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IMPASSE IN MARRIAGE AND FAMILY THERAPY

by

Valentina V. Popkova-Massé

A thesis submitted in partial fulfillment  
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development

## Impasse in Marriage and Family Therapy

by

Valentina V. Popkova-Massé, Master of Science

Utah State University, 2003

Major Professor: Dr. Thorana S. Nelson  
Department: Family and Human Development

The purpose of this exploratory study was to learn about practicing Marriage and Family Therapists' experiences with therapeutic impasse. The study had several objectives: investigate the incidence of impasse; look into therapists' experiences with impasse, their attitudes toward it, and their views on its etiology; and explore clinicians' strategies for impasse resolution.

One hundred and six clinical members of the American Association for Marriage and Family Therapy (AAMFT) responded to a self-designed questionnaire. The majority of the respondents (83%) reported being stuck in therapy for a few minutes and 35% reported being stuck for three or more sessions during the previous year of their practice. The majority of times, the therapists experienced low to medium stress in impasse and predominantly distressing emotions such as frustration and anxiety. Nonetheless, 86% of the participants reported having positive attitudes toward impasse.

This study entertained a qualitative analysis of the first signs of impasse that MFTs reported they noticed as well as therapy situations in which they typically or frequently experienced impasse. Clinicians reported looking into different units of

analysis when noticing the first signs of impasse. Most of them observed client signs, fewer noticed signs in the therapeutic system, and the least noticed signs in themselves. Similar to the question of signs of impasse, the therapists concentrated on client, system, and their own characteristics when describing their typical impasse situations. As many as 65% of the responses contained therapists' accounts of typical client dynamics with which they experienced impasse and only 5% of the responses mentioned therapist dynamics.

A total of 95% of the sample reported high or very high rates of impasse resolution. In addition, 88% of the therapists reported having a strategy/strategies for resolving impasse. The study revealed diverse strategies that MFTs used for dealing with impasse: immediate interventions, larger scale interventions, and complete courses of actions. Implications for research, practice, and training are discussed.

(103 pages)



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## CHAPTER I

### INTRODUCTION

Therapeutic failure is a pressing issue in marriage and family therapy (MFT) as well as other mental health areas. Presently, failure rates among different therapists vary between 30% and 66% (McLennan, 1996). Failed therapy is expensive and devastating for both clients and therapists. It can breed hopelessness, strengthening people's beliefs that their goals cannot be reached. As a result, therapeutic failure can enhance such sad societal phenomena as divorce, addiction, violence, and children living at home without peace or sent to foster homes.

There are various reasons for failure such as higher levels of client disturbance, client-perceived poor quality of the client-therapist relationship, negative perceptions of the client by the therapist, low levels of therapist technical competence, and lower levels of therapist personal adjustment (McLennan, 1996). Unresolved therapeutic impasse, although a great concern in therapeutic practice, is rarely named as a reason for failure and almost never explored as such. Impasse is otherwise described as a sense of being stuck and not progressing in therapy (Pugh, McGolgan, & Pruitt, 1986; Rober, 1999). All therapists periodically face impasses and some of them lack the capacity to resolve them effectively (Berkowitz, 1985). Unresolved impasse may precede clients' abrupt dropping out of therapy. It is also a factor allowing for unnecessarily extensive yet fruitless therapy to happen. Therefore, greater understanding of impasse and learning to deal with it more advantageously will be extremely helpful in preventing failures, dropouts, and unnecessarily long therapies associated with unresolved impasse from happening. Learning more about impasse will help to improve the quality of service offered by

marriage and family therapists and other mental health professionals.

Empirical data coming from the area of psychology show that impasse has a profound negative effect on clients and therapists (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996). Texts and articles, however, are not always of great help in dealing with impasse. One wanting to study this topic would face a paucity of empirical literature on impasse and great theoretical confusion.

It would seem that lacking knowledge about the incidence of impasse may significantly complicate the possibility of substantial open conversation about it. At the present moment, we do not have any information about impasse rates in marriage and family therapy. We believe that in order for a meaningful conversation about an issue to start, its magnitude needs to be known. Therefore, the current study attempted to explore impasse rates in marriage and family therapy.

Theoretical uncertainty in the fields of marriage and family therapy and psychology on the topic of therapeutic impasse is immense. Some authors do not differentiate clearly between the notions of therapeutic impasse and failure and use them interchangeably. The definitions provided by those who distinguish between the terms are not very comprehensible and are not congruent with each other. However, it can be inferred from the writings of many authors that impasse is a therapeutic stalemate (interactional, relational, and/or experiential) that may precede a moment in therapy when it is evaluated as a therapeutic failure (Bernstein & Landaiche, 1992; Carsky, 1985-1986; McLennan, 1996; Pugh et al., 1986; Rober, 1999; Stricker, 1995a; Warkentin & Johnson, 1982). The design of this study was based on the latter outlook on impasse because, as opposed to viewing impasse as a failure, this outlook gives a therapist the opportunity to

intervene. This study explored beliefs of practicing MFTs about the factors that help create and resolve impasse.

In addition to theoretical confusion, there is absolute empirical insufficiency. No empirical studies on therapeutic impasse in marriage and family therapy have been found. Only one study directly related to this topic (Hill et al., 1996) and a few other studies indirectly contributing to it (Dreessen & Arntz, 1999; Samstag, Batchelder, Miran, Safran, & Winston, 1998) have been conducted in the area of psychology. There is consistent evidence in this area that therapeutic failures are not distributed randomly across therapists: Some therapists are, on average, more effective than others (McLennan, 1996). At the present moment we do not know, however, how successful MFTs are in dealing with impasse. We also do not know the attitudes toward, beliefs about, and behavioral strategies during impasse among practicing family therapists. Neither do we know how those attitudes, beliefs, and behaviors affect therapists' progress in dealing with impasse and thus, their therapeutic success. The current study explores these issues.

The purpose of this study was to learn about MFT professionals' experience with impasse. This study explored therapists' views about the incidence of impasse in their practices, impasse etiology, ways of resolving impasse, and the effects of impasse and unresolved impasse on therapists and therapy outcome.

## CHAPTER II

### REVIEW OF LITERATURE

#### Therapeutic Impasse Versus Therapeutic

#### Failure: Definitions

Some authors, emphasizing the evaluative aspect of the notions of therapeutic impasse and failure, used these notions interchangeably. For example, Weiner (1983) considered impasse to be a clients' psychological worsening or failure to improve in a treatment in which improvement would have reasonably been expected. Others, however, differentiated between the notions. Stricker (1995a), agreeing with Strupp, Hadley, and Gomes-Schwartz (1977), considered failure to be "a worsening of [a client's] condition attributable to his having undergone psychotherapy" (p. 92). Stricker believed it to be a more serious condition as opposed to impasse or lack of success. In addition, McLennan (1996) mentioned that one can conclude that a therapy was a failure only after a period of time. Based on his review of the literature about therapeutic failure, McLennan concluded that failure occurs "when, within the therapy-appropriate time frame, there is no evidence that the client's well being has improved, or there is evidence that the client is worse, in relation to his/her identified difficulties" (p. 393). The author did not specify, however, what the appropriate time frame is.

Other authors opposed viewing failure as an objective evaluation of therapy, believing that it is a matter of perspective and timing. They pointed out that what looks like failure from the therapist's perspective may not necessarily be failure from the client's perspective (Bohart, 1995; Jenkins, Hilderbrand, & Lask, 1982; McLennan,

1996). Bugental (1988) indicated that every process inevitably has elements of success and failure. Keith and Whitaker (1985) rejected the concept of failure altogether. These authors suggested that systemically, a success can be a failure and a failure can be a success. That is, what is a success at one level of a system may be a failure at a different level and visa versa.

Most of the authors, talking about impasse, believed it to be either interactional in nature or to have an interactional element (Gorney, 1979). For instance, Bernstein and Landaiche (1992) believed that impasse is essentially interactional, that it involves more than one person. Some authors emphasized relationships and emotional experience in a therapeutic system in impasse. Pugh et al. (1986) accentuated the lack of progress and movement during impasse, saying that impasse in therapy is experienced as inertia, stalemate, and the inability to move towards goals. Rober (1999) and Warkentin and Johnson (1982) proposed that impasse is or is characterized by a deterioration of the therapeutic relationship. These MFT scholars emphasized the emotional withdrawal that occurs in the situation of impasse in its various forms, such as intellectual discussion, emphasis on symptomatology, or periods of futile silence. Rober suggested that superficiality during impasse results in frustration and irritability. He emphasized a paralysis in the circle of meaning during impasse and gave the following descriptives for the situations of impasse: unanimated and repetitive conversation; lack of freedom and flexibility; rigidity in relationships between therapy participants; system rules that avoid direct confrontation; and unsafe and narrow therapeutic culture, which results in emotional withdrawal.

Summarizing, there is great diversity of opinions about therapeutic failure and



impasse. Some authors believed failure and impasse to be the same phenomenon whereas others differentiated between the two. This study agreed with the latter view differentiating between the two phenomena because it gives a clinician an opportunity to intervene. Authors, describing impasse as a separate phenomenon, concentrated on various relational, experiential, and interactional aspects of it. This study explored the views of practicing MFTs on impasse and its resolution.

#### Negative Impact of Impasse on Clients, Therapists, and the Quality of Therapy

In the field of MFT, the effect of impasse on the therapy process, clients, and therapists has been explored only theoretically with some inclusion of case examples. Haber (1990) described how a situation of impasse ended with clients' dropping out of therapy:

A [therapist] trainee discussed his tendency to function as the surrogate parent of adolescents when family therapy seemed unproductive. He commented that he frequently sides with the mother and child to the exclusion of the father. This has resulted in several families' dropping out of therapy. (p. 381)

Haber talked about the anxiety that develops in the situation of impasse and leads to repetitive behaviors that are typical in such situations.

Only one empirical study that explored responses of therapists in situations of impasse to some extent was conducted in the area of psychology. Hill and colleagues (1996) conducted a qualitative study on 12 therapists' retrospective recall of their recent impasse situations. The authors mentioned, however, that they were not sure how representative their sample was. In addition, they speculated about the possibility that the

therapists in the study may have chosen unusual, nonrepresentative cases to report, given that the researchers asked them for the most recent salient examples of impasses. In light of these and other weaknesses of the study, Hill and colleagues recommended that their research be replicated.

Hill and colleagues' (1996) study made various discoveries. The authors mentioned several different reactions of the therapists in the situations of impasse, namely, that they felt frustrated, angry, disappointed, or hurt by their clients. Some of them felt confused or anxious about the impasse. In addition, several of them reported having negative thoughts about their own self-efficacy. A few also reported feeling surprised by the impasse because they had neither anticipated it nor been prepared for it. The therapists conveyed that although they were frustrated with the process, they did not explore the reasons for their frustration soon enough to be able to do something about it. As a result, all twelve impasse situations explored in the study ended in therapy termination.

Samstag and colleagues (1998) conducted a study on early identification of treatment failures with 47 therapists and 73 clients who were in Cognitive-Behavioral or Experiential therapy. They found that therapists were less aware of poor therapeutic alliances and therefore had less capacity to predict future dropouts than their clients. In other words, one could speculate that the therapists were less aware of ongoing relational impasse than their clients. The researchers discovered that therapists placed more importance on smoothness: good sessions were described as "smooth," "easy," and "pleasant." At the same time, clients valued most the sessions that had greater depth (described as "deep," "valuable," "full," "special"). The researchers explained this

preference of therapists by the influence of the supervisory process--the desire to produce sessions that would clearly and coherently demonstrate the treatment model to their supervisors.

In contrast to the findings of empirical studies, some authors, addressing the phenomenon of impasse in their theoretical pieces, saw it as normal and even full of therapeutic potential. Simon (1988) stated that failure or being stuck can be expected in therapy. The author explained that people are in therapy because they tend to get stuck in life and they get stuck there in a particular way similar to the way they get stuck in therapy. Advocating that not achieving objectives is not a real failure, Simon pointed out that the very term *stuck* associated with impasse "highlights the beliefs that things should be moving and not achieving this therefore creates guilt" (p. 8). Simon emphasized that a creative process often includes periods of unsuccess followed by inspiration. In light of this, Simon suggested that the feelings of hopelessness and blame often associated with impasse decrease the creativity necessary to resolve it, which makes it evident how failure breeds more failure. Rober (1999) contributed to this point of view by suggesting that the situation of impasse may in fact be full of potential and may become a key moment in therapy if it is resolved well. The author wrote:

Often, in retrospect, a therapeutic impasse proves to be a key moment in the therapy. The successful resolution of an impasse is usually experienced by therapists and clients as a giant leap forward, because space is suddenly created to say what could not be said until then. (p. 226)

Summarizing, there were differences in ways therapists' attitudes toward impasse were presented in empirical and theoretical literature. Some authors, addressing the phenomenon of impasse from a theoretical perspective, viewed it as a problem affecting

everybody in the therapy room negatively. Others, however, believed that impasse is a normal situation that can be expected in therapy and that its successful resolution can become a great step toward progress of therapy. The current study explored how practicing MFTs tend to view impasse: as an unpleasant situation, a normal situation, or full of therapeutic potential event.

One empirical study in the area of psychology showed the predominant negative responses to and unpreparedness for impasse on the part of psychologists in real therapy situations (Hill et al., 1996). The study explored only cases in which impasse ended in therapy termination and illustrated that the clinicians did not explore the negative emotions they experienced in impasse soon enough to make a difference in the outcome. The current study explored total impasse rates among MFTs, giving them an opportunity to report their experience with both successful and unsuccessful impasse resolution.

### Impasse Variables

The moment of spontaneous therapeutic interaction remains difficult to conceptualize (Carsky, 1985-1986). Psychotherapy research typically divides this moment into therapist and client variables. Some authors, however, advocated looking at the whole therapeutic system in impasse. In this section, we will look at the roles of therapists, clients, and the system in impasse.

#### *The Role of a Therapist in Impasse*

A study on therapist retrospective recall of impasse described therapists' reactions during impasse, such as frustration, hurt, disappointment, and anxiety (Hill et al., 1996).

This was accompanied by the absence of therapists' timely exploration of impasse dynamics, which was followed by therapy termination. The authors of that research did not explore, however, whether and how the reactions and actions of the therapists during impasse were associated with poor impasse resolution and thus negative therapeutic outcome.

In theoretically based sources, authors named various ways in which therapists might contribute to impasse. They pointed out the issue of therapists' inadequate problem assessment and modality formulation when therapists are determined to use a particular modality (individual, couple, or family) even when it does not clearly address clients' concerns (Davison, 1995b; Gehrke & Moxom, 1962). Anscombe (1986) talked about situations when therapists show a lack of capacity to distinguish between different kinds of clients: the clients that lack the capacity to do what they need, versus those who will not do so. Other contributions included the absence of an integrative strategy and failure to form a therapeutic alliance when the therapists were "doing to" rather than "doing with" the clients (Powell, 1995). McLennan (1996) mentioned therapist factors such as low level of general psychological adjustment, rigidity of expectations, limited repertoire of relating styles and skills, and limited or defective technique skills.

Some authors attempted to generalize the impact of a therapist. Pugh et al. (1986) identified two main ways in which the therapist participates in the creation of an impasse: lack of inspiration and lack of courage to share therapeutic insights coming from inspiration. Rober (1999) explained lack of inspiration as poor inner conversation of the therapist. He wrote:

Images, moods, emotions, associations, memories...these aspects of the self are

often neglected by therapists. They may, at least at the first glance, not fit the theories and expectations of the therapist, or they may be scary or shameful for the therapist or for the family, and so on. In these cases, therapists might dismiss these aspects of the self as unimportant, uninteresting, or irrelevant. This is often a missed chance, because the self of the therapist, especially those aspects of the self that the therapist at first glance doesn't really understand or that scare him, can be a rich resource for the therapist and for the therapeutic system since they can give access to things that haven't yet been said. (p. 215-216)

The empirical research of Hill and colleagues (1996) supported this idea, revealing that in actual impasse situations, therapists did not pay attention to and did not timely explore their feelings of frustration associated with their experiencing the stagnation of the impasse. Thus, impasse was not resolved. In light of this, Rober (1999) emphasized, "I hold that the feelings that arise in any member of a therapeutic system have meaning and function with respect to that therapeutic system" (p. 216).

Other authors addressed additional general ways in which therapists can contribute to the impasse. Stricker (1995b) believed that both failure in technique and bad relationships are essentially empathic failures. The author wrote, "A lack of attunement to the patient can produce an incorrect diagnostic formulation, a choice of inappropriate interventions, and a fatal deficit in the therapeutic alliance" (p. 186). Merten, Anstadt, Ullrich, and Krause (1996) spoke of the negative effect of the therapist's codependency on his/her capacity to empathize. They stated that when the therapist has a problem separating himself or herself from the clients, it complicates his/her understanding of the accurate meaning of the clients' emotional expressiveness and at times strengthens the clients' conflictive structures. Merten and colleagues drew attention to the impact that the therapist's countertransference reactions in general have on the therapeutic system. They pointed out that countertransference, the therapist's feelings in response to the patient,

cannot take place without the communication of the therapist's emotions, thus affecting the client. In light of this, the anonymous author (Anonymous, 1978) in the article, "*The Essence of Being Stuck*," described the hard work that she did to resolve issues with her family of origin, as a result of which she felt freer to work with families in therapy, to relate to them with immediate empathy instead of triangulating them.

Several authors spoke about blaming attitudes that therapists have toward clients and that contribute to unsuccessful impasse resolution. Stricker (1995b), for example, mentioned attribution of blame rather than understanding on the part of the therapists. Haber (1990) wrote:

It is much easier (and more typical) for the therapists to relate to the defensive postures of the family rather than to be cognizant of their own rigid responses. The reluctance to describe their own part in the impasse may be due to the difficulty in discerning the impact of our values, family of origin issues, gender and cultural biases, or other idiosyncratic, handicapping manifestations. (p. 377)

Another issue that was addressed by significant number of authors was temptations of power and certainty in the field of therapy, which prevent therapists from understanding and relating to their clients. Authors expressed concerns about prescriptive expertise that dominates articles, books, and manuals about psychotherapy (Amundson, Stewart, & Valentine, 1993; Bohart, 1995; Gold, 1995; Ryan & Johnson, 1983). Amundson and colleagues suggested that "commitment to expert knowledge blinds therapists to the experience in the room" (p. 111). Gold wrote, "In expertly knowing about psychotherapy we fail to know the patient. . . , [he/she is] misdiagnosed, not in a formal, psychiatric sense, but in a more significant way" (p. 168).

Emphasizing the significance of human contact in sessions for clients, Ryan and Johnson (1983) pointed out that often the therapists conclude that because their

interventions did not produce the expected results in the client, nothing was happening. For the patient, on the other hand, "psychotherapy may be a formative interpersonal learning experience, and a unique opportunity for the development of a greater psychological freedom--greater personal openness to interpersonal experiences, and thus greater capacity for intimacy and mutuality" (p. 3). Bugental (1988) agreed, saying:

When our patients bring their living being to us and we treat them as less than that--as symptoms, types, habits, problems, diagnostic categories--we have begun to betray them. We fail our patients when we pull back from genuine investment in our work. We fail them when we do not call on them for the greater investment. We fail them when we divert them from emotional outbursts, transference messiness, or directly facing the ultimate insolubility of life. (p. 534)

In summary, theoretically based literature named both particular and general ways in which a therapist can contribute to the creation of impasse. There has been one empirical study in the area of counseling to some extent exploring this issue (Hill et al., 1996). The study used 12 psychologists' retrospective recall of unsuccessfully resolved impasse situations and revealed clinicians' distressing emotional reactions in impasse, lack of preparedness to face it, and the absence of timely exploration of impasse dynamics. The analysis and use of the results of this single reported study are complicated, however, by the lack of confidence of the authors in how representative their sample was. In addition, the study explored impasse in the process of counseling with some of the therapies lasting as long as seven years, which is hardly comparable to the process of MFT. The current study explored one hundred practicing MFT clinicians' reports of their typical reactions in impasses they experienced during the last year of their practice, whether successfully or unsuccessfully resolved. In addition, it investigated clinicians' attitudes toward impasse. Finally, it revealed therapists' reports of their own



dynamics that they witness in situations where they typically experience impasse.

### *The Role of Clients in Impasse*

Berkowitz (1985) mentioned that even inexperienced therapists have probably noticed that therapy of any type works best with healthy people. Indeed, some authors spoke about ego (self) development problems as significant contributors to therapeutic impasse. Strupp et al. (1977) spoke about low ego strength. Berkowitz mentioned poor ego functions in general and the deficiency of the observing ego in particular, especially present in clients with personality disorders, as important factors of impasse creation. Green (1988), on the other side, criticized views of therapy that leave therapists blaming clients' pathology for treatment failures, rather than "considering how the design of the therapeutic system, itself, may elicit and maintain these perceived incapacities" (p. 384). We will look more closely at the way literature addresses this seeming contradiction.

Dreessen and Arntz (1999) looked closely at the empirical research on the impact of personality disorders on the therapy process and have found that in many projects, concomitant personality pathology diagnosed before the start of treatment did not interfere extensively with therapy other than to increase the frequency of the therapists' interventive efforts. In their own study, the authors found that the very fact of having a personality disorder diagnosed by structured clinical interview before the beginning of treatment did not hinder the therapeutic success of Axis I therapy process such as treatment of depression or anxiety. However, therapist-perceived personality pathology was strongly related to more complications and more efforts on the part of therapists whether their clients were diagnosed with personality disorder or not during in-depth

clinical assessment by several independent clinicians. Positive assessment of therapeutic alliance, on the other hand, by either the clients or therapists was statistically significantly related to improvement in overall functioning in the treatment of Axis I anxiety disorders.

Newirth (1995) proposed a more general explanation of how clients (with or without personality disorders) may contribute to the creation of therapeutic impasse. Namely, they may contribute by having insufficiently developed Selves, which will be manifested in their lack of access to their inner worlds and inability to participate in their experience in a more affectively engaged way, with a sense of personal meaning and agency. With this in mind, Newirth argued, however, that it is therapists' responsibility to help clients with developing their Selves.

McLennan (1996) analyzed various ways in which clients may add to impasse creation and identified a clients' level of psychological disturbance as expressed in his/her impairment to relate to others as a general factor. Implying that therapeutic learning occurs through relational channels, McLennan articulated that only to the extent to which a clients' psychological dysfunction affects their ability to connect well to others will their therapeutic learning be impaired. Frommer, Reissner, Tress, and Langenbach (1996) conducted research on subjective theories of illness in clients with personality disorders and found that as a result of multiple problems, people with personality disorders often end up being self-isolated. Frommer et al. articulated that although the complaints of clients varied, certain commonalities were present. All clients had poor self-esteem and very high expectations of themselves. They often experienced anxiety and uncertainty, were aggressive, and had poor impulse control. They had poor relationships with other people, constantly looking for guidance from them, at the same

time resenting feeling dominated. Frommer et al. discovered that the inability of clients with personality disorders to deal with the above mentioned symptoms led them toward self-isolation, which could affect their ability to form a therapeutic alliance.

Carsky (1985-1986) suggested a theoretical explanation for impasse creation, suggesting that clients in whose therapy an impasse develops may suffer from intrapsychic conflicts and from a tendency to recreate those struggles in the external world. The possibly aggressive nature of such clients' conflicts may strain the limits of a dyadic relationship. The author suggested that clients' primitive attack on the therapist's identity and/or denial or destruction of the significance of the human interaction with the therapist arouses great anxiety in the therapist. As a result, the therapist may experience temptations such as to withdraw emotionally from the treatment, to terminate or threaten to terminate therapy, or silently to accept abuse or criticism from the client. Carsky emphasized that when such submission replaces active limit setting and processing of the clients' attempts to destroy therapy, it becomes the way in which the therapist attacks the client.

Strupp et al. (1977) surveyed therapists and identified client factors related to negative outcome such as lowered motivation and secondary gain from the symptom. Luther and Love (1981) referred to clients' resistance, suggesting that "individuals prefer the security of the relationship systems they formed as a child than to experience the anxiety of developing new ones that may be less painful" (p. 475). Other authors looked at the issue of resistance from a different angle. Cowan and Presbury (2000) stated that resistance as a negative phenomenon only exists when therapists have specific notions of what the patient is supposed to do. Instead of using the term resistance, the author

suggested using Brehm and Brehm's term "reactance," which accentuates that resistance is a phenomenon that preserves personal freedom (Brehm & Brehm, 1981 as cited in Cowan & Presbury, 2000). Wachtel (1999) suggested that the therapeutic relationship is a crucial factor minimizing all kinds of resistance. Weiner (1982) articulated that from a dynamic standpoint, a healthy pattern of resistance entails encounter, evaluation, and choice whether to engage in a relationship and to what degree. He asserted that a lack of resistance means that nothing is being directly encountered and worked through. The author pointed out that the goal of therapy is not to dismantle the ability to resist, which would leave the clients overly vulnerable, but rather, it is to help them to become flexibly defensive.

In summary, there are contradictions between some authors' theoretical views and empirical research about the role of clients in impasse. Some authors believed that clients with low motivation, low ego strength and poor ego functions, especially those with personality disorders, are less capable of progressing in therapy. Empirical research, however, presented data that support the idea that personality disorders do not interfere with therapeutic success (Dreessen & Arntz, 1999). The current study, although not attempting to explore the capacities for therapeutic progression of different client categories, revealed practicing MFTs' views of which client dynamics they witness in situations where they typically experience impasse.

#### *Therapeutic System in Impasse*

Empirical and theoretical research has typically looked into the process of therapy in terms of therapist and client variables. Systemically oriented authors discussed

the limitations of this division. Green (1988), for example, criticized attitudes in the field of therapy that blame clients' resistance, pathology, traumatic history, or lack of motivation for treatment failures rather than "considering how the design of the therapeutic system, itself, may elicit and maintain these perceived incapacities" (p. 384). Ryan and Johnson (1983) argued that in an attempt to locate the problem specifically as opposed to viewing therapy as a relationship, more is lost than gained. Additional literature supported systemically-oriented researchers' concerns. Although traditionally, empathy, genuineness, and warmth have been described as attributes in the therapist rather than as characteristics of interaction between clients and therapists, 154 empirical studies found by Orlinsky, Grave, and Parks (1994) supported that there is a significant association between success rates and these specific aspects of the therapeutic relationship. They identified communication variables such as mutual attentiveness, empathy, expressiveness, and affective exchange of clients and therapists as important predictors of therapeutic success. Wachtel (1999) emphasized the importance of therapists' and clients' collaboration and joint efforts. The author stated that no matter how accurate the therapist's interpretations are, if the clients do not experience the therapist as supportive and as engaged with him/her in a joint effort, change is not likely to occur.

As stated earlier, various authors in their descriptions of impasse mentioned certain emotional numbness and interactional deficits. Johnson, Makinen, and Millikin (2001) normalized this by pointing to the defensive character of numbness, stating that "Avoidance and numbing are natural self-protective responses to the barrage of intrusive symptoms that arise from traumatic experience" (p. 150). The authors cautioned at the

same time that although this strategy of numbing may help to cope with pain, it prevents emotional engagement and thus interferes with resolution of injury, which is very costly for a relationship in the long run.

Tronick (1998) empirically explored why achieving states of emotional connectedness is a necessary condition for therapeutic change. The author reminded us that human beings develop in the process of interaction with other people. At the moment when a dyadic system is created, both partners experience an expansion of their own states of consciousness into a more coherent and complex state. Affective regulation, or coming to know and value current emotional experiences of each other, is an essential requirement for the formation of a dyadic system and thus for change. Creating dyadic states together in therapy provides a chance to access clients' explicit knowledge about their earlier relationships in relation to their current relationships--information about their history with the creation of dyadic states.

According to Tronick (1998), impasse, referred to as a miscoordinated state, is a normal event. It occurs when the participants fail to accurately appreciate the meaning of the other's emotional display and thus react inappropriately. The capacity to resolve impasse is vital for maintaining a dyadic system and thus for therapeutic change. It is achieved through interactive repairs, which would involve attempts at understanding and genuine validation of each others' emotional experiences.

Tronick (1998) emphasized that failure or success in achieving connectedness and successfully repairing interactions has a very powerful effect on the mental health of clients and therapists. By learning to genuinely value emotional experiences of each other, members of the therapeutic system can improve their capacity to create, maintain,

and repair their dyadic states, which are a condition of therapeutic change. Cowan and Presbury (2000) supported this finding by saying that our intent in therapy is "to provide new, affect-integrating experiences that remediate developmental deficits and create alternatives to old patterns of coping" (p. 417).

Several authors discussed the importance of factors of the therapeutic system itself, namely of its emotional context and mutual empathic processes, in the progress of therapy with clients with personality disorders. Stolorow, Brandchaft, and Atwood (1992) argued that characterological disturbances can no longer be viewed as resulting solely from the pathology of clients, but need to be explored in the intersubjective contexts in which they arise. For instance, speaking about persons with borderline personality disorder, Stolorow et al. pointed out that when the clients' self-object connections with their therapists are significantly disrupted by mutual empathic failures, the clients may once again look and act borderline. Ivey (1995) agreed, speaking about therapy with clients with narcissistic disorder. The author stated that therapy is frequently not successful because there is no recognition of the fact that the empathic failure is bilateral and that therapists' typical responses to the narcissist's empathic failures are a representation of therapists' own narcissistic neediness and vulnerability. In light of all of this, Stolorow et al. suggested that in order for therapy to be productive, the primary focus should be on the emotional context for both clients and therapists over the meaning of the clients' experiences. Ivey, in turn, emphasized the clinical significance of mutual empathic processes in the therapy system, revealing a connection between empathy and differentiation. The author wrote, "To imaginatively locate oneself in a psychological space of another requires a stable and separate sense of self that can be temporarily

surrendered in the service of entering the other's experiential world" (p. 354).

In summary, systemically oriented authors energetically advocated looking at the whole therapeutic system in impasse. However, there has been no empirical research whatsoever exploring how the design of the system and the therapeutic relationship between all members of the system affects the system in impasse. The current research, although not entertaining an in-depth exploration of therapeutic systems in impasse, revealed practicing MFTs' reports of particular system dynamics that they witness in situations where they typically experience impasse.

#### Impasse Resolution

Scholars addressed the issue of impasse resolution, emphasizing either the role of a therapist or the dynamics in an entire system. Speaking about the role of a therapist, Haber (1990) wrote:

When the therapist is able to see her own contribution to the therapeutic impasse, she has more options for correcting the situation and can turn it into a learning experience for both herself and the family....As the therapist resolves such a dilemma, the family members will feel safer and can be more open. (p. 378)

Karon (1998) and Rober (1999) recommended making more attempts at empathy on the part of therapists. Other authors' suggestions to the therapists about their role in resolving impasse included working on the therapist's family of origin issues (Anonymous, 1978); framing family therapy in ways that are more consistent with the intensity of clients' presenting problem, for example, family consultation instead of family therapy (Wynne, McDaniel, & Weber, 1997); and using a reflective team (Chen & Noosbond, 1999). In addition, authors suggested broadening the therapist's perspective (Davison, 1995a);



adding a cotherapist (Hollon & Devine, 1995); developing integrative theory (Powell, 1995); examining impasse from a dynamic standpoint (Weiner, 1983); and developing higher tolerance for confusion (Karon, 1998). Anderson (1992) suggested getting to know the client emotionally as opposed to using descriptive explanations of mental processes. Weiner (1983) spoke about making sure that there is equality and balance in a session. Several authors mentioned using countertransference processes. For example, Biagioli (1991) proposed using countertransference feelings as a guide to understanding what patients feel entitled to expect from others. Viederman (1993) advised using the information about clients' transference to formulate corrective emotional experiences when the therapist consciously takes a posture designed to contradict the patient's transference expectations. Cowan and Presbury (2000) agreed with this perspective by suggesting that therapists provide new, affect-integrating experiences that remediate developmental deficits and create alternatives to old patterns of coping.

Recognizing the role of the entire therapeutic system in the creation of impasse as a way to resolve impasse, Green (1988) suggested achieving consensus among the members of a system on the following factors: operation, organization, causal explanations, the problem's history and the problem/system's future, interactional sequences and coalitions, and consensus about openly facing the dangers of change. Aponte (1985) indirectly addressed the issue of impasse resolution, speaking about the quality of the negotiation process in therapy in general. Aponte emphasized that since values are inevitably constantly changing and since the goal of therapy is to help the family to learn to negotiate values more successfully, the question is not whether the therapist's and clients' values will confront each other, but how.

Several authors emphasized the role of emotional experience and a therapeutic relationship in a therapeutic system as a vitally important area to be aware of in order to resolve impasse. Ryan and Johnson (1983) accentuated the necessity of emotional experiencing in the session for impasse resolution by saying, "Only after one's relationship with [the client] becomes mutually experienced as a burden or a bind can it be transformed into a creative bond with a sense of personal freedom" (p. 7). At the same time, the authors cautioned that no elaborate theorizing about hopelessness is necessary and that, in fact, it can distance therapy participants. The authors explained how the meaning of the relationship affects the participants' ability to experience it, pointing out that "sustained by a more complex understanding of what [the client] and the therapist mean to each other, the therapist can allow him/herself to experience more deeply the sense of stagnation" (p. 5). Berkowitz (1985) suggested a somewhat similar way to resolve impasse even with clients with severe personality disorders, such as narcissistic or borderline clients. The author proposed developing a high degree of trust and becoming a real object by talking about the therapist's own problems with ego dysfunction with which he/she has struggled. In addition, Berkowitz suggested facing the issues of destructive behavior of the more pathological partner individually during conjoint therapy.

Tronick (1998) proposed creating dyadic states together in therapy as an opportunity to access the clients' knowledge about their previous relationships in relation to their present relationships--information about the rules that they have learned for creating dyadic states. The author implied that with this information, clients' capacity to create dyadic states can be changed through improving emotional regulation in a system,

namely, by learning to accurately appreciate homeostatic and emotional states of each participant in the therapeutic process. Tronick pointed out that a miscoordinated state, which in this study we call impasse, is a normal event and can be used to develop more appreciation of emotional states of each other and thus to further improve clients' ability to create dyadic states.

In summary, the authors identified various ways to resolve impasses. Some of them emphasized the role of a therapist, and some, the therapeutic system as a whole. The current study completed the list of suggestions from the literature by reporting practicing MFT clinicians' strategies for impasse resolution.

#### Objectives

Given that past research on impasse has been done in the area of psychology, the purpose of this study was to learn more about MFTs' experiences with impasse. Because the single previous study (Hill et al., 1996) explored only 12 cases of unsuccessfully resolved impasse that might have been non-representative, the current research explored a more representative sample of MFTs' opinions about their experiences with both successful and unsuccessful impasse resolution.

This study had several objectives:

1. Investigate the incidence of impasse and the effects of impasse on therapists and therapy outcomes.
2. Look into therapists' experiences with impasse, their attitudes toward it, and their views on its etiology.
3. Explore clinicians' strategies for impasse resolution.

The study investigated the incidence of impasse and the effects of impasse on therapists and therapy outcomes by answering the following questions, using therapists' self-report:

1. How often has impasse of various durations occurred in therapists' practice?
2. How frequently have clinicians experienced stress of different levels of intensity in impasse?
3. Do therapists believe that their clients experience levels of stress similar to theirs in impasse?
4. What are some of the emotions therapists report experiencing in impasse?
5. How often have impasses been resolved in therapists' practice?
6. How often has unresolved impasse resulted in therapy dropouts, less effective therapy, or longer than desirable therapy?
7. What are the effects of unresolved impasse on clinicians' sense of effectiveness as therapists and their personal well-being?

This study also looked into therapists' experience with impasse, their attitudes toward it, and their views on its etiology by seeking out answers to the following questions:

8. Do therapists intentionally watch for the first signs of impasse and what are the typical first signs?
9. Are there situations in which therapists frequently or typically experience impasse and what are they?
10. Do clinicians view impasse as unpleasant situations, a normal part of therapy, or as full of therapeutic potential?

11. Where do therapists place the responsibility for impasse creation?

Finally, the study explored clinicians' strategies for impasse resolution, by answering the following question:

12. Do therapists have strategies for dealing with impasse and what are they?

## CHAPTER III

### METHODS

This research was exploratory in nature. Its purpose was to learn more about MFTs' experiences with impasse by investigating the incidence of impasse and the effects of impasse on therapists and therapy outcomes; looking into therapists' experiences with impasse, their attitudes toward it, and their views on its etiology; and by exploring clinicians' strategies for impasse resolution.

#### Sample

Subjects of the research were all Clinical Members of the American Association for Marriage and Family Therapy (AAMFT) in two states: Maryland and Utah. We selected these states because they had comparable numbers of clinicians and dissimilar demographics—Eastern and more urban Maryland versus Western and more rural Utah. This gave us a reasonable number of therapists and sufficient data to answer the research questions.

Mailing lists were obtained with permission and from the database of the AAMFT. On the same day identical research packets were sent to all 316 prospective study participants—153 in Utah and 163 participants in Maryland. Three weeks later, followup reminder postcards were sent to all those clinicians that had not responded by that time.

One hundred six questionnaires were returned resulting in a response rate of 34%. Two questionnaires were returned notifying us that the individuals were not practicing

therapy at the moment. One envelope was returned due to incorrect address. Two clinical AAMFT members were not able to participate because they were directly involved in this research. Additionally, one survey was returned with only the demographic part completed and for that reason it was not included in the analysis. Thus the data coming from the responses of 100 clinicians were analyzed. Because our final sample consisted of 100 therapists, percentages are not represented in our quantitative reports. However, the reports of qualitative data contain both numbers and percentages.

The final sample consisted of 57 women and 43 men. The mean age was 51 years and varied from 28 to 80 years ( $SD = 11.81$ ) (for a detailed demographic report see Table 1). A total of 94% of the participants were Caucasian; 47% were conducting most of their practice in Maryland and 52% were practicing therapy in Utah. The participants were practicing therapy on average 18 years ( $SD = 9.19$ ) with a range from 3 to 37 years. Average weekly client contact was 18 hours with a broad range from 2 to 40 hours per week ( $SD = 10.03$ ).

The majority of the participants identified themselves as primarily MFTs (72%) or reported dual identification as both an MFT and another occupation such as social work or psychology (10%). A total of 10% of the participants identified themselves as social workers. In regard to the level of education, 44% of the sample had MS/MA as their highest level of education, 40% had PhDs, and 8% had MSW.

Table 1

*Demographics*

Variable	Utah <i>n</i>	Maryland <i>n</i>	Missing <i>n</i>
State of practice	52	47	1
Licensure			2
MFT	50	39	
MFT + other license	8	19	
Social worker	6	13	
Professional counselor	2	12	
Psychologist	0	4	
Registered nurse	1	2	
MD	0	0	
Other	1	0	
Primary identification			1
MFT	44	27	
MFT +	5	5	
Social worker	2	8	
Psychologist	0	3	
Registered nurse	0	1	
Other	1	3	

*(table continues)*



Variable	Utah <i>n</i>	Maryland <i>n</i>	Missing <i>n</i>
Type of practice			2
Solo private practice	20	36	
Group private practice	9	4	
Private non-profit agency	9	3	
For-profit agency	5	0	
Public non-profit agency	3	1	
Private foundation	1	2	
State agency	2	0	
Other	3	0	
Highest level of education			2
MS/MA	27	18	
MSW	2	6	
PhD	21	19	
Post Doctorate	0	1	
Other	2	2	
Practice setting			1
Suburban	21	35	
Urban	18	12	
Rural	13	0	

*(table continues)*

Variable	Utah <i>n</i>	Maryland <i>n</i>	Missing <i>n</i>
Ethnicity/race			2
Caucasian	50	43	
Asian	1	0	
African American	0	1	
Hispanic	0	1	
Multiracial	0	1	
Other	1	0	
Gender			1
Female	23	34	
Male	29	13	

#### Instrument

The nuances of the design of this study and consequently its research packet (see Appendix) came about because of ambiguity in the literature on the definition of the concept of impasse. Two main outlooks on impasse were presented in the theoretical literature: impasse as a failure and impasse as a phenomenon that may precede failure, characterized as being stuck and not progressing in therapy. In order to enhance the validity of the study, we chose to base our research and its instrument explicitly on the latter view of impasse. Our reasoning was that defining impasse as failure does not give

one much freedom to deal with it, whereas defining it as a possibly difficult period that precedes failure leaves one the opportunity of intervening. To ensure the consistency of the concept usage, the cover letter attached to the questionnaire described the chosen view of impasse.

A self-designed questionnaire was used to gather data for the present study. The therapists' beliefs, attitudes, and descriptions of behavior were measured and explored using Likert-type scales, simple "Yes-No" questions, multiple choice questions, and open questions. The questionnaire had 27 questions, 11 of which were demographic. Out of the remaining 16 questions, five were Likert-type scales examining the incidence of impasse, therapists' levels of stress, and the effects of impasse on the therapy process. For instance, clinicians rated the effects of unresolved impasse on their sense of professional effectiveness using a 5-point scale (1 = Very low effect; 5 = Very high effect). Five "Yes-No" questions investigated the facts about therapists' experience with impasse. Among those facts were whether therapists experienced impasse of various durations, whether they believed that their clients experienced stress similar to theirs in impasse, whether therapists consciously looked for the first signs of impasse, whether there were situations in which clinicians typically experienced impasse, and whether they had a strategy for dealing with it. Two multiple choice questions were used to find out about therapists' attitudes toward impasse and where they placed primary responsibility for its creation (see questions 13 and 14 of the instrument). Finally, four open questions explored emotions that therapists typically experienced in impasse, the first signs of impasse, situations where clinicians typically experienced impasse, and therapists' strategies for dealing with impasse.

The self-designed questionnaire was developed on the basis of the researcher's personal experiences, review of literature, conducting a pilot study, and consultation with experts in the field of MFT. During the pilot study the questionnaire was administered to eight MFT colleagues, who provided feedback on the wording of the questions and its internal consistency. Following the pilot study, a more detailed consultation with four MFT colleagues, who were all pilot study participants, was held. In addition to analysis of the questionnaire's consistency, the four MFT colleagues were asked to rate each of the instrument questions on its content, face, and construct validity on a scale from 1 (very low validity) to 10 (very high validity). According to the results of the consultation, the ranges of the mean scores for the items of the questionnaire were between 7.75 and 10. All recommended changes in the wording and order of the questions were made to the questionnaire. Internal consistency of the questionnaire was measured with Cronbach's Alpha with all the Likert-type items (# 2, 3, 6, 7, 8). It was found that internal consistency was at the level of 0.78, which is sufficiently high. The study was exempted from review by the Institutional Review Board for human subjects at the Utah State University.

#### Procedures

Research packets included a cover letter with an informed consent, a questionnaire coded with a number (see Appendix), and a stamped and addressed return envelope and were mailed to all study participants on the same day. Participants were asked to fill out the questionnaire and return it in the return envelope. Upon receiving the completed questionnaires, a neutral, third party matched codes of the returned questionnaires to names. Follow up reminder postcards were sent to all those clinicians

who had not responded three weeks after the first mailing of the research packets. The list of codes and names was then destroyed.

### Data Management

Data were entered into SPSS (2002) for Windows version 11.5. Some participants chose a combination of answers to question number thirteen (exploring therapists' attitude toward impasse) where only one answer was requested. All of the combinations of answers representing more complex attitudes toward impasse were entered into the database as newly created variables and analyzed.

In response to question six exploring participants' professional identification, some participants identified themselves as fitting into more than one category although only primary identification was required. All of the responses were used. When the participants identified themselves as someone in addition to being an MFT, their responses were put into a category of "MFT+." When participants identified themselves as someone in addition to a non-MFT, their responses were put into a category of "non-MFT+."

### Analyses

Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to analyze the data from all of the questions of the questionnaire except from questions 5, 10, 12, and 16. Content analysis was used to analyze the data for those questions. The process of content analysis was carried out by two people, the author and her major advisor, by looking at the responses and extracting from them themes,

subthemes, and categories. First, the data were analyzed independently. After that we met and found that our analyses had 90% agreement. With a few modifications made that both of us considered meaningful, we came to an agreement of 99%. After that, each of us went through all the responses again to confirm that they fit well into our categories and themes. We discussed our discoveries again and came to a 100% agreement. The changes that we considered necessary in placing of particular responses were made.

## CHAPTER 4

## RESULTS

The purpose of this exploratory study was to learn about MFT clinicians' experiences with therapeutic impasse. The study had several objectives: investigate the incidence of impasse and the effects of impasse on therapists and therapy outcomes; look into therapists' experiences with impasse, their attitudes toward it, and their views on its etiology; and explore clinicians' strategies for impasse resolution. The analyzed sample consisted of 100 clinicians; therefore, percentages are not represented. However, qualitatively analyzed data are reported with both numbers and percentages.

First Research Question: How Often Has Impasse of Various Durations  
Occurred in Therapists' Practice?

The participants were asked to indicate whether during the last year of their practice they had been in impasse of various durations (impasse lasting a few minutes, a part of the session, one session, two sessions, and three or more sessions). A total of 83 therapists reported having been stuck for a few minutes (see Table 2). Thirty-five participants reported having been stuck for three or more sessions. Even though the respondents were offered the opportunity to respond either "yes" or "no," many made no response at all. For instance, 30 therapists did not respond as to whether they experienced impasse lasting two sessions. The same number of therapists failed to respond as to whether they experienced impasse lasting three or more sessions.

Table 2

*Incidence of Impasse*

	Incidence		
	Yes <i>n</i>	No <i>n</i>	No response <i>n</i>
A few minutes	83	1	16
A part of the session	78	6	16
One session	54	20	26
Two sessions	43	27	30
Three or more sessions	35	35	30

Further, the participants were asked to identify how often impasse of different durations occurred in their practice (once a month or less, every other week, once a week, a few times a week, or once a day or more). The responses for each duration indicate that the great majority of the therapists were in impasse of various durations with similarly infrequent regularity (see Table 3). A total of 37 participants indicated that they were stuck for a few minutes only once a month or less. Likewise, 28 participants reported the same frequency (once a month or less) of being in impasse for three or more sessions. Quite a few therapists (32) did not respond to inquiry about the frequencies of their being in impasse for two sessions, and 35 therapists failed to respond to how often they experienced impasse lasting three or more sessions.



Table 3

*Frequency of Impasse of Various Durations*

Impasse Duration	Frequency of Occurrence						
	Never <i>n</i>	Once a month or less <i>n</i>	Every other week <i>n</i>	Once a week <i>n</i>	A few times a week <i>n</i>	Once a day or more <i>n</i>	No response <i>n</i>
A few minutes	1	37	13	12	12	6	19
A part of the session	5	39	16	13	6	3	18
One session	18	40	9	4	1	--	28
Two sessions	25	39	4	--	--	--	32
Three or more sessions	33	28	4	--	--	--	35

*Note.* Dash indicates that no participants reported experiencing impasse of a particular duration with a particular frequency.

Second Research Question: How Frequently Have Clinicians Experienced  
Stress of Different Levels of Intensity in Impasse?

The participants were asked how often they experienced very high, high, medium, low, and very low levels of stress: very often (75-100% of time), often (50-74%),

sometimes (25-49%), rarely (1-14%), or never (0%). The majority of clinicians (79) reported having experienced very high stress in impasse rarely or never (see Table 4). In relation to medium stress, some therapists mentioned having experienced it sometimes (40) and some rarely (34). Only 4 clinicians reported never experiencing medium stress. Concerning low stress, 29 participants said that they experienced it often or very often, 32 sometimes, and 21 rarely or never.

#### Third Research Question: Do Therapists Believe That Their Clients Experience Levels of Stress Similar to Theirs in Impasse?

A total of 56 participants believed that their clients' level of stress is similar to theirs in impasse. At the same time, 36 participants thought that it is different. At this point we do not know what therapists' perceptions of the differences are: whether they or their clients experience more stress. There were eight missing responses to this question.

#### Fourth Research Question: What Are Some of the Emotions Therapists Report Experiencing in Impasse?

An open ended question asked therapists to name some of the emotions they typically experience in impasse. Content analysis of the data (see the description of the process on pp. 34-35) revealed that clinicians experience a range of emotions, some of which are distressing to various degrees and some, not distressing. We chose distressing and nondistressing emotions as themes because they adequately describe the range of the responses, each embracing several particular emotional states. Similar emotional states were put into a particular category. For example, the category of frustration

Table 4

*Stress of Therapists in Impasse*

Level of stress	Frequency of Occurrence					
	Very often <i>n</i>	Often <i>n</i>	Sometimes <i>n</i>	Rarely <i>n</i>	Never <i>n</i>	No response <i>n</i>
Very high	0	0	7	49	30	14
High	0	3	12	55	16	14
Medium	5	10	40	34	4	7
Low	10	19	32	19	2	18
Very Low	19	11	28	17	5	20

included emotions such as frustration, anger, irritation, resentment, and annoyance. At times we used the context of a full response to help place a particular emotion into a specific category. For instance, the emotion of concern from the response, "frustration, concern, confusion" was put into the category of anxious as opposed to compassionate emotions because its context reflected frustration and confusion.

The analysis of the responses revealed that the therapists most often reported distressing emotions. Out of the 227 reported emotions, clinicians reported distressing emotions 200 times (87%) (see Table 5). Nondistressing emotions, on the other hand, were mentioned significantly less often (22 times or 10%). The remainder of the

responses (7 or 3%) contained non-emotional reactions, emotions of the category of "other," and responses the meaning of which we could not infer.

### *Distressing Emotions*

Many participants mentioned multiple distressing emotions. Therefore, the theme of distressing emotions included categories of frustration, anxiety, confusion, inadequacy, detachment, fear, and sadness. The frequency with which various emotions were mentioned varied greatly. Frustration and anger were named the most often (70 times), which accounted for 31% of all recorded emotions. Many therapists reported feeling anxious (37 times). A significant number of participants reported feeling confused (29 times) and inadequate (23 times). Some therapists reported feeling detached (17) and fearful (16). Emotions in the category of sadness were named only 8 times.

*Frustration.* Emotions of the category frustration were named the greatest number of times (70). In addition to frustration, the emotions named that fit this category included anger, irritation, resentment, and annoyance. Most of the participants did not point to the source of their more or less angry emotions, although some did. One of the respondents said that he felt "a flash of anger at client reactant behavior." Another participant mentioned that she felt anger from her own helplessness. One of the participants described her reaction as "insecure" anger.

*Anxiety.* The responses of the category anxious emotions also varied in character and intensity. Besides feeling anxious, the therapists also reported experiencing worry, concern, tension, nervousness, and panic. Some of them reported feeling pressured and overwhelmed. One of the participants clarified that she experienced anxiety associated

Table 5

*Emotions in Impasse*

Theme and category	# of Times Mentioned
Distressing emotions	200
Frustration	70
Anxiety	37
Confusion	29
Inadequacy	23
Detachment	17
Fear	16
Sadness	8
Nondistressing emotions	22
Anticipation	12
Compassion	7
Peacefulness	2
Humor	1
Other responses	7

with the belief, "I should know more." Another participant clarified that he was "worried" about what he can do "to give hope and make a difference—to ensure that they see the therapeutic process as valuable." As will become evident later, some of the

responses of "concern" were put into a category of compassionate emotions and some into the category of anxious emotions. We used the context of each response to discriminate between these two kinds of concern.

*Confusion.* Similarly, the context of the responses helped us to make the decision to put the category of confusing emotions into the distressing theme. Although confusion can evoke both positive and negative responses, in our sample, confusion was associated mainly with therapists' feeling anxious, overwhelmed, frustrated, and powerless. Other emotions in the category of confusion included befuddlement, puzzlement, and uncertainty. Some therapists reported feeling unsure and doubtful.

*Inadequacy.* Among the responses of the category of inadequacy, responses also were diverse. The therapists reported feeling incompetent, inadequate, and powerless. One therapist reported feeling demoralized. The clinicians also reported feeling embarrassed, guilty, and awkward. One of the participants added that he felt "the need to rescue the awkwardness."

*Detachment.* The feeling of detachment was reported to be associated with tiredness, loss of focus, and boredom. One of the therapists said that she felt disconnected and mistrustful. Another therapist reported feeling numb. Some therapists reported feeling the desire to be somewhere else at the time, resignation, and apathy. One therapist explained why she felt apathetic, saying, "The client is making choices that keep him [sic] stuck. I can only identify the situation and give suggestions on how to move. He chooses to move or to remain stuck."

*Fear.* The participants reported experiencing different degrees and sources of fear and helplessness. For instance, one of them said that she feared domestic violent

perpetrators. Another mentioned that she feared not being able "to get beyond this point."

*Sadness.* Only a few clinicians reported feeling sad and disappointed in impasse. Most of them did not mention the reasons for their sadness. One of the therapists, however, said that he was disappointed with himself. Another reported that he felt sad when he could not find a way to be helpful.

#### *Nondistressing Emotions*

As mentioned earlier, nondistressing emotions were mentioned significantly less often than distressing. The theme of nondistressing emotions consisted of categories of anticipation, compassion, peacefulness, and humor. Emotions of the category of anticipation were named 12 times. Compassionate emotions were mentioned seven times. The emotions of peacefulness and humor were mentioned two and one time, respectively.

In the category of anticipation, the participants reported experiencing curiosity, anticipation, increased energy, and focus. In the category of compassion, therapists mentioned increased compassion, acceptance, empathy, concern, and patience. In the category of peacefulness, one participant reported feeling calm. The other said that she felt "peacefulness—almost in a sense that [her] impasse is a way for client to take a break." One therapist mentioned his facing the situation of impasse with humor.

#### *Other Emotional and Non-emotional Responses*

Some of the respondents reported experiencing stuckness. One therapist described it as being "shackled." These responses were put in a separate category because, although being stuck is named by the participants as an emotion, it is not an emotion that is easily categorized. Some therapists reported feeling responsible, ambivalent, or betrayed in the

situation of impasse. Because these responses described more complex feeling states and are composed of several emotions (distressing and/or nondistressing) they were put into a category of "other."

Several respondents talked about using their cognitive resources in the situation of impasse. For instance, one participant wrote, "I use a lot of cognitive processing at this time and think strategically to figure out the next therapeutic step/statement/question." All these responses were put into a category of "not emotions." Some of the therapists expressed their main cognitive outlook on the situation of impasse instead of talking about their affective response in impasse. For example, one of them said, "I feel no stress, or sense of personal failure struggling to understand, move forward is what therapy is all about."

One of the therapists said that he experienced a sense of urgency in the situation of impasse. However, we could not infer from his response what kind of urgency he was talking about. Therefore, we put it in a separate category of responses, the meaning of which we could not understand.

#### Fifth Research Question: How Often Have Impasses Been Resolved in Therapists' Practice?

The participants were given five options of frequency of impasse resolution to choose from: very often (75-100% of time), often (50-74%), sometimes (25-49%), rarely (1-24%), and never (0%). The vast majority of the clinicians (95) reported that in their practice, impasses were resolved often or very often (see Table 6).



Table 6

*Frequency of Impasse Resolution*

Frequency	<i>n</i>
Very often	68
Often	27
Sometimes	4
Rarely	1
Never	0
No response	0

Sixth Research Question: How Often Has Unresolved Impasse  
 Resulted in Therapy Dropouts, Less Effective Therapy,  
 or Longer Than Desirable Therapy?

The participants were given the same options from which they could choose their answers as in the previous question: very often (75-100% of time), often (50-74% of time), sometimes (25-49% of time), rarely (1-24% of time), and never (0%). Only 14 therapists said that impasses resulted in dropouts often or very often (see Table 7). In relation to prolonged therapy, the majority of the therapists stated that prolonged therapy in impasse also happened either rarely (28) or sometimes (35). Finally, concerning less effective therapy, 37 of the clinicians reported that it happens sometimes in the situation of unresolved impasse, 27 rarely, and 23 often or very often.

Table 7

*Frequency of Unresolved Impasse Ending in a Dropout, Prolonged, or Less Effective Therapy*

	Very often <i>n</i>	Often <i>n</i>	Sometimes <i>n</i>	Rarely <i>n</i>	Never <i>n</i>	No response <i>n</i>
Dropout	8	6	22	48	4	12
Longer than desirable duration of therapy	4	10	35	28	2	21
Less effective therapy	9	14	37	27	2	11

Seventh Research Question: What Are the Effects of Unresolved Impasse  
on Clinicians' Sense of Effectiveness as Therapists  
and Their Personal Well-being?

The participants were given five options from which they could choose their answers to this question: very high, high, medium, low, very low. In relation to the effect of unresolved impasse on the therapists' sense of professional effectiveness, 31 clinicians reported impasse as having high or very high effect (see Table 8), 29 medium, and 37 low or very low. The majority (62%) of respondents reported low or very low impact of the impasse on their personal well-being.

Table 8

*The Effect of Impasse on Therapists*

	Effect					
	Very high	High	Medium	Low	Very low	No response
	<i>n</i>	<i>n</i>	<i>n</i>	<i>n</i>	<i>n</i>	<i>n</i>
Sense of professional effectiveness	16	15	29	20	17	3
Personal well-being	7	10	18	34	28	3

Eighth Research Question: Do Therapists Intentionally Watch for the  
First Signs of Impasse and What Are the Typical First Signs?

The first part of this question required a yes-no response, whereas the second part was open-ended. A total of 52 participants reported that they intentionally looked for the first signs of impasse and 48 said that they did not. A great number of therapists from both groups—those that looked and those that did not—responded to the second part of the question about typical first signs.

Content analysis of the responses revealed that therapists used different units of analysis while looking at the first signs of impasse. Some of the responses revealed therapists' looking for client manifestations while others looked for therapist or system manifestations. Therefore, client, therapist, and system signs were selected as

themes. The analysis revealed that the therapists looked for client signs of impasse more often than therapist or system signs (44 times vs. 24 and 30, respectively) (see Table 9).

### *Client Signs*

Further elaboration on client signs of impasse allowed us to notice the following groups that became our categories: lack of motivation/withdrawal, defensiveness, lack of cooperation/sabotage, resistance, and lack of change. *Lack of motivation/withdrawal* was mentioned 12 times and accounts for 27% of the responses of the theme of client signs. In this category, the therapists mentioned client manifestations such as lack of responsiveness, no interest in feedback, disengagement, and resignation. They also described behavioral indications: "client isn't talking 85% or more," and "gives just general information." One therapist described it as "failure of the client to work as hard as me or care as much about resolving their issues as I do."

*Lack of client cooperation/sabotage* was the second largest category, mentioned 10 times and accounting for 23% of the responses of this theme. In this category, clinicians mentioned client dishonesty, minimization of problems, avoidance of issues, sporadic attendance, sabotaging solutions to problems, and assuming no responsibility. *Lack of change* in clients was mentioned 9 times, which accounts for 20% of all the responses of this theme. One of the therapists reported lack of change or difference being associated with the situation when "client repeats problematic behavior after several sessions of focusing on the problem and practicing alternative, more adaptive behaviors." In relation to couple's therapy, one of the therapists mentioned "repeated patterns of interactions, of undesirable behavior."

Table 9

*First Signs of Impasse*

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Theme and category	# of times mentioned
Client signs	44
Lack of motivation/withdrawal	12
Lack of cooperation/sabotage	10
Lack of change	9
Resistance	7
Defensiveness	6
Therapist signs	24
Confusion/impotence	8
Trying too hard	8
Lack of connection with clients	5
Other	3
System signs	30
Poor connection/communication	13
Conflict	7
Lack of change	7
Problems related to treatment plan	3

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*Resistance* or noncompliance in clients was mentioned a total of 7 times (16%). Although the responses of this category were somewhat similar to the responses of the category of lack of cooperation/sabotage, we made it a separate category, because, from our standpoint, the responses describing clients as resistant or noncompliant are qualitatively different from the responses describing clients' behavior revealing lack of cooperation/sabotage, such as minimization or avoidance of issues. Some of these behaviors might be interpreted as resistance by some and might not be interpreted as such by others. Since we did not want to interpret meaning from the responses that might not be intended, we put into the category resistance only explicit references to resistance.

*Defensiveness*, the last category of this theme, was mentioned six times, which accounted for 14% of the responses. The therapists gave such descriptors of client defensiveness as argumentativeness, anger, lack of eye contact, and nervous body language. They also mentioned such client behaviors as "finger pointing," confronting the therapist, and "blaming without ownership." One of the therapists mentioned clients' "setting up rigid definitions."

There were three responses in the theme of Client Signs, the meaning of which we could not infer. Therefore, they were put in a separate category. These were, "quiet, closed body language," "boundaries, client is irresponsible with emotions," and "the family/couple shifts."

### *Therapist Signs*

The theme of therapist signs allowed for extraction of the categories of confusion/impotence, trying too hard, and lack of connection with others. The

*confusion/impotence* category included eight responses, which accounted for 30% of all the responses. The therapists reported noticing their own confusion, uncertainty about "how to proceed," "questioning themselves," and their "inability to conceptualize the case" as signs of impasse.

The *trying too hard* category was also composed of eight responses. The therapists reported noticing that they were "working harder than their clients," "trying too hard," "leaning forward and talking too much" as the signs of impasse. A few of them reported noticing getting frustrated in the process.

The category of *lack of therapist's connection with others* consisted of five responses accounting for 21% of all of the responses of this theme. The clinicians reported noticing being bored, not understanding clients, feeling disconnected from them, and "fog blank [sic] thoughts elsewhere" as their signs of impasse.

The *other* category included three responses not otherwise categorized. These included therapists' reports of noticing having "an upset stomach, feeling tired," feeling frustrated, and "frequently inquiring clients as to their goals [sic]" as the signs of impasse.

### *System Signs*

Out of the theme of system signs the following categories were extracted: poor connection/communication, conflict, lack of change, and problems related to treatment plan. *Poor connection/communication* was the largest category, mentioned a total 13 times (43% of the responses of the theme). The clinicians described this as the absence of emotional connection, withdrawal, inability to communicate effectively, boredom, and

lack of energy in the system. They also named "long periods of silence," "limited cooperation/exploration," "and talking in circles." The responses of this category were put into the subtheme of system signs as opposed to therapist or client signs because this particular group of responses spoke about specific signs of impasse manifesting in the therapeutic system as a whole (in all therapy participants) as opposed to manifesting in the therapist or clients exclusively.

*Conflict* in a system was mentioned seven times, which accounted for 23% of all the responses of this theme. In this category, the therapists mentioned growing anger/hostility and escalating conflict in the therapeutic system. They also mentioned "hard-edge decision making," "lack of flexibility," and "mistrust."

*Lack of change* in the system also was mentioned seven times. The therapists described this as "getting into the same routine during therapy each week without progress," repetitive responses/patterns, and lack of resolution.

*Problems related to treatment plan* category consisted of the smallest number of responses (3 or 10%). Among the responses of this category were "deviating from treatment plan," "differences in opinion pertaining to the definition of the problem," and "differences in readiness for change."

Ninth Research Question: Are There Situations in Which Therapists  
Frequently or Typically Experience Impasse and What Are They?

The structure of this question is similar to the previous one. Namely, it was composed of the quantitative yes-no question followed by the qualitative open-ended



question. Whereas 37 therapists reported that they did not have typical impasse situations, 59 of them stated that they did. There were four missing responses to this question.

The participants described their typical impasse situations from different angles of view (see Table 10). Some of them reported noticing certain client characteristics or populations with which they typically experience impasse and some mentioned therapist or system related dynamics. Therefore, we have chosen client dynamics, therapist dynamics, and system dynamics as our main themes. There were 83 typical impasse situations named. Each theme included a different number of responses. Client dynamics included 54 responses (65% of all responses), whereas therapist dynamics consisted of only four responses (5%). The theme system dynamics was composed of 21 responses which accounted for 25% of all responses.

#### *Client Dynamics*

The subthemes of general client characteristics, specific client diagnoses and client populations were extracted from the theme of client dynamics. Each subtheme included about a third of all of the responses for this theme.

*The general client characteristics* subtheme allowed for extraction of several categories such as hostile/domineering, passive/dependent, secretive, unmotivated, and resistant. The participants reported nine times that they frequently experienced impasse with clients described as *passive/dependent*, which accounted for 47% of the responses in this subtheme. The therapists described this group of clients as "passive," "reactant," "uncommunicative," "helpless," and "looking to their therapist to give them answers." Two of the respondents added that the passivity of the clients may have an aggressive or

Table 10

*Typical Impasse Situations*


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Theme, subtheme, and category	# of times mentioned
Client dynamics	54
General characteristics	20
Passivity/dependence	9
Low motivation	4
Secretiveness	3
Hostility/domineering	3
Resistance	1
Specific diagnoses	17
Axis II	13
Depression	4
Populations	17
Married populations	9
Single populations	4
Clients with particular issues	3
Other	1
Therapist dynamics	4

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*(table continues)*

Theme, subtheme, and category	# of times mentioned
System dynamics	21
Mismatched readiness/motivation	7
High conflict/low affection	5
Parenting dynamics	4
Therapy process	3
Secrecy/trust violations	2
Other	4

blaming quality. One therapist described this category of clients as “clients whose underlying problem has to do with not feeling like they have any power or ability to help themselves or change or affect their own situation.” Another therapist revealed that “helpless” or “blaming” clients who will not help themselves are very rare in her current practice. The therapist said, “These are very rare the past 10-12 years as I ‘hear’ them when they call for an appointment and refer them to a therapist who would be more suited to them (i.e., someone who is much more willing to do rather passive therapy).

Four responses (21%) mentioned *lack of motivation* as a dynamic with which therapists frequently experience impasse. One therapist described it as a situation where “client has to be there and doesn’t want to utilize the time.” Another therapist explained that she experienced impasse with “clients who feel forced to come by a spouse or

another source." Two clinicians referred to court orders as a circumstance that often accompanies lack of clients' motivation.

Therapists mentioned client *secretiveness* three times as a dynamic with which they typically experience impasse. The clinicians described this dynamic using words such as "lying," "secrets," and "partial disclosure." One therapist especially pointed to "sexual secrets" as her "worst case scenarios." The therapists mentioned that they typically experienced impasse with *hostile/domineering* clients also three times, which accounted for only 16% of the responses of this subtheme. The clinicians used words such as "excessive," "controlling," "hostile," and "domineering" to describe this category of clients.

One response mentioned client *resistance* as a dynamic with which they typically experience impasse. We put this response in a separate category because we believe it represents a qualitatively different outlook, presenting clients as generally noncompliant without referring to behaviors or dynamics in the system or the clients' life (circumstances such as court order and the like).

The *specific client diagnoses* subtheme was composed of about one third of the responses of the theme of client dynamics. Two categories comprise this subtheme: axis II and depression. The category of axis II consisted of 13 responses, which accounted for 76% of the responses of this subtheme. All of the respondents in this category named various personality disorders as a client dynamic with which they often face impasse. Six therapists mentioned borderline personality disorder. Three clinicians referred to narcissistic personality disorder. One therapist explained that he has a hard time working with borderline females and narcissistic men because they are "convinced they are

'victim' and act powerless/resistant to change their own behavior/attitude/strategies since it's [sic] another's 'fault'." Two other therapists talked about paranoid, dependent, and avoidant tendencies as dynamics with which they often face impasse. One therapist wrote that although she typically faced impasse working with clients with dependent/avoidant/narcissistic/paranoid disorders she does better with borderlines. The therapist said, "I know the treatment plan and have a lot of experience with those."

The category of *depression* was composed of four responses accounting for 24% of the total responses for the subtheme of the specific client diagnosis. All of the responses of this category suggested that when impasse occurs, it often happens with clients who are depressed. One of the therapists stated that to her, a severe depression is problematic. Another clinician added that she has a harder time working with "majorly depressed individuals who aren't motivated to do anything."

*Client populations* subtheme accounted for about a third of all the responses in the theme of client dynamics and was composed of four categories: single populations, married populations, clients with particular issues, and other. The category *married populations* consisted of nine responses, which accounted for 53% of the responses of this subtheme. All of the responses of this category named couple dynamics as dynamics they typically face impasse with. Some therapists referred to conflictual, ambivalent, and rigid couples' dynamics. Three respondents mentioned household violence as a dynamic they often face impasse with. One therapist mentioned parents in a codependent relationship with domestic violence present. Another clinician specifically named "women who are verbally abusive toward their husbands" and another, "angry controlling men."

The category of *single populations* included four responses accounting for 24% of the responses in this subtheme. The respondents pointed to single populations that they frequently experience impasse with such as teenagers and adolescents. Speaking of teenagers, one therapist clarified that she had a problem with teenage girls with self-esteem issues. Referring to adolescents, one clinician said that she typically experienced impasse with "adolescents as identified patient who are resistant," and another with adolescents "who do not want to be in therapy."

Three responses mentioned *specific client issues* as dynamics with which they typically get stuck, which accounted for 18% of all of the responses of the subcategory of client populations. Two responses pointed to addiction, one to drug/alcohol addiction in particular. The third response mentioned severe trauma. The category of *other* consisted of one response. The respondent in this category mentioned clients in a personality stage very different than hers as a group of clients with which she often feels in impasse.

#### *Therapist Dynamics*

The theme of therapist dynamics consisted of four responses accounting for only 5% of the responses. Three therapists mentioned several scenarios they typically experience impasse with: when the situation is new to the therapist and he/she has minimal training in it, when the therapist has too many clients at a time, and when stuck in one approach to the problem. The fourth therapist said that she feels stuck when she is not listening with her whole heart and does not let intuition guide her.

#### *System Dynamics*

The theme of system dynamics was composed of 21 responses, which accounted

for 25% of all the responses. The following categories were extracted: mismatched readiness/motivation, high conflict/low affection, parenting dynamics, therapy process, and secrecy/trust violations.

*The mismatched readiness/motivation* category consisted of seven responses accounting for 30% of the responses of this theme. Although most of the responses of this category were referring to mismatch between clients, some of them pertained to the mismatch between clients and therapist. Speaking about the mismatch between the clients, participants talked about the situation where one partner shows lack of investment, denies responsibility, or blames others. One clinician described the situation when one member of the family starts to change and others do not agree with this or just do not change in turn. Other therapists discussed the situation where the partners have different agendas and neither is willing to change. Three responses talked about mismatching in readiness and motivation between clients and the therapist. One of them described the situation where both partners want to end the relationship but still "half-heartedly" work at it. Another clinician described the circumstances where she touches "on something clients are hurting about and it's difficult for them to deal with."

*High conflict/low affection* category consisted of five responses, which accounted for 24% of the responses of this theme. One therapist talked about pre-divorce situations and another about high conflict divorce or separation. The remainder of the respondents (3) referred to chronic conflict or marital discord over long periods, "especially where they (or one) expresses despair of ever getting better." One therapist said, "I call it 'dead love': when love is gone, apathy is apparent and years of stoicism prevail."

*The parenting dynamics* category was composed of four responses, which accounted for 19% of the responses of the theme of system dynamics. Two therapists referred to step-parenting and blended family conflicts. One respondent talked about the conflict of older clients with the youth in their home. Another clinician talked about the hardship of working with the cases where she needs to report child abuse/neglect.

The category of *therapy process* consisted of three responses (14% of the responses of this theme). In this category, one participant talked about the early stages in the therapy relationship, where she frequently experienced impasse. Other participants mentioned not being clear about the goals and the differences between the therapist and the clients in approaching the problems.

*The secrecy/trust violations* category included two responses, which accounted for 10% of the responses of this theme. One response referred to an affair that is still a secret and the other talked about trust violations in general that evoke a great deal of anger in spouses.

#### *Other Responses*

The category of other consisted of four responses. Two respondents wrote about hopelessness in the system "when the situation is labeled 'impossible'." The others mentioned no-shows, cancelled appointments, and the necessity to evaluate clients' medications. One response ("Therapeutic goals/decisions") was put in a separate category because we could not infer its meaning. Three more responses were put into a category of "not situations." One participant whose response was placed in this category mentioned an idea such as "struggling to move forward is a normal part of therapy." A second said,



"In a sense all therapy is about defenses." The third participant described a situation where the therapy needs to slow down naturally, which cannot be considered an impasse ("when a patient is stuck in a horrific memory and needs more time to work through it").

Tenth Research Question: Do Clinicians View Impasse  
as an Unpleasant Situation, a Normal Part of Therapy,  
or as an Event Full of Therapeutic Potential?

Although most of the participants used the options given to them for their responses, some of the participants indicated a more complex attitude composed of two or even all three options. Most of the participants (86) described their attitudes as positive. Among them, 34 described impasse as a normal part of therapy and another 39 acknowledged impasse as an event full of therapeutic potential (see Table 11). Another 13 of the clinicians had a mixed attitude stating that impasse was both a normal part of therapy and an event full of therapeutic potential. Only five clinicians viewed impasse as merely something unpleasant. Some participants (4) displayed a very complex attitude toward impasse, indicating that impasse was unpleasant to them, but, at the same time, it was a normal part of therapy and a part of therapy with great therapeutic potential.

Eleventh Research Question: Where do Therapists  
Place the Responsibility for Impasse Creation?

The clinicians were given several options from which they could select their responses for this question. Namely, they could indicate that the responsibility was mostly theirs, mostly their clients', or mutual. An 'other' option was given to them also.

Table 11

*Therapists' Attitude toward Impasse*

Attitude	<i>n</i>
(a) Something unpleasant that they try to overcome so that they can move on with the therapy	5
(b) A normal part of therapy that needs to be dealt with	34
(c) A part of therapy with great therapeutic potential that they can use in order to progress in therapy	39
(d) Attitude composed of (b) and (c)	13
(e) Attitude composed of (a), (b), and (c)	4
No response	5

A slight majority of the respondents (55) declared that the responsibility for impasse was a mutual responsibility of the therapist and the clients. Equal numbers of therapists (17) indicated that the responsibility was either mainly theirs or mainly clients'.

Twelfth Research Question: Do Therapists Have Strategies for  
Dealing with Impasse and What Are They?

This question also was composed of two parts: the quantitative yes-no part and the qualitative open-ended part. In response to the first part, most of the participants (88) reported having a strategy (or strategies) for managing impasse. Only 7 therapists

reported not having a strategy. There were five responses missing for this question.

Content analysis revealed that the participants used diverse strategies for dealing with impasse. Some participants named interventions that they used immediately in a session and some interventions that they developed and used on a larger scale—between as well as in the sessions. This allowed us to extract two major themes: immediate interventions and larger scale interventions. In addition, some of the responses included descriptions of complete courses of actions for the situation of impasse. Those responses became a part of a theme of complete courses of actions.

A total of 124 strategies were named. Of those responses, 108 (87%) named various single interventions for dealing with impasse. Among those, 77 responses (or 71%) were strategies applied immediately in a session (see Table 12). The remainder (31 response or 29%) were strategies developed and applied on a larger scale (between as well as in the sessions). There were a total of 16 responses describing whole courses of actions, which accounted for 13% of all responses.

### *Immediate Interventions*

Two subthemes were extracted from the responses of the theme of immediate interventions: a subtheme of immediate system interventions and a subtheme of therapist's immediate actions. The subtheme of immediate system interventions consisted of 57 responses accounting for 74% of the responses of the theme. The subtheme of therapist's immediate actions was composed of 20 responses, which accounted for 26% of all responses of this theme.

*Immediate system interventions.* The following categories were extracted from

Table 12

*Impasse Resolution*


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Theme, subtheme, and category	# of times mentioned
Immediate interventions	77
Interventions in a system	57
Discussing	32
Specific interventions	11
Improving communication	
and emotional connection	7
Trying something different	7
Therapist actions	20
Sharing feelings and thoughts	9
Slowing down	5
Getting more in touch with	
self and clients	4
Self-balancing	2
Larger scale interventions	31
Interventions with the therapist	26
Supervision/consultation	14
Individual work	12
System interventions	5
Complete courses of actions	16

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the responses of this subtheme: discussing, improving communication and emotional connection, trying something different, and specific interventions. The category of discussing was the largest category of this subtheme, including 32 responses and

accounting for 56% of the responses. The responses in this category displayed various sides of discussing impasse with clients. Some therapists reported taking more direct roles, asking more questions, giving the responsibility "back to the clients," and being confrontive about impasse. Others spoke about sharing the responsibility for understanding and solutions with the clients, helping clients become active in addressing impasse, and wondering together about what clients feel and about "usefulness and meaning behind stuckness."

The category of *specific interventions* consisted of 11 responses accounting for 19% of the responses of this subtheme. Among interventions the participants use in impasse were using humor, exaggerations, paradoxical intent, and Solution Focused exercises. In addition, they described using a "Bowenian" approach and "becoming less competent," allowing clients to discover their own resources. Some clinicians reported that they changed seats with the clients, allowing them to be "the therapist" or to make suggestions to a "friend." Others named reviewing and clarifying goals and treatment plans, broadening the focus or unit of treatment, and applying an eclectic approach to doing therapy.

The category of *improving communication and emotional connection* was composed of seven responses accounting for 12% of all responses of the subtheme. The therapists in this category reported that they try to improve communication and connection and to find agreement with their clients. They described increasing empathy, listening for what clients "really need to say," and "getting into the emotions." One clinician described using experiential activities in order to heighten emotions. Another clinician described her approach in this way: "Don't fight it, listen to it, observe where

the energy wants to go, set open nonjudgmental and healthy boundaries and encourage independence and responsibility accountability.”

A total of seven responses were a part of the category of *trying something different*, accounting for 12% of all responses of the subtheme of system interventions. The clinicians who gave responses in this category reported that they try something different, exploring other options and directions in impasse. One therapist wrote, “I get creative and try new things in therapy. I might try a different modality (i.e., inviting in a different family member).” Another therapist stated that he tries to go “somewhere else” with the clients and “then return.”

*Therapist's immediate actions.* The following categories were extracted from the responses of this subtheme: sharing feelings and thoughts about impasse, slowing down, getting more in touch with self and clients, and self-balancing. The category of *sharing therapist's feelings and thoughts* about impasse was the largest in this subtheme. It consisted of nine responses accounting for 45% of all responses. The therapists in this category reported that they honestly and directly spoke to their clients, revealing their feeling of being stuck and commenting on what their clients feel. One clinician said that he “speaks to clients’ pain” so that his clients feel heard.

Five responses in the category of *slowing down* accounted for 25% of the responses of the subtheme. The clinicians in this category reported that they slow down, take a break, “stop trying so hard to ‘get through to the client’,” “purposely lean back in the chair and stretch out,” and become “less directive and avoid pushing ‘buttons.’” One therapist expressed this outlook on slowing down: “Sometimes I just get patient and trust the therapeutic process and accept people need more time and great therapeutic trust to

move forward." Another clinician wrote that the purpose of her slowing down is to go over what her clients are saying to better coordinate her work with where the clients are.

The category *getting more in touch with self and clients* was composed of four responses, accounting for 20% of the responses of the subtheme. Three respondents reported getting more in touch with their clients. One of the therapists reported that he uses curiosity about clients' feelings, intentions, and desires. Another two clinicians described their paying more attention to clients' non-verbal communication. In light of this, one of them used "mirroring" clients' nonverbals so she "can get more in sync with them and therefore have a better understanding of how they see impasse and hopefully get [them] both unstuck." One clinician described her paying more attention to her internal feelings and beginning to ask herself questions in the situation of impasse.

The category of *self-balancing* consisted of two responses accounting for 10% of the responses of the subtheme. The therapists suggested taking a deep breath and self-talk as ways to balance themselves during impasse.

### *Larger Scale Interventions*

Among the responses of this theme, two subthemes were extracted:

(1) interventions with the therapist, and (2) system interventions. The subtheme of interventions with the therapist consisted of 26 responses, accounting for the majority (84%) of the responses of the theme.

*Interventions with the therapist.* Two categories were extracted from the responses of the subtheme of interventions with the therapist: individual work and supervision/consultation. The category *supervision/consultation* consisted of 14

responses and accounted for 54% of the responses of this subtheme. In this category, several therapists reported having discussion/consultation/supervision with a peer. Others mentioned consultation and brainstorming in a peer-supervision group. Some clinicians wrote about their getting supervision from a "master therapist" or a "coach." One of them explained that this helps her "to stay on top of blind spots." Some therapists mentioned that after supervision they plan their sessions and think about how to make things that need to be said, "talkable" with the client.

The category of *individual work* consisted of 12 responses accounting for 46% of the responses of this subtheme. Some therapists in this category reported taking time to reflect on the case, free associating, reconceptualizing a case, doing personal research, and educating themselves after they recognized that they felt stuck. Others mentioned examining their countertransference reactions and working on those responses, doing "personal growth work," and working in their family system. One of the therapists mentioned that after examining her reactions, she used them in therapy as a therapeutic issue.

*System interventions.* This subtheme of interventions consisted of five responses. Among them, two of the responses named terminating therapy for a few weeks and having a "treatment vacation" as a way of impasse resolution. Speaking about couple therapy, one therapist mentioned seeing couples individually for a few sessions, creating "specific rules for proceeding." Another participant mentioned "precipitating crisis" in a system. She did not clarify the specifics, however. The last response of this subtheme mentioned an attempt to "utilize everything," trying to remember that often in impasse "important information connected to more truth [emerges] (e.g., fear of a horrific



memory that is coming to consciousness).”

### *Complete Courses of Actions*

The theme of complete courses of actions consisted of 16 responses accounting for 13% of all responses. The responses had different content and organization. For instance, one of the participants described her course of actions in this way: “1) I stop trying so hard to ‘get thru to the client,’ 2) I purposely lean back in my chair and stretch out, 3) I work on my responses (i.e., frustration) so I can begin to think creatively, 4) I ‘put it out there’ to the client so we can work it through, and 5) Sometimes I use a Bowen approach and become much less ‘competent.’ ‘Gee, this beats me—I’ve run out of ideas—do you have any ideas about how to solve this?’ ” Another participant’s approach, on the other hand, was concentrated on slightly different things: “Review the working relationship with the clients. Check out their social support systems. Review their readiness to change. Review treatment delivery and determine if our assessment was correct—Do we need to intensify the treatment? Change to a new treatment? Ask myself would medication help?”

### *Other Responses*

We put one response into a category of other. In this response, the therapist said that, sometimes feeling confused, she just does nothing in impasse. Three responses, the meaning of which we could not infer, were put in a separate category. Finally, three responses were put into a category of not strategies. In this category, the therapists described their cognitive reasoning about impasse rather than their strategies for dealing

with it. For instance, one of the respondents said that she was usually feeling at an impasse because she was accepting too much of the responsibility for change.

## CHAPTER V

### DISCUSSION

The purpose of this exploratory research was to learn about MFT clinicians' experiences with therapeutic impasse. The study had several objectives: (a) investigate the incidence of impasse and the effects of impasse on therapists and therapy outcomes; (b) look into therapists' experiences with impasse, their attitudes toward it, and their views on its etiology; and (c) explore clinicians' strategies for impasse resolution. Responses for the questions for each objective will be discussed as a whole. New, interesting questions for future research will be posed. Implications for research and practice also will be outlined.

#### The First Objective: The Incidence of Impasse

The first objective of this study was to investigate the incidence of impasse and its effects on therapists and therapy outcomes. Our data confirmed that all participants who responded to questions for this objective experienced impasse of both short and long durations. Interestingly, therapists reported experiencing impasse of long as well as short durations with similar infrequency: once in two weeks to once a month or less.

Analyzing the responses accounting for the incidence of impasse, we encountered great numbers of missing responses (see Tables 2 and 3). For example, 35% of therapists said that they were in impasse for three or more sessions in the last year of their practice. An equal number (35%) reported that they did not experience impasse of this duration. The remainder (30%) of the respondents did not say anything at all. The patterns of

missing data on these two questions evoked several questions. Did therapists simply not bother to check "no" or were they uncomfortable with making certain claims? If yes, what exactly did they feel uncomfortable with?

The data revealed that most of the time, clinicians experienced low to medium levels of stress in impasse. As many as 87% of all of their emotions were distressing. The majority of responses indicated that participants felt frustrated, angry, and anxious, which supported previous research findings (Hill et al., 1996). Only 10% of the responses contained reports of therapists' having non-distressing emotions in impasse. Although the majority of the emotions experienced by clinicians in impasse were distressing, at this point we do not know what they did to manage them. It would seem beneficial for future studies to explore this issue.

Among negative emotions, the participants mentioned feeling inadequate, incompetent, and powerless in impasse. Some therapists reported having emotions of detachment and fear. Sad emotions were mentioned very rarely. It is difficult to hypothesize what evoked various negative emotional responses in impasse. Most of the respondents did not clarify the sources of emotions or elaborate on them. However, a few did, which helped us to look into the connection between therapists' worldviews and epistemology and specific emotions they experienced. For example, one of the therapists reported experiencing anxiety because she felt that she "should know more." One could suppose that it could possibly be true that this particular therapist should have known more and that her anxiety was a productive emotional response reminding her of that. Another possibility, however, is that the therapist's anxiety was created as a result of her mainly irrational belief that she should know more, an expectation that can never be

satisfied due to an extreme vagueness of its objective. Another participant reported feeling apathy and later put this emotion in context by describing her beliefs: "The client is making choices that keep him [sic] stuck. I can only identify the situation and give suggestions on how to move. He chooses to move or to remain stuck." Thus, the results of this study allowed us to notice the diversity in the relationship between therapists' emotional experiences and their beliefs in impasse. To further explore this could be an objective of future research.

Many participants reported feeling confused in impasse, which seems quite natural. It is interesting, however, that, although confusion itself can be both distressing and nondistressing, in this research it was frequently associated with distress. Karon (1998) suggested that development of a higher tolerance for confusion is necessary in order to deal with impasse more productively. One may agree or disagree with this suggestion; however, the therapists in our sample did not report high tolerance for confusion.

Speaking of the dynamics of the therapy process, Simon (1988) wrote that the very term *stuck* associated with impasse "highlights the belief that things should be moving and not achieving this therefore creates guilt" (p. 8), which can seriously impede therapeutic process (p. 8). All therapists who responded to our questionnaire identified with the term *stuck*. This posed a question: did they also hold the belief that "things should be moving," having very specific expectations of therapy and its outcomes? If yes, is this why most of them felt negative emotions in impasse?

A few participants of our study raised a question of whether impasse is really impasse. One of them wrote, "Struggling to understand, move forward is a normal part of

therapeutic process. I feel no stress, or sense of personal failure struggling to...move forward." On the other hand, Ryan and Johnson (1983) wrote, "Only after one's relationship with [the client] becomes mutually experienced as a burden...can it be transformed." These seemingly contradicting positions evoked some questions. Does viewing impasse as a normal and natural part of the therapeutic process allow for not experiencing negative emotions? Is such positive/neutral outlook on impasse more adaptive and therefore allows for more success? Or is it at times necessary to experience impasse as something out of order and live through negative emotions in order to produce greater results? Which attitude in different contexts would allow for deeper and more long-lasting change in a particular case?

As already mentioned, some of the responses (10%) contained the descriptions of nondistressing emotions in impasse. Some therapists reported feeling anticipation in impasse, recognizing that they and their clients are given the opportunity to grow. Others reported experiencing acceptance and peace in impasse. Only one clinician viewed impasse with humor. We do not know how much the therapists in our sample were aware of various kinds of emotions. Neither do we know the meaning of different emotions in different contexts for them. Future research could reveal the relationship between the management of various distressing and non-distressing emotions in impasse in various therapy contexts and therapy outcomes. It could indeed be fascinating to discover the rules of managing emotions in impasse that predict successful resolution.

In relation to the incidence of impasse resolution, 95% of our sample reported that impasses had been resolved in their practice often or very often. In addition, most of the therapists believed that impasse ended in prolonged or less effective therapy only

sometimes or rarely. They also believed that it rarely ended in dropouts. These quite remarkable outcomes posed several questions. Can we trust the results? If the supposition that the therapists felt uncomfortable to talk about certain issues is true, can it be that they also did not feel secure to disclose the actual degree of their lack of success in our survey? Could these results be due to sample bias, namely, that only the clinicians that felt relatively successful returned the questionnaires? The results of the study by Samstag and colleagues (1998) showed that therapists were less aware of ongoing relational impasse than their clients were. Can it be that the clinicians in our sample were more aware of successfully resolved impasses than unresolved impasses? Such questions pose ideas for future research projects. However, if our results are reliable and this sample of therapists from Utah and Maryland does have impressive numbers of successfully resolved impasses, to see other characteristics of this group could be very helpful in our understanding of how to deal with impasse more productively. It is especially so given that the only study available to us that explored impasse in counseling (Hill et al., 1996) explored exclusively unsuccessfully resolved impasses. The following two sections of the discussion will be dedicated to describing other characteristics of this sample, such as their attitudes toward impasse, opinions about its etiology, and their strategies for impasse resolution.

#### The Second Objective: The Experience of Impasse

The second objective of our study was to look into therapists' experiences with impasse, their attitudes toward it, and their views on its etiology. The data revealed that although unresolved impasse affected therapists' sense of professional effectiveness in

different ways (some of them were impacted a lot and some, very little), most of the participants' personal well-being was affected insignificantly. It was very enjoyable to discover that the therapists of this MFT sample seemed to have been able to achieve nice levels of differentiation between their job responsibilities and personal well-being. One could suppose that differentiation (Bowen, 1978) of this kind as well as other kinds can be very helpful in resolving various therapeutic dilemmas, including therapeutic impasses.

More than half of the study participants (55%) believed that the responsibility for impasse is a mutual responsibility of therapists and clients. The remainder of the therapists divided into two equal groups. One reported that the responsibility was mainly theirs and the other reported that it was mainly the clients'. Although we originally supposed that the therapists who believed that the responsibility for impasse was mutual would have the best chance to resolve impasse successfully, the results have shown that therapists with all three different beliefs reported high rates of impasse resolution. It could be interesting in the future, using the help of independent observers, to explore in depth how therapists with the three above mentioned beliefs about the responsibility in impasse resolve impasse.

In spite of experiencing mostly distressing emotions, the therapists reported having mostly positive attitudes toward impasse. Most of the participants viewed impasse as a normal part of therapy or a part of therapy with great potential. This appears to be a contradiction: it seems more natural to suppose that people who have positive attitude toward something would also feel more uplifting emotions in it. We need to mention that we intentionally put the question about emotions in impasse in the beginning of the



questionnaire and the question about attitude toward the end, so that the latter responses would not affect the former. As we could see, although therapists' "conscious" attitudes toward impasse were positive, they tended to have an immediate reaction of distress when thinking back about it. This phenomenon needs further exploration.

Some of the therapists reported intentionally looking for the first signs of impasse and some did not. Those that looked chose different units of analysis when looking. Most of them watched for client signs, fewer for signs in the therapeutic system, and the least for signs in therapists themselves. Clinicians that chose to look for signs in clients and the system came up with respective responses that were qualitatively different. Namely, client signs of impasse such as lack of cooperation, defensiveness, and lack of change are correspondent with the system signs such as poor connection/communication, conflict, and lack of change. However, the first group of signs was a representation of the way therapists evaluated their clients, whereas the latter displayed therapists' overview of the dynamics in the whole system. This difference poses a question of how the chosen unit of observation affects the dynamics of impasse and its resolution.

Among therapist signs of impasse, the participants named their trying too hard, feeling impotent and confused, and experiencing a lack of connection with clients. The literature suggested that it is our desire to be knowledgeable experts in the therapy room that prevents us from authentically connecting to our clients and thus from experiencing true therapeutic effect and growth (Amundson et al., 1993; Bohart, 1995; Gold, 1995). Could it be that therapists' trying so hard and striving to always be competent and knowledgeable creates a lack of connection experienced by the participants as a sign of impasse? If yes, then this poses another question, one of how clinicians can bring their

knowledge into the therapeutic system so that it enriches the process instead of exhausting it.

About 60% of our sample reported having impasse situations typical to their practice. Similar to the question of signs of impasse, the therapists concentrated on client, system, and their own characteristics when describing their typical situations. Very interesting, 65% of the therapists were able to notice typical client dynamics with which they experience impasse and only 5% of the responses mentioned therapist dynamics. This posed an interesting question: did the therapists who managed to notice the characteristics of clients with whom they typically get stuck in therapy also manage to notice their own typical responses or typical system dynamics in those situations? And if they did notice, why did they not mention it? Finally, if the participants were really not aware of their own or system dynamics in impasse situations typical to them, what difference would it make if they were aware?

#### The Third Objective: Impasse Resolution

The last objective of our study was to explore clinicians' strategies for impasse resolution and their opinions about the factors that contribute to its resolution. A total of 88% of our sample mentioned strategies for impasse resolution. Most of the strategies were strategies that could immediately be applied in the session. Among immediate therapists' actions, the clinicians mentioned slowing down, getting more in touch with clients, and sharing feelings and thoughts about impasse. Interestingly enough, self-balancing such as self-talk or breathing deeply was mentioned only in two responses. It

remains a question: how do therapists handle themselves while experiencing predominantly negative emotions in impasse?

Among immediate interventions in the system, participants named discussing impasse with their clients the majority of times. Interestingly, the responses that mentioned therapists' discussing impasse with clients were qualitatively different from the responses of therapists' sharing of their feelings and thoughts about impasse. One is a systemic approach and the other, more linear. It was very gratifying to find out that although both approaches were present in this MFT sample, the linear was mentioned only nine times whereas systemic discussing of impasse mentioned 32 times.

Among other immediate system interventions were named improving communication and emotional connection, trying something different, and various specific interventions, such as trading places with the client or creating a paradox. A body of literature discusses the immense influence of emotional connection in the system on its ability to deal with and resolve impasse (Berkowitz, 1985; Ivey, 1995; Ryan & Johnson, 1983; Stolorow et al., 1992; Tronick, 1998). Lambert (1994) found that approximately 40% of the variance in positive outcomes can be attributed to the therapeutic relationship. In our sample, however, the necessity to improve connection and communication in a system as a strategy of impasse resolution was mentioned only 9 times.

Quite a few therapists in our sample reported doing something additional on a larger scale when in impasse, such as seeking supervision, spending time to reflect on the case, examining their countertransference reactions, and doing work in their families of origin. Some clinicians mentioned that they used what they came up with independently later in the sessions with their clients. In addition, a part of the sample

described full courses of actions that they developed for dealing with impasse situations, which were diverse in content and organization. It seems heartening to know that the majority of our sample took time to think through their impasse situations and came up with strategies for dealing with them. However, while analyzing their strategies, we also thought about the statement made in the literature that one of the problems with addressing impasse productively is when the therapists adhere to their favorite models and strategies without being flexible in a given therapy context (Davison, 1995b; Gehrke, & Moxom, 1962). As a result, the question emerged: How do we as therapists balance competently applying our theories of change with staying sufficiently flexible and adaptive? How can staying flexible and creative be integrated as a part of a competent theory of change?

#### Limitations

It is likely that we experienced the consequences of sample bias. As mentioned previously, 95% of the study participants reported high or very high rates of impasse resolution. This possibly could happen because only the therapists that felt relatively successful at resolving impasses returned the questionnaires. In addition, because significant amounts of information were gathered from the qualitative data of this study, the coding of these data could have been potentially biased.

Because we used clinicians' self-reports as the measure, we were limited to what they were aware of and willing to reveal. In relation to some explored issues, it hindered our ability to understand and draw conclusions. For instance, the therapists reported having predominantly distressing emotions in impasse and later chose mostly positive

attitudes toward impasse out of the list of alternatives. Although this seemed very contradictory, without additional information and another perspective such as the perspective of an observer or interviewer, we were not able to make any certain conclusions. In addition, we explored only therapist perspective. It would be very beneficial in the future to explore both therapist and client opinions on the same cases.

At times, using a paper and pencil questionnaire as our measure proved to be a limitation. For example, we noticed particular connections between therapists' emotional experiences in impasse and their beliefs about it. However, a questionnaire did not have a flexibility and "humanness" of a personal interview, for instance, to explore those issues.

### Implications

#### *Research*

This study was based on therapists' recollections of the incidence of impasse during the previous year of their practice. It would be productive to explore impasse situations in therapy more immediately, preferably when they are happening. Similarly, it can be helpful to entertain in-depth qualitative studies of successful as well as unsuccessful impasse resolution from the perspective of both clients and therapists. We believe that such immediate and/or in-depth qualitative exploration of impasse could reveal some important impasse variables that can in turn be used in larger quantitative studies requiring impasse recall.

As mentioned previously, we encountered significant amounts of missing responses to the questions exploring the incidence of impasse. At this point, we do not know whether the therapists simply did not bother to check "no" for certain impasse

durations or they felt awkward making certain claims, possibly feeling uncomfortable disclosing their experiences of unsuccess. In order to clarify issues such as this, it might be helpful to use personal interviewing in future studies of impasse. In addition, as a first step in future studies, it might be helpful to explore participants' attitudes toward and feelings about disclosing the aspects of their personal experience with impasse.

### *Practice and Training*

Kottler and Carlson (2003) pointed out that in trying to protect themselves from malpractice claims and supervision complications, therapists often select their best performance for demonstration and discussion. As many as 30% of the therapists in our sample chose not to reveal whether or not they were at an impasse for two or more sessions during the last year of their practice. Our being reluctant to look closer at our worst work constrains our timely learning from it. We seem to teach our clients to understand the benefits of honestly looking into their issues, learning from past experiences, and then restructuring their lives accordingly. However, we often fail to do it ourselves with our experiences in therapy. We believe that by learning to process their less successful and worst therapy, clinicians could greatly enhance its quality as well as their psychological wellbeing.

One of the findings of this study was that therapists experienced predominantly distressing emotions in impasse, which supported previous findings (Hill et al., 1996). Therapists in our sample reported mainly reactions such as frustration, anger, anxiety, and a sense of inadequacy. This study was able to notice a connection between beliefs that the therapists held and the emotions they experienced. It may be useful to help

ourselves as MFTs (in practice or in training) acquire more essential knowledge of ourselves, of how our deepest beliefs and attitudes affect the way we feel and conduct therapy. Rodgers (1982), in his exploratory study, "Supervising oneself," revealed that none of his respondents felt that they were ever taught how to supervise themselves. It could be very beneficial for trainers to consider helping their trainees learn the art of self-supervision, including learning to identify, process, and overcome therapeutic impasses.

Simon (1988) wrote that confusion can be seen as a necessary step in a creative process that often precedes new discoveries. On the other hand, the therapists' belief that things in therapy should go a certain way creates a lot of guilt and often prevents therapists from accessing creativity that is necessary for therapeutic success. Karon (1998) suggested developing higher tolerance for confusion as a characteristic helping to deal with impasse productively. As one could see, the sample of therapists in this study did not display high tolerance for confusion, associating confusion mainly with distress. It might be useful to help ourselves as clinicians and to help MFTs in training develop the level of confusion tolerance and exploratory skills necessary to support and maintain therapy as creative process.

Eighty-eight percent of this sample reported strategies for impasse resolution, developed to various degrees of sophistication. However, as literature on impasse suggests, one of the problems with impasse resolution stems from the fact that therapists tend to adhere to their preferred models and strategies without being sufficiently flexible in a particular therapeutic context. It can be beneficial for us to clinically explore how we as therapists can balance competently using our personal theories of change with learning and staying sufficiently flexible and adaptive.

A body of literature about impasse discussed improving emotional connection and communication in a system as a fundamental way to impasse resolution (Berkowitz, 1985; Ivey, 1995; Ryan & Johnson, 1983; Stolorow et al., 1992; Tronick, 1998). Although discussing impasse with clients was mentioned a significant number of times in this study, improving connection and communication was mentioned only 9 times. It may be very rewarding to clinically look into how enhancing emotional connection in the system could increase its ability to deal with and resolve impasse.

### Conclusion

In spite of its limitations, this study had several interesting and useful results. It showed that the majority of our MFT respondents experienced impasse of short and long durations during the last year of their practice. It also revealed diverse strategies for dealing with impasse that could give fresh ideas to practicing MFTs. We hope that this study will be helpful to MFTs in their learning to deal with at times complex dynamics of therapy, allowing them to help people with greater competence and creativity.



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## APPENDIX

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Valentina Popkova  
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Dear colleague,

I am a graduate student in marriage and family therapy at Utah State University. My research is about therapeutic impasse and I would appreciate your participation in it.

Have you ever felt "stuck" in a session? Have any of your colleagues-therapists felt confused and overwhelmed from not knowing what to do next? My review of literature showed that in spite of the obvious existence of this problem in the field, no MFT research exists to help our understanding of impasse and how to deal with it. This study is an exploration of therapists' experiences with impasse. As a Clinical Member of AAMFT, you are invited to be a part of this research. Your participation is voluntary. I hope it will be interesting and beneficial to you to think about your own experiences with impasse while you are completing this questionnaire. It will take approximately 10-15 minutes of your time.

Your response is completely anonymous. No identifying information is contained within the questionnaire. Each questionnaire is coded with a number. A neutral, third party will match codes to names and there will be no way for the researchers to link your name or your institutions to your responses. Your questionnaire response will be returned directly to me, Valentina Popkova, and Thorana Nelson and the third party will not have access to this information. The data will be kept in a locked file cabinet in a locked room. There are no identified risks for participation in this study. You are giving your consent for participation by the fact of returning the questionnaire in the enclosed stamped envelope.

Your response will be of great value in helping us to understand impasse and deal with it more productively. If you would like to have a summary of the results of this study you can send me an e-mail with the word 'results' in the subject line.

Thank you very much!  
Best wishes,

---

Thorana Nelson, Ph.D.  
Major Professor, Ph. 435-797-7431

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Valentina Popkova  
Ph. 435-787-0585





## Therapeutic Impasse Questionnaire

### Section I: Demographics

1. In which state do you conduct most of your practice? \_\_\_\_\_
  
2. What is your chief practice setting?
  - a. Rural
  - b. Urban
  - c. Suburban
  
3. What is your type of practice?
  - a. Solo private practice
  - b. Group private practice
  - c. State agency
  - d. Private foundation
  - e. Private non-profit agency
  - f. Public non-profit agency
  - g. For-profit agency
  - g. Other agency type \_\_\_\_\_
  
4. What is your current average weekly client contact (hours)? \_\_\_\_\_
  
5. Which of the following licenses do you hold? (circle all that apply)
  - a. Marriage and Family Therapy
  - b. Social Worker
  - c. Psychologist
  - d. Professional Counselor
  - e. RN
  - f. MD
  - g. Other (specify) \_\_\_\_\_
  
6. How do you primarily identify yourself?
  - a. Marriage and Family Therapist
  - b. Social Worker
  - c. Psychologist
  - d. Professional Counselor
  - e. RN
  - f. MD
  - g. Other (specify) \_\_\_\_\_
  
7. What is your highest level of education?
  - a. MS/MA
  - b. MSW
  - c. PhD
  - d. Other (specify) \_\_\_\_\_
  
8. How many years have you been practicing MFT? \_\_\_\_\_
  
9. To which racial/ethnic group do you belong?
  - a. Asian
  - b. White
  - c. African American
  - d. Hispanic
  - e. Native American/ Alaskan Native
  - f. Native Hawaiian/ Pacific Islander
  - f. Multiracial (specify) \_\_\_\_\_
  - g. Other (specify) \_\_\_\_\_
  
10. Your gender:    Male        Female
  
11. Age:

**Section II**

Please respond to the following questions, thinking about the past year of your practice.

1. Have you ever been "stuck" in therapy for as long as:			2. If yes, how often has this occurred?				
	Yes	No	Once a month or less	Every other week	Once a week	A few times a week	Once a day or more
a. A few minutes							
b. A part of the session							
c. One session							
d. Two sessions							
e. Three or more sessions							

	Very often 75-100%	Often 50-74%	Sometimes 25-49%	Rarely 1-24%	Never 0%
3. How frequently have you experienced the following levels of stress in a situation of impasse?					
a. Very high					
b. High					
c. Medium					
d. Low-					
e. Very low					

4. Do you believe that during impasses, your clients experience a level of stress somewhat similar to yours?      Yes No

5. Please name some of the emotions you typically experience in a situation of impasse \_\_

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	Very often 75-100%	Often 50-74%	Sometimes 25-49%	Rarely 1-24%	Never 0%
6. Overall, how frequently have impasses been resolved?					
7. If some impasses were not resolved, how often have they ended in:					
a. A therapy dropout?					
b. Longer than desirable duration of therapy?					
c. Less effective therapy?					

	Very high	High	Medium	Low	Very low
8. Please rate the effects of unresolved impasse on:					
a. Your sense of effectiveness as a therapist					
b. Your personal well-being					

### Section III

9. Do you intentionally watch for the first signs of impasse?    Yes    No

10. If yes, what are these first signs? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

11. Are there any therapy situations in which you frequently/typically experience impasse?  
 Yes    No

12. If yes, what are they? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. Impasse generally is:

- a. Something unpleasant that you try to overcome so that you can move on with the therapy.
- b. A normal part of therapy that needs to be dealt with.
- c. A part of therapy with great potential that you use in order to progress in therapy.
- d. Other (please, specify) \_\_\_\_\_

14. In your opinion, the responsibility for the impasse creation is normally:

- a. Mostly yours
- b. Mostly clients'
- c. Mutual
- d. Other (please, specify) \_\_\_\_\_

#### Section IV

15. Do you have a strategy(s) for dealing with impasse?    Yes    No

16. If yes, what are these strategies? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you very much!

*Follow-up Postcard*

**Dear colleague,**

About three weeks ago I sent you a questionnaire about therapeutic impasse. By sending this card I would like to remind you about this study and thank you for your contribution to this research if you have already returned the questionnaire. I hope it was interesting and beneficial to you.

If you did not receive or misplaced the questionnaire and would like to be included in the study you can obtain another copy of the questionnaire in mail by sending me an e-mail with your name and address at [newstudy2003@hotmail.com](mailto:newstudy2003@hotmail.com) with the word 'questionnaire' in the subject line. Your name and other identifying information will be coded, kept separately, and not identifiable to the researchers.

The experiences you will share will be very helpful in our understanding of therapeutic impasse and learning to deal with it more productively.

Thank you very much!

Best wishes,

Valentina Popkova

Thorana Nelson, Ph.D