SEMINAR DAY 2

The Death of Resistance*

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For any conceptual distinction to be useful (5) within the field of family therapy, it needs to lead to some clear answers to the question: What does this distinction mean for clinical practice?

The distinction between (a) the family-as-a-system, and (b) family-therapy-as-a-system leads to a clinical perspective, or stance, that includes a focus on changing. Once this focus is clear, the therapist can help to create the expectation of changing and consequently promote changing. That is, techniques can be developed using positive feedback loops.[1] Moreover, this distinction leads to a therapeutic stance in which not *changing is a surprise.*

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SINCE THE BUSINESS of family therapy is generally thought of as change, the conceptual scheme a therapist uses must include some theory, or at least speculations and ideas, about how to bring about processes of changing in families. As family therapy started to develop, therapists began to describe families as "systems." Although the term is still in common use in the field, it may now mean different things to different therapists.

The notion, or metaphor, of system—as borrowed by family therapists—was based on von Bertalanffy's formulation of an "open system." This concept, according to Wilden (14),

> which has been so important for the development of a systemic perspective, is, in fact, relatively closed. In von Bertalanffy's conception, the "environment" is in essence a kind of passive "ground" in which the "organism" (figure) moves. [p. 39]

Thus, it is not surprising that the idea of von Bertalanffy's relatively closed system was carried over into family therapy in the early days.

Included in this model was the concept of "homeostasis," which was often described as restoring the system to its status quo, thus keeping the patient "sick" (9). Homeostasis was described as maintained by "homeostatic mechanisms," which Wilden (14) views as similar to the idea of a closed loop

> like Ashby's unfortunately labeled "homeostat." Ashby's machine is restricted to random search for stability: it has no memory and it cannot learn. It is in essence a closed system because it is closed to information and control and open only to energy. It is in essence its own environment; it seeks the equilibrium of mechanics. [p. 375]

* This is the sixth version of a paper originally written in 1979.

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[1] It is important to remember throughout this essay that "positive" and "negative feedback loops," "deviation-amplifying," "deviation-counteracting processes," etc., are just heuristic devices or metaphors. Human systems do not *have* such *things*. Human systems are described by an observer "as if."

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As such, this interpretation of "homeostasis" fits the more or less closed system concepts of family systems thinking based on von Bertalanffy's conception. Thus, family systems theory, and therapy derived from it, are based on a mechanical notion of how things remain the same. As Speer (11) points out, change cannot be explained by homeostasis, and he notes the profound irony of founding an approach to therapeutic change on a theory of how systems do not change.

Family therapy developed within the larger context of psychotherapy, and this interpretation of homeostasis fit neatly into the clinical concept of "resistance" or "resistance to change." The idea was that the family-as-a-system seemed to maintain the status quo through deviation-counteracting processes. The changes in the family-as-a-system were seen as mutual, causal, negative feedback loops (10) that kept the changes within certain limits and constraints. To develop and clarify this concept, it was necessary to draw a methodological boundary around the system under consideration (the family). It was then possible to describe the system's behavior in such a way that "homeostatic mechanisms," or negative feedback loops, could be seen as if functioning to keep the "schizophrenic" schizophrenic. The changes within the system's constraints (first-order change [13]) can be seen as differences that do *not* make a difference (1): changes that seem to keep the system within limits. Systemic changes that go beyond the homeostatic plateau (14) either destroy the system or restructure it. The latter type of changes (second-order changes) are differences that make a difference (1).

This methodological boundary around the family-as-a-system becomes a barrier, however, when the description moves up to the next level of complexity: family-therapy-as-a-system (5). On this level, where the focus is therapeutic change, it is necessary to draw the methodological boundary around the therapeutic system, which is composed of the family subsystem and the therapist subsystem. In this way, each subsystem is seen as part of the other subsystem's ecology and thus both become part of a more complex suprasystem. Within this methodological boundary, each subsystem can be described as an open system. To be open means that there is an exchange of information between component subsystems *and*, as Buckley (3) points out, both subsystems and the suprasystem need to be able to change in order to survive.

Since the therapeutic focus of study is *change*, this level of description can be organized around the concept of "morphogenesis" introduced by Maruyama (10). Once a system

> is kicked in the right direction and with sufficient initial push, the deviation-amplifying mutual positive feedbacks take over the process, and the resulting development will be disproportionally large as compared with the initial kick. [p. 166]

The need for a concept of morphogenesis in systemic thinking was further elaborated by Speer (11) and by Buckley (3) as a means of

> dealing with the sociocultural system [because] we jump to a new system level and need yet a new term to express not only the *structure-maintaining* feature, but the *structure-elaborating* and *changing* feature of the inherently unstable system. [p. 15]

To ignore this openness and increased complexity involves the imposition of closed-systems thinking on those aspects of the system under consideration that are open systems. Furthermore, when whole systems, or ecosystems, are split into supposedly independent parts or units, the difference between the components of a whole are reified into "imaginary oppositions" (14), which can lead to attempts to

pply traditional lineal thought to those spects of an ecosystem that have circular, r even more complex, chains of determi- ation.

The concept of resistance locks many amily-systems–based therapies into the revailing epistemology of linear causa- ion, "force," or "power," because it implies separation between the therapist and the amily system. When homeostasis is used s the organizing concept on this more omplex level, the "resistance" is seen as ocated in the family and is described as omething the family is doing. It is not seen s a product of therapist-family interac- ion. This is an "entity-oriented" descrip- ion rather than pattern-oriented and urns the therapist and the family into pponents. That is, the methodological oundary necessary for one level (the study f the family-as-a-system), when carried to he next level (the study of family-therapy- s-a-system), becomes a barrier preventing ny pattern-oriented descriptions of the ntertwining and emerging suprasystemic nteractions.

If these distinctions (family-as-a-sys- em ↑ family-therapy-as-a-system, homeo- tasis ↑ morphogenesis) are to be useful linically, then behavior that is commonly abeled as "resistance" can be usefully re- escribed. One way of doing so is to concep- ualize or think in terms of "cooperating":

> Each family (individual or couple) shows a unique way of attempting to cooperate, and the therapist's job becomes, first, to describe that particular manner to himself that the family shows and, then, to cooperate with the family's way and, thus to promote change. [6, pp. 9–10]

(The term "cooperating" is used in an attempt to avoid reification, because the "ing" helps to keep the therapist thinking in terms of processes or continuing interaction between the subsystems, rather than the *condition* that might be implied by the use of "cooperation," which might describe a principle rather than a process. "Cooperation" tends to disconnect a "something" from its ground and makes it "thing-like": a likely process given the dominance of the old epistemology.)

These distinctions and the relationships between and among them can be mapped as shown in Table I.

That is, if one is looking at the therapy situation with homeostasis as the organizing concept, then the clinical equivalent—the concept of resistance—is reasonable and necessary because the therapist/observer is outside the methodological boundary. If the therapist is included in the description, however, then morphogenesis becomes the organizing concept, since the focus of therapy is changing. The openness of the subsystems, and their ability to change in order to survive, suggest the alternative label or clinical concept: cooperating.

An analogy may further clarify this distinction. With resistance as a central concept, therapist and client are like opposing tennis players. They are engaged in fighting *against* each other, and the therapist needs to win in order for therapy to succeed. As Berg describes it (2), "Therapy became a fight between family and therapist to see who controls the relationship, and who loses the fight and gets to go home changed as a result of defeat." With coop-

TABLE I

Distinction Between Family as a System and Family-Therapy-as-a System

	FAMILY-AS-A-SYSTEM	FAMILY THERAPY-AS-A-SYSTEM
Unit of Study	Family	Family + Therapist
Organizing Concept	Homeostasis	Morphogenesis
Clinical Concept	Resistance	Cooperating

erating as a central concept, therapist and client are like tennis players on the same side of the net. Cooperating is a necessity, although sometimes it becomes necessary to fight alongside your partner so that you can cooperatively defeat your mutual opponent. Since therapist and client are busy working together on changing, which involves the systems' deviation-amplifying processes, the systems' deviation-counteracting processes can be viewed as their mutual opponent.

Family therapy is more complex than some simple ideas about morphogenesis, because human systems are not completely open to their environment; they are only comparatively open. Without some sort of deviation-counteracting processes, a human system with a positive feedback loop with its environment could change simply because any change in the environment would produce change in the system's structure, which in turn would produce similar changes in the environment, which would lead to similar changes in the structure, and so on and on. Clinically, this does not seem to be the case. Some messages from the family system's environment (i.e., therapeutic interventions) seem to promote changing, whereas others do not. That is, human systems can be described as involving both negative and positive feedback loops. The level of systemic description strongly suggests or even determines which metaphor is more useful.

Clinical Implications

Previously a decision tree (6) has been described for helping the therapist describe the evolving, cooperating relationship between the therapist subsystem and the family subsystem. That is not all there is to the concept, however. It implies and suggests a specific stance for the therapist to take during the session. Certain techniques can be used to promote cooperating and to promote changing. These techniques can be useful in helping the family and therapist subsystems develop ways of working together that are therapeutically beneficial.

A Present and Future Stance

According to Milton H. Erickson (7),

> the purpose of psychotherapy should be to help the patient in the most adequate, available and acceptable fashion. In rendering him aid, there should be full respect for and utilization of whatever the patient presents. Emphasis should be placed more on what the patient does in the present and will do in the future than on a mere understanding of why some long-past event occurred. *The sine qua non of psychotherapy should be the present and the future* adjustment of the patient (italics added). [p. 406]

Haley described Erickson's application of this future focus in therapy.

> Erickson appears to approach each patient with an expectation that change is not only possible but inevitable. There is a sureness which exudes from him, although he can be unsure if he wishes, and an attitude of confidence as if it would *surprise* him *if change did not occur* (italics added). [8, p. 535]

Although Erickson probably had different assumptions behind his focus on the present and future of his patients and on the inevitability of changing, his therapeutic stance seems related to a Buddhistic notion about changing. For the Buddhist (12), changing is a continual process and stability is an illusion or a memory of one moment during the process of changing. Again, in Batesonian terms (1), there are differences (changes) that make a difference, and there are changes that do not make a difference. In the latter case, some changes are not perceived as differences because they are so small that they contain no news of difference: the illusion of stability.

Within a framework in which not chang-

ing would be a surprise to the therapist, any response a client makes to an intervention is seen as useful (6). As Erickson said:

> Any of the possibilities constitute responsive behavior. Thus a situation is created in which the subject client can express his resistance in a constructive, cooperative fashion; manifestation of resistance by a subject is best utilized by developing a situation in which resistance serves a purpose. [7, p. 20]

In Erickson's view, "resistance" is cooperative: it is one of the possible responses people can make to interventions.

Techniques

It is part of the therapist's task to help define the context of therapy and to do so with the family. The therapist's behavior can be seen to depend on his stance. He can also help to create certain expectations, and such expectations, once formed, help to determine what one sees as happening and therefore what *is* happening. This line of thinking suggests that interventions like the following homework assignment can help define therapy as changing-oriented, and as present- and future-oriented:

> Between now and next time we meet, we (I) would like you to observe, so that you can describe to us (me) next time, what happens in your family that you want to continue to have happen.[2]

This intervention is an attempt to define therapy as dealing with the present and the future, rather than the past. It attempts to define the family's situation as one in which the therapist expects something worthwhile to happen and continue to happen. Frequently this assumption is the opposite of what the family expects to happen. From this perspective, the assignment lets the family know that the therapist expects changing and that he is confident that changing will occur. Furthermore, this assignment is an easy task for the family to cooperate with since it does not seem to call for anything different. The therapist does not ask for, request, demand, or suggest any changes—just some observations of what happens. This is something the family will do anyway, and the task attempts just to direct the focus of their observation.

To further promote this changing-oriented context, the therapist can receive any and all reported responses to this sort of assignment as *changes* or *news of difference*. The therapist, using this future and changing-oriented stance, needs to indicate that he expects things worth continuing to have happened. Therefore, his question should not be "Did you do the homework?" but rather, "What happened that you want to continue to have happen?" No matter what the family then describes, the therapist can attempt to label the happening as "a change." Even if the family corrects him, the frame of expected change is still established. Sometimes the family might report that "nothing has happened that they want to continue to have happen," and the therapist—who, taking this stance, is so sure of change—can be honestly surprised by this report, and the expectation of changing is created nonetheless.

The form the therapist's questions take during the session can also be used in promoting the expectation of changing. For instance, it is a question of *when* the changes will happen, not *if*. Therefore, the therapist might ask, "What do you think mother will do *when* you stop wetting the bed," rather than "*if* you stop wetting the bed." *When* assumes changing, whereas *if* is conditional. Or, the question is not, "How are you going to overcome the temptations to overeat," but rather "What are

[2] This task was jointly designed by the author, Marilyn La Court, and Elam Nunnally. The responses to this invariant homework assignment are currently being studied at the Brief Family Therapy Center.

you going to do when you overcome the temptations to overeat?"

The reverse choice of words can be used when the therapist wants to indicate his concern about a "relapse." This, of course, is an important area of concern within a context oriented to changing. When expressing concern about the likelihood of a relapse, the question should be *if* and not *when*. The therapist might ask: "What might you do if the bed-wetting were to start again?" and not "when it starts again." The "if" makes it conditional and not too likely. To further promote the expectation of continued changing, the relapse (should it occur) can be framed as "part of the normal process of change: two steps forward and then one back." To keep the relapse within a context of promoting changing, the following *relapse warning* can be usefully given once a change has occured:

> As I see it, progress in solving problems is normally a two-steps-forward-and-then-one-back kind of thing. There is some chance that the bed-wetting might start again, but it might not. If it should start again, it is important to remember that it is only one step back; it is a perfectly normal thing to happen. So I would like you to think about what different thing you might do if the bed-wetting should happen again.[3]

There are times when the therapist needs to be unsure, doubtful, and skeptical, particularly when the therapist is only being more unsure, more doubtful, and more skeptical than the family members. Again, using this stance, the therapist's uncertainty is not about *if* change will happen, but rather *when* will changing start—sooner or later, or who in the family will change first, or what kind of change it will be. That is, the therapist can remain optimistic about the possibilities of changing but be pessimistic (4) at the same time about the speed of changing or the effects of changing.

Like any other approach to therapy and any other stance the therapist might choose, this approach can fail. The therapist and the family might be unable to find a way or construct a way of cooperating, and no useful pattern develops during the attempt at therapy. The therapist might find himself unable to promote the expectation of changing in such a way that it is useful to a particular family. Finally, a focus on an individual's problem (self-starvation, bed-wetting, depression) can sometimes lead to failure when the "problem" blinds the therapist to the patterns involved and therefore limits the options for cooperating and changing.

Conclusion

Once the distinction is drawn between the family-as-a-system and family-therapy-as-a-system (5), the therapeutic focus on changing becomes more clear. That is, changing is a process or processes that involve cooperating between the two subsystems of the therapeutic suprasystem. Within this framework, once changing is seen as inevitable, the therapist's stance of expecting changing and promoting changing can be useful in helping the family to solve the puzzle that brought them to therapy. Techniques can be designed to help the family create their own expectations for changing. Once created, such expectations help to determine what is seen to happen and therefore what is happening. This approach can be seen as building on the deviation-amplifying processes of the system.

Therefore, the therapist's stance is not *if* change will occur, but rather *when*, or *where*, or *what type of* changing will occur. A concept of "resistance" within this framework would hinder and handicap the therapist because it implies that change is not inevitable, setting up a contest between

[3] The responses to this task are also the subject of study at BFTC.

changing and nonchanging. Within Buddhistic thought, this contest would be seen as an illusion. Of course, therapists who build a model on resistance can still view change as possible or probable or even inevitable *after* the resistance is dealt with. However, this seems to involve the therapist in mental gymnastics because of the necessity of leaping from descriptive level to descriptive level.

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RESISTANCE REVISITED: TALES OF MY DEATH HAVE BEEN GREATLY EXAGGERATED (MARK TWAIN)

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There is something perverse in asking two terminal pragmatists to review an article as theoretically oriented as Steve de Shazer's "The Death of Resistance." Nevertheless, in the belief that theory and practice, while not necessarily wedded are at least related, we offer the following thoughts.

We must confess to some initial shock at de Shazer's proclamation that resistance is dead. We thought we had seen it just last week, alive and looking amazingly healthy. If de Shazer's report is not wishful thinking, its death is certainly an untimely one. The concept of resistance has barely been retrieved from the long forgotten trash heap where the forefathers of family therapy left all the old concepts associated with psychoanalysis. We were just looking over the notion, thinking there might be something useful and worth preserving, albeit in

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