Understanding Client Resistance: Methods for Enhancing Motivation to Change

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Clients sometimes work in opposition to their therapists, a phenomenon known as “resistance.” Such behavior is not simply an impediment to treatment, but also a potentially rich source of information about each client. This information can be assessed and utilized to strengthen the therapeutic relationship, help the therapist better understand the ideographic obstacles to change, and devise interventions that may motivate the client toward therapeutic activity and growth. Clinical vignettes of three resistant clients are presented, illustrating both the commonalities and unique factors that lead to resistance across cases. Eight important assessment questions and 10 suggested interventions are listed and discussed in detail. The practical applications of these methods in each of the three case studies shed light on how therapists can enhance their resistant clients’ motivation for therapeutic change.

When clients come to therapy for help in dealing with their problems in living, it is often clear that they are looking for relief from their acute affective symptoms. Frequently, these clients are considerably less certain about whether they are willing to change their longstanding patterns of functioning. Therefore, it is common for clients to fail to collaborate or cooperate optimally with the therapist and the treatment plan.

This can cause therapists considerable consternation; after all, if we’re using our concerted energy, good will, and expertise to help the clients overcome their...
problems, why would they work in opposition to us? Furthermore, what are we to do about this problem?

Therapeutic change is difficult and often somewhat frightening; therefore, it is reasonable to expect many clients to evidence occasional signs of resistance with treatment plans that attempt to induce such change. Indeed, traditional psychodynamic therapists have viewed resistance as part and parcel of the therapeutic process (Milman & Goldman, 1987; Wachtel, 1982)—the result of the clients' ongoing conflict between their consciously professed desires to change and their unconscious fears about losing their safe ground and sense of identity (Fenichel, 1941; Glover, 1955; Greenson, 1968). From this theoretical point of view, psychological symptoms serve a compensatory or defensive purpose for the client (Basch, 1982). Therefore, at some level of awareness, the client understands that he or she becomes even more vulnerable if the "protective" symptoms are relinquished.

Rather than viewing client resistance merely as an annoying impediment to the "real" work of therapy, cognitive-behavioral therapists would do well to look at client resistance as important information in its own right—information that can shape the case formulation, increase the therapist's accurate empathy, and suggest interventions that are tailor-made for the client. Armed with a conceptual understanding of clients' reluctance to change, cognitive-behavioral therapists are in a better position to implement the active, systematic, structured, and testable methods that are the strengths of their orientation.

Additionally, therapists must examine resistance not only as a client variable, but also as a function of the therapist's approach (e.g., Is the therapist acting in a disengaged manner?), as well as a by-product of contextual factors (e.g., Does the client have a spouse who is actively sabotaging the client's progress?) (Golden, 1989).

Illustrations of Client Resistance

The following are brief case illustrations that highlight various aspects of client resistance. These cases will also be discussed in detail later in the paper in the assessment and intervention sections.

Bart is a 43-year-old car salesman who is in therapy in the aftermath of his divorce. His therapist attempts to educate Bart about the cognitive factors involved in negative emotions such as dysphoria, anger, and guilt by encouraging him to purchase the book *Feeling Good* (Burns, 1980). Week after week, Bart reports that he has "forgotten" to buy the book, and the therapist politely explains that although the book isn't necessary for treatment to proceed, it certainly will help to facilitate progress. Therefore, it would be in Bart's best interest to get a copy of the book as soon as possible. Finally, Bart arrives at a session and announces that he has bought *Feeling Good*. The therapist, pleased to hear this, asks "What have you read so far? Shall we discuss some of your reactions to what you've
read as part of our agenda for today's session?" Bart smugly replies, "No, that won't work at all. I threw the book in the trash as soon as I got home."

Sabrina is a 40 year-old, married computer programmer who has entered therapy for chronic depression and generalized anxiety. Early in treatment Sabrina and her therapist conclude that the client's anxiety and dysphoria are triggered most often by thoughts about failing to meet her obligations, such as deadlines for getting out the "bugs" in her programs at work, keeping up-to-date in paying her bills, returning phone calls, and keeping her house from becoming cluttered and messy. She routinely assumes that there will be catastrophic results from falling behind in these tasks, yet at the same time she minimizes the potential positive effects of changing her behaviors so as to complete these tasks. She chastises the therapist for showing optimism and giving encouragement (e.g., "Oh, please! You can't be serious! It's a hopeless situation and that's that. What's the point of doing anything different? It never works out anyway."), and laments the fact that she isn't getting anything out of this "Mister Rogers therapy."

Mitch is a 26-year-old law student who presents with severe depression and panic attacks. After 20 sessions of conjoint cognitive-behavioral therapy and pharmacotherapy, Mitch has shown significant improvement on objective measures. His Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and Beck Anxiety Inventory (BAI: Beck, Epstein, Brown, & Steer, 1988) scores have decreased markedly (indicating reduced symptomatology), he is socially more active, and he is no longer missing classes and assignment deadlines due to hypersonnia and anergia. Nevertheless, Mitch continues to present with subjective signs of distress, stating that "I know that everything is going to fall apart in my life at any time," and "I think my problems are all biological. I'm doomed to always have depression and anxiety." Each time the therapist attempts to point out the client's objective progress, Mitch responds incredulously, and continually asks the therapist to justify his position, whereupon Mitch dismisses it anyway. The therapist begins to find working with Mitch to be tiresome, repetitive, and frustrating, and has to work very hard to keep these feelings in check.

In each of the cases above, the clients work in opposition to the therapist, and they do so for seemingly unknown or "irrational" reasons. Further, their actions do not effect any apparent benefit for themselves, and therefore come across as gratuitously self-defeating. There is often the temptation on the part of therapists to explain this occurrence by saying that "the client would rather suffer than get well," "the client does not really want to change," or "the client is not 'ready' for therapy" (comments that the author has caught himself muttering under his breath on more than one occasion). At best, such pat explanations are grossly oversimplified formulations of the problem, and do not shed any appreciable light on the clients' beliefs, learning histories, and motivations that might account for their particular form of resistance. At worst, such views
prevent therapists from taking a dispassionate look at their own contribution
to the problem, increase their counterproductive feelings toward their clients,
and reinforce clients' beliefs that therapy is unhelpful.

We as therapists, when stumped and deterred by clients' resistant attitudes
and behaviors, need to curb our exasperation and tendency to arrive at general
(but perhaps ill-informed) attributions for the client's behavior. Instead, ther-
apists must take an ideographic approach to the assessment of each client's re-
sistance or low motivation to engage in treatment.

Assessment of Client Resistance

Some general signs of client resistance warrant description in greater detail,
for they represent common phenomena in the therapist's clinical practice. How-
ever, although the overt behavior may look similar across cases, it is vital to ex-
amine the unique etiologic and maintaining factors for each client. For example,
it is only mildly instructive to say that a client neglected to do a homework as-
signment because he or she was afraid and lacking in confidence. It is far more
informative to be able to determine specifically what was frightening for the
client, and precisely what aspects of the assignment he or she believed were be-
yond his or her capacity. This involves an examination of how such fears and
low self-confidence developed, and how the client's related cognitive, affective,
and behavioral signs persist in spite of seemingly negative consequences.

Summarized below are some of the more common, general forms of client
resistance that therapists encounter, followed by a series of assessment ques-
tions that can help therapists to probe into the specific, ideographic aspects of
the resistance.

High-Frequency Forms of Client Resistance

A common manner in which clients are resistant to treatment is their failure
to follow through with homework assignments or other agreed-upon courses of action
between sessions. This form of resistance is especially troublesome in that many
opportunities for therapeutic learning and practice in the natural environment
are lost when clients neglect to engage in their assignments. A number of
cognitive-behavioral authors have noted that neglect of homework is associated
with slower rates of improvement and poorer posttherapy maintenance (Burns
Persons, Burns, & Perloff, 1988; Primakoff, Epstein, & Covi, 1989). Unfortu-
nately, many therapists are apt to abandon formulating and collaboratively as-
signing homework when their clients are continually resistant (in essence, the
clients' lack of responsivity to the assignments extinguishes the therapists' ap-
propriate behaviors). Instead, it would be beneficial to investigate the clients'
overt and covert reasons for not doing their homework, and to continue to for-
mulate assignments.
Another sign of client resistance is seen in those cases where clients react to their own objective improvement with skepticism, reluctance to work toward independence (e.g., termination), and regression (Meichenbaum & Gilmore, 1982). These are the clients who seem to want to remain in treatment longer than the therapist may believe it is necessary or helpful to do so. These are also the clients that therapists all too often see as merely being self-defeating and gladly choosing to hold onto their dysfunctional ways.

Yet another manifestation of client resistance is in high levels of expressed emotion toward the therapist, from hostility to overt flirtation. Although there may be times when such client emotions may be understandable in reaction to maladaptive therapist behaviors that pull for these responses, there are many cases when extreme levels of clients’ emotionality represent their own characteristic patterns. Therapists who treat clients who suffer from borderline personality disorder, for example, are well aware of this phenomenon (Layden, Newman, Freeman, & Morse, 1993; Linehan, 1993).

Other less dramatic, yet still problematic signs of resistance involve subtle avoidances in session. For example, clients may state at the start of a session that they have “nothing to discuss today,” or they may be prone to answer most of the therapist's salient, probing questions with the pat answer “I don't know.”

Understanding the Factors That Are Unique to Each Client

In response to resistance, therapists need to consider the following eight assessment questions:

(1) *What is the function of the client's resistant behaviors?* It is useful to engage the clients in an earnest exploration of the factors that make it in the client's “best interest” to oppose the therapist and/or the course of treatment. In the case of Mitch, the therapist noticed that the client would smile and become uncharacteristically animated at precisely those times when he would rebuff, contradict, or challenge the therapist. In response to Mitch's next smile and energetic banter, the therapist asked, “I couldn't help but notice that you were smiling just then. What goes through your mind when we interact like this?” Mitch chuckled, “I guess it makes me feel good if I can make you sweat.”

Upon further discussion, Mitch and the therapist hypothesized that Mitch felt more intelligent and worthy if he could engage (and perhaps defeat) the therapist in debates. By contrast, Mitch felt weak and ignorant when he would accept new information from the therapist without question. (The therapist replied that he welcomed the client's questions and challenges, but added that there might be a healthy middle ground between meek acceptance and fierce rejection of all that the therapist would say).

Further, Mitch stated that he felt more “in control” when he would verbally spar with the therapist. This phenomenon calls to mind Brehm and Brehm's (1981) "reactance theory," which holds that clients act to maintain their sense of freedom. The implication is that clients may react adversely to the perception
that their therapists are trying to control them, even if their helpers seem benign and the treatment seems to make sense. In this framework, clients who defy therapists are not merely self-defeating or gratuitously oppositional, but rather are attempting to defend their autonomy (albeit in a dysfunctional way).

There are a number of ways that a therapist can anticipate that a client will be likely to defend his or her autonomy via therapeutic resistance. One predictor is a history of oppositional behavior toward authority figures (see assessment question 2 below for more information on historical factors). Another predictor is a high score on pretherapy assessment measures such as the Therapeutic Reactance Scale (Dowd, Milne, & Wise, 1984). Diagnostic information also can earmark such a client. For example, clients who meet DSM-III-R (APA, 1987) criteria for personality disorders such as passive aggressive, obsessive-compulsive, and antisocial are by definition prone to be highly invested in maintaining control over their choices and behaviors, even if this creates conflict with others, including their therapists.

(2) How does the client's current resistance fit into his or her developmental/historical pattern of resistance? Sub-questions to ponder, and perhaps to ask the client directly, include—“When and under what circumstances has the client been similarly disinclined to try to change or accept help in the past?”; “What other relationships in the client’s past and present are called to mind by the current conflict between the client and therapist?”; and “How is the current scenario in therapy similar to and distinct from previous situations in the client’s life when he or she resisted change or direction?”

In Bart’s case, the client could identify numerous times in his life when he believed that someone’s offers of help and advice were thinly-disguised attempts to lead him astray and take advantage of him. He viewed the therapist’s suggestion to purchase *Feeling Good* as involving motives of financial self-interest on the part of the therapeutic agency, and he felt it was not in his best interest to comply. As in the past, his chief mode of resistance was a passive demonstration of protest and hostility. Bart had found that passive resistance was the easiest way to counter-attack what he viewed as his employer’s unreasonable demands and his mother’s and former wife’s undue attempts to control him. Unwittingly, his responses had exacerbated their attempts to try to change him, which further fueled his mistrust.

(3) What might be some of the client’s idiosyncratic beliefs that are feeding into his or her resistance? It is very useful to look into the unique ways that clients interpret various situations, as this may shed light on why the clients think that it is warranted, necessary, and beneficial for them to resist change. For example, regarding Bart’s discarding of *Feeling Good* hours after purchasing it, the therapist asked, “Bart, what was going through your mind when you left the store with the book in hand?” After some puzzled reflection, he replied, “I noticed that the guy who wrote it works at this Center, and I said, ‘Geez!’” The therapist then added, “And what did that mean to you?” Bart retorted, “Well, you want
people like me to buy your books so you can make more money. It’s really not because it’ll help me.”

Once again, as Bart historically had done, he interpreted a benign act as a sign that someone was trying to take advantage of him. Therefore, even though it seemed a waste to discard a book he had just purchased, Bart’s behavior made sense in the context of a belief system that said it was a bad idea to comply with anyone who simply wants to exploit you. Within this belief system, Bart had not taken into account the following data—that he was receiving free therapy, that the book was an inexpensive paperback, and that the author had been independent of the Center for many years. Bart’s fundamental mistrust for others became a focal issue in therapy, something that might have been overlooked had the therapist merely ascribed the client’s behavior to a general motivation not to get well.

In the case of Sabrina, the therapist asked, “What goes through your mind when I give you support and encouragement, and when I suggest that you can make great strides by being more active in taking care of your bills, household, and computer work? What keeps you thinking that it’s hopeless and futile to change or improve your life?” Sabrina’s reply was unexpected and quite enlightening. She noted that “all the great writers and intellects in the world are depressed,” and that “you can’t take an optimist seriously, because the world is so screwed up that nobody with an ounce of brains could possibly be an optimist!” Clearly, she had interpreted her therapist’s positive verbal reinforcement as indicative of a sappy, simple-minded approach to life. Further, she viewed herself as an intelligent person and writer (her chief avocation), and she certainly wasn’t going to give up her membership in the “depressed great writer’s society” without a fight. Therefore, she resisted change that might improve her mood.

As the case examples illustrate, a central method for calling attention to the clients’ resistance is the therapist’s inquiring about the clients’ thoughts that precede or accompany their negative reactions to the therapists’ suggestions. The therapist can ask about thoughts that a resistant client is having live in session (e.g., “You rolled your eyes as I was explaining my point of view just now. What went through your mind?”), or reflect on relevant thoughts that he or she had between sessions (e.g., “What were you thinking as you contemplated doing the homework, and what were the thoughts that convinced you not to do it?”).

(4) What might the client fear will happen if he or she complies? Although the therapist may believe that change is a good thing, clients may have misgivings that must be acknowledged and addressed. For example, some clients (especially those with more longstanding issues and serious problems) cling tenaciously to the status quo in their lives because to some extent it is familiar and safe. To change would mean to venture into the unknown, which can be very frightening and disorienting to many clients (cf. Beck et al., 1990; Layden et al., 1993; Young, 1990). Clients may view changing as incurring further difficulties in their lives,
such as increased demands and decreased caretaking from others. This induces fear, and often leads to avoidance. In some instances, clients fear that they will lose their sense of identity if they change. For example, Mahoney (1991) has written about the "self-preserving function" of resistance, and presents a case example where a client claims that in order for him not to be depressed he would have to be a "different person." In such cases, clients equate change with annihilation.

In the case of Mitch, the client did not fear change per se. However, he dreaded the possibility that the therapist would take all the credit for whatever therapeutic improvements that Mitch made, while Mitch would be left feeling discounted and possibly even shamed. (See point 8 below for further explanation.)

(5) How might the client be characteristically misunderstanding or misinterpreting the therapist's suggestions, methods, and intentions? At times a client's failure or refusal to collaborate with the therapist may be the result of a simple misunderstanding. For example, Sabrina became silent in session because she took offense at what she perceived to be an insult from the therapist. When the therapist inquired about this, it became clear that Sabrina had misheard what the therapist said. In reality, the therapist had been poking fun at himself with a self-disparaging comment.

In other more serious cases, the clients' negatively biased beliefs and information processing lead them consistently to misconstrue interpersonal situations (Safran & Segal, 1990). This leads to anger and other negative emotions that contribute to the clients' resistance. For example, Bart tended to read threatening, exploitive, and demeaning things into what people were saying to him. Therefore, when the therapist suggested that he purchase and read Feeling Good, Bart was predisposed to look for reasons why it would be against his best interest to follow through. He did not understand the concept of bibliotherapy, and therefore needed an explicit rationale as a starting point to overcome his reluctance to read the book.

(6) What skills does the client lack that might make it practically difficult or impossible at this point for him or her to actively collaborate with treatment? Therapists must assess their clients' psychological skills (e.g., problem-solving, planning, communication, rational responding, perspective-taking; cf. O'Donohue & Krasner, 1994) in order to determine how much of their resistance is motivational and how much represents deficits in functioning (Trower & Dryden, 1989). For example, failure to follow through on written homework assignments may reflect a reading or attentional deficit. Similarly, a client's reluctance to engage in interpersonal behavioral experiments may signal a lack of social skills and/or assertiveness. When this is the case, graded instruction and practice are required in the therapy sessions themselves before clients can be expected to generalize these behaviors to everyday life (Meichenbaum & Turk, 1987; O'Donohue & Krasner, 1994).

Even when clients demonstrate a reasonable level of psychological skills, they may still manifest resistant attitudes and behaviors because they believe that they
are incapable and helpless to follow through. In such cases, it is imperative to critically examine the basis for the client's sense of hopelessness and low self-efficacy (Beck, Rush, Shaw, & Emery, 1979).

(7) What factors in the client's natural environment may be punishing the client's attempts to change? It is sometimes unwise for therapists to assume that the client's praiseworthy changes in session will be similarly positively reinforced in the client's everyday life. For example, factors in the client's personal life or work situation may serve as strong disincentives for the client to change (Golden, 1989). If the therapist is unaware of these outside variables, he or she may conclude erroneously that the client alone is responsible for the impasse in therapy. Thus, the therapist may become exasperated with the client's giving lip service to change, and may fail to pursue relevant issues that explain the resistance.

This can be seen in the case of a client who has been referred by his physician for psychological treatment as a result of his hypertension and related cardiovascular symptoms. The client states that his goal is to “learn to relax, not work so hard, and not get so angry.” However, the client does not follow through with the treatment program that includes relaxation, revised work hours, and various anger control techniques. Although it is tempting to explain the client's resistance as being a function of his “Type-A” or “obsessive-compulsive” personality, there may be a host of environmental factors that work against therapeutic change. These may include a critical father who still demands perfection from the client and a job where long work days and an aggressive approach are highly lauded. When these types of variables are identified and addressed, the therapist will have much greater leverage in helping the client to overcome his resistance to change.

Another example is the case of a woman who seeks therapy for “depression and low self-esteem” but doesn’t mention that her husband is emotionally abusive. When the therapist explains that the client’s symptoms could be alleviated in part by her learning to be more assertive, the client seems enthused. However, before the next session the client telephones the therapist, tearfully saying, “You’ve been a great help to me, and I won’t need to come back anymore. Please don’t try to call me, I’ll be fine . . . really.” The client’s failure to follow through with treatment in this case likely is based on the disapproval and punishment received from the abusive husband in response to the client’s attempts to stand up for herself. Therapists who are aware of such potential environmental obstacles to change, and who consider them in formulating a treatment plan, have a better chance of effecting gradual changes that may encounter less backlash than the rather tragic case described above.

(8) Does my conceptualization of this case need to be revised or amended? What do I still need to understand about this client in order to make sense of his or her resistance? When a client rejects a therapist's formulations or suggestions by saying (or thinking), “Doctor, you just don't understand,” sometimes they're right! It is advisable for therapists — when they are stumped by their clients' resistance — to consider the
likelihood that they are missing or overlooking important data. For example, Mitch's tendency to debate with the therapist and deny that he was improving was better understood after the therapist reviewed old session notes in search of conceptual clues. Specifically, Mitch had explained that his older brother had always been the "favored son" in his family of origin. The father often made comparisons between the client and his brother, and usually found the client wanting. As a by-product of this set of family interactions, Mitch grew to harbor a fierce competitiveness and resentment toward the older brother.

Exacerbating this problem was the older brother's tendency to try to "help" Mitch by giving him unsolicited advice about what he should do and how he should do it. In therapy, Mitch bitterly recounted an episode from his school days when he studied extremely hard to get an "A" on a math exam, only to have his father sing the praises of the older brother for having tutored Mitch so well and "setting such a great example."

These historical data helped the therapist to add a new and important facet to his case conceptualization of Mitch. The therapist, realizing that he was close in age to Mitch's brother, hypothesized that Mitch was perceiving and reacting to the therapist as he would his older brother. If this were the case, Mitch likely would resent the therapist's professional status, his suggestions about what Mitch "should do and how he should do it," and his role as "superior." This phenomenon is well-known in the traditional psychoanalytic literature as "transference," but has also been recognized by cognitive-behavioral clinicians under the rubrics of "interpersonal schemas," or "in vivo interpersonal overgeneralization" (cf. Goldfried & Hayes, 1989; Goldfried & Newman, 1992; Segraves, 1982).

The therapist postulated that Mitch was reluctant to acknowledge that therapy was helping him, lest the therapist (like the older brother) take all the credit for "setting such a great example," while Mitch would receive no credit for his own efforts in overcoming depression. If this were how Mitch truly viewed therapy, then it might stand to reason that he believed he could succeed (i.e., defeat his older brother) only by thwarting the therapist at every turn. The therapist presented this tentative hypothesis to Mitch in as humble and supportive a manner as possible, with highly favorable results (see the Interventions section for further details).

**Interventions for Improving Client Motivation**

There are a number of ways that therapists can work to motivate their clients to engage more actively and effectively in treatment. These include methods such as: (1) Educating the client about therapy; (2) Using the Socratic method; (3) Providing the client with choices and an active say; (4) Collaborating and compromising; (5) Reviewing the pros and cons of change, and the pros and cons of continuing with the psychological status quo; (6) Providing accurate empathy for the client's resistance; (7) Discussing the case conceptualization
with the client; (8) Speaking the client's "language"; (9) Maximizing the use of client self-direction; (10) Being gently persistent when a client is "stuck."

In general, all of these interventions are helpful in counteracting client resistance right from the outset of therapy. However, they become particularly effective to the extent that the therapist makes use of the aforementioned assessment questions and comes to formulate a sophisticated case conceptualization (Persons, 1989) as treatment progresses. In this manner, the therapist can put special emphasis on those interventions that best fit the particular needs of each individual client.

Educate the Client About Therapy

An important and basic way to maximize clients' preparedness for therapy is to provide education about therapy (Meichenbaum & Turk, 1987; Young, 1990). Clients often do not understand what to expect when they enter therapy, partly as a function of the diversity of the field, partly due to misconceptions borne of sensationalized or unflattering portrayals of therapists on television and in movies, and somewhat as a function of their own biases and misconceptions (e.g., "Therapy is like a magic pill. I'll just show up and the therapist will say all the right things to make me better").

A cooperative alliance can be established more readily by educating clients about therapy (Macaskill, 1989; Macaskill & Macaskill, 1983). This would include an explanation of the model of treatment (e.g., cognitive-behavioral therapy), a preview about the expected length and substance of the course of therapy, and a discussion about the roles and responsibilities of both the therapist and the client. A number of tacks can be taken in order to achieve this goal, including: (1) Giving clients supplemental readings at the start of therapy, such as Beck and Greenberg's (1976) Coping with Depression, which provides an introduction to the cognitive model of depression, or Burns's (1980) Feeling Good, which is perhaps the most widely read "take-home guide" to cognitive therapy; (2) Providing clients with a verbal and written orientation to their personal roles in the therapy process (e.g., Young, 1990), so as to anticipate and promptly address the kinds of misgivings and apprehensions that clients often have about their decision to enter therapy; (3) Distributing comprehensive guidebooks that outline and explain the entire course of therapy as it will unfold (e.g., Grieber, 1989), a process that is analogous to following a textbook chapter by chapter as one progresses through a college course; and (4) Periodically discussing the clients' progress with them during the course of treatment in order to reassess and update goals, evaluate measurable gains to date, and answer questions that have cropped up.

The process of educating clients about therapy continues throughout the course of treatment. It helps to demystify the experience, it makes clients more knowledgeable consumers, and it facilitates the clients' willingness to collaborate with the therapist toward common goals.
In the case of Sabrina, the therapist responded to the client's assertion that she was receiving "Mister Rogers therapy" by explaining that rational restructuring techniques were not synonymous with idle positive thinking or "sticking one's head in the sand." He stressed that cognitive therapy methods involved teaching clients to think more objectively and constructively so that real problems could be put into better perspective and dealt with proactively. The therapist explained that he would not minimize her problems or tell her superficially to "look on the bright side of life." He added that therapy was hard work, involving empirical methods and systematic application of techniques.

In order to intervene further in disabusing Sabrina of her misconstrual of the purpose and methods of cognitive-behavioral therapy, the therapist recommended that she read Ellis and Harper's (1975) *A New Guide to Rational Living* and Ellis and Knaus's (1977) *Overcoming Procrastination*. The therapist specifically chose books by Ellis and his colleagues as these publications tend to be very direct in presenting the view that life is tough and unfair (a view with which Sabrina was quite sympatico), but that there is a mindset and a technology to deal with this unfortunate fact.

Use the Socratic Method

Clients have been known to resist incorporating their therapists' most well-meaning and accurate feedback simply because the clients didn't think of it first. Therapists can circumvent this problem if they make judicious use of the Socratic method. This involves asking a clever series of questions that leads the client in the direction of synthesizing information and drawing a set of conclusions, the likes of which will be more likely to be remembered and followed because it was the client who generated the information (Beck et al., 1979; Beck, Wright, Newman, & Liese, 1993; Overholser, 1987; 1988; 1993). In order to make the most effective use of Socratic questioning, the therapist must have a goal in mind (similar to plotting a chess strategy four or five moves in advance), must be willing to accept and pursue client responses that seem counterintuitive, and must under no circumstances browbeat the client (e.g., with hostile-sounding rhetorical questions) into agreeing with the therapist's viewpoint.

The Socratic method is especially useful in dealing with clients who highly value their autonomy, and/or fear being controlled by their therapists. Additionally, the Socratic method helps to minimize misunderstandings between therapist and client, as the client produces much of the data. Therefore, the chances that a client who may frequently distort what others say will misread or mistrust the therapist's comments are reduced.

Provide Choices

Brehm and Brehm's (1981) "reactance theory" posits that clients will behave in ways that preserve their freedom, even if the behavior seems countertherapeutic. With this in mind, it is wise to give the client some say in the direction
of a given session or in the entire course of therapy. One basic method of achieving this goal is by showing respect for the client’s agenda (e.g., “What would you like to focus on in today’s session?”). Another is to provide options (e.g., “For homework, you could choose to focus on the readings, the daily thought records, or our proposed behavioral experiments, or any combinations of the above. What do you think would be best for you right now?”). The therapist does not completely turn over the reins to the client, but instead provides a set of choices within appropriate therapeutic limits and judgment. Miller and Rollnick (1991) report that they have had success in implementing this principle in working with substance abusers who are ambivalent about change.

Bart’s discarding of his copy of *Feeling Good* sparked therapeutic discussion about his basic sense of mistrust. At the same time, the therapist backed off his specific recommendation that Bart read *Feeling Good*, and presented him with a list of self-help supplemental readings from which to select the materials of his choice. He opted for Ellis and Harper’s (1975) *A New Guide to Rational Living*, and was satisfied that it would be beneficial for him to study and discuss its principles in treatment.

Collaborate and Compromise

Give-and-take and reciprocity are two hallmarks of healthy relationships. To a large degree, this is true of the therapeutic relationship as well (with the notable exceptions of the lack of commensurate therapist self-disclosure or the returning of romantic gestures). Although the therapists certainly “run the show” in that they are on their own turf (their offices) and possess the specific expertise to be the authority figures in the therapeutic relationship, they are likely to encounter significant resistance if the clients view therapy as a benevolent dictatorship (for some clients with mistrust issues this term is an oxymoron—in their view, anyone who dictates is by definition malevolent). Therapists can create an atmosphere of cooperation by being flexible, such as by being willing to relinquish a hypothesis that doesn’t fit the client’s data, by respecting the client’s wishes to change the topic of discussion if another pressing matter needs to be given attention, and by being willing to admit mistakes or apologize when the situation calls for it (e.g., being late for a session) amongst other ways (Beck et al., 1979; Beck et al., 1993).

On the other hand, good therapy, like good parenting, is not a popularity contest. Although the therapist may be tempted at times to go along with whatever the client’s agenda may be in order to earn the client’s positive regard and trust, this strategy is decidedly inadvisable when taken to the extreme. Therapists must be willing to provide some measure of structure, direction, guidelines, and limits (Ellis, 1983; 1989), or else the client will not receive vital corrective feedback, and therapy will be (at best) a very inefficient process. The key is for therapists to remind their clients in a respectful, humble manner that collaboration is a two-way street, and that although the client’s views will be taken seriously, there
will be times when the therapists' professional judgment will need to prevail. One particularly helpful method that is common in cognitive-behavioral therapy is to couch differing points of view between client and therapist in terms of competing hypotheses that can be tested. By taking this collaborative stance, therapists can find a middle ground between a pedagogical approach and a "permissive" approach, each of which might otherwise feed into the client's resistance to change.

Review the Pros and Cons of Changing and Not Changing

A functional analysis of a client's maladaptive behaviors and attitudes that seem resistant to change often reveals that the client idiosyncratically believes that it is in his or her best interest not to change. For example, a socially avoidant young man may understand that his fear of approaching women is exacerbating his loneliness, but he may simultaneously believe that to try to speak to women would be far worse, bringing rejection and humiliation. In the eyes of this client, all things considered, he has a choice between "bad" (being lonely) and "worse" (being a lonely laughingstock), and therefore chooses to remain avoidant, which he views as the lesser of two evils.

These beliefs are fruitful points of intervention in treatment. Clients may be more inclined to reconsider their status-quo-engendering beliefs if they realize that the therapist can understand their reasons for being hesitant to change. Grilo (1993) suggests that therapists engage their clients in, "... a detailed review of all the potential pros and cons in changing a behavior prior to attempting to change . . . " (p. 220). He notes that therapeutic collaboration is facilitated when therapists show that they are willing to look at the cons of change. In similar fashion, Beck et al. (1979) have found that suicidal clients appreciate the therapist's being willing to examine both the pros and cons of suicide. Beck et al., 1993, likewise have helped addicted individuals by evaluating the pros and cons of both using and not using drugs. Clients then become more apt to cooperate in the exercise of reviewing the long-term costs involved in not changing, including the kind of personal stagnation that has been implicated in some people's increasing unhappiness and bitterness as they grow older (Erikson, 1963). Thus, client receptivity to change is enhanced.

Sabrina was reluctant to relinquish her cynical view of the world and life because she believed that negative thinking was positively correlated with high intelligence. One of Sabrina's few sources of satisfaction in life was her intellect, and she was loathe to adopt any measures that she deemed a threat to her high-brow self-image. Therefore, she was able to identify that an "advantage" of maintaining her depressive thinking was that she would continue to feel superior to others. On the other hand, Sabrina acknowledged that a disadvantage to this approach was that she would continue to be depressed and anxious, and that she would be less likely to enrich her life. On the flip side, a disadvantage to changing her thinking style would be that she would feel disoriented and "not herself," while an advantage might be improved success in completing important tasks and in getting along better with others.
Provide Empathy for the Resistance

Clients are accustomed to encountering disapproval from the people in their lives who have grown weary of exhorting the clients to change, and who now have little sympathy or tolerance for the clients' problems. Therefore, it is a breath of fresh air for clients to ascertain that their therapists have some measure of empathy for their reluctance to relinquish maladaptive functioning (Koerner & Linehan, 1992; Layden, et al., 1993; Mahoney, 1991).

For example, a therapist encountered a mistrustful client who screamed at him because the therapist asked her to consider her own role in her escalating interpersonal conflicts. Following her tirade, the client said, "I'll bet you hate me now, and want me never to come back." The therapist replied, "Not so. I know that you were only trying to protect yourself, and everybody has a right to do that. What we have to find out is why you believed that I was attacking you, and what we can do about this problem." The client's degree of cooperation with the therapist increased following this unexpected empathy for her resistance. In essence, the therapist had demonstrated that he understood the function of her behavior, and that he had compassion for her fears of being attacked.

Mitch's therapist demonstrated accurate empathy with the client's resistance by lamenting his perceived "black sheep" status in the family, and by stating that "I believe that you have a right to receive credit for your accomplishments." The therapist added that he could understand how Mitch might feel competitive with the therapist in light of the client's history with his father and brother. The therapist told Mitch that he respected him for all that he had accomplished thus far in life (e.g., gaining admittance to a prestigious law school) in spite of family strife and a series of bouts of severe depression, the likes of which might have crushed someone with less resolve, strength, and ability. Mitch responded favorably to these comments, and began to see the therapist as an advocate instead of a malevolent competitor. The result was much less contentiousness and much more constructive dialogue in session.

Discuss the Case Conceptualization With the Client

It is good practice for therapists to help the clients make sense of their difficulties by reviewing the problems in the context of a developing case conceptualization (Persons, 1989). This is a collaborative activity that solidifies the therapeutic relationship and gains the clients' active interest and involvement. The conceptualization involves such factors as the client's learning history, idiosyncratic beliefs about the self, world, and future (the cognitive triad, cf. Beck et al., 1979), compensatory strategies and strengths in coping, and situational examples of how all of the above fit into the client's functioning (Beck, in press).

As noted earlier, a breakthrough was achieved with Mitch when the therapist hypothesized a new way to conceptualize the client's tendency to debate with the therapist. Mitch acknowledged that he was primed to view the therapist as being patronizing and condescending, and that Mitch needed to "defend" himself by presenting counterarguments to all of the therapist's comments.
Mitch added that he hadn't given it much thought before, but that the therapeutic relationship did seem to be reminiscent of his relationship with his older brother. When the therapist expressed acceptance and empathy for Mitch's self-protective strategy, and added his heart-felt praise for Mitch's accomplishments, a major shift in Mitch's viewpoint took place. Mitch began to view the therapist (and by extension, anyone who would purport to be his advocate and mentor) on his own merits, and not automatically as a psychological clone of his brother.

Speak the Client's Language

When clients are ambivalent about being in treatment, their decision as to whether or not to invest in therapy sometimes hinges on their perception of their compatibility with the therapist. One important way for therapists to augment a sense of compatibility is to use language that is familiar to the client (Beck et al., 1993; Liotti, 1989). This is not to suggest that therapists should go out of their way to mimic clients, either by using slang, profanity, or parroting responses. Rather, the therapist can make use of an accurate case conceptualization to determine the sort of communication style that, while within the therapist's sincere and natural repertoire, also strikes a resonant chord with the client.

For example, when describing the nature of cognitive therapy to a histrionic, "new age artist" client, the therapist may choose to say that a goal of treatment is to help the client to "gain a heightened consciousness of your innermost thoughts when your feelings are intense," while compulsive, overcontrolled businessman might be told that "cognitive therapy helps you become more objective and productive in dealing with issues that give you a sense of subjective stress." In this manner, the clinician maximizes the chances that the client may view the therapist as someone who is similar and an ally.

When the therapist's standard form of verbal communication seems ineffective in connecting with the client, imagery and metaphors may be a useful alternative in gaining the clients' attention and interest (Layden et al., 1993; Meichenbaum & Gilmore, 1982). The most efficacious use of imagery and metaphors requires an accurate case conceptualization so that the therapist's "pictures and stories" will be personally meaningful to the clients.

For example, a histrionic client did not fathom the aversive impact her highly dramatized behaviors had on others in her life until the therapist made use of an analogy that likened her to her favorite classical composer's music played at 200 decibels. The therapist explained that, "Nobody will be able to appreciate your subtleties and inner beauties if your volume is so loud that people must cover their ears." Similarly, a conduct-disordered and narcissistic teenager who was quite fond of the Star Wars trilogy was likened to Luke Skywalker at the critical crossroads in his life. He could either use the power of The Force to become a Jedi Knight and fight for good, or go over to the Dark Side of the Force and become like Darth Vader. Either way, the client would be extremely powerful.
He could choose to harness his power for success, or become a colossal failure in life (not just any run-of-the-mill failure, mind you). Truly, a good picture that has personal meaning is worth a thousand words for some clients.

Maximize the Use of Client Self-Direction

It is the rare client who is so resistant that he or she never tries to change and always opposes the therapist. Most clients occasionally demonstrate a willingness to try new behaviors and attitudes, and sometimes agree with the therapist's point of view. When clients demonstrate such flashes of cooperation and motivation, it is imperative for the therapist to make ample use of the situation.

The best way to accomplish the above is to document the occurrence of adaptive client responses, so that they may be remembered and reviewed at later dates when the client's resistances once again impede progress. One particularly accurate method of documentation is the use of audiotaped and videotaped recordings of sessions (Ellis, 1985; Newman, 1993). The author makes a practice out of asking clients to keep an archive of audiotapes of "our most optimistic and productive sessions," so that the clients can listen to such tapes in order to boost the momentum of therapy at those times when the client's motivation once again flags. Although it may be easy for resistant clients simply to contradict their therapists, it is almost impossible for them to deny the existence of their own tape-recorded comments. Clients have noted that it is particularly compelling to hear themselves sounding motivated and extolling the virtues of change—far more meaningful than hearing someone else saying the same things. Further, it is a face-saving tactic to encourage a client to "take your own good advice" rather than to risk shaming a client by insisting that he or she listen to what others (including the therapist) are saying. In this manner, cooperation is enhanced, because the clients essentially are complying with the most functional aspects of themselves.

A comparably efficacious method of documentation involves having both the therapist and the client take written notes of the client's most important, healthy, insightful, and mature comments and behaviors that occur both in and out of session. A logbook serves the same function as the audiotapes—namely, to record the clients' most functional responses so that clients can become their own models for change.

For those clients whose resistance extends to their refusing to be audiotaped, and who neglect to take written notes or do homework assignments, therapists can use their own notes as a way to remind clients about productive things that they've said in previous sessions.

An example is described in Beck et al. (1993). Here, a substance-abusing client admitted early in treatment that he was most prone to relapse during those times when he thought things were going well and he would let his guard down. Later, this same client expressed a desire to leave treatment, saying "everything's cool
now, I'm fine, so I don't need to come see you anymore." The therapist responded by reminding him that this was the very situation to which the client alluded earlier when he said that he got in trouble every time he let his guard down. For good measure, the therapist added, "I wrote down what you said, because I thought it was particularly smart and honest of you to make such a statement. It sounds like you predicted that this would happen. Well done." In this scenario, the client was able to admit that his decision to leave therapy might be a bit premature, and he could make this admission with a minimal loss of perceived autonomy.

Gently Persist When Clients Subtly Avoid

Therapists sometimes unfortunately reinforce their clients' resistance when they accept their clients' comments that, "I don't have anything to talk about this week," or "Nothing's happening in my life right now," or "My mind is a complete blank right now" at face value without inquiring further. This tactical mistake often will lead to the session becoming filled with idle chit-chat, and/or the client's gaining the sense that therapy is a waste of time. On the other hand, if the therapist addresses the client's apparent lack of a therapeutic agenda and/or reluctance to talk as topics in their own right, much can be learned about the client's resistance (Beck et al., 1993; Safran & Segal, 1990; Young, 1990).

Using the method of Socratic questioning, as well as an empathic, respectful approach, the therapist may ask or state the following in order to stimulate fruitful discussion in a session:

"I'm surprised that you report that everything is 'fine' this week. Last week you presented a very different picture, and you were quite worried about a number of ongoing problems. How have things changed so radically?"

"If you feel there isn't much to discuss this week, we could review the overall course of therapy thus far, so we can summarize the most important principles that you've learned about yourself and your life as a result of our work together. What do you think?"

"You appear to be quite subdued—maybe even a little distant this week. I'm a little concerned about this. Do you realize that you are coming across this way? What could you be experiencing right now that might account for this?"

"What are the chances right now that our lack of a topic to discuss reflects an 'out of sight, out of mind' trap that we've fallen into? Is it possible that we've gotten away from talking about the most important things, and therefore we're 'forgetting' that these issues exist? I'm willing to explore this further if you are."

"If things are going smoothly in your life right now, do you think it would be a good idea to do some troubleshooting? Do you think it would be helpful if we looked ahead to some potential sources of stress in the future, and discussed how you might handle them?"

"Are you aware of things you are feeling or thinking right now that you would
rather not talk about right now? If that's so, I'll respect your need for safety and privacy. Perhaps we can get into this at a later time, with your consent."

"What could be some of the reasons that your mind has gone blank just now? Is there something you might be experiencing that just seems too difficult to deal with at this time? Is it possible that this could be an indication that there really is something very important to talk about right now, if only we could find a way to make it safe enough to think about?"

At times clients will respond to the above (and other) questions by repeatedly answering, "I don't know." Sometimes this is a legitimate answer, and sometimes it is an unassertive substitute for the statement, "Please respect my need to keep this to myself until I feel ready to discuss it," but more often than not it is an example of a client's putting insufficient energy into deliberating about the issue. At other times it reflects a more active process of stonewalling in order to avoid talking. The author strongly believes that therapists should never take "I don't know" for an answer without further exploration (or at least without requesting to come back to this issue at a later time), otherwise the therapist's failure to pursue the matter will negatively reinforce the client's avoidance. The following are examples of what therapists can say in order to get beyond the "I don't know" roadblock:

"You don't have to know for certain. We can discuss some of your educated guesses about the matter."

"Gee, your 'I don't know' sounded awfully emphatic. Have you ever heard the expression, He doth protest too much? Are you trying to tell me that you'd rather not discuss the issue?"

"I'm not convinced that you 'don't know,' because you've told me in great detail about times in the past when you've been through similar situations. Do you know the times I'm referring to? Can you draw on these valuable past experiences in order to help yourself with the current situation?"

"You may not know right this instant, but would you be willing to give the matter some thought? Let's spend a minute or two pondering this issue silently. I'll look at my watch and let you know when 2 minutes are up, or you can interrupt me if an idea comes to mind before then."

"We're talking about an issue of potentially long-reaching significance in your life, and yet you determined almost instantaneously that you didn't know what you could do about it. Would you agree that a topic of such great importance deserves more of our attention, time, and effort, even if the solutions are not readily apparent?"

"When you say 'I don't know' so quickly, it leads me to believe that you may be avoiding some core beliefs. Was my question discomforting or upsetting to you? That would be another indicator that core beliefs were involved."

As one can glean from the above questions, trying to break through the client's resistance sometimes involves a measure of confrontation. However, this does
not mean that the therapist needs to behave harshly toward the client. On the contrary, the most effective and humanistic uses of therapeutic confrontation are embedded in a spirit and style of collaboration (Newman, 1988). For example, the therapist can make liberal use of the term "we" in place of the more adversarial "you," as in, "We need to try to understand what's getting in the way of our following through with our original plan." Further, the therapist's tone of voice and non-verbal mannerisms are of critical importance. Although the content of what the therapist is saying may read as if it is highly argumentative or accusatory, the live presentation of such can be done in a calm, caring tone, along with a relaxed posture and sympathetic facial expression. Additionally, therapists can gently prepare their clients for confrontational (but caring) statements and questions by prefacing their remarks. For example:

"I hope that this won't sound harsh or unsympathetic, but I must tell you that . . ."

"At the risk of getting you angry with me, can I point something out to you that I've noticed?"

"I hope you won't take offense at what I'm about to say, because I have good intentions and good reasons; but as your therapist it's my professional obligation to do all that I can to help you, even if it means you might become angry with me. I'm willing to take the heat if you are."

(Using humor) "I'm going to be a troublemaker here and say something a little controversial."

The therapist can also check for the client's reactions after the confrontational comment is made, by asking for feedback in the following manner: "How do you feel about what I've just said? I'd welcome any rebuttal, and I'll respect what you have to say. After all, I'm just making an observation, but I don't have any illusions that I have the inside track on ultimate truth."

**Conclusion**

When clients do not improve in treatment, we cannot hide behind rationalizations such as, "The client didn't really want to change," or "The client would rather suffer than get well," or "The client wasn't 'ready' for treatment." As cognitive-behavioral scientists, we have an obligation to understand and to address the phenomenon of resistance as part of our work in assessing and treating clients. If clients seem insufficiently motivated for treatment, it is in large part our responsibility to try to develop and to utilize our knowledge and technology to increase clients' motivation for healthy change and growth.

Therapists can help modify their clients' resistant behaviors and attitudes first by trying to understand the phenomena on a case-by-case basis, instead of prematurely drawing broadsweeping general conclusions. In order to achieve this goal, therapists must formulate the case conceptualization on an ongoing basis, and must ask themselves questions such as "What is the function of the
client's resistant behaviors?" "What idiosyncratic beliefs may be feeding into the client's resistance?" "What might the clients fear will happen if they comply?" "What skills does the client lack?" "What environmental factors may be punishing the client's attempts to change?" and others.

Second, therapists must be self-aware so that they are sufficiently earnest and motivated in the face of clients whose progress is frustratingly slow. A benevolent, persistent, investigatory stance will enable therapists to make the best use of the techniques that can motivate resistant clients to begin to more fully engage in the process of treatment.

Third, depending on the specific needs of a given client (as ascertained, in part, by the answers to the assessment questions above), therapists can choose from a number of techniques to assist and encourage clients to change. These techniques include: using educational materials and pre-briefings; using the Socratic method; providing the clients with choices; taking a collaborative approach; reviewing the pros and cons of change and stasis; expressing accurate empathy based in part on a well-articulated case conceptualization; using images, metaphors, and other forms of the "client's language"; maximizing the client's free will and self-direction in treatment; and gently proceeding in spite of subtle avoidance in session.

Clinicians have witnessed and written about client resistance since the early days of psychoanalysis, and much work has been done through the years to try to conceptualize this phenomenon. However, concrete, systematic steps to practically deal with this issue have been lacking. Fortunately, a cognitive-behavioral approach can provide clinicians with specific steps in order to actively intervene, and therefore increase the effectiveness of therapy.

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