



Pragmatic Existential Counseling and Psychotherapy

INTIMACY, INTUITION, AND THE SEARCH FOR MEANING

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The Centrality of Resistance in Counseling and Therapy

What you resist, persists.

Carl Jung

Why is it that clients do not always respond as counselors and therapists desire? Regardless of the apparent sophistication, elegance, and research evidence of psychotherapeutic interventions, they do not always have the desired effect. How is it that when clinicians do everything “by the book,” the results fail to reach or only approximate the desired outcomes?

Every viable client who voluntarily comes in for therapy is conveying the honest message, “*Please help me. I really need your help.*” What is not said aloud, but must be understood, is the unspoken codicil, “*Of course you understand that I need to fight you every step of the way.*” There are many reasons for this, but the most essential is anxiety about change. Another way to interpret this apparent double message is that the client wishes to stay the same and have the therapist alter the universe to make the client’s life better.

Bugental and Bugental (1984) dramatically referred to the anticipation of change as “a fate worse than death.” They were not the original authors to recognize the natural fear of change. Dostoevski wrote, “Taking a new step, uttering a new word, is what people fear most” (1917, p. 1). Tillich (1952) described this core existential anxiety as related to the conflict that

arises between the tendency to preserve what is and the resourcefulness to strive for what could be. In short, resistance is the natural outcome of the tension between security and freedom: the status quo and the unknown.

When the client is ready and willing to change, therapy usually proceeds quickly and effectively. Many of the crucial theoretical divergences involve the methods to prepare the client to be in that open, highly motivated state. For many clients, solutions to most problems, personality issues, or self-defeating patterns are well-known. They just cannot make these life-changing or even behavior modifying shifts without assistance. A great deal of the time in therapy then is devoted to preparing the client to overcome personal resistance to change.

Historically, resistance has been perceived as a problem in therapy progress; something that has to be endured as nontherapeutic time in sessions. Many systems of therapy provide rationales and methods to avoid, analyze, ignore, take a step-wise approach, slog through, or patiently wait until the client relinquishes behaviors that go against therapeutic progress. It may be a necessary obstacle to “the real therapy,” but resistance per se is not the “good stuff.”

Resistance in This Existential Framework

In most perspectives, resistance is reflected by the client’s inability or refusal to comprehend and meet therapists’ healing insights or directives, the opposite of the current viewpoint. In relationally based existential work, resistance is considered the therapist’s best friend. Rather than a block to therapeutic goals, or a counter to therapeutic work, it is a most useful component of the therapeutic process. In this model, resistance is considered to be

- (1) within the client as a reflection of the fear of change; not as a block to the therapist,
- (2) an inevitable component of the therapy and is likely generated by therapeutic interventions as well as client fears of the unknown, and
- (3) something to be honored and respected as a pathway to understanding client strengths.

Thus, resistance is to be experienced by the therapist as a client’s expression of ego strength, which usually operates somewhat like a global positioning system (GPS) to the area most available for therapeutic work. Client resistance is an indicator of client strengths, which are available to be used jointly to address client weaknesses and needs. When clients block, avoid, or otherwise don’t respond to a seemingly well-timed and apparently appropriate therapeutic intervention, they are likely using their best skills to defend against the risks

of facing the unknown. At such moments, the therapist's job is to experience the resistance in the moment, identify the strengths being exhibited, and to recognize what anxiety is being defended. Once the therapist is aware of these, he or she needs to embrace the defense and use the client's strength by joining the resistance in both content and process.

The essence of this approach is that it fosters effective encounter with both neurotic and existential anxiety. This methodology takes the concept of resistance to a different level, and although the procedures described in this chapter are unique in some ways, they are consistent with Yalom's (1980) writing on clients facing the givens of human existence and May's (1969) discussion of the daemonic and negativity as essential components of intentionality—a core construct in his approach to existential psychotherapy.

Before exploring these atypical and counterintuitive pragmatic approaches to identifying and joining characteristic styles of resistance, it is useful to explore first historical and alternative viewpoints.

A Brief History of Resistance and Healing

The phenomenon of resistance is hardly unique to counseling and psychotherapy. For centuries, a host of methods have been used to facilitate change for those in need. Some methods involve distraction; others immersion. Often, the most powerful process involved was a belief that powers greater than the client were responsible (i.e., Frank, 1961; Frazier, 1890).

Rituals, Ordeals, and Witnessing

Healers, shamans, kahunas, elders, witch doctors, and medicine men created elaborate rituals to help clients change presumably without their own volition. Rituals, drugs, and trances were all common devices to allow ailing members of a culture to experience less anxiety in altering their behaviors, thoughts, or emotions.

These methods have changed in content but still work their "magic" through similar processes today. Rituals, ordeals, and other manner of suspension of disbelief are common antiresistant approaches employed to address modern-day dilemmas.

Up to 5 million pilgrims a year come to Lourdes in France for miraculous healings. In fact, some find the experience curative, but what is particularly fascinating is that the extent of the cures is directly correlated to distance travelled. Thus, a pilgrim from San Sabastian in Spain (2 hours by car) is likely to have fewer benefits from the waters than one from Paris (5 and

one half hours by high-speed rail) and significantly less than a pilgrim from Honolulu. Apparently, enduring the ordeal alters expectations.

Eminent hypnotherapist Milton Erickson frequently recommended that difficult clients trek up Camelback Mountain in Phoenix near his home office as part of their therapy. Many of his clients reported, “I found myself halfway up the mountain one morning before my session with Dr. Erickson, and I began wondering if my hike was due to a posthypnotic suggestion.” One significant aspect of this attribution is the belief that they were complying without full volition. Some more powerful force had taken over and prescribed beneficial actions.¹ Just as for their primitive forebears, the belief that their will had been temporarily overtaken by some philosophically consistent greater force was an essential component of healing. In the 1970s, comedian Flip Wilson captured the notion well with his iconic line “The devil made me do it.”

Don't Even Suggest It's That Easy!

An ordeal in psychotherapy may often be a positive inducement to change. A therapist who hears a client's concerns and responds that a hopefully positive outcome will require some hard work is far more likely to see him or her return for another session. Conversely, a therapist who conveys to a client that the solution is “simple” may never see the client again. A few years ago, I was interviewed on the phone by a potential client. After a briefly describing his needs he asked,

C: So now that you know, do you think you can help?

J: I can't promise anything at this point, but I understand how rough things have been, and I am willing to work with you on giving it a good try.

C: I called another therapist, and he told me he'd have everything up to snuff in 6 weeks with his special program. Do you have the experience to match that?

J: I do not have a 6-week program, and in fact, from what you have told me, I suspect that it would take far longer.

C: Yeah. That's what I thought, too. I'd like it all fixed in 6 weeks. I don't think he really understood the depth of the dilemma. Can you see me this week?

J: Yes, but as much as we both would like a 6 week program or even less, we cannot plan for anything that short.

C: My grandma used to say, “Do it right, don't do it quick.”

The interesting thing about this particular client was that he came into the second session having decided to face, rather than avoid, a very difficult decision. In effect, he had actually turned a crucial corner in his therapy in a few short weeks. He stayed in longer to “be sure I made the right decision. I count on you to hold my feet to the fire, if I try to stray.” For him, the notion of a quick solution was unacceptable, even though he was able to find one himself. What was more important was his desire for empathy for his plight and someone to walk with him on his arduous journey. This client needed someone to honor his resistance and ambiguity and reassure him that the problem was substantive enough to justify his internal turmoil.

An instantaneous assessment and technique-centered cure might have actually been slower, because it carried with it an embedded metamessage that the client was foolish not to see an obvious answer. This client would have entered treatment feeling less secure, more reliant on the powerful therapist, and less confident in his personal ability to face and deal with change. In short, the more certain the therapist, the more resistance is likely to be generated, and the less the client is capable of making desired change himself. Counterintuitively, an ordeal, or empathic support for the difficulty in problem solving, strengthened the client’s resolve.

Maximizing Placebo in Psychotherapy and Counseling

Jerome Frank (1961) identified four features common to healing across cultures:

1. Faith in the healer’s ability, confidence, empathy, acceptance, and caring: This experienced, knowing ambiance enhances client hopefulness.
2. A setting “aura” conducive to hope and expectation of help (i.e., sacred ground or a qualified office): The setting accentuates a disengagement from normal life exigencies and maximizes a sense that it is a place for healing.
3. A rationale or philosophy that explains health, illness, and normality: The myths involved are compatible with the seeker’s worldview (i.e., faulty attachment, learned habits, demonic possession). Within such a belief system, if prophesied cures fail, the belief is maintained, often strengthening hope for future cure.
4. Any form of therapy that reduces demoralization or promotes grounded hope allows for a reduction of alienation and closer connection with others. Treatment is often successful when it is emotionally arousing.

Applying this template to modern-day therapy suggests that whatever format of therapy is used, many extratechnique stimuli deeply affect the

therapeutic outcome. Therapists who maximize their “placebo impact” through environment, ambiance, attention, and real engagement with clients are likely to have greater success. These presumably extratreatment phenomena all work to prepare, or dissuade, the client to change.

When it comes to resistance, a therapist’s asocial responses (Beier & Young, 1984) and acceptance of the client’s desire to avoid change create a far less predictable environment, one in which influence may be more keenly felt. If a therapist honors, even savors, the client’s attempts to create distance, the closer they become. Thus, when a client’s internal antichange codicil does not have the usual impact of reinforcing the familiar and status quo, it opens a door to the therapist to join with the client from within, in a uniquely ego-syntonic manner.

Resistance Across Theories

All forms of clinical work allow in some ways for resistance, although the term itself connoting an unconscious process is anathema to some theoretical schema.

Psychodynamic Theories and the Adaptive Nature of Resistance

Freud (1900/1952; 1915) introduced the term *resistance* to describe an adaptation to anxiety. For Freud, resistance was an unconscious mechanism that kept both unacceptable instinctual impulses and unresolved intrapsychic conflicts from awareness. He further elucidated the construct with a significant insight. Because resistance was *adaptive* in reducing anxiety, it would be quite robust. Modern existential, psychodynamic, and psychoanalytic thought may differ on the particular core fears or whether instinctual impulses are being defended, but the notion that resistance is adaptive still provides understanding of, and direction for, therapy.

For decades, psychoanalysts and other dynamically oriented therapists have considered working with resistance to be a cornerstone of treatment. Within these approaches, developing insight into the resistance and working it through the transference/countertransference relationship at several levels of unconscious depth is a core component of treatment.

Some psychodynamic authors, particularly those promoting short-term dynamic therapies, took quite aggressive approaches to eliminating instead of analyzing resistance. Davanloo (1999), for example, used the term *head-on-collision* to attack the underlying anger in resistance. Sifneos (1973) focused more on the anxiety but also recommended meeting client

resistance with emotional flooding. Both approaches are at odds with existential principles of joining.

Cognitive and Behavior Therapies and Resistance

Most therapists in the cognitive and behavior camps have historically viewed therapy as a learning experience. Basic assumptions include the belief that clients are rational, and given the proper circumstances and instruction, will opt for logical decision making. Habits can be progressively improved and changed with practice, and the core responsibility for change rests on externally applied contingencies, mostly supplied by the therapist-as-teacher. Considerations of unconscious motivation and resistance to desired change do not fit well with objective logic or rational decision making. Thus, *resistance* as classically defined makes little sense and is generally considered irrelevant to treatment within these modalities.

Client missteps or failures are considered primarily as noncompliance with programmatic therapeutic behavior shifts. Noncompliance such as avoidance or improper completion of between-session homework is assumed to be a failure of proper therapist instructions.

Even those who use terms like *resistance*, consider it only as a block to successful therapy. In general, this view correlates with the notion of electrical resistance: the force that blocks or slows the conductance of current. Usually such resistance is corrected by increasing the width of the wire or other conductor or by finding an alternative way of reducing friction to allow ease of passage. There is a logical and external adjustment that fixes the problem.

So it is for cognitive and behavior therapies: the locus of responsibility for client change is the therapist. Any noncompliance is considered to be the patient resisting the therapist or the therapist's instructions, not as resistance to change within the client. Thus, effective resolution involves the therapist being more creative or effective.

In 1980, DeShazer, a cofounder of Solution-Focused Family Therapy, took this notion to its logical extreme when he famously declared "resistance is dead." His hypothesis was that a teamwork approach between a therapist and family and a positive expectation of change on the part of the therapist would obviate the clients' pull toward homeostasis *against* the therapist. From his perspective (an interesting combination of cognitive behavioral therapy [CBT] and family systems approaches²), resistance is reduced to the refusal by the clients to take in the therapists' perspectives. The "dead resistance" was that of a fight between therapist and clients. DeShazer did not consider resistance as a reflection of an internal process involving facing fears of the unknown.

Cognitive Behavior Therapy

Arguably the most common form of therapy today, CBT has an interesting relationship with resistance. Westra, Aviram, Connors, Kertes, and Ahmed (2012) indicated that for practitioners of CBT, resistance in therapy is important to “prevent, identify and minimize.” They wrote, “resistance is an interpersonal phenomenon that is heavily influenced by the therapist, and sustained client resistance can be considered *a clinical skill error*” (p. 163) [italics added].

For CBT in general, the onus for “fixing” the noncompliance belongs with the therapist, not with the client or interaction between the therapist and client. A therapist-centric locus of change requires that adjustments involve a redefinition and reconstruction of contingencies and reassessment of therapists’ approaches.

Beutler, Harwood, Michelson, Song, and Holman (2011), writing more generally than from the purely CBT framework, reported poorer outcomes of therapy when ambivalence-like resistance occurs. They concur with often reported conclusions that noncompliance (and more classically defined resistance) diminishes with nondirective styles of therapy. However, although they recommended enhancements to the therapist-client interactions as resistance reductive, the responsibility for change remained with the therapist.

Exploring attunement to the interactional patterns, Beck, Rush, Shaw, and Emery (1979) concluded that an increase in positive therapist reactions to clients, both behaviorally and emotionally, would enhance outcome. More recently, Judith Beck (2011) has also recommended greater emphasis on the therapist-client relationship. However, within both of these frameworks, noncompliance or resistance, defined as occurrences of “counter-control behavior” or “negative cognitions” may be rectified not in the relationship but in the therapist.

In general, CBT focuses more on the technique, often including manualized treatments based on symptoms, rather than therapist-client interaction or influence. If the client is nonconforming, it is advisable to alter the instructions until a set can be found to which the client will not resist. Resistance is not deemed adaptive. Unconscious ambivalence about change and avoidance of intrapsychic conflicts are not considered.

Variations Within CBT: Motivational Interviewing

CBT is an increasingly large umbrella. Many other techniques have been adopted into the CBT family. Motivational Interviewing (MI), an approach that began primarily as a method to treat addictions, does address resistance

more directly. As with any approach to addiction treatment, noncompliance is a major and ongoing concern. Miller and Rollnick (2012) define MI as “a collaborative conversation style” designed to strengthen a client’s motivation and commitment to change, particularly with regard to self-destructive behaviors. MI is employed when normative and anticipated client ambiguity is highest, especially during the earliest (precontemplation and contemplation) stages of therapeutic change³ (Prochaska & DiClemente, 2005).

Moyers and Rollnick (2002) focused on this dimension of generalized client resistance to change. They argued that client ambivalence about change and the manner in which the therapist addresses the ambivalence will enhance or reduce the likelihood of success.

MI employs techniques that involve “rolling with” the resistance to tip the balance of ambiguity away from the status quo and toward change. A predominant notion of MI is that of close teamwork instead of a conflict between a therapist pushing for change and a client pushing back against the desired change.

In this manner, MI breaks with the majority of CBT approaches by focusing more intensely on the client’s choices, rather than on the therapist as locus of change. This strength-based perspective is more directly respectful of the clients’ abilities to find a path to success. Miller and Rollnick (2012) also promote compassion for the client and recommend the therapist having “your heart in the right place so that the trust you engender will be deserved” (p. 20).

Some of the techniques of MI approximate aspects of the existential approach that follow. However, the existential approach pushes the envelope further with regard to multiple levels of resistance to change and in the strength-base of interventions.

Other Variations

One form of CBT that addresses resistance directly is Acceptance and Commitment Therapy. ACT involves accepting reality as a given and encouraging a client’s commitment to living with both reality and his or her key personal values.

Another variation, Dialectical Behavioral Therapy (DBT), explores with the client aspects of skill-building failures through “functional analysis.” This involves a careful investigation and assessment of what occurred, specifically what went off track, and when it deviated from the planned program. The therapist and client together explore the events, thoughts, and feelings that occurred to interfere with successful completion of homework. Any discoveries of secondary gain or benefit of noncompliance require a shift in approach.

Although the secondary gain construct is used, it is usually referred to with regard to “automatic thoughts” without considering these phenomena

unconscious. This provides a partial bridge to Husserl's (1931) notions of automatic response that correlates with neurotic anxiety.

Resistance Between and Resistance Within

To approach resistance in psychotherapy, it is essential to distinguish resistance that arises from internal ambivalence to change from conscious and deliberate noncompliance.

Opposition, obstinacy, obstructionism, refusal, and rejection may be present in any therapy environment, especially when counseling is mandated by parents, the court, a spouse, or so on. Those working with adolescents, particularly those "in the system," are very familiar with the very conscious stance of refusal, even at the client's personal expense.

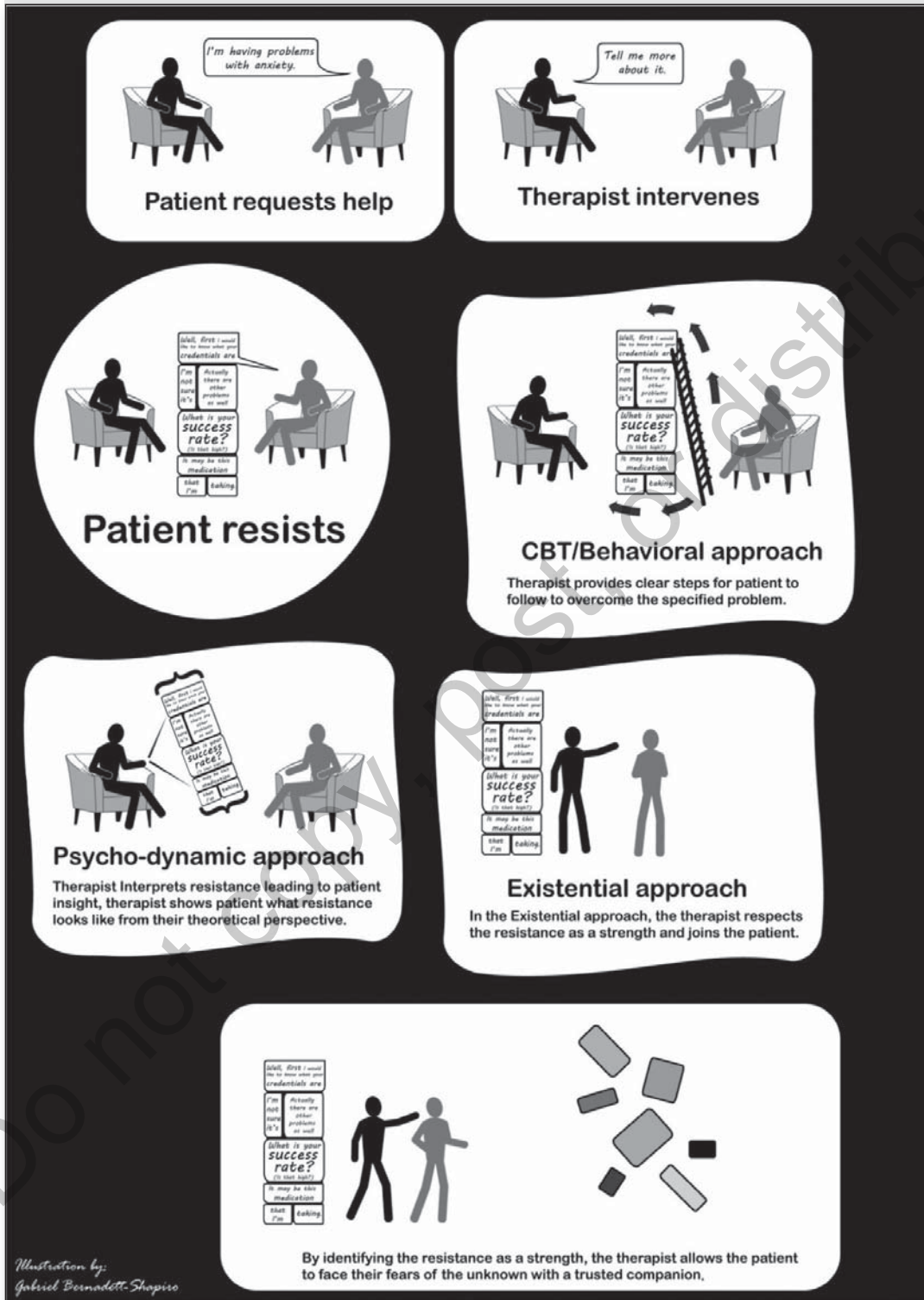
As indicated previously, noncompliance is the sole component of resistance in several approaches, particularly CBT. By contrast, for current purposes, resistance is best understood as an unconscious phenomenon (automatic responding). The client is mentally defending against the fear of change and the anxiety of facing the unknown. The client's defenses support the status quo portion of the freedom-security equation. If the client is perceived as resisting change, instead of resisting the therapist per se, the therapist may take a far more supportive, less confrontational stance. In fact, it is uniquely heuristic to experience resistance as the client's unconscious ambivalence. When therapists recognize that clients defend with strengths rather than weaknesses, they can view true resistance as the client's unconscious mind requesting aid while simultaneously pointing to the best bridge across the anxiety-filled moat. By signaling both the anxiety and the best method for the client to address it, resistance is essentially the therapist's best friend.

It is desirable for the therapist to use enough "press" (Bugental, 1987), "leverage" (Yalom, 1990), interpretation (i.e., Portuges and Hollander, 2011), or relational intimacy (Shapiro, 2010; 2014a) to activate client resistance. Once it is present, it is to be honored and respected as the unconscious indicator of the client's ego strengths. With that handle, therapy may work optimally.

Existential therapists share Freud's belief that anxiety-fueled resistance is adaptive but focus somewhat differently on client anxiety at facing the givens of human existence. Rather than analyzing the resistance to develop insight, existential therapists use the anxiety-based energy toward the development of intimacy and the creation of meaning.

In Figure 5.1, the primary approaches to dealing with resistance are depicted (regardless whether the construct is named, where the locus of change resides, or how it is perceived). Psychodynamic approaches involve helping the client trigger the wall of resistance and then analyzing its

Figure 5.1 Theories of Resistance



components to allow for client insight. Although they do not deliberately attempt to elicit resistance, when confronted with the resistance wall, CBT and other behavioral approaches find ways to build in progressive steps through, around, and over the wall.

The existential approach is designed to get the client and therapist on the same side of the wall of resistance and to use the wall for support in moving into unknown territory. There is no specific desire to remove that support.

A Pragmatic Model of Dealing With Resistance in (Existential) Counseling and Therapy

If resistance is a manifestation of an internal struggle between the guilt of the status quo and fears of the unknown, it is fueled primarily by the pull of the security and corresponding avoidance of substantial anxiety related to change and to freedom. The method to be detailed in the tables below necessitates a close therapeutic relationship with the client. It requires the therapist's awareness of the here-and-now moment and his or her capacity to join with the client in the client's process. In some ways, working with resistance demonstrates the therapist's deep respect and empathy for the client's being-in-the-world process and is emblematic of the strength of the existential approach.

When the therapist joins a client more fully in his or her retreat from freedom and acceptance of the status quo by joining his or her unique manner of expressing anxiety, it paradoxically opens the door for clients to feel safer exploring more fully their existential anxiety and confronting the neurotic anxiety.

Approaching resistance in this manner is a cornerstone of existential treatment as it fosters attempts to create *I-thou* moments with the client. When the method is used in an authentic manner within an intimate therapeutic relationship, it has the potential to enhance the subject-to-subject phenomenological experience and allow the therapist and client to approach the here-and-now ambivalence as a team.

The current approach to resistance in therapy begins with certain assumptions that emerge from the deeply phenomenological work of Binswanger (1963), Boss (1963), Frankl (1959a), Husserl (2014), and Spinelli (1997).

It is essential to acknowledge here that Frankl (1959a) employed a related construct, *paradoxical intention*, as a therapeutic technique. He did it so intuitively that others who later adopted the technique misunderstood its usefulness and scope (i.e., Haley, 1963, 1976). *Paradoxical intention* applied to resistance works consistently well. However, when applied to behavior in general, the impact is more random.

A client's resistance unearths the protective strength fed by his pull to emotional security. By identifying and understanding the manner in which a client is effective in self-protection, a therapist has a window into clients' unique coping skills. This allows the therapist to connect and be with the client, in both content and real-time process in a uniquely ego-syntonic manner.

Within this existential framework, awareness of the givens of human life (isolation, meaninglessness, freedom, and especially mortality) produces useful, beneficial (existential) anxiety. Counteracting awareness of this existential anxiety are unconscious defensive reactions that prevent facing the fears of the unknown. These automatic protective responses (Husserl, 1931), often referred to as symptoms or neurotic anxiety, are uniquely useful in reaching a client.

Systematizing Intuition

A therapist who is oriented toward assessing the clients' strengths through resistance may identify and effectively use the client's momentary style of expressing neurotic anxiety. The methods per se are not novel or unique. They have been employed in clinical settings for decades by clinicians who have been deemed particularly intuitive. Specific studies of such therapeutic masters as Viktor Frankl, Milton Erickson, Carl Rogers, and Carl Whitaker have highlighted this underlying mechanism. For these master clinicians, identifying and joining resistance just seemed natural. What is unique here is the manner of categorizing the style of client resistance and consciously joining with that resistance in a systematic manner. Although this approach may have wide-ranging application within other theoretical frameworks, both the approach and the rationale behind it, are essentially existential.

This method changes the equation. Rather than experience resistance as nontherapeutic time in therapy, or as something to be avoided or endured, it embraces resistance as the path to the client's process, indeed the way to his or her heart.

When clients resist a particular intervention, they are defending against anxiety by using their strengths. When the therapist comprehends the strengths of client, he or she understands the optimal way to reach the client. The therapist's job is to

- identify those strengths,
- recognize what the client is defending within himself or herself,
- discern the extent of neurotic anxiety generating the defense,
- embrace the defense (honoring the client's process and strength), and
- join the resistance.

Resistance Styles

In the chart below, a six-fold classification of resistance styles is offered. They do not represent any form of pathology. They are adaptations to anxiety that pull toward the status quo. Each represents considerable strength.

It is essential to understand that the importance of any of these styles is *in the moment*. They do not necessarily reflect personality or trait patterns. In this form of therapy, it is only important to be aware of the nature and style of resistance in the here-and-now. At another moment in time, the nature of the resistance may be quite different. Thus, this method is most useful in the process of therapeutic interaction.

Resistance to influence and avoidance of change may be demonstrated cognitively and affectively. In cognitive forms of resistance, the client uses thoughts, words, language, intellectual logic, and confusion to ward off the potential for change. Affective forms involve the use of emotion, either by flooding the environment with excess feeling or by withdrawing feeling to the point of disconnection.

The second dimension locates the defensiveness in the relationship. There are three loci: external, internal, and away. External defenses involve moving against the intrusion at a distance. To use a castle analogy, these defenses are across the moat and in the perimeter, away from home. Such defenses are fairly aggressive. Internal defenses allow the therapist inside the walls and even deeper into the depths of mazes, confusions, or intrapsychic quicksand. Here the person supporting the requested change is mired and cannot find much ground to maneuver. Finally, away defenses are those in which the client indicates, often in nonverbal ways, that he or she may have left his or her body in the therapy room, but at least at the moment, his or her consciousness is elsewhere.

If these seem somewhat akin to sympathetic nervous system activation for fight, freeze, or flight, it is no accident. The fear of change is threatening to the ego, and the defenses are similar to life-threatening reactivity. They also mirror Horney's (1945) depictions of movements (toward, away, against) that underlie attempts to deal with neurotic needs.

Table 5.1 Characteristic Resistance (Defense) Styles

	Cognitive	Affective
Internal (maze)	Cognitive Internal	Affective Internal
External (perimeter)	Cognitive External	Affective External
Away (dissociative)	Cognitive Away	Affective Away

As the tables in this section indicate, each style has positive attributes and potential deficiencies.

The Cognitive External Style

When clients are defending their personal status quo with a cognitive-external style, they may seem suspicious, questioning, argumentative, and distant. At times, they may seem more like a prosecuting attorney than a client seeking therapist help. The point of contact is away from the client, and the push is against the therapist intellectually.

Table 5.2 Cognitive External Style

Positive Attributes	Deficiencies
<ul style="list-style-type: none"> • Well defined cognitive, logic, and analytic systems • Good troubleshooting skills • Quick assessment of novel situations • Early warning of danger • Ability to see through obvious to underlying motivation 	<ul style="list-style-type: none"> • Generally poor access to feelings, especially vulnerable feelings • Suspiciousness • Lack of spontaneity • Often rigid adherence to internal beliefs • Some lack of attention to apparent facts • Antagonism and blaming

- T: When we ended last week, you mentioned that you wanted to get into the ongoing battle with your family. Does that make sense today?
- C: I guess as a therapist, you have to hone in on mother, right? (Wary, distant, pushing against the therapist)
- T: I was just wondering if that was worth continuing or if there is something more present for you.
- C: You can't weasel out of it that easily. Do you want to ask about my mother or not? Let's not play games here.

At this point, the therapist is probably back on his heels, wondering what is occurring and what in the relationship between them is so threatening as to need so much more distance. If he were to probe further, the attack would likely increase with a corresponding reduction in possibility of change.

What if instead of pushing against or withdrawing, the therapist *joined* the resistance? He already knows that the client is being defensive in the moment. He also knows that the form is external and cognitive. The path to joining might well be in those realms.

- T: (smiling) So. You are thinking that because I'm a therapist, I see talking about your mother as a dog might see a bone—can't resist.
- C: Well, don't all of you think everything is about mothers?
- T: (Very cognitively) The question on the table before us is whether we should pursue my agenda or yours. How will we negotiate that?
- C: Well, you are the expert. You will probably choose.
- T: On the other hand, you are paying for the therapy time. How would you call the shots?
- C: I want to talk about my childhood, because it is coming up a lot with my son. I just don't want you to think that's all there is.
- T: Just to be sure we are on the same page, what else is there that I might miss in my delight at delving into your childhood?
- C: I saw you in the store last weekend, and I didn't come up to say hello and wondered if you had seen me also and ignored me.
- T: Had I seen you and ignored you that would have been hurtful. Let's talk about that first.

The client was pushing the therapist away, an interesting parallel process to the thought that the therapist may have deliberately ignored him. By understanding that the client had to work in a suspicious manner, and by joining him there, they were able to use the energy to get to an important matter quite readily.

Joining Cognitive External Resistance

- (1) The therapist begins with the expressed thoughts, skepticism, doubts, and suspicions and only slowly moves toward any underlying feelings.
- (2) Working with the content expressed, the therapist openly explores his personal motivations for the interventions or questions.
- (3) The therapist begins by initially respecting and supporting the perimeter boundary, entering only with client's clear welcome and, even then, with proper hesitation.
- (4) All interventions meet the client in the here-and-now. In this case, being cognitive and only moving toward the affective on invitation.

The Affective External Style

When clients are defending their personal status quo with an affective-external style, they may seem emotionally overreactive. They keep distance from the therapist by flooding the room with excess feeling and apparent volatility. At times, they may seem to be having a tantrum or meltdown. The point of contact is away from the client, and the push is against the therapist emotionally. Once the client has flooded the entrance bridge and filled the moat with emotional monsters, he or she can focus on the therapist's inability and avoid his or her internal fear of the unknown.

Although it may seem a bit contrived, I am using the same vignette here to make comparisons between the styles more comparable. In the real world of therapy, there might be far less concordance of content with different resistance styles.

Table 5.3 Affective External Style

Positive Attributes	Deficiencies
<ul style="list-style-type: none"> • Easy access to feelings • Able to express wide range of feelings • Intuitive • Impressionistic • Able to shift attention focus readily • Spontaneous • Able to be theatrical; role play 	<ul style="list-style-type: none"> • Poorly defined cognitive/analytical skills • Global responsiveness • Naïve • Poor differentiation of detail • Unable to keep to long-term planning or delay gratification • Poor discrimination of subjective and objective reality

T: When we ended last week, you mentioned that you wanted to get into the ongoing battle with your family. Does that make sense today?

C: (In a loud and emotional voice) My family! My family! What is with that? I am trying to get my life in order, and you bring up my family!

T: (In a level, empathic tone) My question about how we left off last week seems very upsetting.

C: (Increasing intensity) Upsetting? It's outrageous! Are you trying to devastate me by adding so much to my plate?

As in the cognitive external example, the therapist is probably taken aback by the intensity of the moment, wondering what is occurring and what in the relationship between them is so threatening to require so much

more distance. If he were to probe further, the emotional volatility might increase until the therapist is sufficiently pushed away.

Again, the therapist may pull back, defend his innocence, or preferably, *join* the resistance. He already knows that the client is being defensive in the moment to avoid internal anxiety. He also knows that the form is external and affective. The client is showing the path to connection.

T: (Raising his voice slightly) Here you come in with so much going on, and I just add to it by bringing up the past as well.

C: (Still aroused, but tone is slightly modulated.) It's like I can't win. You always have to bring up more to deal with. Well, maybe enough is enough!

T: (With emotion in tone) You are trying to do the best you can, and here I am making it seem like you'll never catch up. That seems unfair. What would *you* like to address today?

C: At this point, I don't even remember.

T: Well, perhaps we can trust your feelings. What are they saying now?

C: I am having a lot of feelings about how I am parenting my son. It brings up the awful feelings I grew up with. No matter what I do, nothing ever seems right.

T: So when I suggested where we focus, it brought up all those feelings again. You don't feel that you can be right with your son. You didn't feel you could be right as a child, and now you feel that you can't even be right in here. That sounds dreadful. Do you have any sense of what might have precipitated this vulnerability?

C: I saw you in the store last weekend, and I didn't come up to say hello and wondered if you had seen me also and ignored me.

T: Had I seen you and ignored you that would have been hurtful. Let's talk about that first.

The client was pushing the therapist away, parallel to the feelings that the therapist may have rejected her. By understanding that the client had to work affectively and by joining her there, they were able to use that energy to get to the relational issues in the room. By going into her emotional language, he was conveying at a nonverbal level that he was willing to respect her processing at the moment. By joining her in her affective mode, he was also indicating that to continue to be more emotional in the moment would paradoxically increase closeness.

Joining Affective External Resistance

- (1) The therapist begins by reflecting the client's content concerns at approximately matched levels of affect in as empathic a manner as possible.
- (2) Therapist adopts the client's pacing, attitude, and orientation.
- (3) The therapist matches the high level of affect, slowly guiding the client to a more modulated balanced expression of cognition and affect. By accepting the boundary and joining the client there, he demonstrates respect for the client's process.
- (4) All interventions meet the client in the here-and-now. In this case, being affective on invitation and only later on invitation, moving toward the cognitive.
- (5) Developing teamwork at emotional levels may seem at times chaotic and unstructured until a working trust can be established.

The Cognitive Internal Style

Unlike defenses that push against the therapist on the perimeter, internal styles of resistance involve inviting the therapist into the psyche's inner workings and then creating an unmapped maze. This form of protection provides immobility by having too many options to consider. There is no apparent attack, no monsters, but there is a surfeit of frustration available.

When clients are defending their personal status quo with a cognitive-internal style, they may seem unable to make decisions, overly concerned with details and perfectionism. Although they seem to be consistently compliant with the therapist, no change is evident. At times it may seem like they are stuck in quicksand. The point of contact is inside the client, and interventions are often met with excellent reasons for inaction.

Table 5.4 Cognitive Internal Style

Positive Attributes	Deficiencies
<ul style="list-style-type: none"> • Well defined cognitive, analytic skills • Attention to detail • Ability to consider all options before acting • Ability to acknowledge self at least vis-à-vis inward focus • Nonimpulsive • Assessment of internal reality 	<ul style="list-style-type: none"> • Generally poor access to feelings, especially vulnerable feelings • Suspiciousness • Lack of spontaneity • Often rigid adherence to internal beliefs • Some lack of attention to apparent facts • Antagonism and blaming

- T: When we ended last week, you mentioned that you wanted to get into the ongoing battle with your family. Does that make sense today?
- C: Yes. I've been thinking about that all week. It's quite complex. (Apparently compliant, with a negation coming)
- T: Can you share some of your thoughts this past week?
- C: I don't think I ever told you, but I know I told my doctor. I was a bed wetter as a child. I think it was until age 10. No, maybe nine, no wait, my mom said it was 10, but I remember not going on sleepover camp when I was 11.
- T: What about the battle with your family brought it up?
- C: Well, there are several things. They want to come visit, but it upsets my wife because they always tease and embarrass me.
- T: About the bedwetting?
- C: No. Wait it was 10. I remember now.

At this point, the therapist is trying to track, wondering what is occurring, what the relevance of bedwetting is, and why the client is creating so many blocks to connection. If he were to probe further about the bedwetting or the impending visit, it may not be relevant. The more they go down one train of thought, the greater the distance.

How might he *join* this resistance? He is aware of the client's defensive distancing. He also knows that the form is internal and cognitive. The path to joining might well be in those realms.

- T: There is so much to consider here. As I hear you discuss the bedwetting, the visit, the relationship between your wife and your family of origin, I am struck by all these intertwined topics.
- C: Yeah, and that's only scratching the surface.
- T: (Very cognitively) Perhaps it would serve us to consider all the possible variables here and decide if we are best suited to discuss them one at a time or all together. How might we even decide how to progress?
- C: Well, you are the expert. You could choose.
- T: On the other hand, you are paying for the therapy time. How would you call the shots?
- C: I don't know. Everything seems so entangled.

- T: I would agree with you, and choosing one method (all together or individually) would leave the other method untouched. We might miss something important.
- C: Okay. But where do we begin?
- T: I have an idea. It may not be the best starting place at the moment, but we could always switch if we need to. . . . Can we talk for just a moment about how what we are doing together makes you feel like you can't do it right?
- C: I saw you in (the store) last weekend, and I didn't come up to say hello and wondered if you had seen me also and ignored me.
- T: (Staying with the defensive style) Gee. That's a lot to consider. I might have seen you and ignored you. I might not have seen you. If I had seen you, I might not have wanted to violate confidentiality. If I hadn't seen you, was it just that I was preoccupied or was there some unconscious reason why I hadn't seen you? What have I missed?
- C: Yes, that's right. I thought all those things.
- T: That sounds like some burden to wonder about. What did it mean to you that you went unseen by me in the store?
- C: (Hesitantly and with a questioning tone) . . . that you wouldn't want to be seen with me?
- T: And what would *that* mean to you?

The client was avoiding the therapist, in parallel to his worry that he may have deliberately ignored him. By understanding that the client had to assess all the possible ramifications, and by listing all the ones he could think of, the therapist was joining him in his process to address the here-and-now more readily. Somewhere in the relationship is access to the client's fear of freedom.

Joining Cognitive Internal Resistance

- (1) The therapist begins by reinforcing the reality that a decision is difficult by joining with the multiplicity of options and slowly moves toward affect, meaning, and decision making.
- (2) Often the therapist will initiate examination of unconsidered options that might on the surface seem to complicate matters.
- (3) The therapist enters the internal maze and only slowly allows for movement, once momentary security has been achieved.

- (4) Initial interventions will be cognitive and often confusing. Movement to attribution of meaning and/or feelings is on invitation or agreement and is often generated by mounting frustration in the lack of movement in therapy.

The Affective Internal Style

When clients are defending their personal status quo with an affective-internal style, they may seem particularly underreactive. They keep distance from the therapist by withdrawing emotion from the room with what may seem like a temporary depression. At times, they may seem to be nonresponsive or very slow to respond. The point of contact is within the client, and the maze here is affective (on the surface, a lack thereof). It may seem that the client has invited the therapist into a room and then pumped out all the oxygen. Without air, there is little opportunity to explore any other anxiety.

Table 5.5 Affective Internal Style

Positive Attributes	Deficiencies
<ul style="list-style-type: none"> • Ready access to certain feeling states • Particular sensitivity to negative emotions • Understanding of multiple levels of emotional depth • Willing to focus inwardly • Nonimpulsive; unlikely to get into trouble by spontaneous action 	<ul style="list-style-type: none"> • Lack of differentiation of external cues • Lack of access to positive feeling states • Poor attention to detail • Unable to act decisively • Nonspontaneous

- T: When we ended last week, you mentioned that you wanted to get into the ongoing battle with your family. Does that make sense today?
- C: (Long pauses between utterances with quizzical expression) My . . . family . . . I guess (sigh) . . . that'd be okay.
- T: (In a level, empathic tone) You don't seem enthused about that. Is there a more important place for us to begin?
- C: (Very slowly, sighing and showing a pained expression) No . . . it doesn't matter, I guess . . . it's okay.

As in the cognitive internal example, the therapist is probably taken aback by the low level of intensity of the moment, wondering what is

occurring and what in the relationship between them is promoting so much distancing. If she were to probe further, the client might slow down even more and be increasingly elusive.

Again, the therapist may pull back, defend her interest in the client, probe for signs of depression, and (assuming that there are no reasons to expect a depression here) preferably *join* the resistance. She already knows that the client is defensively holding on to the status quo in the moment. She also knows that the form is internal and affective. The path to joining is likely in those realms.

- T: (Slowing pace, exhaling noticeably, and dropping tone) It . . . seems . . . almost like . . . discussing this . . . is almost overwhelming.
- C: (Still with low affect with long pauses between utterances) It's like I can't win. . . . There is so much. . . . My family . . . my wife . . . nothing helps!
- T: (With slow empathic slowly paced tone) You are trying to do the best you can, and here I seem to be adding to the number of issues . . . (long space) like there's almost no way to get going, let alone get on top of things. What would be possible to address today, perhaps not your family?
- C: (Sighing and exhaling) At this point, I don't even remember.
- T: (Sighing and exhaling, slow pace—multiple pauses) Well . . . perhaps we . . . can trust your feelings. . . . What are they saying now?
- C: I'm worried about my son. . . . He's stressed out and seems like I was as a kid.
- T: So when we talk about your family and how you are almost immobilized, it's a double whammy with your empathy for him. It must feel exhausting. Do you know what's happening in here to make that happen again now?
- C: This may not mean anything, but I saw you in (the store) last weekend, and I didn't come up to say hello and wondered if you had seen me also and ignored me.
- T: Had I seen you and ignored you that would have been another situation that leaves you not knowing what to do. Let's talk about that first.

The client was avoiding the therapeutic process by being stuck. No matter what the therapist offered, it seemed like too much. The parallel process here

was the similarity of back home dilemma and the therapeutic relationship. The potential of a nonmeeting at the store precipitated a host of dilemmas.

Understanding that the client had to work in a feeling-centered, questioning manner, the therapist joined in the multiple dilemmas and with very low affect. By staying there with the client, she was not able to be defeated. Once that became evident, they could work as a team to get to the relational issues in the room. By going into the client's (low) emotional language, the therapist was conveying at a nonverbal level that she was willing to respect the client's processing at the moment. In an apparently paradoxical manner, the therapist's enervating approach actually energized the client and brought them closer.

Joining Affective Internal Resistance

- (1) The therapist begins by affective acknowledgement of complexity and depth of emotion.
- (2) The therapist adopts the client's pacing, attitude, and orientation.
- (3) The therapist matches low key, slow affect, and emotional ambivalence and confusion.
- (4) All interventions meet the client at the present moment. In this case, being affective and respectful of the depth and complexity of the client's dilemma and only later moving toward the cognitive—on invitation.
- (5) Developing teamwork at low emotional levels may seem at times like the therapy is moribund and unstructured, until a working trust can be established.

The Cognitive Away Style

Clients defending their personal status quo with a cognitive-away style will seem more distant from the therapist. There is an elusive quality that makes it hard to pin down any basis for connection. They seem to offer only parts of themselves at any given moment. Because there is safety in reduced intimacy and contact in the therapeutic session, the point of contact is away from the client almost as if the therapist and client are observing some objective event as spectators.

- T: When we ended last week, you mentioned that you wanted to get into the ongoing battle with your family. Does that make sense today?
- C: I guess that would be as good as anything (distant, apparently disinterested).

Table 5.6 Cognitive Away Style

Positive Attributes	Deficiencies
<ul style="list-style-type: none"> • High tolerance for ambiguous situations • Ability to perceive a wide variety of perspectives • Ability to function in nonsocial context • Not powerfully affected by rejection • Ability to “act,” role play effectively, and be experimental in novel situations • Not adversely affected by past 	<ul style="list-style-type: none"> • Poor coordination of here-and-now • Lack of coordination of affect and presence • Emotional coldness • Inability to make lasting, sustained, or intimate contact with others • “As if” quality to relationships • Poor access to feelings

T: I was just wondering if that was worth continuing or if there is something more present for you?

C: (Thoughtfully) No, not really. If you think it’s worthwhile. . . .

T: (Going for any affect) What did it feel like when I just brought it up?

C: I was kind of expecting it. I was very upset when you said it last week, but I worked it out myself during the week, so it’s okay now.

At this point, the therapist is faced with a dilemma. The topic is important only in the past. It is no longer an issue in the present, yet there is no other experience that the client is interested in addressing. So the therapist can deal with the client with nothing to work on or deal with something to work on that presumably has been resolved. The choice is between client absence and a lack of anything meaningful to discuss.

How might the therapist *join* this style of resistance? He already knows that the client is being avoidant. He also knows that is away and cognitive. The path to joining might well involve requesting that the client be less present by role playing, one of the most common techniques in psychotherapy.

T: I’m interested that you were able to handle the discomfort at what I said so effectively. Would you tell me what you did to be so successful?

C: I’m not sure. Maybe I just put it out of my mind and attended to other more pressing matters.

T: (Very cognitively) The ability to get over hurts is something that you have been interested in addressing, and here you did it yourself. It

would probably be of value for us both to see the method in action and be able to replicate such success in the future.

- C: (A little warily) Well, you are the expert. How do we do that?
- T: Let's try just a brief experiment. Let's imagine we were back in time to last week. What do you recall that I said?
- C: You said that what I was dealing with at work seemed similar to what is going on with my boyfriend.
- T: Imagine that we are time travelers, and it is a week ago in session. I'll begin. "You know Jean, I wonder if the situation at work is similar to Ryan's anger directed at you." Is that close enough? (Client nods) Now just react the way you did last week, only out loud.
- C: I don't like when you connect the dots that way. It's like you're blaming me for things that others do to me.
- T: Good job! You are feeling irritated with me for blaming you when you feel like the victim here.
- C: Yeah. I'm pretty upset by your taking their side.
- T: Like I don't care for you. I'm only looking for connections.
- C: I saw you in (the store) last weekend, and I didn't come up to say hello and wondered if you had seen me also and ignored me.
- T: Had I seen you and ignored you, it would have been another example that I don't really care. What's that mean for you in here?

The client was resisting the therapist by offering either presence (with nothing to talk about) or affect (which was no longer present). This is analogous to the thought that the therapist ignored her at the store last week. By understanding that she was defending against intimacy by acting as if she were not in the therapeutic relationship, he was able to go with her strength by recommending role playing: Be here, but don't be fully here. This allowed her the space sufficient to engage in the anxiety provoking question of his caring for her.

Joining Cognitive Away Resistance

- (1) The therapist begins with the acceptance of the client's difficulty in being fully present. Early verbal interventions are supportive of clarifying and maintaining the separation.

- (2) Understanding that the client is more comfortable and able to deal with intimacy in an “as if” or pretend fashion, he recommends role playing, role reversals, or other psychodrama-inspired techniques—allowing the client to act in the present in an imaginary (once removed) form.
- (3) The therapist begins a slow movement from there-and-then to here-and-now as trust builds through his willingness to offer a format in which the client feels less threatened.
- (4) If the client is comfortable expressing affect indirectly, the therapist approaches him or her with an ostensibly indirect method to comply with therapy and also to use his or her strengths.

The Affective Away Style

When clients are protecting their personal status quo with an affective-away style, they may seem very tense and jittery during the session. They keep distance from the therapist by appearing nonverbally volatile, as if they are ready to either bolt from the room and from therapy or on the verge of emotional impulsivity. At times, they may seem unable to interpose a cognition between a feeling and (potentially dramatic) action. A therapist confronted with this defense often feels very tentative, “like all of a sudden I have stepped into a room and the floor is all eggshells.” The point of contact is on the tenuous ambience in the room and a stance of mutual spectators who are sizing up together some impending disaster.

Table 5.7 Affective Away Style

Positive Attributes	Deficiencies
<ul style="list-style-type: none"> • Spontaneous • Feelings connected closely with behavior • Here-and-now orientation • Practical intelligence • Able to size up situations and act quickly (i.e., emergencies) 	<ul style="list-style-type: none"> • Poor judgment • Lack of cognitive aspects in decision making • Discontinuous experience of the world • Reckless and arbitrary • Nonreflective; often illogical • Poor long-term concentration

- T: When we ended last week, you mentioned that you wanted to get into the ongoing battle with your family. Does that make sense today?
- C: (Leg jigging and furtive glances toward windows and walls near therapist—no eye contact) I don’t know why we have to get into that. The past is past.

- T: (In a level, empathic tone) Would something in the present or future be more useful to you?
- C: (Continued signs of agitation) No. I guess I just don't feel like talking today.

This leaves the therapist in a conundrum in which she is being told that the client does not want to talk, but the client's nonverbal behaviors indicate that there is something going on.

Although the agitation is not at the level in which she might be concerned for her own safety, she is worried about what is occurring for the client. Any probing might drive him further away. She might pull back and let the client come forward at his own pace, but also wants to engage sufficiently to indicate that she is present and interested. Recognizing the affective and away quality of the resistance, she can join it by focusing on both.

- T: (Moving up her pace to begin to mirror the client's agitation and avoiding eye contact) It seems like you'd prefer to be anywhere else but here right now.
- C: Not anywhere!
- T: (Still avoiding eye-to-eye contact looking up as if thoughtful) So as tense or uncomfortable as this seems, there could be worse situations to be in. That is strangely reassuring to me—probably less for you.
- C: (Rapidly) Well, like the dentist.
- T: Yeah, that can be worse. How might we spend our time here? I promise no drilling.
- C: (Laughing and leg jiggling slows) Okay, no drilling. I could use some nitrous though.
- T: So if we did have some nitrous, what would that feel like?
- C: Floating. No care in the world.
- T: (Fleeting eye contact) It's funny that you should mention "floating" on nitrous. The last time I had dental work done with nitrous, I had this amazing combination of dreams and ideas floating in and out of my mind. The thoughts were both kind of out there and somehow poignant. I was almost regretful when I came down, and of course my sore jaw added to my regret. If there were no risks of drilling here and you were on nitrous, what might we discuss?
- C: This may not mean anything, but I saw you in (the store) last weekend, and I didn't come up to say hello and wondered if you had seen me also and ignored me.

T: What was it like just to see me in another place, let alone if we spoke? It's another situation that leaves you not knowing what to say or do.

C: (Agitation dropping somewhat) I didn't want to talk there either.

T: Had I seen you and ignored you that would have been like I was dismissing you. Could we briefly talk about that? What's it like to be in here talking about the hard things and not being sure if I care at all?

Joining Affective Away Resistance

- (1) Work begins with therapist's early internal recognition of patients' pressure for imminent action.
- (2) It is of value to express empathy for tense, difficult "walking on eggshells" feel in the room.
- (3) It is best to avoid direct confrontation. Often the use of indirect and metaphorical approaches or storytelling is most beneficial.

Joining Must Be Authentic

Jordan (2010) wrote that growth-fostering relationships "lessen the suffering caused by chronic disconnection and isolation" (p. 23). A disingenuous or manipulative relationship will do the exact opposite. It is insufficient to recognize the client's resistance style. The therapist has to find comparable feelings and reactions in himself or herself to be able to genuinely to relate to the client's resistance. A therapist who knows that the client is fearful of and is resisting certain change cannot join with the client unless he or she can tap into his or her own fears of facing the unknown (Stanislavski, 1989).⁴ Being aware of those personal concerns will make connections with the client far more poignant and team-like. This does not mean that the therapist has had to suffer the same content as the client, but that he or she understands and is empathic with the client's fears about losing the status quo for some unknown future. Accessing the therapist's personal self and engaging in the real relationship can be the core factors in change (i.e., Gelso, 2011; Markin, Kivlighan, Gelso, Hummel, & Siegel 2014; Norcross, 2011). By contrast, attempts to fake it or pass in the client's culture or experiences will likely seem phony and fail.

It Seems Counterintuitive. Why Does This Work?

Consider the radical notion that resistance does not demand that the therapist fight through the wall, analyze the wall for windows of insight or

building steps into and around it. Instead, it is the client's way of informing the therapist how to join him or her and using the wall as a back support to set out on a new journey as a team.

When the resistance is designed to block the therapist from encouraging the client to change, attempts to avoid or attack the resistance will inevitably refuel it. Even if there is an appearance of compliance in the session, the pull of the status quo will reassert itself in force between sessions and subsequently reemerge as strong as ever. However, when a therapist joins the client's process of resisting, the therapist is demonstrating caring, respect, and empathy. In a manner that seems paradoxical, the therapist is offering to hold the resistance and the anxiety for the client, to allow him or her the opportunity to explore change more safely.

From this perspective, the proper timing for any intervention involves an acute sensitivity to the client's psychological strengths. It may seem incongruous or ironic, but the best indicator and pathway to those strengths is the nature and viability of a client's defensiveness.

A client's resistance is emblematic of the protective strength fed by the pull to emotional security. It offers the therapist a window into clients' unique ego strengths. Taking this further than the many therapies that encourage empathy with the *content* of a client's interactions, the current approach of joining resistance is an expression of empathy for the client's *process*.

Clara and the Wedding Invitation

Clara, a 38-year-old divorced woman with two children and a successful professional career, was in therapy to "move on after my husband left me." Her progress had been slow but steady, permeated with considerable ambivalence, including a few "late night meltdowns, when I called him to come over for sex and tried to get him back."

Approximately a month before this session, she had discovered through the children that he was planning on marrying a woman he had met about 6 months after their divorce. For several sessions, she was extremely tearful and confused about whether to attend the wedding, "for the kids." She was also extremely upset that the new woman in her ex-husband's life was "attractive, successful, and very nice to the children. I just can't hate her, but I can't abide her being a mother to the children either."

This interaction occurred about 20 minutes into the session.

C: (Through weeping and tears) I just can't decide what to do. What should I do? Will it scar the children if I don't go? What if I go and can't handle it? My God, what will I do? What should I do?

This was a repeat of prior sessions in which the therapist was supportive, understood the dilemma, and expressed empathy of an impossible situation. On frequent occasions, they just sat together. The problem was coming to head, because the wedding was this upcoming weekend. The therapist determined that the resistance at this moment was clearly affective and had primarily external qualities. She began trying to find the level of despair in herself and began expressing it to Clara.

- T: (Very emotionally) This is an almost impossible situation! If you don't go, that will lead to worry about the kids and I suspect about wondering about what is going on all afternoon. If you do, it could be very painful for you to see them marry or try to be happy at the reception.
- C: (More distraught) Oh. The wedding! I haven't even thought about the ceremony. She's some kind of orthodox religion, and I know that will be a real problem for me. My boy said it was a 2-hour deal. I'd have to see the kids be in that! But if I don't, well, I'm going to have a miserable Sunday next week either way.
- T: (With emotion in her voice) It's a terrible dilemma. No good way out. It'd be easier if they got married while you were away somewhere.
- C: I thought about going to Maui with my friend, but then I worried that I might ruin a perfectly good vacation. (in a very loud voice) **I will not let that woman ruin Maui for me!**

After four repetitions of this interaction, the therapist decided to join the resistance by upping the ante on holding to the status quo.

- T: (Raising her voice, talking rapidly) You know, as I think of it, you just can't make a decision about what to do. Either way it's so risky. It's too much pressure, and having such an event in your face would be horrendous. Even if you only went to the reception, it'd be a nightmare!

Following a lengthy silence after the therapist's "outburst," Clara sighed and said,

- C: I have thought about this a lot. I don't want to disappoint you, but for me, not knowing is worse than knowing.
- T: (Not fully matching the new calm) So, how will you begin to protect yourself? What if it becomes too much for you? This just seems very dangerous.

- C: I think I will go, but just to the reception, and I will bring my friend for support. That way, if I have to leave, we will just go.
- T: (Skeptically) That might work, but if you do leave, how will the kids get home?
- C: Good catch. I'll ask my sister-in-law to be available if they need a ride home.
- T: Will she be able to do that?
- C: She actually offered to take them and bring them home. (After a silence) If I need to call you on Sunday or come in on Monday, will you be available?
- T: If you call on Sunday, I'll call you back. We could schedule a Monday meeting right now.

When the therapist was willing to join with Clara's high level of affect, Clara was able to find her inner calm and describe a potentially viable plan of action. Clara's resistance to coming to terms with her ambivalence became more workable only when the therapist took on the affective component. That allowed Clara to face her very real dilemma.

This could be interpreted from a systems perspective (Clara needed a certain amount of emotion in the room, and when the therapist took over some of it, she could feel safe being more rational), from a psychodynamic perspective (Clara felt more fully understood and was able to lean on the therapist to come to a decision), or from a humanistic perspective (Clara felt accepted for who she was without pressure to change, so was able to make a decision). However, the therapist described it as "empathy for the impossible emotional situation. I felt my own distraught feelings when I have had to make a choice between two bad alternatives and let those flow into the moment."

She also acknowledged that she chose to take the "can't decide" position. "I just knew that I had to bring my full feelings into the situation and join her in the full dilemma. I was confident that'd she'd come to sort it out today and just needed my holding up the status quo (no decision) so she could face what she had to."

The Case of Thomas

Thomas is a 33-year-old second-generation Chinese-American man. He initially was referred by his physician for psychosomatic problems.

About 6 months prior to the therapy, he instigated a painful break-up of a relationship. He has a history of daily marijuana use when he was in his twenties, but claims to be only an occasional weekend user now. He has a responsible position at a high-tech company. This interaction occurred in the fifth session.

C: I am having trouble sleeping and am getting more and more irritable.

T: When did this start?

C: This week.

T: Any idea about what prompted it?

C: (In an irritated voice) Well, aren't you full of questions today? I don't know what started it. If I did, I'd get it to stop.

T: (Hearing the irritation and the client's impulse to not discuss the issue he brought in) So this is frustrating. Not only are you irritated by the lack of sleep, but my questions are also annoying, because there is no clear answer.

C: (Calming down) No, it's not the questions and answers. I just need a good night's sleep.

T: Is there something we could do here to help promote that?

C: Do you have any sleeping pills?

T: That'd be a good question for your primary care physician. Maybe there is something on your mind that is getting in the way of a good night's sleep. Lack of sleep can be even painful, well beyond irritable. . . . I know you've already probably rounded up the usual suspects, but perhaps there is something that your mind is tossing around.

C: There is one thing, but I can't imagine that it would cause sleeplessness.

T: (*That sounded seductive, best to let him bring it up. Let's see what happens when I go away from it.*) Well, if you think it's not a factor, we could look elsewhere for alternatives.

C: It's these thoughts about my ex-girlfriend that keep coming up. I know that she was bad for me, and that the break-up was my idea, and it was miserable, so why can't I recall how bad that was when I try to sleep?

T: Is it about her per se or loneliness or just a riddle that needs to be solved?

C: There you go with all the questions again.

- T: *(So I've been seduced twice into following his lead and he is defending—cognitively and externally—by questioning and dismissing what I am doing.)* (joining) My questions seem off today. Mostly what I am aware of is the frustration in the room, and it's hard to get a handle on it. At the risk of another ridiculous question, do you have any ideas about how we might get our heads around this?
- C: (Laughing). No. It's been really lonely this week.
- T: Lonely and no relief in sleep is a painful combination. *(Instead of pushing him to the next level, taking the process back to reinforce empathy with his position)*
- C: I heard that she is going out with this guy.
- T: That's got to be troubling. (Normalizing)
- C: No. I broke up with her, so it shouldn't bother me (resisting cognitive external again)
- T: *(Stay empathic and go to the cognitive—let him come to the affect.)* Even though you don't want to be with her, it doesn't quite fully diminish the news.
- C: Why is that? It doesn't make any sense.
- T: I can think of a few strange ways—you know how I have those kinds of strange thoughts—why you may be upset. I'm interested in your analysis.
- C: Maybe I think that if she is in a relationship before me, maybe it was all my fault.
- T: *(That seems loaded, let me go with it.)* What do you think when you examine that rationale?
- C: I am pretty competitive and egocentric. . . . (after a silence) I don't think that's it. I am very competitive, but I think it's something else.
- T: *(Stay cognitive here.)* You seem to have given this a lot of thought, but competitiveness may not be the answer.
- C: Is it normal for me to remember the good parts and forget the bad parts?
- T: You tend to focus on the good, and your optimism at work has helped you get ahead. There is something else here. I wonder if we could get our heads around this.
- C: (After a long silence) I was in the emergency room last Tuesday. I thought I was having a heart attack. They said my heart was fine. It was a panic attack.

T: That sounds scary. What's it like to tell me that?

C: I haven't told anyone else.

T: This is really important then. I am honored that you trust me with that information.

C: I met this girl a few weeks ago. She's really different. She's quiet and reserved—here's the joke—she's Irish. So I am the talkative Chinese guy with the quiet White girl.

T: How was that for you?

C: (Hesitant, then pause) . . . you didn't ask about the panic attack.

T: What would you like me to know?

As usual, the resistance here was inconsistent. When it did come, approaching him from within the resistant frame was the only useful access he offered. As the session progressed, he disclosed more of his anxiety. Three sessions later, he was able to directly confront some anxiety-based erectile difficulties with the woman. It is important to note that joining the resistance was the most effective method for his progressive self-disclosure. He would push the therapist away whenever he was close to opening up additional vulnerability. When the therapist joined in the method, the more vulnerable side emerged. His sleeplessness dissipated over a 2-week period as they addressed a host of anxiety-laden issues.

Think France in the Early 1940s: Join the Resistance!

The method described here is consistent with other existential approaches and matches the intuitive interventions of many master therapists. The uniqueness of this approach lies in the categorization and systematic application. In all cases, the goal is to identify resistance, recognize it as anxiety about change, and join it sensitively and carefully.

The approach to joining resistance reflects the core of the pragmatic relational-existential method described through the book:

- (1) Empathize deeply, and join with the client in his or her personal manner of being-in-the-world.
- (2) Identify the client's strengths from the way he or she protects himself or herself in the moment.
- (3) Help the client use those strengths to address his or her areas of concern.

- (4) Work together as a team to address anxiety.
- (5) Help the client separate neurotic and existential anxiety and honor the latter.
- (6) Stay as much as possible in the here-and-now relationship.

In many ways, resistance stands as a core of the existential-relational approach.

Notes

1. A testament to the power of the phenomenon was that the assumption that Erickson had secretly inserted the suggestion contradicts a core tenet of Ericksonian hypnotherapy: that the method is predicated on eliciting something from the client, rather than interjecting the therapist's will.

2. Family systems approaches have been typically divided into structural and strategic camps. Although all systems approaches share many commonalities, the structural approach grew out of psychodynamic, and the strategic approach was more informed by behavioral theories.

3. See Chapter 7 of this book for detailed information on stages of therapy and therapeutic change.

4. Named for Constantin Stanislavski, Method acting, which became popular in the 1930s, involves actors eliciting their personal emotional memory to convey true emotion. There is a combination of empathic observation and expression of emotion that is experienced as genuine. This oft-described ability to cry on cue is actually the actor responding to some sad events in her or his own life. Thus, the tears are genuine, albeit mediated.