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Couple Dynamics of Change-Resistant Smoking: Toward a Family Consultation Model*

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Abstract

Smoking is North America's leading cause of preventable morbidity and mortality. Although effective cessation treatments exist, their overall effect is modest, and they rarely reach the high-risk, health-compromised smokers who need them most. Surprisingly, despite evidence that marital relationship variables predict the success of cessation efforts, family systems ideas have had little impact on current intervention research. We review and critique the cessation literature from a systemic viewpoint, illustrate two couple-interaction patterns relevant to the maintenance of high-risk smoking, and outline a family-consultation (FAMCON) intervention for couples in which at least one partner continues to smoke despite having heart or lung disease. Taking into account ironic processes and symptom-system fit, FAMCON focuses on the immediate social context of smoking, aiming to interrupt well-intentioned "solutions" that ironically feed back to keep smoking going, and to help clients realign important relationships in ways not organized around tobacco usage. Currently in its pilot-testing phase, FAMCON is an adjunctive, complementary approach designed to include collaboration with primary-care physicians and to make smokers more amenable to other, evidence-based cessation strategies.

Smoking, the leading cause of preventable morbidity and mortality in the US, is a proven risk factor for a variety of health problems involving not only the smoker but also those with whom he or she interacts (Wetter, Fiore, Gritz, et al., 1998). Nevertheless, nearly a quarter of the adult population continues to smoke despite major societal efforts to discourage their doing so (CDC, 1996). Although effective cessation interventions exist, their overall effect is modest, and they often do not reach the high-risk, health-compromised smokers who need them most (Compas, Haage, Keefe, et al., 1998; Fiore, Bailey, Cohen, et al., 1996).

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Given the gravity of this problem, it is striking what little impact family systems ideas have had on current thinking about change-resistant smoking. In fact, the widely-cited cessation guidelines recently commissioned by the Agency for Health Care Policy and Research (AHCPR) specifically *exclude* family intervention as an empirically supported component of effective treatment (Fiore et al., 1996, p. 47–48)—apparently because interventions based on teaching spouses better social-support skills have not proven successful. In view of promising applications of systemic principles to other addictions (Edwards & Steinglass, 1995; Liddle & Dakof, 1995), however, foreclosing on couple/family interventions for high-risk smokers may be premature. Indeed, nearly 15 years ago in *Family Progress*, Doherty and Whitehead (1986) made a compelling case for considering the social dynamics of cigarette smoking in close (family) relationships—and the implications of such an analysis for intervention have yet to be sufficiently appreciated.

Our aim in this article is to provide further groundwork for a systemic, couple-focused intervention with high-risk, change-resistant smokers. First, in a brief review and critique of the cessation literature, we argue for revisiting couple-level intervention in a way that takes into account the circular relationship patterns in which both smoking and its supporting behaviors are embedded. Subsequent sections highlight two specific relational patterns of problem maintenance—ironic processes and symptom-system fit—and illustrate their relevance to change-resistant smoking. The last part of this article will describe a “family consultation” (FAMCON) approach to intervention that we are currently pilot-testing in a federally funded treatment-development project for couples in which at least one partner continues to smoke despite having heart or lung disease.

Why Revisit Couple-Level Intervention?

Cessation research has shifted over the past 2 decades from a predominantly clinical emphasis aimed at individual smokers who seek help, toward a public-health approach favoring brief, low-cost interventions that target broader populations of smokers (Lichtenstein & Glasgow, 1992). Economical, population-focused interventions increase cessation rates, but the most effective of these rarely yield one-year abstinence rates above 20% (Velicer, Prochaska, Fava, et al., 1999). More intensive (and expensive) clinic-based treatments typically have higher one-year success rates, but these rarely exceed 40% (Fiore et al., 1996). An emerging consensus is that clinical and public-health approaches are both important, with high-intensity clinical interventions most necessary for high-risk smokers such as patients with heart or lung disease, or heavy smokers who have been unable to quit with less intensive programs (Lichtenstein & Glasgow, 1992). Indeed, the AHCPR panel concluded that “intensive psychosocial counseling has at least equivalent, if not greater, cost-effectiveness than does brief or purely pharmacological treatment” (Wetter et al., 1998, p. 666). And despite the use of the less intensive public-health approach, some experts worry that we will soon have convinced most of the least problematic smokers to stop, leaving a core of highly-dependent smokers who are resistant to change (Hughes, Goldstein, Hurt, & Shiffman, 1999).

To date, the only empirically-supported cessation interventions are individually focused. On the basis of meta-analyses, the AHCPR panel concluded that (a) both brief and more intensive cessation interventions make a difference; (b) a dose-response relationship exists between the intensity and duration of a treatment and its effectiveness; and (c) at least three treatment elements contribute to positive outcomes for individual smokers: nicotine replacement therapy (NRT), clinician-provided encouragement and support, and behavioral skills training/problem solving for achieving and maintaining abstinence (Fiore et al., 1996). Interventions aimed at inducing social support from spouses and family members have so far not been found efficacious (Lichtenstein, Glasgow, & Abrams, 1986).

An influential individually-focused development is the conceptualization of cessation as a process with identifiable stages (for example, precontemplation, contemplation, action) that unfolds over time (Prochaska, DiClemente, & Norcross, 1992). A number of studies indicate that stage-matched interventions that take into account an individual smoker's "decisional balance" processes and (un)readiness to change can increase quit rates (Prochaska, DiClemente, Velicer, & Rossi, 1993); and the related technique of "motivational interviewing," which acknowledges an individual's ambivalence toward change, has improved treatment retention and outcome for a variety of addiction problems (Miller, 1996).

The idea that clinicians should use different strategies for smokers at different stages of readiness is reflected in our family-consultation (FAMCON) approach. Because Prochaska et al.'s stage model localizes the process of change entirely within the individual smoker, it detracts attention from social (especially family) processes that influence whether a smoker attempts to quit and stays quit. In fact, a substantial body of evidence indicates that social support provided by significant others, especially spouses, predicts the success of cessation attempts—and at least one study suggests that support may be relevant in different ways at different stages of the cessation process (Roski, Schmid, & Lando, 1996).

More than a dozen studies spanning several decades (for example, Cohen, Lichtenstein, Mermelstein, et al., 1988; Coppotelli & Orleans, 1985; Murray, Johnston, Dolce, et al., 1995) link the continuance of smoking to both the absence of positive partner support behaviors (expressing confidence in the smoker's ability to quit) and the presence of negative partner behaviors (commenting that smoking is a dirty habit). Strikingly, however, attempts to translate the support-cessation correlation to an effective intervention by teaching partners better support skills, usually in a group format, have had consistently disappointing results—which is apparently why the AHCPR guidelines do not include couple/family intervention as an empirically-supported treatment component (Fiore et al., 1996). Reviewing their own studies of social-support interventions in Oregon, North Dakota, and Rhode Island, Lichtenstein et al. (1986) note that each of these programs not only failed to improve cessation rates but also failed to increase the targeted mediating variable of social support. Lichtenstein and Glasgow (1992) later suggested that modifying longstanding interpersonal relationships is a tall order for smoking cessation programs, and perhaps worth pursuing only for high-risk smokers. Reviewing this work from a family-systems perspective, Campbell and Patterson (1995) concluded that the social-support studies "confirm that spousal support and the absence of spousal criticisms are important for smoking cessation but also indicate that these behaviors are not easily changed through education and problem solving" (p. 566). To this, we would add that modifying relational patterns that surround smoking may require addressing reciprocal, couple-specific patterns directly, rather than teaching a partner or spouse general principles of support and communication skills.

Although, from a systems perspective, the social-support interventions were a step in the right direction, their failure to increase support and to promote sustained cessation may reflect methodological and theoretical limitations not inherent to a couple- or family-level approach. Several of the previously studied social-support interventions, for example, mixed dual- and single-smoker couples together in the same treatment group, while others made little distinction between partners in committed relationships and more casual acquaintances (friends) willing to participate in the cessation program. These programs also focused rather narrowly on the smoking and support behaviors of individual actors; in fact, only one of the intervention studies assessed other aspects of the marital relationship and found that dual-smoking couples reported a temporary *decrease* in marital satisfaction coincident with the initiation of cessation efforts (Nyborg & Nevid, 1986). In general, the social-support studies paid little attention to how the intervention may have fit (or not fit) already existing couple *relationships*, and this may help to explain apparently low rates of compliance with support instructions.

A related issue is that basing psychoeducational interventions on the aggregate (group-level) correlation between support behavior and cessation assumes that the support-cessation correlation holds for everyone. This risks missing important couple-specific patterns where, for example, positive support (e.g., cheerful praise) provokes resistance, or where a spouse's refusal to allow smoking in the house (used in previous studies as a negative, nonsupportive behavior) actually helps certain smokers stay quit. In fact, the group treatment format may itself limit the amount of attention that can be given to the specific behavioral sequences of each couple, in addition to adding unmeasured complexity to the dynamics of social influence operating in such a setting. The most important caveat, however, is that virtually all attempts to increase supportive partner behaviors did not manage to do so—and this fact alone suggests that a different approach to couple-level intervention may be indicated¹ (see Endnotes on p. 28).

In our view, the limitations noted above reflect a more fundamental theoretical division between the social-learning/skill-training framework that informed most of the social-support interventions tested to date, and the systemic/interactional view emphasized here. The former framework assumes that if individual smokers and their spouses learn, practice, and effectively apply various coping, problem-solving, or support skills, they should be more successful in achieving cessation (Lichtenstein & Glasgow, 1992). In contrast, a systemic perspective assumes that smoking is inextricably interwoven with the specific family and social context in which it occurs. While not discounting the individual's history or biology, systems models assume that smoking, like much other problem behavior, persists as an aspect of current, ongoing interaction between the smoker and his or her significant others (Hoffman, 1981; Weakland, 1977). Because problem-maintaining interaction patterns vary from couple to couple, the same spousal “support” behaviors that facilitate cessation for one smoker may actually hinder it for another. For this reason, a systemic analysis of smoking is necessarily idiographic, or case specific, and looks beyond the skills and characteristics of individual actors to the relationships in which smoking is embedded.

In applying a family-systems perspective to cigarette smoking, Doherty and Whitehead (1986) emphasized the communication and emotion-regulation functions that smoking often serves in the context of close relationships. One such function concerns regulating closeness (or distance) in a relationship; for example, smoking may convey such messages as “let's talk” or “let's relax together” or “I need to be alone”—and giving up smoking may entail giving up relational rituals integral to the bond or balance among intimate partners. Another function involves establishing and maintaining autonomy or control, as in relationships where smoking becomes a symbol of personal freedom from an overbearing partner, or where well-intended attempts to influence a smoker only contribute to further smoking (see Whitehead & Doherty, 1989).

Some implications of Doherty and Whitehead's (1986) formulations for intervention are (a) that partners and important family members should be involved in treatment, not merely as “adjunct therapists” but as full participants with a stake in the changes that will occur; (b) that a central therapeutic task is to help partners negotiate substitute rituals that fulfill functions formerly served by smoking, or failing this, to anticipate and neutralize behaviors such as bursts of anger and irritability that may threaten or undermine the perceived relational status quo; and (c) that therapists avoid aligning themselves with family members' unproductive efforts to persuade smokers to quit, so as not to recapitulate ironic problem-maintaining “solutions.” Our work with FAMCON builds directly on Doherty and Whitehead's observations by taking into

¹It is important to note that family-focused psychoeducational interventions that incorporate skills training have been effective with major mental disorders such as schizophrenia (Goldstein & Miklowitz, 1995). An intriguing possibility is that the potential efficacy of these psychoeducational/skill-based interventions may be fundamentally different for addictions and other types of psychiatric problems.

account two empirically-grounded principles of problem maintenance—ironic processes and symptom-system fit.

Interrupting Ironic Processes

An ironic process occurs when repeated attempts to solve a problem keep the problem going or make it worse (Rohrbaugh & Shoham, 2001; Shoham & Rohrbaugh, 1997). Although the term “ironic process” was coined by social psychologist Dan Wegner (1997) to describe ironic effects of attempted thought suppression on mental control, it also captures a much broader range of ironic phenomena earlier introduced to family therapists by the Palo Alto group (Watzlawick, Weakland, & Fisch, 1974; Weakland, Fisch, Watzlawick, & Bodin, 1974). Indeed, where human problems exist, ironic processes are ubiquitous: persistent attempts to force sleep may perpetuate insomnia; a spouse's demands for intimacy may provoke her partner's withdrawal; and a therapist's push for sobriety may drive an alcoholic out of treatment. Whether occurring within people or between people, ironic processes persist precisely because people continue in unsuccessful attempts to solve a problem (Fisch, Weakland, & Segal, 1982; Weakland & Fisch, 1992). Problem and solution become intertwined in a cybernetic positive-feedback cycle, or problem-solution loop, in which more of the solution leads to more of the problem, leading to more of the same solution, and so on. As emphasized by the Palo Alto group, formulations of case-specific ironic loops provide a useful template for assessment and intervention: they tell us where to look to understand what keeps a problem going (look for “more of the same” solution) and what needs to happen for the problem to be resolved (someone must apply “less of the same” solution).

Although most evidence is anecdotal, systematic empirical studies suggest that ironic cycles help to maintain the manifestations of such disparate clinical problems as obsessional thinking (Wegner, 1997), conduct disorder (Patterson, 1982), schizophrenia (Rosenfarb, Goldstein, Mintz, & Nuechterlein, 1995), and depression (Coyne, Kahn, & Gotlib, 1987). Research also documents a common yet potentially devastating ironic cycle in couples whereby the more one partner demands, nags, criticizes, or pursues change, the more the other withdraws, distances, defends, or avoids changing (Christensen & Heavey, 1993). Another ironic effect observed in couples involves “protective buffering,” a coping strategy in which a partner's attempts to avoid upsetting a physically ill spouse sometimes lead to more distress (Coyne & Smith, 1991). Also in the health arena, research on “social control” suggests that attempts by spouses and social-network members to influence health-compromising behavior, such as smoking and drinking, often appear to increase those behaviors (Lewis & Rook, 1999). Interestingly, because significant others seem especially prone to use negative control tactics to influence smoking, Lewis and Rook suggest that earlier social-support interventions for smoking cessation may have inadvertently fostered ineffectual social control.

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

- Wife (W), a health-conscious nurse, “keeps a watchful eye” on husband's (H) smoking, and conveys indirectly her disapproval. H is equally vigilant about W's watchfulness and tries to conceal his smoking, to which W responds by increasing her own vigilance. H preempts more direct intervention by W, saying “When she tells me she worries about my smoking it makes me reactive—and she knows if she says anything it will make me smoke more.”
- H smokes in the presence of his nonsmoking wife, who comments how bad it smells and frequently waves her hand to fan away the smoke. H, who had two heart attacks, shows no inclination to be influenced by this and says, “The more she pushes me, the more I'll smoke!” Although W tries not to nag, she finds it difficult not to urge H to

“give quitting a try.” (She did this when he had bronchitis, and he promptly resumed smoking.) Previously H recovered from alcoholism, but only after W stopped saying, “If you loved me enough, you’d quit”; when she said instead, “I don’t care what you do,” he enrolled in a treatment program.

- H and W, both smokers, say they are impervious to each other’s influence attempts. H, who has peripheral vascular disease, says no one can tell him what to do, though W says she can make him smoke more by telling him not to. Both know that “nagging doesn’t work,” but they do it any way—and their smoking continues unabated.
- H, who values greatly his 30-year, “conflict-free” relationship with W, avoids expressing directly his wish for W to quit smoking. Although smoke aggravates H’s asthma, he fears that showing disapproval would upset W and create stress in their relationship. W confides that she sometimes finds H’s “indirect (nonverbal) messages” disturbing, though she too avoids expressing this directly—and when he does this she feels more like smoking.

A central focus in FAMCON is identifying and interrupting ironic processes such as these. Problem-maintaining solutions may thus involve either action (commission) or inaction (omission), and they may bear on smoking either directly (nagging to quit) or indirectly (pushing exercising or a particular quit strategy). Ironic loops relevant to smoking can also occur *within* people, as when self-injunctions (“don’t smoke”) or attempts not to think about cigarettes result in increased urges. Whatever its form, successful interruption of an ironic process depends, first, on accurately identifying particular solution efforts that maintain or exacerbate the problem; second, on specifying what less of those same solution behaviors might look like; and third, on persuading at least one of the people involved to do less or the opposite of what they have been doing (Fisch et al., 1982). Thus, if the thrust of a spouse’s solution effort is to push directly or indirectly for change (and this has the ironic effect of making change less likely), we will look for ways he or she might do “less of the same” (by declaring helplessness, demonstrating acceptance, or simply observing).² On the other hand, if the spouse’s main solution is to *avoid* dealing with the complaint, we will usually encourage a more direct course of action. How to present suggestions for “less of the same” is of course a crucial consideration—and following the Palo Alto group, we try to do this in terms consistent with clients’ preferred views of themselves, the problem, and the world (Eron & Lund, 1996; Fisch et al., 1982).

We should emphasize that therapists, too, can easily become entrapped in ironic processes. For example, a study comparing cognitive-behavioral and family-systems treatments for alcoholism (Shoham, Rohrbaugh, Stickle, & Jacob, 1998) illustrates how high-demand interventions can drive alcoholics out of treatment, especially when the intervention recapitulates ironic influence processes occurring between a male drinker and his spouse (in this case, a demand-withdraw couple interaction). Ironic therapy processes have also been noted in individual therapy for problems ranging from depression (Castonguay, Goldfried, Wiser, et al., 1996) to procrastination (Shoham-Salomon, Avner, & Neeman, 1989). And in a relevant smoking study, Zelman, Brandon, Jorenby, and Baker (1992) found that directive, skill-oriented interventions (for example, contracting, thought-stopping) produced poorer outcomes for a subgroup of smokers high on negative affect than did a nondirective approach in which therapists refrained from suggesting specific coping strategies.

²Although some of these interventions might be called “paradoxical,” their overriding rationale is to interrupt ironic processes by promoting “less of the same” solution pattern, and there are many *nonparadoxical* ways to do this. In therapy parlance, the term “paradoxical” connotes a grab-bag of intervention techniques with varying rationales (Shoham & Rohrbaugh, 1994). Here we wish to emphasize a specific, systemic view of problem maintenance, and for that, “ironic process” is the better term.

FAMCON aims to avoid ironic therapy processes, which may occur, for example, when a counselor's demand for change intensifies client resistance, or when a therapist aligns with failed solutions attempted by others in the smoker's interpersonal system. Not surprisingly, in the terms of psychological reactance theory (Brehm & Brehm, 1981), many of the smokers we see appear highly motivated to restore “threatened behavioral freedoms”—especially their freedom to smoke. For this reason, a key overarching guideline is to maximize the smoker's *choice* about various facets of the FAMCON process. We also believe that presenting FAMCON as “consultation,” a term that connotes collaboration and choice, arouses less reactance than calling it “treatment” (Wynne, McDaniel, & Weber, 1987).

Accommodating to Symptom-System FIT

A central idea in family systems theory is that problems both maintain, and are maintained by, the system of relationships in which they occur. Clinicians have observed that problems ranging from child misconduct to adult addiction sometimes have adaptive relational consequences for couples and families that can, in effect, reinforce and perpetuate the symptom (Hoffman, 1981; Steinglass, Bennett, Wolin, & Reiss, 1987). By our definition, a problem “fits” a relational system to the extent that it helps to preserve and support important relationship patterns (Rohrbaugh, Shoham, & Racioppo, in press). Thus, as Doherty and Whitehead (1986) point out, smoking can serve relational functions such as regulating emotional expression and interpersonal closeness, and defining a smoker's autonomy in relation to others.

The symptom-system fit idea provides a conceptual bridge to the emotion-regulating functions of nicotine for the individual smoker. It is well documented that nicotine has powerful effects on the user's mood. Indeed, many smokers appear to use cigarettes to relieve stress and cope with dysphoria or anxiety (Carmody, 1989; Seidman & Covey, 1999), and the experience of negative affect is a common precursor of relapse (Brandon, Tiffany, Obrenski, & Baker, 1990; Shiffman, 1986). This intrapersonal form of affect regulation seems central to physiological addiction, and may help to explain the beneficial effects of both the antidepressant Zyban (bupropion) and behavioral mood-management techniques for some smokers (Hall, Munoz, Reus, & Sees, 1993; Jorenby, Leischow, Nides, et al., 1999). In addition to regulating emotional *experience*, however, smoking can play a role in regulating emotional *expression* within its immediate interpersonal context (Doherty & Whitehead, 1986). The latter happens when emotional exchanges between intimate partners become patterned and smoking helps to maintain those patterns. Like the ironic processes of problem maintenance described above, the processes of emotion regulation occur both within and between people—and when smoking helps to regulate emotion between people, we have a symptom-system fit.

The following vignettes illustrate how this can happen:

- Husband (H) and wife (W) have an early morning ritual of smoking together in their garage on favorite lawn chairs. W says smoking together is the only thing H will let her initiate: “If we didn't smoke in the garage I doubt we'd talk much—and he wouldn't even miss me.” When the couple does talk, W feels that H calms her down—and they mostly talk when they smoke. W had quit smoking some years previously but resumed “because I felt such a distance between us.”
- The partners have mostly nonsmoking friends, but say, “We enjoy our forbidden pleasure together. We like being outside the mainstream.” W says, “If one of us quits and the other doesn't, I think our dynamics will change—and probably not for the better.”
- W says, “I can't talk without a cigarette in my hand,” yet she smokes most in the presence of her husband, especially when they argue, but also when she feels close

to him (“it helps me ignore his bad moods”). In the laboratory, this couple spoke more softly and intimately when they smoked.

- W of a nonsmoking spouse says, “He knows that when I go out to the porch, I’m going to light up. We don’t need to talk. I don’t need to say ‘I need to be alone right now’; I don’t need to tell him I’m upset; I just pick up the pack and the lighter and we understand each other.”

Some of the best evidence of symptom-system fit comes from studies of alcohol abuse. For example, in clinical observations of conjointly hospitalized “alcoholic couples” during sobriety and intoxication, Steinglass, Davis, and Berenson (1977) noted apparent benefits of “wet” family interaction compared to “dry” (sober) interaction (that is, increased or decreased intimacy or affect), and these temporary benefits varied from couple to couple. Further documentation of adaptive consequences comes from daily-diary studies showing that the spouses of some (but not all) alcoholics report *decreased* marital satisfaction following reductions in drinking (Dunn, Jacob, Hummon, & Seilhamer, 1987), and from experimental evidence that some (but not all) couples actually show improved problem-solving behavior when the problem drinker is intoxicated (Jacob & Leonard, 1988). These findings highlight the heterogeneity of links between drinking and marital interaction, in that drinking appears to “fit” relationships in different ways for different couples. For some—perhaps most—couples with an alcoholic partner, drinking is clearly an invader or irritant to the relationship; yet for others, drinking appears to be more of a friend or ally—a kind of lubricant that promotes positive relational stability, at least in the short run.

Symptom-system fit is especially salient in couples where both partners abuse substances. For example, couples in which both partners drink heavily often report better marital adjustment than couples with only one problem drinker, apparently because spouses develop a “drinking partnership” in which alcohol use becomes a basis for cohesion rather than a source of conflict (Fals-Stewart, Birchler, & O’Farrell, 1999; Roberts & Leonard, 1998). With tobacco addiction, having a spouse who smokes appears to be a major relational risk factor for continuing to smoke, with smokers in dual-smoker couples less than half as likely to quit and stay quit as those in single-smoker couples (Murray et al., 1995; Venters, Jacobs, Luepker, et al., 1984). A smoking spouse probably provides less support for quitting and buffers the smoker from external pressure to change. In addition, to the extent that smoking contributes to a couple’s relational stability (by fostering cohesion or marking their boundaries in relation to outsiders), moves toward cessation may threaten that stability and prompt a smoking relapse. As mentioned earlier, Nyborg and Nevid (1986) found a temporary decrease in marital satisfaction concomitant with participants’ quit efforts in a treatment program for dual-smoking couples—and this apparently made sustained cessation much more difficult.

This is not to say that symptom-system fit is *only* relevant when both partners smoke or abuse substances. For example, nondrinking wives sometimes report decreased marital satisfaction when an alcoholic husband is *not* drinking (Dunn et al., 1987); and we have encountered single-smoker couples where, for example, smoking helps to maintain an interpersonal distance that one or both partners perceive as crucial to the stability of their relationship. There are of course important differences between the interpersonal consequences of smoking and drinking—smoking does not impair current functioning the way alcohol does, and drinking does not pollute other people’s air space—but we believe that treatment planning for either addiction will benefit from taking into account the fit between the symptom and the system.

Accordingly, a key feature of FAMCON involves assessing how and to what extent smoking fits a particular couple’s relationship. Based on an assessment of smoking as ally or invader, we can help the partners anticipate interpersonal difficulties likely to accompany cessation attempts, and to plan substitute rituals and activities that do not involve smoking—that is, to

make nonsmoking fit the system. When both partners smoke, a therapeutic objective is often to create or negotiate space for each partner to change independently of the other, without threatening relational stability, and space for one partner to slip or even relapse without threatening the other's newly acquired abstinence. To the extent that couples achieve this, they should be better able to maintain relationship quality through initial cessation attempts and changes in smoking status.

Famcon for Change-Resistant Smokers

We are now in the process of systematizing and pilot-testing the family consultation (FAMCON) intervention for couples in which at least one partner continues to smoke despite having heart or lung disease. By targeting change-resistant smokers whose health is directly compromised by continued smoking, and by including dual-smoker partnerships that are themselves resistant to change, FAMCON represents an attempt to reach smokers who have failed previous quit attempts and are less likely to be helped by existing cessation methods. The treatment takes into account the immediate social context of smoking by aiming to (a) interdict or avoid ironic processes that contribute to problem maintenance, and (b) help clients realign important relationships in ways not organized around smoking. FAMCON is not an alternative treatment, but an adjunctive, complementary approach that incorporates state-of-the-art cessation guidelines (including pharmacotherapy and behavioral skills training). We present these components as choices within an intervention framework that takes into account the immediate social context of smoking. In this way, FAMCON attempts to integrate and contextualize existing cessation interventions in ways that fit and protect clients' vital relationships.

Ideally, FAMCON proceeds through three sequential phases—the preparation phase, the quit phase, and the consolidation phase—encompassing up to 10 sessions spread over 3 to 6 months. The protocol also includes collaboration with the referring primary-care physician, so that when clients wish to consider pharmacological quit aids (nicotine replacement therapy or the antidepressant bupropion), the FAMCON therapist, with support from the project's medical supervisor, consults with the physician responsible for prescribing.

Preparation Phase: Sessions 1–3

The main goals of this phase are assessment of problem maintenance and preparation for change, with assessment at the front end and preparation more figural in sessions 2 and 3. Procedurally, the preparation phase entails two assessment sessions scheduled about a week apart, and a third, feedback session, which, depending on clients' choice, may or may not also mark the beginning of the quit phase.³

The therapist's first objective is to understand what the partners *do* when one or both of them smokes: Who smokes how much? How, when, where, and with whom? Smoking history is relevant too, particularly past quit attempts and how they failed. Careful questioning about behavioral sequences, rituals, and routines helps to identify possible ironic processes and symptom-system fit. For example, when one partner prefers that the other not smoke, or smoke less, how does he or she attempt to influence this, and how does the smoker respond (that is, does it work)? If both smoke, how and when do they smoke together? Does smoking relate to

³In addition to clinical interview information, assessment draws on 18 days of quantitative, daily-diary data, which both partners provide via daily calls to our answering machine. The diary-diary data serve both research and clinical purposes. Patterns of covariation within and between partners help to illuminate couple-specific ironic processes (e.g., one partner may smoke more on days the spouse made more influence attempts) and symptom-system fit (e.g., one or both partners may feel closer on days they smoke more). We use this data clinically to inform key points in the feedback session.

how they feel and what they talk (or don't talk) about? And do they ever try to encourage or discourage each others' smoking, even in subtle ways?

The therapist also looks beyond the couple to assess how smoking fits the partners' relationships with other people. Who else in the family or immediate social network smokes? Are relationships different with smoking vs. nonsmoking friends and relatives? Does smoking play a role in important alliances or coalitions (e.g., smoking buddies)? How do people the partners care about attempt to influence their smoking? The answers to these questions help the therapist evaluate outside influences on within-couple symptom-system fit, as well as who else might later be included in the FAMCON process in case of a therapeutic impasse.

In addition to assessing what the partners do, the therapist pays close attention to how they *view* themselves and their efforts to have a healthy, satisfying life together. How do the partners explain their own and/or each others' smoking? What percentage of time do they control smoking vs. smoking controlling them? What is most important to each of them in life, and how do they wish others to view them? Perhaps more importantly, how do the partners view themselves as a couple, and how does smoking fit their life together? To clarify this, we have found it useful to ask couples to imagine smoking as a metaphorical third party in their relationship (Papp, 1983): for example, if smoking came to dinner, what would he or she—or it—look like and do? Some couples have come up with illuminating metaphors such as “the ghost in our relationship,” “John's dangerous mistress,” and “a friend from childhood.”

As the clients' views become clearer, the therapist begins to introduce elements similar in concept to motivational interviewing (Miller & Rollnick, 1991), but with a couple-level, contextual focus. To highlight love and concern within the couple, we have asked smokers if they think their partner worries about them, and what they think the partner worries about. For example, a wife confessed that she secretly checked on her elderly, smoking husband each night while he slept to be sure he was still breathing. A guiding principle in this is to identify and gently juxtapose discrepancies between continued smoking on one hand and the clients' goals and preferred views of themselves on the other (Eron & Lund, 1996). Some questions are intended to seed the possibility of change and enhance the partners' perceived efficacy to change. For example, the therapist may ask about times in the past when the partners have made important life decisions to do or not do something—both individually and as a couple—and followed through. Other questions concern a smoke-free future (Berg & Miller, 1992). When the smoker does quit, how will that happen? What will be most challenging about quitting for them as individuals and as a couple? What will they be most proud of when they succeed? To do all this, the therapist must maintain an empathic, curious, nonjudgmental stance; respect resistance; use the clients' own language; and avoid joining one partner in an explicit or implicit coalition against the other.

Several other assessment points are covered as well. First, to the extent that a couple shows negativity and overt conflict in the session, spending some time with each partner alone may be helpful later in interdicting ironic processes. Second, if the pretreatment assessment indicates that one or both partners may be depressed, the therapist will evaluate how fluctuations in mood are related to smoking and the couple's relationship. If a partner seems to be using tobacco to alleviate depression, or if smoking seems to elevate the mood of the couple, finding alternative behavioral or pharmacological means to alter mood may be an important consideration in the quit phase. Third, when assessing past quit attempts, the therapist pays close attention to both partners' attitudes about specific techniques and approaches that they perceived as helpful or unhelpful. Knowing the partners' expectations and beliefs about this, including points of agreement and disagreement, helps us prepare a more meaningful menu of quit options for them. Fourth, although our focus is primarily interpersonal, assessing *intrapersonal* ironic processes that involve just the smoker is relevant to FAMCON as well.

Most smokers have tried, and many continue to try, various “solutions” to smoking that feed back to exacerbate the problem—making resolutions, then feeling less efficacious for breaking them; trying to suppress thoughts of smoking, then having them intrude.

In session 3, the therapist provides carefully prepared feedback designed to set the stage for more direct consultation about quitting and achieving stable cessation (see Rohrbaugh, Shoham, Spungen & Steinglass, 1995). Drawing on observations from the assessment sessions, the feedback addresses both pros and cons of quitting that are specific to the couple. In terms consistent with the clients' own language, the therapist empathically acknowledges the difficulties as well as benefits of quitting, not only for the smoker as an individual but also for the partners as a couple. For example, the therapist may document how smoking has invaded both the smoker's body and his or her close relationships; however, the feedback may also include observations about how smoking seems to fit the system and how quitting will be difficult when one or both partners decide to attempt it. The therapist is careful not to assert that smokers *should* quit, but rather defines quitting as a choice that only a smoker can make. The therapist goes on to express confidence that the smoker(s) *can* quit with appropriate support from FAMCON and each other, though accomplishing this goal will not be easy. Then, after outlining FAMCON's emphasis on providing quit options and choices that fit the unique needs of particular smokers and families (with examples of some options that may appeal to each couple), the therapist concludes the feedback by inviting the smoker(s) to make a crucial first choice—setting a quit date, preferably 2–3 weeks in the future.

Understanding ironic processes and symptom-system fit is important in the preparation phase and beyond. For example, a central consideration in designing both session-3 feedback and subsequent cessation suggestions is to promote “less of the same” solution behaviors by one or both partners, in ways that interrupt (or avoid) problem-maintaining ironic processes. Similarly, anticipating interpersonal difficulties likely to arise when tobacco is removed from the system (especially when both partners smoke) will facilitate the transition to stable abstinence by helping the partners plan substitute rituals and activities that do not involve smoking.

Quit Phase: Sessions 3–5

The quit phase begins when one or both smokers agree on a quit date, which ideally happens in session 3. The therapist recommends 3 weeks of scheduled, reduced smoking prior to the quit date, explaining how, for many smokers, this makes cessation easier and more enduring (Cinciripini, Lapitsky, Scay, et al., 1995), but giving the client a choice of whether or not to pursue this path. Near the end of session 3, and in subsequent meetings before the quit date, the therapist and couple begin to negotiate specific plans for how cessation will happen. Important issues to be discussed include how to remove tobacco from the smoker's immediate environment; how to cope with recurring urges and possible withdrawal symptoms; how to plan substitute activities and rituals; and the need to consult with the clients' physician(s) about medications and health concerns. The therapist in this phase serves as a knowledgeable consultant, presenting a menu of both behavioral and pharmacological options that may help with quitting, along with observations and recommendations about how each of these may fit (or not fit) the particular smoker(s) and the couple. These options include evidence-based pharmacological quit aids, including nicotine replacement therapy (nicotine patch, gum, inhaler) and bupropion (Jorenby et al., 1999), as well as behavioral strategies for recognizing high-risk situations, developing delay of gratification skills, and creating behavioral alternatives to smoking (for example, exercise, dietary modifications). The overarching principles in all this are, first, to maximize client choice within the constraints of responsible medical practice, and second, to take into account the interpersonal system by (a) encouraging

quit strategies that interrupt or avoid problem-maintaining ironic processes and (b) reducing relationship difficulties likely to arise in a smoke-free system.

To interrupt ironic processes, the therapist reviews solution patterns related to smoking—pushing the smoker to quit, counting the number of cigarettes smoked, avoiding direct discussion of quitting—and identifies couple-specific ironic processes in which “more of the same” solution seems to feed back to keep smoking or some related behavior going. To interdict such problem-maintaining solutions, therapists implement interventions promoting “less of the same,” such as (a) interdicting negative social control tactics by making them more positive; (b) interdicting over-engagement in attempts to influence (whether positive or negative), for example, by shifting from action to observation or admitting helplessness; or (c) interdicting over-detachment from influence attempts by getting a spouse to express concern or take a position.

Coaching people to do less of the same, when what they are doing makes sense to them, is not an easy proposition. To do this, as noted above, the therapist must maintain a nonblaming stance, respect clients' solutions as well-intended, and present suggestions for less of the same in terms consistent with the partners' preferred views of themselves and each other. To maintain a nonblaming attitude in the therapeutic system, it is sometimes necessary to coach partners individually about how to do less of the same. This can be especially important for couples who show high conflict in the session.

Consolidation Phase: Sessions 5–10

Consolidation begins as soon as a smoker has quit, and many of the clinical interventions and considerations from earlier phases continue to be relevant in this longer, more diffuse phase. The main goal is to build and reinforce confidence that cessation can be permanent—to seal the solutions that work, not just for an individual smoker, but also for the couple as a unit. The focus here typically involves reinforcing not only the skills of individual smokers (like dealing with high-risk situations), but also alternative relational patterns that support continued abstinence.

General Considerations

Several more general considerations guide our approach to treatment. First, FAMCON is an adjunctive, complementary approach intended to make high-risk, change-resistant smokers more amenable to established quit strategies. By intervening not just with the smoker, but also with his or her intimates, we aim to mobilize or neutralize interpersonal influences in ways that make smokers more accessible to behavioral and pharmacological techniques that have helped less change-resistant clients. Second, consistent with “motivational interviewing” (Miller, 1996), we aim to enhance readiness to quit by approaching clients in an empathic, nonconfrontational manner, while rolling with resistance and appealing to discrepancies between smoking and clients' life goals and values. In addition, however, we view an individual's motivation as responsive not only to what a therapist does, but more importantly to what happens between smokers and their intimates. Thus, in the preparation phase, FAMCON addresses patterns of ironic influence loops and/or collusion between partners that may inadvertently impede motivation to quit. Third, we assume that the interpersonal processes most relevant to smoking maintenance will be heterogeneous across couples. A research hypothesis is that ironic processes will be a primary obstacle to change among single-smoker couples, whereas symptom-system fit will be more important for dual-smoker couples—and accordingly, different intervention strategies may be required for these two groups. Finally, in addition to incorporating and contextualizing existing cessation guidelines (Fiore et al., 1996), FAMCON attempts to maximize the smoker's choice throughout

the consultation process. Emphasizing choice may be especially important in view of the reactance-laden influence processes so familiar to most change-resistant smokers.

FAMCON will ultimately be described as principle-driven guidelines, in the form of a flowchart with, at minimum, differential paths for single- and dual-smoker couples, and for clients who do and don't accept our initial offer to set a quit date. Other likely choice points and guidelines will concern questions such as (a) the salience of identifiable ironic processes and symptom-system fit; (b) how to address different types of ironic processes; (c) what to do when one or both partners are clinically depressed; (d) what to do when couples exhibit overt conflict; and (e) when to see partners individually and/or involve other family members.

The methodology for treatment development proceeds through a *formulation stage*, during which we developed a preliminary manual based on cases seen by the first two authors (MR and VS); a *standardization stage*, in which we revised the preliminary manual and standardized procedures for training therapists and monitoring their adherence and competence; and an *implementation stage* in which additional therapists are applying FAMCON to a larger cohort of cases following the revised manual. The goals are (a) to evaluate consumer acceptance of FAMCON and smoking outcomes up to one year; (b) to test change processes and principles of the model; and (c) if results are satisfactory, to prepare a final version of the manual for testing FAMCON in a randomized clinical trial.

This 3-year treatment-development project is now in its second year. Although it is too soon to present reliable cessation rates, the couples who have participated to date report high satisfaction with the program, and their preliminary smoking outcomes have been encouraging. The value of this systemic (and relatively intensive) approach will depend on whether it increases the probability of stable cessation for health-compromised smokers who have failed previous quit attempts and not responded to other treatments.

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