A Cognitive Perspective on Resistance in Psychotherapy

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The phenomena that comprise resistance in therapy are described and discussed from a cognitive viewpoint. The cases of Brian, Julie, and Victoria are reviewed to illustrate similar and contrasting manifestations of resistance, and suggestions for further individualized conceptualization and intervention are presented. Emphasis is placed on gaining an accurate, empathic understanding of the client’s difficulties in changing. This is coupled with methods that allow the client some autonomy in charting the course of therapy, at the same time reinforcing the importance of the therapist’s active involvement in educating and stimulating the client toward greater awareness and adaptability. In order to be maximally effective in encouraging such changes, therapists must be aware of their own tendencies to react adversely to client resistance. It is vital that therapists maintain their professionalism and confidence in persevering toward a better understanding of what will be helpful to their clients. © 2002 John Wiley & Sons, Inc. J Clin Psychol/In Session 58: 165–174, 2002.

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As a practicing cognitive therapist, I take a very active, structured, and directive stance with my clients. The benefits of this approach are that many clients can progress rapidly, learn important skills for a lifetime, and feel a great deal of enhanced self-confidence.

A cognitive approach has a great deal to offer the client who is reluctant to change. In my clinical work, I offer the client support and encouragement, I try to understand the client’s unique viewpoints about what it means to become aware of problems and to work toward goals, and I address the client’s beliefs about life as it is and life as it could be. I help clients to ascertain the ways in which their problems and symptoms have come to play a particular role in their life and identity, and what it would mean to their views of...
themselves and their future if they experimented with new ways of thinking, acting, and feeling. This is a shared journey, and the collaboration is enhanced when I can convey to the clients that I accept them for who they are, regardless of whether or not they pursue or meet their goals.

What Is Resistance?

Resistance is one of those concepts that is very difficult to define precisely, but many therapists seem to know it when they see it. One of the problems in defining resistance is that therapists’ views about this concept often have been linked to their particular theoretical orientation. The most stark contrast can be seen between some cognitive-behavioral clinicians who liken resistance to behavioral noncompliance and see it as a hindrance to treatment, and traditional psychoanalytic therapists who view resistance as a natural reflection of the client’s internal conflicts, and therefore as a necessary part of the therapeutic process (cf. Wachtel, 1982). Theoretical differences aside, resistance entails those aspects of clients’ functioning that seek to maintain the status quo in their psychological lives. Resistance works against constructive change, but it also provides us with valuable information about clients and their struggles. This information can help therapists to understand and empathize more accurately with each client, and to design interventions that are tailor-made to the individual.

Most therapists agree that therapeutic change can be a frightening proposition for many clients. While it is often the case that clients would like to be relieved of their acute anxious or depressive symptoms, it also frequently is true that they are much more unsure about giving up long-standing patterns of functioning. At first glance, this may seem to be contradictory. However, consider what we are asking clients to do when we suggest that they broaden their psychological awareness, skills, and experiences in life. We are asking them to:

1. Trust your therapist, who certainly knows what is best and really has your best interests at heart, even though you know very little about him or her personally.
2. Work at learning new skills, even though you feel fatigued, bruised, shaken, and encumbered by your problems.
3. Be someone who is somewhat different than you once were, even though you may be grasping for a stable identity as it is.
4. Listen to and understand all of the challenging and complex things that your therapist tells you, and pay less attention to some of the things you routinely and easily tell yourself.
5. Commit to a process that is demanding yet not guaranteed to help, even though indecision and tentativeness may be something that you experience every day even when you are not in therapy.
6. Explore the unknown, in spite of the fact that familiarity and predictability may offer you your only sense of safety.
7. Have hope that your life will improve, even though you may be terribly afraid to have your hopes dashed yet one more time.

In this context, it becomes clear that participation in therapy is no mean feat—indeed, it often is an act of courage. Therefore, it should come as no surprise that clients often do not collaborate automatically with their therapist and treatment plan. They have
doubts, fears, hesitancies, missteps, blind spots, and other internal obstacles to growth and change. Furthermore, they are faced with a potential slew of external impediments to therapeutic progress, including a punishing home or socioeconomic environment, and imperfect therapists who cannot always be optimally effective (although we certainly can strive to show goodwill and to persevere in trying to find healthy solutions to problems that arise in the therapeutic relationship).

The phenomenon of client resistance takes on many forms too numerous to mention exhaustively. What they have in common is that they either temporarily or continuously distract or detract from the process of therapeutic change, at the same time providing a potentially rich source of information about the client that can be used therapeutically. The following are some examples of resistance, most of which can occur in any model of psychotherapy:

1. Refusal or other failure to follow through on therapy homework assignments (more apt to occur in cognitive-behavioral therapies).

2. Repeatedly making decisions and taking actions that run counter to what was agreed upon in session (e.g., Victoria).

3. High levels of expressed emotion toward the therapist, from excessive flirtation to overt hostility (e.g., Brian).

4. In-session avoidance, such as lengthy silences, habitual overuse of the answer “I don’t know” in response to the therapist’s questions, abrupt shifts away from important subject matter, and professed unawareness of experiences that seem blatantly apparent to the therapist or other observers in the client’s life (e.g., Victoria).

5. Gratuitous debates with the therapist, such as when the therapist’s encouraging words repeatedly are met with cynical replies, and when the client disavows the therapist’s accurate reflections (e.g., Brian).

6. Relapses in functioning that occur when the client has difficulty enduring the increased anxiety that accompanies initial attempts to function more adaptively and maturely (e.g., Julie).

7. Repeatedly misinterpreting the therapist’s comments, skewed in the negative direction (e.g., Brian).

8. Ill-advised interruptions of therapy or similar interspersing of sessions, such as the client’s utilizing sessions only in response to crises (e.g., Brian, Victoria), cutting back on sessions in order to make a symbolic statement of independence (e.g., Julie), avoiding direct communication with the therapist by not returning phone calls (e.g., Brian), and abruptly leaving therapy before substantive issues can be discussed (e.g., Brian).

9. Attempts to prolong therapy unduly, as manifested by overextended sessions and avoidance of the process of termination (e.g., Julie), thus impeding the client’s emergent sense of self-reliance.

10. Unreasonable demands placed on the therapist, such as expectations for swift and effortless cure (e.g., Brian), and requests for extra therapy assistance on inappropriate or dubious matters (e.g., letters from the therapist to help with an unspecified legal or financial matter).
Conceptualizing and Working with Resistance

In an earlier article (Newman, 1994), I suggested that therapists may gain a better understanding of the nature of their clients’ resistance by addressing some or all of the following eight assessment questions:

1. What is the function of the client’s resistance?
2. How does the client’s current resistance fit into his/her developmental/historical pattern of resistance?
3. What might be some of the client’s idiosyncratic beliefs that are feeding into the resistance?
4. What might the client fear would happen if he/she engages in treatment?
5. How might the client be characteristically misunderstanding or misinterpreting the therapist’s suggestions, methods, and intentions?
6. What skills does the client lack that make it difficult or practically impossible at this point for him/her to collaborate actively in treatment?
7. What factors in the client’s natural environment may be punishing the client’s attempts to change?
8. Does my conceptualization of this case need to be revised or amended? What do I still need to understand about this client in order to make sense of his/her resistance?

By asking these questions, therapists more readily can remain in the role of benevolent and capable professional helper, while minimizing the all-too-human tendency to become annoyed, exasperated, passively resigned, defensive, and/or argumentative in response to the client’s resistance. In discussing the three cases, I will make use of some of the above assessment questions.

Furthermore, I have found that by employing one or more of the following ten general strategies, I have been able to enlighten and motivate some of my more resistant clients to engage more actively and effectively in treatment (Newman, 1994):

1. Educate the client about therapy.
2. Use the Socratic method.
3. Provide the clients with choices and an active say.
4. Collaborate and compromise.
5. Review the pros and cons of change, and of the status quo.
6. Provide accurate empathy for the client’s resistance.
7. Discuss the case conceptualization with the client.
8. Speak the client’s language.
10. Gently persist when a client is stuck.

In my review of the interventions that could be used with Brian, Julie, and Victoria, I will make reference to some of these ten strategies.

The Case of Brian

First, a rather obvious function of Brian’s resistance to my suggestions was to reduce his already heightened anxiety. This is a basic form of self-care with which I wish I had been
a little more overtly empathic. Second, Brian’s aversion to taking on major challenges in life was rooted firmly in his modeling of his parents’ coping styles, as well as his own social, scholastic, and vocational experiences. For example, his father apparently self-medicated his anxiety with alcohol until he died, and his mother adopted a stoic view of life in which hurt and disappointment ostensibly could be diminished by having no strivings and no expectations. Brian’s own experiences taught him that he could get through school, maintain a decent job, and have sex with women who would not reject him simply by minimizing his efforts and by choosing his battles wisely. It was only when he unexpectedly lost his job that his long-time strategy failed him, thereby leading to his psychological crisis and concomitant wake-up call that something needed to change.

I can only speculate what sorts of maladaptive beliefs Brian maintained in response to my attempted intervention—I wish I had asked him directly, on the spot. My best guess is that he believed he was incapable of succeeding at his new job, and that to persevere would be foolish and self-defeating. He quite possibly also believed that I was unsympathetic and controlling, thereby lessening his trust in me, and increasing his desire to rebel. Further, Brian may have felt certain that his life situation would have worsened if he remained in his new job, and that I could not be counted on to be nonjudgmental nor to help him get on with his life in the aftermath. Therefore, I ceased to be an ally; instead I became a perceived adversary.

Although I asked Brian to consider the pros and cons of remaining on the job, he retorted that he was not going to keep the position just because I thought he should. If I had had more opportunities to learn about his relationships with his parents, with women, and with colleagues, perhaps I would have seen that he had an exaggerated tendency to view people as trying to bend him to their will.

Based on Brian’s report of his academic and vocational history, I never got the sense that he lacked the requisite skills to meet the demands of his new job, and I never had reason to believe that his work environment was unduly hostile or toxic. Still, I lacked sufficient information to be as confident as I came across in expressing my views. Similarly, I knew just enough about his background to formulate a preliminary case conceptualization, but my initial surprise at his hostile reaction to my proposed intervention tells me that I was missing something in understanding him. Sadly, he left treatment before I could learn more and put it to productive use.

If I could go back and recapitulate my final session with Brian, I would be less apt to push my agenda in such a rushed and heavy-handed way. Instead, I would have focused initially on being more validating and empathic toward his feelings of being overwhelmed, especially in light of his family and work histories. Regrettably, I tried to fight fire with fire—Brian had a rigid conceptualization of his predicament, and wanted a solution right away, while I had an alternative formulation of Brian’s problems that I wanted him to accept very quickly. I needed to slow down, let him vent, and provide support before launching into frightening new territory. Brian felt demanded upon by his job, and I succeeded only in making him feel demanded upon by his therapist as well, which further compounded his sense of being pressured and encouraged him to bolt from treatment.

I wish I had not been quite so glib with my use of clichés, my exaggerated “Ah-hah!” statement, and my clever little references to lines from Let’s Make a Deal and a song by The Clash. I thought I was talking as a regular guy, but it probably sounded too irreverent. I noticed that whenever I asked Brian an open-ended question, he responded as if I had given him a directive. It might have been instructive had I pointed this out to him and asked him if he believed that I was being unnecessarily bossy. This might have led to a fruitful discussion of his sense of autonomy and his need to be in firm control of his life.
I then could have focused on the life experiences that taught him to be so doubting of his coping skills on the one hand, but so sure of his self-protective decision making on the other. By being especially empathic to this conflict, I could have helped Brian to be a bit more receptive to considering alternative, more functional approaches to his problems.

A further sign of good will on my part would have been to ask Brian what he wanted to do, and then asked him if he saw any other choices. If he vacillated, I would have had a natural entry point into talking about his ambivalence about the situation, along with all of its ramifications. On the other hand, if he was definitive in his answer, I then could have made hay by asking what role he needed me to play, given that he already was so certain. These methods, along with a more empathic and respectful tone, probably would have kept Brian at least engaged in the process of therapy.

The Case of Julie

Satten worked with Julie for over three years. In that time, he established and “field-tested” a sophisticated conceptualization of his client’s psychological life and had established a rich, rewarding, complex, and instructive therapeutic relationship. The vicissitudes of Julie’s resistance to striving toward emotional independence, as well as her desire to remain a “good little girl” who earned the innocent praises of the male authority figures in her life, seemed well understood by the therapist.

Julie’s cited comments in session provide a window into some of her idiosyncratic beliefs pertinent to her pattern of seeking and maintaining emotional dependence on male authority figures. It is plausible to hypothesize that she viewed a mature level of emotional self-sufficiency as entailing her taking on a role of being a bad or selfish person—the polar opposite of her self-image as the good girl. Such difficulty in grasping the middle ground is a classic problem in cognitive processing amongst psychotherapy clients.

It is also likely that she believed that she lacked the necessary knowledge and confidence to get most of her important needs met. In this scenario, the quality of her life would certainly diminish (in her estimation) if she moved toward independence and general growth. Additionally, it is not too great a stretch to surmise that Julie feared that she would wind up alone if she abandoned her long-standing interpersonal patterns. In some respects, she might have been partly right—she might have been forced to confront the deficiencies in her marriage, a topic that was conspicuous by its absence in the overview of the case.

It also is important to consider the positive and negative consequences that other people in Julie’s life might impose upon her if she made significant changes in therapy. For example, the reactions of Julie’s husband and father certainly would play a role in determining whether or not Julie would take what she learned in therapy and apply it in her everyday life.

Satten’s obvious strong points in processing his client’s resistance were in the case conceptualization, accurate empathy for Julie’s sometimes regressive stance, collaboration and compromise about the frequency of sessions (as a function of the client’s attempts to be her own person), and trying to maximize Julie’s forays into self-direction.

After three years of therapy, it is tempting to conclude that the therapist and client had covered all the relevant clinical material, and that now the issue was simply to wait until Julie was ready to enact that which she had learned in therapy. However, there are two possible informational gaps that I would like to address. I would make a point of discussing the implications of these missing data with Julie in order to elicit her views on what they indicated and what action she could take next. Perhaps this would serve to propel Julie to the next level in her progress.
First, I would pursue more in-depth focus on Julie’s perceived pros and cons for both stasis and change. I especially would emphasize the distinction between fantasized consequences and reality-tested consequences. There were a number of times when Julie feared losing her therapist (e.g., if she were to act in a flirtatious manner with him), worried about falling into disfavor with her father (e.g., if she disregarded his financial advice), and felt wounded by criticism when she would act assertively at work. These reactions usually led Julie to assume a fallback position, and she would resume being deferential, dependent, and good.

However, had Julie ever considered the long-term consequences of her patterns of behavior? For example, what would actually happen if she allowed herself to acknowledge her sexual feelings, or if she politely stood up for her position irrespective of what her father might think, or if she continued to exude confidence and take initiative at work? Had Julie ever allowed herself to envision a positive result to these scenarios?

Further, had Julie considered the long-range drawbacks to staying the same? Did she see that her choices in life were more fear-driven than goal-driven? Did she understand that she could try to remain frozen in time, but that time would march on inexorably, with or without her accompanying personal development? Did she take a prospective glance at what her life might look like in 5, 10, or 20 years if she tried always to remain the “good little girl?” I have joked at times that in order to motivate their clients to change, therapists sometimes have to adopt the role of Dickens’ Ghost of Christmas Yet to Come. It seems that Julie needed to take this hypothetical journey into her future in order to increase further her motivation for change.

Second, I would spend a good deal of time talking about Julie’s marriage, especially since her husband seemed to be the forgotten man in her therapeutic discussions, as presented earlier. This is ironic (or is it predictable?), given that a spouse is the person with whom one is supposed to be adult and sexual. In Julie’s case, her husband could have been the ideal person with whom to test out new ways of mature interacting. At the same time, if Julie were dissatisfied with her marriage, this issue needed to be discussed as soon as possible, either to work on her marital problems, or to leave the relationship and find mature love elsewhere. Julie likely was not happy in her marriage. This seems like a necessary focal point for her therapy.

The Case of Victoria

Victoria’s resistance was conceptualized by Engle and Holiman as consisting of at least three components:

1. Her marked lack of awareness of her own emotional states and their immediate effect on her behavior;
2. Her pattern of soliciting and then disregarding advice; and
3. Her inconsistent use of therapy sessions, such that they served more as crisis intervention rather than as a way to build toward a steady accumulation of insights and concrete changes.

One function of Victoria’s resistance appeared to be a desire to stay engaged with important others, no matter what the cost, regardless of whether or not the interactions actually were positive and productive, and irrespective of the fact that each of these relationships required individualized approaches that did not generalize well from one to the other. The case study shows Victoria to be someone who was trying desperately to maintain ties with her son, her boss, her therapist, her father, her estranged husband, her
new boyfriend, and others. Unfortunately, in order to do so, she probably had to ignore many of her feelings, such as rage toward her father and estranged husband, resentment toward her boss, and love for her son and new boyfriend. Interestingly, I cannot make heads or tails out of her feelings toward her therapist. I wonder if Victoria ignored these latter feelings so completely that even the therapist himself was at a loss to know where he stood with her.

Let us look at the traumatic experience that Victoria encountered as a 4-year-old, when she was placed inappropriately in the center of a situation where the father acted enraged and abusive and then abandoned the family. One may infer that the impressionable young child learned that one minor interpersonal transgression could lead to catastrophic results in her entire sphere of close relationships. This belief was reinforced later in adulthood when Victoria’s seemingly “perfect” husband walked out on her, and never offered an explanation. Clearly, she feared that Paul (the new boyfriend) would do the same thing if she allowed herself to love and trust him.

Victoria’s sense of trust, both in herself and in others, was minimal. To comply with her therapist and/or attorney must have seemed inordinately risky to her. Unfortunately, she wavered in her own position as well, a condition that was not helped by her lack of awareness of her more intense feelings and behaviors. At every turn, Victoria seemed to be faced with loss of autonomy or loss of love.

Victoria’s listening skills probably were impaired, especially when she was distracted by her highly emotional and conflicting thoughts. Her interpersonal environment was rich with both positive and negative feedback, but it is not clear how much of this important differential feedback Victoria could perceive and what she made of it. There was tremendous competition for her time and attention between her boss/job and her son/boyfriend, which caused her no small degree of conflict and guilt, and yet she continued to invest time, emotions, and energy in dead-end situations—namely, with her father and estranged husband. In addition, her therapist got too little of her time as well! Most importantly, Victoria did not give time to herself, and her self-awareness suffered for it, as did any sense of peace or security she might have gained.

The client repeatedly and desperately sought the best advice that her therapist, Engle, had to offer, and then, typically, she disregarded it. This pattern was at the center of Victoria’s between-sessions resistance. Engle made concerted efforts to focus Victoria’s attention on her immediate feeling states, but her “torrent of words” often got in the way of her emotional self-awareness, and probably interfered with her ability to hear her therapist. This tendency was central to her in-session resistance. Additionally, the running debate that Victoria held with herself about almost every important emotional and practical decision served as her internal resistance to change, whether she was actively in treatment or not.

Engle and Holiman report that Victoria’s first major goal for therapy was to formulate ways to keep her husband in the marriage. This was the first clue that Victoria was insufficiently focused on her own functioning. To use one’s own therapy primarily in order to try to change another adult’s behavior is usually both inappropriate and ineffective. Early in treatment, I would try to educate Victoria about the need to pay more attention to her own psychological functioning and relatively less on others in her life. By addressing this as delicately, empathically, and perhaps as repeatedly as possible, I would hope to reorient Victoria’s agenda for therapy. I have no illusion that this would be an easy or quick task.

Given Victoria’s pattern of soliciting and then disregarding the advice of others, I would shift away from giving direct suggestions; instead, I would utilize more Socratic questions. I especially would focus on Victoria’s sense of the short-term and long-term
pros and cons for each of the potential choices she would proffer. I would ask Victoria to write down her responses and perhaps to audiotape the therapy sessions as well, in order to keep an objective record upon which she could refer at any time. Further, by listening to her own verbal behavior from the sessions, Victoria could gain a more objective awareness of both her interpersonal manner and her emotional shifts. Hopefully, this later would translate into the client’s having a greater ability to achieve a more accurate and immediate subjective sense of her thoughts, feelings, and behaviors as they occurred live.

Given Victoria’s catastrophic fears of making the “wrong” decisions, it is likely that she would be noncompliant with the above interventions. Instead, it is more likely that she would escalate her attempts to get the therapist to make direct suggestions. I would make every effort to point out this dance, and to reflect empathically on the client’s traumatic interpersonal losses as being somewhat responsible for her difficulties in following the therapeutic plan. When therapists humbly discuss the case conceptualization with their clients in this way, a sense of accurate empathy is communicated quite readily, the therapeutic alliance is strengthened, and the clients’ active participation in the therapeutic process often is enhanced (Layden, Newman, Freeman, & Morse, 1993; Persons, 1989).

Along these lines, I would help Victoria to see how she maintained implicit dysfunctional beliefs that could account for much of her problematic, perplexing, and ineffective behavior. For example, we would address her belief that every problem had an absolutely correct solution, and that if she did not find this singular and perfect answer, terrible consequences could result.

Finally, in terms of her investment in interpersonal relationships, I would urge Victoria to focus on rewards and drawbacks with each person in the present. She seemed overly concerned with the past (e.g., her absentee father), and with the future (e.g., what troubles might later occur with her boss and her boyfriend). As a result, she missed out on experiencing the present to the fullest, thus diminishing her ability to relate in a happy, secure, and relaxed manner with herself, her son, and her boyfriend.

Undoubtedly, Victoria would continue to struggle to change, and she would certainly remain somewhat anxious in making decisions. In order to deal with this, I would follow Engle and Holiman’s wise, accurate, and empathic lead in stating that Victoria was having a battle within herself, and that our job was to support and embolden the maturest aspects of herself.

Therapist Reactions to Client Resistance

When clients work in opposition to their therapists’ attempts to help them change, they put their therapists’ professionalism and character to the test. This is so because while it is very easy to become fed up with highly resistant clients, it is very difficult to maintain a doggedly steady, caring, confident, hopeful stance with them. Yet, this latter approach is vital to the success of working through therapeutic impasses.

We, as therapists, actively must be aware of our (perhaps overdeveloped) needs to be helpful and to be in control. Resistant clients tend to thwart such needs, leading us, at times, to become even more intent on imposing our will (e.g., my escalated directiveness with Brian), and/or to become frustrated, cynical, and considerably less empathic (e.g., when we say tersely that our client “would rather suffer than get well”). Instead, we must not take our clients’ reactions personally, but rather remain observant, reflective, understanding, and open to formulating new hypotheses, and/or new ways to couch them. This requires a healthy mixture of humility and self-confidence, along with a sense of hope and optimism for one’s fellow human beings. This is challenging stuff, indeed.
I also believe that therapists should not be so in awe of the persistence and power of their clients’ resistance that they become too passive and unstimulating of change. Interpersonal control is a two-way street between the therapist and client. Therefore, while it may not be prudent to become overly directive with a resistant client, it equally is problematic to be so accepting (or resigned, perhaps?) that the client continues to flounder indefinitely while the therapist’s valuable skills and knowledge lie dormant and unpurveyed. We cannot always wait until the client reaches that magical ready-for-change stage. Change is not simply an internal maturing process—if it were, there would not be a need for therapists! We have a responsibility to educate, stimulate, and encourage our clients to broaden and deepen their awareness, and to expand their repertoire of behaviors, feelings, and cognitions. Maintaining a collaborative set can facilitate this process and keep the struggle and conflict to a manageable minimum.

Conclusions

When clients come to see us for treatment, they seek our help in alleviating their psychological discomfort, dilemmas, and suffering. Nevertheless, therapeutic change itself often is a difficult and frightening process; therefore, clients frequently respond in ways that support the status quo. This overt or covert reluctance to change and grow is known as resistance, and it occurs regardless of the theoretical orientation of the practitioner.

The cases of Brian, Julie, and Victoria have illustrated the phenomenon of resistance. For example, Brian misinterpreted the therapist’s comments as being critical and controlling, became angry, and abruptly terminated therapy without considering the merits of the therapist’s conceptualization. Julie was overinvested in being a compliant, unassertive, innocent “little girl” who would earn the approval and love of the important men in her life. She found herself in the bind of trying to please her male therapist by being more emotionally independent, leading to great ambivalence about her degree of involvement in therapy. Victoria had multiple life problems that called for decisive and timely action, but her fear of the catastrophic results of being wrong led her to vacillate and equivocate. As a result, she often was in need of crisis intervention, but her problems never seemed to get resolved.

It is extremely important for therapists to gain an accurate, empathic understanding of the client’s resistance to change, and to use this knowledge constructively to make therapy a more hospitable, educative, and nurturing environment for the client. Eight assessment questions and ten suggested interventions were reviewed in order to pursue this goal.

Additionally, therapists must be aware of how their own errors in judgment and adverse emotional reactions unwittingly may exacerbate the client’s resistance. By owning some of the responsibility for the client’s difficulties in changing, the therapist makes the process of therapy more collaborative, less threatening, and more conducive to working through resistance.

Select References/Recommended Readings


