2008

Therapists' descriptions of their beliefs and practices regarding engaging resistant caregivers of children and adolescents

Sarah Becker Crane

Sarah Crane

Therapists' Descriptions of Their Beliefs and Practices Regarding Engaging Resistant Caregivers of Children and Adolescents

ABSTRACT

This exploratory-descriptive study was designed to address the question: "How do child and adolescent clinicians describe their beliefs and practices with resistant caregivers in ways that adhere to or diverge from their theoretical orientations?" This study was based on the understanding that effective treatment of a child or adolescent must involve their parents, grandparents, or other caretakers, but that not all caregivers are interested in or able to engage with clinicians and/or the child's therapy.

The instrument was a survey with fixed and open-ended questions, developed by the researcher. Sixteen child/adolescent clinicians were surveyed. Each respondent held a Master in Social Work and/or a Ph.D. in Psychology, had five or more years of practice experience, and was trained in Psychodynamic/analytic theory, and/or Behavioral theory, and/or Structural theory.

The most significant findings were that most clinicians describe being informed by a conglomeration of multiple theories, professional experience, and professional identity. In addition, clinicians may have more similarities than differences in their beliefs and practices with resistant caregivers. Also, Psychodynamic/analytic clinicians' used a variety of theory-rooted approaches to engage caregivers that were more proactive than expected. These methods included stressing to the caregiver his/her relationship with his/her child, and using the child as a sort of tool to convey to the caregiver the

child's importance and needs. This study reveals the “artfulness” of a seasoned clinician’s approach, which may have origins in theory but includes the therapist’s own interpretations and unique delivery.

THERAPISTS' DESCRIPTIONS OF THEIR BELIEFS AND PRACTICES REGARDING ENGAGING RESISTANT CAREGIVERS OF CHILDREN AND ADOLESCENTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Sarah Crane

Smith College School for Social Work
Northampton, Massachusetts 01063

2008

ACKNOWLEDGEMENTS

To Dr. Marian S. Harris, my thesis advisor, for her valuable feedback and encouragement through my research and writing process.

To Dr. Gayle McCarthy, my Research Methods professor, for keeping me excited *and* unfazed (most of the time) by the idea of writing a thesis.

To Kevin, Mom, Dad, Liz, Lizzy, Lillian, Megan, Laurie, and Josh, my support crew, for their endless care.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Successful psychotherapy of any variety hinges upon trust and open communication in the client-therapist relationship. When a client displays a trait, state, or behavior that gets in the way of meeting the goals for their treatment, a clinician must try to spark the client's willingness and commitment to change. Children are heavily reliant upon their parents, grandparents, or other central caregivers to live happy, healthy and balanced lives. For this reason, child and adolescent therapists must work in tandem with caregivers. Caregivers sometimes resist collaborating with their child's therapist, for reasons related to mistrust, dislike, cultural barriers, or stress/chaos in the caregiver's life. Clinicians seem to create or repair their bond with a caregiver in myriads of ways. Therapists' training and theoretical orientation can provide helpful ways of understanding and approaching resistance, but this may or may not inform clinicians' techniques.

A short discussion of the themes of the literature from the theoretical approaches will serve as a framework to the literature review. First, it is useful to explore the meaning of the concept "resistance" as it is traditionally applied to describe an individual client (not a caregiver). Resistance as a concept was born out of classical psychoanalytic theory, to describe “the patient’s unconscious avoidance of or distraction from the analytic work” (Beutler, Moleiro, & Talebi, 2002, p. 130). Resistance, by this thinking, is not only normal for the client to experience, it is desirable for the therapist to try to evoke in the patient (Beutler et al., 2002). Current psychodynamic and psychoanalytic and family systems therapists tend to conceptualize resistance in a similar way. Many

behavioral therapists think about resistance in a somewhat different way that will be explored in the literature review.

Second, it is helpful to discern the themes across the literature on individual and caregiver resistance. The current research across theoretical frames, according to Beutler et al.'s literature review (2002), focuses on a client's "failure to improve," for the leading reasons of focusing more on self-control than treatment compliance, not engaging in the therapeutic relationship, or failing to complete homework (p. 134). Current literature concludes that in order to handle resistance effectively, a therapist must recognize its manifestations "both as a state and as a trait," or as emotions and types of behavior (Beutler et al., 2002, p. 139).

Across theoretical orientations, therapists recommend tapping into a caregiver's/family's pride and strengths as soon as resistance is apparent (Nelson et al., 2000; Sori et al., 2006; Szapocznik et al., 2003). Empathizing with resistant caregivers by acknowledging their stress and difficulties is also widely supported (Love, 1991; Weidman, 1986). Beginning in the 1980's, family work became more focused on supporting caregivers, rather than attempting to correct their dysfunctions (Johnson et al., 1998). Sori et al. (2006) argue that regardless of their theoretical orientation, therapists should treat the caregiver as an expert on their child. By saying, "I need your help" to a caregiver, therapists empower parents as agents for change.

Once a therapist recognizes resistance, there is congruence in prior studies that the therapist should modify their use of self, by either emphasizing or de-emphasizing their authority (Beutler et al., 2000). Beutler et al. (2006) suggest that a therapist acknowledge

and reflect the patient's concern or emotion, discuss it in the context of their therapeutic relationship, and renegotiate the therapeutic goals and/or roles.

The researcher will explore therapists' practices around resistance through a different lens than any found in literature. Some existing research in psychodynamic/analytic and behavioral frames addresses individual client resistance. Only family systems theory-based research does a thorough job of exploring and promoting therapist approaches to resistant caregivers. Current research across theoretical frames pays little attention to how therapists actually address caregiver resistance. There is no research that discovers how practices with resistant caregivers relate to theoretical orientations. This investigator's goal is to begin to fill that void in the field.

CHAPTER II

LITERATURE REVIEW

Literature on individual client resistance and caregiver resistance will be reviewed in the following theoretical orientations: Psychodyanamic/Psychoanalytic, Behavioral, and Structural/Family Systems. Although more attention will be paid to research on caregiver resistance, outlining how the research understands individual client resistance gives a conceptual framework. This array of theoretical approaches provides a framework for understanding how therapists in the author's research sample may have been trained to view caregiver resistance. Family Systems Theory is more extensively analyzed for its relevancy to this researcher's study, particularly in its attention to family members' roles in an individual client's therapy, and understanding of resistance as a relational dynamic between client and therapist.

Psychodynamic/Analytic Theories

Individual Client Resistance

Postmodern psychodynamic conceptualizations of resistance revolve around the central idea of unconscious protest to change. Yet, they also have varied ways of interpreting and approaching resistance. Frankel and Levitt (2006) conducted a literature review of how six contemporary postmodern psychotherapies discuss resistance. They determine two general theoretical categories. The first category, encompassing Motivational Interviewing and Narrative Therapy, is "Problem-resolution" by nature, in which "resistance is (thought to be) the result of desired change that is experienced as unfeasible" (Frankel & Levitt, 2006, p. 223). The second category, describing Relational

Psychoanalytic Therapy, Personal Construct Therapy, Process-experiential Therapy, and Depth-oriented Brief Therapy, is “Self-revolution”- focused (Frankel & Levitt, 2006, p. 223). Such theories assert that “resistance is the natural manifestation of self-preservation in the face of threatening change” (Frankel & Levitt, 2006, p. 223). Postmodern psychotherapies tend to conceptualize resistance as either the client’s feeling of discouragement in the face of self-transformation, or desire to protect him or herself from change.

Psychoanalytic/dynamic thinkers also attribute client resistance to transference in the clinical relationship. Plakun discusses how resistance is "unwitting encoded communication from the patient," which serves as a "metaphor for aspects of the patient's life history" (2006, p. 6). In addition, resistance is often symbolic of a "loss of the patient's authority" (Plakun, 2006, p. 6). Particularly if a client has been abused or neglected, resisting treatment may be one of the few ways in which he/she can feel a sense of control in life (Plakun, 2006). If the therapist cannot engage or tolerate the client's resistance, the client will disengage from or drop out of treatment. Part of tolerating the client's resistance may necessitate the therapist examining his or her countertransference in the relationship (Plakun, 2006).

Caregiver Resistance

The research finds that psychodynamic and psychoanalytic therapists view and judge resistance in various ways. Psychodynamic child therapists (PCTs) tend to believe that children and adolescents resolve their struggles best through individual sessions with play and/or talk therapy that may be well supplemented with family work or parent

sessions. Family involvement in the treatment, or formal family therapy, is only necessary if the problem seems inherent to the family, not the child (Webb, 2003).

Though in individual child work clinicians often communicate regularly with parents about the child's growth and development, they tend to not inform parents of the content of the child's therapy (Sori et al., 2006). In ideal practice, psychodynamic child therapists regularly meet with a caregiver to exchange information and feedback regarding the child, or possibly have occasional family sessions (Webb, 2003). Webb (2003) warns that formal family therapy, without individual child work, can overlook a child's needs and well-being. Generally PCTs believe a child's environment must be taken into account, but that high involvement from other parties is not absolutely critical to child's treatment.

Psychodynamic child play therapist Nancy Boyd Webb points out that parental resistance may be an indication of the therapist's lack of accounting for socioeconomic differences between themselves and the family. She notes that if a clinician does not truly start "where the client is" and help with more tangible needs such as housing or food, the caregivers may perceive this to be a therapist's "lack of empathy" (Webb, 2003, p. 101). Webb reasons that this perception leads the client to miss appointments and "subsequently (be) label(ed)… resistan(t)" (Webb, 2003, p. 101). Such a relational understanding of resistance, and attention to the role of class privilege, is extremely important and somewhat undeveloped in the realm of psychodynamic child therapy.

For some PCTs, a caregivers' lack of interest in their child's treatment is a sign that caregivers should not be involved in their child's treatment. Sori et al. argue that regardless of their theoretical orientation, clinicians need to know when a parent is too

emotionally unavailable to be engaged in treatment (2006). Parents grieving the death of a family member, for example, may be too involved in their own process to be available to their child (Sori et al., 2006). Or, resistance from parents and an adolescent to be in therapy together due to deep animosity may imply for a clinician that separate therapy is necessary, at least for the time being (Sori et al., 2006). Thus, some therapists see resistance as indicating that the child's treatment should not currently involve family members. It should be noted, however, that therapists may value family treatment but see some individual work with children as absolutely crucial to their treatment, in order to understand the child separately from the "problem," and evaluate the effects of the parents' problems on their child (Sori et al., 2006).

Psychoanalytic Family Therapists (PFTs) perceive resistance as a product of previous life encounters. "Resistance is viewed as a result of layers of defenses created to avoid reencountering the pain of unfinished early experiences and/or as the result of unrealistic desires for unattainable perpetual gratification" (Anderson et al., 1983, p. 15). PFTs do not see resistance as existing in limited, sporadic episodes that act as barriers to effective treatment. Rather, they view resistance as an ever-present tension that speaks of the underlying material for the resistant individual (Love, 1991, pp. 176-177). In this way, parents resisting involvement in their child's therapy, for example, may be showing their own need for therapeutic help (Love, 1991). Somewhat similar to family systems therapists, PFTs are interested in the messages inherent in resistance. PFT, however, remains focused on the family's role in the resistance. PFT does not address how the therapist, because of her/his approach or what they trigger in the family, might contribute to the resistance.

Modern Analytic Family Therapists (AFTs) posit that it is most effective to ally with the family's perceptions of the problem and the source to blame. Love highlights the importance of "initially (going) along with the family's perceptions and requests as to who is the actual patient" (1991, p. 177). AFTs tend to value the original client's (or identified patient's) views and wishes more so than their caregivers. In fact, rather than demanding that all family members participate in sessions, an AFT is more likely to only ask a family member to come to treatment if the identified patient gives their consent for this to happen (Love, 1991). By exhibiting a shared view of the problem, therapists can indirectly help these members let go of their antagonism and defensiveness (Love, 1991). The resistant member may then voluntarily join treatment (Love, 1991). In this way, AFTs believe that resistance, when met in an utterly embracing way by the therapist, will resolve itself.

Behavioral Theories

Individual Client Resistance

Behavioral theorists, perhaps because they tend to discredit the existence of the unconscious, discuss resistance with a different focus and vocabulary. For these theorists, resistance is a client's failure to comply with the treatment regimen. In behavioral frames, resistance is "understood as noncompliance, or noncollaboration, with a here-and-now problem-solving role" (Leahy, 2001, p. 10).

There are three "classic" cognitive models of resistance. Firstly, Albert Ellis' model discusses how irrational beliefs such as "shoulds," low frustration tolerance, and absolutist thinking all bring about resistance. Ellis's approach will be discussed further. Secondly, Burns' model is similar to Ellis' in that it looks at how cognitive distortions and

automatic thoughts lead to resistance, particularly in client behaviors around homework assignments. Thirdly, Beck's model hinges on Beck's own notion of there being personality schemas, or "general themes of interpersonal and self-functioning" (Leahy, 2001, p. 19). Beck thinks of avoidance and compensation as two general "coping styles" based on personality schema. Thus, avoidance is "the tendency either not to enter into or to escape from situations where the schema might be activated" (Leahy, 2001, p. 19). There is an array of cognitive conceptualizations of resistance, which deal with thinking, personality, behavior and other more "conscious" aspects of self.

Cognitive theorist Robert L. Leahy (2001) coined another frame that pulls from both behavioral and psychoanalytic theory: the integrative social-cognitive model of resistance. Through this lens, "resistance is often the result of emotional dysregulation (or overregulation), early (and later) childhood experiences, and unconscious processes" (Leahy, 2001, p. 20). To intervene using this model, Leahy suggests the therapist use various techniques, such as evaluate how homework is being explained and assigned, do psychoeducation in session, pace what material the client works on when, or use agenda-setting.

Albert Ellis (2002), a Rational Emotive Behavioral/Cognitive Behavioral therapist, is one of the few behavioral thinkers to pay significant attention to resistance in his writing. Ellis concludes that irrational beliefs, such as a belief that change is not possible, may be at the core of resistance (2002). Thus, Ellis' view of resistance seems more akin to the "Problem-resolution" grouping of theories examined by Frankel and Levitt.

In Ellis' thinking, a client's tendency to have unrealistic, severe negative beliefs about themselves or the world may cause them to be resistant (Ellis, 2002). To intervene, Ellis asserts that the therapist should directly acknowledge and explore the resistance with the client, to help him or her modify and re-shape personal beliefs in a way that makes treatment feasible and hopeful to the client (Ellis, 2002). The therapist can also explore with the client how their own and the client's treatment goals may be different, or choose a modality that best suits the client and his/her resistances (Ellis, 2002).

Caregiver Resistance

Behavioral theorists do value caregiver involvement in a child's treatment, but they do not discuss caregiver resistance in a very in-depth way. Child/adolescent trauma focused cognitive behavioral therapy greatly values parental involvement. TFCBT practitioners Cohen, Mannarino and Deblinger posit that although this model is child focused, parents of traumatized children are often traumatized themselves, and "including parents in therapy provides such parents with trauma-focused components that may help them cope better as well as allowing them to optimally encourage their children in practicing these skills" (2006, p. 36). Their involvement also tends to improve their parenting skills and improve the quality of their relationship with their child (Cohen et al., 2006).

The behavioral models of trauma focused cognitive behavioral therapy (TFCBT) and parent-child interactive therapy (PCIT) give some recommendations to therapists around navigating a caregivers' opposition to involvement. Cohen et al. state that sometimes situations arise in which the caregivers "cannot or will not agree to be involved in treatment" (2006, p. 40). Situations include the following: when "a child is in

a group home, foster parents refuse to participate, the child's single parent has died and the child has been placed in a temporary shelter setting, (or) the child is a 'street person'" (2006, p. 40). These authors do not consider a resistance scenario in which caregivers, regardless of how physically present they may be, refuse involvement out of the maladaptive power relationships in their family, their fears of being blamed, or any of the other previously discussed reasons. There were no recommendations located in the literature regarding how TFCBT therapists should speak to resistant members in their initial encounter.

Parent- child interactive therapy is more dependent upon parent involvement than TFCBT. PCIT practitioners "do not recommend this approach for parents who are highly resistant to treatment" (Hembree-Kigin & McNeil, 1995, p. 7). Hembree-Kigin and McNeil (1995) claim that the model tends to be ineffective in families with serious marital problems, severe psychopathology or substance abuse on behalf of the parents.

Family Systems

Caregiver Resistance

Basic Understandings

Family systems therapists (FSTs) tend to see familial resistance as a sort of blueprint of the therapeutic work to come. "Resistance," according to this approach, "is nothing more than the family's display of its inability to adapt effectively to the situation at hand and to collaborate with one another to seek help" (Szapocznik et al., 2003, p. 45). Resistance is an expression of the very familial issues the clinician needs to try to involve themselves in so that family members will come to treatment.

Most typically, according to FSTs, the resistance scenario is one in which an adolescent is the identified patient and she/he refuses to come in to treatment (Szapocznik et al., 2003). The adolescent resists therapy because it is part of the parents' agenda, not her/his own, so joining treatment would threaten her/his place of power in the family (Szapocznik et al., 2003). The second most common form of resistance is when the family member in contact with the therapist is a protective parent who wants to safeguard the family's unhealthy patterns (Szapocznik et al., 2003). Often families displaying resistance for this reason have one parent that is disengaged from the family system, and the other parent is protecting this member. Resistance can also come when family members fear that family secrets will be revealed in treatment (Szapocznik et al., 2003). Structural family therapists perceive resistance as an illustration of the maladaptive family patterns at hand.

Similarly to FSTs, structural ecosystems therapists (SETs) see resistance as an expression of family dynamics. This theoretical frame is an offshoot of FST and social ecological therapy. However, SETs pay special attention to bridge individuals and institutions in the client's life into the treatment, to enhance support.

Clients' resistance is viewed by SETs as a developmentally normal response; such a take resonates with the original psychoanalytic understanding of resistance as healthy and expected. In structural ecosystems therapy, "'resistance' is regarded as natural and even adaptive protective response to the context of therapy" (Nelson, Mitrani, & Szapocznik, 2000, p. 133). Resistance is also viewed as not rooted in the client discretely, but as an "interactive process" between both client and therapist (Nelson et al., 2000, p. 133). In Nelson et al.'s case example, the therapist finds she is feeding into the

client's deep-seated hopelessness derived from her past interactions with institutions. The therapist adapts her approach to capitalize on the areas in which the client does have hope. Systemic family therapy focuses on the relational context through which the client came to oppose the treatment.

Practical Approaches

FSTs tend to have more direct, targeted approaches towards resistant members. These approaches tend to not completely ally themselves with the resistant members' views, but to varying degrees. Weidman represents a view that is less challenging towards resistant members. He articulates that at the beginning of the initial contact with a family member, the therapist should at first "initially accept the family's view of the problem and empathize with the caller" (1985, p. 101). Later in the conversation, the therapist should "widen the problem definition by asking how other people react to the problem and how these other people are affected by the problem" (Weidman, 1985, p. 101). Anderson and Stewart support a similar tactic of legitimizing the family's conception of the problem, while "(widening) the problem definition" (1983, p. 46). Weidman believes that it is best to let the resistant caregivers' goals for their child (such as to not use drugs anymore, be more responsible, etc.) be the therapist's adopted goals for treatment.

Other FSTs feel it is important for the therapist to exert her/his own conceptualization of the problem on the family, and worry less about allying with their view at all. Szapocznik et al. posit that agreeing with family members' views of the problem causes the therapist to lose credibility and essentially collude with the family's problem (2003). As will be described later, Szapocznik et al. have very specific

recommended practices of negotiation with the "engaged" family member to involve a "resistant" member in treatment.

A number of FSTs posit that the therapist must be transparent with the resistant caregivers. They argue that authenticity and a willingness to acknowledge "the elephant in the room" is vital to forming a kind of contract or working agreement with resistant members. The therapist should blatantly convey to these individuals "(her/his) understanding that they may not be terribly interested in what we have to offer, or know what they are here for, or even trust (the therapist)" (Ackerman, Colapinto, Scharf, Weinshel, & Winawer, 1991, p. 263). In addition, the clinician can address the individual's fear of being blamed for the identified patient's problems (Anderson et al., 1983).

Further recommending transparency, Jensen, Josephson, and Frey (1989) recommend an informed consent model between therapist and family. In such an agreement, the therapist warns the resistant caregivers of the potential hazards involved in family work. This could include a statement about family involvement that will necessitate discussion around certain difficult topics, or how parental involvement could literally add to their stress or increase conflict in their marriage (Jensen et al.,1989). These therapists contend that very direct outlining of the downsides to involvement lessens family scapegoating, prepares the family for the experience ahead, and strengthens the therapist-family relationship (Jensen et al., 1989). Such transparency could facilitate conversation about members' concerns, and set up therapy to be a shared endeavor between the therapist and the family.

Some FSTs recommend using psychoeducation in the initial contact. They suggest stating to the resistant member that research or her previous casework point to the usefulness of having all family members present in therapy (Anderson et al., 1983; Weidman, 1985). Some SFTs assert to resistant individuals that all family members need to be present in the first therapy session, but not necessarily in later sessions (Weidman, 1985). However, the therapist can use a negotiating stance to focus on how the identified patient's problems are not necessarily caused by the family, but if the whole family is present the identified patient will be helped much faster (Anderson et al., 1983).

Ideally the therapist is able to make contact with the resistant member. Weidman (1985) recommends that the therapist try to contact this individual directly (at her/his work or cell phone, for example) when they learn from the initial referral that they will not want to participate. By simply inviting this member to treatment, rather than insisting they come, the individual may be more open to coming (Weidman, 1985).

Utilizing structural family theory, Szapocznik, Hervis and Schwartz (2003) offer very specific advice for therapists' first encounters with resistance when they cannot contact the resistant member. Since initially the therapist may only be in contact with the family member who called for help and/or others who are prepared to cooperate with treatment, she needs to join with those members as fully as she can (Szapocznik et al., 2003). The therapist in these early stages who is in contact with only part of the family is "(focused)... strictly to work with these people to bring about the changes necessary to engage the entire family in counseling" (Szapocznik et al., 2003, p. 47). The therapist eventually tries to use this individual as a link to the resistant family members (Szapocznik et al., 2003).

The structural family therapy approach recommends the therapist use other family members as support people to engage the resistant, "key player" family member(s). For example, when a family member first calls a counselor to arrange an initial appointment, the therapist should ask this person questions about the family's patterns for interaction. Szapocznik et al. (2003) suggest that the therapist ask the engaged individual how she asks the resistant family member to come to treatment to discuss how the interaction unfolds. The therapist should then recommend new, potentially less blaming ways of talking to this member. Based on how the engaged family member responds to the therapist's suggestions, the therapist also learns more about how she/he functions in her family system (Szapocznik et al., 2003).

If and when the therapist gains contact with a resistant member, Szapocznik et al. advise that the therapist reframe the purpose and nature of treatment to her/him. To an adolescent who is the identified patient, for example, the counselor might say, "'I want you to come into counseling to help me change some of the things that are going on in your family'" (Szapocznik et al., 2003, p. 50). To the family member fearful of family secrets being illuminated or scapegoating happening, the therapist should explain that she/he will direct the therapy and create limits for exploration. Once treatment begins and members are somewhat joined, however, the therapist repositions her place of power in the family and becomes more of a chief facilitator of the treatment (Szapocznik et al., 2003). Family systems therapies promote directness on behalf of the therapist, towards the resistance and the resistant member, to ultimately bring that individual to the session(s).

Clinician's Use of Self

Family therapists have also examined clinicians' varied interpersonal techniques that seem to organically evolve out of a resistance scenario. Such practices may not have origins in theoretical training or frame alone, but also from the therapists' tendencies around their use of self. Again, child and adolescent therapists fail to explore this area comprehensively. Analyzing this family therapy discussion provides a springboard into imagining the factors that shape how child therapists encounter resistant caregivers.

Piercy and Frankel's (1989) study brings to light the creative interpersonal alterations of integrative family therapists. Integrative family therapy "integrates present-centered, problem-focused skills from structural, strategic, functional, and behavioral family therapies," to reduce family resistance to treatment (Piercy & Frankel, 1989, p. 3). The therapists in the study were treating 138 substance-abusing youth, which included 108 males and 30 females from Indiana, with unstated racial backgrounds. The therapists' sociocultural identities are not mentioned by the researchers, to the study's discredit.

Although asked to follow various integrative family therapy protocols, the researchers find that it is the "richness of the therapists' intervention strategies" that truly engaged families. The therapists used "positive connotation" in their work with families, originally as a technique that often evolved into a sort of "way of being;" therapists began genuinely caring for families and were able to maintain optimism in their work with difficult families (Piercy & Frankel, 1989, p. 14). For some therapists, interpersonal techniques included making home visits, or self-disclosure (in the case of two therapists who were former substance abusers) (Piercy & Frankel, 1989). Positive connotation was

only useful when families were invested in solving the substance abuse problem (Piercy & Frankel, 1989). Directness on behalf of the therapist, e.g., saying, "'this situation is bad. Your son could go to jail or die if this isn't turned around,'" was more effective for those families who weren't committed to change (Piercy & Frankel, 1989, p. 15). Piercy and Frankel's study is a testament to the less quantifiable but extremely useful ways that a therapist's wording and regard can diminish caregiver resistance.

Decisions around Inclusion

Research in the realm of family therapy has examined the frequently arising dilemma of whether or not to include a child in a family's treatment. Analyzing this literature provides a helpful framework for appreciating how child and adolescent therapists may go about their decision-making to include caregivers in treatment. In the family therapy field "there is little agreement… about how and when to involve children in sessions" (Johnson & Thomas, 1999, p. 3). Despite this, researchers are finding commonalities in what informs therapists' decisions.

Two studies found that a therapist's comfort level in working with children and/or children with particular problems dictates how much they involve a child in family work. Although Johnson and Thomas (1999) were not able to deduce why family therapists expressed discomfort around including children, Korner and Brown (1990) found that exclusion of children correlated directly with clinicians' coursework and supervision around working with children. Therapists who viewed their training as inadequate were more likely to exclude children from family treatment.

To their discredit, none of the researchers in this area have directly considered factors such as gender, race, and class in therapists' decisions. In Korner and Brown's

study, for example, ninety five percent of the responding therapists were male, but the possible implications of social constructions of masculinity and comfort level with children was not addressed at all. Although Johnson and Thomas (1999) claimed their sample was representative of the pool (the American Association for Marriage and Family Therapy) in terms of age, sex, ethnic background, and professional factors, they did not outline the demographics of the sample at all, much less identify the potential sociocultural bias in what is likely a majority White, middle and upper-middle class representation.

Although these studies did an inadequate job in addressing important variables and factors, they point to deeper questions around the meaning of a clinician's "discomfort." Where does discomfort come from, and how do therapists see it influencing how they interact with a family? This researcher's study will flesh out such questions in a new way. Discomfort on the therapist's behalf is a somewhat inevitable reaction to a resistance scenario; the present study will assume, to some extent, that therapists experience this feeling in the clinical situation at hand.

To apply past studies to this researcher's study, it could well be that a child or adolescent therapist who has insufficient training in working with adults would avoid engaging them in their child's treatment, particularly if they were resistant. It will also be key to take into account how clinicians are encountering racial, ethnic, and other differences between themselves and their clients as they navigate decision-making and approach application.

Family Stress and Cultural Impasses

Vital to this investigation is exploring the engagement process from the perspective of the family. Various researchers in family studies have investigated how the chaos of poverty, role-shifts amidst change, and unique needs of families play out in interfaces with mental health services. From the literature, one speculates that many mental health agencies have treatment approaches that are designed to work best for a certain subset of society (perhaps, middle class, in-tact, English-speaking families). Clients who do not fit this demographic may not receive the benefits of the service; therefore, they leave the provider. In turn, clinicians deem these clients "resistant."

Golding and Wells (in McCubbin, Thompson, Thompson & Fromer, 1995) highlight in their 1990 study that the very reason a family may seek support for their child might be the breakdown of the family network. In their study of Mexican-American and Non-Hispanic White families, "being unmarried and lacking support from one's spouse, work associates, friends and relatives was associated with the use of formal service providers" (Golding & Wells in McCubbin, Thompson, Thompson & Fromer, 1995, p. 387). If caregivers seeking counseling for their child are unsupported by other adults in their family or community, they likely have more stressful lives and less time, energy, or ability to communicate consistently with the therapist.

San Miguel, Morrison, and Weissglass' (in McCubbin, Thompson, Thompson & Fromer, 1998) research finds that some families' underutilization of the social service system is also a product of culturally-insensitive/inappropriate services. Their study sample was 185 elementary school children whose parents received Aid to Families with Dependent Children; 87% were Latino and 83% spoke Spanish at home. San Miguel et

al. found that not only were there not enough Spanish speaking service providers to really be of help to families, but situational factors, such as a lack of insurance, expensive care, or lengthy waits for service all lead to underutilization of services. Families' "unfamiliarity with the 'culture' of the social service system serve only to exacerbate their needs and feelings of frustration" (San Miguel et al. in McCubbin, Thompson, Thompson & Fromer, 1997, p. 397). Indeed, seeking counseling for children may be a process that is unfriendly to many families. Although no studies could be found as evidence, it seems that caregivers may be less likely to engage with their child's therapist if they have had poor experiences with the social service system in the past. Caregivers may have a kind of negative transference towards mental health providers.

Race and Ethnicity

As family therapists are beginning to examine, cultural and economic factors embedded in a family's race or ethnicity often impact a therapist's success in engaging the family. Such research is highly applicable; family therapists and child therapists encounter the same ethnic and racial factors in the task of engaging a caregiver. There is only one family therapy study (Santisteban, Szapocznik, Perez-Vidal, Kurtines, Murray, and LaPerriere, 2007) that directly acknowledges how clients' race and class correlated with clinicians' effectiveness in engaging with caregivers.

Santisteban et al. (2007) wanted to explore the efficacy and various variables involved in effectiveness in working with the family of an identified patient. The researchers assigned 193 Hispanic families to a group of therapists whose ethnicities were unacknowledged. Here is the first problem of the study; without attention to

therapists' sociocultural identities, potential conclusions around ethnicity as a factor in the therapist-client relationship are unfounded.

In the study, therapists were assigned to various groups employing different family therapy methods, including Strategic Structural Systems Engagement and Engagement Family Therapy. They selected "193 Hispanic families of adolescents of or at risk for drug abuse" for the sample (Santisteban et al., 2007, p. 5). About half of the group was Cuban and the other half was composed of Nicaraguan, Columbian, Puerto Rican, Peruvian, Mexican and Salvadoran families. Santisteban et al. (2007) found that there was a "striking difference in treatment effectiveness," i.e., family engagement into treatment, between Cuban and non-Cuban Hispanics, often drastically so (p. 16).

Harris and Hackett (2008) compared the trajectory of Caucasian, African American, and Native American children involved in the foster care system across various points in the child welfare process (from reporting abuse/neglect to exiting the child welfare system). The study has important implications for how child therapists may also operate in ways that exercise their racial privilege, and further entrench their clients' oppression. This study drew upon extensive literature focusing on the disproportionality of children of color in the child welfare system. Harris and Hackett found that social service professionals are not always aware of how race and racism are at play in their service delivery. Indeed,

> "Some (child welfare workers) believed that race or culture played no role (in their own process of assessing risk or in the family's approach to child safety) and others believed that they lacked the training or awareness to understand the role that race or culture might play in their own process of assessment" (Harris & Hackett, 2008, p. 6).

In addition, sometimes workers were found to have overly idealized impressions of the effectiveness of social or justice systems, and thus they did not advocate for their clients of color who are more likely to be failed by these systems. Child therapists, like child welfare workers, operate in larger institutions with particular "blind spots" and biases, which often negatively impact clients of color.

Research highlights the importance of awareness, sensitivity, and agency on behalf of the clinician. Indeed, it is key to "(be) responsive in adapting interventions to subtle, changing contextual conditions" such as racial and ethnic implications (Santisteban et al., 2007, p. 22). Santisteban et al.'s statement seems somewhat obvious; therapists need to modify their approach in a way that is culturally competent with the family at hand. The study did not fully acknowledge that part of being "responsive in adapting interventions" relies upon a high degree of reflexivity around one's racial and ethnic identity (Santisteban et al., 2007, p. 22). This author's study will go further than Santisteban et al.'s study; it will provide a space for clinicians to reflect upon how their practices might be shaped by their cultural and economic standpoints.

Other Family Characteristics

Santisteban et al. (2007) induced that resistant families had certain characteristics, such as a "powerful identified patient," and that "eight of the nine intervention failures involved some form of parental resistance" (p. 18). The conclusion that parental resistance dictates failure to commence family treatment is particularly pertinent to this researcher's study. Indeed, parental resistance is a deciding factor in the path and success of a child's therapy. Santisteban et al. conclude that the most effective way to engage caregivers is to join with their perspective before trying to change their view.

To summarize, two areas of all of the relevant existing research seem particularly strong and useful to the author's study. The first area is the findings on how theoretical frames conceptualize resistance. From such understandings come treatment protocol or suggested approaches for dealing with resistance, which therapists may or may not completely follow; the author's study will help clarify therapists' practices.

To briefly encapsulate the theoretical perceptions and approaches, psychoanalytic/dynamic child and family therapists seem to be more likely to see resistance as an indication that their focus on the individual child/adolescent, at least in the moment, is preferable over family treatment. For analytic family therapists, the resistance is imbued with clinical meaning, though this does not seem to be so for individual child psychoanalytic/dynamic therapists.

To behavioralists, resistance can symbolize avoidance of material or change, emotional dysregulation or overregulation, irrational beliefs, or absolutist thinking. In this frame, resistance calls for the therapist to directly address the resistant behavior and possibly modify the structure of the therapy to counteract the noncompliance.

Family systems therapists appear more likely to see resistance as evidence of the family's problems, and understand the nature of the resistance as helpful information towards trying to engage members. To Szapocznik and his colleagues, initial resistance is a sort of invitation for the therapist to better understand and empathize with the family, and try new techniques for engagement.

The second major area of useful literature to this study is family therapy's empirical evidence of the many techniques clinicians use to engage family members into treatment, and the cultural, class-related, and racial/ethnic factors at play in client-

therapist engagement. Family therapy researchers have a perspective that highlights the relational aspect of therapy. This frame also appreciates how therapist and client/caregiver can shift and change in their trust and involvement in the therapeutic relationship.

Although the research described serves as a useful framework to the author's study, there are also major gaps and shortcomings of the knowledge base. The author will attempt to reconcile them. Too few researchers acknowledge and explore how client *and* therapist sociocultural variables such as gender, class, and race can greatly impact resistance scenarios. The author's study will not only gather extensive demographic information from therapists, but also ask open-ended questions in which therapists can explore such issues, as they are aware of them.

In addition, there is no existing study that has provided a kind of venue for varied perspectives on caregiver resistance. Researchers and practitioners can become more entrenched in their ways of seeing when studies stay within one theoretical frame. Psychodynamic/analytic and behavioral approaches tend to see resistance as more one-sided; resistance is the client's presentation. The family systems approach appreciates resistance as a form of communication about the therapist/client relationship. The author's study will attempt to invite all therapists, regardless of their orientation, to be inquisitive about their clinical experiences and roles in those experiences. This study's results and discussion could be more fruitful with such an eclectic research sample.

This author's study is designed to delineate how child and adolescent psychologists and clinical social workers describe their beliefs and practices in working with resistant caregivers, and how this information adheres to and diverges from their

theoretical orientation. By comparing clinician's responses with their theoretical orientation's perspective, this researcher will come to conclusions about whether and how theory informs practice in such treatment situations.

This study will explore the following research question: “How do child and adolescent clinicians describe their beliefs and practices with resistant caregivers in ways that adhere to or diverge from their theoretical orientations?” The sample includes clinicians that ascribe to Psychodynamic/analytic Theory, Behavioral theories, and/or Family Systems Theory. This researcher’s study will focus on a general concept of resistance in an attempt to bridge theoretical frames; resistance is conceptualized as any client state, trait or behavior that inhibits their reaching treatment goals.

CHAPTER III

METHODOLOGY

This exploratory-descriptive study was designed to address the question: "How do child and adolescent clinicians describe their beliefs and practices with resistant caregivers in ways that adhere to or diverge from their theoretical orientations?" The Clinician Questionnaire was an instrument that was developed by this researcher. Fixed-answer questions gathered data regarding the importance clinicians ascribe to engaging caregivers and resistant caregivers in particular. Open-ended questions determined how clinicians (a) describe their direct and indirect approaches with resistant caregivers; and (b) think about whether and how their beliefs and practices are informed by their theoretical orientation. Demographic information was collected to ascertain information about respondents' sociocultural and economic positions, and academic and professional background.

The method of measurement was reliable in that each participant received the exact same survey. Any threats to the study's trustworthiness (for example, respondents being biased) was minimized by the fact that respondents were alone when they answered survey questions, and had little or no personal connection to the researcher. The validity of this study was sound in that the questions asked clinicians in direct ways about their perceptions and practices. Questions were fairly general and open-ended so as to improve the chance that each response would clearly represent the therapist.

The main variable of the survey was therapists' theoretical orientation. Other variables that were not measured but existent included the gender, race/ethnicity, age, income, and educational/professional backgrounds of the respondents.

The data from the fixed response questions would have been analyzed with a crosstab, but due to the nature of the data and sample it was found to be useless to do such an analysis. Thus, the researcher conducted content analysis for responses to open-ended questions and to uncover general themes around respondents' descriptions and the theoretical implications of their answers.

Sample

Sixteen clinicians voluntarily participated in the study. Clinicians among the researcher's contacts and the researcher's professors' colleagues who met the inclusion criteria were selected for the sample. Thus, the selection procedure was more purposive than random.

Clinicians had to have either a Ph.D. in Psychology and/or a Master in Social Work, and currently work with children or adolescents or have worked with that population no more than five years ago. Clinicians had to be currently employed in an outpatient clinic or private practice or have worked in one of these settings no more than five years ago. Participants also had to have been trained in one or more of the following theoretical backgrounds: 1) Psychodynamic/psychoanalytic, 2) Behavioral (Cognitive, Dialectical, or Rational Emotive) or 3) Family Systems. In addition, clinicians needed to have at least five years of experience post-licensure (if they had a Master in Social Work) or five years of practice experience post graduation (if they had a Ph.D). The informed

consent stated that by clicking on the survey from the informed consent form, therapists indicated that they understood the criteria and agreed to take the survey.

Of the sixteen respondents, twelve stated they were female, and four stated they were male. Ten identified as Caucasian/White, and six identified as African American/Black. They ranged in age from 39 to 63 years with a mean age of 50.13 years; one respondent did not indicate his/her age. Annual income for respondents varied and ranged from $36,000 to $150,000 with a mean of $73,909.09. The range of practice experience for clinicians was 15 to 30 years with a mean of 23.43 years. The range of practice experience post-licensure was 7 to 30 years with a mean of 16.38 years.

Ten clinicians were trained in Psychodynamic/analytic theory, seven in Behavioral (Cognitive or Dialectical) theory, and eight in Structural (Family Systems) theory. Eight of the sixteen respondents indicated they were trained in more than one of the three theories. Twelve respondents had a M.S.W., and seven had a Ph.D. Two therapists currently worked in an agency, thirteen in private practice, and one in a university. Eight respondents saw children in sessions, thirteen saw adolescents, thirteen saw adults, and ten saw families. Most respondents stated they treated more than one age group.

Data Collection

The researcher received approval from the Smith College School for Social Work Human Subjects Review Committee to complete this project (See Appendix A). Potential respondents were sent an informed consent form electronically, and this outlined the criteria for participation and nature of the research. Each participant indicated that they read and understood the informed consent form (see Appendix C).

Permission was received from the director of the Children's Treatment Program at Catholic Community Services to recruit the agency's therapists. In addition, the researcher recruited professional contacts, some of whom were colleagues of her research advisor and professor. The researcher attempted to obtain permission from the Washington Department of Health (DOH) to recruit DOH-accredited licensed social workers (LICSW's). The procedure was timely, but permission and a list of LICSW's was given to the researcher. However, all social workers on the list had only received licensure within the past two years and thus did not qualify to be included in the study, and due to time constraints the researcher could not appeal to the DOH to obtain other lists of names.

About one hundred and eighty clinicians were sent the recruitment letter via e-mail, along with a link to the survey. Sixteen clinicians voluntarily completed the survey. Some of those clinicians recruited replied to the researcher via e-mail, indicating they could not participate because they did not meet the inclusion criteria.

CHAPTER IV

FINDINGS

This study was designed to uncover how clinicians of various theoretical backgrounds describe their perceptions and approaches with resistant caregivers, and examine the theoretical implications. The major findings were that most of the respondents strongly agreed or agreed that caregivers, including resistant ones, should be engaged into a child's treatment. Overall, clinicians were slightly more ambivalent about the importance of engaging resistant caregivers. Most clinicians of the three theoretical groups reflected one or more of their theoretical orientations in their general lens or focus, but some, particularly Psychodynamic/analytic clinicians, endorsed strategies that were not promoted by the literature within their theoretical frame(s). Since most respondents endorsed more than one theory, it is difficult to do a theoretical analysis of their statements.

In terms of direct and indirect approaches towards resistance, Behavioral and Structural clinicians tended to use methods promoted by their theoretical orientation, and Psychodynamic/analytic clinicians used approaches that were related to their theoretical background but not necessarily endorsed by literature. About two thirds of all respondents felt their theoretical orientation guided them by conjuring the "larger picture" in resistance scenarios. Conversely, about one third of the sample stated professionalism, common sense, or experience informed them as much or more than their theoretical framework.

It may seem surprising that Psychodynamic/analytic clinicians so widely supported engaging resistant caregivers into treatment. Based on the literature reviewed, it was expected that these clinicians could be more neutral in this area. One limitation of this research was that some survey statements (such as: "It is important to engage a resistant caregiver into his/her child's treatment," in which clinicians were asked how strongly they agreed/disagreed) gathered information on beliefs rather than practices, necessarily. So, although Psychodynamic/analytic respondents may believe it to be important, it is unknown how often they actually attempt to engage resistant caregivers.

Clinicians with a Psychodynamic/analytic background were more likely to describe how they explore – in their own thinking or in their dialogue with the caregiver – themes underlying the resistance. One clinician with a Psychodynamic/analytic and Structural background wrote that his/her method for directly addressing resistance is to "systematically, thoroughly, and integratively explore underlying immediate factors (behind the resistance)." This disposition reflects the theory's inquisitive and introspective nature.

More than the Behavioral or Structural clinicians, Psychodynamic/analytic clinicians also referred to the relationship between the caregiver and child. One clinician wrote, "I make it clear that their (the caregiver's) input /involvement is important for the client and for their relationship." Psychodynamic/analytic theories do emphasize the healing power of relationships, but the literature did not promote dismantling resistance by focusing on relationships per se.

As an indirect approach to addressing caregiver resistance, three of the ten Psychodynamic/analytic clinicians stated they would use the child's needs as a sort of tool

to lessen caregiver resistance. One clinician with a Psychodynamic/analytic and Structural background wrote,

> "I will 'speak through the child' to the parent about the needs of the baby or child. I most often use the child as the port of entry to the parent, focusing on the child's issues and attempting to build reflective function in the parent."

Another Psychodynamic/analytic respondent wrote that he/she would allow the child to journal or write to his/her resistant caregiver. Another endorsed suggesting to the child/adolescent client that he/she tell the caregiver that they want his/her involvement in the therapy. This focus on the child as the client at hand reflects Psychodynamic/analytic theory. However, no literature from this frame recommended using the child so directly to engage the caregiver.

In answering the final question about how clinicians see their theoretical orientation informing their perceptions or approaches to resistance, three clinicians with a Psychodynamic/analytic background discussed theory as helping them stay positive or maintain hope in difficult situations. One respondent with a Psychodynamic/analytic and Structural background wrote,

> "(Theory) helps me with ways to keep myself from getting stuck in negative feelings about the parent. Then I can be curious and learn how the parent is thinking and feeling in a way that is not attacking the parent and keeps communication open."

Theory reminded these clinicians that the caregiver resistance was not necessarily a personal attack of the therapist, but, rather, evidence of systemic issues.

On the whole, Behavioral clinicians were more likely to discuss what they do or say in resistance scenarios. This was different from Psychodynamic/analytic clinicians, who were more likely to allude to the meaning of the resistance. Again, this is in line

with how Behavioral theory operates. One practical approach that three Behavioral clinicians endorsed was making the child's treatment contingent upon caregiver involvement in the therapy. One respondent with a Behavioral and a Psychodynamic/analytic orientation wrote, "It is a requirement of my work with an adolescent that the caregiver participate when necessary. I also screen people at point of entry for compliance." Such a selection technique was promoted in the literature on Parent Child Interactive Therapy (a Behavioral approach). Since many (five out of seven) of the Behavioral respondents ascribed to another theoretical approach, it is impossible to deduce how Behavioral theory exactly influences these clinicians. Overall, Behavioral clinicians did not refer to the doctrines of their theory in their responses. Only one clinician with knowledge about Behavioral theory discussed how resistance is based in false cognitions. This respondent claimed to be trained only in Psychodynamic/analytic theory, but was evidently steeped in Cognitive Behavioral theory as well. He/she wrote,

> "The cognitive approach suggests that children's problems are 'thinking' problems and that addressing the problems centers on changing the maladaptive thinking. Parent involvement in this sense remains important, but not critical."

Other respondents who stated being trained in Behavioral theory did not draw similar conclusions per se, though their Behavioral background did not seem to advise them on resistance. Five of the seven respondents who were trained in Behavioral theory were also trained in another theory. When discussing how their orientation informed their perception or approach to caregiver resistance, these clinicians cited Psychodynamic/analytic or Structural theory or general experience, not Behavioral

theory. This was not surprising, given that the Behavioral literature and approach focuses more on pragmatics and service delivery than on case conceptualization.

Clinicians who stated training in Structural theory were more likely to discuss collaboration, interaction, and trying to engage caregivers into a sort of team with the therapist and client. One clinician trained only in the Structural approach wrote his/her direct way of addressing resistance is to "collaborate with the caregiver around what they want and how we might best get at it." Another respondent from a Behavioral and a Structural background stated, "Typically I ask for the caregiver's help." Such responses represent Structural theory, but again, since seven out of eight of the Structural clinicians were trained in one or two other theories, one cannot conclude exactly how Structural theory informs these clinicians. It does seem that Structural theory serves as a guide to these therapists: seven of the eight Structural clinicians said their orientation does inform their work with resistant caregivers. In contrast, only ten of the sixteen total respondents said their orientation definitely directed their interfaces with resistant caregivers.

There were a few themes across the three groups of respondents. Clinicians valued using a gentle, non-blaming tone with resistant caregivers, while still thoughtfully working to reduce the resistance. They said such things as "I try to create a nonthreatening atmosphere" and "I would directly address resistance or non-compliance, in a non-interpretive and non-confrontational way." One respondent wrote "I… use what I see as resistance in the parent to talk to them about how that comes across to me and what I am wondering about, quite tentatively so as to help them think aloud with me." A neutral and respectful yet purposeful stance with resistant caregivers pervades across theoretical backgrounds.

Ten of the sixteen clinicians were sure theory advised them in these clinical scenarios. A handful of therapists wrote about how some aspect of their professional identity helped them see the "big picture" in resistance scenarios. A Behavioral and Structural clinician wrote, "My identity as a social worker and therapist tells me the social environment where young people reside/engage offers support and it is important to utilize them." A Psychodynamic/analytic clinician stated that his/her "sense of professional ethics and boundary issues" guided him/her more than theory. For some clinicians, professionalism is more useful than theory to keep larger systems in mind.

Of the five clinicians who stated they were ambivalent or unconvinced that theory served them in these situations, several noted intuition or experience informing them more. To the question, "Do you think your theoretical orientation informs how you perceive or approach caregiver resistance? If so, how?" one Psychodynamic/analytic clinicians responded, "I'm not sure. It has always made common sense to me for the caregivers to be involved in their child's treatment in order to enhance their relationship and the treatment." As is expected for experienced clinicians, this respondent's theoretical orientation and "common sense" may be somewhat fused together. Similarly, a Behavioral respondent stated, "Experience informs me a whole lot more (than theoretical orientation)."

No clinicians alluded to complexities around race, class, or family stress in caregiver resistance, nor did any refer to their own sociocultural/economic identities. One respondent (with a Psychodynamic/analytic and Structural background) did note using a "culturally competent assessment" to address caregiver resistance. The respondents may not have cited race, culture or class because they do not encounter these

factors in resistance scenarios, or are not aware of them. Perhaps they did not have enough training or support to recognize these factors, especially if they were not directly referenced in the survey questions.

It seems most therapists feel it is important to engage caregivers and resistant caregivers into a child's treatment, and they are loosely informed by their theoretical orientation in how they approach resistant caregivers. Therapists seem to find that Psychodynamic/analytic theory and Structural theory offer helpful concepts and a plethora of approaches to resistance, and Behavioral theory offers techniques for addressing resistance but fewest ways of conceptualizing it. In addition, therapists are often informed by more than one theory and a myriad of other professional and experiential factors, making their awareness and technique multi-faceted. Especially for an experienced therapist, it may be difficult to know what exactly informs one's approach.

One limitation of the findings relates to the sample. Thirteen of the sixteen respondents worked in private practice. Generally speaking, such clinicians see more affluent clients. The type of caregiver resistance they encounter *may* relate more to issues around mistrust or family discord and stress, and less to cultural barriers or life chaos associated with poverty. Thus, their understandings of and approaches to caregiver resistance could be limited.

The sample was also less diverse than desired, although probably close to representative of clinicians in the U.S. Only two racial groups were represented – African American/Black and Caucasian/White – and only six of the sixteen respondents identified as African American. Also less than ideal, only four of the sixteen respondents

identified as male, and the rest were female. A more inclusive and representative sample would have been larger and included a more diverse sample of clinicians based on race, ethnicity, culture, gender, sexual orientation, etc.

CHAPTER 5

DISCUSSION

This research further illuminates the "artfulness" of clinical social work. Therapists are usually trained in multiple theories and their beliefs and approaches become eclectic and unique. Particularly in dealing with caregiver resistance, therapists describe their wisdom and skill set in ways beyond their specific training. Theory often helps therapists conceptualize resistance and decide on an area of clinical focus. However, theory coupled with practical experience makes for the therapist's "presence," and this is what they describe as dismantling resistance. This presence or use of self includes skills around empathizing, reflecting, timing, tone, and word choice. So, theory acts as a contextual and conceptual launching pad, but rarely a final destination.

The survey results seem to hold the most implications for Psychodynamic/analytic theory and therapists. The existent research in the Psychodynamic/analytic frame suggested that these clinicians might devalue caregiver engagement, or lack the tactics for approaching resistance that Structural or Behavioral therapists have. Sori et al. (2006) and Webb (2003) discussed the value of individual child treatment, positing that family sessions are only sometimes valuable, and need not be frequent or constant. Love (1991) stated that Analytic Family Therapists should only involve family members who the identified patient (or original client) consents to have join treatment; this suggested the Psychoanalytic clinician might not pursue resistant members' participation. However, this study illuminates Psychodynamic/analytic clinicians' large variety of theory-rooted, proactive approaches to engaging caregivers.

Some of Psychodynamic/analytic clinicians' stated techniques were not found in the literature, but do echo their conceptual base. One example was how these clinicians stress the relationship between the caregiver and child in their dealings with the resistant caregiver, in order to engage them. Another example was their "use" of the child (through speaking to the caregiver from the child's perspective, or enhancing the child's communication with the caregiver) as a means to convey the child's importance and needs and thus lessen resistance. These methods do reflect Psychodynamic/analytic theory and Analytic Family Therapy, in that they revolve around the clinician's relationship with the identified client as the "heart" of the therapy.

There can only be a preliminary analysis of the Behavioral clinicians' responses, due to their background in multiple theories. However, it seems that clinicians rely upon their Behavioral training for tangible approaches with clients/caregivers, rather than for theoretical conceptualization. Such a finding is mostly consistent with how research in the Behavioral field discusses resistance. Leahy (2001) outlined resistance as the client's refusal to engage in problem-solving, and Burns (1989) and Ellis (1985, 2002) deduced that resistance is the manifestation of irrational beliefs: all of these understandings revolve around the here-and-now presentation of the client, rather than their full psychosocial picture. Even Leahy (2001), who suggests that resistance arises due to such factors as childhood experiences and unconscious processes, recommends the clinician intervene concretely via homework, agenda-setting, or other means, rather than necessarily analyzing the client. Reflecting the literature, the Behavioral respondents to this study use Behavioral theory for its practical applications, rather than for clinical analysis.

The findings suggest Structural theory does inform clinicians' perceptions or approaches to caregiver resistance in some capacity, perhaps more so than Behavioral theory. Only a preliminary analysis is appropriate due to the multi-modal training of the Structural clinicians. Some clinicians with Structural training used vocabulary and techniques consistent with Weidman's (1985) general promotion of collaboration and aspects of Anderson et al.'s (1983) argument for transparency. The majority of these clinicians said their theory base does orient them in resistance scenarios. No clinicians cited the very specific tactics cited by Weidman (1985) or Szapocznik et al. (2003). It remains unclear how theory informs Structural clinicians exactly.

This research also shows how different methods can achieve the same treatment goals. More child-focused therapy, such as in the Psychodynamic/analytic frame, may or may not bring the caregiver into better communication with the therapist. However, this approach can certainly enhance the child and caregiver's relationship, and the caregiver's parenting skills; most likely these are some of the end goals of caregiver involvement in treatment anyway. Using the child as a sort of path to the caregiver is a technique reminiscent of Structural theory. In the Structural frame, clinicians are encouraged to use the already engaged family member (or identified patient) as leverage for engaging with the resistant members. Structural clinicians Szapocznik et al. (2003) promoted such a technique. Therapists of different theoretical backgrounds may use their orientation in more similar ways than the research had suggested.

This study leads to two major questions for future research to consider. First, how frequently, directly, and intentionally do therapists cite addressing and counteracting resistance? This investigation delineated their ideals, but not their employment of their

ideals. Second, how do clinicians see their sociocultural and economic identity, and that of the population with which they work, shaping their experiences of caregiver resistance? Future research could better determine the demographics of therapists' clients, and ask clinicians about how they see sociocultural and economic variables playing into their views and practices.

References

Ackerman, F., Colapinto, J. A., Scarf, C. N., Weinshel, M., & Winawer, H. (1991). The involuntary client: Avoiding "pretend therapy." *Family Systems Medicine*, *9*(3), 261-266.

Anderson, C. M., & Stewart, S. (1983). *Mastering resistance: A practical guide to family therapy*. New York: The Guilford Press.

Beutler, L. E., Moleiro, C. M., & Talebi, H. (2002). Resistance. In J.C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 129-143). New York: Oxford University Press.

Cohen, J. A.,, Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.

Ellis, R. (2002). *Overcoming resistance: A rational emotive behavioral therapy*. *approach*. New York: Springer Publishing Company.

Frankel, Z., & Levitt, H. M. (2006). Postmodern strategies for working with resistance: Problem resolution or self-revolution? *Journal of Constructivist Psychology, 18*(4), 219-250.

Golding, J.M. & Wells, K.B. (1990). Social support and use of mental health services by Mexican Americans and Non-Hispanic Whites. In H. I. McCubbin, E. A. Thompson, I. A. Thompson, & J. E. Fromer (Eds.), *Resiliency in Native American and immigrant families* (pp. 385-400). Thousand Oaks: Sage Publications.

Harris, M., & Hackett, W. (2008). Decision points in child welfare: An action research model to address disproportionality. *Children and Youth Services Review, 30*(2), 199-215.

Hembree-Kigin, T. L., & McNeil, B. C. (1995). *Parent-child interaction therapy*. New York: Plenum Press.

Jensen, P. S., Josephson, A. M., & Frey, J. (1989). Informed consent as a framework for treatment: Ethical and therapeutic considerations. *American Journal of Psychotherapy, 43*(3), 378-386.

Johnson, H. C., Renaud, E. F., Schmidt, D. T., & Stanek, E. J. (1998). Social workers' views of parents of children with mental and emotional disabilities. *Families in Society: The Journal of Contemporary Human Services, 79*(2), 173-187.

Johnson, L., & Thomas, V. (1999). Influences on the inclusion of children in family therapy: Brief report. *Journal of Marital and Family Therapy, 25*(1), 1-15.

Korner, S., & Brown, G. (1990). Exclusion of children from family psychotherapy: Family therapists' beliefs and practices. *Journal of Family Psychology, 3*(4), 420-430.

Leahy, R. L. (2001). *Overcoming resistance in cognitive therapy*. New York: The Guilford Press.

Love, S. (1991). Who is the patient in modern analytic family therapy: A modern psychoanalytic perspective. *Modern Psychoanalysis, 16*(2), 169-182.

Nelson, R. H., Mitrani, V. B., & Szapocznik, J. (2000). Applying a family-ecosystemic model to reunite a family separated due to child abuse: A case study. *Family Therapy, 22*(2), 125-146.

Piercy, F. P., & Frankel, B. R. (1989). The evolution of an integrative family therapy for substance-abusing adolescents: Toward the mutual enhancement of research and practice. *Journal of Family Psychology, 3*(1), 1-34.

Plakun, E. M. (2006). A view from riggs – treatment resistance and patient authority: A psychodynamic perspective on treatment resistance. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 34*(2), 1-18.

San Migeul, S. K., Morrison, G.M., & Weissglass, T. (1995). The relationship of sources of support and service needs: Resilience patterns in low income Latino/Hispanic families. In H. I. McCubbin, E. A. Thompson, I. A. Thompson, & J. E. Fromer (Eds.), *Resiliency in Native American and immigrant families* (pp. 385-400). Thousand Oaks: Sage Publications.

Santisteban, D. A., Szapocznik, J., Perez-Vidal, A., Kurtines, W. M., Murray, E. J., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology, 10*(1), 1-27.

Sori, C. F., Dermer, S., & Wesolowski, G. (2006). Involving children in family counseling and involving parents in children's counseling. In C. F. Sori (Ed.), *Engaging children in family therapy: Creative approaches to integrating theory and research in clinical practice* (pp. 139-157). New York: Routledge/Taylor & Francis Group.

Szapocznik, J., Hervis, O., & Schwartz, S. (2003). Engaging the family into treatment. *Therapy manuals for drug addiction: Brief strategic family therapy for adolescent drug abuse* (pp. 43-53). Washington, DC: National Institute of Health.

Webb, N. B. (2003). *Social work practice with children*. New York: The Guilford Press.

Weidman, A. A. (1985). Engaging the families of substance abusing adolescents in family therapy. *Journal of Substance Abuse Treatment*, *2*(2), 97-104.

Appendix A

HSR Approval Letter

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 15, 2008

Sarah Crane

Dear Sarah,

Your second set of revisions has been reviewed and all is now in order. We are now able to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Marian Harris, Research Advisor

Appendix B

Permission Letter from Agency

Children's Treatment Programs

CATHOLIC COMMUNITY SERVICES
of King County

November 26, 2007

Chairperson, Smith College SSW Human Subjects Review Committee
Lilly Hall
Northamton, MA 01063

Dear Chairperson,

I am aware that Sarah Crane is interested in surveying clinicians in our Children's Treatment Program, at Catholic Community Services, as a part of her Masters in Social Work thesis. I give permission for Sarah to do this. I understand that I retain full responsibility for the clinicians in our program.

We do not have our own Institutional Review Board at Catholic Community Services. Thus, I am requesting that the Smith College School for Social Work conduct a review on a consultation basis. Thank you.

Sincerely,

Susan Mowrey

Susan Mowrey, MA, LMHC
Children's Treatment
Program Manager
206-328-5906

100 - 23rd Avenue South • Seattle, WA 98144-2302 • *Phone:* (206) 323-1950 • *Fax:* (206) 328-5909 • *TDD:* (206) 328-5646

A United Way Agency

Appendix C

Informed Consent Form

Dear Social Worker or Psychologist:

My name is Sarah Crane. I am conducting a study of clinical social workers and psychologists as part of my Master of Social Work thesis at Smith College School for Social Work. My research will gather information about how therapists describe their practices with resistant caregivers, and the theoretical implications of this information.

You are being asked to participate in this study if meet all of the following inclusion criteria:

1. Have an M.S.W. or a Ph.D. in psychology;

2. Are currently employed in an outpatient clinic or private practice or have worked in one of these settings no more than five years ago;

3. Have five or more years of post-licensure experience in the field of social work, or five or more years of experience in the field of psychology since completing a Ph.D.;

4. Currently work with children or adolescents, or have worked no more than five years ago with children or adolescents;

5. Have been trained in psychoanalytic/dynamic theory, and/or behavioral theory (cognitive, dialectical, and/or rational emotive) and/or family systems theory.

6. Are fluent in English

If you meet the above criteria and agree to participate, you will complete a survey via the online tool Survey Monkey. The survey will have both fixed and optional, open-ended questions. Questions will ask how greatly you value engaging caregivers, including resistant caregivers, whether and how you directly and indirectly address resistance with a resistant caregiver, and whether and how you think your theoretical orientation informs your beliefs and practices in this area. The questionnaire will take approximately 10-15 minutes to complete.

Your participation is voluntary. You will receive no financial benefit for your participation in this study. There is a chance that answering these questions will remind you of difficult treatment scenarios and cause you distress. However, you may personally or professionally benefit from knowing that you have contributed to the knowledge in the field around these treatment issues.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. To protect your confidentiality, Survey Monkey will code your survey with a number and remove your name as soon as it is completed. An electronic version of your survey will be kept only on my personal computer. In addition, a hard copy of the survey will be stored in a locked file for a maximum of three years. Your name will never be associated with the information you provide in the questionnaire. The data may be used in aggregate in other educational, professional publications and activities as well as in the preparation for my Master's thesis.

This study is completely voluntary. You are free to decline to answer any question. You may also stop taking the survey part way through by clicking on the "exit survey" button, and all data relating to you will be destroyed immediately. However, once you submit the survey, you cannot withdraw from the study, since this is an anonymous survey.

BY RETURNING THIS QUESTIONNAIRE, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

If you have any questions about any aspect of the study, please contact: Sarah Crane at ******. If you have concerns about your rights as a research subject, you are encouraged to call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

If you have consented to participate in this survey, please click here to begin.

FORWARD BUTTON TO FIRST PAGE OF SURVEY

Appendix D

Survey

Demographic Information

Gender

_____ Female
_____ Male
_____ Transgender/Gender Queer (please specify)

Race/Ethnicity

____ African American/Black
____ Alaskan Native/Native American
____ Asian American
____ Caucasian/White
____ Native Hawaiin/Other Pacific Islander
____ Multi-Racial (please specify)
____ Other (please specify)
____ Hispanic/Latino/Latina
____ Non-Hispanic/Non-Latino/Non-Latina

Age: ____

Annual Income:____

Education and Employment Information

Total years of practice experience: _____

Years of practice experience post-licensure:_____

Theoretical Orientation(s) of graduate school or other training

_____ Psychodynamic/Psychoanalytic
_____ Behavioral (Cognitive or Dialectical)
_____ Structural (Family Systems)

Theoretical Orientation(s) currently using in work with clients

_____ Psychodynamic/Psychoanalytic
_____ Behavioral (Cognitive or Dialectical)
_____ Structural (Family Systems)

Education

____ M.S.W.
____ Ph.D.

Current Employment

____ Agency
____ Outpatient Clinic
____ Outpatient Hospital
____ Private Practice
____ Other (please specify)

Current Population(s) Serving *via Clinical Sessions*

____ Children
____ Adolescents

____ Adults
____ Families

Clinical Practice Data

Please respond to the following questions regarding your experience/practice with caregivers (parents, grandparents, etc.) of children and adolescents. Please do not use names or identifying information of any cases you might use as examples in your responses.

1. It is important to engage a child or adolescent's caregiver in his/her treatment.
____5 – Strongly Agree
____4 – Agree
____3 – Neither Agree nor Disagree
____2 – Disagree
____1 – Strongly Disagree

2. When a child or adolescent's caregiver is resistant to being involved in their child's treatment, it is important to engage that caregiver into his/her child's treatment.
____5 – Strongly Agree
____4 – Agree
____3 – Neither Agree nor Disagree
____2 – Disagree
____1 – Strongly Disagree

3. Do you directly address resistance/non-compliance with a caregiver? If so, how do you do this?

4. Do you indirectly address resistance/non-compliance with a caregiver? If so, how do you do this?

5. Do you think your theoretical orientation informs how you perceive or approach caregiver resistance? If so, how?

Appendix E

Recruitment Letter

Dear Social Worker or Psychologist,

My name is Sarah Crane, and I am a second year MSW student at Smith College School for Social Work. I received your name and contact information through A) Marian Harris, my thesis research advisor or B) Susan Mowry, director of the Children's Treatment Program at Catholic Community Services. (Indicate in each letter one or other, depending upon respondent.) I am writing you to tell you a bit about my research and ask for your help in it.

I am eager to explore the little-studied area of how clinicians approach caregivers who resist involvement in their child or adolescent's treatment. I am distributing a brief (10-15 minute) survey to clinicians to find this out. You may be a good candidate for my research.

I am looking for clinicians who meet all of the following criteria:

1. Have an M.S.W. or a Ph.D. in psychology;

2. Are currently employed in an outpatient clinic or private practice or have worked in one of these settings no more than five years ago;

3. Have five or more years of post-licensure experience in the field of social work, or five or more years of experience in the field of psychology since completing a Ph.D.;

4. Currently work with children or adolescents, or have worked no more than five years ago with children or adolescents;

5. Have been trained in psychoanalytic/dynamic theory, and/or behavioral theory (cognitive, dialectical, and/or rational emotive) and/or family systems theory.

6. Are fluent in English

If you meet the above criteria and are interested in participating, please click on the link to my site on Survey Monkey below. First you will be taken to the Informed Consent form. If you sign this form, you will then be guided to the survey itself.

LINK TO SURVEY

Feel free to e-mail with any questions or concerns.

Thanks very much for your consideration.

Sincerely,
Sarah Crane

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 15, 2008

Sarah Crane

Dear Sarah,

Your second set of revisions has been reviewed and all is now in order. We are now able to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman | fhcw

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Marian Harris, Research Advisor

Children's Treatment Programs

CATHOLIC COMMUNITY SERVICES
of King County

November 26, 2007

Chairperson, Smith College SSW Human Subjects Review Committee
Lilly Hall
Northamton, MA 01063

Dear Chairperson,

I am aware that Sarah Crane is interested in surveying clinicians in our Children's Treatment Program, at Catholic Community Services, as a part of her Masters in Social Work thesis. I give permission for Sarah to do this. I understand that I retain full responsibility for the clinicians in our program.

We do not have our own Institutional Review Board at Catholic Community Services. Thus, I am requesting that the Smith College School for Social Work conduct a review on a consultation basis. Thank you.

Sincerely,

Susan Mowrey

Susan Mowrey, MA, LMHC
Children's Treatment
Program Manager
206-328-5906