Difficult Clients: Who Are They and How Do We Help Them?

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Abstract

A review of the literature on dealing with resistant clients is presented. Based on this review, the authors developed a survey designed to elicit counsellors' reactions to and experiences with resistant clients. Responses received from 215 members of the American Mental Health Counselors Association suggest that nearly all counsellors have encountered resistant clients, but the counsellors' reactions to and methods of dealing with these clients differ considerably.

Résumé

Cet article présente une revue de littérature se rapportant aux clients résistants. Basé sur cette revue, les auteurs ont développé un questionnaire dans le but de mettre à jour les réactions des conseillers face aux clients résistants et leurs expériences avec ceux-ci. Les réponses reçues de 215 membres de l'American Mental Health Counselors Association suggèrent que pratiquement tous les conseillers ont rencontré des clients résistants, toutefois les réactions des conseillers face ces clients et leurs approches diffèrent considérablement.

"I've tried everything I can think of with this client and nothing seems to work. What do you suggest?" This is a question the authors have heard so many times, not only from students, but from seasoned professionals. The experience of coping with difficult clients seems to be one all counsellors share. It can be painful and frustrating or it can be challenging and intriguing. According to Miller and Rollnick (1991), "Resistance is often the life of the play. . . . The true art of therapy is tested in the recognition and handling of resistance. It is on this stage that the drama of change unfolds" (p. 112).

However, not all therapists view resistance so positively. They may react by feeling threatened, frustrated, annoyed, resentful, exasperated, or angry. Fremont and Anderson (1986) found anger to be a particularly common response to resistance, although its likelihood was negatively correlated with amount of therapist experience. The purpose of this article is to present an overview of ways to understand and deal with difficult clients, according to both the literature and a survey of members of the American Mental Health Counselors Association. An examination of the professional literature related to describing difficult clients is first presented, followed by a review and discussion of the results of the survey.

THE NATURE OF CLIENT RESISTANCE

Many terms have been used to describe challenging clients including resistant, reluctant, involuntary, coerced, noncompliant, uncommitted,

oppositional, reactant, and difficult. Resistant seems to be the generally accepted term in the professional literature and that term, along with difficult, will be used interchangeably through this paper to refer to the construct of client resistance.

If counselling is viewed primarily as a process of promoting positive change in affect, cognition, and behaviour, then resistance can be defined as ". . . all behaviours, feelings, patterns or styles that operate to prevent change" (Anderson & Stewart, 1983, p. 152). In family therapy, resistance typically is viewed as an attempt to maintain homeostasis. Resistance can take many forms including withholding, disengaging, and obstructing or subverting efforts to effect change (Hartman & Reynolds, 1987).

Otani's (1989) review of the literature yielded 22 types of resistance, evident primarily in individual counselling, that have been incorporated into the questionnaire discussed later in this paper. Other forms of resistance such as collusion, family secrets, scapegoating, and pseudohostility (arguing about unimportant issues) may appear in family counselling (Anderson & Stewart, 1983). Some therapists equate defense mechanisms with resistance but Anderson and Stewart (1983) point out that clients' use of defense mechanisms only becomes a problem when that use is rigid and circumscribed.

To understand resistance, such dimensions as motivation, pervasiveness, and severity should be considered. Brehm and Brehm (1981), for example, suggested a *reactance theory* in which apparent resistance may reflect a healthy effort to maintain autonomy. Building on that concept, Dowd and Seibel (1990) viewed resistance as situation specific, arising from a "schema-disconfirming event" (p. 460) or cognitive dissonance, while reactance is evidenced in response to a perceived threat to freedom and is more characterological.

Munjack and Oziel (1978) described five categories of resistance in therapy. Type I resistance stems from the client's confusion about how to behave. Type II resistance arises from a specific skill deficit. Type III resistance stems from past experiences such as unsuccessful previous therapy, negative expectations engendered by family and friends, and learned helplessness. Type IV resistance reflects client anxiety or guilt. Type V resistance reflects secondary gains clients derive from their symptoms. In other words, resistance refers to many facets of client behaviour.

THEORETICAL CONCEPTIONS OF RESISTANCE

Many authors in the field, regardless of their theoretical orientation, view resistance as one of the predictable challenges of the therapeutic process (Anderson & Stewart, 1983; Breshgold, 1988; Firestone, 1988; Lewis & Evans, 1986; Vriend & Dyer, 1973). Nevertheless, theoretical differences

exist in terms of conception of resistance and recommended therapist response.

For example, *social influence theorists* postulate that resistance is aroused by the client's perception of the counsellor's influence as illegitimate (Ruppel & Kaul, 1982). They believe that resistance can be reduced by increasing the client's perception of the therapist's expertness, trustworthiness, and attractiveness (Corrigan, Dell, Lewis & Schmidt, 1980; Heppner & Claiborn, 1989).

Alfred Adler viewed resistance as ". . . a cooperative failure on the part of both therapist and client" (Lewis & Evans, 1986, p. 427), a conflict of movement and goals between therapist and client. A favourite Adlerian technique for handling resistance is called spitting in the patient's soup, an effort to reframe resistant behaviour so it becomes less appealing to the client.

Freud (1966) described resistance as violent and tenacious and cautioned the therapist to remain "distrustful and on his [*sic*] guard against it" (p. 355). Freud viewed resistance as linked to repression, reflecting the client's struggle to prevent the therapist from making the unconscious conscious.

Strategic approaches focus on the role of the therapist in both causing and alleviating resistance. According to Fisch, Weakland and Segal (1982), therapists can reduce resistance through careful use of timing, pacing, and interventions.

According to Fritz Perls, resistance is "valuable energies of the personality which are harmful only if misdirected" (Breshgold, 1988, p. 83). Modern Gestalt therapists view the concept of resistance as unnecessary and incompatible with the practice of Gestalt therapy that emphasizes therapist-client collaboration (Wheeler, 1991).

Cognitive and behavioural therapists, too, do not place much emphasis on resistance. They usually view resistance as "the client's noncompliance with prescribed behavioural assignments" (Otano, 1989, p. 458) and commonly attribute resistance to the failure of the therapist to find the correct approach.

Some therapists, particularly those from strategic, Gestalt, and Neurolinguistic Programming orientations, take issue with the whole concept of client resistance (Bandler & Grinder, 1982; de Shazer, 1989; Wheeler, 1991). Instead, they encourage a focus on growth and change. According to Bandler and Grinder (1982), "No part of a human being resists a therapist. All they ever do is demonstrate you are on the wrong track" (p. 137).

CLIENTS LIKELY TO BE RESISTANT

Few articles have been written about the relationship between client characteristics and resistance. Kottler and Blau (1989) believed that

resistance was particularly common among people having borderline personality disorders, chronic problems, problems with impulse control, a significant disturbance, or a pattern of externalizing problems. Jahn and Lichstein (1980) described clients most likely to terminate therapy prematurely as young, female, from lower socioeconomic classes, socially isolated, less anxious and depressed, more aggressive and passive-aggressive, poorly motivated, less psychologically minded, more dependent, and with treatment expectations that differ from those of the therapist.

EMPIRICAL STUDIES OF RESISTANCE

Although many theoreticians have written about resistance, few have actually conducted empirical research on that process. However, some data-based research on resistance does exist.

Chamberlain, Patterson, Reid, Kavanagh and Forgatch (1984) developed the Client Resistance Code (CRC) to operationalize the definition of resistance. They found a high incidence of resistance in the middle stages of family counselling, when therapists tried to modify parenting behaviour.

Verhulst and van de Vijver (1990) surveyed behavioural and psychodynamic therapists; both groups found the concept of resistance a useful one and ". . . considered resistance a phenomenon that occurs in every therapy" (p. 181). They found that resistance was most likely to occur during the early, information-gathering stage of therapy. Their study suggested that directive, structured, and problem-solving techniques such as asking probing questions were most likely to trigger resistance.

A study by Patterson and Forgatch (1985), using a variation of the CRC, the Client Noncompliance Code (CNC), obtained similar results. They concluded that teaching and confronting on the part of the therapist increased noncompliance while resistance was less likely when therapists attempted to facilitate or support. Patterson and Forgatch raise the question, "Given that necessary therapist behaviours increase client noncompliance, how does a skilled therapist reduce noncompliance?" (p. 851).

Another scale, the Resistance Scale, based on psychoanalytic views of resistance, was developed by Schuller, Crits-Cristoph and Conolly (1991). Using their scale to study five-minute clinical segments, they concluded that resistance is a multidimensional construct consisting of four dimensions of client behaviour: abrupt/shifting, flat/halting, vague/doubting, and least important, oppositional. The authors were surprised to find that manifestations of resistance seemed more related to individual client characteristics than to therapist behaviours.

Dowd, Milne and Wise (1991) developed the Therapeutic Reactance Scale, based on the work of Brehm (1966) and Brehm and Brehm

(1981). This scale was designed to measure enduring, relatively stable motivational states, rather than situation-specific expressions of resistance.

Empirical study of resistance is relatively new. However, the authors believe that only through a combination of theoretical and empirical study of resistance can therapists really understand and deal effectively with resistance.

DEALING WITH RESISTANCE EFFECTIVELY

According to Vriend and Dyer (1973), "Effectively dealing with reluctant clients might be the most important overall competency that counselors can develop" (p. 246). Anderson and Stewart (1983) agreed and stressed the importance of dealing with resistance from the very first telephone call: "All therapists must learn to ask themselves repeatedly, 'Why now? What just happened that would provoke this behaviour, this feeling, this action? What does this behaviour mean at this point in time?'" (p. 154).

Many therapeutic techniques for dealing with resistance have been presented in the literature. They range from those that are universally accepted such as empathy, rapport-building and understanding, through those that are used by most therapists such as confrontation and self-disclosure, to those such as story telling and hypnosis that are unusual.

Establishing a Positive Therapeutic Alliance

The establishment of a positive therapeutic alliance seems to be an essential step in reducing resistance (Bordin, 1979). Such an alliance can be characterized by client and counsellor agreement on the goals and tasks of the therapeutic process and the development of a bond between client and counsellor. Kokotovic and Tracey (1990) found that the quality of the alliance after the third session was related to eventual outcome. Providing pretherapy information or doing role induction or preliminary preparation for counselling in which client's expectations are explored and client and therapist roles are explained is recommended by many as a way of reducing resistance (Hartman & Reynolds, 1987; Kottler, 1991; Seligman, 1990).

In addition, relationship-building techniques such as empathy, joining, reflection, warmth and positive regard have been used to reduce resistance. They may be used either along with more directive interventions or alone when those techniques seem inappropriate (Lewis & Evans, 1986). Sexton and Whiston (1991) found these techniques to be correlated with a positive outcome in counselling. Raubolt (1983) recommended the use of hypervaluation, a form of empathy that supports and values resistance. For example, silence might be reframed as an ego

strength. This technique can reduce tension, promote rapport, and increase client insight.

In a similar vein, Lewis and Evans (1986) recommend joining the resistance as a way to reduce anxiety and encourage self-disclosure. This approach also seems to be more forgiving than such techniques as interpretation and confrontation that depend on the counsellor making a correct analysis of the resistance.

Confrontation

Most discussions of difficult clients support the use of confrontation. According to Kottler (1986), "We are specifically paid to say things to the client that nobody else has the courage and finesse to say" (p. 12). Bergman (1985), a family systems therapist, agreed, stating that confrontation and provocation, used with warmth and caring, can give the therapy hour a healthy jolt. Higgs (1992) advocated the use of confrontation as a way of handling resistance in group counselling, but emphasized the importance of strong leadership and an atmosphere of trust to reduce the risk of harm. Edelwich and Brodsky (1992) listed seven guidelines for using confrontation in the group setting. Confrontation should be solicited rather than imposed, gentle and caring rather than aggressive, descriptive rather than evaluative, specific rather than general, concrete rather than abstract, and timed and presented to maximize the likelihood that clients can hear the message being delivered. In addition, counsellors should be sure their confrontations do not stem from their own needs, a way of ventilating their frustration with the therapy, or an unwillingness to view problems from the client's perspective (Harris, 1991; Harris & Watkins, 1987). Miller and Rollnick (1991) caution against the sort of aggressive or hostile confrontation sometimes advocated in treatment of addictive disorders.

Interpretation

Interpretation is another approach often used particularly by psychodynamic therapists to address resistance. Reber (1985) defined interpretation as "explaining a thing in a meaningful way" (p. 370) and clarifying the significance and underlying symbolic meaning of a client's statements. Fromm-Reichmann (1960) emphasized the importance of bringing resistance to awareness but suggested several cautions in using interpretation with difficult clients: interpretations tend not to work well with very negative clients and, other than focusing on open manifestations of resistance or security operations, are best used after the overall personality and psychopathology of the client are understood. Challenging questions and interpretations can be experienced as an attack, leading to increased defensiveness and even premature termination (Teitelbaum, 1991).

One of the few empirical studies of interpretation was conducted by Jones and Gelso (1988). They studied the differential effects of tentative and absolute interpretation on three groups of subjects, resistant (defined as being dogmatic and having an external locus of control), intermediate, and nonresistant (nondogmatic and having an internal locus of control). Although no significant differences emerged, clients tended to prefer the tentatively phrased interpretations.

Strategic Interventions

Recent models of brief therapy have emphasized the use of strategic or indirect interventions such as metaphors, reframing, paradox, story telling, and humour, either alone or in combination. These techniques can neutralize rigid ways of thinking, increase the power of counsellor's suggestions, and lead to a change in perception. This is particularly likely if the interventions shift focus from negative to positive or from linear to circular causality (Coche, 1990). Humour is yet another strategic technique that can reduce resistance by diffusing tension, facilitating discussion of painful or avoided topics, disrupting fixed patterns, providing a new perspective, and building rapport (Bergman, 1985; Fay, 1978; Kottler, 1993).

Therapist Self-disclosure

A survey of social workers conducted by Anderson and Mandell (1989) found that 29% used self-disclosure to reduce resistance. Respondents reported that self-disclosure could increase client awareness of alternative viewpoints and options, increase client self-disclosure via modelling, and decrease anxiety. On the other hand, Kottler and Blau (1989) and Kottler (1991; 1992; 1993) viewed self-disclosure as one of the most abused interventions; when used excessviely or inappropriately, self-disclosure could lead to therapist self-indulgence and harmful transference reactions in clients. In general, self-disclosure seems most likely to be effective in reducing resistance when it keeps the focus on the client, is carefully timed, is relatively impersonal, is used sparingly, presents a balanced view of the therapist, is not used in response to client self-disclosure, allows for client reaction, and is avoided with clients who are fragile or in poor contact with reality (Anderson & Mandell, 1989).

Other Options

Numerous other techniques have been suggested for addressing resistance. These include silence and changing the ground rules of therapy (Langs, 1980); questioning, describing the client's behaviour, discussing client's readiness for treatment, inviting clients to pretend or invent a response, offering to answer questions for the client, and examining the

client-therapist relationship (Sack, 1999); acceptance, encouragement of the resistance, having the client move from one chair to another, and modifying cognitions (Otani, 1989). Brief approaches to therapy such as those of O'Hanlon, de Shazer, Haley and Madanes, and Weiner-Davis are particularly rich in ways to address resistance.

DEALING WITH RESISTANCE IN SPECIAL POPULATIONS

Harris and Watkins (1987) suggested that involuntary clients (e.g., court referred, incarcerated, hospitalized) respond less positively to confrontation and interpretation than do voluntary clients. Unwise use of these interventions with involuntary clients is likely to exacerbate a struggle for control and increase resistance. Instead, they recommend the following interventions be emphasized:

1. Provide structure and establish expectations.
2. Maximize choices and minimize demands.
3. Help clients save face.
4. Ignore resistance.
5. Create enough anxiety to stimulate self-examination.
6. Delivery interventions at critical moments.
7. Pique curiosity.
8. Use nonverbal techniques.
9. Empahsize positive intentions.
10. Identify and capitalize on client's preferred styles of learning and change.

These interventions also can be effective in addressing resistance in adolescents. According to Mishne (1986) and Shulman (1983), adolescents' extreme sensitivity, intolerance of anxiety, mistrust of adults, and need for emotional support contradicts the use of confrontation and interpretation.

Because of the importance their peers have for adolescents, brief group counselling has been recommended as an effective and developmentally sound way of addressing their resistance (Raubolt, 1983). Reframing and other paradoxical and indirect interventions also have been found useful (Wexler, 1991).

MODELS FOR ADDRESSING RESISTANCE

Counselling difficult clients effectively typically involves more than a single strategy. Considering the context of the relationship and planning

a sequence of interventions seems likely to enhance therapist effectiveness. Miller and Rollnick (1991) suggest combining five key processes in addressing resistance: expressing empathy, clarifying discrepancies, avoiding arguments, rolling with resistance, and supporting client self-efficacy.

Success in counselling depends less on specific interventions or theoretical approaches than it does on the attitudes and skillfulness of the therapist. "The therapist most likely to achieve a positive outcome is active, optimistic, expressive, straightforward yet supportive, involved, and in charge of the therapeutic process but also able to encourage client responsibility (Seligman, 1990, p. 49).

SUCCESS NOT A CERTAINTY

Even with dedication and an armamentarium of powerful techniques and strong skills, counsellors sometimes have treatment failures. Whether the cause is the therapist, the client, or their interaction, Kottler and Blau (1989) encourage counsellors to pay attention to what has not worked, respect the process of therapy and believe in their own creativity and resources. "We expand our knowledge, develop our theories, improve our performance with every negative result" (p. 66). Based on the above review of the literature and the words of Kottler and Blau, the authors saw the need to survey therapists on their perceptions of client resistance and their efforts to address that phenomenon. Our review of literature on dealing with resistant clients revealed that only a few publications were based on therapist responses rather than theory. We believe that the experiences of our colleagues can increase our understanding and facilitate application of the literature on resistance.

METHOD

The authors designed a 43-item research questionnaire to elicit information on counsellors' conceptions of resistance, the types of resistance they have encountered, ways they have coped with resistance, and their own responses to resistance. In addition, respondents were asked to provide a profile of the most resistant client they had counselled. Respondents also were asked to provide information about their gender, age, experience, academic degree, theoretical orientation, work setting, and whether they had experienced personal psychotherapy.

A pilot study we conducted suggested that mental health counsellors were more aware of and concerned with client resistance than were school or college counsellors. Consequently, we sent the questionnaire and a stamped return envelope to 500 randomly selected members of the American Mental Health Counselors Association, a division of the American Counseling Association. A follow-up postcard was mailed several weeks later. A total of 215 usable questionnaires were received, a 43% rate

of return. This return rate is consistent with previous national surveys of psychotherapists (Wogan & Norcross, 1985).

Respondents

Of the respondents, approximately 40% were male and 60% were female. Most of the respondents (55%) were between 35 and 49 years old, with 17% younger and 28% older. More than 95% of the respondents were White, while 2.4% were African American, 1.9% Hispanic, and .5% having another ethnic background. The highest degree of most of the respondents (72%) was a masters degree while 4% had a bachelors degree and over 23% had doctoral degrees. Years of experience varied considerably, with 18% having 0-2 years experience, 24% with 3-5 years, 20% with 6-10 years, 24% with 11-19 years, and 14% with 20 or more years experience. Respondents' work settings were approximately equally divided between public and private settings. Most of the counsellors reported that their typical therapeutic relationship was either 5-12 sessions (32%) or 13-24 sessions in duration (38%). Counsellors reported a variety of theoretical orientations including Humanistic (21.7%), Cognitive-behavioural (20.8%), Psychodynamic (11.1%), Family counselling (10.6%), Reality Therapy (6.8%), Adlerian (5.3%), and other (13.5%). Over 80% of the counsellors had had therapy themselves.

DESCRIBING RESISTANCE

Resistance seems to be a widespread phenomenon. Over 87% of the respondents believed that resistance was an inevitable and normal part of counselling while only 7% did not view it that way (6% were uncertain).

Many terms have been used in the professional literature to describe resistant clients including difficult, involuntary, noncompliant, oppositional, reactant, reluctant, resistance, and unmotivated. Respondents preferred the term resistant (54%), although 17% favoured reluctant and 17% preferred difficult.

Respondents were asked which of seven definitions of resistance, synthesized from the literature, best reflected their views. "Resistance is all those behaviours, feelings, patterns or styles that operate to prevent change in the counseling process" was preferrred by 52%. Other appealing choices included "Resistance is the process of clients' avoiding or limiting self-disclosure because of discomfort or anxiety" (19%), "Resistance is viewed neutrally as a form of communication" (15%), and "Resistance is a universal process, caused by unconscious factors; it must be interpreted and counteracted" (8%). The following definitions were selected only by a small number of respondents: "Resistance is the nonacceptance of the therapist's legitimacy as a source of influence" (1%), "Resistance is client behaviour that the therapist labels as antitherapeutic" (2%) or "Resistance is a rationalization to explain treatment

failures" (3%). Respondents, then, generally viewed resistance from a broad, atheoretical perspective.

Responses to another question about counsellors' understanding of the reasons for resistance provided further clarification of counsellors' definitions. Respondents were presented with seven possible reasons for client resistance. Sixty-seven per cent of the respondents viewed anxiety and guilt related to material that is being discussed as the most common source of resistance while 15% saw secondary gains as the most important determinant of resistance. Other options were selected by only a small percentage of respondents: not feeling understood or accepted, having a fear of closeness (each 6%), lack of understanding (2%), deficits in skills or information (1.5%), and feeling hopeless and unmotivated (2%). Most counsellors, then, view resistance as a way for clients to protect themselves from anxiety or guilt.

Most respondents emphasized the importance of the therapeutic relationship in resistance. For most (53%), the locus of resistance was in the interpersonal interaction of therapist and client, while only 30% saw resistance as residing in the client. In addition, over 95% believed that resistance could be caused by a client-therapist mismatch, while only 1% did not think that was likely.

Timing seems to be a factor in resistance. Most respondents (66%) viewed resistance as a process that ebbs and flows throughout the counselling relationship, depending on the material being considered. However, a substantial percentage of respondents (30%) believed that resistance was greatest in the early counselling sessions. Few believed resistance was greatest toward the end of counselling or was manifested at a stable level throughout the counselling process.

Respondents manifested less agreement on the relationship between resistance and progress. When asked if they believed resistance was negatively correlated with client progress, 25% agreed, 39% disagreed, and 36% were uncertain. The manifestation of resistance, then, does not necessarily reflect minimal progress.

COUNSELLORS' EXPERIENCE OF RESISTANCE

Although nearly all counsellors have encountered resistant clients, they do not perceive most of their clients as highly resistant. When asked what percentage of their clients they would describe as highly resistant, 79% of respondents reported that they would describe fewer than 25% of their clients in that way. Only 2.4% of respondents described more than 75% of their clients as highly resistant. Most counsellors (66%) reported no change in the prevalence of client resistance over the course of the counsellors' careers. However, 26% viewed resistance as becoming less common, while 8% thought it was becoming more common. Although the reason why so many saw resistance as a becoming less prevalent was

not ascertained, several possible explanations might be considered. Perhaps experienced counsellors are more skilled at deflecting resistance and so encounter it less frequently. It is also possible than an increasing psychological-mindedness and acceptance of psychotherapy in society has led to some decline in resistance.

To gather information on how resistance was most likely to be presented, the many forms of resistance identified in the literature were organized into the following five categories (Kottler, 1992; Otani, 1989):

1. *Witholding Communication*—silence and withdrawal, minimal responses, rambling, apathy and indifference, concreteness, indecisiveness.
2. *Manipulation*—discounting, acting seductively, externalizing responsibility, misunderstanding, threatening harm, superficial compliance, dependent behaviour.
3. *Restricting Content*—making small talk, intellectualizing, forgetting, focusing on limited topics, asking irrelevant questions, constantly complaining.
4. *Violating Rules*—missing appointments or coming late to sessions, delaying payment, making improper requests, making frequent unnecessary telephone calls, failing to complete tasks.
5. *Hostility*—verbal attacks/criticisms of counsellor or counselling process; argumentativeness; stubbornness; blaming others for problems; enraged, belligerent, or defiant behaviour.

Respondents were asked to rank order the five broad categories in terms of their frequency of experience in the counsellors' practice and to indicate the subtypes of resistance they had experienced most frequently. Rank ordering indicated that Restricting Content was the type of resistance counsellors encountered most frequently followed in order by Withholding Communication, Manipulation, Violating Rules, and Hostility.

Most frequently encountered subtypes of resistance included blaming others for problems, making small talk, externalizing responsibility (similar to blaming others), missing appointments or coming late to sessions, and failing to complete agreed tasks. Counsellors reported encountering passive forms of resistance far more likely than they did aggressive forms of resistance.

When repondents were asked which of the five major categories of resistance they found the most difficult to manage, responses varied considerably. Hostility was the most frequent choice, selected by 30%, but 24% chose Withholding Communication, 21% selected Manipulation, 15% chose Violating Rules, and 10% selected Restricting Content.

COUNSELLORS' REACTIONS TO RESISTANCE

Although the term resistance seems likely to have negative associations, counsellors actually have a wide variety of reactions to that process. Respondents were asked what feeling was most commonly elicited in them by resistant clients. They were given a choice of 15 responses culled from the authors' review of the literature as well as the option of writing in their own response. Frustrated and Challenged were the most common reactions, each selected by approximately 30% of the respondents, while Cautious was the third choice, selected by 9%. However, other reported feelings included, in order of frequency, Impatient, Creative, Angry, Neutral, Irritated, Attacked, Vulnerable, Bored, Helpless, and Excited. No respondents selected Disliked or Hopeless.

Clearly, working with resistant clients is not always a negative experience. This is supported by counsellors' responses to the question of how often they enjoy working with resistant clients. Over half (58%) reported they sometimes enjoyed dealing with client resistance while 25% said they often enjoyed the process and 3% always enjoyed it. On the other hand, 12% rarely enjoyed dealing with resistance, while only 1% never enjoyed it.

HANDLING RESISTANCE EFFECTIVELY

In determining how counsellors typically address resistance, the questionnaire presented respondents with a list of 40 techniques, cited in the literature as useful in handling resistance. The techniques most frequently used include empathy (24%), confrontation (14%), reframing (9%), and self-disclosure (6%). Other techniques were individually selected by fewer than 5% of the respondents.

When they were asked to indicate at least five but no more than ten techniques they often used to address resistance, empathy, selected by 66%, reframing (58%), and confrontation (47%) again were the most often cited. Less commonly used interventions incuded humour (44%), rapport building (40%), self-disclosure (32%), goal setting (30%), metaphors (29%), problem solving (26%), providing structure (24%), questioning (24%), reflection (23%), focusing on positives (23%), lowering anxiety (22%), interpretation (21%), making a contract (20%), focusing on nonverbals (20%), homework (19%), using paradox (18%), providing freedom (16%), visual imagery (16%), changing expectations (15%), setting limits (15%), bibliotherapy (14%), modeling (14%), silence (12%), summarizing (12%), doing the unexpected (10%), shifting focus (9%), hypnosis (8%), skill training (7%), giving away power (6%), piquing curiosity (6%), focusing on the past (5%), referral (5%), termination (3%), increasing anxiety (3%), inducing frustration (2%), having client review tapes of sessions (1%), and giving up (1%).

Clearly, counsellors have a broad repertoire of skills to use in dealing with resistant clients. It is interesting that the three relied on most heavily, empathy, reframing, and confrontation, are very different in nature, reflecting the lack of consensus on the one best way to handle resistance.

Counsellors also are divided on when they address resistance. Although 31% were most likely to address resistance as soon as it was recognized, 64% waited until rapport was established. Only 4% waited until many demonstrations of resistance had been manifested and 1% never addressed resistance.

Counsellors are very likely to seek help with their resistant clients via supervision or peer consultation. Nearly 70% of the respondents stated they always or often sought advice on resistant clients, while 25% sometimes consulted a colleague.

Some counsellors try to anticipate client resistance and take steps to avoid it. Although most of the respondents did not screen out potentially resistant clients, 13% reported that they tried to screen out difficult or resistant clients. In addition, 77% of the respondents always or often gave clients information about the nature of counselling during or prior to the first session while only 10% rarely or never supplied that information.

Although survey results indicate that giving up is not a preferred mode of response for dealing with resistance, sometimes counsellors believe resistance is so insurmountable, they terminate their relationship with the client. Half of the respondents indicated that they had at least once terminated counselling because a client was resistant or uncooperative, while 53% reported that they had referred a resistant client to a colleague. Most common reasons for counsellor-initiated termination included missed appointments and the client not being motivated to change. Only 6% expressed the belief that counsellors should never give up on a resistant or difficult client, while 85% suggested that counsellors should often or sometimes stop working with such clients. At the same time, counsellors do not seem quick to give up on clients; 85% reported that they would take steps to contact a client who had missed an appointment without notice.

CHARACTERISTICS OF RESISTANT CLIENTS

In an effort to develop a profile of a typical resistant client, respondents were asked to describe their most resistant client. This information must be interpreted with particular caution because each reply is based on the sample presented by each therapist's practice and is in no way based on a broad or representative group of clients or of the general population.

Most respondents reported that their most resistant client was an adolescent, a young adult, or an adult in mid life. Nearly 80% stated that their most resistant client was White. Forty per cent viewed men and

women as equally resistant while approximately 20% viewed women as more resistant and 40% viewed men as more resistant. Intelligence level was most likely to be average or above average, while socioeconomic level was most likely to be middle class or lower-middle class. Single and married clients were about equally represented as candidates for most resistant client, while separated clients were selected more often than divorced clients as most resistant. Although resistant clients came from many referral sources, court-referred clients were viewed as the most resistant.

Diagnosis was expected to bear a relationship to resistance. Respondents were asked to indicate the two disorders most frequently manifested by resistant clients. Four disorders were selected with approximately equal frequency: personality disorders, selected by 31%; substance abuse, by 31%; antisocial/aggressive behaviour, by 30%; and depressive disorders, by 27%.

CONCLUSION

The findings from the survey reported in this article are limited in generalizability since they were based only on responses from mental health counsellors. Counsellors in schools, colleges, and other settings might have different perceptions of resistance and that should be explored.

This article, however, has indicated that client resistance is a pervasive phenomenon, of relevance to almost all counsellors. Although practitioners seem to have some agreement on terminology and definition of resistance, reactions to and treatment of resistance vary widely. Further research is needed to provide more information on effective treatment of resistance as well as on the relationship between counsellors' responses to resistance and their effectiveness in coping with resistance in clients.

These findings are encouraging in demonstrating that therapists certainly have a great deal of company in their efforts to understand and address resistance; that a broad range of interventions are available to reduce resistance; and that sometimes, resistance can be positive in its reflection of growth and in the interesting challenge it presents to the therapist.

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