

RESISTANCE IN PSYCHOTHERAPY: A PERSON-CENTERED VIEW

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The purpose of this paper is to consider client resistance from a client-centered view of psychotherapy.

Client or patient resistance in psychotherapy has been the concern of therapists since the time of Freud. Freud identified several kinds of resistance. These included the patient's resistance to uncovering repressed material; resistance to the insights provided by the therapist's interpretations; resistance to the therapist as the provider of these insights--the negative transference; resistance to giving up symptoms, which provide certain gains; the resistance of the id to being deprived of its satisfactions; and the resistance of the superego to giving up the need for punishment to assuage its guilt.

While Freud at first saw resistance only as an obstacle to uncovering the unconscious, he later recognized it as something not simply to be overcome, but as an important element in psychotherapy along with patient psychodynamics and transference, and, like them, something to be interpreted.

The origin or source of these resistances were, and are still, seen by many therapists as residing in the client. The therapist bears little, if any, responsibility for client or patient resistance. Or, if any responsibility is accepted by the therapist, resistance is considered to be the client's nontherapeutic response to the good therapist's necessary and desirable methods of therapy. Resistance is thus inevitable, a universal and unavoidable element in psychotherapy. It is something to be overcome, and not something to be avoided.

The question arises as to whether psychotherapy, to be successful, must necessarily operate to lead to resistance in the client, or whether therapy can be practiced so as to eliminate, or minimize client resistance.

Resistance is a defense; defense is a response to threat. Therapist interventions can be, and often are, threatening to the client. Interpretations are often threatening to the client. Attempts to persuade the client through reasoning and argumentation, as in cognitive therapy and rational emotive therapy, as well as behavior therapy, can be threatening. Even less overt and obvious therapist behavior can be threatening to the client. Rogers (1961, pp. 44, 54) cites research by Dittes which found that "whenever the therapist's attitudes changed even slightly in the direction of a lesser degree of acceptance, the number of abrupt GSR deviations significantly increased" (p. 44). And "the psychogalvanic reflex...takes a sharp dip when the therapist responds with some word which is just a little stronger than the client's feelings" (p. 54). There is thus

physiological evidence that therapist judgmentalism, evaluation, and interpretation are threatening.

Now, it is well known that threat is inimical to learning and (voluntary) behavior change. Under threat people resist, cling to what they have and are, become more fixed in their ideas and feelings. Perception is narrowed, as in tunnel vision, so that there is failure to perceive all the elements in a person's experience and environment (Combs & Snygg, 1959, pp. 171-188, ff).

But can threat be eliminated from psychotherapy, or at least be minimized? Rogers (1942) dealt extensively with resistance and its source in therapist's statements. (Curiously, resistance does not appear in the index to "Client-Centered Therapy" (Rogers, 1951). The hypothesis, he wrote, "is that resistance to counseling and to the counselor is not an inevitable part of psychotherapy, nor a desirable part, but it grows primarily out of poor techniques of handling the client's expression of his problems and feelings...out of unwise attempts on the part of the counselor to short-cut the therapeutic process by bringing into discussion emotionalized attitudes which the client is not yet ready to face" (p. 151). "Insight," he wrote, "is an experience which is achieved, not an experience which can be imposed" (p. 196).

Anything that is really helpful, that leads to real and lasting learning, is not the result of imposition. The only effective learning in psychotherapy is self-discovered learning. "I have come to feel that the only learning which significantly influences behavior is self-discovered, self-appropriated learning" (Rogers, 1961, p. 276. *Italicized in original*).

Trying to speed up therapy or client progress by interpreting, or bestowing on clients the therapist's insights, does not facilitate therapy but retards it. Learning can occur only at the rate the client is able to progress on his/her own.

There is discussion in the literature about the need for the client to experience an "optimum" level of anxiety if he/she is to be motivated to make progress. For example, Strupp and Binder (1984, pp. 191-192) write about the therapist as "someone who evokes anxiety": "As always in therapy, the trick is to steer a course which on the one hand maintains sufficient tension, thereby keeping the patient motivated, and on the other, prevents the experience of too much anxiety." What is "optimum," "sufficient" or "too much" are not specified; Strupp and Binder do not tell us how to perform the trick.

Client-centered therapy, on the other hand, provides a simple, clear and valid method for maintaining optimum anxiety in the client. Rogers states it succinctly: "[I]f I can free him (the client) as completely as possible from external threat, then he can begin to experience and to deal with the internal feelings and conflicts which he finds within himself" (Rogers, 1961, p. 54).

There are sources of resistance in the client that are not caused by threatening aspects of the therapist's behavior. There are resistances to change, resistance to facing negative and painful aspects of the self and one's behaviors. Clients may have difficulty in trusting the therapist, and in self-disclosure. There is resistance against giving up old habits, or symptoms.

Such resistances cannot be avoided or eliminated. They are accepted and responded to as any other statements or behaviors of the client. Therapy is accompanied by a certain amount of client anxiety. Learning is to some extent accompanied by anxiety; in fact, low levels of anxiety may facilitate learning.

CONCLUSION

Client resistance has received little attention in the literature on client-centered therapy. This is probably for the same reason that transference has also apparently been neglected: "In client-centered therapy, this involved and persistent dependency relationship does not tend to develop" (Rogers, 1951, p. 201). Client-centered therapy minimizes resistance by minimizing threat to the client. The therapist conditions of client-centered therapy--empathic understanding, respect and warmth, and therapeutic genuineness--provide an atmosphere and relationship that minimizes threat. A relationship between the therapist and client characterized by these conditions provides the optimum conditions for meaningful voluntary learning and progress on the part of the client.

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