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Examining Therapist Experience with Resistant Clients

Elisha Ibebunjo

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**EXAMINING THERAPISTS' EXPERIENCE WITH NON-PSYCHOTIC
RESISTANT CLIENTS**

Doctoral Dissertation Research

Submitted to the Graduate Faculty of

National Louis University

College of Professional Studies and Advancement

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education in Counseling Psychology

By

Elisha I. Ibebunjo

June, 2021

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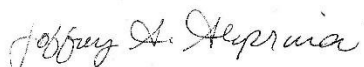
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ABSTRACT

This qualitative phenomenological study involved an exploration of the lived experiences of 10 licensed therapists with substantial encounters with resistant clients. The phenomenon under investigation is relevant to those working in the mental health industry because resistance in psychotherapy is a common challenge. It is not a matter of if a therapist will encounter resistant clients, it is a matter of when. The goal in this qualitative study was to discover how the 10 participants, all of whom were experienced therapists, navigated through resistance; to identify the methods and procedures they used; and to compile their successful approaches and methods into recommendations for supervisees, supervisors, and counseling educators. The findings of this study revealed therapists' perceptions of resistance depended on their own theoretical orientation. Also, therapists providing mandated counseling were more likely to encounter resistance than were those providing voluntary therapy. Results also showed resistance to therapy is not all negative, but a positive indication of effective therapy as opposed to a passive response to therapy. Other findings that emerged in this study included that motivational interviewing is an effective approach in encouraging ambivalent clients. Though resistance in therapy is a challenge to therapists across various modalities, it can develop the acumen of therapists when they persevere. Finally, some suggestions were advanced to clinicians and counseling educators and areas for future study were recommended.

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DEDICATION

This study is dedicated to my Savior and Lord Jesus Christ.

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CHAPTER I: INTRODUCTION

Background of the Problem

In a therapeutic relationship, the rapport between the therapist and client is an essential factor that influences the therapeutic outcomes both in individual and group therapy (Aviram et al., 2016; Yalom, 1995). When a client is resistant to therapy for any of a variety of reasons, other than psychosis, the result can be a lack of therapeutic rapport, collaboration, and trust, as well as a failure to accomplish therapeutic objectives and goals (Aviram et al., 2016). The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of therapists with clients' resistance to psychotherapy in order to illuminate their experiences and hopefully equip novice therapists with a functional perspective and approach to managing and mitigating resistance in therapy.

To better facilitate this qualitative study, the phenomenological approach was used to explore the lived experiences of the participants as a means to identify patterns and relationships (Creswell, 2006, 2008; Levitt et al., 2018). Results reflect the behaviors of non-psychotic resistant clients, the challenges encountered by therapists throughout the therapeutic process, the intrapersonal and the interpersonal experiences from the therapists' viewpoints, and the potential impact of resistance on therapeutic outcomes.

This researcher did not necessarily intend to seek solutions to dealing with non-psychotic resistant clients but intended to examine the therapists' personal experiences. This included therapists' perceptions of the resistance, ways therapists navigated through resistance, and how resistance affected the therapeutic dynamics and outcomes.

Significance of the Problem

Encountering resistance on the part of clients is a common experience for providers in the mental health industry. Westra et al. (2012) found treatment noncompliance and resistance to change to be significant determinant variables in treatment outcomes. Correspondingly, results of a recent survey of therapists' experiences conducting cognitive behavioral therapy (CBT) for generalized anxiety disorder revealed most participants acknowledged client resistance as a hindrance to treatment efficacy (Szkodny et al., 2014). Similarly, Zickgraf et al. (2015), in a study on factors associated with therapeutic progress and outcomes, indicated variables such as resistance and ambivalence have a strong impact on both process and outcome. In spite of the significant impact of resistance on mental health therapy, it has not received adequate attention in the qualitative psychotherapy literature.

Purpose of the Study

There were several purposes for conducting this study. First, this researcher has experienced resistance with non-psychotic clients and has wondered at each encounter, "What did I do wrong or what could I have done differently?" Consequently, the decision was made to examine this phenomenon as a means to better understand the dynamics in play with resistant clients in the therapeutic relationship.

Another purpose of this study was to gain insight from veteran therapists who have encountered similar cases. Specifically, the intention was to understand the therapists' intrapersonal conditions during the experience, the strategies they used in the process, and the impact on therapeutic outcomes. The goal was to conduct a firsthand

examination of fellow clinicians' ways of dealing with a non-psychotic client's resistance.

The final purpose of this study was to respond to curiosity; except in a supervisory experience, clinicians hardly talk about their unsuccessful experiences. They are more inclined to share their success stories than they are to share unpleasant stories about unmotivated clients or almost impossible cases. This researcher's intention was to examine the experiences of other counselors and provide awareness to empower counseling educators, current therapists, and students who will become therapists.

Initial Review of the Literature

Some quantitative studies have been conducted on the impact of resistance on the therapeutic process, though a search of the current literature revealed not enough phenomenological studies have been done on the subject. One study showed clients with issues such as addiction, youth with behavioral problems, single parents, sexual offenders, mandated clients, unemployed clients, discouraged clients, and unconfident clients are more prone to resistance (Amundson & Borgen, 2000). Flückiger et al. (2020) reported clients who are more likely to be resistant to therapy are youth, mandated clients, street workers, single parents, and ethnic and cultural minorities. However, not all resistance is caused by the client, as therapist variables also can cause resistance, including the therapist's failure to fit the therapeutic strategy to the client's proclivities (Norcross, 2011).

One common factor among most resistant clients is the lack of desire or motivation to change. According to Prochaska and DiClemente (1983), there are five stages of change: precontemplation, contemplation, preparation, action, and maintenance.

Precontemplation is the stage at which there is no intention to change behavior in the foreseeable future. Lack of readiness is a predictor of resistance to change (DiClemente & Velasquez, 2002; Prochaska et al., 1992). The phenomenon of resistance almost mirrors the adage, “You can take the horse to water, but you cannot make the horse drink.” The movement of change is not usually linear but occurs in a back and forth spiral movement (Lang & Bliese, 2009). Identifying the level of readiness in a resistant client is crucial and ascertaining whether clients are willing and ready for a change is a prudent approach in dealing with resistant clients. When a client appears to be resistant to therapy, understanding the process of change and identifying the stage of change of the client is helpful (Prochaska et al., 1992).

Other literature showed some resistance is related to somatic problems, which was beyond the scope of this research (Shedden et al., 2020; Ryder et al., 2008). What has been written on the topic of resistant clients was presented in mostly quantitative and statistical studies (Hara et al., 2015; Urmanche et al., 2019). There have been few studies on the lived experiences of therapists related to dealing with resistant clients (Aviram et al., 2016; Levitt et al., 2018). The strategies therapists used in dealing with resistance needed to be explored and emulated. Thus, this study was designed to investigate the unexplored aspects of resistance from the perspectives of experienced therapists.

Research Questions

1. How does resistance in psychotherapy affect therapeutic rapport?
2. How does resistance in therapy affect the therapeutic process?
3. How does the attitude of the client affect the therapist?
4. How do therapists effectively navigate through the resistance?

Research Methodology

The chosen research methodology for this study was a qualitative phenomenological approach because the study was designed to examine the personal experiences of therapists. The intended population was therapists, such as licensed mental health counselors (LMHCs), licensed social workers (LSWs), and licensed clinical psychologists with a minimum of 10 years of experience.

A total of 10 counselors participated in this study. The procedure used to gather data was semi-structured questions posed during one-on-one interviews. Because hypotheses are rarely used in qualitative studies, the answers to the research questions emerged during the analysis of data. A questionnaire was used to gather demographic data to ensure the participants met the parameters for the study.

Limitations of the Study

Limitations are elements in a study that are outside of the researcher's control and that can potentially affect the researcher's endeavor to obtain accurate data and conclusions (Eisenberg, 2020). One of the limitations encountered in this study related to the number of participants. In spite of the elaborate effort this researcher invested in recruiting a large population of participants, only 10 therapists actually qualified and chose to partake in this study. A larger number of participants would have yielded more comprehensive data and findings (Petkari et al., 2011). However, Fusch and Ness (2015) reported that in qualitative studies where the number of participants ranges from 10–20, data saturation may occur if the number of participants exceeds 20, which means no data saturation can be claimed for this study.

The second limitation related to paying participants rather than using volunteers. The population studied (i.e., licensed therapists and psychologists) was unwilling to volunteer to participate. Instead, they insisted on billing this researcher their hourly rate of pay. Offering payment to clinical research subjects in an effort to enhance recruitment is a common yet uneven and contentious practice in the United States (Grady, 2005). Dunn and Gordon (2005) believed paying participants in a research study may negatively affect the study because payment unduly influences participation and thus obscures risks, impairs judgment, or encourages misrepresentation. That is what makes doing so a limitation to a study.

The third limitation is that the nature of qualitative research and the subjective nature of participants' accounts limited the generalizability of the results. The experiences of therapists may not necessarily be the same in every part of the United States. Findings would have had wider application if participants represented every region of the United States. Also, this researcher's opinion and bias could have influenced the results of this study. Steiner et al. (2010) recommended that qualitative researchers detach their bias and prejudice from influencing the research. On the contrary, Creswell (2006, 2008) believed researchers naturally bring some biases, experiences, and prejudices to a study.

Delimitations

The researcher made choices to maintain the boundaries set for this study. One significant choice was to investigate the phenomenon through the viewpoints of therapists rather than clients. Because some of the participants' clients were imprisoned, authorization from correctional institutions would have been needed to include those

clients. However, including those clients' experiences would have provided a more holistic understanding of the topic.

Another delimitation was collecting data face to face. This approach limited the scope of location of the participants because this researcher chose to only travel limited distances to collect data. Interviews were conducted only in person.

Definitions

Client/patient: The word "client" denotes a recipient of services. As it applies to counseling, its origin can be traced to the mid-20th century humanistic approach to psychological counseling promoted by Carl Rogers (i.e., client centered therapy). The word was specifically selected to avoid a connotation of being sick or ill. Users of this term (i.e., client) seek to convey a non-medical and humanistic approach to health care delivery that is thought to be more empowering to the actual recipient of health care (Rogers, 1951).

Degree of resistance: The extent to which a client pushes back against a therapist's suggestions, even those that could help solve mental or emotional health concerns. Resistance can be classified as mild, normal, or severe (Westra et al., 2012).

Mandated therapy: Mandated treatment is typically ordered by a court. A person might have to undergo treatment for a set period of time, receive an evaluation from an approved mental health expert, pursue treatment at a specific facility, or agree to treatment as a condition of probation or parole (Perloe & Pollard, 2016). This form of therapy has also become a widespread and commonly accepted practice on college campuses throughout the United States (Miovic, 2004). The practice bestirs heated

controversy and ethical challenges when college administrators require students to undergo counseling in instances of misconduct that pose little danger to self or others.

Psychosis: To be in an abnormal condition of the mind described as involving a loss of contact with reality (Moe et al., 2021). People with psychosis are described as psychotic (American Psychiatric Association, 2013, p. 34).

Psychotherapist: A clinician who helps people with a broad range of mental illnesses and emotional difficulties (American Psychiatric Association, 2013).

Psychotherapy: A general term for treating mental health problems by talking with a psychiatrist, psychologist, or other mental health provider. During psychotherapy, individuals learn about their condition and their moods, feelings, thoughts, and behaviors (Rogers, 1961).

Resistance in psychotherapy: Conscious, deliberate opposition to psychotherapeutic initiatives with clients who fail to understand or accept help (Aviram et al., 2016).

Summary

This chapter addressed the nature of resistance to psychotherapy (RIP), a problem that most therapists already have or will encounter. This study is important in light of the complexity of resistance to counseling. Therapists, especially those considered entry level, might want to explore ways to understand all the variables that cause clients' resistance and how to effectively navigate through them. This study was intended to advance some recommendations to that effect. Furthermore, this study was designed to contribute to the body of literature on the subject. Details of existing literature on this subject are discussed in the next chapter.

CHAPTER II: LITERATURE REVIEW

Resistance has been identified as a common problem in psychotherapy (Beutler et al., 2003; Norcross, 2011) though it is viewed differently within various models of counseling. A definition of the term resistance in psychotherapy (RIP) that encompasses all of the variations in several modalities is elusive. A general definition is a client's oppositional behavior to the therapist's leadership, resulting in a lack of collaboration between the therapist and client (Beutler et al., 2011).

Various theoretical orientations include a recognition of RIP as an important concern; however, therapists working within each modality conceptualize resistance from the lens of their model. For example, a therapist who works within the classical psychoanalysis theoretical perspective would conceptualize RIP as an unconscious process that displays as both a trait (i.e., genetic disposition) and state (i.e., circumstantial), which the therapist may interpret as a client's avoidant struggle to uncover painful unconscious materials (Lim & DeSteno, 2016).

Contrarily, those who subscribe to the cognitive and behavioral model would perceive resistance as an impediment to goal achievement and change that manifests through homework noncompliance, in-session debates, and other disengaging behaviors (Hara et al., 2015). A therapist who works from the humanistic model would perceive resistance as a type of self-feedback loop in which two opposing opinions result in a client's struggle to create and maintain stability in self-narrative (Greene & Petruzzello, 2015).

Other researchers have acknowledged resistance to counseling to be a multidimensional problem that includes cognitive, affective, and behavioral components

(Oreg, 2006). However, Verhulst and van de Vijver (1990) believed RIP is a special form of coping mechanism in which the client tries to defend against threats caused by the therapeutic process. Bischoff and Tracey (1995) defined resistance as any behavior that indicates covert or overt opposition to the therapist, the counseling process, or the therapist's agenda. Engle and Arkowitz (2006) stated clients who hold higher levels of ambivalence about change are more likely to oppose the therapist's leadership, and W. R. Miller and Rollnick (2013) viewed resistance as an interpersonal issue that involves tension between the counselor and counselee.

The cultural theory implies cultural evolution has affected economic, social, relational, and gender dynamics and is a factor in RIP (Grossberg, 2010). Grossberg (2010) further reported clients' intrapsychic ambivalences manifest as resistance within the therapeutic relationship. Most recently, Urmanche et al. (2019) reported ambivalence is a state of having simultaneous conflicting reactions, beliefs, or feelings toward change.

Historical Trend of Resistance in Psychotherapy

The Early Philosophers

The Ancient Greeks, such as Aristotle, lived centuries ahead of Freud and his identification of RIP in the early 1900s. Early philosophers in human behavior did not use the term RIP because the term was not yet coined. However, Aristotle and other philosophers of that time were familiar with ambivalence, which they described as the man who is equally hungry and thirsty. Aristotle perceived ambivalence as representing distinctions and conflicts between knowledge of the universe and personal experience (Organ, 1949). According to Watson (1978), the rest of the early philosophers, including Theophrastus and Galen (372 B.C.E.) and those in the Hellenistic and Roman eras from

300–100 B.C.E., understood the concept of ambivalence but lacked the empirical resources to clinically expound or validate the concept.

Origin of Resistance to Psychotherapy

The phrase resistance to psychotherapy emerged in the early 20th century and was uniquely recognized by Sigmund Freud as the concurrent presence of love and hate (Freud, 1920, 1940). Freud, the originator of the process of psychoanalysis, recognized the concept of RIP in 1892 (Freud, 1920). Adherents of the psychoanalytic model viewed RIP as an inherent unconscious effort by clients to avoid painful thoughts and feelings brought up during psychoanalysis (Weller, 2003).

In Freud's (1920) "Introductory Lectures on Psychoanalysis," he stated that when therapists try to relieve clients of the symptoms of their illnesses, they meet violent and tenacious resistance to treatment because patients are unaware of the unconscious root of the presenting problem. Consequently, such clients became resistant to therapeutic help. Freud's interpretation of resistance was similar to the theoretical foundation of psychodynamic theory, which indicates clients are suffering from suppressed and unconscious past trauma that still affects them in the present (Freud, 1940). According to Greenson (1967), soon after Freud's presentation of his insight on RIP, his contemporaries expanded on the concept and concluded resistance reflects all forces exerted in opposition to the processes and procedures of psychoanalysis, whether consciously or unconsciously.

Theoretical Perspectives on Resistance in Psychotherapy

By the mid-1900s, resistance in counseling had become a phenomenon that was recognized by scholars of various theoretical orientations (Verhulst, 1987). Developers of

various theoretical models perceived the concept from the lenses of their theoretical orientations. A general working definition of RIP was developed in the early 1900s that reflected thoughts, actions, attitudes, and beliefs that interfere with the accomplishment of specific therapeutic goals (Basham, 1992). Some therapists and theorists perceived resistance as a reflection of internal factors (intrapersonal conditions), whereas others perceived resistance as external factors (interpersonal issues) in the therapeutic relationship between the client and the therapist (Weller, 2003).

Psychodynamic Perspective

For decades, psychodynamic scholars reported resistance to be a reaction aroused when an individual's freedom is threatened (Wicklund & Brehm, 1968). Later, the psychodynamic definition evolved to describe every attempt by the client to resist access into their unconscious (Basham, 1992). The psychodynamic perspective was clear, as Freud (1896) wrote resistance reflects the unwillingness to bring suppressed memories into consciousness.

A major tenet within the psychodynamic model is that the cause of resistance is the client's unwillingness to reveal repressed painful memories. In other words, the client is hindering access to suppressed memories. Freud's followers built on his discovery by exploring resistance in the context of mourning (Holder, 1975), resistance in the context of adulthood and parent-child relationships (Arnett, 2007), resistance in the context of politics (Song & Eveland, 2015), and resistance in the context of sex treatment (Bronsard et al., 2010).

Cognitive Behavioral Theory Perspective

Cognitive behavioral therapy (CBT) is primarily oriented toward the relationships among cognition, mood, and behavior. Techniques used within this approach include identifying thinking patterns, deciding, questioning, doing, and re-deciding.

Psychoeducation is a common strategy in CBT and group therapy is used as a learning process for teaching new skills, ways of thinking, and ways to cope with problems (Corey, 2009). Cognitive and behaviorist therapists view resistance as a hindrance to goal achievement and change. One of the perspectives within the CBT tradition with regard to resistant clients is that resistance is a function of the therapist's skills or personal qualities and never a function of the client (Lazarus & Fay, 1990). Cognitive behaviorists perceive resistance as a failure to comply with therapeutic procedures and assignments (Priebe, 1995). A recent study on managing general anxiety with CBT showed a client's resistance limits the efficacy of CBT, rendering the display of resistant behaviors an important marker for clinicians (Aviram et al., 2016).

Humanistic Perspective

Subscribers to the humanistic model do not perceive resistance as a hindrance to therapy. Carl Rogers and B.F. Skinner did not focus on the concept of resistance, but on motivating the client with empathic positive reinforcement to effect change (Westra & Aviram, 2013). J. Martin (2017) stated the humanistic approach involves the use of therapeutic congruence, unconditional positive regard, and empathetic understanding to overcome any ambivalence or resistance on the part of the client. The humanistic model is client centered, client driven, client paced, client directed, and client timed; thus, resistance is almost nonexistent.

Gestalt Perspective

The idea within Gestalt theory is that psychological illness and wellness depend on how a person gets in touch or interprets interactions with the self, others, the environment, and the spiritual field (Corey, 2005). The perspective of resistance within the Gestalt approach aligns with the foundation of the theory, which is to restore the client's self-awareness internally, external, socially, environmentally, and spiritually (Joyce & Sills, 2018). Gestalt therapists have identified seven factors that contribute to resistance (Prosnick & Woldt, 2014): (a) confluence, (b) desensitization, (c) introjections, (d) projection, (e) retroflection, (f) deflection, and (g) egotism.

Priebe (1995) generalized that the Gestalt concept of resistance is as basic as a client's loss of awareness or distorted awareness, or simply, the client's attempt to work out an unresolved issue. Priebe went on to report that the Gestalt response to resistance is to encourage, explore, and heighten the client's intellectual, emotional, social, environmental, and bodily awareness in order to enhance purpose and meaning.

Systemic Model Perspective

Bowen's family system contains a focus on the reduction of anxiety, differentiation, and autonomy (Ng & Smith, 2006). The theoretical aim of the systemic approach is to understand the individual in relationship with others rather than in isolation, and also to identify deeply entrenched patterns within an individual's relationships and with family members (Peleg et al., 2015).

Those who subscribe to the systemic model do not recommend engaging in an oppositional stance with resistant client (Wark, 1994) but encourage therapists to provide the proper conditions for change. The therapist is responsible for the activation of change,

including avoiding confrontation (Ohlsen et al., 1988). Adherents of this model perceive therapy as a reaction to the dynamics of the system, or resistance to change within the family system (Basham, 1992).

Narrative Theory Perspective

Constructivists believe reality does not exist on its own; it is only a construct of an individual's subjective interpretation of an experience or observation (Wilson & Ritchie, 1994). Another study reported constructivism includes the view of resistance as repressing and refusing to reconstruct a negative construct (Nichols & Schwartz, 1995). Narrative therapy helps clients rewrite harmful storying of their lives (McKenzie-Mohr & Lafrance, 2017).

Factors Contributing to Resistance to Psychotherapy

Therapist Factors

There are both specific and nonspecific therapist variables that affect therapeutic relationships. Sandell et al. (2007) estimated therapeutic variables account for 9% of the variance in treatment outcomes. Leonhardt et al. (2018) reported the therapist variables that influence therapy can be divided into two categories: (a) relational variables, such as empathy, attachment style, unconditional positive regard, respect, warmth, and genuineness; and (b) professional variables, including theoretical orientation, training level, experience, view on psychotherapy, activity/neutrality, overall caseload, and supervisory status.

Another way variable that may contribute to resistance is adherence to treatment model (Lucero, 2003). A study on factors associated with therapists' adherence in CBT revealed clients' resistance noticeably diminished the CBT therapist's adherence to the

treatment model, even among most experienced therapists. The therapist's failure to adhere to the treatment model is a potential trigger for resistance (Zickgraf et al., 2015).

Another therapist factor is a lack of collaboration. When the therapist fails to involve the client in developing a collaborative agenda but imposes their agenda on the client, conflicts of interest may occur that potentially may trigger resistance (Mitchell, 2016). A collaborative alliance, including developing a session agenda, reduces client resistance and improves treatment outcomes (Beutler et al., 2011; Norcross & Lambert, 2019). Another study showed a variety of therapist factors, such as counseling alliance, diversity, and personality, are ways therapists influence the therapeutic process (Kivlighan et al., 2014). An essential component in breaking through resistance is maintaining a foundation of understanding through dialogue that engages the client's experience with empathy (Clark, 2010; Norcross & Lambert, 2019).

Relational and demographic variables such as age, gender, race, ethnicity, values, and client-therapist similarities can also be sources of resistance (Fowler et al., 2015). Personality variables include personality traits, attitudes, flexibility, kindness, trustworthiness, and adjustment capacity. Developmental and personal variables reflect the therapist's level of personal development, the therapist's functioning level, self-efficacy, degree of self-directed hostility, and interpersonal problems. One therapist relational variable that may contribute to resistance is a lack of empathy.

Empathy

Empathy literally means the power of understanding things outside the self (Safi et al., 2017). The ability to relate to feelings expressed by others depends on the ability of the therapist to compare them with personal experiences, which allows for an inference of

what the other person must be going through (Farrow & Woodruff, 2007). Empathic intuitiveness and perception are the result of the individual's cumulative psychosocial development and subjective experience of life. Most empathic responses occur automatically, but humans are also capable of voluntarily focusing their empathy on others (de Greck et al., 2012). Empathy involves both perception and an understanding of the client's struggles. External empathy is when the therapist recognizes, yet remains outside of, the experience of the client (Hart, 1999). Deeper empathy occurs when the therapist can think and feel about the inner life of the client. The clinician needs a clear and separate sense of self while attempting to be an observer who compares what they imagine the client experiences to their own repository of similar experiences (Hart, 1999). When the therapist is unwilling to connect deeply with the client or is incapable of doing so, resistance to therapy can occur.

Empathic closeness is, paradoxically, dependent on the ability to distance oneself from another in order to be able to observe the other without distortion (Guerra et al., 2011). Although the therapist senses what it is like to be where the client is, they retain their own identity. This is accomplished by imagining and modelling, or mirroring, the client to better experience what the world is like through the client's eyes (Hart, 1999). Occasionally, the therapist may experience particular emotions, thoughts, and body sensations that seem to come from the client. When that occurs, the therapist needs to discern the differences between their own emotions, thoughts, and sensations and those of the client. In such instances, telling the client what is occurring is useful, especially if the therapist feels certain emotions the client does not seem to display (Zimmerman & Bambling, 2012).

According to S. R. Miller (2015), empathic responses are of two types: validating and limit-setting. Validating responses mirror the client's feelings, experiences, and behaviors, thereby allowing the client to feel heard. Limit-setting responses allow the clinician to create an atmosphere of protective containment and an atmosphere of safety in the session, which functions to encourage the client's growth (e.g., if the client constantly interrupts the therapist, the therapist can note the behavior and interpret it as a way of expressing what the client feels, while at the same time encouraging the client to express feelings in another way). Empathy is a multiphase process that involves a series of experiences, including the therapist's attunement with the client's experience, the therapist's expression of empathy, and the client's reception of this expression (Wynn, 2006).

According to S. R. Miller (2015), responding empathically can assist the therapeutic process in the following ways: (a) by building rapport and the working alliance with clients; (b) by encouraging clients' exploration of feelings, thoughts, and behaviors; (c) by allowing clients to explore ambivalence toward change; (d) by providing methods to clarify clients' responses in sessions; and (e) by providing the foundation for later interventions.

Empathy is often described as either an affective phenomenon (affective empathy) relating to the emotions of the client, or as a cognitive construct (cognitive empathy) referring to the intellectual understanding of the client's experiences (Elliott et al., 2011). According to Elliott et al. (2011), therapeutic empathy is expressed in three main modes. The first is empathic rapport, in which the therapist exhibits a compassionate attitude toward the client and tries to demonstrate an understanding of the client's experience.

The second, communicative attunement, is an active, ongoing effort to stay attuned on a moment-to-moment basis with the client's communication and unfolding experience. Last, person empathy is a sustained effort to understand the kinds of experiences the client had, both historically and presently, that formed the background of the client's current experiencing.

Empathy can be classified as subjective, interpersonal, or objective (Clark, 2010). Subjective empathy relates to the therapist's awareness of their sensibilities and internal reactions in response to the experiencing of a client. When attempting to empathically understand a client, the therapist engages in a process involving identification, imagination, intuition, and felt level experiencing. Clark (2010) stated that when a therapist empathizes with a client, there is often a perceived similarity of experiences that evokes a level of identification, even if it lasts for only a moment. Through the process of identification with the client, the therapist may engage in an imaginative quest to infer what it might be like to be the client. Intuition relates to the therapist's sensitivity to immediate responses and hunches that come to mind in interactions with a client.

Felt level experiencing refers to resonating with a visceral sensation with the client. The therapist reacts in a bodily felt way to the evocative expressions of a client. Clark (2010) further reported interpersonal empathy involves perceiving a client's internal frame of reference and conveying a sense of the private meanings to the person. The therapist can empathically understand the client on an immediate here-and-now basis and also develop a general sense of how the client experiences life from an extended empathic perspective. The third type Clark discussed is objective empathy, which relies

on a consensus of judgements from reputable reference groups composed of individuals external to a client's frame of reference.

Understanding the client on an emotional level and evoking the right atmosphere reduces client resistance. Shared emotions and physiological arousal experienced between the client and therapist contribute to the empathic connections developed during psychotherapy (S. R. Miller, 2015). A much stronger working alliance is formed in therapy when clients perceive their therapists as communicating higher levels of empathy (Stebnicki, 2008). Based on their meta-analyses, Elliott et al. (2011) made the following clinical recommendations: (a) an empathic stance on the part of the therapist is an essential goal regardless of theoretical orientation, (b) therapists must make efforts to understand their clients and demonstrate this understanding through responses that address the perceived needs of the clients, (c) therapist responses that accurately answer to and carry forward the meaning in the client's communication are highly useful, (d) empathetic understanding responses convey the understanding of client experience, (e) empathic affirmations are attempts by the therapist to validate the client's perspective, (f) empathic evocations try to bring the client's experience alive, and (g) empathic conjectures attempt to get at what is implicit in the client's narratives but not yet articulated.

Elliott et al. (2011) further explained that by expressing empathy, therapists assist clients to express their emotions and experience, which, in turn, enables clients to deepen their experience and reflexively examine their feelings, values, and goals. Additionally, empathy entails individualizing responses to certain clients. Fragile clients may find the usual expression of empathy to be too intrusive, whereas hostile clients may find empathy

to be too directive; empathy has to be offered with humility and consideration of the client's receptibility. Elliott et al. stated therapists must remember they are not mind readers and clients may not feel understood even if the therapists make every effort to understand them. Therapists should seek to offer empathy in the context of positive regard and genuineness.

Unconditional Positive Regard

In 1951, Carl Rogers emphasized three basic conditions for therapeutic change with less resistance: empathy, unconditional positive regard, and genuineness. Many years later, Tolan (2011) agreed with Rogers's approach and presented conditions that reduce resistance to therapy. The first precondition in the therapist–client interaction is psychological contact. When individuals feel uncomfortable, threatened, or angry, psychological contact can be blocked. Both the therapist and client have a certain availability for psychological contact depending on personality and cultural variables. Tolan stated everyone has a certain tolerance level; there are things to which they adapt more easily and certain behaviors that trigger withdrawal and resistance. For therapists, certain clients can be more difficult to work with than others, and it is sometimes hard to be supportive within the limits of their own tolerance window. Unconditional positive regard refers to acceptance of the client's expression of negative and positive feelings and of the client's consistencies and inconsistencies. Wilkins (2000) believed level of regard means caring for the client as a separate person, with permission given to the therapist to have their own feelings and experiences.

In contrast to unconditional positive regard, conditional positive regard is the offering of warmth, respect, acceptance, or other positive feelings only when the client

fulfills some expectation, desire, or requirement. Conditional positive regard may distort perception. For example, when a child receives conditional positive regard from a parent or caregiver, there may be some resulting distortion in the child's perception and worth as they develop. Similarly, positive regard can occur in therapy when the therapist has an agenda that differs from that of the client and acts to reward appropriate behavior (Wilkins, 2000).

Wilkins (2000) reported unconditional positive regard promotes client self-acceptance, reduces resistance, and allows for change. For therapists, the challenge sometimes comes from wanting their clients to change and perhaps even from a vision of what change might lead to in clients' lives. However, for some clients, only when this desire is released does change become possible. The psychotherapist's ability to provide positive regard is significantly associated with the therapeutic alliance and outcome.

B. A. Farber and Doolin (2011) offered the following recommendations for clinical practice:

- positive regard may, in some cases, be enough by itself to effect positive change, and, at a minimum, sets the stage for other interventions.
- there is no research-driven reason to withhold positive regard.
- positive regard serves two functions—to strengthen the client's ego and to strengthen the client's belief in their capacity to be engaged in an effective relationship.
- positive regard serves as a positive reinforcer for the client's engagement in the therapeutic process, including difficult self-disclosures.

- positive regard serves to facilitate the client's natural tendency to grow and fulfill their own capacity as a human being.
- positive regard may be particularly important in situations in which a nonminority therapist is working with a minority client.
- therapists should ensure their positive feelings toward clients are communicated to the clients.
- therapists should communicate a caring, respectful, and positive attitude that serves to affirm a client's basic sense of worth; and
- therapists need to monitor their positive regard and adjust it as a function of the needs of particular clients and specific clinical situations in order to avoid resistance.

Genuineness

Congruence/genuineness means the therapist's feelings and attitudes are sincere and timely. Therapists should allow themselves to be expressive, rather than hiding behind a professional role or holding back feelings that are obvious in the encounter (Kolden et al., 2011). Even in a non-therapeutic relationship such as marriage, family, or business, a lack of congruence/genuineness diminishes engagement and closeness.

Genuineness is associated with qualities such as congruence, authenticity, openness, and honesty. Therapists may have a better alliance with clients if they own up to their own experience, whether good, bad, or ugly. Kolden et al. (2011) called this internal congruence and further defined the therapist's ability to reveal their experience to the client as transparency or external congruence. According to Kolden et al., the therapist is

able to use both the right and left hemisphere in order to communicate with the client, addressing the client at the level of plastic self and core self.

Essence of Time

The common goal of every therapeutic engagement is to bring about a change. The questions become: What if the client is not ready for a change and the therapist fails to see a client's unreadiness? Would the therapist's failure to understand a client's position with regard to readiness to change be a predictor of resistance? Prochaska et al. (1992) developed a transtheoretical model in which they delineated the five stages of change. Most clients hesitate to participate in therapy simply because they are not motivated to change at that point. When therapists fail to determine whether a client is at the precontemplation, contemplation, preparation, action, or maintenance stage, resistance is likely to occur in the process.

According to Prochaska and DiClemente (1983), in the precontemplation stage, people do not intend to take action in the foreseeable future (defined as within the next 6 months). People are often unaware that their behavior is problematic or produces negative consequences. People in this stage often underestimate the pros of changing behavior and place too much emphasis on the cons of changing behavior. In the contemplation stage, people are intending to start the healthy behavior in the foreseeable future (defined as within the next 6 months). People recognize their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both. Even with this recognition, people may still feel ambivalent toward changing their behavior.

In Prochaska and DiClemente's (1983) preparation (determination) stage, people are ready to take action within the next 30 days. According to Quinlan and McCaul (2000), people start to take small steps toward the behavior change and they believe changing their behavior can lead to a healthier life. In the action stage, people have recently changed their behavior (defined as within the last 6 months) and intend to keep moving forward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors. In the maintenance stage, people have sustained their behavior change for some time (defined as more than 6 months) and intend to maintain the behavior change going forward. People in this stage work to prevent relapse to earlier stages. Finally, in the termination stage, people have no desire to return to their unhealthy behaviors and are sure they will not relapse. Because this stage is rarely reached and people tend to stay in the maintenance stage, this stage is often not considered in health promotion programs (Armitage, 2008). The therapist's ability to stay present, or to be in the here and now, throughout the entire process is critical. When a client perceives the therapist is only partially present with them or is absent mentally, the result can lead to resistance. Flynn (2011) believed it is a significant event or key moment in the therapy process when a client disagrees and is oppositional to the therapist's direction, the manner in which the therapist responds is very important. Aviram et al. (2016) stated catching the moment correctly and decoding what the client is encoding both verbally and nonverbally may reduce resistance. Doing the right thing at the right time is impactful (T. Martin et al., 2005). In addition, the rate of progress of therapy dictated by the therapist's leadership could induce resistance if the process is occurring too slow or too fast for the client. Mitchell (2016) argued that when a therapist

over accelerates the rate of therapy, the client may become overwhelmed and resist the therapist. Lack of sensitivity on the part of the therapist may lead to a failure to notice important clues that might prevent resistance.

Cultural Competence

Another therapist variable that can contribute to resistance in therapy is cultural incompetence. The therapists' words may become ambiguous or be misconstrued as a result of cultural and linguistic barriers. Clients of different cultures than their therapists have low tolerance for ambiguity during therapy (Doutrich & Storey, 2004). Disregard for social norms and indifference toward one's reputation and worldview have been associated with resistance (Beutler et al., 2003). A study on cultural competence and therapist–client ethnic matching revealed the cognitive match between therapist and client has an impact on resistance (Sue, 1998).

Therapist's Self-Care

The therapist's overall condition can be a factor in resistance; additionally, the therapist's mental health condition could induce resistance. In their 2018 study, Tay et al. (2018) found 10% of psychologists who were experiencing personal distress made no disclosures to anyone, citing concerns of being judged or experiencing a negative impact on their careers. Given the serious worry about the confidentiality of treatment, a clinician's search for a personal psychotherapist is, unsurprisingly, often driven by reassurances that their confidentiality concerns will be adequately addressed. According to White et al. (2006), 65% of psychiatrists who were questioned about their experiences and perceptions of personal psychotherapy reported they would select a psychotherapist solely on perceived confidentiality rather than the quality of care offered or reported by

the clinician. Although many of the fears of stigma arise from the specific personal topics discussed over the course of therapy, some therapists are wary of colleagues knowing they are seeking psychotherapy at all.

N. K. Farber (2000) found some psychotherapists view the need to seek personal psychotherapy as a personal failure or as evidence that they are unable to effectively do their job. N. K. Farber stated that despite the culture of acceptance among psychotherapists, there also exists a real or perceived need to maintain an image of professionalism, composure, and self-reliance that may be damaged by colleagues knowing about the pursuit of personal psychotherapy. Even though psychotherapists are not more likely to intentionally breach confidentiality with their clients who are also clinicians, the interconnected nature of the clinician community may facilitate unintended disclosures during typically innocuous activities such as supervision or consultation. That inherent risk, despite psychotherapists' best intentions and good practices, may drive many of the confidentiality-related concerns they describe. The therapist factors provided in this research are not exhaustive, as there could be more aspects regarding resistance that were not discussed in this literature review.

Client Factors

Sometimes the factors that cause resistance to therapy comes from the client. Teyber (2000) identified some of the ways and reasons a client may resist therapy. First is fear of failure. The client lacks an understanding of how to be a client and has a high need for success or perfectionism and thus, resists as a result of the fear of failure. Second is a fear of taking risks. The client sees counseling as a highly risky behavior but is actually very conservative in their life approach. The third is that the client enjoys

manipulating others and by not “moving” or responding therapeutically, they experience power in recognizing they can manipulate the therapist. The fourth is passive–aggressive behavior. The client is angry with the therapist or some other adult/authority the therapist represents (i.e., transference). Thus, resistance can be a reaction to authority figures in general. Fifth is having feelings of shame that exist because the client has been unable to resolve their issues (Teyber, 2000) or because of the social implications of the issues. Sixth is jealousy or desire to sabotage the therapy relationship. The patient’s line of reasoning is as follows: if they improve and get well, they cannot continue to attend these therapy sessions where they receive attention and thus maintain their relationship—however unhealthy—with their therapist. In that instance, an unhealthy dependence has developed between the client and therapist. Teyber stated the seventh is an indication the client is psychologically drained and lacks the energy to take on the tasks that will lead to change. Here, the therapist needs to back off and allow for the replenishment of energy through taking a therapeutic break. Eighth is personality style. Many people instinctively respond to change with resistance. However, some people enjoy the battle of resisting, the stimulation of arguing, and controversy long beyond the initial reaction to change. Another author reported such people often switch positions if they find others agreeing with them, in order to keep the stimulation going (Morrison et al., 2017). Additional client factors that may induce resistance to therapeutic engagement are cultural differences, readiness to change, gender issues, developmental stage, and labeling and stigma (Morrison et al., 2017).

Cultural Differences

When a client's culture does not align with that of the counselor, a weaker connection may be formed between the client and the provider (Smith & Trimble, 2016). Epidemiological studies have shown the majority of European Americans with mental disorders seek mental health services whereas fewer than a third of African Americans, Latinx Americans, and Asian Americans do so (Jackson, 2013; Le Meyer et al., 2009; Villatoro et al., 2014).

Ethnic groups, such as African Americans, display the highest level of resistance because they lack trust in the system and hold personal and family affairs as private (Morris et al. 2011). Morris et al. (2011) further reported African Americans believe seeking outside help is a sign of weakness and some members of the African American community have a longstanding lack of trust in the government and healthcare system because of centuries of abuse, slavery, and inequality. Additionally, counseling literature and studies were developed based on the dominant Caucasian ethnic groups and may fail to capture certain variations in other ethnic groups. At the end, vital information that may have a significant impact on therapeutic outcome may not be reported by the client because of the therapist's duty to report.

Suggested Remedies to Resistance to Psychotherapy

Lucero (2003) suggested some ideas to minimize or eliminate resistance to therapy as follows:

- Therapists should update their skills and toolbox with new discoveries of science and research in order to avoid becoming stuck in old intervention techniques.

- Therapists should encourage their clients to let go of any anxiety over what may or may not happen in the future.
- Therapists should retain childlike innocence, allowing for openness without judgement or imposing their own values.
- Therapists should be who they are naturally. Therapists may consider being transparent to attract the same from clients.
- Therapists should lose self-consciousness and ego and be less critical toward the client.
- Therapists should maintain a therapeutic atmosphere that is free of fear and anxiety, make their work together inviting to the client.

Summary

Prior research indicated resistance is widely recognized in mental health treatment. Scholars and researchers have written extensively on the evolution of resistance in therapy. The term resistance to psychotherapy entered the vernacular of psychology in the early 20th century through the work of Freud. Various providers perceive resistance from the lenses of their theoretical orientation. Subscribers to the psychoanalytic model perceive resistance as a negative unconscious force that needs to be worked through, whereas humanistic and narrative theorists see it as a factor of the therapeutic relationship between a therapist and a client. What has not been explored in detail is the experiences of therapists with resistant clients. The intention within this study was to conduct that exploration.

CHAPTER III: METHODOLOGY

Research Design

The purpose of this study was to explore and understand the lived experiences of therapists with clients who are resistant to psychotherapy. The goal was to analyze the therapists' experiences working with resistance clients to illuminate the strategies they used and, hopefully, equip entry-level therapists with a functional perspective and approach to managing and mitigating resistance in therapy.

To better facilitate this qualitative study, a phenomenological approach was chosen as a means to explore the lived experiences of the participants in order to identify patterns and relationships of meaning (Creswell, 2006, 2008). Levitt et al. (2018) reported the phenomenological approach is a qualitative method in which the researcher explores the cases through detailed interviews and questionnaire.

Research Questions

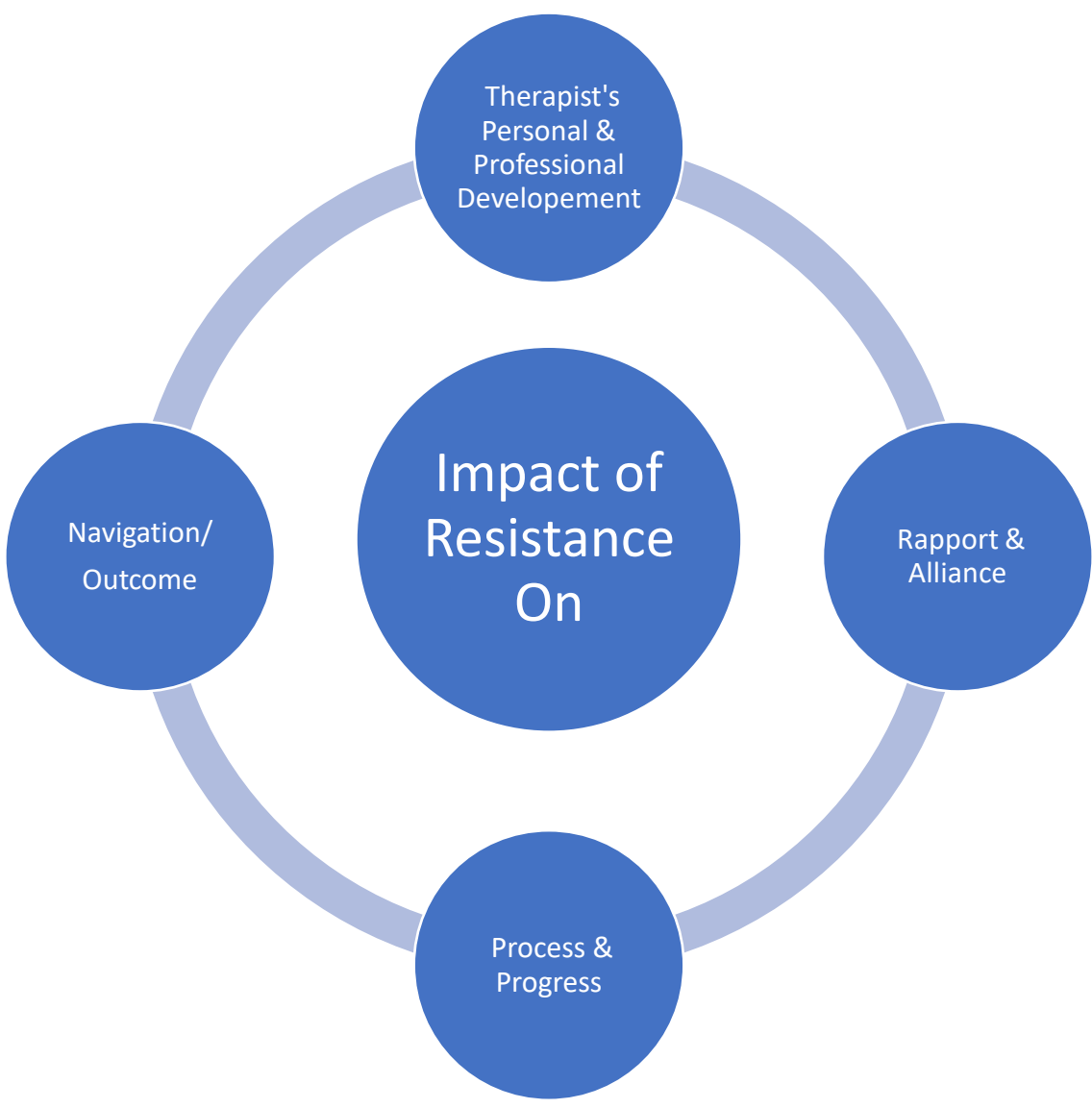
This study addressed the following primary research questions:

1. How does resistance in psychotherapy affect therapeutic rapport?
2. How does resistance in therapy affect the therapeutic process?
3. How does the attitude of the client affect the therapist?
4. How do therapists effectively navigate through the resistance?

Figure 1 illustrates the purpose of this study.

Figure 1

Impact of Resistance



Selection of Participants

The therapists who participated in this study were selected from mental health agencies in South Florida, such as Drug and Alcohol Foundations (DAF), the Comprehensive Alcohol Rehabilitation Program (CARP), and the South County Mental Health Center (SCMHC). About half of the clientele of these facilities are ordered by Drug Court for a mandatory residential substance abuse treatment. Participation was

solicited through both institutional and individual solicitation letters (Appendices A and B) and follow-up phone calls.

The process of data collection started with ascertaining, through the demographic questionnaire (Appendix C), whether potential participants were eligible for the study. The rationale for taking this extra step was to ensure all participants had adequate experience with the subject of the study. The demographic screening ensured the participants had a minimum of 10 years of experience, had sufficient professional encounters with resistance, and understood the nature and dynamics of resistance. Among all the factors considered in the demographic questionnaire, the main qualifications were substantial personal experience with resistant clients and understanding the nature and dynamics of RIP. After completion of the screening, a total of 16 qualified participants were identified, but none granted an appointment even after 6 months. Consequently, an incentive was offered to those participants who qualified because of the essence of time. The researcher could only afford to compensate a total of 10 therapists and chose two psychologists and eight licensed mental health therapists (two men and eight women). These 10 participants granted the researcher an appointment for an interview immediately after the offer of an incentive to participate.

This study was approached without a preconceived hypothesis or bias, as much as possible, to enable the answers to the research questions to emerge naturally from the data collected. The interviews were conducted at the participants' various institutions of employment. All the participants met with this researcher after work at their offices to ensure privacy and avoid interruptions. The participants ranged in age from 35 to 64 years ($M = 46.2$ years) and had a minimum of 10 years of experience. Written informed

consent for participation and permission for audio recording was presented to all participants in accordance with the National Louis University Institutional Review Board (IRB) and the American Counseling Association (ACA, 2005; Appendix D).

Instrumentation

Semi structured interview was one of the instruments used in this study. As previously consented to by all the participants, a device was used to record each interview. The researcher transcribed each interview verbatim. The researcher wanted to hear, understand, and become familiar with the data from each participant during the repeated play back throughout the transcription process. The purpose was to guarantee the transcripts were 100% accurate, this researcher listened simultaneously to the audio and read the script to ensure every word was accounted for and attributed to the right participants.

Limitations

Limitations are elements in a study that are outside of the researcher's control and that can potentially affect the researcher's endeavor to obtain accurate data and conclusions (Eisenberg, 2020). One of the limitations encountered in this study was the number of participants. In spite of the elaborate effort this researcher invested in recruiting a large population of participants, only 10 therapists actually qualified and chose to partake in this study. Many licensed therapists were unwilling to volunteer to participate. A larger number of participants would have yielded more comprehensive data and findings (Petkari et al., 2011).

The second limitation related to paying participants rather than using volunteers. The population studied (i.e., licensed therapists and psychologists) was unwilling to

volunteer to participate. Instead, they insisted on billing this researcher their hourly rate of pay. Offering payment to clinical research subjects in an effort to enhance recruitment by providing an incentive to take part or enabling subjects to participate is a common yet uneven and contentious practice in the United States (Grady, 2005). Dunn and Gordon (2005) believed paying participants in a research study may negatively affect the process and the outcomes and stated payment unduly influences participation and thus obscures risks, impairs judgment, or encourages misrepresentation.

The third limitation is that the nature of qualitative study and the subjective nature of participants accounts limits the generalizability of the results. Additionally, because this inquiry involved the experiences of therapists in Southern Florida, the findings of this study may not be the same if a similar study was conducted in other parts of the United States. It would have been beneficial if participants were from across the nation to examine whether the results would be the same. Findings would have wider application if participants were represented from every region of the United States.

A final limitation was that this researcher's opinion and bias could have influenced the results, though Steiner et al. (2010) recommended qualitative researchers detach their bias and prejudice from influencing the research. Creswell (2006, 2008) also believed researchers naturally bring some biases, experiences, and prejudices to a study.

Ethical Issues

Ethically, a counselor strives to achieve beneficence (i.e., obligation to do good), non-maleficence (i.e., avoid harm and exploitation of clients), fidelity (i.e., faithfully performing therapist's duties), autonomy (i.e., promoting client's independence), and justice (i.e., impartial and fair to all; Brown et al., 2014). The above ethical standards

were upheld in this study. In accordance with the ACA's (2005) *Code of Ethics*, this study was conducted following the highest ethical standards. For example, no values were imposed upon participants, nor were they influenced to respond in any way.

Additional issues related to the rights of research participants are addressed in section G.2 (ACA, 2005). Sections A.2 and A.7 also cover issues related to informed consent, which states participants should be able to choose whether to be involved in the research or not, as well as have the right to withdraw at any time during the study (ACA, 2005). One may question whether the participants in this study could maintain freedom of choice if they were being paid. Though they were paid for their time, which was an incentive to participate, the conditions of the informed consent were still upheld.

Anonymity and Confidentiality

Pseudonyms were used to conceal the identities of participants to ensure anonymity. Additionally, all interviews took place in private settings and any identifying information was removed from the data. To ensure confidentiality, all information regarding the participants and their interview materials was handled with the utmost care by storing the data in a password-protected computer. All audio and paper materials were stored in a locked cabinet in a locked room. All materials were upon completion of data analysis and coding.

Consent

Participants signed an informed consent document that contained detailed information about the purpose of the study as well as what partaking in the study entailed (Appendix D). The informed consent document identified the specific reasons the participants were invited to participate, the risks or benefits of participation, and the

precautions that would be taken to safeguard their identities. Participants were also informed that all interviews would be audiotaped and the tapes destroyed after the study. In addition to the researcher's contact information, participants were provided with contact information for the IRB.

Data Processing and Analysis

Phenomenological interpretive analysis involves identifying a core framework in a shared experience through studying a program, event, activity, or process of one or more individuals (Creswell, 2008; Levitt et al., 2018). The analysis of the data within this inquiry began with a thorough examination of the collected data using the interview transcripts. The researcher transcribed the interview audio tapes verbatim and then checked and rechecked the transcripts to ensure no mistakes were made during transcription. In addition, the researcher read the transcripts while listening to the audio records to ensure 100% accuracy. Then the researcher read the transcripts repeatedly to capture significant common themes and patterns. Another independent coder and analyst, with a PhD qualification, was hired to also code and analyze the transcripts independently of the researcher and develop a separate coding system. Then this researcher and the hired co-analyst compared and contrasted their final notes for accuracy. The themes that surfaced in the two independent codes and analyses reflected 90% similarity.

Further rigor was achieved by using the participants' feedback. Each participant was asked to review the transcript to ensure the reports were accurate and the data reported the meaning the participant originally conveyed. Furthermore, the researcher ensured there was no shift in coding by keeping a list of the codes and their definitions and by constantly comparing the data with the second coder.

As a final step, a group of peers, consisting of five psychotherapists, were presented with the results of this study and were asked to compare the findings with their personal experience as being valid or otherwise. The five peers were asked five specific questions:

1. Did you encounter more resistance from mandated clients than voluntary clients?
2. Did your encounter with resistance motivate you to seek additional skills and strategies to be more successful in your next encounter with resistance?
3. Did you become more flexible and creative in navigating through resistance after your past encounters with resistance?
4. Do you agree that resistance could be beneficial in psychotherapy?
5. Do you agree that understanding resistance as an essential component of psychotherapy alleviates anxiety from fear of resistance?

Each of the five peers reported the findings of this study corresponded to their personal experiences. In other words, the peer review validated the findings as true and authentic to their experiences. Triangulation with a co-coder, participant validation of accuracy, and peer reviews were the measures taken to ensure rigor and validity and to diminish researcher bias.

CHAPTER IV: DATA CODING AND ANALYSIS

Data in this study were largely drawn from the interview questions about participants' experiences working with resistant clients. Responses revealed typical sources of resistance in clients, as well as participants' professional experiences. All participants were licensed psychologists or mental health therapists with a minimum of 10 years of experience.

The purpose of this study was to explore the patterns and dynamics of client resistance to psychotherapy from the perspectives of therapists as a means to develop a phenomenological study of counseling resistant clients. The findings of this research revealed a trove of valuable experiential knowledge based on seasoned therapists' experiences with resistant clients.

Research Questions

This study was designed to address the following research questions:

1. How does resistance in psychotherapy affect therapeutic rapport?
2. How does resistance in therapy affect the therapeutic process?
3. How does the attitude of the client affect the therapist?
4. How do therapists effectively navigate through the resistance?

The rationale behind the research questions was to capture narratives of the participants' experiences with clients who are resistant to psychotherapy with regard to process, outcome, and the reciprocal self-appraisal of the therapists in the end. The intent was to understand some of the motivational reasons behind clients' displayed resistance. A further goal was to understand the perceptions and reactions of the therapists throughout the therapeutic process. The research questions were structured to illuminate

effective ways in which the therapists (participants) navigated through the resistance and the impact it had on therapeutic outcomes. Additionally, a thorough examination of the research questions was used to reveal the behaviors of the therapists and clients and how they influenced each other.

Data Collection and Analysis

The research methodology for this study was qualitative and the data collection approach was phenomenological because this study was designed to examine the personal experiences of therapists. This was an appropriate approach because qualitative analysis is an interpretative, naturalistic study of the subject matter of interest using the individual perceptions of the study participants (O'Sullivan et al., 2016). In this study, the goal was to gather therapists' perspectives of the impact of resistance on rapport, process, the therapist, and navigation through resistance and use the results to develop a guiding framework to inform new therapists about working with resistant clients.

The process of data collection started with ascertaining, through the demographic questionnaire (Appendix A), the eligibility of participants. A total of 25 participants responded to the demographic questionnaire and 16 participants were determined to be eligible based on the result of the screening (Table 1). The demographic screening ensured participants had a minimum of 10 years of experience, had sufficient professional encounters with resistance, and understood the nature and dynamics of resistance. However, none of the 16 eligible participants were willing to schedule an appointment for an interview for over 6 months. Consequently, the researcher offered an incentive to 10 participants who best fit the desired population. Among those were two psychologists and eight licensed mental health therapists (two men and eight women). Appointments were

scheduled with the 10 participants. The rationale for taking this extra step was to ensure all participants had adequate experience with the subject matter and were willing to grant this researcher an appointment immediately. Among all the factors considered in the demographic questionnaire, substantial personal experience with resistant clients and understanding of the nature and dynamics of RIP were the most valued.

Table 1

Demographic Information

Participant	Age	Race	License Type	Marital Status	Gender	Years of practice
1	56	Black	Psychologist	M	Male	20
2	49	Black	Psychologist	M	Male	16
3	42	Caucasian	LMHC	M	Female	14
4	47	Caucasian	LMHC	M	Female	10
5	35	Caucasian	LMHC	S	Female	15
6	36	Caucasian	LMHC	S	Female	11
7	53	Caucasian	LMHC	M	Female	19
8	64	Caucasian	LMHC	M	Female	22
9	41	Latino	LMHC	M	Female	11
10	39	Latino	LMHC	M	Female	10

A written informed consent for both participation and permission for audio recording was presented to all participants in accordance with the National Louis University IRB and the ACA (2005; Appendix B). To protect the confidentiality of the 10 participants, the demographic questionnaire contained no request for any personal information. Additionally, in reporting the study's findings, to protect the participants' anonymity, they are referred to as Participant 1 through Participant 10. The semi-structured interviews took place in South Florida and consisted of 12 open-ended questions and, when necessary, follow-up or clarifying questions (Appendix E).

Participants were asked to choose a secure place for the interviews that would allow for privacy and all 10 participants agreed to use their office after work. Each interview began with the researcher reiterating the conditions stated in the letter of informed consent (Appendix B), reminding participants that the interview would be recorded, and asking participants to again give verbal permission that they voluntarily agreed to receive an incentive to participate. Participants were asked whether they had any final questions. No one had any final questions before the interview began. Each participant was assured that their responses were of utmost importance to the study and each was encouraged to be candid, understanding that their responses, for the sake of anonymity, would be attributed only to a pseudonym that was untraceable to them. The interviews were originally intended to last 1 hour each; however, the interviews with the two psychologists lasted over an hour with their permission. Interviews were recorded digitally and the researcher transcribed and analyzed the data immediately after completing the first interview.

To ensure authenticity and rigor, this researcher analyzed and coded the data and used triangulation with an independent analyst and coder at the request of the dissertation chair. This researcher coded the narrative data and hired a second coder to confirm the categories for the purposes of cross-validation and verification. The two analyses were 90% similar, varying only in the level of detail, but nonetheless identified the same basic ideas in the therapists' approaches to counseling resistant clients. Additional validity was achieved by presenting the findings of this research to a group of five licensed mental health therapists for a peer review and further validation. They validated that the findings corresponded with their experience with resistant clients.

Participants' Responses to Interview Questions

Interview Question 1

The first interview question was: How do you define resistance? Participant responses were as follows:

I define resistance as the person's vacillation or indecision to change. Counseling involves change. Change, in turn, involves losing A to gain B; as well as venturing out of one's known comfort zone. Indeed, some individuals may be "resistant" to change because of this. (Participant 1)

Resistance is when one party would like for something to change and the other does not want to acknowledge it is a problem nor want to change it. (Participant 2)

A client who does not want to engage in therapy, consider changing, or change in any way. A client who states that they are interested in change but whose behavior contradicts it. (Participant 3)

I approach the question from an analytical perspective. In the context of a psychotherapeutic relationship, when psychological defenses like denial, avoidance, projection, etc. are evoked in response to anxiety producing situations. A therapist may assign homework for the client to complete before each session. The homework may require the client to confront their fear and anxiety over a past traumatic event. The client is unwilling or unable to complete the task, hence resistance has occurred. (Participant 4)

When a client is not ready for a change or not motivated enough to engage in a therapeutic relationship or is in denial of the problem. Usually, substance abuse clients or mandated clients seem to be the most resistant clients in my experience. I also have encountered a few resistances from teenage clients who fear psychotherapy due to negative stigma they hold against counseling. (Participant 5)

Resistance involves client's refusal to accept, comply with, or openly participate in/with therapeutic process. (Participant 6)

When a client displays ambivalence to change, not just verbally, but by oval observations and behavior, that is resistance. (Participant 7)

Effective therapy is the willingness to seek change, participation, and compliance with therapeutic process. In a nutshell, there must be a willingness to change. When the client lacks some or all those factors, the client is resistant to therapy. (Participant 8)

I define resistance as a client refusing to accept or cooperate with therapy because they have been forced to therapy and not ready or willing to change. (Participant 9)

Clients that have no business being in therapy are forced to therapy for the wrong reasons, they end up wasting my time, fight all through the therapeutic process because they are not ready to change. (Participant 10)

Both the researcher and the independent coder agreed that all 10 participants perceived resistance as opposition to change. Participants' perceptions of resistance were indicative of an unwillingness or lack of readiness to change. Participants' responses implied that compulsory therapy induces resistance in clients. Participant 4 mentioned that, in her experience, client resistance was a type of defense mechanism displayed through denial, avoidance, and projection. A common thread within the participants' responses was that resistance occurs when a client is not ready to change, is unwilling to change, or is mandated to therapy.

Interview Question 2

The second interview question was: Tell me about your experience working with resistant clients. Participant responses were as follows:

I have encountered resistance with offenders of driving under the influence [DUI], domestic violence, drug, and sex. I noticed that their motivation to therapy was only to avoid a long jail sentence and not to change the criminal behavior that got them arrested. Unfortunately, I was not employed to save criminal offenders jail time, but to rehabilitate them; consequently, such clients displayed resistance because of difference in goals. However, rehabilitation is impossible without volition, I spend reasonable time trying to motivate such clients to accept path to change, but when it becomes obvious that such clients have built an impenetrable wall of resistance around them, as a last resort, I threaten to report their negative therapeutic progress to their sentencing judge. Such a drastic step sometimes curtails the resistance but rarely eliminates it completely. Like the saying, you can take the horse to the water, but can't force the horse to drink. (Participant 1)

One that stands out occurred in family therapy, when family members gave ultimatum to my client to seek therapy and change or face consequences. Resistance to therapy is a common occurrence and could mean a variety of things. Resistance is not necessarily bad, to me, it is indication that penitent issues are

being addressed. I don't mind such resistance, but the type of resistance that I have a problem with is the type that prohibits accomplishment of treatment goals and objectives, that obstructs therapy sessions and progress, and that destroys therapeutic rapport. I usually encounter disruptive resistance when a family member has been given an ultimatum to get counseling or else divorce or move out. Such clients turn therapy sessions to trial and judgement instead of processing presenting issues. Also, some sort of addiction that is apparently perceived by family system as detrimental to the rest of the family. In short, I have encountered resistance in my practice and do not mind as long as it helps to process presenting problems. (Participant 2)

I've worked with hundreds of resistant clients. I've worked in a prison and in child protective services, as well as those mandated to substance abuse treatment after a DUI or after breaking the substance abuse policy at their work or university. Denial is very common with such clients, and it is okay with me for a while, but when it affects treatment progress and goals, it becomes a problem. (Participant 3)

Court ordered referrals come to mind at the top of my list. Often, such clients deny all the allegations made against them and project blame on others for their actions. They may portray themselves as the victims, deny or minimize responsibility for their actions, and sometimes suggest they were provoked into or made to act accordingly by the victim, accuser, or even the legal authorities. Such stance becomes a problem especially when they are criminally adamant and denies any need for change. (Participant 4)

The most resistance I have encountered was from teenage clients. Usually, these clients are resistant because they were mandated to counseling by their parents and are in denial of the presenting problems which are usually drugs and gang involvement. Also, I perceived that negative stigma teenagers and their peers hold about counseling caused resistance. One of the stigmas is that their peers view them as "psycho" if they go to counseling and consequently, dislike identifying with therapy. Teenagers put too much value on how their peers perceive them and would do anything to avoid negative appraisal by their peers. I have had some success in overcoming such resistance, by changing treatment location and strategy, motivational interviews, and providing incentives for participation. (Participant 5)

I have worked with clients that were resistant due to manic nature of their diagnosis, such as posttraumatic stress disorder [PTSD], bipolar disorder 1, anxiety disorder, and maniac disorders. From my experiences, psychiatric evaluation and medication was helpful with clients with psychosis. However, resistant clients that are not psychotic, but willfully deny their presenting problems are harder to deal with. They were not ready to change, therefore, could not be helped. I did not take it personally because the choice to change was their prerogative, unfortunately they were not ready to commit to change. I recommend

that treatment of unwilling clients be deferred until client voluntarily needs help. (Participant 6)

My experience with resistance is from working as a correctional mental health counselor. Offenders such as DUI, sexual offenders, assault and battery, financial fraud, and substance abuse that have been mandated to counseling displayed resistance most. The nature of their resistance was by denial, disruptions, manipulation, ego-trips, non-compliant, overly confrontation or overly withdrawn. I quickly reminded them that if they don't need help, it's okay, but I would have to report their refusal for help to the third party that mandated them to counseling. My experience is that such client usually recommit the same crime; their rate of recidivism is very high. (Participant 7)

I have had clients who were forced to seek treatment by the courts, family members, or employers. Some of them displayed unusual resistance, which in my experience was their reaction to mandated counseling. They were not ready and could not be persuaded. I employed motivational strategy to evoke voluntary commitment to treatment. Some came around while others were adamant and could not be helped. I am fully aware that I cannot help every client and that's fine with me. (Participant 8)

I try to respect clients' resistance and build rapport until the client is less resistant and more receptive to treatment. Sometimes, it was a challenge to motivate the resistant client to cooperate. I have used a motivational interview to persuade a client to participate. Some of them changed their ambivalent attitude, but I regret to say that there were some that were incorrigible, and consequently, I had to let them go. (Participant 9)

I have encountered many clients whose spouses were mandated to therapy to prevent divorce. Some of such clients were resistant, argumentative, and in denial, especially ones in addiction. Since the clients were not ready to change, they eventually got tired of faking it, and became uncooperative and eventually relapsed or dropped out of therapy. (Participant 10)

Interview Question 3

The third interview question was: How did resistance to psychotherapy affect therapeutic rapport? Participant responses were as follows:

The therapist and the client may blame each other for the resistance they perceived. The client, for example, may perceive the therapist as unable or unwilling to understand his situation from his position while the therapist may view the client and his or her behavior as unwilling (or resistant) to change. Pointing fingers eventually affected therapeutic rapport negatively. (Participant 1)

The resistance affected rapport because the client's motive was different from the objective and goal of the therapy, resulting to tug-of-war between client and therapist. (Participant 2)

Initially, client was cooperative, participative, and compliant. Rapport was warm and positive. However, when presenting problems were brought up, client became overly defensive and argumentative. Client became overly confrontational with group members that were probing through his lies. When client could not get away with their lies, they withdrew and shut down, which affected rapport negatively. When client's games of manipulation were not detected or addressed, client seemed to have positive rapport with therapist but when confronted, client became angry and uncompliant and rapport deteriorated. (Participant 3)

My experience from a residential program is that resistance, such as non-compliance and disruptive behaviors, was displayed. Such disruptive behaviors were documented and confronted. The clients were eventually expelled from the program. In my experience with voluntary out-patient treatment setting, resistance is handled with a milder approach than in a residential setting. The goal is to maintain the patient in treatment without using too intense or aggressive methods which might result in the patient dropping out of treatment. When a client's resistance became disruptive to therapeutic rapport, progress, and goals, continuing therapy becomes useless. (Participant 4)

Ambivalence, detachment, lack of motivation, and lack of collaboration were ways clients have displayed resistance in my experience, and yes, excessive resistance affected therapeutic rapport. (Participant 5)

Generally, after establishing rapport with most of these clients, some of these clients agreed to try a few sessions of psychotherapy, resulting in stronger bonds of rapport formed. Unlike in cases where a client persisted with resistance, rapport was negatively impacted and, in some cases, affected the outcome, too. (Participant 6)

The therapeutic rapport was warm and positive in the beginning, but when clients got confronted by the therapist on their phony stance to therapy, rapport deteriorated fast. My experience was that such clients came to therapy with the wrong agenda that did not correspond with the therapeutic goal and objective; consequently, resistance increased, and rapport decreased. (Participant 7)

The client can't move forward in therapy while being resistant. I tried to find ways to help the client to want to change, thereby reducing resistance. I have had some success in some cases, but there were some that I could not help. Indeed, resistance has impact on rapport. (Participant 8)

In my experience, normal resistance can improve therapeutic rapport. However, excessive amount of resistance destroys therapeutic rapport due to lack of collaboration. (Participant 9)

Rapport was poor because the therapist called the clients on their games and wrong goals for therapy. Usually, the wrong goal for therapy, common in correctional institution counseling, is to escape long term jail through therapy. In my experience, clients became argumentative, non-compliant, disruptive, and manipulative which ultimately ruins rapport. (Participant 10)

Participants' experiences clearly indicated therapeutic rapport was negatively affected by resistance.

Interview Question 4

The fourth interview question was: How did resistance to therapy affect your therapeutic process? Participant responses were as follows:

In my experience, mild or normal resistance was an opportunity for growth, such resistance was instrumental to achieving treatment goal. It also challenged my creative skills as a therapist. However, I have encountered unusual amount of resistance that negatively impacted treatment process by stalling, disrupting and ultimately damaging the therapeutic process. (Participant 1)

Too much time was spent on motivating ambivalence, to actively engage in therapy. I have encountered cases that stalled progress and process. (Participant 2)

In my experience, resistance is an important component of therapeutic process. I prefer normal resistance to passive participation from my clients; resistance could enrich the quality of engagement. However, excessive resistance sometimes impacts treatment process and progress, as much time may be spent on securing trust and rapport, especially when it appears that client's goal was to frustrate intervention. (Participant 3)

I started my career in residential treatment programs in which overly resistance was considered as disruptive behavior and could result in dischargement of client. The reason for such a steep measure is that therapy is usually in group format, undue resistance in group effects the group cohesiveness. I am more tolerant to unusual resistance in my private practice because it does not affect other patients as in residential programs. Either way, resistance differs from client to client as well as program to program, but in general, it does affect therapeutic process. (Participant 4)

I experienced lots of no shows from resistant clients. No shows later became drop out of therapy. Sure, resistance affects therapeutic process. I had to do a lot of motivational interviews to get the resistant client to meaningfully engage. Sometimes it worked, other times it did not. You never know. (Participant 5)

I expect some degree of resistance from all my clients at some point during therapeutic process. I try to minimize disruptive resistance by proactively describing therapeutic roles, establishing therapeutic boundaries, and collaboratively developing goals and objectives. When resistance interferes with the elements of therapy stated above, I consider therapeutic process negatively impacted by resistance. Yes, resistance can negatively affect treatment process. (Participant 6)

From my experience, the level of commitment, collaboration, and willingness of my client affects the process. If my client displays lack of commitment, collaboration, and willingness to therapy (elements of severe resistance), therapeutic process becomes negatively affected. (Participant 7)

In my experience with resistant clients, especially in correctional counseling in south Florida, where there is endless flow of foreign immigrants into the jails, socioeconomic status, cultural differences, and different worldview and belief is common. Such diversity has caused resistance. Cultural differences have caused resistance in some of my experiences and affected therapeutic process. (Participant 8)

I have encountered resistance that stagnated therapeutic process and progress. It was a challenge to me as a therapist, I had to seek creative strategy to break down the resistance from clients, some cases were salvageable, but there were some that was practically impossible and consequently therapeutic goals and objective were unachieved. (Participant 9)

I have encountered situation where a family member was brought to therapy but lacked the support of their family members. The family took a prescriptive stance instead of supportive; consequently, the client's motivation to engage actively in therapy decreased. For example, when a spouse or family member points at the presenting problem, the client feels isolated and loses motivation to continue. Such lack of support caused resistance behavior to therapy and the therapeutic process suffered. In extreme conditions, the clients have dropped out of therapy. Yes, resistance affects process. (Participant 10)

Participants agreed that resistance slows, hinders, damages, and most likely prolongs the therapeutic process. Some of the participants reported resistance abruptly ended the therapeutic process. Participant 9 said they had to seek creative strategies to break down clients' resistance with apparent success. The majority of the data support that resistance negatively affects the therapeutic process.

Interview Question 5

The fifth interview question was: How did you navigate through resistance to therapy? Participant responses were as follows:

My first reaction to resistance during therapy was to acknowledge what was happening. Then I identified the associated behaviors and brought them to the attention of the client. I checked with the client if they were aware of the behaviors and informed them that it was inappropriate. I asked the client if the identified inappropriate behaviors were intentional and found the meaning behind them. I assessed the motives behind the behaviors and determined if what it seemed was what the client meant. I suggested to the client alternative acceptable ways to communicate or convey his/her meaning positively. I validated the client's reasons when they were genuine and truthful or invalidated them when they were not. I owned up all the factors from me such as my leadership, perception, cultural incompetence. I did not proceed with other objectives in the agenda till appropriate adjustments were made. When the client's reasons for resistance were reasons other than myself, such as different culture, worldview, misconception, intrapersonal or interpersonal etc., I as well acknowledged, validated, and processed them with the client right there and then before proceeding to other objectives in the agenda. There have been times my approach enriched the therapeutic engagement, and other times failed to help. (Participant 1)

I have encountered clients resistant to therapy quite a few times. My first course of action was to construe correctly what was happening. Next, I determined if it was intentional or not, and if the client was even aware of the resistant behavior. I believe that for client to be actually resistant, there would have to be elements of knowledge, volition, and choice; otherwise, it was a misconception that could be easily corrected. I avoided every oppositional or confrontational approach, rather, allied with the client and collaboratively explored the factors that caused resistance. In my experience, some of the factors were transference, level of stage of change, conflictual personality, theoretical approach, cultural difference and much more. Regardless of what and the source of client's resistance, I endeavored to meet the client where they are at as long as it did not conflict with therapeutic goal and objectives. (Participant 2)

Getting past resistance often depends on the therapist's ability to develop rapport, trust, honesty, and genuineness in the early stage of therapy. Some of my practical approach in navigating through resistance has been to never engage with a client in a power struggle. I can reasonably agree to disagree. When a therapist engages with a client into power and ego trips, all therapeutic goals and objectives go out the door. Rather, I try to understand the root of my client's resistance. Client's resistance could be intentional or provoked by situational factors. I have had some success with identifying which is in play. Establishing the atmosphere of trust and rapport has been my most effective approach. When I had established a warm

rapport and trust with the client in the early stage of therapy, my agreement or disagreement with the client's opinion has little or no impact on client's engagement.

Also, being genuine (keep it real), empathetic (it would likely suck to be in the client's position), and honesty goes a long way. I believe this applies to all relationships, whether therapeutic, professional, or personal. For example, unless I truly believe that the client is genuinely working on change, I will not report that they are as that would be dishonest. I let them know that I will not be dishonest with others about them and I will not be dishonest with them. I tell my clients when it is true that I have some skills which I am willing to share with them which may keep them out of trouble, improve their relationships, and make them feel less pain, whatever the case may be. I also honestly tell them I can't.

In addition, I know the power of choice. I constantly remind my clients the importance of their choice in the therapeutic business ahead, I mean . . . it is their prerogative to take advantage of the opportunity they've been given to make use of my service or not. The choice is theirs. My most effective motivational speech to my resistant client, especially the ones in jail is that I'm still going to get paid whether they engage or not. I'm going to walk past the bars and go home. I'm not the one who will receive whatever consequences come their way if they choose not to "do" therapy. The choice and consequence are theirs and theirs alone. Again, depending on the client and situation I may soften this greatly, leave it out completely, or take a strong "reality therapy" approach. I said all that bunch to say that the therapeutic atmosphere that the therapist cultivated in the early stage such as trust, honesty, rapport, and genuineness has been my most effective tools in navigating through resistance. (Participant 3)

I expect resistance in therapy and do prefer it over passivity. I navigate resistance by expressing empathy through reflective listening. Also, I point out to the client the pros and cons of resistance. I focus on adjusting client's behavior rather than opposing it head-on. Determining client's stage of readiness to change and motivating them to accept change has worked for me in the past. When all my effort to motivate my client fails, I explain to the client his/her choice and implications thereof including reporting his opposition to therapy to the judge or third party, give the client choices and let the client decide where we go from there. (Participant 4)

I believe that resistance is an essential part of therapy and can be overcome with intentionality and some effort. For example, motivational interview is one way I have dealt with resistance in the past. I have used lots of solution-focused approaches by avoiding judgement, asking why, focus on client's strength, moved at the pace of the client, and provide alternative construct. I have also used incentives to motivate the client to more active engagement, such as promising the client a shorter session if he/she meaningfully engages. In closing, I used motivational interviews and incentives to navigate through resistance. (Participant 5)

Ways I navigated through resistance were by increasing rapport, effective listening, choosing my words carefully, acknowledge the client's stance even if I don't agree, and being careful not to take the client's behavior personally. I have also used motivational approach to persuade resistant client. (Participant 6)

I navigate through client's resistance by not taking the resistance personally. I do not allow client's resistance to frustrate me. Rather, I remind myself that it is client's right to accept or reject help, in the end, they are paying for the service. Regardless, I try not to give clients more reason to resist help; rather, I assess the reasons and motive behind the resistance. There were times when just acknowledging and validating the client's position dramatically reduced resistance. I have learned that every resistance has a reason behind it and the ability of the therapist to properly identify the motivating factors behind the resistance is crucial to overcoming the resistance. (Participant 7)

My approach to resistance is that building rapport is key to helping clients decrease resistance. I spend a great deal of time on fostering sustainable rapport with a client before proceeding to process presenting issues. This is because there will not be significant progress until trust is established. Part of my building a strong rapport with my clients is reflecting to my client that I rightly conceptualized their case and their position. In addition, I have used motivational interview to navigate through ambivalence to therapy. (Participant 8)

I focused mainly on building rapport, trust, and providing a safe atmosphere. Unfortunately, I have learned that there were cases where I exhausted all motivational tools in my box to get the horse to drink the water and still failed. When I encounter a client that is not ready to change, I send the client to the authority that mandated them to therapy till they are ready. (Participant 9)

I perceive resistance from a client as a statement, I try to clearly understand what the client is saying at the moment. It takes sensitivity, intentionality, and ability to capture all nonverbal clues the client is sending. I then validate or challenge the reasons for client resistance. It is crucial that client's position must be rightly understood, not necessarily agreed for any progress to be made. Specifically, I approach resistance by identification of resistance, validating or challenging the reasons for resistance, and giving client options of choices. Ultimately, the client decides if we proceed or not. (Participant 10)

Most of the participants reported the importance of understanding the meaning and reasons for resistance. They reported that rightly conceptualizing the client's issues is a vital step in mitigating resistance. Also, participants stated they used motivational interviewing techniques to work through resistance. Almost all the participants emphasized the importance of building rapport and trust, and one participant remarked

that in every relationship, rapport is necessary. Most respondents offered several examples or analogies to explain their process of navigating through resistance. One common fact among all the participants was their willingness to move the client from an oppositional stance to a collaborative position. Some participants reported termination of therapy was an option when all other resources failed. Most participants recognized when they encountered a resistant client. Some participants pointed out that resistance could be caused by therapist factors and stated that in such cases, they made the appropriate adjustments.

Interview Question 6

The sixth interview question was: How did the client's attitude toward psychotherapy affect the therapeutic outcome? Participant responses were as follows:

My experience is that clients' resistance usually creates variances in the outcome. When my clients display resistance, it attacks therapeutic alliance; sustained resistance by a client impairs collaboration between the client and I. Usually, when alliance and collaboration is lost, treatment goals and objectives become harder to achieve. I avoid getting into opposition with my clients even during resistance. I expect some level of resistance from each client and because of that expectation, I invest a lot of effort in the beginning to build solid alliance and rapport hopefully before emergence of resistance. Previously established trust and rapport helps me work through my client's resistance. Resistance has affected outcome in ways like, drop-out, early termination, cancelations, and no show. (Participant 1)

The nature of client's resistance and the severity of it affected treatment outcome. My first response to resistance usually is to work through it and overcome it, but in cases where resistance could not be overcome, definitely treatment outcome was affected. (Participant 2)

In my experience, most clients do engage in therapy and their initial resistance had little impact on outcome because some resistance can actually enrich the therapeutic engagement. However, I have not been able to overcome every resistance I have encountered. In such case, the outcome was affected in various degree. Yes, resistance has impact on outcome. (Participant 3)

Coercion in counseling causes resistance, and resistance affects treatment outcome because most mandated clients recidivated after treatment. (Participant 4)

Clients mandated to therapy gave me the most resistance. I have seen cases where therapy was terminated because of several no shows and no call. Therapeutic goals were not accomplished because such clients drop out or get into legal problem and get locked up again. (Participant 5)

When clients held a more positive attitude toward therapy, the outcome could still be positive in spite of resistance. However, resistance could not be reduced or eliminated due to ambivalence, cultural hinderances, and perceived coercions to therapy; the therapeutic outcome gets impacted. I perceived a direct correlation between voluntary counseling and positive outcome and vise-versa, coerced counseling and negative outcome. Volition to therapy has relationship with resistance and outcome. (Participant 6)

My experience is that resistance impacts all the factors of counseling depending on the nature of resistance. I have offered incentives to clients as a payoff to stop resistance, even in such case, extrinsically motivated behavior lasted only while extrinsic control is in place. Long term positive outcome is not always possible. (Participant 7)

In my experience, clients' resistance comes in different shades and degrees. Some can be overcome while others were not. Resistance has caused a significant deviation from the originally intended goal. Yes, resistance can impact outcome. (Participant 8)

Client's resistance affected the outcome. In my experience, resistance affected therapeutic outcome by client dropping out of therapy, premature referral, premature termination, or unsatisfactory outcome. It all depends on the client's willingness to change, I don't mean to say resistance is necessarily bad, but if the client is not ready to change, the desired outcome may not be achieved. (Participant 9)

My experience reflected that mandated clients are more resistant to therapy than voluntary clients. My experience has been resistance is a common client's reaction in compulsory therapy. I believe that, naturally, loss of freedom and independence induces resistance. My experience indicates that commitment to therapy by mandated client is a cycle of back and forth ambivalence and does affect therapeutic outcome. (Participant 10)

All participants indicated the client's attitude affected therapeutic outcomes in that a positive client attitude resulted in mostly positive outcomes, and sometimes, a negative client attitude resulted in negative outcomes. Over half of the participants noted

therapists should expect resistance in every therapeutic encounter and proactively set the stage to overcome any resistance with solid alliance and rapport. Most participants indicated outcomes do not have to be negative because of resistance. Resistance can enrich the outcomes if the therapist is creative enough to overcome resistance with motivational interview techniques and therapeutic rapport. Some participants reported examples of ways in which resistance affected outcomes, such as no call-no show, cancelations, dropouts, deviation from the original goal, and recidivation.

Interview Question 7

The seventh interview question was: How did gender, race, and socioeconomic class affect resistance? Participant responses were as follows:

As a psychologist, I encountered some difficulties administering specific tests with minority groups that have been culturally isolated and do not speak English fluently. Cultural barriers can interfere with helping minority groups. (Participant 1)

I use empathy to reduce the impact of cultural differences when I see clients of a different culture and race than mine. I have never lived in their minority culture and do not understand what it means to walk in their shoes. I ask what it means and feels to walk in their shoes. Asking when I didn't know or understand has helped me reduce resistance due to cultural and racial differences in the past. (Participant 2)

My experience from being a female therapist, working in a juvenile male sex offender's program that has various different cultures and ethnic groups, has taught me experientially the impact of culture on resistance. Different cultures and ethnic groups have different meaning and worldviews. Such differences cause misconceptions and misunderstandings that may lead to resistance to therapy. For example, having a group of 16 males convicted of sex offenses attend therapy with a female has its pros and cons. One advantage is that my gender became a motivation and incentive to attend and participate. The gender, racial, ethnic, and cultural differences of this group impacted the group dynamic in several ways.

For example, I had to establish numerous boundaries above-and-beyond normal to maintain order and safety. Inversely, my race (white culture) meant that I made assumptions about their minority groups that may not be true. Assumptions which they picked upon and brought to my attention. The most significant factor contributing to resistance in my groups is social class difference. In large, these clients assume that I am a member of the upper class and have

always been financially privileged and are clueless of what it is to be in their shoes. They concluded that I would be unable to see the world through their eyes. Indeed, gender and cultural variables can affect counseling and cause resistance. (Participant 3)

A lack of understanding of cultural norms, traditions and culture was a challenge in my experience. My frame of reference is middle-class, mid-western family values and lifestyle. Though I might not have had my client's unique cultural experiences, my multicultural competence helped me to understand their worldview. Understanding that individuals and families have different hierarchical structure and needs helped me understand whether we were both on the same page. Yes, perceived cultural difference contributed to client's resistance. (Participant 4)

Gender was not much of an issue; however, sociocultural factors were large scale factors within minority cultures, and it affected the client's thoughts, feelings, and behavior in therapy. Cultural factors affected attitude to therapy and the dynamics. (Participant 5)

The population I dealt with in the jail were mainly minority cultures that required cultural sensitivity. Understanding the clients' background, ethnicity, and belief system was important for effective therapy. My cultural sensitivity helped me to accommodate and respect differences in opinion, values, and attitudes of various different cultures. Cultural difference can affect treatment process. (Participant 6)

My experience is that there are numerous problems involved in counseling minority groups [race]. Rapport is difficult to establish because of the racial and/or cultural attitudes client have towards my difference. Consequently, the client often finds his own goals in opposition to counseling goals. Culture impacts therapy. (Participant 7)

In my experience, a cultural gap did lead to transference and counter transference. In some cases, clients expected punishment and rejection from me. There were times I drifted into excessive sympathy and indulgence with minority clients. (Participant 8)

I encountered a language barrier in cross-cultural counseling which hindered effective communication. Other problems I encountered were unwillingness to self-disclose and machismo attitude. (Participant 9)

I have had positive and negative experiences on how my gender and race relate to resistance to therapy. I do not agree that any group is totally bias-free, rather it manifests in different degrees. Various ethnic groups and cultures are apprehensive toward each other. I strive to improve my cultural awareness and skill by studying cultural competence journals and articles. I do not claim that my cultural competence is good enough to overcome cultural issues, but I find

admitting honestly to a client of a different culture when I did not understand and ask for meaning very helpful. (Participant 10)

Most of the participants indicated they encountered some level of barriers in counseling related to cultural differences, race, and gender. It appears that gender, culture, and economic class affect therapy. The majority of the participants reported developing their cultural competence skills, asking questions when there was doubt about the client's meaning, and using empathy to overcome cultural barriers.

Interview Question 8

The eighth interview question was: How did transference and countertransference contribute to resistance? Participant responses were as follows:

As a therapist, clients have projected feelings about someone else or a system onto me. When such projection persists, I have been tempted to display countertransference which can only intensify resistance. I deflated transference by avoiding responding or reciprocating my feelings (countertransference) towards the client to reduce resistance. (Participant 1)

My clients have occasionally directed their feelings and desire for another person toward me as a form of resistance. The most common type I encountered was mandated clients who blame their criminal behavior on their parents and consequently displayed oppositional and transference behavior to authority figures. As much empathy as I have for such clients, the fact is that transference stands in the way of positive therapeutic experience. (Participant 2)

Clients have resisted my therapeutic help by using a defense or enacting a past relationship with me. Transference impacts negatively on the therapeutic process and I avoid it by avoiding countertransference, picking up cues of defense, following anxiety and the wishes and feelings beneath them. (Participant 3)

My experience is that transference could be good or bad and can affect therapy positively or negatively. When a client reflects enjoyable aspects of their past relationships toward me as their therapist, therapeutic outcome is usually optimistic. In such case, my clients perceived me as caring, wise, and concerned about them. The reverse, when the transference was a negative memory, I addressed it right then and there. (Participant 4)

My clients have unconsciously shifted their emotions and desire that originally was associated with other persons, such as a parent or family member. I navigated through such transference by becoming aware of it and avoiding feeding into it.

Transference could lead to resistance if the therapist feeds into it. My clients have displayed oppositional behavior towards me that I realized was because I reminded them of a monster they encountered in the past. When I helped the client identify the incident where hostile emotions came from and through my preciously established empathy and rapport, assured the client of my nonjudgmental stance, transference and the attributing behavior stopped. (Participant 5)

I have personally encountered resistance due to transference stemming from racial and cultural prejudice. Memories of a traumatic experience could easily be transferred by any member of the hostile race and culture. Another population that I have experienced resistance due to transference with were teenagers that have problems with authority, especially ones that have a bad relationship with their parents. (Participant 6)

In my experience, transference and counter transference issues can impact resistance in therapy. For example, if a therapist is unaware of their own transference issues with the client, they might unknowingly create bias in the session by overly reacting towards the client. Such behavior can cause resistance in clients. This can be harmful to the therapeutic relationship and treatment because the therapist loses sight of the client's issues and are influenced more by their own personal issues. Similarly, the client might become increasingly resistant or less open to therapy if they are stuck in transference. Therapists should be aware of their own biases and transference issues in order to effectively help clients. (Participant 7)

In my early practice as a therapist, I did not have keen awareness of my own transference issues. As I became a more experienced therapist, I became aware of my issues and limitations. I am better now at avoiding transference and counter transference, consequently, resistance has reduced. (Participant 8)

In my experience, transference and counter transference were factors creating resistance. When I notice that my client was resisting because I remind him or her of somebody they hate or despise from past, I called attention to it right then. When the transference issue was resolved, resistance dropped. (Participant 9)

Rapport that I cultivated with the client before resistance helped me resolved the transference issue. Clients have projected their affect, emotions, conflicts, attitudes, wishes, and fantasies during therapy on me. My ability to recognize it as a form of transference helped the clients recognize their transference and resistance stopped. (Participant 10)

This question struck a nerve in all participants. They all strongly believed that transference and counter transference can significantly influence resistance, the therapeutic process, and ultimately outcomes. Most responses indicated transference

should not be ignored but should be addressed right then and there. Participants agreed that transference aggravates resistance and must be addressed if therapy is going to progress effectively. None of the participants indicated they responded to transference with countertransference.

Interview Question 9

The ninth interview question was: How did negative outcomes due to resistance reflect on you as a therapist? Participant responses were as follows:

My automatic response to a poor outcome of therapy is self-reflection. Unique and complex situations occasionally occur in my practice, but I use them as an opportunity for learning and development. When therapeutic intervention is unsuccessful, it affects my professional morale, but I try not to internalize the incident. (Participant 1)

Irrespective of the outcome, I habitually reflect on my performance afterwards for improvement. I strive to improve my strengths and reduce my limitations. To make sure I was not the reason for negative outcome, I reflect on my performance, level of stress, and personal matters to determine if they have any bearing on the negative outcome. (Participant 2)

Negative outcome in therapy is not my goal and gives me concern when it occurs. Consequently, I evaluate and refine my performance after each counseling session. To eliminate or avoid negative outcome in therapy, I am committed to continuous growth and professional development. Treatment outcome could be undesirable due to reasons beyond the control of the therapist, but no therapist enjoys negative outcome. (Participant 3)

In my opinion, negative outcome in therapy could be caused by client's factor, therapist's factor, or both. When I encounter a negative outcome, I thoroughly reflect on all the potential factors and determine what factors I am responsible for. I evaluate my performance, my self-awareness, potential burnout, and self-care and take necessary steps to avoid future repetition. (Participant 4)

Clients have dropped out of therapy because they lack interest to change and the employer agency blamed me for the negative outcome. Some agencies become more interested in financial gain and frown at losing a client. Such incidents cast a poor reflection on some therapists, even though, in actuality, various factors could have caused the drop out. (Participant 5)

In my first few years in the helping field, I was bothered each time therapy outcome was negative. Later, I realized I can't save them all. However, I invest in

my professional life continuously, acquiring certifications, studies, and training that can reduce or eliminate entirely a negative outcome of my sessions. There is no 100% mechanical efficiency; we all can only do the best. (Participant 6)

I have wondered what I could have done differently for a better result each time therapy outcome was not desirable. My passion is to help my clients; when that does not happen, some part of me takes it personal. I reflect on my approach, process, skills, knowledge, and determine if any of my personal variables contributed to the outcome. I invest in my personal development to be better than what I was last year. I give my best to each client I see. What happens in the end sometimes does not depend only on the therapist. It is a two-way street, between the client and the therapist. (Participant 7)

It taught me patience and how every client is different. Therapists need to develop various strategies because each client responds differently. My resistant clients triggered lots of growth for me through the years. Each case with bad outcome was an opportunity for growth and expansion of my tools. I am better off to face similar encounters in the future because I learned from the past. (Participant 8)

I am fully aware that there are client's variables that must be in play for therapy outcome to be successful. I have been trained and licensed to deliver effective service, and I ethically and conscientiously do my job. I will acquire the skill and knowledge necessary to be effective all the time, but the client factors are also in the equation. If other variables that are beyond my control affects outcome adversely, I will not worry over it. (Participant 9)

If your question is whether I develop low professional esteem when I encounter poor outcome, no I do not. So many things can go wrong in therapy that has nothing to do with the therapist. I can only take responsibility for my own actions or lack of it. There is no need to take responsibility for actions I had nothing to do with. (Participant 10)

Except for Participants 5 and 10, all respondents agreed that working with resistant clients does affect the therapist but usually for the better. Resistant clients offer the therapist an opportunity to develop better skills and increased patience. Participants reported engaging in healthy reflection on the causes of negative outcomes and making appropriate adjustments to achieve a positive outcome the next time. Participants did not allow their professional esteem to be damaged by poor results of therapy.

Interview Question 10

The 10th interview question was: How did working with resistant clients impact your effectiveness as a therapist? Participant responses were as follows:

Helped me to see resistance as a challenge and not hinderance. Also, it helped me redefine resistance in a more positive light. Finally, it motivated me to learn how to effectively navigate through one. (Participant 1)

Resistant clients can be a learning point, a growing point, and motivation to be better. Resistance made me patient., empathetic, and more competent. (Participant 2)

Working with resistant clients helps me to grow as a therapist. Resistant clients helped me understand that, just as each person is different, therapeutic interventions must be individualized to fit the client's need. The reasons for resistance can be personal and so must remedies be individualized. My experience with resistant clients has also motivated me to develop ability to recognize one and the motive behind it. I finally have realized the importance of developing strong rapport with my clients before resistance. (Participant 3)

Early in the field, I was too confrontational with the resistance. I had problems building stable rapport with my clients. However, after all these years, I have learned a lot about not engaging or allowing myself to get into confrontation with clients. Rather, building sustaining rapport with my clients has reduced the impact of resistance on my effectiveness. (Participant 4)

It actually improved my skills in motivational interviewing. It challenged me to devise creative ways to motivate resistant clients. (Participant 5)

My work with resistant clients has added to my effectiveness as a therapist and ability to work with diverse clients regardless of motivation level and presenting problems. (Participant 6)

Dealing with resistant clients challenged me to be the best I can be. I do not mean I don't struggle with some resistance anymore, but I have developed some tools to overcome most of them and I am getting better each time I encounter them. My confidence and competence to deal with resistance have come a long way. (Participant 7)

I think that working with resistant clients forces you to seek new strategies and approaches. (Participant 8)

Like they say, "Necessity is the mother of invention." Resistant clients challenged me to practice and develop new skills and interventions. (Participant 9)

All participants expressed positive aspects of working with resistant clients. All felt strongly their experiences made them better therapists. All believed these experiences were worthwhile and made them more effective as therapists.

Interview Question 11

The 11th interview question was: What advice would you give to new therapists who encounter resistant clients? Participant responses were as follows:

Expect resistance at one point; don't get into confrontation or opposition with your clients when it comes at you. Develop good rapport with your clients in the early stage of therapy; it will help to mediate resistance when it comes. (Participant 1)

Do not take the impact of resistance personally. Adjust areas you were responsible for and grow from it. (Participant 2)

First, relax. It's not your therapy. Second, be honest, trustworthy, genuine and empathetic. Third, study Choice Theory. Fourth, Identify and address transference and counter transference and address it immediately. Fifth, do not let it grow into a giant and yield negative outcomes. Sixth, study your client's body language and trust what it says. Seventh, seek consultation or supervision from someone with experience in the kind of resistance that you're encountering. (Participant 3)

It may be an indication the patient is not ready to change or deal with the issue. Proceed with caution and avoid fighting with the resistant client. Do not take it personally; it happens to seasoned therapists too. (Participant 4)

You can't win them all the time. Do not take it personally when they are not ready. Take responsibility when it was your fault and correct the mistakes. (Participant 5)

Don't get caught up if the client is resistant. Everyone is human. Don't feel like a client's resistance is your fault. Client's factors beyond your control can be the cause of the resistance. It happens to the best of us; make necessary adjustment and move on to the next. (Participant 6)

It came to my awareness that even when I have done everything right, other variables I cannot control can still bring up resistance. I can't save them all. Take resistance as a challenge, expect and prepare against it in every session. Invest lots of empathy, sympathy, and correctly conceptualize the issues. Be creative with your strategies. (Participant 9)

Resistance may not be a bad experience. Internalizing it or getting into an oppositional stance will destroy therapeutic alliance and rapport. Understand the meaning behind resistance. Take responsibility for the therapist's factors and make the clients aware of his/her factors. Pay attention to racial, cultural, ethnic, and social class differences. Identifying the root of resistance has been helpful to me in the past. (Participant 10)

All participants provided advice that addressed coping with resistance from diverse, significant angles. Some remarkable strategies included admitting responsibility and adjusting, establishing dependable rapport in the beginning, being creative with tackling resistance, letting negative outcomes motivate the therapist to use a new effective approach, and remembering they cannot save all clients. Participant 2 urged colleagues to "remember that all behavior has a purpose." Participant 1 advised "rolling with resistance as opposed to resisting resistance."

Interview Question 12

The final interview question was: What advice would you give to new clinicians who encounter resistant clients? Participant responses were as follows:

Resistance is not necessarily bad; it actually could enrich therapy. (Participant 1)

Do not fear resistance, actually expect it and the anxiety of encountering one would disappear. (Participant 2)

Do not respond with countertransference. (Participant 3)

Do not get into oppositional stance with client. (Participant 4)

Be culturally sensitive. (Participant 5)

Resistance could improve you. (Participant 6)

Resistance makes you a better therapist. (Participant 7)

Seek out training on navigating through resistance. (Participant 8)

Don't hesitate to consult your peers and supervisor. (Participant 9)

Don't hesitate to admit you are wrong when you are. (Participant 10)

Analysis of Data

The theme-based schematic shown in Figure 2 shows the phenomenological examination of counseling resistant clients. The themes that emerged from the data were (a) resistance is normal and is an expected part of therapy, but it is particularly likely to emerge among individuals who are mandated to therapy; (b) there are degrees of resistance that can be conceptualized as occurring along a continuum; (c) degrees of resistance are closely related to clients' motivation toward therapy; and (d) understanding the root of a client's resistance is vital to addressing it effectively.

Figure 2

Interrelationship Between Research Questions (RQs) and Participants' Responses

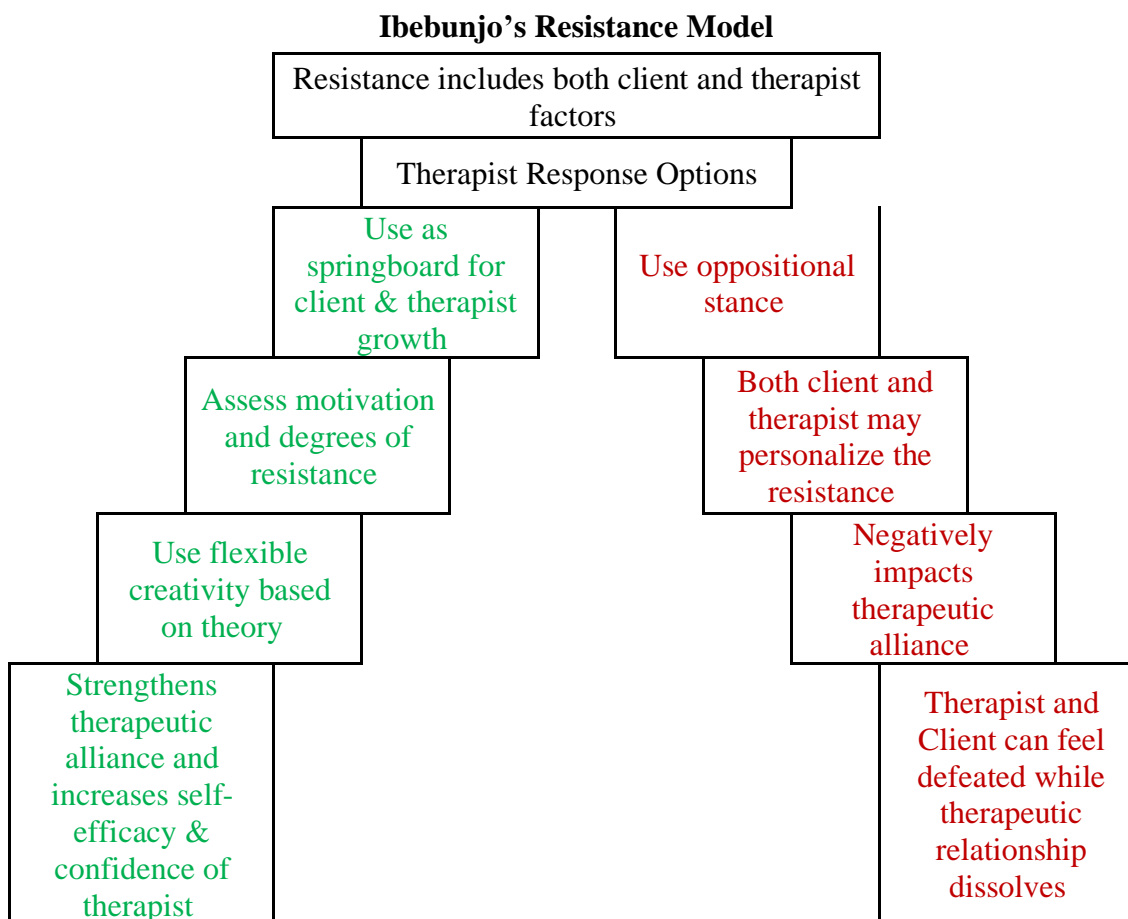


Figure 2 also illustrates the conceptualization of the responses to the research questions. RQ1 addressed managing resistance and its impact on the therapeutic process, RQ2 dealt with the personal impact of resistant clients, RQ3 related to navigating resistance to achieve the desired outcome, and RQ4 related to navigating through resistance with a flexible and creative approach. Greater effectiveness improves the therapist's clinical acumen, which circles back to the next resistant client.

Theme 1: Resistance is an Essential Component of Therapy

Figure 2 shows the responses from participants indicated how a therapist views resistance is vital and affects how the therapist deals with its presence in therapy. If the therapist sees resistance as an essential component of therapy, sees resistance as potentially beneficial, and expects some degree of resistance from every client, such a mindset will alleviate any anxiety or fear of encountering resistance. Expecting potential resistance from every client then becomes a catalyst for growth both for the client and the therapist. Understanding that resistance may be beneficial will motivate the therapist to determine the source, nature, and meaning of the client's resistance in order to address the opposition knowledgeably and meaningfully. If the therapist construes rightly the why, what, and how of the client's resistance, the therapist can then develop a flexible and creative intervention based on theory. Such an approach, as illustrated in Figure 2, would yield a strengthened therapeutic alliance, increased self-efficacy and confidence on the part of the therapist, and increased client satisfaction. On the contrary, if the therapist believes resistance is not beneficial, the therapist may get into an oppositional stance with the client. Both the client and therapist may personalize the resistance, which negatively affects the therapeutic alliance and results in both the therapist and client feeling defeated

as the therapeutic relationship dissolves. Participant 6 spoke for all of the participants when they stated, “I expect some degree of resistance from all my clients at some point during therapeutic process.” More than just being expected, the evidence presented in the data indicated resistance is a component of psychotherapy and may be more common when working with mandated clients.

Theme 2: Assessment of Degrees of Resistance

The nature, meaning, frequency, and intensity of resistance differ from one client to another. Proper assessment of resistance is necessary for effective intervention. The narrative accounts of the participants indicated there are levels or degrees of resistance. Degrees of resistance can be conceptualized as occurring along a continuum from mild resistance at the low end, normal resistance approximately in the middle, to excessive resistance at the high end. As such, conceptualizing resistance correctly is necessary in developing effective interventions. The degree of resistance is related to motivation toward therapy and the tactics resistant clients correspondingly employ to obstruct treatment. Thus, a therapist must remain alert to the client’s location on the continuum of resistance.

Participants referred to degrees of resistance several times in a variety of ways. Participant 5 believed resistance was an essential part of therapy that can be overcome with intentionality and some creative effort. Participant 4 expected resistance in therapy and preferred it over passivity. Participant 3 also preferred “normal resistance to passive participation from my clients” over resistance so extreme that it “prohibits treatment goals and objectives, obstructs therapy sessions and progress, and destroys therapeutic rapport.” Participants 2 and 9 viewed resistance as not necessarily negative. For example,

Participant 2 said they did “not mind such resistance” nor is “resistance necessarily negative—because it is an indication that pertinent issues are being addressed head on.”

The data also revealed transference can emerge as a form of resistance. For example, participants differentiated between transference that places the therapist at fault (e.g., “It is YOUR FAULT that I am here, and that makes me very angry with you!”) and transference that places another person at fault (e.g., “It is my DAD’s fault that I am here but YOU remind me of my dad! That makes me very angry with you!”). In the final analysis, just as clients have various ways and reasons to display resistance, therapists must have creative ways to tackle resistance. A client’s readiness for change emerged as a significant factor in resistance according to Participant 9: “If the client is not ready to change, the desired outcome may not be achieved.”

Theme 3: Resistance as a Springboard for Personal and Professional Growth

The data collected in this study indicated RIP prompted the participants to seek out better approaches or interventions to RIP, making resistance a springboard for growth both for the therapist and the client. Discovering evidence that therapists in this study thought resistance enhanced therapy was illuminating (Figure 2). For example, Participant 9 said, “In my experience . . . normal resistance can improve therapeutic rapport.” Participant 3 not only considered resistance to be “an important component of the therapy process,” she further claimed “the therapeutic process could be enriched by nominal resistance.” Participant 2 did not mind resistance when “it helps to process presenting problems.”

In these conditions, client resistance can serve as a springboard for improvement and the discovery of more effective approaches. Participant 4 described the situation with

a medical metaphor: “Sometimes resistance can be a way of locating the problem area much like a physician would isolate the infection or problem area to treat.” As such, resistance can inform the therapist’s approach to establishing rapport (RQ1), managing the therapeutic process (RQ2), dealing with personal impacts of resistant clients (RQ3), and navigating resistance to achieve the desired outcome (RQ4).

As with the physician locating a physical problem, resistance can provide an encouraging place to start addressing a mental issue. For example, Participant 1 urged therapists to “redefine resistance in a positive way.” That optimistic stance helped this participant to “redefine resistance positively.” It also motivated this participant to view resistance as an opportunity for both personal and professional development. Further, other participants indicated resistance can encourage greater collaboration; for example, Participant 1 proposed a diplomatic way to give a client ownership and feelings of efficacy and support by creating a co-collaborating environment: “I own up every way my behavior or leadership has provoked resistance and then modify factors within my control that are causing resistance.” As per Participant 10, the client’s position “must be rightly understood, not agreed, for any progress to happen.” To accomplish this, Participant 10 “validates reasons for resistance” and gives the client choices to determine whether they proceed or not.

Theme 4: Flexible Creativity Allows Customized Solutions

In the left wing of Figure 2, flexibility and creativity are used to (a) rightly conceptualize the source and meaning of resistance and, (b) develop custom designed interventions that are unique to each individual client. According to the participants, this approach is relevant because the motive, source, nature, and display of resistance differ

from one client to another. The ability to constantly modify and remodify strategies that will effectively address the twists and turns from a client's resistance is necessary. This ability can be gained from the evidence reflected in the statement made by Participant 2: "I think resistant clients can be a learning point to make a clinician better, more empathetic, and even more skilled." The evidence presented in the findings showed this positive attitude emerged from the affirmative reciprocity between approaching resistant clients with flexible creativity and improving one's clinical skill set. According to Participant 2, "In my experience, mild or normal resistance was an opportunity for growth. Such resistance was instrumental in treatment goals and an effective therapeutic process." Participant 5 acknowledged that resistance "actually improved my skills in motivational interviewing" because "it challenged me to devise creative ways to motivate resistant clients." Participant 3 reiterated the beliefs of the other participants:

Working with resistant clients helps me to grow as a therapist. Just as each person is different and therapy must be individualized, the reasons for resistance can differ and the approach to overcome it must be individualized [READ creative and flexible]. Developing my ability to recognize resistance and where it comes from is an essential first step toward being effective. Resistant clients also force me to be flexible if I am to be effective. I have to adapt and work toward gaining my client's respect and trust before therapy can begin.

Flexibility is important to working through resistance. In Participant 3's experience, "If the therapist and client work through the resistance, most clients *do* engage in therapy. Their initial resistance had little impact on outcome." The evidence showed therapists who approach resistant clients with an open mind and a willingness to be flexible and creative, without taking anything personally, are more effective with resistant clients. Table 2 provides further evidence that resistant clients helped the participants develop better skills and patience.

Table 2*Further Evidence of Flexible Creativity with Resistant Clients Improving Effectiveness*

Participant	Flexible creativity to fit client's proclivity.
Participant 4	Early on I was too confrontational with the resistance. It caused major problems maintaining a therapeutic rapport.
Participant 6	Similarly, my work with resistant clients has added to my effectiveness as a therapist and ability to work with diverse clients regardless of motivation level and presenting problems.
Participant 8	Working with resistant clients forces you to seek new strategies and know your own limits.
Participant 9	It challenged me and allowed me to practice and develop new skills and interventions.

Participants' Definitions of RIP

Table 3 contains details of participants' definitions of resistance that reflected how they perceived and dealt with resistance. The definitions were largely similar, indicating this study's participants had the same general attitudes, and correspondingly, exhibited the same general behaviors during the interviews. Participant 1's definition of resistance centered on indecision about making indicated changes, a perspective included in virtually all of the definitions. Participant 7 noted ambivalence can be verbal, behavioral, or both. Participant 3's definition of resistance was on target as it succinctly addressed opposition to therapy and to change. It was similar to Participant 5's definition, which included the added explanatory element of denial. In fact, Participants 3, 5, 8, 9, and 10 gave definitions with very similar components, although Participant 10's comment about wasting her clinical time made it appear to be more personal for her. Participant 4 provided a focused context of resistance but also included a generic definition: "The client is unwilling or unable to complete the task, hence 'resists' or 'becomes resistant' to completing the task." Despite the strong undercurrent of references

to resistant clients' negative impacts on other people, such as family members, Participant 2's definition was the only one that framed resistance as the contradictory perspectives between two persons.

Table 3

Participants' Definitions of Resistance

Participant	Definitions of resistance
Participant 1	I define resistance as the person's vacillation or indecision to change. Counseling involves change. Change, in turn, involves losing A to gain B, as well as venturing out of one's known comfort zone. Indeed, some individuals may be "resistant" to change because of this.
Participant 2	Resistance is when one party would like for something to change and the other does not want to acknowledge it is a problem nor want to change it.
Participant 3	A client who does not want to engage in therapy, consider change, or change in any way. A client who states that they are interested in change but whose behavior contradicts it.
Participant 4	I approach the question from an analytical perspective. In the context of a psychotherapeutic relationship, it occurs when psychological defense(s) (ex. denial, avoidance, projection, etc.) are evoked in response to anxiety producing situations. A therapist may assign homework for the Client to complete before each session. The homework may require the Client to confront their fear and anxiety over a past traumatic event. The Client is unwilling or unable to complete the task, hence "resists or becomes resistant" to completing the task.
Participant 5	When a client is not ready for a change or not motivated enough to engage in a therapeutic relationship or is in denial of the problem.
Participant 6	Resistance involves refusal to accept, comply with, or openly participate in/with something.
Participant 7	When a client displays ambivalence to change, not just verbally, but by overt observations and behavior.
Participant 8	Effective therapy is the willingness to seek change, participation, and compliance using a therapeutic process. In a nutshell, there must be a willingness to change. When the client lacks some or all the factors of effective therapy as listed above, the client is resistant to therapy.
Participant 9	I define resistance as a client refusing to accept or cooperate with therapy because they have been forced to therapy and not ready or willing to change.

Participant	Definitions of resistance
Participant 10	When clients that have no business in therapy are forced to therapy for the wrong reasons and they end up wasting my time, fight all through the therapeutic process because they are not ready to change.

Summary of Findings

Results of the study showed resistance is normal and is an essential component of therapy, though it is particularly likely to emerge among individuals who are mandated to attend therapy. Results also showed there are degrees of resistance that can be conceptualized as occurring along a continuum and that are closely related to clients' motivation toward therapy with corresponding tactics and transference. A client's degree of resistance (with its intervening motivation toward therapy with its corresponding tactics and transference) can serve as a springboard for professional and personal development that, in turn, improves the efficacy of the therapist and yields better client satisfaction, which ultimately enhances the therapeutic alliance (RQ1). RQ2 related to the impact of RIP on therapeutic process and results showed perceiving RIP as potentially positive can have benefits for the therapist, such as (a) personal and professional development, (b) creative flexibility for diverse clients, (c) expansion of techniques and strategies, and (d) knowledgeably and effectively navigating through RIP with the acquired development may improve therapeutic process and outcome. In addressing RQ3, results showed the challenges presented by resistant clients prompted therapists to search for more effective approaches and strategies, resulting in professional improvement and confidence that boosted the confidence and satisfaction of the therapists and resulted in positive self-appraisal. Results for RQ4 showed perceiving RIP as an essential component of therapy and viewing RIP as potentially positive may reduce or even

eliminate fear and anxiety of resistance. Also, because challenges from resistance can result in self and professional development, the therapist becomes more knowledgeable and effective in navigating through RIP in each new encounter.

Conclusion

This chapter presented the participants' responses to the interview questions, which were then used to address the research questions. The themes that emerged were (a) resistance is normal and is an expected part of therapy, and it is particularly likely to emerge among individuals who are mandated to therapy; (b) there are degrees of resistance that can be conceptualized as occurring along a continuum; (c) degrees of resistance are closely related to clients' motivation toward therapy; and (d) understanding the root of a client's resistance is vital to addressing it effectively. A summary and discussion of these themes are provided in Chapter V, along with suggestions for professional practice and recommendations for future studies.

CHAPTER V: DISCUSSION

Chapter IV offered the results of the analysis of the participants' responses to the interview questions and their relevance to the research questions. The themes that emerged were presented to provide a glimpse into the therapists' experiences with resistant clients in psychotherapy. A discussion, summary of the themes and their relationship to existing literature, and a conclusion are provided in this chapter. Additionally, some suggestions for professional practice are offered to therapists, especially entry-level therapists who may encounter resistance in the future. Last, recommendations for future research are advanced.

Restatement of Purpose of the Study

The purpose of this qualitative phenomenological study was to explore and understand the lived experiences of therapists who dealt with resistance to psychotherapy and how that resistance affected therapeutic rapport and the process, progress, and outcome of therapy. The intention was to understand how the therapists overcame resistance and the impact of client resistance on the therapists as professionals.

Relating Findings to Prior Literature

Prior research indicated resistance is a common problem in the mental health industry (Beutler et al., 2011; Norcross, 2011). The participants' responses supported this idea as they stated resistance was a frequent encounter in their professional experience as mental health therapists and psychologists. Results of one study indicated clients who hold a high level of ambivalence to therapy are prone to resistance (Norcross, 2011). The findings of the current study correspond with the Norcross (2011) study in that there is a relationship between level of motivation and degree of resistance. Norcross also reported

fitting the therapeutic strategy to a client's proclivities reduces resistance. One of the findings of this study was, specifically, that the use of flexible creativity to fit the uniqueness of each individual client reduces resistance. Though the literature included recognition of the problem of RIP, no studies were found related to how resistance affected the therapists through their experience, how the therapists perceived the experience, how they navigated through the experience, and the impact on the outcomes of counseling. The current study was designed to explore, in much detail, the lived experiences of therapists' encounters with resistance to counseling.

This study was facilitated using the phenomenological approach of the qualitative methodology. One round of interviews, each lasting approximately 1 hour, was conducted using a semi-structured interview process based on 12 open-ended questions, and, when needed, follow-up or clarifying questions were asked. After meeting the qualifying participation criteria, 10 participants (two clinical psychologists and eight licensed mental health therapists) with extensive experience with resistant clients agreed to participate after being offered a financial incentive. The findings of this research revealed valuable experiential knowledge of dealing with resistant clients. The findings satisfactorily answered the four research questions:

1. How does resistance in psychotherapy affect therapeutic rapport?
2. How does resistance in therapy affect the therapeutic process?
3. How does the attitude of the client affect the therapist?
4. How do therapists effectively navigate through the resistance?

Research Findings

Findings showed resistance is normal and an expected part of therapy, but it is particularly likely to occur with individuals who are mandated to attend therapy. Findings also showed there are degrees of resistance that can be conceptualized as occurring along a continuum. A third finding indicated degrees of resistance are closely related to clients' motivation toward therapy. Fourth, there is a relationship between a client's motivation to therapy and resistance. Finally, resistance can serve as a platform for personal and professional development. This development, in turn, can positively influence rapport (RQ1), the ability to manage the therapeutic process and outcome (RQ2), the ability to deal with the personal impact of resistance (RQ3), and the ability to navigate through resistance to achieve the desired outcome (RQ4).

Relating Findings to Research Questions

In reviewing the data collected from the participants in this study, the following themes emerged: (a) resistance is normal and is an expected part of therapy, but it is particularly likely to emerge among individuals who are mandated to therapy; (b) there are degrees of resistance that can be conceptualized as occurring along a continuum; (c) degrees of resistance are closely related to clients' motivation toward therapy; and (d) understanding the root of a client's resistance is vital to addressing it effectively. The data collected from the participants strongly indicated resistance can be controlled and successful navigating through resistance is possible. One technique the participants used to navigate through resistance effectively was to anticipate resistance in every therapy and see resistance as an opportunity to enrich the therapeutic relationship. The data also

showed the continuous assessment of resistance is beneficial in conceptualizing the nature of the resistance correctly and designing a corresponding strategy of approach.

The first research question related to the impact of resistance on therapeutic rapport. The findings yielded that resistance could influence therapeutic rapport in two ways depending on how the therapist responds to RIP. For example, if the therapist views resistance as an essential component of therapy, understands the motive behind the resistance, and is able to creatively design a strategy that fits the underlying motive of RIP and the individuality of the client, the therapeutic alliance will be strengthened. Conversely, if the therapist internalizes resistance and gets into an oppositional stance with the client, the therapeutic alliance will diminish.

The second research question related to how resistance affects the therapeutic process. Again, the therapist's reaction to RIP is crucial and predicts how RIP will affect the therapeutic process. If the therapist views RIP as an important component of therapy, understands the underlying factors of the resistance, avoids internalizing the RIP, and avoids taking an oppositional stance with the client, then resistance may positively affect the therapeutic process (RQ2).

RQ3 surrounded the impact of resistance on the therapist. The findings of this study indicated the therapist's reaction to a client's resistance determines how RIP affects the therapist. Figure 2 illustrated therapists' response options. How RIP affects the therapist hinges on the choice made by the therapist. If the therapist chooses the left-wing option (i.e., uses as springboard for client and therapist growth, assesses motivation and degrees of resistance, uses flexible creativity based on theory), the impact will include increased self-efficacy and confidence of the therapist. However, if the therapist chooses

the alternative option illustrated in the right wing of Figure 2 (i.e., uses oppositional stance, or both client and therapist personalize the resistance), the findings in this study indicated the therapist and client will feel defeated as the therapeutic relationship dissolves (RQ3).

The last research question related to how the therapists navigated through resistance. Again, the therapist has options as illustrated in Figure 2. If the therapist expects resistance as an important component of therapy, uses resistance as a springboard for client and therapist growth, and engages in flexible creativity based on theory, based on the findings of this study, the therapist will have used these strategies to overcome resistance, thereby successfully navigating through resistance (RQ4).

Relevance of Findings to Counseling Industry

Resistance is an Essential Component of Therapy

Based on the responses from the participants, a logical conclusion is that resistance is an expected part of therapy. Participant 6 spoke for all the participants when she said, “I expect some degree of resistance from all my clients at some point during the therapeutic process.” More than just being expected, the evidence presented in this study showed resistance is an essential part of therapy and can be beneficial and almost guaranteed when clients are mandated to counseling.

Use Flexible Creativity to fit Clients’ Proclivity

The use of flexibility and creativity enables therapists to create custom-fit interventions for each unique client resisting therapy. Participant 2 stated, “I think resistant clients can be a learning point to make a clinician better, more empathetic, and even more skilled.” The evidence presented in this study showed this positive attitude

emerged from the affirmative reciprocity between approaching resistant clients with flexible creativity and improving the therapist's clinical skill set. Participant 1 said resistance affected her therapeutic practice by providing opportunities to cultivate her skill set: "In my experience, mild or normal resistance was an opportunity for growth. Such resistance was instrumental in treatment goals and an effective therapeutic process." Participant 5 acknowledged that resistance "actually improved my skills in motivational interviewing" because "it challenged me to devise creative ways to motivate resistant clients." Participant 3 stated:

Working with resistant clients helps me to grow as a therapist. Just as each person is different and therapy must be individualized, the reasons for resistance can differ and the approach to overcome it must be individualized [READ creative and flexible]. Developing my ability to recognize resistance and where it comes from is an essential first step toward being effective. Resistant clients also force me to be flexible if I am to be effective. I must adapt and work toward gaining my client's respect and trust before therapy can begin.

Flexibility is important to working through resistance. In Participant 3's experience, "If the therapist and client work through the resistance, most clients do engage in therapy. Their initial resistance had little impact on the outcome." The evidence supports that therapists who approach resistant clients with an open-minded willingness to be flexible in treatment without taking anything personally are more effective with resistant clients. Such flexibility may support looking at resistance from a variety of perspectives rather than just the counselor's primary theoretical orientation. From a humanistic perspective, a counselor might view the client's resistance as avoidance of any unpleasantness that might negatively alter their client's life scripts (Watson, 2006). If that does not provide an advantageous perspective for overcoming the resistance, adapting to another perspective such as family systems that perceives resistance as stemming from an attempt to protect the family's status quo may be more beneficial (Watson, 2006). Looking at multiple

options for explaining the resistance can support more creative, flexible and effective interventions to overcome it.

There are Degrees of Resistance

Results of this study showed there are levels or degrees of resistance that can be conceptualized as occurring along a continuum from mild resistance at the low end, normal resistance approximately in the middle, to excessive resistance at the high end. Thus, understanding the degree of resistance is necessary for the assessment of the source, nature, meaning, and the underlying motive of resistance and is vital in constructing appropriate countermeasures.

The degree of resistance is related to motivation toward therapy, tactics the resistant client correspondingly employs to obstruct treatment, and issues of transference. Thus, a therapist must remain alert to the client's location on the continuum of resistance. The data indicated effective therapists may wish to conduct regular "resistance checks" to establish the client's initial degree of resistance and continue to monitor whether or how resistance varies across sessions.

Participants referred to degrees of resistance in several ways. Participant 5 believed resistance was an essential part of therapy that can be overcome with intentionality and some effort. Participant 4 expected resistance in therapy and preferred it over passivity. Participant 3 also preferred "normal resistance to passive participation from my clients" as well as over resistance so extreme that it "prohibits treatment goals and objectives, obstructs therapy sessions and progress, and destroys therapeutic rapport." Participant 9 simply allowed that resistance was not "necessarily bad."

In addition, the data collected in this study indicated more precise knowledge of the degrees of resistance predicts the counselor's therapeutic approach. Correspondent to that, the therapist can try to qualify the degree of transference or differentiate between transference that places the therapist at fault and transference that places another person at fault.

In the final analysis, as per Participant 9, "If the client is not ready to change, the desired outcome may not be achieved." The other participants' opinions did not correspond with Participant 9, as they reported resistance has important information, nonetheless. For example, Participant 2 "does not mind such resistance" and "resistance is not necessarily bad—because it is indication that penitent issues are being addressed." In this way, resistance can also provide footholds to launching therapy. Perhaps resistance manifests as an inverse reaction to one's readiness for action (change). In Prochaska and DiClemente's (1983), stages of change model, perhaps the degree of one's resistance may be represented by the client's perceived gap between their current stage and the action stage. If that is true, counselors would benefit from meeting the client where she or he is in that model and setting a course for incremental change within that framework.

Resistance can be a Springboard for Personal and Professional Development

The participants in this study thought resistance enhanced therapy. For example, Participant 9 stated, "In my experience . . . normal resistance can improve therapeutic rapport." Participant 3 not only considered resistance to be "an important component of the therapy process," she further claimed, "the therapeutic process could be enriched by

nominal resistance.” Participant 2 did not mind resistance when “it helps to process presenting problems.”

As with the physician locating a physical problem, resistance can provide an encouraging place to start to address a mental issue. For example, Participant 1 urged therapists to “redefine resistance in a positive way for the client and therapist to address.” This more optimistic stance helped Participant 1 to “redefine resistance in a more positive light that lends itself to be worked on or addressed. It also motivated me to learn how to address it.” As a foothold for launching therapy, resistance can encourage greater collaboration; for example, Participant 1 proposed a diplomatic way to give a client ownership and feelings of efficacy and support by creating a co-collaborating environment: “I own up every way my behavior or leadership has provoked resistance and then modify factors within my control that are causing resistance.” Participant 10 similarly reported the importance of rightly correctly conceptualizing the underlying reasons for the client’s resistance in order to be helpful.

There is a Relationship Between Motivation to Change and Resistance

Participants’ definitions of resistance were largely similar, suggesting they had the same general attitudes, and correspondingly, exhibited the same general behaviors during the interviews. Participant 1’s definition of resistance centered on indecision about making indicated changes, a concept virtually all of the definitions included. Participant 7 noted ambivalence can be verbal, behavioral, or both. Participant 3’s definition of resistance succinctly addressed opposition to therapy and to change and was similar to Participant 5’s definition, which included the added explanatory element of denial. In fact, Participants 3, 5, 8, 9, and 10 gave definitions with very similar components,

although Participant 10's comment about wasting her clinical time made it appear to be more personal for her. Participant 4 provided a focused context of resistance but also included a generic definition: "The client is unwilling or unable to complete the task, hence 'resists or 'becomes resistant' to completing the task." Despite the strong undercurrent of references to resistant clients' negative impacts on other people, such as family members, Participant 2's definition was the only one that framed resistance as the contradictory perspectives between two persons. This means the therapist's perception of resistance sets the stage for how they handle resistance.

Relevance of Findings to Counseling Education

Because resistance has been described as a common problem (Beutler et al., 2011; Norcross, 2011), counseling educators may consider teaching students to anticipate resistance in every psychotherapeutic interaction. Findings of this study support that counseling educators should teach students that it is counterproductive to engage in an oppositional stance with resistant clients. Based on the findings of this research, counseling students may benefit from being taught, while in training, that resistance is potentially beneficial and can serve to enrich the therapeutic experience. Students can be taught that resistance is preferred over passivity in therapy, creative flexibility is an effective way to navigate through resistance, and the client's resistant behavior is not nearly as important as how the therapist responds. A student-therapist's concept of resistance will determine how the therapist navigates through resistance.

Recommendations for Future Studies

Ways to effectively cope with resistant clients were not exhausted in this study. Therefore, more studies are needed to gain a greater understanding of the dynamics of

resistance and ways of navigating through them through evidence-based strategies. Also, a case study approach that involves observations of both clients and therapists may reduce bias and enrich findings. Additionally, the use of a case study approach is warranted to determine the efficacy of mandated counseling and whether it is beneficial. Last, a comparison of voluntary clients versus mandated counseling may help identify which group is more prone to resistance and which group benefits more from psychotherapy.

Summary

The challenges psychotherapists face with resistant clients can be overwhelming. This study involved an exploration of the lived experiences of psychotherapists with resistant clients to understand the impact of resistance on therapeutic rapport, process, outcome, on the therapist, and navigating through resistance. The researcher used the results to develop a framework for effectively dealing with resistant clients that includes the following: (a) expect resistance as an essential component of therapy, (b) use flexible creativity to fit the proclivity of diverse clients, (c) assess for degrees of resistance, (d) use resistance as a springboard for personal and professional development, (e) understand there is a relationship between motivation to change and resistance, and (f) never take an oppositional stance with a resistant client. The findings of this study were used to offer some professional suggestions to the mental health industry, to counseling educators, and for future study.

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APPENDICES

APPENDIX A:
Institutional Solicitation Letter

Institutional Solicitation Letter

To Whom it may concern,

I am writing to tell you about a dissertation study on Examining Therapists' Experience with Resistant Clients being conducted by this PhD Student at Argosy University. The purpose of this research study is three-fold: Resistance with non-psychotic clients is a prevalent issue, causing clinicians to ponder "What did I do wrong or what could I have done differently?" Consequently, this study examines this phenomenon to better understand the dynamics in play. Another purpose of this study is to gain insight from veteran therapists who have encountered similar cases. Specifically, to better understand the therapist's intrapersonal conditions during the experience, the strategies they utilized in the process, and the outcome of the therapy. This will provide this researcher with a firsthand examination of fellow clinicians' ways to deal with a non-psychotic client's resistance. The final purpose of this study is curiosity; except in a supervisory experience, clinicians hardly talk about their bad experiences. They are more inclined to share their success stories than those that drudged, that were unpleasant, with unmotivated clients, and almost impossible cases. This study intends to examine such experiences and afford awareness and encouragement to other clinicians that are presently or will have their own personal encounter with non-psychotic resistant clients.

You may be eligible for this study if you are between the ages of 18 and 71, are a licensed psychotherapist, with minimum experience of five years.

It is important to know that this letter is not to tell you to join this study. It is your decision. Your participation is voluntary. Whether or not you participate in this study will have no effect on your relationship with [institution's name eg: Drug Abuse Foundation).

If you are interested in learning more, please take this quick demographic questionnaire:

<https://docs.google.com/forms/d/1PF2ZerNKrn70KQR8MCYiHB48mIr5K1xImFOd45n2OB4/edit#responses>

You can also call me at 561-290-9149. Based on your responses, an informed consent form will be mailed to you to be signed and returned before the study will go forward.

You do not have to respond if you are not interested in this study. If you do not respond, no one will contact you, but you may receive another letter in the mail which you can simply disregard.

Thank you for your time and consideration. I look forward to hearing from you.

Sincerely,

ELISHA I. IBEBUNJO

National Louis University

5110 Sunforce Drive Suite 102

Tampa, Florida 66364

561-290-9149

APPENDIX B:
Individual Solicitation Letter

Individual Solicitation Letter

To Whom it may concern,

I am writing to tell you about a dissertation study on Examining Therapists' Experience with Resistant Clients being conducted by this PhD Student at National Louis University. The purpose of this research study is threefold: Resistance with non-psychotic clients is a prevalent issue, causing clinicians to ponder "What did I do wrong or what could I have done differently?" Consequently, this study examines this phenomenon to better understand the dynamics in play. Another purpose of this study is to gain insight from veteran therapists who have encountered similar cases. Specifically, to better understand the therapist's intrapersonal conditions during the experience, the strategies they utilized in the process, and the outcome of the therapy. This will provide this researcher with a firsthand examination of fellow clinicians' ways to deal with a non-psychotic client's resistance. The final purpose of this study is curiosity; except in a supervisory experience, clinicians hardly talk about their bad experiences. They are more inclined to share their success stories than those that drudged, that were unpleasant, with unmotivated clients, and almost impossible cases. This study intends to examine such experiences and afford awareness and encouragement to other clinicians that are presently or will have their own personal encounter with non-psychotic resistant clients.

You may be eligible for this study if you are between the ages of 18 and 71, are a licensed psychotherapist, with minimum experience of five years.

It is important to know that this letter is not to tell you to join this study. It is your decision. Your participation is voluntary. If you are interested in learning more, please take this quick demographic questionnaire:

<https://docs.google.com/forms/d/1PF2ZerNKrn70KQR8MCYiHB48mIr5K1xImFOd45n2OB4/edit#responses>

You can also call me at 561-290-9149. Based on your responses, an informed consent form will be mailed to you to be signed and returned before the study will go forward.

You do not have to respond if you are not interested in this study. If you do not respond, no one will contact you, but you may receive another letter in the mail which you can simply disregard.

Thank you for your time and consideration. I look forward to hearing from you.

Sincerely,

ELISHA I. IBEBUNJO

Argosy University

5250 17th St, Sarasota, FL 34235

561-290-9149

APPENDIX C:
Demographic Screening Questionnaire

Age: _____

Gender

Male

Female

Transgender

Other _____

Race/Ethnicity

African American

Caucasian

Hispanic American

Asian American

Bi/Multi-racial American

Other _____

Years of Practice

5 Years

10 Years

Above 10 Years

Your Licensure

LMHC

LSW

LMFT

Licensed Psychologist

Other _____

Religious Affiliation

- Baptist
- Catholic
- Jewish
- Methodist
- Mormon
- Muslim
- Orthodox
- Protestant
- Seventh Day Adventist
- Other: _____

What percentage of your clients do you identify as resistant clients?

Place of Employment

- Private Practice
- Government Agency
- Private Agency
- Not currently employed
- Other: _____

Would you be willing to grant this researcher an interview?

- Yes I will participate
- No I am not interested

What method of interview do you prefer?

- Over the phone
- Face to face
- Video Conference
- Other _____

APPENDIX D:
Informed Consent

Examining Therapists' Therapeutic Experience with Non-Psychotic Resistance Clients

Study Consent Form

You are being asked to take part in a research study of Therapists' therapeutic experiencing treating non-psychotic resistant patients. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about:

Many new counselors when encountering a resistant, non-psychotic client, may wonder "What did I do wrong or what could I have done differently?". This research is intended to examine this phenomenon to better understand the dynamics in play. By gathering the perceptions and experiences of seasoned therapists who work with resistant clients, this research hopes to better understand the therapists' intrapersonal therapeutic relationships during the experience, the strategies they utilized to address resistance, and its impact on the therapy. This will provide a firsthand examination of fellow clinicians' ways to deal with a non-psychotic client's resistance to assist emerging and seasoned clinicians to better address their own resistant clients.

What we will ask you to do: If you agree to be in this study, we will conduct an interview with you. The semi-structured interview questions include:

1. How do you define resistance?
2. Tell me about your experience with working with resistant clients.
3. How did resistance to psychotherapy affect therapeutic rapport?
4. How did resistance to therapy affect your therapeutic process?
5. How did you navigate through resistance to therapy?
6. How did the client's attitude toward psychotherapy affect the therapeutic outcome?
7. How did your gender, race, and theoretical orientation relate to resistance to therapy?
8. How did transference and countertransference impact resistance?
9. How did working with resistant clients impact you as a therapist?
10. What would you do differently if you saw your resistant clients all over again?
11. How did working with resistant clients impact your effectiveness as a therapist?
12. What advice would you give to new clinicians who encounter resistant clients?

The interview will take about one hour to complete. With your permission, we would also like to audio record the interview. Although follow up contact is not anticipated, any follow up contact will be conducted by email or phone and only consist of clarification questions that should not exceed 30 minutes maximum.

Risks and benefits:

Although risks should be minimal, if unforeseen consequences occur by sharing your experiences, you will be referred to a mental health professional for assistance. The primary benefit is an opportunity to assist mental health clinicians with insights and strategies to address resistant clients. You will receive a copy of the findings of the study if so desired.

Compensation: No compensation

Your answers will be confidential. The records of this study will be kept private. In any sort of report, we make public, we will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researchers will have access to the records. If we tape-record the interview, we will destroy the tape after it has been transcribed. The transcript will be coded, and the identity of the respondent remains anonymous.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide to take part, you are free to withdraw at any time. Also, the time, location, and mode of interview is absolutely the prerogative of the interviewee.

If you have questions: The researcher conducting this study is **Elisha I. Ibebunjo** under the supervision of Dr. Joffrey S. Suprina, his dissertation Chair. Please ask any questions you have now. If you have questions later, you may contact Elisha Ibebunjo at ibebunjoelisha@yahoo.com or at 561-290-9149. If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) at IRB#: SC16-083 or access their website at https://mycampus.argosy.edu/portal/server.pt/community/argosy_university_campus_common/200/_Institutional_Review_Board

You will be given a copy of this form to keep for your records.

Statement of Consent: I have read the above information and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____ Date _____

Your Name (printed) _____

In addition to agreeing to participate, I also consent to having the interview tape-recorded.

Your Signature _____ Date _____

Signature of person obtaining consent _____ Date _____

Printed name of person obtaining consent _____ Date _____

This consent form will be kept by the researcher for at least three years beyond the end of the study.

If you wish to participate, please click the link below for demographic survey:

<https://docs.google.com/forms/d/e/1FAIpQLSce6l37zRbpxOA6kqXKLk6gwXd42LsvUe6WxjVRpBo7YHfsiQ/viewform?c=0&w=1>

APPENDIX E:
Structured Questionnaire

1. How do you define resistance?
2. Tell me about your experience with working with resistant clients.
3. How did resistance to psychotherapy affect therapeutic rapport?
4. How did resistance to therapy affect your therapeutic process?
5. How did you navigate through resistance to therapy?
6. How did the client's attitude toward psychotherapy affect the therapeutic outcome?
7. How did your gender, race, and theoretical orientation relate to resistance to therapy?
8. How did transference and countertransference impact resistance?
9. How did working with resistant clients impact you as a therapist?
10. What would you do differently if you saw your resistant clients all over again?
11. How did working with resistant clients impact your effectiveness as a therapist?
12. What advice would you give to new clinicians who encounter resistant clients?