Resistance in Existential-Strategic Marital Therapy:
A Four-Stage Conceptual Framework

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Based on an integration of strategic and existential approaches, the author defines resistance as discussed by Ackerman, Whitaker, and Bugental. She outlines a four-stage intervention system employing strategic techniques within an existential framework. A case of a multiproblem couple illustrates the concepts.

Resistance to change—friend or foe? A two-faced Janus created by the human spirit to frustrate psychotherapists? No dialectic in the psychotherapy process is more fundamental: The tension between stability and change forms a grounding concept in both strategic and existential family therapy. Indeed, Freud's (1974) discussion of the life forces and death forces, Sartre's (1947) conflict between activism and quietism, or Tillich's (1952) varieties of existential anxiety relate to fundamental conflict between the tendency in interpersonal systems to preserve what is and the resourcefulness to strive for what could be. As observers described of clients seen by Olga Silverstein, "The family was caught in a reality where change prescribed stability and stability prescribed change" (Keeney & Ross, 1985, p. 184). Watzlawick, Weakland, and Fisch (1974) begin *Change* with the French proverb, "Plus ça change, plus c'est la même chose." They explain:

> The French proverb according to which the more something changes the more it remains the same is more than a witticism. It is a wonderfully concise expression of the puzzling and paradoxical relationship between persistence and change. It appeals more immediately to experience than the most sophisticated theories that have been put forth by philosophers, mathematicians, and logicians, and implicitly makes a basic point often neglected: that persistence

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> and change need to be considered together, in spite of their apparently opposite nature. (p. 1)

The authors later comment further on the stability-change dialectic, as they, and the strategic family therapy school, see it:

> Resistance to change can be turned into an important vehicle of change. This can best be accomplished by reframing the resistance as a precondition for, or even an aspect of, change. A few examples will illustrate this.
>
> Uncommonsensical as it may seem to the layman, quite a few people seem to enter therapy not for the purpose of resolving a problem and being themselves changed in the process, but behave as if they wanted to defeat the expert and presumably "prove" thereby that the problem cannot be solved, while at the same time they clamor for immediate help. (p. 133)

Anderson and Stewart (1983) summarize the position taken on resistance by various family therapy schools. The authors define resistance as "all those behaviors in the therapeutic system which interact to prevent the therapeutic system from achieving the family's goal for therapy" (p. 24). Although they cite conceptual differences that they presume to exist between the schools, they and this author agree that theorists seemingly very different from one another, representing psychodynamic and strategic viewpoints, "regard resistance as highly significant" (p. 13). The authors include the existential position by quoting Whitaker and Keith's statement that they have trouble with the concept of resistance. The authors elaborate more on the strategic position, in which the therapist takes enormous responsibility for change. Seemingly these views are diametrically opposed. Or are they?

This article demonstrates, through conceptual material and clinical case example, that a judicious integration of the approaches of existential and strategic family therapy can provide maximum positive use of resistance while keeping its negative face turned firmly away. Existential and strategic theories of psychotherapy share a conviction in the centrality of resistance in the change process. Both schools view resistance in the change process. Both schools view resistance as a constructive force in the psychotherapy relationship. The use of existential psychotherapy in conjunction with strategic therapy allows the therapist to engineer the couple's or family's resistance to the most advantageous position for change. A greater variety of options becomes available to channel a fear of change into the impetus for change. Following a brief description of the strategic and existential positions on resistance, this article presents a four-stage model to deal with resistance. The model integrates the positions enumerated below in a practical manner that can facilitate treatment planning by being teachable and learnable.

STRATEGIC VIEWS OF RESISTANCE

The Ackerman Family Institute, founded by Nathan Ackerman, is a center for strategic family therapy. A pioneer in the field, Ackerman understood resistance from a psychodynamic perspective: "The striving for a state of static equilibrium can be understood as . . . a defensive avoidance of shock and frustration, or as an escape from psychic pain" (1958, p. 72).

Describing Carl Whitaker, a major figure in existential family therapy. Neill and Kniskern (1982) mention Ackerman's use of indirection and paradox.

> Nate was an expert in the put-on. I help the family get confused, and I frequently help them sense the fact that this is what they are there for, and I'm not trying to get them anyplace, I am trying to confuse them so they won't go on the way they have been going. (p. 221)

Whitaker looks at this put-on induced confusion as a "forced transference." In this description, the relationship between strategically based interventions and a broader value system underlying existential family therapy becomes discernible.

Haley's description (1973) of Milton Erickson's fundamental approach to human problems is applicable: "What happens when one 'accepts' the resistance and even encourages it? The subject is thereby caught in a situation where his attempt to resist is defined as co-operative behavior" (p. 24). Once he is cooperating, he can be diverted into new behavior. The analogy Erickson uses is that of a person who wants to change the course of a river. If he opposes the river by trying to block it, the river will merely go over and around him. But if he accepts the force of the river and diverts it in a new direction, the force of the river will cut a new channel.

At Ackerman Family Therapy Institute in the 1980s psychotherapy has been problem focused. The therapeutic problem is defined by the reality frame of the family members. The therapeutic task is to achieve symptom change through strategically based systemic interventions. As Silverstein states, "During a session I am always looking to see how small elements of change can be inserted at the most fortuitous moment" (Keeney & Ross, 1985, p. ix).

Keeney and Ross (1985) discuss the cybernetic model of communication as "patterns of organization that maintain stability through processes of change" (p. 51). "A cybernetic view of therapeutic intervention suggests that a therapist mirror the multiple communications a troubled family presents. Accordingly, therapists may inform families to change and stabilize." And,

"in another way of thinking about change and stability the distinction is made between co-operation and resistance" (pp. 51-53). Here, the behavior of clients can be divided between those actions that are seen as cooperating with the therapist's efforts to promote the change and those that appear to resist proposals of change. What has traditionally been called *resistance* is now reframed as a system's proposal of stability. With a cybernetic frame of reference, it is not possible to see cooperative behavior without resistance or vice versa:

> Each is only one side of the more encompassing cybernetic complementarity of stability and change. Thus strategically trained family therapists plan and exercise therapeutic interventions which provide three communications to a family: 1) a request for change, 2) a request for stability, and 3) some meaningful noise (i.e. psychotherapy) from which an alternative structure for reorganizing change and stability can be constructed. Families themselves bring all of these communication resources to therapy. (pp. 55-57)

EXISTENTIAL VIEWS OF RESISTANCE

Whitaker, in a typically existential manner of thought, stresses the necessity of despair in promoting human change. "Augmenting the despair of a family member so the family will unite around him" is one of the seven techniques of marital-family therapy from a symbolic-experiential perspective (in Neill & Kniskern, 1982, p. 349). However, Whitaker has trouble with the word resistance: it implies that the therapist must do something about it. He prefers to think of it as differential motivation for change, or absence of desperation.

> One way to induce desperation is to move to the negative side of the ambivalence and often to end the therapy so the family can reunite after they get rid of the therapist . . . another move is to augment the differences and suggest that the family members cannot really get together as long as they are clearly fighting each other. (Neill & Kniskern, 1982, p. 351)

But, whatever the specific interventions employed, Whitaker is definite that a family changes when there is nothing left to do and that the family has the capacity to grow:

> When I meet with a family, I am absolutely certain that they have the capacity to struggle and grow. There is no need to assess or evaluate this. I know it is possible. The real question becomes one of courage. (Whitaker & Bumberry, 1988, p. 20)

Central to the themes of individual existential psychotherapy is Whitaker's commitment to psychotherapeutic intimacy: the necessity for the therapist to be a person. For Whitaker, in effect, the dynamics of the therapy are in the person of the therapist.

> One can deal with the family . . . by manipulative intervention in the social structure of the family and its environment. . . . Therapists must decide for themselves and with each individual family whether they will work on the level of such intervention for symptom relief or whether they would prefer to invest the time and struggle to demand the maximal growth of the family in all dimensions available (Neill & Kniskern, 1982, p. 285)

To get a clear statement of the existential stance in relation to resistance, it is helpful to go outside the family therapy community and to attend to the thinking of James Bugental. This commitment to therapeutic intimacy that is central to the existential position is detailed by Bugental (1981, 1984). Describing the therapists' *Pov Sto* (place to stand, base of operations), Bugental states: "We are not consultants in how to live. We can be consultants in how to use our capacities to better guide our lives" (1984, p. 15). Comparing six levels of counseling/psychotherapy, Bugental reports that, in its deepest form, change is evocative in nature, that the therapeutic alliance is one of "companions in the unknown; and that the growth process becomes a major life commitment, even after therapy ends" (p. 9). A central concept in this transpersonal therapy is that of resistance.

> Perceptions of the psychotherapy client's "resistance" as being opposition to therapy or as being neurotic or as being something which must be overcome, analyzed away, or circumvented—such perceptions themselves are countertherapeutic. . . . Our lives, our well-being require that we maintain a measure of continuity in our way of living in the world and that we develop a repertoire of skills for responding to our existential needs. . . . Therapists must find ways of supporting this capacity to maintain continuity and must abandon efforts to undermine it. (p. 358)

Offering three suggestions in dealing with resistance, Bugental stresses the need for the conviction that the client can protect what is threatening while yet relinquishing what is threatening or crippling the patient's well-being. In other words, Bugental is hopeful that resistance can remain useful to therapeutic growth throughout the process of change.

Existential and strategic schools of psychotherapy share a fundamental conviction in the centrality of resistance in the change process, and its usefulness as a constructive force in the psychotherapy relationship. The dialectic between stability and change is central in individuals, couples, and

families. The use of the therapist as a catalyst is also common to both approaches, although utilized with differing emphasis by each.

When the therapist works systematically, a greater variety of options is available to channel this very natural fear of change into the impetus for change. This article presents four stages in dealing with resistance: All are teachable and learnable. These stages integrate the positions described above in a practical manner that can facilitate treatment planning by being teachable, learnable, and recognizable.

FOUR STAGES IN HANDLING RESISTANCE AND CASE DISCUSSION

Stage 1: The Halo Effect and Cynical Disbelief

Resistance on an unconscious level often begins prior to the first telephone call to the therapist and may be implicit in every fantasied or actual therapist-family interchange from then on. Unless the therapist is on the lookout for signposts of this process, she may miss out on a very important part of engaging a family in therapy. Stage 1 is a dialectic (i.e., it consists of complementary and opposing processes) The halo effect is an imaginary fan club for the chosen therapist that can sometimes be discerned in the enthusiastic voice of a potential client. Most clients, unless assigned a therapist by an agency, choose their therapist. Perhaps a friend has said, "Dr. X has an excellent reputation," or "Dr. Y is a real mensch." Or a colleague refers a client because Dr. Z specializes in one disorder or another. All are variations on a theme—the theme of hope—hope that the new therapist will work magic. Hope that this therapist will do for a family or for an individual that which the family has been unable to do for themselves.

Simultaneously, however, every client comes to a therapist with a healthy and natural dose of cynicism and doubt. Although the words are rarely stated, if one listens to the undertones, one hears refrains of "What is all this business about family therapy anyway?" or "You charge *how* much?" or "You don't really think that people change do you?" Clients will openly state the halo effect message of "It was so hard to get an appointment with you" or occasionally the mixed message of "I hope you're as good as everyone *says*." But rarely will anyone dare to speak aloud the other secretly felt challenge: "We really don't think you can do anything for us, but go ahead and try." This author is convinced that the dialectic between wishing and being afraid, between longing and despair, forms the earliest stage in the resistance-change dance. Recognition and acceptance of the dynamic gives a therapist a window into the ambivalence of the family beginning treatment.

The Case Introduced

Harrison and Margaret met at a New England college, where both got B.A. degrees and Harrison went on for professional training. Handsome, tall, clean-cut people of English heritage, they seemed to all observers a well-matched, if not enviable, pair. They married after college in the early 1960s and at seemingly developmentally ideal junctures. They had a son and then a daughter, completing a close approximation of the model family as postulated by sociologist Talcott Parsons. The family settled into an affluent section of the Delaware Valley, and Harrison went through a series of promotions in his chosen career. This upper-middle class, Norman Rockwell-type family was only the cover for intense pain by all members. Within months after the wedding, Margaret began to cry to herself about her inability to experience Harrison as a caring lover. Although he said that he adored her, attempts at lovemaking were fraught with his difficulties in maintaining an erection and nonresponsiveness on her part. The inability of the couple to discuss the issue magnified the problem. As Margaret became quieter and less sexually responsive, she felt more guilty. Harrison became harsher, more demanding, and felt more righteous. Thus the family continued for two decades: They raised "model" children who were clinically depressed and underachieving. Margaret went to graduate school and on to a good professional career. They socialized in a bright and sparkling network. They lived in silent and isolated misery from one another's passions.

Five years before the first contact with this author, Harrison became severely depressed and entered individual psychotherapy. Concomitantly, the couple was referred to a marriage counselor. Neither therapy nor counseling was successful. Antidepressants were added for Harrison shortly thereafter, and Margaret determined not to leave the marriage as long as Harrison was depressed and the children were not doing well in school. With this history, the first telephone call was placed by Harrison's individual therapist to this author, the second family therapist to be approached within four years.

Margaret carried the halo effect with politely stated accolades like "We've heard a lot about you" and "You are highly credited." Harrison carried cynical disbelief openly for the couple, saying to the author: "We can't do anything here unless you can get Margaret to talk. She only cries when I talk to her." Although Harrison was quite concerned about his son's underachievement, he refused the author's recommendation to "have the children join us" and said, "Let's see how we do here before we include the children." In the language of resistance, Harrison was saying, "I want to see how good you are before I expose my innocent children to you." He also stated clearly that

earlier therapy had not helped and that the problem in the marriage was that he was depressed, which needed to be treated medically not with psychotherapy.

The challenge to the therapist was obvious. To accept their heroine worship would have been as serious a therapeutic error as to have engaged in verbal battle about therapist competence or patient motivation. Instead, this author concentrated on listening to the by-now-familiar themes in all psychotherapeutic beginnings—ambivalence about trusting the change process and about the therapist as change agent.

It is possible for a couple to "split the ambivalence." In this case, the dialectic was neatly packaged: One partner carried the halo and one partner carried the cynicism. In most couples and families, each member carries a percentage of each sentiment. For example, a woman calls to say, shamefacedly, that her son refuses to come and isn't it awful? This is a typical Stage 1 dilemma: embarrassment over one's cynicism toward the therapist, and toward one's own capacity to change, is projected onto a symptomatic member who is labeled "bad" for being unwilling to enter into the heroine worship, feigned but not sincerely experienced, by the "highly motivated member."

The author chose a multifaceted intervention for Margaret and Harrison: First, she briefly initially engaged the couple at a level of comfort for them (the level of social banter) in order to decrease awkwardness at discussing "private" matters. Second, she decided to sidestep confronting the cynicism prematurely. She handled matter-of-factly the worshipping and disparaging projections onto the therapist. Thus she reported to Harrison that "most psychiatrists do not recommend medication unless there is an ongoing psychotherapy relationship" and told the couple the reasoning for this position.

Stage 2: Joining the Couple and Reframing the Problem

Working actively with therapeutic resistance is central to emotionally allying oneself with an individual client or a client system. Whitaker "joins" through an out-and-out "battle for structure," in which a family's willingness to bring in all members becomes a metaphor for the commitment to psychotherapy. This author chose a gentler method of negotiation and opted to communicate with the couple at its level of readiness as a method of increasing therapeutic trust. Because Harrison and Margaret were socially very comfortable and skillful, the therapeutic key in joining the system was to spend the first and the last few minutes of each session in social pleasantries—inquiring where vacations were spent or commenting about restaurants or clothing styles. Allowing the couple to begin and end therapy

as a "social call" enabled the couple to slide into a solid 40 minutes of therapeutic engagement in a manner safe enough for them to facilitate increased therapeutic "steam" and commitment. During this period, Harrison would say that he liked our "visits."

The specifics of joining a family vary as greatly as the family one joins but are determined by the therapist's analysis of what makes this family tick and which strategy will enable greater therapeutic engagement. Keeping the value system and the interactional style of the family as an organizing principle, the "social call" intervention was based on this couple's British, Protestant heritage, affluent life-style, and faultless social graces. The intervention also reflected the couple's inability to engage in a mutually highly charged emotional confrontation outside of a competitive, socially sanctioned work environment. Despite a clear battle for structure around the time for sessions (no evenings were available by the therapist, and no office hours by Harrison) and members present (no children allowed), the author and the family won this round together via peaceful and gentle unstated acknowledgement of the level of intimacy the couple was capable of handling.

Therapeutic interventions in these very early sessions emphasized the strategic method of circular questioning. In circular questioning, symptom exploration is simultaneously reframed within an interpersonal context. Success in this reframing is apparent when family members begin to relate interpersonal events to their symptom (depression) or problems (no sex) with increasing spontaneity and frequency. Harrison and Margaret, like most couples, entered systems therapy with a linear causality model: "Well, if Harrison could only be less depressed and the children could do well in school, everything would be back to normal." Making therapeutic use of this resistance to thinking systemically enables clients to take responsibility for their own part in the symptom. Reducing resistance to thinking systemically minimized linearity: By inducing circularity (when Margaret cried, Harrison became harsh with his son, who in turn was unable to do his homework) and discussing interaction sequences, the therapist lays the foundation for major change later in the process. The therapist begins to reframe reality for the family turning a nonsolvable problem (medical depression) into a solvable one.

Reframing the problem became the central focus in the working (i.e., nonsocial) minutes of the initial sessions. Despite Harrison's need to deny the centrality of the interactional component in his depression, he was quite ready to blame himself for sexual impotence, temperamental outbursts, and excessive nightly alcohol intake. Margaret was ready to blame herself for crying when she needed to talk and to blame Harrison for being unsympa-

thetic to her needs for greater independence and role flexibility. Thus the mutual blame cycle became an entrance point for the therapist to begin circular questioning: "When you ask Harrison to limit his drinking, how does he react? And how do you handle his reaction?" or "When you offer to take the kids to the doctor so Margaret can go to work, how does she react?" and "How do you handle his reaction?" This chaining of behaviors previously experienced by the couple as discrete into interactional sequences repeatedly highlighted *themes* or *patterns.* As the couple began to express therapy issues in this manner with increased frequency, their increased ability to reframe their issues into interactional terms was reinforced verbally by the therapist. "Harrison, that time you really traced the cue to becoming depressed to Margaret's unwillingness to go to the boat with you on Thursday." Thus the couple began to connect symptoms with the significant interpersonal forces that were so painful to them.

Reframing into circular thinking is an ongoing process throughout psychotherapy—it is not fully achieved before moving to Stage 3 but must be begun before interactional change can be expected. The attitudinal change that underlies the shift from linear to circular attribution of causality acts as the most frequent precursor to a readiness to change interactional behavior because it indicates a shift in attribution of meaning from a discrete to a contextual focus. This attitudinal shift is most evident in the language shift that occurs in the family's description of their discomfort, as described above. The author believes that skillful questioning in these early sessions simultaneously functions to increase therapeutic intimacy among all present and to nudge members gently into new positions of increased contextual responsibility. Stated differently, working skillfully with resistance produces early and stable systemic changes. These minute yet perceptible and palpable shifts in attitude and meaning pave the way for the more dramatic interventions and symptom shifts to follow.

Stage 3: Pulling for the Despair

Individual and family existential therapy stresses and respects the importance of despair as central in the human experience and mobilizes despair as a change carrier. Typically, as the therapy becomes less "polite," a couple begins earnestly to expect the therapist's magic to take hold and the symptom to disappear. This stubborn resilience to symptom change is what has more traditionally been called *resistance.* At this point, therapy appears more earnest, and the despair of the member is clear, as the family battles against its responsibility for change that it fears it is unable to accomplish.

Despair—the universal human condition of being emotionally ripped asunder by life's disappointments—is the existential therapist's cotherapist. Despair waits in the wings of every therapeutic session ready to provide the impetus for behavioral, attitudinal, and interactional change. But, as with other powerful human motivators, human despair must be handled with sensitivity, good pacing, and skillful timing. Knowing when to actively introduce and to discuss the despair level as part of the therapeutic encounter is primarily dependent on a therapist's sense of timing.

Margaret's evident despair, in the form of crying outbursts in the sessions, rendered this highly cultured and articulate woman an emotional infant when she needed to discuss something important with her husband. Issues not discussed were filled with desperation. She despaired that she would live her life without good sex in order to remain married. She despaired that her children were being harmed by their father's drunken temper fits, which she could only call "excessive intake." She despaired about her own lack of courage to change and her resignation to accepting financial security as an excuse for pursuing meaning in her existence. Margaret despaired about her mother's untreated alcoholism while Harrison drowned his despair in alcohol and muffled it in a depression that sometimes rendered him unable to go to work and unable to maintain the former cutting edge he had enjoyed as a competitive executive. Underneath the social banter, the language of despair lurked in the corner of every therapeutic session. "Pulling for it," engaging the couple on the level of the pain that kept them returning session after session, made them more trusting of the therapeutic relationship as a supportive contact in which to try a new way of being with each other. In Stage 3, the therapist begins to focus on what had been previously allowed to lie dormant, asking questions such as, "How long have you been convinced that sex in this marriage is bankrupt?" or "If you weren't too depressed to pull it off, what might you say to Margaret?" In this way, the despair became public for the first time. Thus a factor in this marriage previously too toxic to address became a therapeutic ingredient to be added to the social banter and circular patterning that had become trusted ways for the couple to interact in psychotherapy. As the level of mutual awareness of the despair in self and in spouse increases, the therapist's *own* despair in causing change for the couple can finally be brought into the open. Statements like, "I don't know what to tell you to do—do whatever you can" or "I wish I had the expertise to solve this for you, but your lives are in your hands" serve to increase the rising need for the couple to change—to believe something different about themselves, each other, and the marriage—and to courageously put into action their new resolve. The risk of ending a highly stable and highly

unsatisfying marriage becomes less than the risk of continuing the torture. This mutual recognition that some new behavior is better than having things stay the same, and that the new behavior must come from the couple, acts as the immediate precursor to change.

Conceptually this has elements of Whitaker's "take it or leave it therapy." The family begins to understand that the therapist is able to be only a facilitator, or catalyst. Changing is really up to the couple. And in the therapist's statement "You have to figure this out for yourself, because I can't do it for you," in this sincerely humble admission of the therapist to not being all knowing, the family learns through experience the elements that promote solid and existential change. The family learns that the therapist does not know all the answers. They also learn that the therapist knows that she does not know all the answers, and finally, the family learns that is okay. When this level of human vulnerability and acceptance is actually experienced in the therapeutic encounter, resistance has been well utilized. The couple, fed up with doing the same thing over and over, does something different.

There are any number of direct and indirect ways by which therapists can reach this level. *Sturm und Drang,* boxes of Kleenex, and beating on pillows constitute one way, but not the only way. Depending on the flavor of the moment, humor can be very effective. This therapist often acknowledges that the situation is truly "hopeless but not serious," as Watzlawick (1953) quips. Likewise, a tender and caring joining in an emotional catharsis often bathes old wounds and precipitates healing and systemic change.

Stage 4: Turning the Corner

A decision not to live unhappily ever after is a major leap of courage and faith in one's own resources. It is an "outward bound" jump into an existential unknown. Once made, after years or, in this case, decades of humdrum or painful stability, the therapeutic moment seems remarkably ordinary. Far from being experienced as "magic," the therapeutic shift is a natural "fit," a little like an old pair of jeans buried deep in one's closet, ready to be unearthed and worn well.

At times, this is reflected in a humorous quizzicalness on the part of the couple—"Gee, it really wasn't nearly as hard to change as we imagined—why didn't we do that years ago?" At other times, as in this case, the shifts are traumatic enough that the inevitable relief by all members is accompanied by considerable loss and anxiety about the future. However, a well-turned therapeutic corner results in a hard-won and permanent shift in meaning for the members. And, to borrow the Thomas Wolfe metaphor, once left behind

for new vistas, clients "can't go home again" to the previous good fit of the old symptom. The symptom actually no longer fits. Change has occurred.

Healing forces mobilized and despair in gear, Harrison and Margaret made shifts. Margaret began to be able to speak with Harrison about her concern about his drinking, which enabled him to stop ("It clashed with the anti-depressant" was the reason he gave). Both became adamant about the need for improved sex if the marriage were to continue. Margaret stated her willingness to leave the marriage if no improvements proved possible. Harrison asked to have the children join them in therapy in order not to pass down the depression to the next generation. The therapist was permitted to work with the school concerning the son's underachievement, breaking the family secret that the family was seeking "professional help." Those indicators that the couple had turned the corner of nonchange were blatant and unavoidable—sessions became spunky, even explosive, as the marriage moved to a painful but necessary end, and as each partner opened to new vistas of personal experience. A poignant and highly meaningful level of despair was reached. There was unanimous recognition by all family members that splitting up the marriage was preferable to the self-imposed jail of living together year after year.

Conclusion: Life Around the Corner

There is a clearly experienced sense of having completed "a piece of work" at this therapy juncture. Everyone knows change has occurred and each member is left to accept the consequences and to move on. There is a sense of closure on this particular therapy project, which introduces a natural decision point in the therapy. To end? To continue? To stop for a while and check in after some months or years? Various alternatives are available and need to be considered.

To end? If one contracts for brief therapy, therapy is defined as problem focused. Strategic interventions have most likely succeeded, and the problem has been altered. The system has shifted, and, far from encouraging dependency, a therapeutic decision to terminate is likely to be salutary. For example, in a case presented by Olga Silverstein to a class on strategic Family Therapy at Ackerman Institute in 1987, a marriage showed a similar dynamic to the case described here. The alcohol abuse had subsided, dramatic changes in dress were evident in the wife, and the couple was enjoying more passion. Despite obvious possibilities for further change the couple chose a tentative ending in therapy. The "door was left open" for reentry as needed, but the couple and therapist opted to let the couple "live life" with their new-found changes.

To continue? As one corner is turned, another therapeutic vista presents itself. As Harrison and Margaret separated, each was left to ponder life as a single adult. For Harrison, this had to mean "no more therapy." For Margaret, however, new foci for therapy emerged: Her concern shifted to her self-abusive posture of choosing and trying to rely on men who were emotionally unavailable. For this next therapy project a different therapy modality (group therapy) became the treatment of choice. New therapy goals were defined and the "re-gearing up" began. Thus, by moving back to Stage 1 in this new arena, Margaret recontracted for more extensive personal change.

To live life and check in later? The children in this family opted to go off but to check in around separation issues at Christmas vacation from their respective schools. This third alternative—try it on your own until something in life brings you back in—is a developmental model of psychotherapy this author supports and encourages. Psychotherapy is a part of life and can be used to advantage at levels of crisis in human development.

The author finds it useful to think of psychotherapy as occurring in "chunks" or "rounds," which can be as brief as a few sessions and as lengthy as a few years. If psychotherapy is a part of life, then change is maximized by having clients experience periods of psychotherapy and leave it for a while and live life. Then, as development unfolds and clients need another "chunk," they (individuals, couples, families) return to psychotherapy—often with the same psychotherapist. Having taken time to live life without the assistance of therapy, clients come back into psychotherapy with renewed energies and renewed desperation. And on the pattern goes.

To summarize, in each of the four stages, the existential strategic system of therapy described uses resistance to therapeutic advantage. In Stage 1 (the halo effect and cynical disbelief), resistance is channeled into issues concerning the structure of the therapy (in this case, scheduling sessions, who was to participate) and away from the validity of the therapy itself. In Stage 2 (joining the couples and reframing the problem), resistance to dealing with the issues of importance was handled by allowing the couple to slide into and out of serious consideration of their problems through an initial few minutes of social conversation. Second, the strategic technique of circular questioning educated the couple into systemic thinking, the foundation upon which major change will occur. In Stage 3 (pulling for the despair), resistance is highlighted in order to induce despair, which in turn forces the client to admit to the need for change. In Stage 4 (turning the corner), the resistance is dismantled as the client comes to realize that positive change has occurred and that to the future belong new solutions not the stubbornly clung-to dysfunctional paths of the past. These four stages, relying on a theoretical

blend of existential and strategic techniques, can be adapted to each particular client system. The therapy that ensues can be suited to that client and enables the therapist to take control of resistance to change and mold it into a positive lasting change.

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