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RESISTANCE, DILEMMAS AND CRISES IN FAMILY THERAPY: A FRAMEWORK FOR POSITIVE PRACTICE

ABSTRACT

When clients believe that they have not got the personal resources to cope with the demands of either living with their problems or taking steps towards the resolution of these, stating their therapeutic dilemma may precipitate a therapeutic crisis. A therapeutic dilemma is a concise statement of the disadvantages and difficulties associated with leaving the presenting problem unresolved and the disadvantages and risks entailed by solving the problem. Invariably, therapeutic crises involve some family members doubting an interactional formulation of the family's problems and redefining these as individual difficulties of a specific family member. That is, someone in the family becomes defined as *bad, sad, sick* or *mad*. The pressure to collude with the family and other network members in abandoning an interactional construction of the problem and accepting an individual description is usually very intense. When therapists follow this route they become part of the problem maintaining system. In this paper a framework for conceptualizing therapeutic crises and guidelines for their management are described. These guideline allow the therapist to avoid becoming involved in problem maintenance and to retain a position from which to promote problem resolution. The framework and guidelines evolved within the context of a brief integrative approach to consultation with families who require help with child-focused psychosocial difficulties.

INTRODUCTION

Positive Practice is a brief integrative approach to consultation with families who require help with child-focused psychosocial difficulties (Carr, 1995). The approach looks to the tradition of Milan systemic family therapy for its central clinical framework (Campbell et al, 1991). Aspects of psychodynamic therapy (e.g. Malan, 1979) and social learning theory (e.g. Falloon, 1991) are integrated into this core approach to practice along with elements drawn from the wider fields of family therapy (Gurman & Kniskern, 1991) and brief therapy (Gilligan & Price, 1993). Within this approach a clear distinction is made between the stages of assessment and treatment. Clients formally contract for both phases

of consultation (Carr, 1990a). In each phase, treatment plans are based on an integrative formulation. Formulations are constructed in a way that allows therapists and clients to map information about the pattern of interaction around the presenting problem, beliefs that constrain family members from altering their roles in these problem maintaining patterns and factors that have predisposed family members to hold these beliefs (Carr, 1990, b). Positive Practice offers methods for evolving new behavioural patterns and belief systems within sessions and for arranging homework tasks for clients between sessions. It also incorporates methods for dealing with resistance; for managing therapeutic crises; for convening individual sessions (Carr, 1994) and broader network meetings; for disengaging from the consultation process and for recontracting for further episodes of therapy. In this paper, the focus is on the midphase of therapy and the issues of resistance and crises that may occur when the dilemmas entailed by resistance are explored.

RESISTANCE

Between contracting for consultation and disengagement many hitches occur in most family therapy cases. For example, family members may miss appointments, not complete homework assignments, participate in therapy sessions in ways that prevent progress or revert to an individualistic formulation of the problem (Anderson and Stewart, 1983). Let us here become acquainted with a case example which will be followed throughout the paper to illustrate points made. The Barrow family comprised two teenage children, Caroline (14) and Mat (18) and their parents Dick and Sheila. Caroline was referred to a child and family clinic in the UK concurrently by a paediatrician and an educational psychologist. Their respective concerns were Caroline's abdominal pains for which no medical explanation could be offered and her school non-attendance. With the Barrows, resistance was first apparent in the third session when Sheila reported that she failed to complete the task of allowing Caroline to autonomously manage her abdominal pains. Resistance intensified in session four. Dick failed to attend the session. He also failed to follow through on his agreement to phone Sheila each morning at 8.30 to help her deal with the difficulty she experienced in allowing Caroline space to manage her pain independently. In addition, Sheila and Caroline did not visit the family doctor on three mornings when the intensity of the abdominal pains led to school non-attendance. The agreement was that in such situations, the judgement about Caroline's medical fitness for school attendance would be left with the GP.

In Positive Practice resistance is dealt with in a systematic

manner. The discrepancy between what clients agreed to do and what they actually did is described. Second, inquiries are made about the difference between situations where they managed to follow through on an agreed course of action and those where they did not. Third, their beliefs about factors that blocked them from making progress are explored. Fourth, their beliefs about whether and how these blocks may be overcome are examined. Fifth, strategies for getting around the blocks are brainstormed. Sixth, the pros and cons of these courses of action are delineated. Seventh, a therapeutic dilemma is framed in which the costs of maintaining the status quo and the costs of circumventing the blocks are juxtapositioned.

DILEMMAS AND CRISES

If clients see that they have not got the personal resources to cope with the demands of either living with the problem or taking steps towards its resolution, stating the therapeutic dilemma may precipitate a therapeutic crisis. A therapeutic dilemma is a concise statement of the disadvantages and difficulties associated with leaving the presenting problem unresolved and the disadvantages and risks entailed by solving the problem. It is rarely enough to say that the symptoms are bad but the prospect of change is worse. Rather, when articulating the therapeutic dilemma it is important to relate the way in which family members are trapped in the cycle of interaction around the presenting problem to their belief systems that underpin their roles in this cycle and also to note that these belief systems have roots in their personal histories, their families of origin or their membership of other systems such as work or school. It is also important to specify or give examples of the types of action that might lead to resolving the presenting problem in the future and the emotional costs of these.

Stating the therapeutic dilemma may precipitate a therapeutic crisis. If clients see that both the problem and its resolution entail emotional pain and that the responsibility for resolving the problem is largely theirs, they will experience a crisis if they believe that they have not got the personal resources to cope with the demands of this responsibility.

Invariably, therapeutic crises which follow the articulation of a therapeutic dilemma, involve some family members doubting the interactional formulation of the problem (Carr, 1990b) and redefining the problem as an individual difficulty rather than as an interactional phenomenon. This happened with the Barrows following the fourth session. Dick attempted to force Caroline to attend school and she responded with aggression, fearfulness and

threats of self-harm. In a phone call to the therapist, Dick insisted that Caroline's difficulties reflected an underlying individual psychopathological condition rather than an interactional difficulty and requested hospitalization and sedation for her. Details of the management of this crisis phonecall will be outlined in the next section.

In later sessions when we discussed the episode that preceded the crisis phonecall, it became apparent that Dick chose to disregard a complex interactional systemic understanding of the problem and construe Caroline as a *bad* girl who needed firm handling, and forcibly return her to school. When Caroline bit Dick, crooned and rocked back on forth like a baby on the car seat in response to his treatment of her as a disobedient child, he was extremely distressed and began to doubt his framing of her as *bad* and the wisdom of the firm and ineffective approach he took in returning her to school.

In response to the doubt, he chose another simplistic individualistic framing of Caroline's behaviour. He chose to see his daughter not as *bad* but as *mad.* This is not surprising. Under stress all of us choose cognitively simple rather than complex framings of challenging or threatening situations (Kelly, 1955). Also, we all choose to avoid emotionally distressing situations. When Dick reframed Caroline's difficulties as *madness* and the solution as *hospitalization and sedation* he selected a framing that would help him to avoid considerable emotional distress. By selecting an individualistic framing rather than the interactional formulation, he chose a way of conceptualizing the problem that would allow him to continue to avoid the painful process of negotiating a shared understanding of the problem with Sheila. If Caroline were *mad* then she needed expert help, *hospitalization, and sedation*. His role in the management of the problem would be peripheral. He could therefore avoid emotional pain and possibly protect Sheila from emotional pain also. He could also preserve a view of himself as a good father who was doing the best he could for his *mad* daughter.

Invariably, therapeutic crises involve some family members doubting the interactional three column formulation of the problem and redefining the problem as an individual difficulty rather than as an interactional phenomenon.

That is, someone in the family becomes defined as *bad, sad, sick* or *mad*. There is usually some attempt by a member of the problem-system to convince the therapist that an individual definition of the problem is true and an interactional definition of the problem is false. Often, another professional is coopted into the

system to help the family convince the therapist of the truth of the individual formulation, or to disqualify the therapists interactional formulation. This pressure to collude with the family and other network members in abandoning an interactional construction of the problem and in accepting an individual description is usually very intense. Without a framework for understanding these crises and guidelines for managing them, therapists are easily *sucked into* colluding with those members of the problem-system who wish to label one person as the problem (Selvini-Palazzoli and Prata, 1982).

PROBLEM MAINTAINING AND PROBLEM RESOLVING THERAPEUTIC SYSTEMS

Figure 14.1 is a map of a therapeutic system which faces a crisis and evolves in such a way that ultimately the therapeutic process maintains the presenting problem. In systems such as these, the therapist abandons a systemic or interactional framing of the problem and accepts the family's individualstic framing of their difficulties. Subsequent consultations premised on this individualistic framing, maintain rather than resolve the family's problems (Anderson, Goolishan & Windermand, 1986).

In Figure 14. 2, the evolution of a therapeutic system which remains premised on an interactional problem formulation is presented. The therapist and family avoid an individualistic framing of the problem because the therapist has followed a series of guidelines which maximize the chances of creating a context within which a systemic interactional formulation of the problems can be privileged. It is to these guidelines that we now turn.

GUIDELINES FOR MANAGING THERAPEUTIC CRISES

The overriding goal in managing a therapeutic crisis is to help clients retain an interactional construction of the problem which opens up possibilities for achieving their long term therapeutic goals. By implication this involves avoiding collusion with an individualistic construction of the problem which would lead to short term relief but hinder long term goal attainment. What follows are guidelines for dealing with crises. They are framed *as if* the crisis takes the form of a phonecall from a parent. Of course this is not always the case. Some crises occur during a consultation. Others are mentioned through letters from involved professionals. However, the majority of crises in my practice have taken the form of phonecalls from parents, and so it is in this context that the guidelines are framed.

1. Assess and manage danger. Family violence, abuse, self-injurious gestures, running away, staying out late, theft, and the discovery of substance abuse are some of the incidents that occur when a therapeutic crisis is reached. In Positive Practice the clinician's first duty is to establish if anyone in the family is a danger to themselves or to other people. If there is a high risk of danger, an immediate family consultation should be scheduled. The goal of this is to help the family manage the immediate danger.

Figure 14.1. Map of a problem maintaining therapeutic system

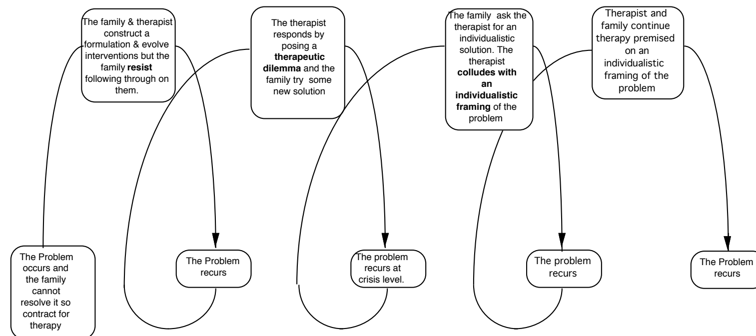
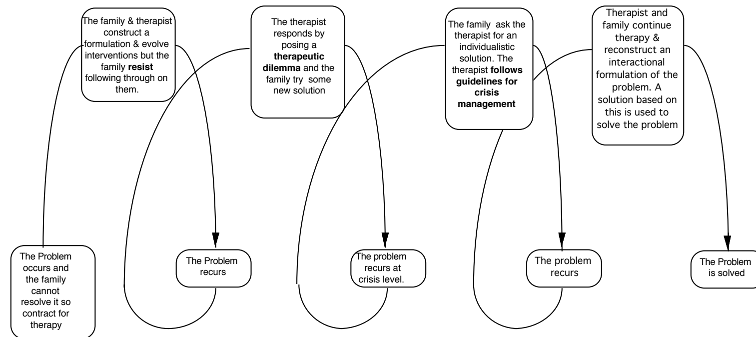


Figure 14. 2. Map of a problem resolving therapeutic system



2. Empathize with the caller's emotional pain without colluding with their simplistic solutions. Parents typically make crisis calls if they perceive the demands of the situation to outweigh their capacity to cope. If their child has run away or slashed their wrists, or if their spouse has screamed at them and hit a child, they may believe that these are situations with which they cannot deal. Often, in such circumstances, patents are overwhelmed by fear, sadness or anger, and these intense emotions have compromised their capacity for clear thinking and systematic problem solving. They find themselves locked into black and white thinking, unable to tolerate the complexities or ambiguities of their problem situation. So, for example, with the Barrows, Dick saw Caroline as mentally ill and was unable to entertain a complex three column formulation or even a simple reframing of her difficulties as part of a broader pattern of interaction that included the family and involved professionals. In Positive Practice it is recognized that parents need a chance to ventilate overwhelming emotions, often by discussing simplistic black and white descriptions of the problem and simplified solutions like hospitalization or reception into care. The expression of empathy for the overwhelming feelings with which parents are faced is therefore important. However, this empathy and support must be given without accepting the simplistic problem definitions and solutions that accompany the intense emotions. Here are some typical examples of constructive empathy and contrasting examples of collusion in black and white thinking and individualistic problem formulations and solutions. This is constructive empathy.

- *It sounds like you're really worried about her. You're driven to*

distraction wondering what she will do next.
- *You have both been in a battle and now she has walked out. This has left you with a deep feeling of loss and failure.*

This is destructive collusion
- *It sounds like you see her as really agitated and needing something to calm her down. Well, I will phone the GP and ask that he consider medication.*
- *You see her running away as a sign of delinquency and you see boarding school as a way of containing that. I can suggest two places you could call.*

It is not intended in these examples to give the impression that medication and residential placement have no place in Positive Practice. Far from it. Many excellent examples of how these interventions may be integrated into systemic approaches to formulating and resolving a variety of very difficult problems have been described (e.g. Falloon et al, 1993; Manor, 1991). Rather, the central point is that it is not Positive Practice to use these interventions within the context of a formulation that labels one system member as *bad, sad, sick* or *mad* and the other members of the system as being uninvolved in the maintenance or resolution of the problem.

3. Acknowledge that labelling one person as the problem would provide short term relief but may lead to long term difficulties. Defining complex interactional problems in simple individual terms usually provides short term relief for parents. Individual problem definitions (like *sad, bad, sick* or *mad*) usually entail clear unambiguous solutions. These allow parents a way of avoiding the emotional pain which goes with exploring an interactional problem formulation and carrying out the solutions that follow from it. However, in the long term simplistic solutions to individual framings of interactional problems may lead to major difficulties.

For example, when children are defined as *sad* or depressed, the simplistic solution is to cheer them up by arranging for them to join the scouts, go to a sports club or take up a hobby to make them happy. In the long term, the child may find that scouts, sports and hobbies leave them as sad as ever. Both the parents and the child may be left with a sense of despair that the depression is unresolvable, and anger that the solution did not work.

Punishment is the simplistic solution for *bad* or delinquent children. In the long run, sustained punishment untempered by understanding and warmth leads children to become alienated from their parents. This alienation may lead to further conduct problems.

Punishment may take many forms from physical or verbal abuse to threats of abandonment or actual placement of the child in care or a boarding school situation. That is not to say that residential and foster care or boarding schools are necessarily alienating or destructive. Rather, the point is, that if the child sees the placement as an act of punishment, then it may lead to alienation and this may further compound the problem.

Hospitalization, individual assessment or therapy and medication are the more common simple solutions suggested when youngsters are defined as *mad, sick,* or mentally ill. All three of these interventions, when used outside of an interactional systemic framing of the problem, run the risk of confirming the youngster's identity as a problem person, victim, or invalid. Once youngsters accept this type of problem- saturated identity, their problem behaviour may increase and the quality of their relationships with their parents may deteriorate.

In my clinical experience no parents want to reap the potentially disastrous consequences that may arise from individualistic framings of their children's problems. They do not want to run the risk of casting their children into despair, destruction, alienation or invalidity. However, they are often unaware that individualistic framings have these long term consequences. An important part of crisis management in Positive Practice is to acknowledge parent's understandable wish to avoid the emotional pain that pushes parents to adopt individualistic framings of the problem, and to point out to them the destructive long-term consequences that may inadvertently arise from their individualistic construction of their children's problem behaviour.

4. Offer an urgent appointment and a plan. When a crisis occurs, parents may feel helpless and threatened yet aware that they must take action. Once they have ventilated their feelings and seen that individualistic problem definitions and simplistic solutions are inappropriate, they will feel supported. However, they may still be at a loss to know how to proceed. In Positive Practice, it is crucial to help parents form an immediate action plan. It has already been mentioned that this plan should offer precedence to managing risks of danger. A second priority is that it will maximize the chances of them accepting the interactional problem formulation and related solutions.

A useful place to start constructing such a plan is to decide on a date for the next appointment. This should be as soon as possible. During crises, people are open to accepting new framings of old problems. Usually, the further from a crises a

family moves, the less open it will be to change. A second consideration is who should attend the post-crisis consultation. In Positive Practice, significant members of the wider network, including involved professionals and important members of the extended family, may be included in the consultation. With the Barrows, Caroline's year-head, the GP and the school nurse were invited to the post-crisis consultation. Where important members of the network are unavailable for this consultation, the therapist may phone them beforehand, inform them of the situation, request comments and relay this information to those who attend the consultation. These absent network members should be briefed after the consultation as to the outcome and about the plan.

Once a decision has been reached on the time, place and composition of the post-crisis consultation, the parents or children may be offered a plan to carry out between the phonecall and the consultation. Often the most appropriate plan is to monitor a specific aspect of the situation or to avoid engaging in escalating patterns of behaviour. With Caroline, she talked explicitly to me about the importance of being left alone in her room and asked that her parents respect her right to do this during the forty-eight hour period before the post-crisis consultation. Here are some examples of tasks given to family members during crisis phonecalls.

- *Between now and the meeting tomorrow, there are a couple of things that you can do that may provide useful information for yourself and your family. First, notice those situations where the sense of tension in the house subsides and keep a note of the time and circumstances surrounding these episodes. Second, if you feel yourself being drawn into a typical bickering session, tell Marie that you have been asked by me to avoid this until after tomorrow's meeting and then make a cup of tea instead of continuing.*
- *We will meet in three days. Tonight, tomorrow night and Thursday night may be stressful for you. You may want to know what is the best thing to do. May I suggest this? Follow your usual routine of putting the kids to bed, doing the story and then watching the news. But after that, phone Colin and tell him in detail about how you managed the strong feelings of anger that you felt during the routine. Rate these on a ten point scale. We can discuss the fluctuations in your feelings at the meeting on Friday.*
- *You may find that the urge to run away becomes very strong. If you don't know what to do, here is something that another boy in your sort of situation found useful. He would lock himself in his room and then write a letter to me telling me why he had*

to run away and why he found it difficult to do so. You may find this sort of thing useful. If you do decide to write me some letters, we can set aside time on Monday for you and I to read them privately. Or you may wish to keep them a secret. Its up to you. But the thing is, the writing itself may help you contain the urge to run away.

DISCUSSION

The approach to managing crises presented in this paper draws on ideas from a variety of sources. Some of these deserve elaboration. The idea that resistance in therapy is an expression of a perceived imbalance between therapeutic demands and client resources is taken from the field of health psychology (e.g. Sarafino, 1994). The notion that under stress most people automatically revert to cognitively simple rather than complex constructions of problems is drawn from a body of research conducted within the constructivist tradition which grew from the work of George Kelly (Jankowicz, 1987; Kelly, 1955). The idea that well intentioned therapeutic interventions may exacerbate problems is drawn from the work of the MRI associates (Watzlawick et al, 1994; Segal, 1991) and this idea was expanded by Anderson, Goolishan & Windermand (1986) when they distinguished between problem maintaining and problem resolving therapeutic systems.

Figure 14.3. Guidelines for managing crisis phonecalls

1. Assess and manage danger
2. Empathize with the caller's emotional pain without colluding with their simplistic solutions
3. Acknowledge that labelling one person as the problem would provide short term relief but may lead to long term difficulties
4. Offer an urgent appointment and a plan
5. Significant network members should be included in the post-crisis consultation
6. The plan for managing the situation until the post-crisis consultation should include symptom monitoring tasks and tasks that prevent the escalation of destructive interactional spirals

Finally, within both the structural family therapy tradition (Colapinto, 1991) and the therapeutic approach adopted by the original Milan associates (Campbell et al., 1991) there was an

emphasis on promoting therapeutic change actively working precipitate crises (Jenkins, 1989). Salvador Minuchin, founder of Structural Family Therapy, invited families to enact their routine solutions to presenting problems in the consulting room, but encouraged family members to progress further with these solutions than they would typically go. For example, in families with anorexic teenagers, he invited the parent who saw the child as bad or disobedient and who favoured force feeding, to show him how this solution worked in practice by making the anorexic girl eat food during the consultation. When this enacted solution ended in a crisis of failure, he would invite family members to consider other ways of reframing the problem and other solutions (Minuchin, Rosman and Baker, 1978). The original Milan associates precipitated family crises by articulating the necessity of the family members' roles in maintaining the presenting problem and pointing out the costs of changing the family game (Campbell et al, 1991). Therapeutic approaches which aim to precipitate a crisis, challenge clients to act-out or think-through their current framing of the problem and its solution. When the limitations of this are seen and the intense sadness, fear or anger associated with this realization are foreseen or experienced, clients begin to doubt their original framing of the problem.

While this paper has focused on an approach to crisis management, it should be stressed that within the Positive Practice approach to family therapy, it is accepted that a therapeutic crisis does not have to occur in every case. If the responsibilities that the therapist invites clients to take on are well within their capacity to cope, then no resistance will occur, no therapeutic dilemma will be framed and no crisis will occur. Certain types of client are less likely to experience a therapeutic crisis. Where clients have single rather than multiple problems and mild rather than severe difficulties then they are less likely to experience a therapeutic crisis. A crisis is also less likely where clients have good coping skills and where their social support network is well established. There are certain things that a therapist can do to minimize the chance of a therapeutic crisis occurring. Therapists can help clients co-construct a formulation that entails solutions which can be broken down into a number of manageable tasks. For example with behavioural training in problem solving skills, clients begin by being trained in how to solve emotionally neutral problems and only when they have mastered these skills are they invited to move on to tackle emotionally loaded issues relevant to the presenting problem (Falloon et al, 1993).

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