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Resolving a Therapeutic Impasse Between Parents and Adolescents in Multidimensional Family Therapy

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This study explored the process of resolving an in-session impasse between a parent and an adolescent in family therapy. Focusing on altering the content and affective tone of a discussion, the "shift intervention" was used to direct a family's conversation away from trying to solve behavior management problems and toward a discussion of fundamental relationship problems. Task analysis was used to specify problematic family interactions, the intervention strategy, and successful and unsuccessful outcomes. Descriptive analyses of 5 successful and 5 unsuccessful interventions yielded a detailed performance model of therapist and family behaviors involved in breaking the impasse. The Beavers Timberlawn Family Evaluation Scale was used to verify the presence of the shift intervention in the data set and to embellish the performance model. The model suggested that adolescents became more cooperative and engaged in treatment when parents shifted from trying to control them to trying to understand them. A detailed performance map for accomplishing this shift is offered.

Several research reviews have concluded that family-based treatments can treat a variety of disorders effectively (Diamond, Serrano, Dickey, & Sonis, 1996; Shadish et al., 1993), including adolescent drug abuse (H. L. Liddle & Dakof, 1995). Despite this progress, few studies have identified and examined core change processes associated with these interventions (Friedlander, Wildman, Heatherington, & Skowrow, 1994). Many family treatments target change in multiple dimensions of a family's social ecology (e.g., child, parent, school, peer, work). Principal among them is the parent–adolescent relationship as it manifests in interactional behavior and communication patterns. Family therapy theory assumes that an individual's symptoms decrease to the extent that family relationships improve. Recent studies of therapy process and outcome have begun to support this claim (Mann, Borduin, Henggeler, & Blaske, 1990; Schmidt, Liddle, & Dakof, 1996; Szapocznik et al., 1989).

Although improvement in family interaction is a primary goal, achieving this can be a formidable task, particularly with adolescent substance abusers. Family environments of these adolescents can be characterized by excessive chaos, extreme criticism and blame, authoritarian or disengaged parenting, and low levels of emotional support and cohesion (H. L. Liddle & Dakof, 1995; Patterson, 1986). These types of stable, negative processes create considerable conflict between family members and repel or resist therapists' typical interventions (e.g., reframe, enactment, education, behavioral directives, etc.). When therapists fail to effectively reduce this conflict in a therapy session, families feel hopeless about change and dissatisfied with treatment; therapists feel discouraged and incompetent. Consequently, the likelihood of noncompliance, early termination, and treatment failure greatly increases (McMahon, Forehand, Griest, & Wells, 1981; Patterson, 1982). Given the frequency of this impasse when working with adolescents, refining interventions that effectively resolve this problem state could enhance treatment effectiveness.

Toward this goal, we designed the "shift intervention" to specifically resolve in-session conflict (impasse) between parents and adolescents. This intervention strategy is a central feature of Multidimensional Family Therapy (MDFT), an integrative, empirically based treatment for adolescent drug abuse and related behavior problems (H. L. Liddle, 1992; H. A. Liddle & Dakof, 1994). We defined the impasse as negative exchanges (i.e., blame, accusations, defensiveness) that thwart the therapist's attempts to facilitate parent–adolescent negotiations about daily household routines (i.e., curfew, chores, homework). To resolve this problem state, MDFT therapists attempt to shift the content and emotional tone of the conversation to topics and affective states that engender a more productive therapeutic dialogue. Typically, this is accomplished by linking the extreme negative affect to long-standing disagreements about interpersonal or relationship problems.

The present study used task analysis (Rice & Greenberg,

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1984) to refine a performance model that represents the patterns of therapists' interventions and family interactions necessary to resolve this impasse. Task analysis guides the intensive study of discrete intervention strategies and client responses and increases our understanding of how change occurs, moment by moment, during a therapy session. Modeling of the microcomponents of therapy can increase treatment specification and help identify model specific criterion variables (Miller & Prinz, 1990). This study represents the initial stage of the task-analytic, model-building process.

Method and Procedures

Stating the Rational Model

On the basis of clinical experience, parenting and adolescent development research, and the ideas explicated below, we outlined, a priori, several subtasks believed to be essential to the resolution process. First, adolescents need to believe that an honest and direct conversation with their parents could be helpful (H. L. Liddle & Diamond, 1991). Second, adolescents need to access more vulnerable feeling states (e.g., sadness and hurt) than they typically share with their parents. Third, parents need to consider alternative explanations for their adolescent's disruptive behavior. Fourth, both the parent and adolescent need to remain receptive to each other's point of view.

Explicating the Underlying Assumptions of the Shift Event

Several domains of knowledge informed our thinking about the shift event. The shift is a variant of an enactment technique (Minuchin & Fishman, 1981). This technique involves eliciting a family's typical interactional behaviors in the therapy session and then shaping those interactions to resemble healthier behavior. Unlike structural family therapy (Minuchin, 1974), MDFT focuses on intrapersonal processes as change targets in and of themselves, as well as a means toward changing interactional sequences (H. A. Liddle, Dakof, & Diamond, 1991). MDFT also highlights the importance of altering negative cognition before or during an enactment (H. L. Liddle & Diamond, 1991). Interventions that alter negative attributional sets can increase positive interpersonal interaction (Baucom & Lester, 1986).

MDFT also focuses on affect as a primary mechanism for facilitating change. As Greenberg and Safran (1987) have argued, accessing primary emotions such as fear, sadness, anger, and resentment, helps motivate clients to reevaluate cognitive schema regarding self and other, which can, in turn, lead to new behavior. When used appropriately, the expression of vulnerable emotion can also reduce hostility and elicit support and compassion from others (Greenberg & Johnson, 1988; H. A. Liddle, 1994).

Selecting and Describing the Task and Task Environment

Using the rational model as a guide, we set aside 25 videotapes of therapy believed to contain shift intervention. Three experts in MDFT reviewed all 25 tapes and agreed that 14 of these tapes contained exceptional examples of the attempted shift intervention. For descriptive model building purposes, the team then selected five episodes believed to represent a successful resolution of the impasse and five episodes believed to represent an unsuccessful resolution ($N = 10$). The remaining four tapes were used to train raters.

In the final sample, the age of the adolescents averaged 15.4, with a range from 14 to 17. Six of the adolescents were female, and 4 were male; 8 were Caucasian and 2 were African American. Four of the adolescents were on probation, and 3 of these 4 were court ordered to treatment. Two adolescents lived with both biological parents, and 8 came from divorced homes. Of the 8, 5 were living with their mother, and 3 lived with their mother and stepfather. All but 2 of the parents had a full-time job. The therapy was conducted by 6 therapists (4 social workers and 2 psychologists), all with 5 years of clinical experience and at least 1 year of training in MDFT. Four of the therapists participated in both a successful and unsuccessful resolution episode. Howard A. Liddle provided live supervision through a one-way mirror on all of the episodes, thereby increasing therapist's adherence and competency.

Operationalizing the Task and the Task Environment

To better understand the change event, we divided it into three phases: the impasse (Phase 1), the intervention (Phase 2), and the resolution (Phase 3). The impasse and the resolution phases were characterized along several dimensions as being important in the MDFT model: content, affective states, problem attributions, temporal focus, and attachment behavior. These domains were used to operationalize Phases 1 and 3 and to guide observations and inferences during the descriptive examination of Phase 2.

Defining the impasse phase. During the impasse, the content of the discussions focused on daily routines pertaining to behavior management tasks (e.g., parent and adolescent negotiations about chores). Affectively, the parents appeared hopeless and frustrated and the adolescents seemed hostile and revengeful. Both the parents and adolescents blamed each other for the family's problems. Discussions focused on the recent past. From an attachment perspective, the parents appeared disengaged and the adolescents appeared ambivalent (wanting a relationship but distrusting the parent).

Defining the intervention phase. To be included in the study, the episode had to contain an attempted shift intervention. To identify the shift intervention, we described several content and affective features that differentiated therapists' statements typical of the impasse and intervention phases. During the intervention phase, for example, therapists tried to shift the content of the discussion (a) from daily routines to interpersonal problems, (b) from behaviors to feelings, and (c) from the present to the past. In the affective domain, the therapists increasingly focused on (a) amplifying emergent feelings of sadness or hurt or (b) making covert hostility overt.

Defining the resolution phase. Resolution of the impasse was achieved when the family discussion shifted from a focus on behavioral problem solving to a conversation about the nature of the relationship itself. Typically, the parents' affect became more empathic, whereas the adolescents began to disclose memories and feelings (sadness or anger) about old or long-standing problems and disappointments. The parents began to accept more responsibility for problems in the relationship, and the adolescents became more entitled to ask for appropriate accountability from the parents. The parents also became more protective, and the adolescents began to welcome the parents' offers of comfort. Unsuccessful resolutions were characterized by the presence of the impasse and the delivery of the shift intervention but with no family statements indicating resolution.

Reliability, Adherence, and Markers

Reliability. After operationalizing the change event, we verified its presence in the videotapes. The persistent presence of the impasse was judged and agreed on by 3 clinical observers familiar with MDFT and the shift intervention. To reliably identify the intervention and resolution phases, we wrote two 10-page manuals. One manual specified the types of therapist statements we expected to see in Phases 1 and 2. The second manual specified the types of family member statements we ex-

pected to see in Phases 2 and 3. Two BA-level raters, who had not been informed of the goals of the study, were used to rate the phases. Both groups received 10 hr of training with their respective manuals and several practice videotapes. Using Cohen's coefficient of agreement (kappa), raters reached an average of .93 agreement on identifying therapist statements that characterized the shift strategy and an average of .95 on identifying family statements that characterized the resolution phase.

Therapist adherence. In both successful and unsuccessful episodes, an average of 9% (range, 2% to 15%) of therapists' statements in Phase 1 consisted of shift strategy statements, whereas an average of 76% (range, 65% to 84%) of therapists' statements in Phase 2 consisted of shift strategy statements. These data provide further evidence for therapists' adherence to the intervention strategy across all 10 episodes.

Similarly, on all 10 episodes, an average of 6% (range, 1% to 11%) of family statements in Phase 2 were rated as resolution statements. In episodes with a successful resolution, 63% (range, 46% to 82%) of family statements in Phase 3 were rated as resolution statements. In episodes with unsuccessful resolution, 19% (range, 12% to 25%) of family statements were rated as resolution statements. These data provide further evidence for the accurate identification of successful and unsuccessful episodes.

Markers. We used the ratings to mark the beginning of Phases 2 and 3. The first therapist statement that both raters judged as a Phase 2 statement served as the marker for Phase 2. To mark the beginning of Phase 3, we used the same procedure with the family members' statements. Therapist markers included questions such as "What makes this topic so difficult for you?" Family markers, usually made by the adolescents, were typically statements such as "All right, I'll tell you why I am so mad."

Length of phases. For the episode to qualify for the study, the impasse and resolution phases had to last at least 10 min. The length of the intervention phase varied from 1 to 14 min. To determine the length of Phase 2 on unsuccessful shifts, we used the average length of the intervention phase in the five successful shifts (7.6 min). On the basis of this method, the 10 episodes ranged in duration from 21 to 34 min.

Descriptive Procedures

All tapes were transcribed and each videotape was reviewed (roughly 10 hr per tape). In addition to the dimensions used to define the phases (discussed earlier), we attended to the therapeutic alliance, the family's response to interventions, sequencing of interventions, and the unfolding of specific themes such as entitlement, retribution, and forgiveness. The descriptive analysis resulted in the construction of a performance model that we describe later.

Application of the Beavers Timberlawn Family Evaluation Scale (BTFES)

We used data from the BTFES (Lewis, Beavers, Gossett, & Phillips, 1976) to help validate the selection of the successful and unsuccessful episodes, embellish our description of a successful resolution, and identify outcome targets for future analysis. The BTFES is a macrolevel coding instrument that measures family interactions along several dimensions important in MDFT. Theoretically based in family systems theory, the BTFES consists of 13 five-point, Likert-type scales. Low, middle, and high scores correspond to severely disturbed, midrange, and healthy functioning, respectively. Eight of the scales were used in this study.

The Overt Power scale assesses parental leadership and authority ranging from chaotic to dominant–submissive to egalitarian. Goal-Directed Negotiation assesses the family's efficiency in negotiating problems (i.e., openness to others' opinions, search for consensus, ability to compromise). Responsibility assesses how much family members take responsibility for their past, present, and future actions. Permeability assesses how open and receptive family members are to each other's statements. Range of Feelings assesses how directly family members express their feelings and the range of different feelings they express. Mood and Tone assesses the affective quality of the interactions. This is a categorical scale ranging from warm and optimistic, to hostile, to hopeless and pessimistic. Unresolvable Conflict assesses the degree of conflict and its impact on family functioning. Empathy assesses the family members' consistency in showing sympathy and care toward each other.

Interrater reliability on these scales has been reported to range from .58 to .79 and from .95 to .97 with experienced clinicians as raters (Green, Kolevzon, & Vosler, 1985). The BTFES has been used to discriminate between distressed and nondistressed families (Lewis et al., 1976). Ten minutes of family interaction provide adequate material for coding all of the scales.

For coding purposes, we edited all 10 videotapes into the three phases, using the therapist and family marker as the division points ($N = 30$ segments). We randomized the segments to avoid sequentially coding two phases from any one episode. Two MA-level research assistants, unaware of this study's goals, served as coders. The coders had extensive experience using this instrument and they received 15 hr of additional training for this project. We instructed the coders to judge family behaviors only, not therapist behavior. On all eight scales, the coders obtained adequate reliability ranging from .69 to .95 (Pearson's r).

Results

Descriptive Data

Figure 1 represents a revision of the rational model based on the descriptive data. This model summarizes a generic pattern of interaction, particularly in the affective domain, that characterizes a family's progression from the impasse to the resolution. Based on the observations from the unsuccessful resolutions, the table also highlights several parent and adolescent affective or cognitive states that impeded this progression or derailed it completely. Although the successful progression could be described sequentially (in the center of the Figure 1), the inhibiting factors appeared randomly or remained present throughout (Figure 1, top and bottom).

The therapists held a central role in orchestrating the resolution sequence. They actively blocked, diverted, ignored, or worked through the families' negative affect, mutual blame, and debilitating helplessness. They also implanted, evoked, and amplified thoughts and feelings that promoted constructive dialogue. The therapists punctuated even the slightest decrease in hostility or defensiveness and increase in emotions such as caring, sadness, or curiosity. These positive emotions were used as motivation or leverage to engender new affective states in other family members. Using a kind of "shuttle diplomacy," the therapist went back and forth between family members, crafting an emotional treaty that would permit the identification of more meaningful content and promote more productive dialogue (see Diamond & Liddle, 1996, for a detailed description of therapist behavior).

Although each episode included several tangents or subtasks, the following sequence offers a generic version of the resolution process. The therapist initially circumvented a parent's blaming and hopelessness by pulling for feelings of regret. The therapist might have said, "It must be disappointing that you don't

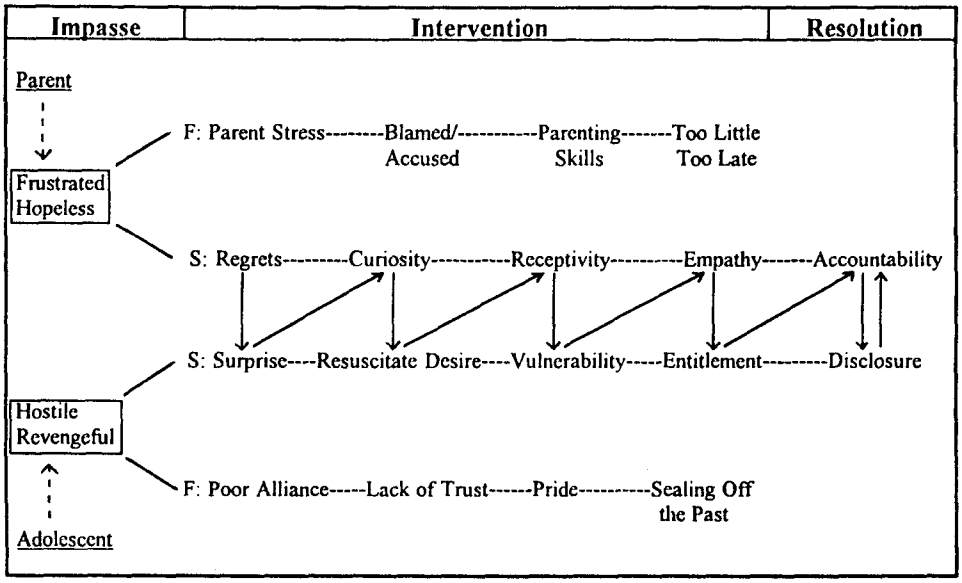

Figure 1. Process of change during the intervention phase. S = sequence of affective and cognitive states that lead to resolution of the impasse. F = individual and interpersonal challenges that inhibited resolution of the impasse.

get along with your child." Highly distressed parents often refused requests for this initial shift. However, if the parent agreed, the therapist could then ask the adolescent, "Did you know that your mother misses you?" Typically, the adolescent would protest or display ironic surprise (i.e., "Oh sure!"). Here the therapist blocked the parent from responding defensively and, instead, encouraged curiosity about the adolescent's disbelief.

The therapist might then directly ask if the adolescent believed that his or her parent was concerned and, if not, why. Often the adolescent continued to respond with blame or indifference. In response, the therapist might have asked whether the adolescent missed his or her parent as well. Questions like this attempted to resuscitate that part of the adolescent that still desired a relationship with his or her parent. At this point, the adolescent's lack of trust in the parent or poor alliance with the therapist often derailed the dialogue. Similarly, the adolescent's pride often inhibited him or her from admitting vulnerable feelings. Sometimes addressing this resistance directly (i.e., "You seem unwilling to forgive her") shifted the adolescent into a more vulnerable state. The therapist could then turn to the mother and ask, "Did you know your son was so angry? Would you like to know why?" This type of questioning clearly moved the conversation away from behavior management and toward a focus on family relationships.

This phase of the dialogue could be difficult, particularly when the parent was reluctant to engage the adolescent in a positive way. At this point, many parents began to feel blamed or accused by the therapists as the cause of the adolescent's problems. In addition, parents often failed to understand the value of this kind of listening or lacked the parenting skills to do it. Therapists countered these tendencies by emphatically conveying support and admiration for the parents while also helping them understand the importance of listening to their adolescent's side of the story. If the adolescent's negativity had diminished, and a more vulnerable affect had emerged, the parents often remained or became patient, receptive, and sometimes empathic toward the adolescent's complaints. Amplifying the parent's empathy often resulted in a more open, reasonable, and less defensive stance by the adolescent.

Some adolescents resisted this opportunity, rigidly refusing to discuss past events with the parent. However, other adolescents, when offered this moment of respect and acknowledgment felt entitled and safe enough to disclose the feelings, thoughts, and memories that fueled their resentment toward their parent. The adolescents typically identified themes of neglect, abandonment, and abuse (e.g., "You abandoned me when you divorced Dad"; "You love your bourbon more than you love me"; "You think I'm the family failure"). On hearing these kinds of claims, some parents remained unmoved. As one father said, "You want me to cry and hug you now? Well it's too late! I've been through this before and it didn't help." However, when parents listened to and acknowledged their adolescent's point of view, these disclosures often led to more productive, although no less difficult, dialogue between family members, and more receptivity to the therapist's intervention.

Quantitative Data

In all analyses, we used a nonparametric strategy to control for the potential violations of population assumptions common to small sample sizes. Mann–Whitney *U* tests were performed to compare the baseline and change scores (Phase 3–Phase 1) of the two groups (see Table 1). Sign rank tests were used to compare changes within group. Regarding baseline comparisons, Figures 2 and 3 show a difference on all variables, and a Mann–Whitney *U* test revealed that two variables were statisti-

Table 1
Between-Group Comparison at Baseline and on Change Scores (Mann–Whitney U Test) and Change Scores Within Group (Sign Rank Test)

	Between groups		Within group	
Variables	Baseline comparison[a]	Change scores (Phases 3–1)[b]	Successful	Unsuccessful
Overt power	1.27	1.79*	4.5	−7.50*
Goal-directed negotiation	1.06	1.88*	5.0	−4.50
Responsibility	1.17	1.51	5.5	−2.00
Permeability	1.70	2.52**	7.5*	−7.50*
Range of affect	1.40	0.10	2.5	3.50
Mood and tone	2.12*	0.42	1.0	−1.50
Unresolvable conflict	2.42**	0.62	1.0	−2.50
Empathy	1.80	0.84	4.5	−2.00

[a] Two-tailed. [b]One-tailed.
*$p < .05$. **$p < .01$.

cally different at baseline: (a) Unresolvable Conflict scores ($z = 2.4, p > .01$) and (b) Mood and Tone scores ($z = 2.1, p > .03$). This suggests that families that did not resolve the impasse were initially more conflictual and presented a more depressed and pessimistic affective tone.

Visual inspection of the graphs and results of the sign rank test (within-group change scores) further validated our accuracy in selecting successful and unsuccessful episodes. As a group, families judged as having resolved the impasse showed improvement in all but one variable (Unresolvable Conflict),

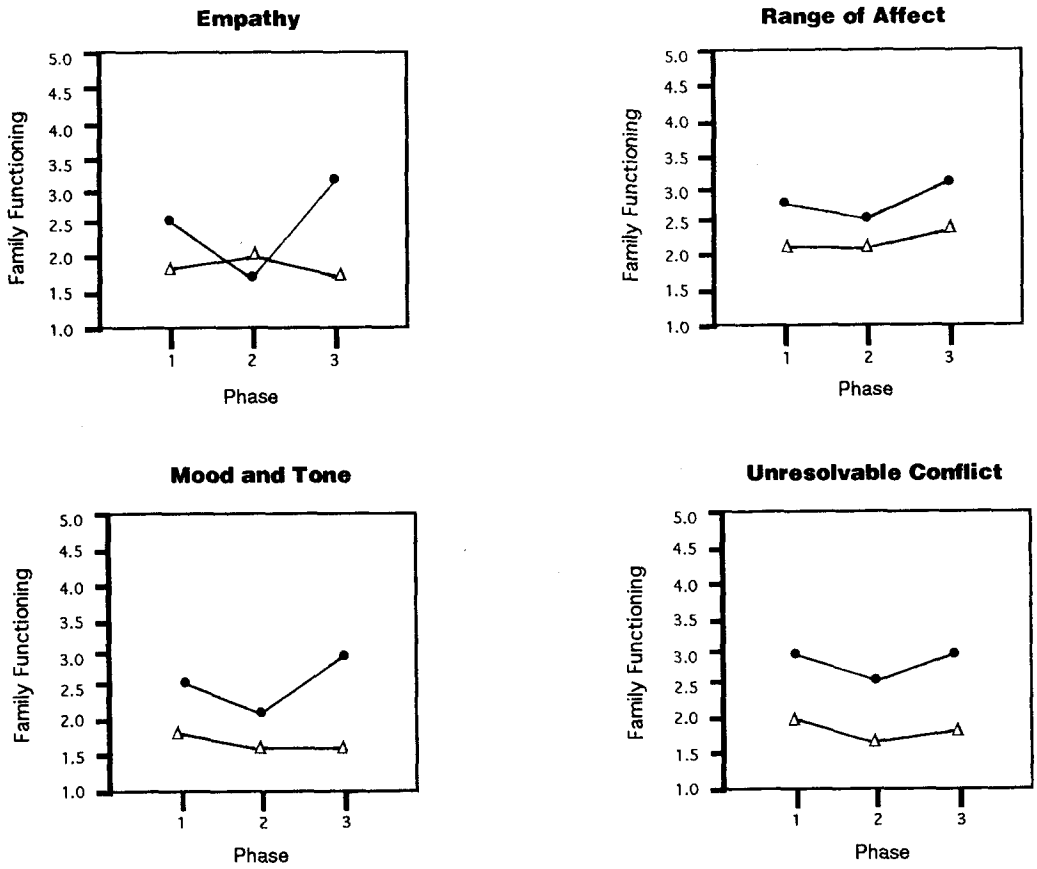

Figure 2. Mean scores on the Beavers Timberlawn Family Evaluation Scale for each phase of the successful and unsuccessful shifts. Closed circles indicate successful shifts, and open triangles indicate unsuccessful shifts. Family Functioning scores range from 1.0 (*disturbed*) to 5.0 (*healthy*), with a midrange of 3.0.

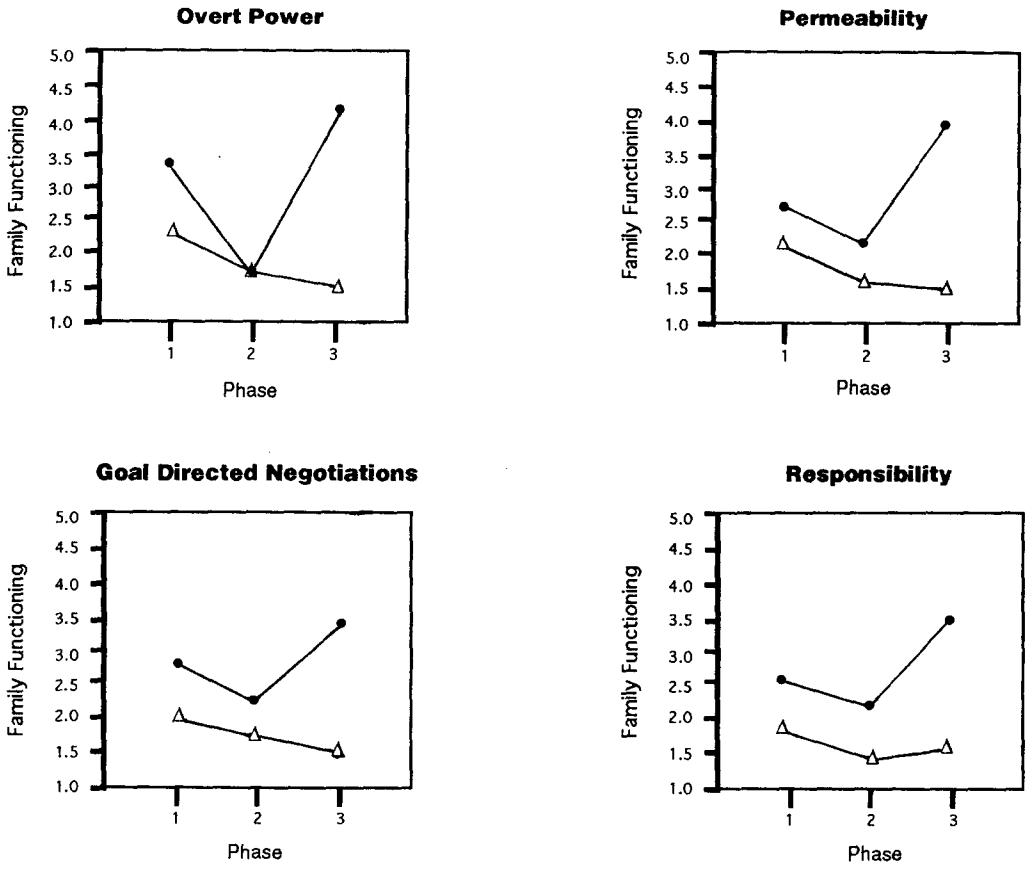

Figure 3. Mean scores on the Beavers Timberlawn Family Evaluation Scale for each phase of the successful and unsuccessful shifts. Closed circles indicate successful shifts, and open triangles indicate unsuccessful shifts. Family Functioning scores range from 1.0 (*disturbed*) to 5.0 (*healthy*), with a midrange of 3.0.

with one variable reaching statistical significance (Permeability, 7.5, $p = .03$) and another not reaching significance at the $p = .06$ level (Goal-Directed Negotiation, 5.0). In contrast, all families designated as having not resolved the impasse showed a decline in functioning on all but one variable (Range of Feeling), and two variables reached statistical significance (Overt Power, -7.5, $p = .03$; and Permeability, -7.5, $p = .03$).

A second finding from the graphs concerned the "V" pattern found on all variables in the successful episodes. This pattern reflects a decrease in scores from Phase 1 to Phase 2, and then an increase in scores in Phase 3, either back to baseline or better. This suggests that, when first faced with the intervention, most families initially showed a decline in functioning on several variables (i.e., increased parental control, minimization or denial of responsibility, deleterious conflict, diffused problem-solving focus, lower receptivity, decreased empathy, excessive pessimism, and restricted range of affect).

Families that shifted their discussion to a thematic relationship level (successful shifts), however, regained or improved their initial level of functioning. The Mann–Whitney U test comparing change scores between the two groups revealed that resolvers showed significant improvement over nonresolvers in Overt Power ($z = 1.79$, $p = .04$), Goal-Directed Negotiation ($z = 1.88$, $p = .03$), and Permeability ($z = 2.53$, $p = .006$). Changes in Responsibility were not significant at the $p = .06$ level ($z = 1.5$).

Discussion

This study discovered several ingredients and processes required in the resolution of a parent–adolescent impasse in family therapy. The performance model focuses on affective states as the driving force and primary target of a multistage and multicomponent intervention. The success of this task relies on the use of in-session affective and cognitive shifts in one family member to instigate shifts in another family member. Typically, the therapist first encourages parents to reflect on their regrets and disappointments regarding their child. From this position, parents often become more respectful and receptive to their son's or daughter's own experiences, feelings, and memories. This shift becomes more difficult when parents are under stress, when their personal functioning is impaired, when they lack effective parenting skills, or when they experience the therapist's intervention as blaming them for the adolescent's behavior problems.

The BTFES data suggest that, in fact, all families showed an initial decline in functioning when faced with the shift intervention. Parents and adolescents may feel anxious or resistant when

asked to address core, long-standing, typically avoided problems. Parents may also feel threatened when they are encouraged to relinquish unilateral power and, instead, listen actively to their adolescent's point of view, concerns, and complaints. The data also suggest that families with poorer functioning at baseline may be less receptive to the intervention, at least within the time frame studied.

In the context of these challenges, eliciting parents' feelings of sadness, loss, and disappointment can set the stage for a new interactional experience. The therapist uses this initial parental shift to potentiate the expression of heretofore unexpressed affective states in the adolescent (i.e., sadness or direct anger). Adolescents often reject this "reaching out" when they have a deep mistrust of their parents or therapist. For some, responding to their parents would mean to lose face, give in, or offer premature forgiveness. As one adolescent girl said "you can't make up now for what you did to me in the past." However, parents' strong acknowledgment of their adolescent's concerns as reasonable and justified often reduces negative emotion and diffuses resentment. Reciprocally, when an adolescent begins to speak more honestly and directly, the parents, impressed with the adolescent's sudden maturity, often remain attentive and affectively attuned. It is within this zone of reduced negative emotion and increased positive exchange that new interpersonal experiences can be achieved. These new interactional sequences are believed to form the basis of change in family therapy.

The BTFES offers further description of the resolution phase and highlights potent intervention targets. When the impasse was resolved, mutual receptivity and respect increased, problem-solving negotiations became more focused, and parents became less authoritarian. Although not statistically significant, families also showed an increase in accepting mutual responsibility for other's problems. In contrast, families that did not identify and discuss problems of a more interpersonal nature were characterized by no change, an increase in power struggles and defensiveness, and an overall decline in functioning that did not rebound. These findings support the observations that resolution is possible when parents shift from trying to control to trying to understand their adolescent and when adolescents shift from punishing their parents to seeking acknowledgment and accountability. Further refinement of this component of the shift may increase the potency and acceptability of the intervention.

The next set of studies should include several methodological and conceptual improvements. For example, a microanalytic coding system (e.g., SASB, Structural Analysis for Social Behavior) would provide needed empirical description of the resolution process itself. Variations of the change event according to gender of the adolescent and parent and according to therapist effects are also important areas of further exploration. Eventually, linking this change event to different outcome points (i.e., multiple or all treatment sessions) would also illuminate how this event affects the course of treatment. For instance, we will study how identification of these core conflictual themes during the shift affects the content and direction of therapy in later sessions. This study could explore whether families that fail to achieve the shift in one session achieve it in later sessions and what factors lead to the resolution of the identified relational conflict itself. In this kind of hypothesis-testing phase, studies would benefit from larger sample sizes and better matched samples at baseline.

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