularly resistant throughout the entire process or who have made minimal changes, a last ditch effort may be employed to induce the desired changes. Essentially, the therapist pronounces the treatment a failure, minimizes whatever changes have occurred, and confidently predicts that the problem behavior will reoccur shortly. He may predict that if by some chance violence doesn't reoccur immediately, it will certainly happen at some time in the future.

The authors are aware of a case in which this tactic was

used, by a physician through exasperation rather than design, with a chronic alcoholic who had had multiple admissions to the state hospital. For the next 15 years of sobriety, whenever this client knew someone would be going to the hospital, he would instruct them to "Tell that son of a bitch doctor that I'm still sober".

A quite different problem is posed by clients who become dependent on the therapist and refuse to leave treatment. Generally, this problem will become evident when the therapist suggests that perhaps it is time to discuss termination and the couple immediately has a relapse. It is possible to minimize this problem by insisting on relapses before allowing the couple to terminate. Several rationales are available. The therapist may "wish to be certain that the couple has mastered the problem and this can only be ascertained if the problem reimmerges." Another advantage to a relapse is that the "couple can be sure that there is nothing from the way that they were that they wish to salvage." The therapist may even argue against termination because the couple has not ha a sufficient number of relapses to ensure that the problem has been "worked through".

For the majority of clients it is sufficient to suggest that they will continue to have a variety of problems, to express confidence that they have acquired new skills which will be useful, and to invite them to look forward to creatively resolving conflicts as they arise. In all cases it is a good idea to to stress that conflict is inevitable and an important part of marriage, and that the therapist would be very concerned if all conflict left the marriage, because this probably meant

that "the strong feelings between them are dying".

The final session is an opportunity ,also, for the therapist to compliment the clients on changes made and to discount his own role in this. He can comment on how impressed he has been in the ability of the conscious or unconscious mind to adapt and can question them at length about some aspect or another of the changes they have made which are particularly impressive. The therapist may ask for this information so that he can better instruct other clients in the future how to solve this sort of problem. If the couple insists on attributing their progress to the therapist, the therapist may tactfully acknowledge thanks that may be offered but should avoid taking credit for the success of treatment.

CONCLUDING REMARKS

As stated at the outset, the purpose of this paper is to describe a set of therapeutic tactics that are strategic in nature. We wish to reiterate that these tactics are only one aspect of a treatment program that employs a variety of more traditional techniques. The tactics are used to enhance the effects of other interventions.

Not all clients are appropriate for these tactics. Therapist skill and sensitivity are needed to discriminate between those clients for whom a straight forward approach is indicated and those who will be aided by these strategies.

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