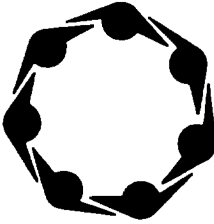

Therapeutic Utilization of Client Resistance

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The problem presented by the family seems simple: a father and his son argue about the child's homework. There is clearly a power struggle between the parent and the child. So, in the therapist's best "Dreikursian" voice, the therapist suggests the father withdraw from the conflict and allow his son to take responsibility (and the logical or natural consequences) for his homework. The problem is evident; the analysis is accurate; the solution is apparent. The father, however, responds, "But if I don't keep after him, he'll get behind in his schoolwork, and I can't allow that." He is resolute. The counselor eventually labels the father "resistant" and implies that he is not ready to make the changes necessary to foster independence and responsibility in his child.

Resistance is a common therapeutic experience and client response. Indeed, moving clients through their resistance to the point at which they can make the changes necessary to reduce or erase their symptoms is one of the tasks of therapy. The skill and ability of the therapist to achieve this end is the test of his or her competence.

This article describes an approach to clients' resistance—an approach which allows resistant symptoms or behavior to be converted to therapeutic use. The approach is based on an understanding of the dynamics of clients' resistance, and the utilization of those dynamics in creative and client-enhancing ways. Three specific techniques for using resistance will be defined and described in application.

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The Adlerian Concept of Resistance

Resistance can be understood phenomenologically as the situation which occurs when clients and a therapist no longer cooperate on the reduction or remission of the presenting problems. Despite the therapist's best guidance, advice, or influence, resistant clients simply will not change the patterns which give rise to the symptomatic behavior. Typically, these clients present excuses, limitations on change, or other evidences of a hesitating or "yes, but" approach to the problematic behavior.

What might motivate clients to maintain and protect symptomatic or problematic behavior? Why might clients wish to continue actions, thoughts, or feelings that are distressful and disruptive? If one is to understand the dynamics and motivation of clients' resistance, at least three elements need to be considered: the inevitability of clients' resistance to change, the purposive nature of clients' symptoms, and the misalignment of therapeutic goals.

Resistance as Inevitable. When clients come to therapy, an assumption can be made: given the clients' circumstances and resources, they are making the best choices and adjustments possible according to their private logic and apperceptions—even if those choices appear to be symptomatic or dysfunctional. Indeed, the clients are coping with the challenges of their situations in accordance with their perceived best interests.

In contrast, a therapist, by advocating changes, is suggesting that clients stop responding to their circumstances in the ways they have assumed offer the most control, safety, and opportunity for success. Thus, from the clients' perspective, it appears that the therapist is asking them to perform against their own best interests. As a result, resistance to the therapeutic suggestion is not only logical, but imperative. When a therapist asks clients to surrender or modify their symptoms without first considering the private logic and apperceptions which justify and require the behavior, it is natural for resistance to follow and therapeutic directives to fail.

The Purpose of Symptoms. A fundamental principle of Adlerian psychology is that behavior—including resistance—is purposive and goal directed (Adler, 1956; Dreikurs, 1950, 1967). Contrary to the protestation of clients, even the symptoms and complaints which motivate treatment are used by clients to accomplish some personally significant ends.

Commonly, symptoms are used by clients to achieve two primary goals. First, symptoms may be used to avoid personal responsibility. Eric Berne described this phenomenon astutely in the game, "Wooden Leg" (Berne, 1964). This game's thesis is clients seek to excuse themselves

from the demands of life, others, and even themselves by asking the rhetorical question, "What do you expect from someone with a wooden leg?" (p. 159). The implied answer is, "Nothing."

Clients frequently ask similar rhetorical questions demonstrating resistance to change: What do you expect from someone who is co-dependent? What do you expect from people who are phobic? What do you expect from persons who are depressed? In all these cases the clients' implicit demand is to be exempted from responsibility for their behavior and the need to change.

Adler (1956) explicitly connected the evasion of personal responsibility for behavior to therapeutic resistance: "Every therapeutic cure, and still more, any awkward attempt to show the patient the truth, tears him from the cradle of his freedom from responsibility and must therefore reckon with the most vehement resistance" (p. 271). And: "The so-called resistance is only lack of courage to return to the useful side of life. This causes the patient to put up a defense against treatment . . ." (p. 338).

A second goal clients may achieve with their symptoms is the gain of respect or sympathy due to their heroic struggles to overcome their problematic behavior. Dreikurs (1950) stated: "The neurotic's tendency to hide his hostile impulses toward his fellow human beings helps him to carry on a sham fight with his symptoms" (p. 68). Of course, these struggles are a pretense; but by demonstrating good intentions and valiant efforts, clients may earn the tolerance of others. Observers will notice how hard the clients are "trying" and give them credit for sincere efforts to change where none are genuinely made.

If a therapist naively accepts clients' assertions that they wish to be rid of their symptoms without understanding the purposive nature of the complaints, or the benefit accrued by the struggle to overcome them, intervention will most certainly be met with resistance.

The Misalignment of Goals. The final element contributing to clients' resistance is disagreement regarding the goals of therapy. Dreikurs (1967) considered this a primary source of clients' resistance, remarking: "What appears as 'resistance' constitutes a discrepancy between the goals of the therapist and those of the patient" (p. 7).

In the therapeutic process itself there are many occasions for goal divergence. The Adlerian therapist works to move clients toward responsibility; clients strive for exemption and evasion. The therapist advocates equality and social interest; clients pursue superiority and personal interest. This conflict between the goals of the therapist and those of the clients, often implicit and unacknowledged, forms the very fabric of therapy and contributes significantly to resistance.

In addition, more calculated goal divergence may occur when clients

come to therapy with a hidden agenda. For example, a couple may claim that they need marriage counseling, when in fact they are after a justification or an endorsement for a divorce. If the therapist is unaware of the clients' true goal, all directives aimed at resolving the marital problems will be to no avail. Resistance will be the natural conclusion of this misalignment of goals.

Summary of the Adlerian Concept of Resistance. From an Adlerian perspective, clients' resistance to therapeutic directives is the outcome of several factors working together. First, clients, though they are symptomatic, believe they are acting in a manner most consistent with their perceptions of the circumstances and demands of the situation. Second, clients' symptoms and complaints function to protect their self-esteem within their schema by evading responsibility for behavior, or by demonstrating honorable, but unsuccessful, attempts to change their actions. Finally, the clients and the therapist may be unable to agree on the direction therapy should take in solving clients' problems because of hidden, unaddressed goals and needs.

The Utilization of Client Resistance

Of the many contributions made to the field of psychotherapy by Milton H. Erickson, perhaps none is more powerful or important (especially with chronic or resistant clients) than the principle of "utilization" (Erickson, 1959, 1964, 1965; Erickson & Rossi, 1975; Erickson, Rossi, & Rossi, 1976). According to Dolan (1985):

> Utilization is the process of incorporating aspects of the client's current behavior and perceptions, current and past relationships, life experiences, innate and learned skills, and abilities into the therapeutic change process. . . . The concept of utilization implies that every part of the client's behavior, personality, relationships, personal beliefs and situation is potentially valuable and useful in enabling the client to achieve more rewarding choices (pp. 6–7).

Utilization simply means taking all that clients present—strengths, abilities, symptoms, and resistance—and using that as the basis for creating therapeutic changes.

Characteristics of the Utilization Approach. There are four therapeutic qualities which characterize and enable the utilization of client resistance: cooperation, trust, acceptance, and the shift from "either/or" to "both/and" logic. The first three qualities are clearly Adlerian in philo-

sophy; the fourth one, while not specifically Adlerian in style, is quite compatible with the Adlerian approach to therapy.

Cooperation. The language of therapy can disclose an attitude of competition when resistance is considered something to be "overcome" or an obstacle to be "surmounted." Clients and the therapist then compete in a battle of wills, techniques, and influence. Unfortunately, this competition is heavily weighted in favor of resistant clients; all they have to do to thwart the therapist is to do nothing.

In contrast, the utilization approach views resistance as a legitimate response to therapy and as something to be "seduced," not overcome. Whatever the clients' resistant behavior, the therapist finds a way to accept it and use it as a lever to bring about therapeutic changes. Thus, the therapist and the clients are no longer competitors but rather collaborators in a cooperative venture leading to change.

Trust. A second characteristic of utilization is trust in clients' wisdom to know which goals and values are most important according to the demands of their private logic and life-styles. The therapist surrenders the position of super-parent who knows what is best for clients and becomes instead an equal in the therapeutic relationship, facilitating movement toward goals and needs that clients have determined are important. The therapist trusts that when clients are resistant, their goals (rather than the therapist's) must be given first consideration.

Acceptance. This dimension of utilization functions at two levels. First, for utilization to succeed the therapist must accept clients as people entitled to dignity, respect, and unconditional value. This acceptance creates a therapeutic atmosphere which permits trust or rapport to be established, and directly influences clients' ability to risk changes.

At a second level, the utilization process accepts resistance as meaningful information from clients regarding personal values, perspectives, and goals. Like all other client communication, it is legitimate and important. The rejection of resistance is the denial of a significant part of clients' realities or perspectives.

Both/And Logic. One of the factors that allows utilization to work so effectively is the shift in therapeutic logic from either/or to both/and predicates. Clients present problems with reasoning that call for mutally exclusive conclusions, that is, either/or logic: "Since I am agoraphobic, I cannot get a job." Or, "My wife and I have been fighting so much we're afraid we're headed for a divorce." In this style of reasoning clients must

choose between the subject and the predicate: "I can be agoraphobic *or* I can get a job." Or, "*Either* we stop fighting *or* we must get a divorce."

Through utilization, the therapist attempts to shift clients' logic to a new taxonomy. Both/and logic combines clients' resistant or symptomatic behavior with the desired therapeutic change, allowing clients to escape the trap of mutual exclusion and see new alternatives. In the dilemmas cited earlier, both/and logic might suggest: "Even though you are agoraphobic, you can get a job." Or, "You and your wife have a relationship strong enough to endure disagreement, and your marriage can grow even stronger."

The process of using clients' resistance to create therapeutic change depends on an attitude characterized by cooperation with clients, trust in their goals and wisdom, acceptance of all their behavior as meaningful, and the shift of logic to a both/and paradigm which allows for change.

Techniques of Utilization. Many of the techniques in the utilization of client resistance come from the category of paradoxical psychotherapy (Adler, 1956; Fisch, Weakland, & Segal, 1982; Haley, 1973; Mozdzierz, Macchitelli, & Lisiecki, 1976; Watzlawick, Beavin, & Jackson, 1967; Watzlawick, Weakland, & Fisch, 1974; Weeks & L'Abate, 1982). This is due to the fact that from the perspective of the clients, the therapist's suggestions (which accept, join, abet, and use symptoms or resistance) seem paradoxical, unusual, or even contrary to common sense.

Some particular paradoxical interventions and approaches have proven to be effective in a wide variety of circumstances. Among the more useful interventions are reframing, expansion of context, and intensification.

Reframing. When a symptom or behavior is psychologically or physically placed in a new context, its cognitive, affective, and behavioral components can change (Mozdzierz et al., 1976; Yapko, 1990). This phenomenon is valuable for utilizing client's resistance therapeutically. By recontextualizing or reframing the resistant symptom of the client, the therapist can alter the significance of the problem, decrease the resistance to change, and increase options for new behaviors.

Consider a clinical example of utilization by reframing: A couple came to therapy because of the wife's jealousy. While the husband was at work, the wife would imagine that he was with other women. She would stay at home and get herself into such an angry, jealous mood that when her husband returned from his job, she would begin to interrogate him, accuse him, and become hostile. He would respond by withdrawing, which convinced the wife that she was correct in her accusations. The cycle was vicious and threatened to destroy the marriage.

The therapist was faced with several choices: First, the therapist could

confront the wife on the irrationality of her jealousy and suggest she practice relaxation exercises as counterthoughts; second, the therapist could explain the purpose of her jealousy (control of the husband) and address the dynamics of her hidden goals; or third, the therapist could find a way to use the symptom as the means of therapeutic change.

Since the wife presented herself as the "victim" of her jealousy, out of control, and not responsible for her feelings, it appeared that she would resist any efforts made by the therapist to intervene with direct, congruent, and logical suggestions. She would simply plead "powerlessness" regarding her jealousy. As a result, the therapist chose to utilize reframing to place the wife's behavior in a new context.

The therapist told the wife that she was making a serious mistake. What she was defining as jealousy was, in fact, love; indeed, she loved her husband so much that the thought of losing him to another woman was quite painful. The therapist then suggested that when the wife began to feel jealous, she was to think about how much she loved her husband; further, she was to think about how a woman who loved her husband that much would demonstrate her devotion when her husband came home from work.

Soon after the therapy session, the couple reported that their problem was resolved. In fact, the wife's change in attitude and behavior had become an incentive for the husband to return home from work more quickly than ever.

The utilization process allowed the therapist to accept the behavior of the client (jealousy) and to use it as the means of creating therapeutic change. The technique of reframing allowed the original negative emotional and cognitive associations of the problem to be set aside, and new positive and cooperative ones to be developed.

Expansion of Context. Clients' symptoms typically function in a narrow field; for example, a client is compulsive about X or phobic about Y. When that field is broadened (e.g., the client is urged to obsess or fear A, B, and C as well), the resistant symptom may take on a new meaning and significance which facilitates therapeutic change (Yapko, 1990).

Again, consider a clinical example: A family (father, mother, 10-year-old son, and six-year-old daughter) came to therapy because of the son's lying. The son's behavior had no particular pattern or focus; he would lie about anything for any reason. The parents had tried punishment, bribery, and withdrawal of privileges as responses to the lying—all to no avail.

The therapist believed that confronting the son and requiring change of him would generate resistance to the intervention and noncompliance so another plan was devised. The therapist chose to accept and cooperate with the son's behavior (telling lies) but to broaden that field of misbehavior by involving the rest of the family in creating lies as well.

The assignment was directed at the parents and the sister, bypassing the son's anticipated resistance: Whenever the son told a lie, the parents or sister were to make no immediate comment but were to respond by telling him a lie later in the day. For example, the son might lie about doing a chore; the parents could respond by later telling the son that supper was ready when it was not. In this way the therapist expanded the field of the problem beyond the son's misbehavior, eliminating its power: all statements made in the context of the family became meaningless when none could be trusted to be accurate or truthful. By the end of the first week of intervention the son had stopped his lying.

Intensification. As was noted previously, often clients' symptoms are maintained and supported by the struggle to overcome them. Clients engage in a psychological "tug of war" with the problematic behavior, and typically lose. As a result, clients feel helpless but blameless concerning their symptoms.

A therapeutic alternative to this psychic conflict might be not only to prescribe the resistant symptom (Watzlawick et al., 1967), but to suggest that it be intensified. This accomplishes two therapeutic goals: First, it utilizes clients' behavior as the framework for change; second, it subverts clients' resistance. If clients are going to refuse a therapeutic directive, they must do so by reducing or stopping the problematic behaviors.

When considering intensification as an intervention be cautious: The therapeutic intensification of misbehavior or symptoms calls for special attention so that the technique does not violate clients' values, ethics, or morals. Further, care must be taken so that intensification will bring no damage or harm to clients or others, and yet be effective in creating change. As in all cases of intervention, therapeutic intensification must be suggested respectfully and responsibly.

Consider a final clinical example which illustrates intensification: A middle-aged woman came to therapy complaining of stress. She was married, parented two teenage children, kept an immaculate home, prepared the family meals, and was employed in a position of responsibility. She felt overworked, underappreciated, and emotionally burned-out.

If the client had been confronted by the therapist with the observation that she was not taking care of her own needs, she would probably have agreed. Furthermore, if the therapist had suggested that the client might do some things for herself (take a few bubble baths, read a good book, or enjoy a favorite hobby), she again would have agreed. At the following session, however, she would likely have reported that she did not have the time to carry out the assignments, or that she simply had not done so (resistance).

The therapist chose instead to join and use the client's problematic

behavior (caretaking), and intensify its effect to generate resistance to the therapist, and thus to the problem. The therapist commended the client on her desire to take care of her employer, her husband, and her children. It was pointed out, however, that there were many other successful women who were accomplishing even more at home and at the office. According to the therapist, the client's stress was the result of her unconscious awareness that she was just "skating by." The therapist then suggested that the client take the next week to think of at least three more things that she could do to take care of her family and employer.

In this case the therapist unbalanced the client's struggle with her symptom. The therapist accepted and utilized the client's ongoing behavior to escalate and intensify the effect of the problem until the client decided for herself to do a better job of self-care by delegating some responsibilities.

Summary of the Utilization of Client Resistance. An understanding of the dynamics and structure of client resistance allows the therapist to use the client's resistant symptoms and behaviors to create therapeutic changes. This therapeutic utilization depends on cooperation with, trust in, and acceptance of the client, as well as a shift in logic from either/or to both/and paradigms.

Conclusion

Client resistance is a fact of life in any therapeutic setting. The ability of the therapist to turn resistance to his or her and the client's advantage may make the difference between the success and failure of an intervention or treatment plan. The utilization concept is a powerful approach to using clients' own dynamics and symptoms to create and facilitate therapeutic change.

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