"I dare you to try and heal me": Alliance formation for cases of complex resistance

DAN SHORT

The notion of 'resistance' in therapy has a controversial history—when interpersonal interactions do not go well, the tendency is to blame the problem on the personality of the person seeking professional care. In this article, DAN SHORT explores the notion of 'complex resistance' in which the client seeks a powerful intervention and, at the same time, is ambivalent about treatment. Such clients may announce they are ready to comply with the treatment they desperately need, but then respond with resistance to any procedure that requires compliance. Clinical situations characterised by this form of resistance are viewed as a display of complex interpersonal needs that if unmet will result in prolonged frustration for both client and therapist. In preference to traditional responses of blaming the client or referring on, the task of the skillful therapist is to adjust his or her style of relating in order to meet the needs of a particular client. A case study is used to illustrate how to respond to complex resistance through an interplay of dominant and submissive postures that is sensitive to the unique needs of each client.

The decision to request treatment from a psychotherapist, or mental health counsellor, can create feelings of apprehension in almost anyone. However, for some individuals, the decision to seek professional help can feel as necessary as breathing, yet as threatening as taking a dive off a cliff. Therefore, it is not surprising that care providers occasionally encounter clients whose ambivalence produces refractory behaviour.

For example, recently I sat across from a woman who, when asked what she wanted from therapy, curtly replied, *"I have issues with control, especially when it comes to males"*. As I was wondering whether she should have chosen a female therapist rather than a male, she added that she wanted me to use hypnosis with her (i.e., a procedure that is likely to exacerbate control battles). Further clarifying her position, she added, *"Over the years, I have seen many hypnotists. None of them have been able to get me into a satisfactory trance"*. The contradictions were not in her words alone. While inviting me to exercise great influence over her, she sat with her arms crossed and her spine rigid, as if making a dare. This was not the first time I had seen this behaviour. The defiant stare, the arms folded across the chest, and the history of failure by other therapists are the tell-tale signs of *complex resistance*.

I use the term 'complex resistance' to differentiate this dynamic from other more common forms of resistance. With resistance that is less complicated, the client merely feels uncomfortable receiving direction from an authority figure. What we know from research is that clients with high resistance respond better to self-control methods and minimal therapist directiveness, whereas clients with low resistance experience improved outcomes with therapist directiveness and explicit guidance (Ackerman et al., 2001). However, in the case of complex resistance, the client is seeking a powerful intervention and, at the same time, is defending him or herself against outside influence. What makes the situation particularly tricky is that this deep ambivalence often exists outside the realm of conscious awareness. Rather than recognising that he or she is torn in two separate directions, the individual will transpose the struggle onto the interpersonal context.

When a client is ambivalent about his or her role as someone submitting to psychological care, and is convinced that he or she has no reservations, then that individual will remain unaware of their intentional efforts to defy the

therapist. Under these circumstances, a confusing set of interpersonal dynamics can occur. Such clients may announce they are ready to comply with the treatment they desperately need, but then respond with resistance to any procedure that requires compliance. In other words, they are only aware of the positive half of their ambivalence and do not recognise the existence of negative attitudes that impede their willingness to comply.

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To understand how this happens, it is helpful to recognise that when highly inconsistent cognitions are rendered accessible simultaneously, negative affect is experienced (Newby-Clark, McGregor, & Zanna, 2002). Because this affect is aversive, there is an intrinsic drive to avoid awareness of the cognitive inconsistency. Thus, it is possible for clients to believe they should submit to care, while not noticing that they do not feel like accepting the guidance they are requesting. This is essentially a split between cognitive and affective processes. In cognitive validation, the attitude is tagged as either true or false (e.g., *'It is right to comply with treatment requests—true'*). In affective validation, the attitude is associated with positive or negative affect (e.g., *'This situation feels good'*, or *'This situation feels bad'*). Because these processes are presumed to reside in independent mental systems, the two attitudes can be affected and act independently (Petty & Brinol, 2006).

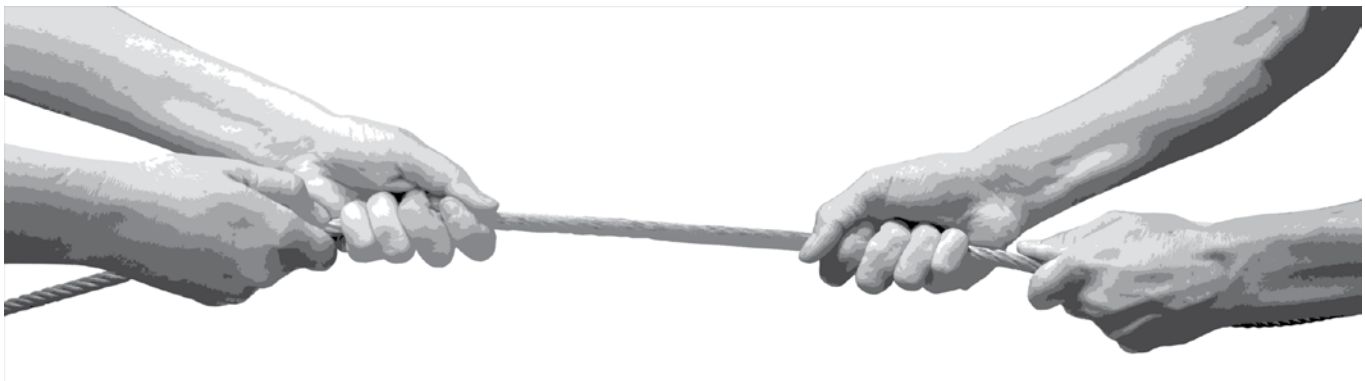
Returning once again to the client mentioned earlier, after I agreed to use hypnosis with her, I felt it would be helpful to give her more space to exercise her ambivalence. Therefore, I carefully asked, *"Are you ready to start?"* She promptly responded, *"My bladder needs emptying"*. To justify her actions, she added, *"They call me Tiny Tank"*. She then headed out the door. We were less than ten minutes into the session and she had already physically left the office, thus making it impossible for me to do what she had just requested. In other words, she knew what type of care she needed, but she did not feel ready to submit to this care. Of course, after she returned, she made further attempts to block the type of care she was requesting (e.g., as soon as she returned to the office, she grabbed her water bottle and took another long drink—just in case). This was not just a matter of resistance, it was a display of complex interpersonal needs that if unmet would have resulted in prolonged frustration for both this client and myself.

Fortunately, there is a remedy for this type of impasse. In the case of this client, I was able to negotiate an acceptable trance experience within the first 30 minutes of meeting her. After she awakened, she sat silent and motionless for a couple of minutes and then commented that she had never experienced anything like this before. By the end of the second session, we were able to have a clear and straightforward discussion about her needs. At the end of the third session, she decided she was in a much better place psychologically, and that her primary goals had been realised. Exactly how this positive outcome was achieved, with her and many similar clients, will be the focus of this article.

Why individualise treatment

To begin this explanation, it is important to note that all clients come to therapy with a unique set of social abilities, with different degrees of tolerance for supportive care, and thus very different interpersonal needs. Therefore, clients cannot all be treated the same. A style of relating that is perfectly acceptable for one client may not be for another. The task of the skillful therapist is to adjust his or her style of relating in order to meet the needs of a particular client. Similarly, as highlighted by Duncan (2010), what makes some therapists better than others is their ability to secure a good alliance across a variety of client presentations and personalities.

This level of expertise requires sensitivity to differences and flexibility in responding. In other words, it is not enough to practice as a technician, with three or four techniques that



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are used at the start of each session. For expert care, a greater level of discernment is required. While most relationships formed within the general community can rely on standard social protocol (i.e., good manners), relationships in therapy require a more sophisticated understanding of interpersonal dynamics (Short, 2010). In choosing their actions, therapists need to be able to predict which responses to expect from the client, so that immediate emotional states and prominent situational factors can be used as building blocks upon which the therapy is constructed. This skill is important because, as demonstrated in research, an individually responsive relationship is associated closely with positive outcomes in therapy (Ackerman et al., 2001).

Unfortunately, since the beginning of psychotherapy, when interpersonal interactions do not go well, the tendency is to blame the problem on the personality of the person seeking professional care. This is a distortion in the attribution process and it has been known to impact clinical judgement (Ross, 1977). As an analogy, in the same way that an unhappy spouse might attribute his marriage problems to the selfishness of his wife—while failing to recognise his own contributions to the problem—an unhappy therapist might attribute problems in therapy exclusively to client resistance. Few bother to analyse the relationship as a set of evolving dynamics in which nonproductive interaction strategies can be replaced by other more successful strategies. There is also an equally disempowering tendency to attribute the problem to fate: *"I am going to have to refer this client to a different therapist because we simply do not have the right chemistry."* The latter is a person × partner causal attribution—the notion that a fit between one's own traits and their partner's traits acts as the sole determinant of relationship quality. However, this view does not take into account the impact of the physical and social environment on relationship formation, or the effect of interpersonal dynamics under volitional control (Berscheid, 1999). These biases can lead to a premature abdication of the professional's responsibility to build a positive working alliance. Accordingly, one survey found that when therapists were asked how they handle failing cases, 30% said they refer to someone else, 41% continue with the same treatment, and only 26% said they change their treatment (Kendall, Kipnis, & Otto-Salaj, 1992). As will soon be seen, it is not necessary to blame the client, or automatically refer out, when the therapy relationship is not flourishing. The other option is for the therapist to change his or her approach.

How to respond to complex resistance

Do not feel bad if in the past you have had difficulty working with clients affected by the type of ambivalence described above. You are certainly not alone. On more than one occasion I have listened to a keynote speaker, or other equally prominent therapist, humbly describe their experience with a client who seemed to want help, but whose symptoms got worse as the therapist applied well-documented, evidence-based techniques. According to these speakers, a seemingly inexplicable turn of events occurred when the therapist finally confessed to the client that his approach had failed and that he felt rather powerless. Following this act of surrender, the client would make instant and sometimes remarkable progress. As would be expected, there was also reports of an overall improvement in the therapeutic alliance. Given the fact that progress is possible, the next step is to gain a better understanding of what needs to be done and how to do it during the *first* session (rather than stumbling onto the solution, out of sheer fatigue, ten or more sessions down the road).

While the following strategies are derived from my experience with clients who came to me with a history of failure in treatment, there is also some independent research that seems to support the theoretical perspective offered in this article. More precisely, it has been found that interpersonal antecedents influence subjective feelings of ambivalence. Furthermore, this influence is greatest for high-importance topics, and the valence of the relationship moderates whether the influence is positive or negative (Priester & Petty, 2001). What this means for therapy is that the therapist is in a perfect position to reduce or even eliminate the client's experience of ambivalence, if he or she knows how to maintain positive interactions that are mutually rewarding.

Even if one's intent is positive, it is not wise to try to force change upon a client.

Rather than viewing this problem exclusively through the lens of resistance (i.e., an intrapersonal perspective), I make sense of these complicated needs in terms of ambivalence about dominance and submission (i.e., an interpersonal perspective). As mentioned earlier, in common cases, a client will either be more comfortable with a directive approach (dominant therapeutic posture) or a client-directed approach (submissive therapeutic posture). However, clients who are exceedingly ambivalent are not entirely committed to a position of dominance or submission.

With this population, seemingly straightforward requests for help are not exactly what they seem. When a client says to a therapist, *"You just need to tell me what to do"*, there seems to be a readiness to submit to care. However, if the comment is examined more closely, you can see that the communication contains internal contradictions. The client has stated simultaneously a conscious intention to submit *and* a felt desire to maintain a position of dominance. Otherwise, why would he or she be telling the therapist what to do? The client has issued a command. Equally dominant is the statement *"I want you to hypnotise me and make me do X, Y, or Z"*. My experience has been that if the therapist acts on the explicit request for a highly directive intervention, clients

who are ambivalent automatically shift their energy to the implicit imperative, which is to resist the process (e.g., *"I'm sorry to interrupt you again, but I suddenly realised I need to go to the bathroom"*). In other words, some clients both want to be in control *and* want someone else to take charge. They want treatment and at the same time wish to remain unaffected.

The solution I have learned to use for this dilemma is to meet the client's needs on both sides of his or her ambivalence. This requires a willingness to take charge of the total situation after having surrendered to the client. In order to have a good understanding of this strategy, one should begin with a careful study of the interpersonal dynamics that underlie ordinary resistance.

Most individuals possess an instinctual tendency to resist or oppose anything that seems to unjustly limit their freedom of choice. Coercive forms of dominant behaviour are likely to produce a stronger desire for whatever it is that has been denied (Miller & Rollnick, 2002). That is why a therapist should not take unilateral action against the client's symptoms. There is a strong instinct in humans to resist any unsolicited attempt to take away something that has become associated with the *'self'*. As most parents know, this instinctual behaviour can be seen clearly in children as young as two years of age. Even if one's intent is positive, it is not wise to try to force change upon a client. Remember, the strength of the therapeutic alliance is associated closely with positive outcomes in therapy, while efforts by therapists to control client behaviours have been correlated negatively with alliance (Lichtenberg et al., 1998). What makes complex resistance so confusing is that the client seems to be telling the therapist to take away the symptom, so if the therapist eagerly complies and tries to take away the symptom—which the client is ambivalent about surrendering—is the client or the therapist in a dominant position? The answer is that both are seeking to exercise dominance, and thus neither are likely to feel comfortable with the relationship. The same type of trouble would develop if each was seeking a submissive position.

When interpersonal dynamics are not complementary, the most likely outcome is mutual frustration and disappointment.

My experience has been that in instances of complex resistance, the client needs a therapist who can simultaneously meet his or her need to submit *and* to be in charge. In other words, the therapeutic posture is one of submissive dominance. The therapist will not succeed by submitting entirely to the will of someone who does not know what he or she wants. Similarly, the therapist will not succeed by constantly dominating someone who needs to know that he or she is in charge. This is why therapists are wise to take charge of the total situation after having surrendered to the client.

In order to see what this might look like, we can return to the case I have been using as an example. When I asked this woman if she was ready to go into her trance, I was exercising dominance. She said that she had to go to the bathroom so I stopped what I was doing and waited on her (i.e., submission). I was not frustrated or tense when she returned because she was doing exactly what I felt she should be doing (i.e., identifying her needs and then finding a way to express or assert those needs). After returning, she told me that Ericksonian strategies work best with her, so I agreed to use an Ericksonian strategy (i.e., submission). Then, I told her to close her eyes and do what she does best, resist going into a trance! (i.e., strong dominance). She responded with instant compliance, she closed her eyes and tried to resist going into a trance. This was an Ericksonian strategy, so I was doing what she told me to do. She went quickly and easily into a deep trance so she was doing what I told her to do. When I suggested that her arm was about to float up in the air all by itself, I also added that it was just fine with me if her hand remained where it was, but that she might want to know what it is like to experience arm levitation (which she did). As you can see, I was moving rapidly between both sides of her ambivalence, thereby neutralising the ambivalence or making it irrelevant. All that was left was an enjoyable exchange between two people. When she awoke, she was delighted with her experience and I was happy to share that joy with her. For the rest of her first visit, she was reasonably cooperative. Although she chose not to complete my end-of-session feedback form, she did take it home with her. Before leaving, she commented that she felt understood and certain that the

therapy accomplished positive results, which she had not expected (i.e., she politely refused my request to complete the end of session feedback form, while submitting to my request to provide me with feedback about her experience in therapy).

If you are not familiar with hypnosis or Ericksonian strategies (Short, Erickson, & Erickson-Klein, 2005), then my example may seem strange and complicated. However, it is not a difficult process. All that I am doing with the client is taking turns with who is in charge. The same process can be used while delivering cognitive-behavioural interventions, processing emotions, or using a psychoeducational approach. The ambivalence is tied up by first meeting the client's demands, then adding on your own demands and waiting to see if the client will make new demands, which you submit to and then follow up with a dominant response. This cycle is repeated until the client decides that meaningful change is taking place. Fortunately, it does not seem to matter in which direction the cycle proceeds. For example, if the therapist assumes a dominant posture by applying a technique (e.g., offering advice, using hypnosis, or replacing dysfunctional thought patterns) and, when progress is not forthcoming, he or she switches to a submissive posture by admitting failure, a surprising thing occurs—the resistance disappears. In other words, if the therapist meets the client's self-contradictory needs, by offering behaviour that is both dominant and submissive, the ambivalence is nullified.

As mentioned earlier in the article, it is vitally important that the interactions between client and therapist remain positive. This is what makes the exchange feel safe for the client, thus making it much easier to resolve his or her ambivalence about seeking help from a therapist. To achieve this, the therapist must have some means of remaining calm and confident, even when his or her actions have been questioned or outright rejected. When I encounter a client who insists on receiving direction yet responds with resistance, my tendency is to isolate my initial display of dominance to a small component of the therapy (e.g., processing the client's emotions for a specific event). Afterward, when the client insists that the technique was not helpful, I am able to affirm the client without having to discount myself or the value of the total therapy relationship. For example, I might say, *"After having given it a good try, I see that discussing your emotional experiences is not going to produce the results we need. It seems that you are ready for a more advanced form of counselling. So now please tell me about the insights you gained from the event."* After I've secured the client's confidence in this way, the resistance typically vanishes. Once again, the submissive posture of the therapist is temporary and timed to occur at a strategic moment, as is the subsequent dominance.

One last point is to mention why the use of reason and explanation are not a sufficient means of addressing this type of resistance—the main problem being that this sort of ambivalence often exists outside of conscious awareness. Thus, when you try to tell clients that they are asking for help and then blocking the help that you offer because they are ambivalent, the response is not favourable. My experience has been that this only frustrates the client and causes him or her to believe you are making up excuses to cover your ineffectiveness as a therapist. The other reason this type of logical explanation is not likely to work is because it will seem to the client that you are telling him that he does not know what he is feeling inside and that somehow you do. In other words, this dominant behaviour might feel condescending and, if so, is likely to weaken the alliance. This is similar to problems that develop in the alliance when the therapist resorts to the use of transference interpretations to deal with resistance (Piper, Azim, Joyce, & McCallum, 1991).

Remember, these are clients who are highly resistant. and therefore inclined to disagree with their therapist. Thus, the way to make logic and reason work interpersonally would be to submit to the client when he tells you that you are wrong, and thus you agree that he is not ambivalent. This still leaves the idea lodged in the client's mind and available for later consideration (in the privacy of his own home). Using this strategy, I have had some clients return the following week and announce they have had a new insight. They may then tell me the idea that I had communicated earlier, but without any conscious recognition of its origins. This again offers an opportunity for the therapist to submit (i.e., by validating the client's new insight), and then exercise dominance (i.e., directing the client to explore the implications of his new insight). Once again, the interpersonal dynamics are of primary importance, while the intellectual processing acts as an adjunctive intervention.

Broader implications

Hopefully, it is obvious by now that although hypnosis was the technique used in the case example, the principles that have been described apply to the use of any technique or procedure. Any attempt to provide direction, whether it be cognitive behavioural interventions, experiential techniques, or even reflective listening, can be met with the type of response described in this article. Therefore, regardless of the theoretical orientation of the therapist, the negotiation of a comfortable interpersonal exchange between client and therapist is needed to ensure the business of providing care can proceed.

These interpersonal dynamics commonly operate outside of conscious awareness, but that does not mean that they are not amenable to volitional control. Just the opposite is true. Once the therapist recognises that, on a minute-by-minute basis, they have the option of utilising either a dominant or submissive posture, then the opportunities for exercising good clinical judgement increase dramatically.

While the main focus of this article has been on ambivalence about treatment, there are many other things about which a client can be highly ambivalent. Those who have worked in the field of domestic violence know it is not uncommon to see clients who are ambivalent about whether or not to leave the relationship. When well-intentioned friends, family members, or therapists begin to pressure the person to leave the relationship, an unfortunate result occurs. She suddenly becomes less aware of the part of

her that wishes to leave. Thus many frustrating conversations ensue, with the client defending the perpetrator and desperately trying to explain how much she loves him. Once professional care providers become aware of the interpersonal dynamics of ambivalence, and how it can translate into interpersonal conflict, they can avoid getting caught up in these types of nonproductive struggles.

Finally, the most general point to be taken from this discussion is that it is not enough to have only one way of engaging clients. Some clients come to therapy requiring a great deal of direction and guidance, some need a safe space to assert themselves and, as described, some need both. When the therapist is willing to accept full responsibility for creating a satisfactory interpersonal fit, then the probability of creating a strong therapeutic alliance with a wide variety of clients greatly increases.

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AUTHOR NOTES

DAN SHORT Ph.D. is most well-known for his scholarly work in Ericksonian hypnosis and short-term therapy. He is the lead author of *Hope and Resiliency*, a best-selling book that has received world-wide attention. His most recent book is *Transformational Relationships*. Dr. Short maintains a practice in Scottsdale, Arizona where he continues to learn from those he seeks to help.

Comments: hope@iamdrshort.com