CHAPTER 10


CHAPTER

11

Resistance

If change were too easy and mental structures too fluid, the result would be greater instability, not quicker psychotherapy.

—Harry Guntrip

I cannot hurry, for I have so much more at stake than you.

—Louise White

Several years ago, one of us supervised a student who received feedback from two clients within one week. This student had just read about resistance and thought it might be helpful to share with his clients whenever he thought that was what they were doing. Watching tapes of the sessions, the supervisor came across: “Well, hell yes I’m ‘resistant!’” the first client told her therapist. “All these new ways of doing things may seem easy for you to say, but let me tell you—they ain’t so easy to implement! Gimme a little while to make sense of them! And the reason I’m late is, the city bus picked me up late. I got the first damn one I could after I got off of work. Get off my back, why don’tcha?” This is a fascinating transaction from the supervisor’s perspective. The client’s style was certainly a bit abrasive. Perhaps this same defensive posture causes her trouble in other aspects of her life and might merit attention in therapy at some point. But the content of what she said, the fact that she was protesting an easy labeling of her failure to capitulate with the therapist’s agenda, seemed quite legitimate.

The second client, a psychology student who had been in therapy before, said something similar to our student: “You know, it’s true I came in here and we had a contract to work together on something. But it’s like someone with a bunch of broken bones going to a doctor to get them fixed. It’s a lot easier for the surgeon to say ‘Let’s do this in 15 minutes ’cause I got another patient’ than it is for the patient to go through that. Slow down and give me a little time!” The student was actually lucky to get this feedback from these two clients. Others had simply quit coming, with no explanation, and the student was left wondering what it was about “them” that precluded a therapeutic alliance.
Regardless of what they call it, writers from most schools of thought note that clients don’t always follow the therapist’s agenda. For the student, whose confidence in her or his own skills is still evolving, it may be tempting to personalize this. And, as in the above cases, sometimes the therapist is the problem. But in general, if our empathic abilities are in tune, we should be able to sense when we have moved too fast or too far away from the clients’ experience and go back to “pick them up.” An analogy that may capture some of this is of two people ice skating; one is quite proficient and has done it for years and knows this stretch of ice very well, and the other is a rank beginner. If the goal is to get to the other side of the lake together, the first skater will need to take the second skater’s anxiety and lack of expertise into perspective and slow down when the skating partner seems to be lagging behind. For those of you who have been in therapy, it may be easier to understand the client’s inability to maintain a steady rapid pace. Indeed, some research (e.g., Hill, Corbit, Kanitz, Rios, Lightsey, & Gomez, 1992; Tracey, 1986) suggests that resistance is not only inevitable, but may be instrumental in the counseling process. Thinking of resistance as part of the package, as an expected part of the client’s difficulty in making changes, gives the therapist more compassion, as well as providing the possibility of devising some creative interventions to help.

Temporary Understandings of Resistance

Resistance is a term used so loosely and often naively that it is difficult to know what other mean when they say it. Beginning therapists may use it ubiquitousy to describe virtually anything the client does that makes them feel inadequate. Although behaviorists generally don’t use the term, Davison (1973) mentions it as a substitute term for “counter-control,” and it could describe, for example, a client who refused to do her assignment from the last session and is now crying rather than recommitting herself to the new behavior. Conversely, many therapists would view automatic defensiveness to the therapist’s agenda as resistance (e.g., Rennie, 1994) and assume that the client was unwilling to explore difficult material. It depends, then, on what his or her definition of the goal for therapy is, to know what a given therapist means by saying a client is “resisting.” The literature seems to provide three, possibly overlapping, understandings of resistance.

Psychodynamic

Psychodynamic writers and others who partially rely on such approaches view resistance as the client’s avoidance of pain (e.g., Bauer & Kobos, 1987; Strupp & Binder, 1984; Teyber, 1997). Patton & Meara (1992) specifically discuss this “pain” as aggressive feelings or loss; Teyber’s (1997) suggestion is that shame is a probable contributor. This kind of resistance is most obvious when the therapy involves uncovering work—exploration of suppressed feelings (which, arguably, would not have needed suppression if they were that easy to accept!). The client who says she needs help in resolving the grief over a deceased family member, but who seems to change the subject whenever painful feelings arise, is a “classic” example. This definition of resistance also helps us understand, however, the client with a low sense of efficacy who is trying to take on a new large project. If the therapist is using a cognitive/behavioral approach to help her get started and maintain momentum, but each new step feels to her that this is another opportunity for humiliating failure, her “resistance” to following through on homework assignments might be construed not so much as lack of motivation or as counter-control, and more as the reluctance to undertake a task that seems certain to end in failure, shame, and even lowered self-esteem (in other words, as matching the psychodynamic definition of resistance).

Behavioral

Another approach to resistance is to define it in behavioral, rather than intrapsychic, terms. Bischoff and Tracey (1995), for example, define resistance for the purposes of their research study as “any behavior that indicates overt or covert opposition to the therapist, the counseling process, or the therapist’s agenda.” This approach to resistance certainly makes research easier to do; one can look at content analyses or transcriptions of tapes and simply note when and under which circumstances clients do not follow the therapist’s guide line. Although this sounds suspiciously like the subjective definition of the threatened therapist—that he or she had to be “right,” and that the client’s resistance indicated a failure on the client’s part to cooperate—those connotations are not necessarily appropriate in many cases of researchers’ findings. Using the Client Resistant Scale that he developed, Mahalik (1994), for example, found in analyzing the first and third film sets of “Three Approaches to Psychotherapy” that certain types of therapist behaviors—interpretation (what others might call advanced empathy), open questions, and minimal encouragement—were the most effective response modes, that closed questions was the least effective response mode, and that providing information was connected to greater opposition of expressing painful feelings, to the therapist, and to insight. This process approach to resistance can be helpful to students when they review their tapes of sessions. Discovering what approaches “work” with a given client and which ones do not can help the therapist orchestrate his or her style accordingly.

Social Constructionism

A final broad approach to resistance is one that urges therapist caution and humility before defining client behavior in such a way. This approach, in opposition to what was seen as an inherent arrogance in psychoanalytic interpretations, stresses that therapist direction might have been wrong. As Omer (1997) says, “The arguments against the concept of resistance have changed with the years. In the last decade, however, they have converged upon one unifying theme: since therapists have no privileged access to the truth, their formulations cannot claim to be more
acceptable than those of clients." This approach has been espoused through the years by a variety of therapists representing various theoretical orientations, especially from those with a phenomenological basis. It has gained great momentum since the blossoming of constructivist and social constructionist approaches to therapy (e.g., Neimeyer & Mahoney, 1995; Rosen & Kuehlwein, 1996), which in general posit that the client's attempt to find meaning will be a joint construction of that meaning arising from an ongoing dialogue between client and therapist. The therapist is not assumed to have the "answer," but rather will, in working with the client's narrative, help construct meaning (McAdams, 1993).

Writing from within this approach, Omer (1997) suggests several reasons why clients will "resist" therapists' formulations: (a) the formulations are experienced as offensive, (b) they are in contrast to the client's feelings, (c) they entail values or goals unlike the client's, (d) they seem abstract or foreign, (e) they conflict with other, accepted, understandings, or (f) they are delivered in the wrong tones or in improper words. He refers to such formulations as, by definition, coming from an "external narrative," and directs therapists confronted by impasses with clients to acknowledge the externality of the previous approach and propose a more empathic one instead.

While we cannot wholly agree with all aspects of social constructionism, we do believe that much of what the approach offers tends to confirm our own understandings of the optimal therapeutic process. We especially concur with Omer's six possible reasons for clients' "balking," and suggest that student therapists look to such possibilities first, before they assume more intrapsychic explanations.

stance

For the purpose of this book, we will define resistance as "an intrapsychic or interpersonal process marked by ambivalence about claiming and exploring little-known feelings and motivations within one's self." The ambivalence is rooted in the conflict between urges toward growth and completeness on the one hand, and fear of pain or punishment on the other.

Consider a client one of the authors had, whom we will call Raquel. Raquel had been an abused child, beaten regularly by her father and relatively ignored by her mother. She came for therapy because she wanted to be more assertive with her husband rather than continue to acquiesce through fear of his displeasure. As she worked to improve her assertion skills, she simultaneously began to explore her fears of standing up for herself. She acknowledged that she almost never felt angry with her husband, even when intellectually she knew her needs were being discounted. What happened to the anger? She didn't know. As nearly as she could tell, she had never assumed that her feelings and needs should be considered. She did, however, admit to behavior that seemed to be superficially passive-aggressive, and traced it back to childhood. Even with her father, whom she greatly feared, she had exhibited such behavior. Believing that perhaps under such behavior might lurk some justifiable, self-affirming anger, the therapist encouraged Raquel to continue her exploration of her memory of those times. Surely, in addition to all the fear toward her dad, must there not have been some anger? Raquel experienced enormous anxiety at such a notion—anger toward her father was simply unthinkable—and missed the next session. Only over a period of months was she able to slowly accept her early rage as justifiable and healthy. Why the resistance to such an appropriate feeling?

Consider what Raquel must have been like at four or five years of age: lonely, unsupported by her mother, and frightened of her father. Even when she tried very hard to second-guess her father and be "good," she received almost daily beatings. Simply thinking about expressing anger to him must have seemed terribly dangerous, especially since at that age admitting feelings seems tantamount to acting on them. Small wonder, then, that Raquel "resisted" experiencing anger as a child. By the time she entered therapy as an adult, she had been out of her parents' house for years and her father had in fact died. Neither time nor death had been of much help, however, in erasing the old pattern of repressing anger—a pattern that had helped her survive as a child, but which now was dysfunctional.

Raquel's resistance exemplifies the way we see resistance operating generally. A pattern of coping with anxiety-provoking feelings, often originating in early childhood and an adaptive pattern at the time, continues into the present in a client's life and is demonstrated both in and out of the therapy session (Bauer & Kobos, 1987). Trying to strip away the resistance without dealing with the resulting fear can leave the client feeling overwhelmingly vulnerable and out of control. Good therapists do not assume resistance in an adversarial way; they "woo" the client, to use Roth's (1987) word, into trusting them enough to gradually expose the underlying feelings and motivations. That is a fearful process, for Raquel, as it is for all of us, to venture into the hidden places within oneself. We fear opening Pandora's box, lest all sorts of painful and evil aspects fly out.

In Raquel's case, the fear was related to early associations of the expression of anger to the expectations of severe punishment. Similarly, someone shamed as a child for showing sadness or pain may be understandably reluctant to explore such feelings later in life. Other clients' fears may be less related to specific early episodes than to damage that they would incur on their self-image by admitting to what they would consider to be illegitimate feelings. In either case, the issue often is that the client does not feel entitled to certain feelings (Wile, 1984). Much of the therapeutic "working through" of resistance is thus dependent on the therapist's ability to help the client feel entitled to feelings and needs which the client had previously assumed must be denied.

Encouraging entitlement is not as simple as it sounds. Clients are likely to sense the power of unexplored material, and perhaps even overestimate such power (Langs, 1981), and look to you, the therapist, for reassurance that their feelings will not overwhelm and destroy them. Whether that reassurance is asked for overtly or not, your faith in the process will need to be somehow conveyed. Unless you have personally explored similar material within yourself, it will be difficult for you to be helpful with your client. We offer you the caution we have given our students: Never ask a client to do what you would not be willing to do yourself.
We want to underscore a point that should be obvious by now. Clients do not demonstrate resistance out of irresponsibility, or obstinacy, or dishonesty. They resist because they are ambivalent about change and self-exploration; they want greater freedom, but fear the pain that might be necessary. As Singer (1970) indicated, "Resistance reflects both the patient’s disbelief in an alternative way of life, reflects...desperate holding on to familiar self-esteem-furthering operations and at the same time...intense fear that any other approach to living would be self-esteem shattering" (p. 235).

We encourage beginning therapists, rather than to personalize their clients’ resistance or be annoyed by it, to realize that without resistance, they would probably be out of a job. If every client were perfectly ready to change and able to do it, if it were really that easy, there would be little need for psychotherapy. When we view client resistance as a signal of fear, that thus deserves our support and empathy, rather than as some annoying obstacle we must batter down, it becomes easier for us to do our job of continuing to maintain the therapeutic alliance while encouraging client self-exploration.

Bugental’s (1978) definition of the therapeutic alliance is worth noting. He refers to it as “a bond between what is best and most dedicated in the therapist and what is most health-seeking and courageous in the client” (p. 72). Your ability to offer the best of yourself rather than withdrawing or becoming adversarial when you sense resistance is what inspires the client to persevere even when he or she is fearful. If you become impatient, you add to clients’ sense of unitletment, since now you have communicated to them that they do not have the right to their own fear.

True resistance, as we define it, is a process marked by client inner conflict. As Taft (1933/1973) explains eloquently, it is a reflection of the inherent ambivalence of the human being toward growth and individuation. To quote more fully (Taft, 1933/1973)

However speculative it may sound and however differently it may express itself in any particular case, the fact remains that always, at bottom, every serious blocking in a human life is the expression of an unsolved or rather unaccepted conflict between the will to become more and more individualized, to develop one’s own quantum of life, and the reluctance to pursue wholeheartedly a course which is beyond control of the individual will and which inevitably leads to the annihilation of this dearly bought individuality. (pp. 784–285)

trust

There is a related process that is often mistaken for resistance. For lack of a better term, we will call this process distrust. Distrust, in contrast to resistance, has an interpersonal root. It arises, not primarily out of ambivalence within the client, but rather out of the interaction the client has with the therapist. Its origins are not so much fear of growth, as fear or anger or mistrust of the therapist. In both cases, the client balks at further therapeutic self-exploration, but the reasons behind the two processes vary. (Note that this discussion bears marked similarity to Omer’s 1997 list of “external narrative” mistakes that therapists may make.)

The primary reason, we believe, that clients become mistrustful (either temporarily or permanently) of continuing with therapy is that from their perspective the therapeutic alliance has either been broken or was never satisfactorily forged in the first place. Clients who feel attacked or accused or unsupported are likely to “put on the brakes,” less perhaps because they are unwilling to proceed, than because they are unwilling to proceed with this person. Their trust in the therapist is at least temporarily shaken, and they feel unsafe and discounted. As Wile (1984) points out, in ordinary human discourse, when people feel criticized, they often respond with anger and/or defensiveness. It should come as no great surprise that they respond similarly in therapy also. In effect, their balking is a protest. It is a way to say to the therapist, “Do not do to me what I do to myself. Do not attack and criticize me; I can do that at home, for free, by myself. I need your support and understanding.”

Obviously, it makes little difference at this point whether the therapist intended to criticize or slight the client. It is the client’s perception that matters, and until the client feels reassured and supported again, not much therapy will be taking place. We agree with the supervisor who told his supervisee when he heard a tape of a client becoming reluctant and balking, “This is an important process. Nothing else is more important. This is where you stop and park your truck!”

We underscore again that the relationship you offer is often what is healing to the client. To clients who have felt discounted and wounded, and who often discount and wound themselves, having a therapist listen to their protests—however inarticulately they may have been voiced—is indeed a corrective emotional experience. As one terminating client told her therapist after years of therapy, “What you did that I remember most, what helped more than anything else, was when you listened to me that time I got so mad at you. You didn’t get defensive or angry, although you didn’t cave in either. You listened to me and even changed some of your behavior. I was amazed!” We agree with Stone (1981) that the possibility of therapist error needs to be consistently acknowledged, and that (as in the prior situation) a willingness to listen to client feedback and change behavior can increase the therapist’s credibility.

Lewis and Evans (1986) suggest three reasons other than broken alliances for clients to balk at the interpersonal process inherent in therapy. First, they suggest that the client may be experiencing fear or anxiety, some of which may be what we earlier referred to as fear of individuation, but which they believe often has the clear interpersonal focus of fear of control by the therapist. Since we dealt rather extensively with this and other client fears in a previous chapter, we will not further expand on this factor.

The second reason Lewis and Evans suggest for client reluctance to proceed in therapy is that they may not believe that the interactions the therapist is suggesting will be helpful. We think this may especially be operating with beginning therapists, who often do not take the time or do not know how to explain briefly
to clients why they are recommending a course of action. If clients want to know why they should explore painful feelings, can you give a brief explanation in layperson's terms? If you wanted a client with an eating disorder to monitor food intake and she objected because of shame and embarrassment, could you explain convincingly why the benefits should outweigh the cost? When you suggest a role play, an empty chair, or other interventions, do you understand the rationale and believe in it enough to explain it to clients, if that seems necessary? We are not suggesting that you always expect client opposition and offer lengthy explanations to fend off their possible questions. We do believe, however, that when you sense reluctance on the part of the client, you should be willing to explore the source of their reservations and if necessary be able to explain briefly why you think it would be helpful for them to do what you have suggested. (Again, to gain an appreciation of their perspective, it may help to imagine yourself going to a physician because you have what you believe is a sinus infection. You want an antibiotic. If the physician were to suggest an unexpected and possibly painful treatment instead, wouldn't you want an explanation? And if you asked for one, and the physician couldn't or wouldn't give it, wouldn't you be offended?)

Finally, Lewis and Evans suggest that clients may appear uncooperative because they simply do not understand what the therapist expects of them. Unless they have been in therapy before, they may have only vague and misinformed ideas about how to proceed. Even if they have been in therapy, their first therapist's orientation and expectations may have been quite different. When our students complain that their clients are being too superficial, telling too many stories, changing the subject, and so forth, we often ask if they have explained what they want the clients to do differently. Delineating roles and responsibilities is not always done directly, and clients can often pick up on fairly subtle clues, but some beginning therapists are sufficiently unclear themselves about the roles that they offer few clues at all. So if clients seem to be doing the "wrong" things, our first suggestion is that therapists clarify for themselves and their clients what behavior would be more helpful. Our second suggestion is that they not expect that one persuasive five-minute explanation will be sufficient to change a lifelong pattern of relating, and that instead, it should be assumed that clients' new behaviors, both in and out of therapy, will need to be encouraged and reinforced over time.

Other writers, such as Dowd and Wallbrown (1993) and Brehm and Brehm (1981) refer to interpersonal "reactance." By this they mean, "The natural tendency to react against or resist pressures or influence from others" (Kleinke, 1994, p. 105). (It should be noted that Bischoff and Tracey, 1997, as well as others have found empirical support for this phenomenon in therapy.) While this kind of reaction can be carried to the point of characterological oppositionalism, we also need to remind ourselves that this unwillingness to be unduly influenced by others is the basis for our maintaining a strong sense of self or identity. It would not be helpful if clients simply bought into everything we suggested and became our clones. Reactance is likely to be activated if clients had (or their view of things was that they had) dominating or controlling parents who felt threatened by independent thinking. In such cases, the client was likely to grow up feeling the need to fight for his or her identity, and to view any "parental" influence (including what may be coming from you) as highly suspicious. Even when the client agrees that it makes sense, it may feel quite uncomfortable for them to cooperate. One therapist, when faced by such consistent oppositionalism, said with some humor, "Does it feel like it used to when your parents told you what to do?" (The client agreed) "You know, my favorite definition of maturity is 'doing what you want to, even if your parents approve.'"

Before we leave this topic of client mistrust, we would like to suggest one more reason for the client's itching at the therapist's input. It might be that the therapist is simply wrong. Foreshadowing the social constructionism emphasis, Singer (1970) noted with some irony:

It must also be remembered that practitioners of psychotherapy are not necessarily oracles of wisdom, and therefore the patient's outright rejection of some interpretation or confrontational comment... is frequently a sign of remarkable well-being. Indeed it would indicate gross pathology were a patient to accept as gospel truth the therapist's misconceptions or inconsequential and irrelevant interpretations. (Or he [sic] would have to be very hostile to the therapist, because in accepting his silly pronouncements and pontifications, the patient would allow the therapist to live unchallenged in a fool's paradise.) (pp. 225-226)

Transference Resistance

The third related process we wish to discuss that involves the client's balking is called by Freud (1926/1981) "transference resistance." If resistance, as we defined it, is an intrapsychic phenomena, and distrust an interpersonal one, transference resistance is somewhere between the two. Or more succinctly, the resistance is in fact intrapsychic, but as the client manifests it, it appears interpersonal. Allen Wheelis (1973, p. 42) described transference resistance when he said, "The trigger for anxiety is the giving of an account for which I may be judged." It is as if the client is so certain that what he or she is experiencing is unacceptable that the therapist is presumed to be unaccepting and critical, all evidence to the contrary. Thus a simple empathic comment on the therapist's part, such as, "That must have been really tough for you," can elicit an angry, "What? Do you think I'm such a baby I can't take it?" The process is transference in the sense that the client is transferring onto the therapist feelings that probably rightfully belong to an earlier relationship. In terms of present dynamics, however, the mechanism is a form of projection. The client's own self-judgments and worst fears about himself or herself are projected onto the therapist, with no awareness that the therapist may in actuality be feeling quite understanding and compassionate.

Clients exhibiting transference resistance often present themselves quite combatively; they require consistent support from their therapists as they sort out what they fear the therapist is feeling (or might feel) from what she or he actually is experiencing. If the therapist can remain emotionally available to the client and
deal over and over with the immediacy of their relationship, gradually most cli-
ients will come to claim more readily their own fears, which can then be dealt with
therapeutically. Prime requirements are the therapist's patience and ability to
carry nondefensively “not guilty” when accused of being judgmental, assuming
you were not being judgmental. The classical psychoanalytic way to deal with
transference resistance was to remain emotionally neutral and to offer an interpre-
tation of the process (Meningaer, 1956). Therapy with a more supportive, interper-
sonal focus lends itself to a somewhat different approach. We believe that brief,
supportive clarifications will work best: “Sounds like you felt judged just now.
Actually, I was feeling pretty good about what you were saying.” Or as one ther-
past said after a series of accusations, “You know, I don’t have to feel about you the
way you feel about yourself.” Another therapist sometimes used humor: “Well, I
greatly believe that someone in this room might feel critical of you, but it isn’t me. Who’s
left?” Whatever the style used, the goal is to help clients acknowledge and then
deal with their projected self-judgments, after which the resisted material can be
more easily explored.

stant or Distrustful Behaviors

As we briefly describe behaviors that therapists have come to recognize as poten-
tially signaling resistance, distrust, or transference resistance, we will not attempt
to differentiate between the three processes. The behaviors could signify any of
the three processes—or perhaps none. We list some of these, not so that in cook-
book fashion you can identify them and then apply the appropriate remedy, but
rather so that you can approach your clients with heightened awareness of pro-
cesses that might profit from further exploration. Otani (1989) classifies resistant
behaviors as response quantity resistance, response quality resistance, response
style resistance, and logistic management resistance. For purposes of this discus-
sion, however, we will categorize these client process behaviors in terms of how
they affect most therapists; behaviors are categorized as disarming, innocuous,
and provocative. We would like to repeat at this point that clients do not use such
behaviors as maneuvers to win at some imagined therapeutic chess game; rarely
are they trying to outfox you.

Disarming Behaviors

Some of your clients will probably be charming, socially skilled, and very likable.
They will be quite practiced at being engaging, and you may find yourself wish-
ing that you had met them in another context so that you could be friends. The
problem such clients may have is that it is such second nature for them to read
others’ cues and be accommodating that they have trouble exploring difficult feel-
ings and motivations that might be less socially acceptable. They will need your
encouragement and permission to give up their usual interactive style and be
more transparent. You will need to resist the temptation to collude with them to
stay “likable” and avoid such problematic issues.

Some behaviors that beginning therapists seem to find disarming that might
perhaps signal resistance, distrust, or transference resistance are:

- humorous, charismatic storytelling
- mild flirting
- asking about therapist’s feelings, personal life, and the like especially when
done with genuine tact and concern
- praising therapist’s skills, wisdom, and so forth
- psychologically sophisticated “safe” self-disclosure (e.g., I know I’m resist-
ing, but...)

Whether your clients present with such styles or resort to them under pres-
sure, it will be important for you to be empathically curious enough to invite them
to explore the deeper issues that may lie underneath. One therapist we know said
to a client that fit in this category, “You’re a great storyteller and I enjoy hearing
them, but I worry that we’re not paying attention to what we really need to. What
do you think?” and, lightly, to another, “I don’t know if you know it, but you
could come in here next time and never say anything funny and I would still like
you!”

Innocuous Behaviors

There is another set of client behaviors that again may be either stylistic or situ-
tional. These behaviors are more clearly seen as defensive (i.e., self-protective) and
less engaging than those in the previous list and so are more clearly identified by
beginning therapists as potentially warranting attention. Our impression is that
students sometimes feel helpless when confronting them. It can be frustrating to
sense that there is something in the client under the surface, ask the client, and be
met by denial. What then? The frustration that therapists feel is as often directed at
themselves as at the client, since they feel inadequate and directionless. Some of
these “innocuous” behaviors are:

- changing the subject away from affect-ladened issues
- an unemotional recounting of powerful experiences
- becoming helpless and passive
- becoming “confused”
- retreating into silence
- obsessing about trivial details when describing an event or situation

We suggest that when you see such client behaviors, one of your hypotheses
should be that they don’t know how to “do” therapy and are falling back on typi-
cal behaviors, for what seems good reasons from their perspective. If you have
evidence to justify this hypothesis, it may well help if you can explain to clients what they need to do differently for your kind of therapy to work, and why.

For example, one of the authors had a dependent, insecure client who seemed to find it necessary to recount long stories in infinite detail. She had to start at the beginning, recount every event with meticulous thoroughness, and then move chronologically through the event piece by piece to the end. After suggesting that maybe they could “fast forward to the end,” and “jump to the chase,” to absolutely no avail, the therapist realized that the client was probably manifesting the same behavior with her that she had done with herself. Presumably the client had gone over and over the details, rehearsing them thoroughly, probably to reassure herself that she was blameless and entitled to feel bad. If that were the case, then skipping a detail, in her mind, could mean that the therapist might not get the whole picture and might judge her negatively. So the following set of interventions was made: “I can tell by your face that you get frustrated when I interrupt and ask you to slow down and tell me what you were feeling, and then sometimes I want you to skip portions and tell me how it all ended and what it meant to you. Must be confusing! ‘What does the woman want?’” (Client agreed.) “Tell me what’s the worst that might happen if you leave out an important detail. Are you worried that I might not ‘get it’?” (Client tentatively agreed and launched into another long story!) “I’m sorry to interrupt, but I’m looking at the time and realize we only have 15 more minutes. Let me tell you what I want. If you could just give me the essence of what happened, in just a paragraph or two instead of a page, I could figure out better what it all meant to you. That’s what I really want to know, what it was like for you. The details are interesting, but we don’t have time to do both, and you are more important than the details. I promise I’ll believe that it was very important, even if you skip some of the specifics. Can we try that focusing-on-the-essence idea for the rest of the session? Before you leave, you can tell me how it was for you.”

Proconvective Behaviors

Finally we want to describe behaviors that are alarming and provocative enough that “counterresistance” is likely, even for very experienced therapists (Strean, 1993). In our experience, these kinds of behaviors are most often evidenced by clients with personality disorders or more severe pathology. Since your typical reaction outside of therapy would very likely be to become punitive or to withdraw, neither of which is generally therapeutic, it is especially important that you be prepared to deal professionally with such behavior:

- punitive, withholding silence
- accusations of therapist’s unhelpfulness, biasses, learning, uncareing, and the like
- demands for a closer, personal relationship (e.g., the film What About Bob?)
- pattern of missed sessions, tardiness, emergency midnight calls, and the like
- sexual overtures toward the therapist

Mehlman and Glickaf-Hughes (1994), in their article about therapists’ hateful feelings toward clients, quote Groves’s (1978) list of client types that engender hate: dependent clingers, entitled demanders, manipulative help-seekers, and self-destructive deniers. While we think “hate” is a stronger affect than most experienced therapists feel, we agree that these categories can be added to our list.

One approach to dealing with such behaviors is to say matter-of-factly and nonpunitive, “Before we can proceed, we need to get something out of the way. I know therapy is a strange place—different expectations and goals and all that. Maybe I should go back over why I’m here and what I’m doing, and see if you still want to come. It may be that this just doesn’t fit with what you’re looking for....”

On inpatient wards, when the patient makes a clearly sexual suggestion or overtone, many staff members have learned to say calmly but firmly, “No, that’s inappropriate behavior. We don’t do that here.” That is the stance we think is most helpful when dealing with very provocative behaviors.

One therapist, in conducting an intake session, was asked by the client, “Can I talk about sex in here?” The therapist, assuming it was a matter of some concern for him, said, “Sure, if it’s important to you,” to which the client said, “Do you like oral sex?” After a pause to gather her wits about her, the therapist said, calmly, “Oh, I see, you thought we could share experiences. No, I don’t ever do that with clients. I was thinking you had some sort of concern you wanted to talk about regarding yourself. Sorry I misunderstood,” and proceeded with the intake (noting in supervision that she had clearly gotten some unexpected diagnostic information!).

Working through Resistance/Distrust

Writers as theoretically diverse as Ellis (1985), Milman and Goldman (1987), and Teyber (1997) suggest that the therapist’s ability to properly handle client resistance is a crucial therapeutic skill. There is some experimental evidence that level of client resistance should be used in considering type of psychotherapy (e.g., Beutler, Engle, Mohr, Dalsrup, Bergan, Meredith, & Merril, 1991). Beutler and his colleagues (e.g., Beutler & Consoli, 1993; Beutler, Consoli, & Williams, 1995) have identified client resistance as one of the critical dimensions of assessment (with treatment implications) in their approach to therapy—systematic eclectic psychotherapy.

We will now briefly outline several approaches to understanding resistance as framed by various theoretical orientations.

Psychodynamic Approach

The crucial ingredient in this approach, the goal of which is client uncovering of affect and eventual insight, is to refuse to adopt an adversarial stance and instead to “join” with the client, thereby providing client support, lessening his or her fear, and encouraging the exploration of avoided material. Bugental (1978) outlined
chapter 11

this as a three-part process: First, the therapist, in a warm, nonchallenging way, draws the client’s attention to the behavioral manifestation of the resistance as nonthreatening as possible. For example, you might say, “For the last five minutes you’ve hardly looked at me,” or “Lately I notice you’ve been late for our appointments.” The second step may be combined with the first step or, with more fragile clients, not made until after the first has been noted many times; it puts the behavior in a context. For example, you might say, “As we’ve been talking about your sexual abuse by your dad, for the last few minutes, you’ve talked very rapidly and looked away.” The final and most important step is to invite the client to explore the process. This might be merged with the first two, but may be quite separate. With genuine curiosity, you may say something like, “I notice that for the last couple of sessions you’ve been more distracted, and I remember your being upset with me the session before when I suggested you look at your feelings about your brother’s success. Are you feeling differently about coming here now that I’ve brought him up?”

The therapist, in order to invite such exploration, clearly needs to be willing to hear anything the client says, whether the material is intrapsychic or has arisen out of the client’s feelings about the therapeutic relationship. If the issue is interpersonal, we believe it is very important for the therapist to be open to client feedback rather than to automatically chalk off the client’s reactions as transference. If in fact the therapist erred in some way, he or she needs to be able to acknowledge the mishap nondefensively. This not only reestablishes the therapeutic alliance by legitimizing the client’s feelings and showing respect and influence, but it also provides a good model for the client that making mistakes is a normal part of human life and does not have to diminish one’s self-esteem.

“Joining” with resistance does not mean that the therapist is not setting limits. Especially with clients with poor impulse control, your task will be to continue to set limits nonpunitively and still remain emotionally supportive enough to encourage client self-exploration.

Narrative Approach

This and the following three approaches are especially useful in brief therapy, where relatively quick change is hoped for. There are a number of avenues that this narrative approach can take, and the last ten years has seen a plethora of books and articles available on this topic (e.g., Eron & Lund, 1996). We summarize them here, but before using them, be familiar with them and do not use them without supervision. To summarize briefly, images, stories, and narrative self-disclosure can be used to help the clients get a different perspective on themselves or their situation. For example, one client, Chantal, a college sophomore putting herself through college, had been raised by poorly educated working-class grandparents. They and others in the family were actively critical and disparaging of her interest in studying art and music in college. After several weeks of counseling to help her work on study skills, Chantal was still held back from wholeheartedly investing in school because of her preoccupation with her family’s massive disapproval. In one session the therapist said something like,

Think about a pasture someplace that has some dandelions growing in it. I don’t know about you, but I like dandelions—good, hearty flowers that can grow almost anywhere and provide a lot of color. Often they are the first ones up in the spring. Of course, the plants have stickers on them, and you wouldn’t want to step down on one barefoot, but otherwise they are perfectly nice plants. Now imagine that, in this family of dandelions, all of a sudden a rose bush was born. A rose bush, of all things! Not only was it different, it needed more stuff—pruning, fertilizing, and all that. You can imagine the dandelion family’s reaction when the rose requested those things: ‘Hey, don’t be so high-falutin’! You don’t need all that junk; use some regular manure, it’ll do fine. Works for us!’ I guess some rose bushes would tell themselves they should listen to the family, but it sure would deprive the world of some prize-winning roses, huh?

Similarly, using clients’ own images and metaphors, and empathically adding to them, can sometimes be very helpful.

Paradoxical Interventions

These interventions are used when a more straightforward approach does not seem indicated. They involve sidestepping the resistance, rather than using or working through it. The two usual categories of such interventions are compliance-based and defiance-based (Kleinke, 1994). As she describes the contexts for each, compliance-based interventions involve “prescribing the symptom,” and are used with clients who are not highly reactive to help them gain a sense of control by flowing with and experiencing their symptoms. For example, you might use this with a client presenting with a concern about overeating. Telling the client to gain one pound before she returns in a week is an example of symptom prescription.

For highly reactive, defiant clients, conversely, the technique suggested is “restraining.” (Laypersons are familiar with the more obvious forms of this technique as “reverse psychology.”) Along these lines, the therapist might suggest delaying change, (e.g., “We don’t want you to rush into this, take your time.”), forbidding change, (e.g., “Don’t try to make any changes until we can thoroughly explore what all this means. It might take months before we can really understand it.”), and predicting a relapse if things are going well. Again, it should be remembered that these approaches are to be used with truly reactive, oppositional clients.

Agreeing with Part of the Client’s Stance

This is an approach that we find helpful with resistant clients, although we have not seen it described by anyone else. The idea is to listen closely to the content of the client’s position (e.g., “hypnosis is bad and the work of the devil, my church told me so,”) and to legitimize part of it; then add exceptions. For example, in this
instance you might say to a client’s husband, who accompanied his wife to a session, who was angry because you were using hypnosis to help the client quit smoking, “Boy, I know what you mean! Some of those guys that do all that hypnosis on stage and make people look stupid, who’d want to do that stuff? You can’t help wondering what makes them do that—a need for power, or what? Pretty weird! Like you, I wonder if people like that might ever try to use hypnosis to get people to really veer off from their values! Of course, what Sandy and I are doing is a lot different, since we always agree ahead of time what she wants to work on, but I can really understand your concern!” In fact, there often is a partial basis to many concerns that are raised to our approaches, and being able to legitimize those concerns and show how what you’re doing is different can sometimes provide reassurance and also enhance your professional credibility.

Informed Consent

This is another approach that is helpful when all else fails. This approach is useful with clients who insist that they have no choice (often because of ideological/religious belief systems) but to behave in a certain way. The therapist does not attempt to attack or change the client’s belief system, but adds information to it, leaving the client to deal with his or her cognitive dissonance. For example, you might say to a father who refuses to let his daughter back into the house because she married a person of another race, “Well, you might need to honor that instinct to punish her that way. I couldn’t tell you not to do that. But you may want to know, as you continue to struggle with your reactions to the situation, that as psychologists we know when parents do that is that the kid tends to withdraw and that many of the values that the parent has tried so hard to teach her over the years get thrown out along with the relationship. I would hate to see you lose the positive influence you have had. Think about it, and see if that’s o.k. with you.” In more extreme situations, you might employ the same tactic. “Well, it looks like you’ve made up your mind what you want to do, even though it’s illegal. I know you won’t do it recklessly, but will make a clear decision. Let’s see, we’re looking at losing your job; 10 years, minimum, in the can (which is no picnic, as you know); alienating your family, and not seeing your grandkids grow up.” After such an intervention, change the subject! Plant the seed and then move on. With stubborn clients like this, even if they are inclined to change their minds, they can’t if they think you’ll believe you “won.” It is hard enough for them to reconsider their position without feeling like they have lost face also.

BIBLIOGRAPHY


Discussion Questions

- How will you distinguish between resistance and distrust in a cross-cultural counseling situation? What ideas do you have for making a cross-cultural client more comfortable with you?
- How do you feel about using paradoxical techniques? Do you see the implementation of them as counter to your values or theoretical orientation?
- Imagine a range of “provocative” resistant behaviors. Rehearse in your mind how dealing with clients manifesting each of these would feel to you, and how you might respond from within an appropriate therapeutic role. Role-play in class, and see if you all can brainstorm a number of appropriate responses that you can add to your repertoire.

In dealing with resistance, reluctance, or transference resistance, it is easy for the therapist to be tempted into an adversarial role. From our perspective, doing so jeopardizes the therapeutic alliance and thereby sabotages some of the most valuable aspects that therapy has to offer. As one comes to view clients balking as a normal, expected component of the therapeutic process, it will be increasingly easy to stay respectful and emotionally available to them while simultaneously and empathically implementing an intervention that will help get the therapy back on track so that the clients’ goals can be attained.


A 22-year-old college senior sought psychotherapeutic services from a university counseling center. She was involved in a committed relationship, and she reported that this relationship was a very positive one. She was the oldest of four children. Her mother had died when she was six years old and her father when she was 10. She and her siblings were raised by a loving uncle and aunt. In many respects, the client acted as a “mother” to her younger siblings and, despite the fact that her aunt and uncle were very supportive, she had an extremely difficult time adjusting to her parents' deaths. The client identified herself as a lesbian and seemed to have no concerns about her sexual orientation. She sought treatment when her minister's wife seemed, in her estimation, to pull away from her emotionally. She reported a similar pattern of feeling abandoned when a college teacher for whom...

“We thought Oz was a great Head,” said Dorothy.

“No, you are wrong,” said the little man, meekly. “I have been making believe.”

“Making believe!” cried Dorothy. “Are you not a great wizard?”

“Hush, my dear,” he said. “Don’t speak so loud, or you will be overheard—and I should be ruined. I’m supposed to be a Great Wizard.”

“And aren’t you?” she asked.

“Not a bit of it, my dear; I’m just a common man.”

—from The Wizard of Oz

The idea of mother means, first of all, unqualified, unwavering love, no matter how obnoxious and unadorable the years have rendered us. And, second, it signifies that once there existed another living soul who knew about and had been in intimate contact with our purest and most unblemished childhood self, the self we still believe we are, the self with whom we still commune in our interior conversation, the self that, despite all the evidence to the contrary, still insists, still knows, that we are good.

—from Toya Reich