A STRUCTURED APPROACH TO DISENGAGEMENT IN FAMILY THERAPY WITH CHILD-FOCUSED PROBLEMS

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ABSTRACT: The aim of this paper is to describe a structured approach to managing the disengagement process. Six distinct disengagement scenarios are first outlined. Thereafter, phasing out therapy, dealing with family belief systems concerning the permanence of improvements and relapse management are discussed. Ways in which disengagement from specific episodes of therapy may be construed as part of an ongoing therapeutic relationship and the practicalities of recontracting for further episodes of therapy, handing over cases, and referring cases on to other professionals are considered. An approach to therapeutic failure analysis is presented. Finally, ways in which disengagement may lead to significant loss experiences are discussed.

KEY WORDS: family therapy; child-focused problems; disengagement from therapy.

Family therapy with child-focused problems may be conceptualized as a stage-based process, such as that set out in Figure 1, with distinctions made between the stages of engagement, assessment, therapy, and disengagement (Carr, 1995a,b). While much attention within the literature has been given to the first three stages of family therapy, relatively little has been written about the process of disengagement. The aim of this paper is to describe a structured approach to managing the disengagement process when working with families who present with child-focused problems.

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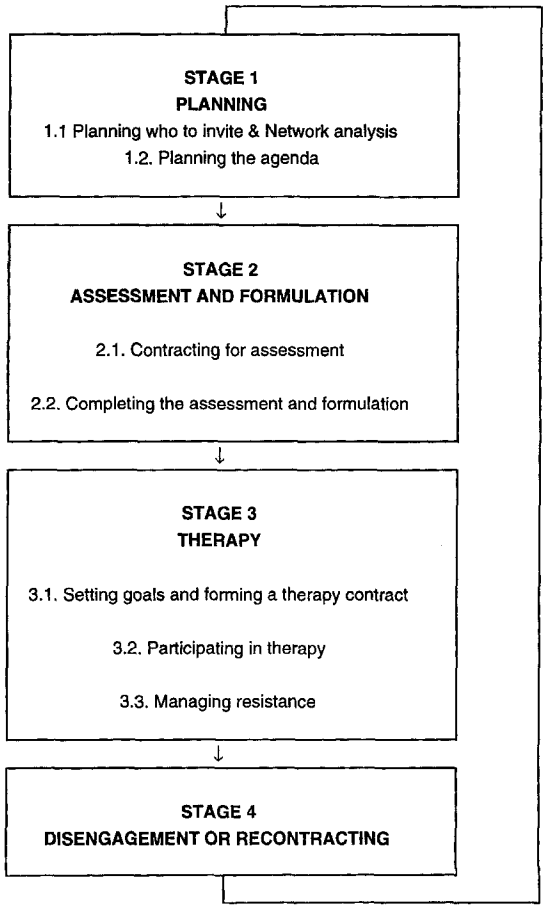

FIGURE 1

Stages of the Consultation Process

First, six distinct disengagement scenarios will be outlined. Second, the issue of phasing out therapy will be addressed. Third, a discussion of how to deal with belief systems concerning the permanence or transience of perceived improvement will be presented. Fourth, relapse prevention and management will be discussed. Fifth, ways in which disengagement from specific episodes of therapy will be construed as part of an ongoing therapeutic relationship involving a

number of episodes will be considered with particular reference to cases requiring intervention across the lifespan. Sixth, the practicalities of handing over cases, recontracting for further episodes of therapy focusing on problems other than those for which the case was referred and referring cases on to other professionals or agencies will then be considered. Seventh, an approach to failure analysis will be presented for use in cases where deterioration or dropout has occurred. In the final section of the paper, significant loss experiences associated with the disengagement process will be discussed.

SIX DISENGAGEMENT OR RECONTRACTING SITUATIONS

Assuming that a therapeutic contract specifying goals and the maximum number of sessions for which therapist and clients will work toward these goals has been established as the outset of therapy, a distinction is made between the following disengagement or recontracting situations:

1. Situations where goal attainment occurs before the end of the series of sessions agreed in the initial contract.
2. Situations where goal attainment occurs at the end of the series of sessions agreed in the initial contact.
3. Situations where partial goal attainment is noted at the end of the series of sessions agreed in the initial contact but where it is clear that this improvement may not be sustained without further therapy.
4. Situations where, at the end of the series agreed in the initial contact, goal attainment occurs but where it is clear that further consultation focusing on child problems, marital problems, or individual therapy may be requested.
5. Situations where no progress has been made or where deterioration has occurred.
6. Situations where families drop out of treatment.

In situations 1 and 2, with cases where the consultation process has been effective at or before the number of sessions in the original contract have been completed specialized disengagement skills are not required, although the issue of loss of contact with such cases may pose a personal challenge to the therapist. The issue of loss is

discussed in detail later. In situations 3 and 4, recontracting for further work is the central therapeutic task. In situations 5 and 6, analyzing the reasons for lack of progress, deterioration, or dropout and liaising with the referring agent are the central therapeutic responsibilities.

PHASING OUT THERAPY

Once progress toward therapeutic goals begins, the process of disengagement commences. Therapy sessions may be scheduled farther apart. This sends clients the message that the therapist is developing confidence in their ability to manage their difficulties without sustained professional help. A crucial part of spacing sessions farther apart is framing the process in a way that helps the family develop a sense of competence, rather than a sense of rejection. Here is an example of how widening the gap between sessions was framed to a family where the teenage daughter suffered from panic attacks.

> Since Mary has gone for two weeks now without a single episode of panic, I'm wondering if this is the time to widen the gap between our meetings to see if things go OK without such frequent contact here. It might be a useful experiment to see what happens if we widen the gap between sessions to three to four weeks. What do you think about this idea?

In this case, after three fortnightly sessions, contacts were spaced three weeks apart for two sessions, and the last two sessions were a month apart. Heath (1985) has argued that phasing out therapy should be spread across a number of sessions to give clients an opportunity to experience an approximation to the absence of therapeutic contact that will occur when the therapy is over. The Milan group were among the first to suggest that less time-intensive therapy may be more effective (Selvini-Palazzoli, Boscolo, Cecchin, & Prata 1978). They argued that a longer interval between sessions allowed the family system time to respond to interventions.

BELIEFS ABOUT THE PERMANENCE OF CHANGE

Once clients have made progress toward goals and this has been sustained for a few weeks, it is important to help them evolve belief

systems in which these changes are construed as relatively permanent rather than transitory (if such beliefs are consistent with available research on similar sorts of cases). A useful starting point in the construction of such belief systems is the flash in the pan question:

> Do you think that the improvement we have seen is a permanent thing or just a flash in the pan?

The flash in the pan question throws light on the way in which family members construe the changes that have occurred. If changes are seen as transitory, then it is important to inquire about additional events that would have to occur in order for these changes to be construed as relatively enduring. The following sorts of questions may be asked toward this end:

> How would you know if the improvement was not a flash in the pan?
>
> What do you think your dad/mum/wife/husband would have to see happening in order to be convinced that these changes were here to stay?

The answers to these sorts of questions will suggest interventions that may help family members come to construe improvement as relatively permanent. For example, the father of a 16-year-old boy who was referred because he had stolen money at home and repeatedly got drunk, said that he would know his son's improvement was permanent when three months had gone by without incident and when the boy did some work around the house without being asked. Three further sessions were scheduled at monthly intervals. The father was asked to keep a daily diary of any signs of spontaneous help on the son's part. The diary was reviewed in the therapy session. In the second of these the father confessed that he had gathered sufficient evidence of spontaneous help on his son's part to be convinced that the change was permanent.

Once family members are convinced that relatively enduring change has occurred, it is useful to ask for their theory about why they believe it is permanent rather than transitory. This will help them recap how symptomatic relief is related to systemic change. This process of recapping the relationship between the symptom, the problem-system, and the therapeutic system is a central part of the termination.

RELAPSE MANAGEMENT

Because empirical evidence suggests that with child and family psychological problems relapses are very common, relapse management is a critical part of family therapy (Herbert, 1991). When clients show that they believe enduring change has occurred, and when they have recapped the way in which they found a solution to their presenting problems, they are in a position to consider the relapse management process. The therapist's task is to help clients develop a framework for predicting the conditions under which relapses may occur and also to help them develop a plan for relapse management. The process begins by introducing the idea of relapse in as nonthreatening a way as possible. Here is an example of how this was achieved in a case where Barry, the son, successfully learned from his father, Danny, how to manage explosive temper tantrums. The following excerpt is addressed to Barry's mother:

> You said to me that you are convinced now that Barry has control over his temper . . . that he has served an apprenticeship to Dad in learning how to manage this fierce anger that he sometimes feels. OK . . .? It looks like the change is here to stay also . . . that's what you believe. That's what I believe. But there may be some exceptions to this rule. Maybe on certain occasions he may slip . . . and have a big tantrum . . . Like when you gave up cigarettes, Danny, and then had one at Christmas in the pub . . . a relapse . . . It may be that Barry will have a temper relapse. Let's talk about how to handled relapses?

Many relatively simple behavioural problems may be used as analogies to introduce the idea of relapse. Smoking, drinking, nail-biting, thumb-sucking, and accidentally sleeping late in the morning are among some of the more useful options to consider. It is crucial that key members of the family understand the analogy. Parents find it easy to empathize with the idea of a child relapsing if they themselves have been heavy smokers, quit, and later relapsed. Siblings will easily identify with habits like nail-biting, thumb-sucking, or sleeping late.

Once all family members have accepted the concept of relapse, then the therapists asks how such events might be predicted or anticipated.

If that were going to happen, in what sorts of situations do you think it would be most likely to occur?
What signs would you look for, if you were going to predict a relapse?
From what you know about the way the problem started this time, how would you be able to tell that a relapse was about to happen?

Often relapses are triggered by similar factors to those that precipitated the original problem. For example, Lucinda, a nine-year-old pianist, began refusing food shortly before a major concert. About 18 months later she relapsed before another major performance. Sometimes relapses occur as an anniversary reaction. This is often the case in situations where a bereavement has occurred and where the loss precipitated the original referral. More generally, relapses seem to be associated with a buildup of stressful life events (Cummings, Gordon, & Marlatt, 1980). These factors include family transitions such as members leaving or joining the family system; family transformations through divorce or remarriage; family illness; changes in children's school situation; changes in parents' work situation; or changes in the financial situation of the family. Finally, relapses may be associated with the interaction between physical environmental factors and constitutional vulnerabilities. For example, people diagnosed as having seasonal affective disorder are particularly prone to relapse in early winter (Wehn & Rosenthal, 1989), and youngsters with asthma may be prone to relapse in the spring (Lask & Matthew, 1979).

Once family members have considered events that might precipitate a relapse, it is useful to inquire about the way in which these events will be translated into a full-blown relapse. He is an inquiry made in the case of Barry (with the explosive temper) mentioned earlier:

> Sometimes when a relapse occurs, people do things without thinking and this makes things worse. Like with cigarettes . . . if you nag someone that has relapses, they will probably smoke more to deal with the hassle of being nagged! Just say a relapse happened with Barry, what would each of you do. . . . if you acted without thinking . . . that would make things worse?

This type of inquiry allows family members an opportunity to apply their systemic understanding of the problem that led them to

therapy to a new but similar situation. This is often a very humorous part of therapy, where the therapist can encourage clients to exaggerate what they believe their own and other family members' automatic reactions would be and how these would lead to an escalation of the problem. The final set of inquiries about relapse management focuses on the family's plans for handling the relapse. Here are some examples:

> Just say a relapse happened, what do you think each person in the family should do?
>
> You found a solution to the problem this time round. Say a relapse happened, how would you use the same solution again?

The therapist's role is to acknowledge that the family, at this stage of the consultation process, has most (if not all) the answers. Where families have made substantial progress toward stated goals, they will usually develop useful relapse management plans. If the therapist has anything to add to the refinement of relapse management plans, suggestions should be offered as minor modifications rather than major revisions. This supports rather than undermines families' confidence in their own problem-solving abilities.

DISENGAGEMENT AS PART OF A RELATIONSHIP

If long-term therapy runs the risk of fostering client dependency, brief interventions like family therapy may leave clients feeling abandoned. Providing clients with a way of construing disengagement as the end of an episode of contact rather than as the end of a relationship is a useful way of avoiding engendering feelings of abandonment. Three strategies may be used to achieve this. First, a distant follow-up appointment may be scheduled. Second, families may be told that they have a session in the bank which they can make use of whenever they need it without having to take their turn on the waiting list again. Third, telephone backup may be offered to help the family manage relapses. In all three instance, families may disengage from a schedule of regular therapy sessions while at the same time construing themselves as connected to the therapeutic system.

With families where there are chronic problems, construing the disengagement as marking the end of an episode rather than the end of a relationship is particularly important. Multiproblem families, families where a member has a chronic illness, and families where a

member has a physical disability or a mental handicap are typical examples of families requiring this approach. In these cases, each time a therapy contract is completed, the family is invited to recontact the therapist as further problems arise or at critical transitions in the family life cycle. This approach offers a framework for long-term involvement to the majority of family therapists who work within time-limited therapeutic contracts of about 10 sessions (Carr, 1991b).

HANDING OVER, RECONTRACTING, AND REFERRING ON

In a variety of situations it may be necessary for one therapist to hand over a case to another staff member. Interns in training, temporary staff, or professionals who are retiring or changing jobs all face the issue of handing cases over to colleagues. Handover sessions are appropriate where work on a given episode of therapy is incomplete or where an episode of therapy has been completed but the possibility of further episodes is likely because of the chronic nature of the family's problems. The therapist who has worked with the family uses the handover period to introduce the family to the staff member who is taking over the case and to let clients know that this is a colleague whose expertise fits with the family's current need. The handover session is also an excellent opportunity to highlight the family's strengths. Here is an example of a handover statement in a family meeting attended by the family and the new therapist:

> As you know I'm leaving town next week . . . Today is about introducing you to Dr. Rawlie, who eh . . . will be available to work with you over the rest of this contract and in future if need be. Dr. Rawlie is a clinical psychologist like myself and both of us work a lot with families where diabetes is a concern. So . . . let me just fill us all in on where we're at right now. We began working about three months ago. The big problem was keeping Tim's diabetes under control. He was having real problems sticking to his diet and was in and out of the hospital here regular as clockwork. Laura and Bob (his parents) were putting a lot of energy and concern into helping Tim stick to his regimen. Most of our work has been about helping Tim to be as independent as possible in managing his diet, tests, and injections. Laura and Bob have

> pulled back from reminding him about stuff and have encouraged him to deal with his diabetes like an adult. Tim will be 18 next fall. Ronnie (Tim's younger brother) has been real respectful of Tim's privacy since the boys moved into separate rooms about six weeks back. Tim has worked hard to develop a routine and keeps records of his diabetic self-management programme. That is going smoothly now. Everyone has worked really hard, but there is a sense that these changes might not be permanent, so we were talking about that last day.

In virtually all families that are referred with child-focused problems, both marital and individual adult issues that could serve as a potential focus for further consultation emerge. It is useful to acknowledge these issues when they arise. However, it is probably good practice to defer offering a contract for therapy or referral to another agency to deal with these issues until the child-focused problem has been solved, unless there is good reason not to wait.

DISENGAGEMENT

The reasoning behind this approach is as follows. First, if the family and therapist devote their energy to solving more than one problem at a time, then the chance of failure increases because of the increased demands on the family's coping resources. Second, if families successfully solve a child-focused problem, this may enhance their view of themselves as good problem-solvers. The parent may then progress to dealing effectively with marital and adult issues without the help of a therapist. Third, and most importantly, in family therapy with child-focused problems the original contract is work on a child-centered problem. The therapist therefore has no mandate to address marital or adult individual problems without very good reason. If the therapist, without an agreed contract, begins to explore marital or adult individual issues in a family session, the parents may find this invasive or threatening and drop out of therapy. For example, the parents of a teenage boy referred because he ran away from home appeared to have serious marital problems. The family dropped out of treatment after two sessions. Later feedback from the family physician confirmed that they dropped out because they felt as

if too much of the consultation time was focusing on their relationship and not enough time was being devoted to parenting issues.

The main exceptions to the rule of deferring marital and adult issues until the contract for child-focused problems is completed are situations which are dangerous or which seriously compromise the parents' problem-solving abilities. Marital violence, self-injurious behaviour, clinical depression, and psychotic symptoms are among the most common examples of such problems. In each of these instances, the therapist points out that the child-focused work cannot progress until the outstanding marital or individual adult issue is dealt with.

LACK OF GOAL ATTAINMENT, DETERIORATION, AND DROPOUT

In some cases, if clear progress toward the therapeutic goals set at the beginning of the consultation process is being made, a further contract for a limited number of extra sessions may be made. A major pitfall, however, is to continue the consultation process indefinitely without a review of progress toward goals and without a clear session limit to the therapeutic contract. This type of open-ended therapy can lead to the therapist and clients developing a pattern of interaction which maintains rather than resolves the problem. In cases where no progress toward goals has been made at the end of a time-limited period such as six or 12 sessions, then the clients and the therapist must accept that the approach to therapy described here is not suitable for the problems presented, and referral back to the original referring agent or on to another professional, agency, or treatment modality with the consent of the referring agent may be considered. In other instances clients drop out of therapy. In about 10% of cases families deteriorate as a result of therapy (Carr, 1991a).

Where dropout, deterioration, or lack of goal attainment occurs, analyzing why this occurred is an important therapeutic responsibility (Coleman, 1985; Spellman & Harper, 1995). Failures may occur for a number of reasons. First, they may occur because of the engagement difficulties. The appropriate members of the problem-system may not have been engaged. For example, where fathers are not engaged in the therapy process, dropout is more likely (Carr, 1990a). The construction of a systemic formulation of the family's problem which does not open up possibilities for change or which does not fit

with the family's belief systems is a second possible reason for failure (Carr, 1990b). A third reason why failure occurs may be that the therapist did not design therapeutic tasks appropriately, or had difficulties in offering the family invitations to complete the therapeutic tasks (Carr, 1990c). Problems with handling families' reservations about change and the resistance that this may give rise to is a fourth and further source of failure (Carr, 1995b). Disengaging without empowering the family to handle relapses is a fifth possible factor contributing to therapeutic failure. A sixth factor is countertransference (Carr, 1989). Where countertransference reactions seriously compromise therapist neutrality and the capacity to join in an empathic way with each member of the problem-system, therapeutic failure may occur. Finally, failure may occur because the goals set did not take account of the constraints within which family members were operating (Carr, 1993). These include biological factors such as illness, psychological factors such as intellectual disability, economic factors such as poverty, social factors such as general life stress, and broader sociocultural factors such as minority group membership. The analysis of treatment failure is an important way to develop therapeutic skill. A checklist for analyzing treatment failure is contained in Figure 2.

FAILURE ANALYSIS

1. Engagement problems
2. Formulation did not open up possibilities
3. Tasks poorly designed or offered
4. Problems with managing resistance and beliefs about change
5. Inadequate preparation for relapse
6. Violation of neutrality
7. Set goals without taking constraints into account (biological/psychological/economic/social/cultural)

FIGURE 2

A Checklist for Failure Analysis

LOSS

Much of the time, therapists are not emotionally overwhelmed by the disengagement process and manage it satisfactorily. However, in some instances disengagement may lead to a profound sense of loss. Where therapy has been unsuccessful, disengagement may lead to a sense of loss of professional expertise. Loss of an important source of professional affiliation and friendship are often experienced when therapists disengage from successful cases. Both types of loss will now be examined in more detail.

Where therapists attribute many therapy failures to their own personal or professional inadequacy, there is a danger that they may lose their sense of personal and professional self-worth. This loss in turn may lead at an emotional level to sadness that one has not met personal expectations. It may lead to anger that clients have caused this. It may also lead to anxiety that the process of repeated failure may continue. At a cognitive level it may lead therapists to believe that there is nothing that they can do to be effective in helping clients. At a behavioural level it may lead to an avoidance of clinical work and a retreat into other activities such as administration. At a somatic level it may lead to frequent illness due to immunological deficiencies associated with the stress of repeated failure. This analysis is based on ideas drawn from the burnout literature (Malasch & Jackson, 1982), the learned helplessness model of depression (Abramson, Seligman, & Teasdale, 1978), and recent advances in psychoneuroimmunology (Levy & Heiden, 1991).

The key to managing therapeutic failure is, first, to analyze all failures using the framework outlined above so that an understanding of the precise factors that contributed to the lack of goal attainment may be pinpointed. This failure analysis should then be examined within supervision with peers or more experienced clinicians. The supervision context provides the technical and emotional support required to understand unsuccessful cases and work through emotional reactions to them.

Disengagement from successful cases may also lead to a profound sense of loss, since such cases when they are ongoing may affirm both the personal and professional identity of the therapist. At an emotional level, the actual or expected loss may lead to both sadness and anger associated with a primitive sense of abandonment. At a behavioural level, anticipated disengagement in successful cases may lead

therapists to prolong the consultation process unnecessarily or to disengage too abruptly. After disengagement in successful cases, the sense of loss may lead to anger toward new clients or to an avoidance of them. Underpinning this may be a belief that a new client cannot take the place of the successful clients that have recently disengaged from therapy. Overly abrupt endings, prolonged consultation, avoidance of new clients, and related feelings of anger and sadness are all issues requiring analysis and discussion in supervision with peers or experienced clinicians.

DISCUSSION

This analysis of the disengagement process draws a clear picture of the tasks to be completed by therapists in the final stage of therapy. The process of disengagement begins once improvement is noticed. The interval between sessions is increased at this point. The degree to which goals have been met is reviewed when the session contract is complete or before this if improvement is obvious. If goals have been achieved, the family's beliefs about the permanence of this change is established. Then the therapist helps the family construct a systemic understanding of the change process. Relapse management is discussed. Disengagement is constructed as an episodic event rather than as the end of a relationship. This is particularly important when working with families where members have chronic problems. In some instances, the end of one therapeutic contract will lead immediately to the beginning of a further contract. This subsequent contract may focus on the original child-centred problems, marital difficulties, or individual work for the adults in the family. Referral to other therapists or agencies for this additional work may be appropriate. If goals are not reached, the therapist avoids doing more of the same (Segal, 1991). Rather, therapeutic failures are analyzed in a systemic way. The understanding that emerges from this is useful both of the clients and for the therapist. From the clients' perspective they avoid becoming trapped in a consultation process that maintains rather than resolves the problem. From the therapists' viewpoint it provides a mechanism for coping with burnout that occurs when multiple therapeutic failures occur. In some cases therapists may find it necessary to seek supervision for managing loss experiences associated with disengaging from both successful and unsuccessful cases. Guidelines for disengagement are presented in Figure 3.

DISENGAGEMENT

1. Increase the intersession interval when improvement begins
2. Review goal attainment when the session contract is complete or before it if improvement is obvious
3. If goals are not reached, do not do *more of the same*
4. If goals have been achieved, find out if the family believes the change is temporary or permanent
5. Help the family construct an understanding of the change process
6. Discuss relapse management
7. Construct disengagement as an episodic event rather than as the end of a relationship
8. Schedule follow-up
9. Analyze failures
10. Acknowledge and process feelings of loss

FIGURE 3

Ten Guidelines for Disengagement

The approach to disengagement described here may be used by therapists working with a time-limited therapeutic framework where relatively clear therapeutic goals have been set. It is probably an inappropriate approach to take to the disengagement process in long-term growth-oriented therapy where the therapeutic process depends upon regular and frequent contact and where therapeutic goals are less clearly defined. The approach to disengagement described here, particularly in cases where therapeutic goals are not achieved, may also be at variance with the practice of some strategic therapists. Some strategic therapists argue that, in certain resistant cases, the therapist may tell clients that further therapy is no longer necessary and frame this in such a way that clients are forced to solve their own problems (Weeks & L'Abate, 1982). In other instances strategic therapists interpret dropout as indicating that therapy has been successful. Clients who drop out are assumed to have found a way to cope with their problems without the help of a therapist. With strategic disengagement or a strategic interpretation of dropout, clients are

usually unaware that the therapist assumes that the paradoxical position he or she has taken has led to their improvement. There are a number of problems with this viewpoint (Carpenter & Treacher, 1989). The most obvious is that the strategic position provides no opportunity for the client to negotiate the disengagement process. The second problem is that the strategic stance provides no avenue through which the therapist can obtain feedback from the client on therapeutic effectiveness in the form of follow-up data. A final problem with strategic disengagement is that it makes engagement in later therapeutic contracts problematic.

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