



Working with Resistance in Therapy: A Theoretical Evaluation

Terapide Dirençle Çalışmak: Teorik Bir Değerlendirme

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ÖZ

Danışanlar terapide kimi zaman kendilerini ifade etmekte zorlanabilir ya da terapiye karşı direnç gösterebilir. Danışmanlık seanslarında kendilerini ifade etmekte güçlük çeken, direnç gösteren danışanların birçok nedeni vardır. Danışanın direncini anlamak, terapötik ilişkiyi, direncin nedenlerini ve oluşturduğu diğer problemleri anlamak ya da müdahaleler yardımıyla danışanı motive etmek için faydalı olabilir. Bu bağlamda, bu makale psikolojik danışmanlık yaklaşımları dikkate alınarak danışan direncine genel tanımlar içinde odaklanmaktadır. Bu derleme makalesi sonucunda danışanların terapideki direncinin "problemleri sürdürme-deneyimin reddi ve çarpıtılması", "başa çıkma süreci", "paylaşma ya da paylaşmama: danışman kendini ifade etme" kavramları etrafında kümelendiği görülmektedir.

Anahtar kelimeler

Psikolojik Danışmanlık, Direnç, Özsavunma, İnkâr, Çarpıtma.

ABSTRACT

Clients sometimes have difficulties to express themselves in therapy or may resist the therapy process. There are many reasons of clients' who have difficulties to express themselves and resist in counselling sessions. Understanding the resistance of the client can be useful to understand the therapeutic relationship, the causes of resistance and other problems it creates, or to motivate the client with the help of interventions. In this context, this article focuses on client resistant within general definitions considering the psychological counselling approaches. As a result of this review article, it was determined that the resistance of the clients in therapy is clustered around the concepts of "maintaining the problems—denial and distortion of experience", "coping process", "to share or not to share: counsellor self-disclosure".

Keywords

Psychological Counselling, Resistance, Self-defence, Denial, Distortion.

INTRODUCTION

Client resistance is an area where there are several perspectives on the subject. There are many different viewpoints about the definitions of the process that clients have difficulties to express themselves to their counsellors in counselling sessions. For instance, Dent and Goldberg (1999) claimed that resistance is a result of negative attitudes which prevents people from improvements. Piderit (2000) also used a similar definition to explain the resistance however; he suggested that although one may have negative emotions preventing the change, the individual might have positive intentions about it. Corey (2004) also defines resistance as a situation that offers in-depth research into clients' personal problems and painful feelings. These situations are assessed differently by the approaches. It is generally seen as resistance. Also such behaviours are assessed as a rich source of information about clients.

There are many indicators of the emergence of resistance in therapy. These are (Voltan- Acar, 2012):

- Selective silences
- Protecting yourself
- Talking about side problems, not basic problems
- Failing to establish behavioral goals

Some of the resistant behaviours include; not attending sessions (forgetting the day/time of the session), coming late, questioning trust in the group, temporary silences, asking for advice, not setting behavioural goals, protecting other members, ignoring each other, not contributing to each other, talking too much or not speaking, talking about side problems rather than basic problems, stopping suddenly when speaking, trying to correct a word he said, slipping, wanting to socialize outside the group without speaking enough in the group, not doing the assigned homework, and dealing with other things in the sessions (Bölükbaşı, 2020; Koydemir, 2016; Ozer, 2017; Tuna, 2016).

Although there are many approaches to therapy, the notion of resistance is rooted in psychodynamic tradition (Watson, 2006). However, it is possible to come across as many resistance patterns as there are psychotherapy theories. For all approaches, the notion that resistance is a defense or a shield is common. In this article, it is considered important to talk about the way some important approaches deal with resistance in terms of providing a general perspective. Also, to work within a multicultural framework, it is important to use different techniques in therapy. In this context, common therapy approaches are discussed in this article. Accordingly, psychoanalytic approach and person-centred approach were mentioned as pure therapy types. Also, cognitive-behaviour approach, which is one of the integrated therapy approaches, and the multimodal approach, one of the eclectic approach types, have been emphasized.

Psychoanalytic Approach

In the psychoanalytic model, which first used the notion of resistance in the early 1900s, resistance may be any element that prevents therapeutic communication and prevents the client from revealing the previous subconscious material (but not all resistance is negative). Resistance refers to any thought, attitude, emotion, behavior that the client consciously or

unconsciously puts forward that strengthens the status quo and prevents the path of change (Corey, 2008). By the view of psychoanalytic approach, sometimes the clients show 'resistance' against their therapists. To give an example of a resistance statement: "Sometimes it feels like we are wasting our time. However, I come to therapy to solve my problems. Not to describe the things I love. It feels like you're just listening to me and walking around my problems". This attitude, as well as being an obstacle for the treatment, also bears a large amount of information which can be used for the good of clients. According to psychoanalytic approach, one type resistance is about the clients who are unwilling to end the therapies. Such clients stop making progress, become reluctant to being independent and feel sceptical about their potential. Shortly, they attempt to slow down the therapy process (Newman, 1994). Another kind of resistance sources from the abnormal relationships ranging from hostility to over flirtations between the clients and the therapist. It should also be noted that such emotional instabilities might sometimes occur because of the faulty attitude of a therapist. Nevertheless, majority of these cases happen owing to a client's personality (Layden, Newman, Freeman, & Morse, 1993). There are also other types of resistance mostly related to the clients' reluctance in communicating with the therapist. Such cases can usually be realised when the client expresses that s/he does not want to discuss in a session or when s/he simply gives cliché answers to the therapist's questions (Newman, 1994).

Resistance has been interpreted as an integral part of the therapy by many traditional psychodynamic therapists (Milman & Goldman, 1987). It is caused by an internal conflict between the one's desire to alter him/herself and fear of the change which sources from losing the seemingly safety of old habits. Therefore, the resistance could be regarded as an unconscious defence mechanism of psychological symptoms. Newman(1994) states that therapist should not indicate any sense of discomfort because of such resistance, instead s/he should take this into his/her advantage to understand and help the client better; such an attempt would be successful if the therapist is capable of transforming the resistance into a tool of empathy and tailor-made inventions for the clients. In the psychoanalytic approach, interpreting resistance before conflict is the standard procedure. Because if the conflict is interpreted first, the client can use his/her pre-existing defenses to reject those comments. Instead, if one interprets resistance first and emphasizes how the client uses silence to protect herself, less resistance may be encountered. In addition, according to the therapist who handles resistance with a psychoanalytic approach, when the client shows resistance, she/he is actually very close to gaining an insight. For this reason, instead of being seen as an antitherapeutic factor, resistance is analyzed and translated into a therapeutic factor. The therapist enables the client to confront her resistance, talks about the reasons and makes interpretations, and provides an insight into her/his resistance (Corey, 2008). The analytical approach does not aim for rapid changes in the therapy process. Psychoanalytic therapy takes a long time. Maybe resistance will continue for a very long time. However, when identified and interpreted over and over, clients begin to have a greater understanding of their resistance than before. In sum, major techniques include gathering life-history data, dream analysis, free association, and interpretation and analysis of resistance and transference.

Cognitive-Behavioural Approach

Cognitive-Behavioral therapists are similar to psychoanalysts in that they see resistance as an ordinary phenomenon, but they differ from them by attributing this to the effect of change on

people rather than unconscious forces (Newman, 1994). In this approach, irrational beliefs are seen as the source of resistance. Clients' references to therapy and how change will take place are the most important factors that determine resistance. Accordingly, adherence to treatment does not depend on resistance, but on the client's thoughts on resistance. In other words, it is thought that underlying the resistance are the "how to/ must" thoughts, unrealistic expectations and irrational beliefs observed in most clients. Although clients' beliefs that "it is very difficult to change" or "I will not succeed somehow even if I try" are not functional, such thoughts are not easy to change (Ellis, 2002). According to the cognitive approach, resistance in therapy is generally seen as "schematic resistance, approval resistance, moral resistance, procedure resistance". The schemas of the clients are decisive in the schematic resistance. For example, a scheme such as "smart person does not go to therapy" affects the client's approach to the therapeutic process. Resistance to affirmation refers to the client's intense expectations of being understood and approved by her/his counsellor. On the basis of moral resistance are the thoughts of the client, which manifest themselves with the words "how to/must". Resistance to the procedure is the type of resistance observed in clients who have difficulties in accepting the rules of the therapeutic process. The schematic processing of the clients also manifests itself in the therapy environment and may interfere with the therapeutic relationship (Leahy, 2003). Schemes, which have a personal content, can be briefly defined as the basic parts of the personality that add a systematic bias to the processing of information (Beck, Freeman, & Davis, 2004).

In addition, resistance is often viewed as non-compliance with treatment, which is often seen in forms such as not completing homework or tasks between sessions (Leahy, 2003). This non-compliance is explained using learning and reinforcement models. In this perspective, the factors that frequently contribute to resistance are the client's lack of skills, reinforcement conditions (eg, inappropriate reinforcers), and goal incompatibility between the therapist and the client. Shaping can be given as an example of many techniques used to increase compliance with the therapeutic process. For example, if non-compliance with therapy is caused by keeping goals too high, small behavioral goals can be planned and each step can be rewarded with appropriate reinforcers (Leahy, 2003). Cognitive-behavioural therapists use methods such as psycho-education, questioning irrational thoughts, enhancing cooperation, determining the returns and consequences of change in order to better adapt the client to therapy (Newman, 2002).

Person Centred Approach

In the individual-centred approach, resistance is a concept categorized by the therapist's inability to address the client's emotions and behaviours (Rogers, 2007). In other words, resistance is a natural form of defense created by the client who feels threatened against wrong counselling attitudes. According to this approach, Rogers's primary aim was to enter and understand the client's perception and inner world as deeply as possible. For the sake of such a compelling task, it is important to put aside the judgement and personal point of view, and to try to be a part of the client's experience; to become integral with the client. Rogers describes the relation between the client and therapist as the act of two subjective perceptions becoming one in the client's inner world on the purpose of creating an improved perception for the client. Rogers defines this process as the phenomena of therapy and he seeks to understand what actually happens in this mutual experience. The 'why' questions in this context seeks to

explain the experience with the help of knowledge about human nature and the dynamics of human behaviour. Rogers also stated that when the therapist enters the world of a client, s/he would find him/herself in a foreign land where s/he should not try to use his/her own authority to intervene events, instead, he should try to be attuned to it (Rogers, 1959).

Rogers (1959) introduces two psychological mechanisms which he termed as denial and distortion. The existence of denial and distortion is caused by a division between the experiences in organismic level and the acknowledgements in the 'self-concept'. These terms function as the guardians of the conscious awareness; any new information which threatens the individual's perception of reality is not given access to his/her inner world. The self-concept is protected against alien experiences with the help of denial and distortion and the alien information, which is contradictory for the client's state of mind, is prevented from being identified as the self-experience. Thus, the individual's conscious awareness does not become obliged to strive against ambivalences or the individual's positive self-regard. Also Rogers (1951) describes these psychological mechanisms as follows:

- Denial: Denial happens when the individual's self-concept is in contradiction with his/her emotions. The new information is prevented from reaching the consciousness, since it might lead to the fall of positive self-regard. For example, a mother's role to take after her children might become a boring task however; conscious awareness does not allow this experience to be acknowledged. Since a caring maternal role, which is adopted by the aforesaid mother, contradicts with the feeling of boredom, the organismic experience is seen as a threat to the mother's world-view and consequently it is denied.
- Distortion: Distortion functions as a misinterpretation mechanism. While denial aims to ignore the information, distortion aims to manipulate it for the sake of self-concept and for resolving contradictions. The boredom concept in the mother example above could be interpreted as being worn out and thus, the acknowledged version of the boredom does not possess a threat against the self-concept.

Gillon (2007) claims that there is no place for psychological defence mechanism in healthy minds. Such people are completely open to any messages and the information they convey from the outer world. Every organismic experience, either good or bad, is received by the individual with no fear of contradiction. Such information flow would consequently lead to an unconditional positive regard, and the individual finds him/herself in a position where s/he does not worry about satisfying certain set of values. Eventually, the individual embraces every organismic experience without any separation. Reflection rather than confrontation seems important when working with resistance in individual-centred therapy (meeting client resistance with reflection rather than confrontation). For example, when working with substance addiction, when clients' resistance to substance use increases, it is important to implement client-centred approaches and interventions that allow clients to claim their own indecision about substance abuse (Sommers-Flanagan & Sommers-Flanagan, 2004).

Solution-Focused Brief Approach

Solution-focused therapy treats the concept of resistance as the client's unwillingness to change and the therapist's departure from the treatment system (Selekman, 1993). Besides, resistance is not seen as a useful concept. Collaborative approach to resistance is important, rather than power and control. Collaboration is the essence of solution-focused approach, for this reason,

resistance and denial irrelevant concepts in this approach. Therefore, it is vital for therapist to keep the communication channels open for the client. deShazer (1994), states that the notion of resistance prevents therapists because it implies that the clients do not want to change. If the therapist initiates a therapeutic relationship by seeking a negative reaction (resistance) from the client, there is a possibility that this will be discovered and reinforced. Treatment might become ineffective for a number of reasons; therapist's inadequate ability to establish empathy, losing the interest of the client by focusing on unimportant issues, or remaining limited to a single treatment method. In the existence of such problems, therapists are responsible for creating better conditions to revive cooperation (Sharry & Owens, 2000).

According to the solution-focused approach's perspective on the concept of resistance, there is no resistant client, there is therapist who cannot cooperate. Within this approach, therapists try to establish collaborative communication with clients, rather than dealing with situations resistant to change. Although the state of being useful and focusing on solution is temporarily suppressed by adverse conditions, clients have the ability to act in a solution-oriented manner (Gingerich & Eisengard, 2000). The important thing is to be receptive to the client and to give him time. For example, "patience of the therapist is needed in cases of willingness or prejudice towards therapy for such attitudes "Is it necessary to talk? What will change when you tell it? In such cases, the solution-focused approach suggests approaching with non-directive, game-based or expressive techniques that do not rely only on verbal communication (Gil, 2002). In addition, the use of metaphors is among the important techniques that can be used when working with resistance in solution-focused therapy (Zatloukal, Žákovský & Bezdičková, 2019).

Motivational Approaches

In terms of motivational approaches, resistance and noncompliance are usually interpreted as signs of conflicting emotions and reluctance to improve (Engle & Arkowitz, 2006; Westra & Arkowitz, 2010). The statement of "I don't understand why I have to go through the therapy process," said an alcohol-addicted client. Isn't it okay if I only get consultancy for my problem?" reflects an example of this. Low motivation can be a result of the actions of the therapist; lack of indirectness or requests regarding change (Beutler, Harwood, Michelson, Song, & Holman, 2010; Miller, Benefield & Tonigan, 1993; Patterson & Forgatch, 1985). Such incidents reveal that the client is being pushed by the therapist for a change s/he is not ready for, and the pressure causes the client to develop emotional contradictions about the change or treatment (Miller & Rollnick, 2002; Moyers & Rollnick, 2002). As a result of this, clients create a self-defence mechanism against change unconsciously. Maladjustment of the therapists also calls forth to the appearance of resistance signs. Misalliances are usually accompanied by lack of collaboration in therapies and evoke hostility against therapist's suggestions (Watson & McMullen, 2005). Resistance is most usually seen in people who are defensive and conservative, and clients who do not bear such characteristics get better results from the treatments. Last but not least motivation plays a key role in therapies; although it is hard to define and measure motivations, studies indicate that motivation gained during the treatment process is more beneficial than the motivation which already existed before therapies (Preston & Murphy, 1997).

Unlike traditional approaches, the motivational approach encourages thinking about how counselors' interaction styles can affect resistance in the therapeutic setting. In motivational

approaches, techniques of "avoiding discussion, rolling with resistance, expressing empathy, developing inconsistencies and supporting self-efficacy" are used in increasing intrinsic motivation and decreasing resistance (avoiding argumentation, rolling with resistance, expressing empathy, developing discrepancies, and supporting self-efficacy. Because arguing with the client speeds up resistance and defensive attitudes. Instead, the reluctance to change an existing behaviour is considered natural and understandable. It is also thought that instead of assuming that all clients are "ready for action", they may initially be indecisive about change. This consulting approach provides a perspective that facilitates movement throughout the change process (Miller & Rollnick, 2002)

Multimodal Approach

Multimodal approaches have an eclectic structure that aims to benefit from many interventions and strategies in therapy. 'Aim of Multimodal Therapy is to reduce psychological suffering and to promote personal growth as rapidly and as durably as possible'. Problems with resistance stem from numerous influences: "misinformation such as incorrect beliefs and assumptions, defensive reactions such as avoiding situations that trigger negative feelings, lack of self-acceptance" (Lazarus, 1981). This approach suggests that clients often suffer from a large number of problems. In this respect, one tries to look at resistance from multiple angles (Dryden & Mytton, 1999). Resistance is generally considered to be the main factors that make it difficult for clients to successfully cope with the problems they bring to therapy. Generally, problems interpreted as client's resistance are believed to actually involve the therapist's resistance. Therefore, putting the client in a single pattern in interaction with the client and evaluating it from there is seen as the main source of resistance (Lazarus, 2006).

Defensive reactions bear similarities with Freud's defensive mechanisms. They are basically a medium for self-distraction used for ignoring situations which are undesirable to realise. Lazarus (1997) states that the multimodal therapy is not a mixture of other theories but it is typical. Defensive reactions help individuals to overlook disturbing emotions by means of denial, losing touch with one's self and deception. Defensive reactions mostly occurs unconsciously and they can be observed in situations where the acceptance of a specific situation is painful (e.g. seriousness of an illness). Lazarus suggests that they are diversions such as the replacement of one necessity, which cannot be satisfied, with another. For example, a woman who is unable to give birth to a child may choose to satisfy her necessity for an offspring by means of animal caretaking. In the multimodal approach, there is little ground for stereotypical assumptions because, the method itself advises to be receptive to every possibility and to make use of different kind of techniques (Dryden & Mytton, 1999). The general goal of this approach when working with resistance is to adapt the treatment to the client by addressing factors such as the client's expectations, readiness for change, and motivation. The therapist's style (e.g. degree of direction and support) depends on the client's needs and the situation (Corey, 2013). Also, in the therapeutic process, a multifaceted evaluation is made, such as "behaviour, affect, sensation, imagery, cognition, interpersonal relationships, and biological factors". Also, a process of guided discovery, using open questions, helps the client to explore their own defensive attitudes. Additionally, Lazarus (2007) recommends a questionnaire created as a Multimodal Life History Inventory in studies on resistance. This inventory is intended to evaluate the motivation of the client towards the therapy process. After the first clinical evaluations in which this information belonging to

clients is reviewed, it is important to determine the appropriate therapeutic approaches and to create a modality profile. This multimodal framework then provides a basis for utilizing unique intervention techniques, bridging and tracking.

DISCUSSION

In this part, the ways of working with challenging clients and turning their difficulties to express themselves in counselling sessions to being more disclosure to their counsellors were discussed. Also information about counsellor self-disclosure which is seen crucial by some researchers to help clients to be more disclosure was presented.

Maintaining the Problems—Denial and Distortion of Experience

According to the perspective of Person Centred Approach, individuals who are in need of evaluations from outer sources become addicted to inflating their worth in order to protect their self-concept against any threats. When they encounter ambivalence, they suffer from incongruence and start feeling disturbed. Next, a psychological defence mechanism intervenes to remove the discomfort and the contradictions.

However, defence mechanisms most usually functions as a double edged sword; they both keep the person away from distress and cause disturbance because of the oppression of organismic experiences. There are also masters of managing these defence techniques. Such people rarely feel disturbance in their lives and do not even consider going through therapy sessions. However, isolating the self-concept for a long term inevitably produces catastrophic effects for those individuals; a triggering tragic event would force the individual face his/her hidden weaknesses. Because the person has not developed any ability to cope with instability, fear or confusion before, his/her whole world turns upside down. To sum, making excessive use of these defence mechanisms damages the user sooner or later. On the other hand, having an unconditional positive regard redeems the individuals by awakening them and helping them to understand that trying to fit in specific set of values is only an illusion preventing them from uniting with their inner self. Overcoming the defensive behaviours would eventually rewards the individuals with an opportunity to be truly him/herself and still be accepted (Dryden & Mytton, 1999).

Coping Process

There are many ways to deal with resistance and decrease the rate of defence mechanisms. Some of them will be expressed in this theme. Newman (1994) suggests some ways to encourage clients to express themselves much more in counselling sessions.

1. The question “Why the client resists” is an important one and it should be answered by the client. Engaging the client to discover the facts behind his/her resistance might be very beneficial for treatment process.
2. The types of resistance might change over time; clients may have different patterns of resistance in their treatment history. To reveal these differences, the client might be canalized by the therapist to examine him/herself, or s/he could even be asked directly. There could be several questions to ask such as: When and why did the client felt reluctant to receive help in the past? Is there any similar experience in the client’s memories which resembles the emotions

in his/her current resistance? Is the client's current resistance bears any similarity to his reluctance to change in the past?

3. Could there be a distinctive problem for the client that prevents him/her from changing? Sometimes, having a better grasp of the client's inner world, way of think, perception or values could illustrate the obstacles to change.

4. Fear factor is one that should be dealt with delicately; most clients have a sense that they have underlying fears waiting to surface when they comply to change. It could be comforting for the client if these fears are discussed. For instance, in some cases where the problems have deep roots, clients might get used to the safety of familiarity; it could be very challenging to give up excuses which are created for the deficiency of something (e.g. shyness and the depression of loneliness: feeling comfortable alone). Attempting such changes could be terrifying for the client and could induce resistance as a result (cf. Beck et al., 1990; Layden et al., 1993; Young, 1990). It is also possible for clients to feel that their lives would become much more compelling if they become subjected to change. Such processes could even lead to a sense that they would lose their identity. Mahoney (1991) termed such resistance as "self-preserving function". In order to show the seriousness of such resistance Mahoney (1991) exemplifies a case where the client considers the change and annihilation as equals.

5. Misunderstandings in communication can also lead to resistance. If the therapist cannot express him/herself clearly, or if the client cannot interpret the therapist's message accurately, the client might stop collaborating with the therapist.

6. Is the client advanced enough to understand that change is positive? Some client's might not be ready to change since they do not possess the necessary skills and understanding required to undergo such changes. Therapists could find out these deficiencies (problem-solving, planning, communication, rational responding, perspective-taking) (O'Donohue & Krasner, 1994) so that they could seize if the resistance is motivational or related to deficits.

7. However traditional psychoanalysts, therapists should seem neutral and anonymous medium to their clients, humanistic framework changed this attitude. In the late 1950s, therapists who adopt Roger's approach are the first practitioners of therapist self-disclosure (Farber, 2006). Some of the research results show that over 90% of therapists self-disclose to their clients (Mathews, 1989; Edwards & Murdock, 1994). Yalom (2002) claims that: "If therapist disclosure were to be graded on a continuum, I am certain I would be placed on the high end. Yet I have never had the experience of disclosing too much. On the contrary, I have always facilitated therapy when I have shared some facet of myself."

The solutions mentioned above are general ways for counsellors to deal with challenging clients in sessions. Each client has different traits and they need also different sensibilities. On the other hand, therapist self-disclosure is a controversial and discussed subject. Also "therapists are inhibited from talking honestly and comfortably about their boundary crossing and self-disclosure practices when they fear that their words and actions will be misconstrued as unethical." Therapist self-disclosure is a very broad term that has been defined differently by many researchers. One of the comprehensive definitions is made by Bloomgarden & Mennuti (2009) as "anything that is revealed about a therapist verbally, nonverbally, on purpose, by accident, wittingly, or unwittingly, inclusive of information discovered about them from another source."

Successful therapy is seen related to depending on a “good therapeutic relationship” or “alliance.” Therapists’ attitude is so crucial and determinant in this context. For instance, therapists who are too chit-chatty, willy-nilly about their personal life and personal experiences with their children, their families, their own trials and tribulations, may affect their clients’ motivation. Thus, clients are obliged to waste their time while they are listening to their therapists. Also this can decrease the clients’ trust to their therapists that is why they do not focus on their clients enough. On the contrary, therapist who has too distances to their clients. For this reason, clients may be lack of the richness of being connected with therapist. That is extremely harmful for the clients’ positive change. The best acceptable way is being neither “too much” nor “too little”. It is struggling issue for therapists that how they can make the best choices and the ideal amount of self-disclosure to give their clients. “Balance” is seen as the most outstanding term and the most effective way of change and healing process. It is clear that when the self-disclosure is used properly, clients feel themselves more comfortable to connect with their therapist and express their private sides (Bloomgarden & Mennuti, 2009).

CONCLUSION

Resistance can be defined as an element that prevents clients from living their unique worlds in the process, their inability to be here and now, their isolation from the therapeutic environment, and therapeutic communication in both individual and group counselling environments. However, despite this general definition, how we define and conceptualize resistance is largely based on our theoretical stance and our expectations from the client (Umucu & Voltan-Acar, 2011). As Benjamin Disraeli mentioned above “Actions may not bring happiness, but there is no happiness without action.” There are many different reasons of clients for having struggles to be open and expressive in counselling sessions. Therefore it is exactly difficult to suggest certain ways for counsellors to deal with it for each client. Therefore, identifying the processes which contribute to the clients’ process of change is not easy for counsellors. It is proposed that counsellors should try to find the right fit for each client and be careful with sensitivity their clients’ needs (Bloomgarden & Mennuti, 2009).

As it was mentioned in the literature review part, while some approaches define clients as “resistant”, others do not prefer to use this term. Although psychoanalytic approach emphasises the different types of client resistance, cognitive behavioural approach focuses on conflicting emotions and reluctance to improve. Nevertheless, person centred approach claims that counsellors should become integral with the client and also one in the client’s inner world. Also, this approach describes psychological mechanisms of clients as “denial” and “distortion”. On the other hand solution focused brief approach emphasises the importance of collaboration between clients and counsellor to open channels for client to grow. Finally, multimodal approach talks on defensive reactions and claims to be receptive to every possibility and to use of different kind of techniques. Nonetheless, as I mentioned above, some researchers give importance to counsellor self-disclosure. Kottler (2003) states that the therapist who uses therapy-relevant self-disclosure invites the client to follow the lead and cultivates trust, perceived similarity, credibility, and empathic understanding. Furthermore, when we look at the ways of helping clients to decrease their expressions and self-disclosure in sessions, it can be said that first point is trying to understand the reasons why clients resist. In conjunction with that having an unconditional positive regard, being consistent, having better grasp of the client’s inner world and expressing a positive way of communication are too

crucial. Additionally it could be useful to talk on the importance of change with clients to encourage them.

LIMITATIONS AND RECOMMENDATIONS

The limitation of Turkish resources that provide information about the concept of "resistance" encountered in the process of psychological counseling reveals the importance of this introductory article. In addition, although there are many therapy approaches used in the therapy process, some of them are included in this article. This is an important limitation of this article. In this respect, it is thought that conducting studies on how resistance is handled in both theory and practice in different therapy approaches and how to work with resistance will meet an important need.

REFERENCES

- Beck, A.T., Freeman, A., Davis, D.D., & Associates (2004). *Cognitive therapy of personality disorders*. New York: Guilford.
- Beutler, L.E., Harwood, T.M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance level. In: J. Norcross (Ed.). *Psychotherapy relationships that work*. Oxford: Oxford University Press.
- Bloomgarden, A. & Mennuti, R.B. (2009). *Psychotherapist revealed: therapists speak about self-disclosure in therapy*. New York: Routledge.
- Bölükbaşı, A. (2020). Bireysel psikolojik danışma sürecinde sessizlik öncesi ve sessizlik sonrası sözel tepkilerin incelenmesi. *Journal of Advanced Education Studies*, 2(1), 94-110.
- Corey, G.(2004). *Theory and practice of group counseling*. Belmont: Thomson Learning.
- Corey, G.(2008). *Psikolojik danışma, psikoterapi kuram ve uygulamaları*. (Çev. Tuncay Ergene). Ankara: Mentis Yayınları.
- Corey, G. (2013). *Case approach to counseling and psychotherapy*. USA: Brooks/core.
- deShazer, S. (1994). *Words were originally magic*. New York: Norton.
- Dent, E. & Goldberg S. (1999).Challenging "resistance to change". *The Journal of Applied Behavioral Science*, 35(1), 25-41.
- Dryden, W. & Mytton, J. (1999). *Four approaches to counselling and psychotherapy*. New York: Routledge.

- Edwards, C., & Murdock, N. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling & Development, 72*(4), 384–389.
- Ellis, A. (2002). *Overcoming resistance: A rational emotive behavior therapy integrative approach*. New York: Springer.
- Engle, D.E., & Arkowitz, H. (2006). *Ambivalence in psychotherapy: Facilitating readiness to change*. New York: Guilford Press.
- Farber, B.A. (2006). *Self-disclosure in psychotherapy*. New York: Gilford Press.
- Sommers-Flanagan, J. & Sommers-Flanagan, R. (2004). *Counseling and psychotherapy theories in context and practice*. Canada: John Wiley & Sons, Inc.
- Gil, E. (2002). Play therapy with abused children. In F. W. Kaslow (Ed.) & R. F. Massey & S. D. Massey (Vol. Eds.). *Comprehensive handbook of psychotherapy*. (Vol. 3, pp. 59–82). New York: Wiley.
- Gillon, E. (2007). *Person-centred counselling psychology: An introduction*. London: Sage Publications.
- Gingerich, W.J. & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process, 39*(4), 477-498.
- Kottler, J. A. (2003). *On being a therapist*. San Francisco: Jossey-Bass.
- Koydemir, S. (2016). Psikolojik danışma gruplarında geçiş aşaması. *Grupla psikolojik danışma içinde* (Ed. A. Demir & S. Koydemir). Ankara: Pegema Yayıncılık.
- Layden, M.A., Newman, C. F., Freeman, A., & Morse, S. B. (1993). *Cognitive therapy of borderline personality disorder*. Needham Heights, MA: Allyn and Bacon.
- Lazarus, A.A. (1981) *The practice of multimodal therapy: Systematic, comprehensive and effective psychotherapy*. New York: McGraw-Hill.
- Lazarus, A.A. (1997) Brief but comprehensive psychotherapy: The multimodal way. New York: Springer.
- Lazarus, A.A. (2006). *Brief but comprehensive psychotherapy: The multimodal way*. New York, NY: Springer.
- Lazarus, A.A. (2007) Multimodal therapy. In R. J. Corsini, & D. Wedding (Eds.). *Current psychotherapies*. Belmont, CA: Brooks Cole.
- Leahy, R.L. (2003). *Overcoming resistance in cognitive therapy*. NY: Guilford Press.
- Lipinska, D. (2009). *Person-centred counselling for people with dementia: Making sense of self*. London; Philadelphia: Jessica Kingsley Publishers.
- Mathews, B. (1989). The use of therapist self-disclosure and its potential impact on the therapeutic process. *Journal of Human Behavior and Learning, 6*(2), 25–29.
- Miller, W.R., Benefield, R.G., & Tonigan, J.S. (1993). Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*(3), 455-461.

- Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. (2nd ed.). New York: Guilford Press.
- Milman, D.S., & Goldman, G. D. (Eds.). (1987). *Techniques of working with resistance*. US: Jason Aronson.
- Moyers, T. B., & Rollnick, S. (2002). A motivational interviewing perspective on resistance in psychotherapy. *Journal of Clinical Psychology*, 58(2), 185-193.
- Newman, C.F. (1994). Understanding client resistance: Methods for enhancing motivation to change. *Cognitive and Behavioral Practice*, 1(1), 47-69.
- Newman, C.F. (2002). A cognitive perspective on resistance in psychotherapy. *JCLP/In Session: Psychotherapy in Practice*, 58(2), 165-174.
- Özer, İ.Ö. (2017). A Bump in Therapeutic Journey: Resistance. *Inonu University Journal of the Faculty of Education*, 18(3), 217-228.
- Patterson, G.R., & Forgatch, M.S. (1985). Therapist behavior as a determinant for client noncompliance: a paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology*, 53(6), 846-851.
- Piderit, S. (2000). Rethinking resistance and recognizing ambivalence: A multidimensional view of attitudes toward an organizational change. *Academy of Management Review*. 25(4), 783-794.
- Preston, D.L. & Murphy, S. (1997). Motivating treatment-resistant clients in therapy. *Forum on Corrections Research*, 9(2), 39-43.
- Rogers, C.R. (1951). *Client-centred therapy: Its current practice, implications and theory*. London: Constable.
- Rogers, C.R. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centred framework. In S. Koch (ed.). *Psychology: A study of science, Vol. III. Formulations of the person and the social context*. pp. 184-256. New York: McGraw-Hill.
- Rogers, C.R. (2007). The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy: Theory, Research, Practice, Training*, 44(3), 240-248.
- Selekman, M.D. (1993). *Pathways to change*. New York: Guilford.
- Sharry, J. & Owens, C. (2000). 'The rules of Engagement': A case study of a group with 'angry' adolescents. *Clinical Child Psychology and Psychiatry*, 5(1), 53-62.
- Tuna, E. (2016). Psikoterapide direnç anlamak ve dirençle çalışmak. *AYNA Klinik Psikoloji Dergisi*, 3(3), 10-25.
- Umucu, E. & Voltan-Acar, N. (2011). Counselors' intervention of the cultural factors that have elements of resistance in group counseling. *Ege Journal of Education*, 1(12), 99-113.
- Voltan-Acar, N. (2012). *Grupla psikolojik danışma ilke ve teknikleri*. Ankara: Nobel Yayın Dağıtım.

- Watson, J. C., & McMullen, E. J. (2005). An examination of therapist and client behavior in high and low alliance sessions in cognitive-behavioral therapy and process experiential therapy. *Psychotherapy: Theory, Research, Practice and Training*, 42(3), 297-310.
- Watson, J. C. (2006). *Addressing client resistance: Recognizing and processing in-session occurrences*. Retrieved January 29, 2021 from <http://counselingoutfitters.com/Watson>.
- Westra, H. A., & Arkowitz, H. (2010). Combining motivational interviewing and cognitive behavioural therapy to increase treatment efficacy for generalized anxiety disorder. In D. Sookman, & B. Leahy (Eds.). *Resolving treatment impasses with resistant anxiety disorders*. pp. 199-232. UK: Routledge.
- Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapist and their patients*. New York: HarperCollins.
- Zatloukal, L., Žákovský, D. & Bezdíčková, E. (2019). Utilizing metaphors in solution-focused therapy. *Contemporary Family Therapy*, 41(2), 24–36.