



# Redundant Attempted Solutions: 50 Years of Theory, Evolution, and New Supporting Data

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The theory of redundant attempted solutions (RAS) is described from its origins to today. Based in cybernetics and introduced at the Mental Research Institute in Palo Alto, California, the main principle of RAS is that repeating an unsuccessful solution may actually serve to perpetuate and further entrench a problem. A true reducer of complexity, a definition of RAS is presented that appreciates biopsychosocial dimensions of diagnosis and intervention. Data are also presented from SYPRENE, a systemic therapy practice research network that documents the use of strategic interventions to stop RAS.

**Keywords:** redundant attempted solutions, mechanisms of change, strategic-systemic therapy, cybernetics, Mental Research Institute

## Key Points

1. The concept of redundant attempted solutions (RAS) originated at the Mental Research Institute in Palo Alto, California.
2. The main principle of RAS, based in systemic thinking, is that repeating an unsuccessful attempt to solve a problem may actually serve to perpetuate and further entrench the problem.
3. The main purpose of the therapist, therefore, is to disrupt repetitions of RAS.
4. RAS are often based on the (il)logics of avoidance or false control – or some combination of these.
5. Evidence is presented from SYPRENE, an international systemic therapy practice research network, supporting the therapeutic problem-solving effectiveness of stopping RAS.

We cannot solve our problems with the same thinking we used when we created them.  
Albert Einstein

Darwin (1859) pointed out that the survival of a species may be threatened by its inability to abandon what was at one time an optimal (and therefore non-pathological) adaptation, but whose obstinate maintenance in the face of changing environmental conditions may ultimately threaten its survival. The belief that the optimal solution has been found (combined with the persistent attempt to ‘perfect’ this solution strategy in the face of increasing difficulties) blinds people to change strategies that can be present and available at any time. Freud (1914) also was aware

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that many of his patients tended to make the same mistake over and over again. He called it the *repetition compulsion*.

A human system caught in this vicious circle is likely to expect from therapy one and only one form of help: ‘Change us without changing us . . .’ (Watzlawick, 1997, p. 277). It is ensnared and trapped in what can be called an ‘endless game,’ in which recurring behaviours are strictly governed by rules but without any rules for changing the rules (see Fraser & Solovey, 2007). Not recognising the important difference between a *first-order change* (a change of one or more rules in the system without changing the system) and a *second-order change* (a change in the system rules themselves) as the way out of this circle (Bateson, 1972; Fisch et al., 1982; Hoyt, 2011; Weakland et al., 1974), only maintains and deepens the (dysfunctional) status quo. The concept of redundant attempted solutions (RAS) can, therefore, provide an effective and efficient way out of such impasses.

How was the RAS concept developed? What is the potential role of the RAS concept in today’s therapies? How can we evaluate its efficiency? In this article, we will examine the RAS concept and its evolution. We will introduce the research network SYPRENE and analyse what we can learn about RAS with data from the network.

### **From the repetition compulsion to the concept of redundant attempted solution**

As Watzlawick (1997) points out, Freud (1914) thought of repetitive behaviours as symptoms, but he did not consider these behaviours to be central to the formation of a problem and its persistence. Frankl’s work (1963, p. 116) also takes into account repetitive and paradoxical dimensions that led him, for example, to declare that ‘the fear of insomnia creates a hyperintention to sleep that eventually keeps you awake,’ but even if the phenomenon of redundancy in the client’s problem had been noted, it was only approached from a linear (not systemic) causal perspective.

Wender (1968, p. 309) in his theory of *vicious and virtuous circles*, evokes the concept of deviation amplifying feedback (DAF):

This explanatory mechanism is usually introduced *ad hoc* so that its generality and applicability are not recognized. It is most commonly identified in its pathological form, the vicious circle, although the similar mechanism, with beneficent effects, has been noted and called the virtuous circle. Both vicious and virtuous circles are examples of what is called, in cybernetic terms, positive feedback, or what Maruyama has called “deviation amplifying feedback.”

The recognition of DAF leads to the implication that fixed behaviour patterns may be sustained by present – not past – forces. This does not deny the existence and importance of attitudes, values, or habits, nor the role of unconscious motivation. It does raise the useful question, however, of whether or not persistent behaviour is due to these factors – that is, whether behaviours are rigid because they were learned at an early developmental stage, imprinted, or acquired in a hypnoid state.

If we look at the DSM-5 (APA, 2015), which is intended to be atheoretical, the example of the diagnostic criteria for a ‘specific phobia,’ avoidance conduct, is cited several times as a symptom, although it is not considered to be the essential characteristic of this disorder and even less so to be the cause or maintainer of the disorder.

Another clue was noted by Rorhbaugh and Shoham (2001), who quote Jay Haley: 'Also at variance with the pathology-focused psychodynamic viewpoint was [Milton] Erickson's take on why people have problems in the first place. Rather than viewing problems as "symptoms" of some deeper, underlying pathology, Erickson's implicit assumption was that problems arise from the mishandling of common, everyday difficulties encountered in the course of the family life cycle.'

### **The systemic and biopsychosocial perspective**

In each action we must look beyond the action at our past, present, and future state, and at others whom it affects, and see the relations of all those things. And then we shall be very cautious.

Blaise Pascal, *Pensées* (1670/1869–1872, p. 378)

In 1925, the biologist and psychologist Ludwig Von Bertalanffy began work on a general theory that would enable living things to be approached as systems. His major book (1969) shows his claim to make *general systems theory* a meta-logico-mathematical discipline intended to concern all sciences. He argues that a living organism cannot be understood by studying separately each of its 'components,' but as interactions between its different parts, its organisation, its exchanges with its environment, etc. In 1948, the term *cybernetics* was coined by Norbert Wiener. At that time, he defined it as 'the study of control and communication in the animal and the machine' (1948, pp. 14–18). In 1951, Gregory Bateson and Jürgen Ruesch published a book that laid the foundation for the cybernetic approach to communication. In this book they observe that the rules of a relationship are not defined once and for all. There is a perpetual mutual adaptation, conscious or not: it is a process with feedback. All living things adapt, everything that does not adapt stagnates and dies. This is true in both biology and interpersonal relations. Hence, a problem-solving intervention is about change. This conception may seem elementary, but as Bateson and Ruesch (1951, p. 7) note, 'the knowledge of a supposed *why* is neither necessary nor sufficient to change.' The question that interests us is *how* this problem is being maintained here and now. Knowing putative root causes in the past seldom allows for change in the present.

The *biopsychosocial model* was introduced by George Engel (1977, 1981) at the end of the 1970s. At that time, both psychoanalytical currents and biological reductionism dominated. Engel criticises reductionism as unscientific and points out that in a biological system, no element can be understood except in relation to the whole – they are all intertwined and inexorably inseparable. The roots of his biopsychosocial model were derived from general systems theory. Engel was able, based on the work of Paul Weiss and von Bertalanffy (see Von Bertalanffy, 1969) to examine 'how the biopsychosocial model allows the physician [including psychiatrists] to extend the application of the scientific method to aspects of daily practice and patient care' (Engel, 1981, p. 102).

For Bateson and Ruesch (1951, p. 28), the unit to consider is the overall social situation: 'A social situation is established when people enter into interpersonal communication.' The system to be taken account of, when considering the health of an individual, is the entire biopsychosocial system. Or, to say the opposite, to hope that only one of these fields (somewhat arbitrarily distinguished as bio, psycho, or social)

on its own, would make it possible to find and treat mental pathologies is illusory. In their manifesto *To End the Stranglehold of the DSM*, Douville (2012, p. 7) states that: ‘the most recent scientific advances in the field of neuroplasticity or epigenesis show that it is no longer possible to oppose psychological and organic casualties, since the former influences the construction of the latter.’ Similarly, Lieberman (2015), a biologically oriented psychiatrist, strongly argues for a ‘pluralistic psychiatry’ that combines brain and mind; the mind is not the same as the brain. When research on mental illnesses reduces the individual’s field in its biological prism, it neglects the psychosocial domain and encounters difficulties in seeking to identify explanatory and maintaining factors. Isolating one area from other areas is a fundamental epistemological error in the way complexity is addressed. Indeed, as will be further discussed below, systems theory (Von Bertalanffy, 1969) teaches us that the whole is more and different than the sum of its parts.

### **The Mental Research Institute: The birth of the concept of ‘attempted solutions’**

As we will discuss below, Stafford Beer (1967, 1970) developed the concept of a *complexity reducer*, which inspired the authors at the Mental Research Institute (MRI). The concept of attempted solutions was formalised in the article ‘Brief Therapy: Focused Problem Resolution’ in which Weakland, Fisch, Watzlawick, and Bodin (1974) iconically express the concept of attempted solutions as ‘The problem is the solution.’ As Watzlawick and Weakland (1977, p. 281) explain:

We assume that once a difficulty begins to be considered a “problem,” the continuation, and often the exacerbation of this problem comes from the formation of a closed-loop positive feedback system, which most often revolves around the behaviors of individuals in the system, designed to solve the difficulty: the original difficulty is the subject of an attempt at a ‘solution’ that intensifies the original difficulty, and so forth.

For the MRI team, the very effort that was being made to eliminate the problem could be the same effort that kept it going and made it worse. Thus, Wittezaele and Garcia (1992) recount comments made by Richard Fisch: ‘In our discussions, we called them “solutions”, until we finally said to ourselves: “But they are not solutions, let’s call them ‘attempted solutions’ because, in fact, they do not solve anything.”’ As Rohrbaugh and Shoham (2001, p. 66) summarise:

The model of brief therapy developed [...] in Palo Alto is based on identifying and interrupting ironic processes that occur when repeated attempts to solve a problem keep the problem going or make it worse. Formulations of ironic problem-solution loops provide a template for assessment and strategic intervention, indicating where to look to understand what keeps a problem going [...] Whether occurring within or between people, these processes persist because problem and attempted solution become intertwined in a vicious cycle, or positive feedback loop, in which more of the solution leads to more of the problem, leading to more of the same solution, and so on.

In their book *Propagations*, Weakland and Ray (1995) identify attempted solutions as the cornerstone of MRI’s work. Thus, Wittezaele and Nardone (2016, p. 69) comment: ‘It is these unsuccessful efforts to find relief [that the Palo Alto School] considers the therapist’s first job to stop this dysfunctional process.’ The target of treatment thus becomes the cessation of attempts at a solution which, instead of allowing the problem to disappear, aggravates the situation by a process of amplifying the difficulty.

Other authors also have suggested the importance of not continuing unsuccessful attempts at solution. For example, in their work with ‘intimidating cases,’ Fisch and Schlanger (1999, p. 2, italics in original) write: ‘Thus the thrust of therapy is not to get the complainants to *do* something so much as to *stop* what they have been doing about the problem [...] In that sense, we would say that we don’t treat problems, we treat attempted solutions.’ Nardone and Portelli (2005, p. 73) instruct their clients: ‘Every day, choose a small but concrete thing as if you had already overcome your problem, and voluntarily put it into practice. Every day choose something different.’

Along similar lines, de Shazer (1988) counsels the solution-focused rule, ‘If it doesn’t work, don’t do it again; do something different’; O’Hanlon (1999) advises ‘Do one thing different’; Hoyt (2017, p. 220) says, ‘Get the client to do something different or differently – more of the same does not make a change’; and Soo-Hoo (2019) recommends ‘the 180-degree turn in therapeutic interventions.’ As Bobele (2019, p. 33, italics in original) explains: ‘[MRI] described a problematic, interactional cycle where participants reciprocally escalated ineffective efforts to change one another’s behavior in an attempt to solve their mutual problem [...] [Based on the] understanding of the positive feedback loop that maintained the problematic situation [their] recommended solution was deceptively simple – *interrupt the problematic cycle.*’ Mark McKergow (2021, p. 23) similarly notes: ‘For the MRI team, a problem arises when a difficulty is mishandled and persists, producing a situation which is deadlocked, knotted or an impasse. The problem situation is being held in place, unwittingly, by the actions that the family are trying to take to resolve it! A vicious cycle has been created, where “more of the same” leads to “yet more of the same”. As the problem is the result of continued misapplication of the wrong attempted solution, the therapist’s job is to have them stop doing that and do something else.’

### **The epistemological basis of a meta-model: Interactional psychotherapy from a cybernetic perspective**

Pascal (1869–1872) expressed with dazzling intuition the concept of non-separation in Nature: ‘The parts of the world all have such a relationship and such a sequence with each other that I believe it is impossible to know each other without the other and without the whole.’ This means that to know is always to connect and not to separate, decompose, or oppose, which is often a characteristic of the butchery of the ordinary intellect.

As explained by Watzlawick, Beavin, and Jackson (1967), systemic therapists eschew linear formulations (such as ‘A causes B’), preferring to work from a ‘meta-perspective’ that focuses on circular causal explanations in which problems both originate and are sustained by patterns of interacting with important others. Hence, Watzlawick explains (in Nardone & Watzlawick, 2005, p. 3): ‘[M]odern family therapy . . . no longer asks, “Why is the identified patient behaving in this bizarre, irrational fashion?” but rather, “In what sort of human system does this behavior make sense and is perhaps the only possible behavior?” and “What sort of solution has this system so far attempted?”’

### **Redundant attempted solutions: A ‘complexity reducer’**

For the theoretician Stafford Beer (1967, 1970), solving a complex problem with a seemingly simple solution requires what he calls a *complexity reducer*. The concept of RAS (following Nardone & Salvini, 2007/2018, p. 14 the word *redundant* emphasises

the repetitive nature of the unsuccessful attempted solution) is a major step forward because it is precisely a reducer of complexity in terms of formalisation and problem-solving. This concept of attempts at solution makes it possible to bring to Engel's biopsychosocial model the key systemic property of *emerging quality* aimed at reducing complexity without distorting it.

Watzlawick (1997, p. 277) describes precisely the meaning of and interest in the attempts at a solution:

In our work at the MRI, we have gradually achieved a complexity reducer that seems to us to be the most practical and therefore the most useful when confronted with the complexity of human interaction: the attempted solution. After obtaining what appears to be a sufficiently clear definition of the problem, we ask our clients what they have done so far to solve it and what advice they have received from others. This information is relatively easy to obtain and allows us to identify the very mechanisms by which the system maintains its homeostasis.

RAS (Vitry et al., 2020, 2021) are: 'Communication actions repeatedly attempted by the person, his entourage or his cultural system to solve a life difficulty with him/herself, others or the world, without succeeding; they create a problem that they perpetuate and aggravate by keeping the affected person(s) blocked in a restricted perception of the situation. These redundant actions, which can generate further emotional distress, take the form of language, behaviors or thoughts, intentional or unintentional. They have been learned and are perceived as consistent through feedback.'

### **Evolution of the concept of redundant attempted solutions in strategic therapy**

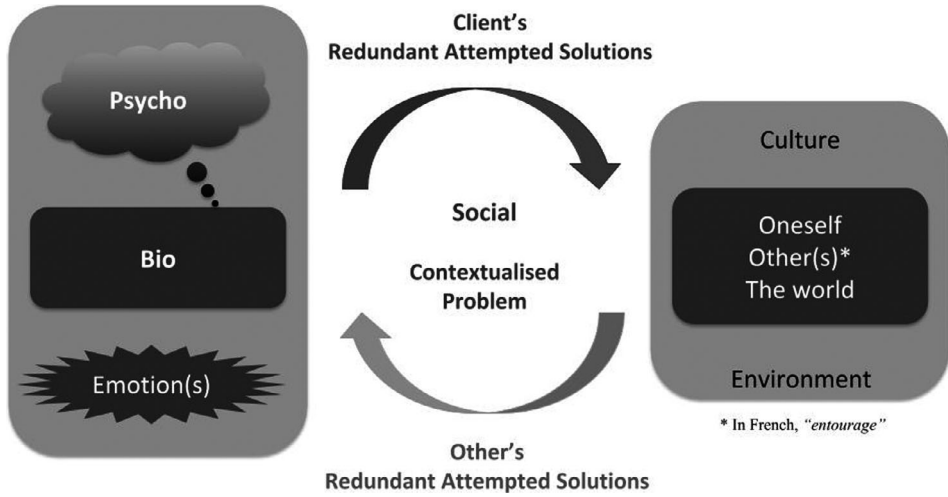
Wittezaele and Nardone (2016, p. 264) indicate that their position is 'to identify the systemic causal links that explain how the problem works and sustains itself, not to seek to determine where it originated or to try to make sense of it. The way is then open to propose reframing and tasks that will go in the direction desired by the patient and marked out by the therapist.'

Thinking in terms of process requires, as we present in the following diagram: (1) to take into account what is perceived (PERCEPTION) *and* (2) to take into account the usual REACTIONS (REACTION = REPEATING ACTIONS). That is, in the end, to be able to address any complex situation in terms of mental health according to what Nardone (Nardone & Balbi, 2012, p. 94) calls the *Perceptive-Reactive System*. As shown in Figure 1, this requires a systemic-interactional biopsychosocial perspective.

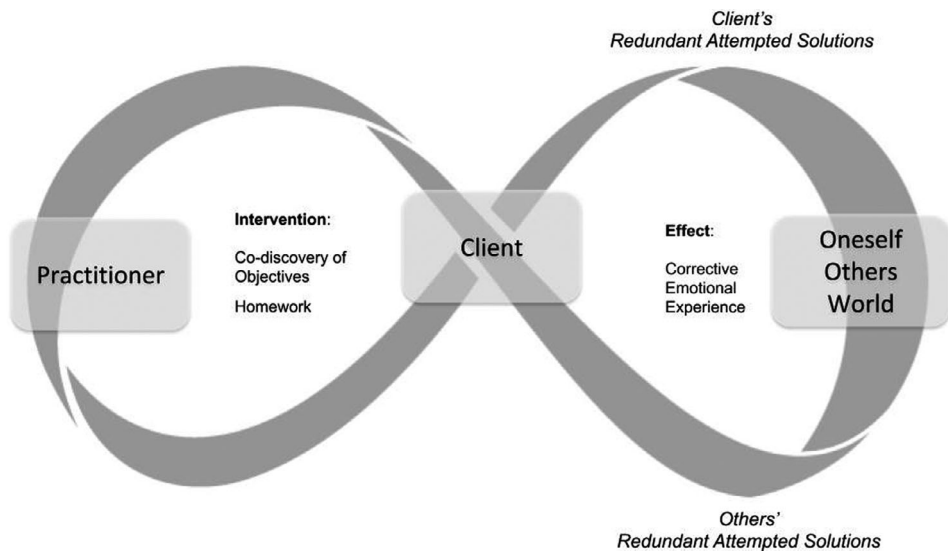
The RAS ends up confirming the underlying perceptions, sensations, and emotions, thus keeping vicious circles operative. Changing rigid perceptions can take place by reframing and using performative language, such as prescriptions/homework, that block RAS and enable clients to experience different emotions and realities – which William James and Milton Erickson (see Short, 2020) both consider fundamental to change and which Alexander and French (1946) call a 'corrective emotional experience' (see Figure 2).

### **The processes of RAS**

Mental health disorders can be mapped onto two types of processes. The first type of operating logic is *avoidance*. Faced with an obstacle, one may tend to avoid it and if



**FIGURE 1**  
Biopsychosocial and Perceptive-Reactive System (©LACT 2020. Used with permission)



**FIGURE 2**  
RAS in Therapist-Client-Others Context (© LACT 2020. Used with permission)

this is exacerbated, avoidance becomes pathological. The second type of operating logic is *paradoxical control*. We find here people who face an obstacle and quickly confront it. But if this control is exacerbated, it becomes paradoxical in that the control action simultaneously creates the opposite effect. These two (il)logics can be combined with one another.

## **SYPRENE: Evaluation and Process Studies**

SYPRENE, a systemic practice research network created by LACT<sup>1</sup> Research (Vitry et al., 2020), is a unique online data collection tool which allows naturalistic studies of the differential effectiveness of therapeutic processes by type of problem treated. Although MRI strategic-interactive therapy has ‘stood the test of time’ (Hale & Frusha, 2016) and there is some empirical support that strategic therapy works (e.g., see Horigian et al., 2016; Jackson et al., 2018; Wittezaele & Nardone, 2016), the limited transferability of laboratory-based efficacy research into everyday clinical practice is often stressed in the literature (Baucom et al., 2018; Seligmann, 1995; Tasca et al., 2015; Teachman et al., 2012). Looking for solutions to fill the gap between laboratory and naturalistic psychotherapy outcome studies, practice research networks (PRNs) were introduced in the 1990s, in the hope that large numbers of cases coming from real-life clinical practice would allow specific information valid for everyday practice and thus greater generalisability of results and conclusions to be obtained. SYPRENE was developed to accomplish this with systemic therapies, beginning with the MRI strategic approach (Vitry et al., 2020).

## **Method**

### **Participants**

Between 2015 and 2020, 1,277 individual clients<sup>2</sup> with completed cases across a wide variety of diagnoses were registered in the SYPRENE database by 22 systemic and strategic practitioners working in five countries (French,  $n = 14$ ; Italian,  $n = 4$ ; Mexican,  $n = 2$ ; Spanish,  $n = 1$ ; Canadian,  $n = 1$ ). Clients self-identified as 35% male and 65% female; their average age was 40.5 years old. Practitioners reported having an average of 16 years of experience as psychologists ( $n = 9$ ), therapists/counsellors ( $n = 7$ ), or psychotherapists ( $n = 6$ ). All practitioners identified themselves as ‘strategic therapists’ and four also specified Ericksonian hypnotherapy as a secondary specialisation. All clients were seen in private practice (not in public clinics or hospitals).

### **Assessments**

Data in SYPRENE are collected from both practitioners and clients, and then entered digitally into the data-recording system by the practitioners (Vitry et al., 2020). Practitioners all undergo an initial 90-minute training in the use of SYPRENE, and then engage in a monthly online conference to discuss cases and assessments.

Standardised information for each client’s case is recorded:

- date, time, duration and setting of a session;
- practitioner’s problem diagnosis, level of potential risk;
- type of session (first appointment, continuing, last appointment);
- client’s evaluation of the therapeutic alliance (Session Rating Scale/SRS, Miller & Duncan, 2004 – discussed below) scores obtained after each session;
- stage of the therapy (e.g., defining the objective of the therapy; unblocking [problem attempted solution]; consolidation [when problem is solved]; follow-up at 6 months; type of ending [completed or drop-out]);
- client’s evaluation of the outcome: (1) General Health Questionnaire (GHQ-12 – discussed below) scores obtained before the first, fourth, and after the last session; (2) Outcome Rating Scale/ORS (Miller & Duncan, 2004) for each session;<sup>3</sup> (3)



- client's evaluation of the problem-solving outcome (on an 11-point scale) at the end of the therapy; (4) client's evaluation of change (to what extent – *not at all, little, mostly, or completely*) before the fourth and after the last session;
- practitioners' evaluation of the problem-solving outcome (on an 11-point scale) at the end of the therapy.

## Results

### Treatment effectiveness and intensity (length of effective intervention)

With SYPRENE it is possible to evaluate the relationship between length and effectiveness of therapy, defined by the number of cases in which the problem situation is resolved or improved. As reported in Vitry et al. (2021), the data show that (1) 59% are completed in 1 to 5 sessions ( $n = 754$ ); (2) 28% in 6 to 10 sessions ( $n = 358$ ); (3) only 13% of cases required more than 10 sessions ( $n = 164$ ). According to the practitioners' evaluations, a significant improvement or complete problem resolution was achieved in 79% of cases, with an average of 5.9 sessions and 5.5 months length of treatment. These results indicate that it is possible to obtain very good results in less than 10 sessions (90%,  $n = 890$ ). SYPRENE data indicate the average duration of treatment 5.5 months.

Effectiveness was assessed on an 11-point scale (from 0 to 10), by both the therapist and the client, according to whether the problem that led the client to consult was considered *resolved, improved, or unresolved*. Ratings also indicated whether or not the therapist had helped the client to stop his or her redundant attempted solutions (RASs), which are conceptualized as the perpetuating force behind his or her problem. Outcome was further assessed using the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1991), a well-documented 12-item instrument measuring 'mental distress' that is completed by the client. Client self-ratings of resolved/improved/not improved and of GHQ-12 scores showed similar improvements (see Vitry et al., 2021).

### RAS observation

Thirty-nine attempted solutions have been listed by the SYPRENE research group, based in particular on the recent work of Wittezaele and Nardone (2016): 13 correspond to *avoidance*, and 26 are associated with a will to *control*. In SYPRENE, however, because encoding RAS is not mandatory, they were only reported in 17% ( $n = 220$ ) of cases. The distribution of RAS is as follows: (1) *control* in 79% of those 220 cases, (2) *avoidance* in 76% of cases. Among the RAS related to *avoidance*, the main ones are: (1) avoiding social situations that generate fear (35%); (2) avoiding necessary regulations (19%); and (3) denying information or emotions or trying to escape from them (18%). The main RAS related to control are: (1) wanting to control one's behaviour (28%); (2) wanting to control one's emotional reactions rationally (22%); and (3) ruminations (22%).

For example, a male client suffered from social phobia which led him to stay at home and give up all social activities. The therapist identified that the client avoided all feelings of fear (RAS 1) and avoided social situations generating fear (RAS 2). By encouraging and directing the client to experience the fear that he has been avoiding,

he could regain control over his sense of fear in social situations. When he did this, the client was instructed to then assess whether his situation had been resolved, had improved, or was unresolved.

In the strategic approach, the goal of intervention is to stop RAS. Emotional experience is at the heart of strategic intervention. During therapy, the nature of the emotion observed by the practitioner can be identified in SYPRENE. For the 342 clients for whom an emotion was rated (a client could score on more than one emotion) the results are as follows: (1) fear ( $n = 221$ ); (2) anger ( $n = 173$ ); (3) psychic pain<sup>4</sup> ( $n = 136$ ); (4) guilt ( $n = 84$ ); (5) shame ( $n = 60$ ); (6) pleasure ( $n = 22$ ); (7) disgust ( $n = 11$ ); (8) jealousy ( $n = 6$ ); and (9) surprise ( $n = 1$ ). SYPRENE also allows the practitioner to record the different categories of RAS. Relying on practitioners' assessments (as a naturalistic PRN study, there were no audio or videotapes of sessions and no independent observers) the most common RAS observed ( $n = 76$ ) concerned clients who 'avoid social situations that generate fear (e.g. fear of rejection, judgment, ridicule, refusal . . .)'. This dysfunctional process of emotional regulation corresponds to what Gross (2002) calls 'avoidance of situations that trigger negative emotion.' The second most common RAS ( $n = 49$ ) observed by practitioners concerned clients who want to 'control their emotional reactions rationally,' a form of dysfunctional emotional regulation in which the person tries to put at a distance, through a cognitive process, a sensation that they fear. The third most common observed RAS identified was for clients who 'deny emotions or information' ( $n = 40$ ). They are in a state of avoidance that neutralises certain painful aspects of a situation; in terms of emotional regulation, these people develop a form of modification of the representation of the situation so that it loses its emotional significance. By following the main prescriptions, the emotional dimension is once again at the centre of the strategic intervention.

The strategic-systemic approach is based on a feedback concept that makes a complex learning process of change visible with RAS. In cybernetic terms, the practitioner places the therapeutic alliance at the centre of intervention, constantly taking into account both the client's position and feedback (e.g., regarding improvement), and thus continuously influencing and readjusting the evolution of the therapy for both the therapist and the client (see Figure 2).

SYPRENE (Vitry et al., 2020) takes into account different elements (in order to better analyse the link between the intervention and the effect obtained: (1) RAS with evaluation of the problem-solving outcome from the client's and therapist's perspective; (2) effect of homework and reframing; (3) emotional change; and (4) since 2019, the ORS/SRS<sup>5</sup> (Miller & Duncan, 2004) have also been administered. When larger data samples are collected, these assessments will make it possible to better understand the processes that help to resolve clients' problems.

## Conclusions

The theory of RAS explains the development of how one adapts in ways that inadvertently perpetuate the problem. As Watzlawick and Weakland (1977, p. 512) state: 'From this perspective, there is evidence that what has caused a problem to emerge – these may be minor or rather ordinary causes – is often less important than what causes the problem to persist and develop.'

The reports of 27 systemic and strategic therapists across 8 countries, collected by SYPRENE, found that the most common RAS identified and used involved logics

intended to *control* or *avoid*. Consistent with the theory of RAS from which the MRI strategic approach was derived, when people try to solve situations that they meet by using these strategies, they often perpetuate the very problems they seek to solve. Disrupting RAS can resolve ‘stuckness’ and allow change to occur. In MRI-style strategic-systemic therapy (Fisch et al., 1982; Nardone & Portelli, 2005; Nardone & Watzlawick, 1993, 2005; Watzlawick et al., 1974) this is accomplished as the practitioner and client continuously provide one another with feedback and make adjustments.

While our measures all rely on *prima facie* self-reports made by clients and their therapists, credibility comes from the good correspondence between the various evaluations with the following implications: (1) strategic therapy is effective when measured from clients’ and practitioners’ perspectives regarding improvement of both the problem situation and clients’ feelings of subjective distress; and (2) practitioners’ and clients’ evaluations of problem-solving outcomes are strongly linked – both groups evaluate problem improvement quite similarly.

At this point, we can conclude that outcome evaluations on all three measures are related. Therefore, practice research networks such as SYPRENE should include both clients’ and practitioners’ perspectives when assessing outcomes in naturalistic settings in order to provide a greater overall understanding of therapeutic change.

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### Conflict of Interest

The authors declare that they have no conflict of interest.

### Notes

<sup>1</sup> LACT is an acronym signifying ‘Liberating Actions for Transformation.’ LACT is a freestanding research, training, and psychotherapy institute based in Paris. It is supported by tax credits from the French government. SYPRENE was originally called ‘LACT Research’; the name was changed to SYPRENE in 2018.

<sup>2</sup> The terms *client* and *patient* are both used extensively throughout the literature. Each term carries certain implications (see Hoyt, 2017, pp. 1–5 and 217–218). *Client* tends to emphasise a more egalitarian and less hierarchical therapeutic relationship with a subsequent de-emphasis on implications of pathology, diagnosis, and expert (top-down) strategic treatments in favour of more collaborative/facilitative/strengths-oriented approaches (see Hoyt, 1994, pp. 2–4). Keeping with popular practice in Australia, the authors herein use the term *client*. As noted in Hoyt and Talmon (2014, p. 11), ‘What one calls the participants and the process (*therapy? counseling? treatment? intervention? consultation? facilitation? work? practice? meeting? encounter? conversation? coaching?*) helps to establish a meaning context (topics, roles, power relations, ideas about how change occurs), and thus, influences their work together.’

<sup>3</sup> Different outcome measures have been added to the SYPRENE data recording system at different times. The ORS and SRS (Miller & Duncan, 2004) as well as the client’s evaluation of the problem-solving outcome and the evaluation of change were added in the last trimester of 2019.

<sup>4</sup> In French, ‘*douleur*.’

<sup>5</sup> The Outcome Rating Scale (ORS) measures how a person feels just before the session (on a scale from 0 to 10) on four dimensions (individually, interpersonally, socially, globally). The Session Rating Scale (SRS) measures the therapeutic alliance just after the session on four dimensions (relationship with the therapist, objectives worked, the method, and the overall evaluation of the session).

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