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## TRANSFERENCE, COUNTERTRANSFERENCE, AND RESISTANCE: UNCONSCIOUS DETERMINANTS OF DILEMMAS

Transference, countertransference, and resistance are all psychological processes that affect the ongoing nature of psychotherapy, and all are presumed to be unconsciously determined (Auld & Hyman, 1991). *Transference* is an unconsciously influenced emotional reaction of the patient to the psychotherapist and (in a less technical sense) other health care providers that originates from the patient's earlier experiences related to significant others, especially caregivers, and that are inappropriate to the present context or way in which the therapist is currently dealing with the patient. *Countertransference* is the unconscious reactions of the psychotherapist (and other clinicians as well) that are stimulated by a given patient, the characteristics of a given patient, and, in particular, to the transferences of a given patient, that is, "countertransference proper" (Orr, 1954). If not consciously recognized by the therapist, these internal reactions are likely to be dealt with inappropriately by the clinician in his or her verbal or behavioral responses to the patient. Finally, *resistance* is an unconscious influence within the psy-

chotherapy patient that acts against the therapeutic process, which results from the patient's wish to avoid the anxiety associated with his or her traumatic experiences, painful recollections, or personally unacceptable thoughts, wishes, or emotions that threaten to come into the patient's awareness.

Because all three of these important psychotherapeutic concepts are presumed to be unconscious mental processes, that is to say, processes operating outside the level of awareness, they are all predicated on a psychoanalytic or psychodynamic conceptualization of psychotherapy (e.g., Freud, 1912/1958a). In addition, most psychodynamically oriented psychotherapists would likely agree that the ambiguity that arises out of each of these processes tends to be a major source of clinical dilemmas, although perhaps seen as specific to the psychoanalytically oriented psychotherapist. For instance, there is substantial ambiguity surrounding what aspects of the session have been generated by the clinician and the current treatment context versus that which may be a carryover from the patient's past experiences, both with transference in the patient and countertransference in the clinician. Historically, all of these terms—transference, countertransference, and resistance—have felt somewhat out of place to psychotherapists working within a cognitive-behavioral or family systems framework (e.g., Scaturo, 2002c). Although the psychoanalytic terminology may feel awkward in other theoretical paradigms, the dilemmas that these processes generate have been viewed increasingly by those working in the area of psychotherapy integration as sources of conflict that are common to most treatment contexts with health care providers from diverse theoretical orientations and disciplines.

### DILEMMAS OF TRANSFERENCE

Transference is a term that is formally reserved to refer to the unconscious relationship that a psychotherapy patient has with his or her psychotherapist, and more specifically a psychoanalyst. However, there has been increasing recognition that such a relationship exists not only in other forms of psychotherapy (e.g., cognitive-behavioral and family systems) but in other health care contexts as well. In essence, there is the potential for a variant of transference to exist whenever there is a relationship with a health care "provider" who is taking on some sort of caretaking role with the patient, reminiscent of the patient's relationships with earlier caregivers (e.g., parental) in his or her life. When applied to interpersonal relationships outside of the psychotherapeutic context, the transference phenomenon is technically designated as *projective identification* in object relations terms (J. S. Scharff & Scharff, 2003). However, this phenomenon, as well as its pervasiveness outside the context of psychotherapy, has become most evident in the literature on the doctor-patient relationship with the family physician. Recognition of the importance of this relationship in all of its forms (i.e., conscious and

unconscious) in part accounts for the proliferation of case consultation seminars, known as “Balint groups,” in family practice residency training programs at medical schools across the country to grapple with the psychosocial aspects of the medical patient (Johnson, 2001; Johnson, Brock, Hamadeh, & Stock, 2001). The name of these case consultation groups is derived from the seminal work in this area in the 1950s and 1960s by Michael Balint (1957), a British psychoanalyst.

Balint’s goal in conducting such case consultation seminars was to teach psychotherapeutic skills and recognition of the influence of the doctor–patient relationship to physicians in general medical practice (Keith et al., 1993). Because Balint’s (1966) theoretical perspective was predicated on psychoanalysis, he tended to confine his attention to the patient’s transference and countertransference relationship with the family doctor. That is to say, the patient’s subjective distortions of the family doctor’s relationship that emanate from the quality of the patient’s past relationships with family, caregivers, and significant others, rather than from the objective current reactions of his or her family doctor, was of major concern to Balint. For the psychotherapist, these “parataxic” distortions (Sullivan, 1953) from the patient’s past are most often considered to be the major foci of treatment. For the family physician, however, the patient’s medical problems are the primary foci of treatment, rather than his or her emotional reactions or distortions in their relationship to his or her physician that are generally considered to be of secondary concern. Nevertheless, increasing the health care provider’s recognition that such distortions by the patient (i.e., transference and transference reactions affecting, in turn, the physician’s countertransference to the patient) are ever present in the health care context is of enormous value in treatment and in clarifying doctor–patient communications about treatment.

### **In the Family Physician’s Office**

Consider, for example, a somewhat hostile young male patient in his early 20s in a visit to his primary care physician for a variety of symptoms of abdominal distress. A number of brief, one-word answers and hostile demeanor would appear to be unprovoked and seem to the physician as if to be “coming out of left field.” In short, the patient’s angry reactions appear to be excessive to the context and to be more than just the irritability associated with stomach distress. When emotional reactions are excessive to the context, the excess is likely an emotional overflow that comes from somewhere else, not simply “from out of left field” as is often the initial reaction, but usually from actual experiences in the patient’s past. In this instance, a psychosocial history reveals that this patient was raised in a series of foster homes as a child with a series of caregivers who were minimally, or at least only temporarily, committed to this young man’s physical and emotional well-being. A thor-

ough history also reveals that some of these caregivers were variably physically, verbally, or psychologically abusive to this young man as a child. Although an understandable reaction from the primary care physician to the patient's apparent anger, especially a physician whose time constraints have been expanding exponentially in the current health care environment, might be a defensive reaction to the patient's cynicism or to simply ignore the evident hostility and provide a prescription, perhaps a more tempered response might engage the patient more so. A comment acknowledging the obvious and noting the history might provide a better doctor–patient connection:

I can see that you are irritated, although I'm not sure what's causing it. I can see from your history that you have had a rather turbulent background, and I'm not sure if your previous contact with your doctors has seemed to you to be all that helpful, but here is what I think I can do to help . . .

Such a preamble to the medical aspects of the interview is direct and nondefensive, expresses understanding and empathy, and leaves the conversational door open for further discussion, if desired by the patient.

### **In the Psychotherapist's Office**

To the therapist, this same patient would be likely to present not only as hostile but also guarded, avoidant of conversation, and cynical or sarcastic in interaction. The transference issues with the authority figure of the psychotherapist are played out with a kind of verbal sparring to keep the therapist at some degree of emotional distance. However, for the psychotherapist, in contrast to the role function of the family physician, the patient's unprovoked hostility in his or her office in particular, and in the patient's interpersonal world in general, may be the primary focus of the patient's contact with a mental health specialist. The patient, understandably, may see his reason for being there from a more externalized perspective. That is to say, the patient's viewpoint may be more from the confusion that he experiences in wondering why so many people (e.g., boss or coworkers) whom he meets in life seem to be either hostile or uncaring. The task of the psychotherapist, however, is to help the patient to examine and modify his own contribution and to the creation (and possibly the selection) of such familiar relationships to assist this patient in considering what he may do about improving this scenario in his life through the modification of his own contribution. However, the difficulty as well as opportunity for interpersonal learning, and a "corrective emotional experience," arise when such unprovoked hostility becomes incorporated into the relationship that the therapist has with the patient, not simply the patient's relationships with others outside of the consulting room. However, because both the ambiguity and intensity of such interactions make navigation difficult, this is where the psychotherapist's skill and training come into play.

Two common emotion-laden areas of the patient's transference that have strong potential to stimulate a countertransferential reaction on the part of the therapist are that of the patient's *anger* and the patient's *seductiveness* toward the therapist. Take, for example, a patient with borderline pathology and a history of physical and verbal abuse followed by parental denial and invalidation of the abuse by his or her family. Such a patient may unjustly or inaccurately accuse the clinician of "not caring" about him or her after, for example, changing an appointment time. Following the patient's accusatory remarks, it is necessary for the clinician to respond to the patient, but how a given clinician might respond may vary, and such variations may have considerable impact on the therapeutic alliance. Ultimately, it will be important to point out the distortions that the patient is making in his or her perception of how the clinician has treated him or her by confronting the patient with real data (e.g., the therapist's history of very few canceled appointments with the patient), both now in the current situation and in the patient's treatment history with the therapist. However, it is critical that such confrontation not be a defensive reaction on the part of the clinician (such as a counteraccusation about the patient's missed or canceled appointments), but rather a matter-of-fact presentation that the patient's accusations do not conform to the reality of their clinical contact and history together. In doing this, though, the therapist runs the risk that the patient will perceive such confrontation as an invalidation of his or her experience, as was also a part of this particular patient's family history as noted above (e.g., "So you're telling me that it's all in my head!"). Such a misperception would likely be predicated on the *pseudomutuality* (Simon et al., 1985; Wynne, 1984; Wynne, Ryckoff, Day, & Hirsch, 1958) in his or her own family history in which there was the façade of harmony and an appearance of mutually respectful relationship with one another that is, in reality, undercut by the invalidating behaviors that follow. Clinically, then, it is incumbent on the therapist to point out to the patient that there is a substantial difference between what would be an "understandable distortion" by him or her given the family history and suggesting to the patient that "it never really happened."

The second emotion-charged area of the patient's transference that is likely to generate some sort of countertransferential response is that of an erotic transference to the therapist that is manifested through some form of seductive behavior by the patient. At a surface level of understanding, some type of gratification or flattery in the therapist might be obvious and expectable from the seductive behavior of a patient, especially one who might be acknowledged by the common culture as generically physically attractive. Fortunately, most adept therapists are able to monitor this reaction in them and respond with clinical appropriateness. What may be more problematic for the therapist, however, is the countertransferential reaction that is idiosyncratically evoked by an erotic transference from a patient (regardless of

his or her actual physical attractiveness) that is reminiscent of the therapist's maternal or paternal figure from whom the therapist may have felt, for example, a paucity of gratification in his or her own family history. In such instances, these erotic transferences carry with them even more power to disorient the therapist and evoke an unconscious degree of personal gratification in the therapist that may make it increasingly difficult for the therapist to either monitor or make appropriate boundary management by the therapist more complicated. Transferences in such patients can evoke countertransferential reactions in psychotherapists that have the ability to start the therapist down a slippery slope of seemingly innocent responses that bring otherwise ethical therapists to tenuously skate the boundary of clinical ethics. Such responses are, in fact, ethical dilemmas that disguise themselves to the therapist as technical dilemmas, as noted previously in chapter 1. For example, the therapist may rationalize to him- or herself that this particular patient requires a greater degree of warmth from the therapist. At this point, such a quandary ceases to be a dilemma of psychotherapeutic technique and becomes primarily a dilemma of the therapist's countertransference. Indeed, many instances of sexual exploitation of patients in therapy might be avoided if the therapist were able to recognize the growing attraction and immediately seek consultation to either assist with the countertransference or make an appropriate referral of the case (e.g., Pope, 1994; Scaturro & McPeak, 1998).

## DILEMMAS OF COUNTERTRANSFERENCE

The dilemma that every psychotherapist faces in grappling with strong countertransferential reactions is the question as to whether his or her reactions to the patient are stemming from, to paraphrase Framo (1968), "my life or my patient's life." In other words, the therapist must ask him- or herself, "whose agenda is being addressed in a given therapy session with a given patient or family, and why?" (Scaturro & McPeak, 1998, p. 6). A strong identification with a particular patient's life situation or defensive structure is not, by definition, a sign of poorly conducted psychotherapy. Rather, it is a marker of some increased intensity and complexity in the clinical context. In moments of greater candor, almost all psychotherapists will admit that they do not feel the same sense of rapport, identification, or closeness with each and every patient. In this respect, it is impossible to guarantee a uniform level of service to all patients as most managed care companies would like to claim. The psychotherapist, were he or she to have met certain patients prior to and outside of the clinical context, might easily imagine being friends with certain patients and definitively not with certain others. The patients with whom the therapist closely identifies, because of the therapist's almost instinctive understanding of their difficulties, stand to receive one of two things: either the very best or the very worst that such a clinician has to

offer. If the clinician has sufficiently worked through the particular emotional issue that runs parallel to the issue in the life of the patient and is able to thereby maintain adequate objectivity in therapy, then the patient stands to gain much from the hard-earned intuitive understanding, which that clinician has by virtue of his or her own life experience. However, if the therapist overidentifies with the patient's conflicts and loses proper clinical perspective, then a grave disservice is being rendered to such a patient.

A powerful example of the intensity of these countertransference feelings is portrayed in the dialogue of the play, *Equus* (Shaffer, 1973). The drama depicts a disturbed adolescent stable boy, named Alan Strang, in England who is undergoing court-mandated treatment after blinding six horses with a spike. The horses provided the boy with his first sexual experience. He would ride them naked in the evening until he reached the point of orgasm. The blinding incident occurred after his first sexual experience with a young woman that occurred in the stable with the horses present, leaving the boy feeling that he had betrayed them. The middle-aged psychiatrist, Dr. Martin Dysart, who is treating the boy is struggling with his own conflictual feelings surrounding the powerful yet destructive passion that his patient feels, a passion that has been long since absent in the therapist's own life and marriage. The following is an excerpt of a conversation that Dr. Dysart is having one evening with his friend, Hester Solomon, the magistrate who referred the boy for treatment (Shaffer, 1973, pp. 81–82)<sup>1</sup>:

*Dysart:* He lives *one hour* every three weeks—howling in a mist. And after the service kneels to a slave who stands over him obviously and unthrowably his master. With my body I thee worship! . . . Many men are less vital with their wives.

[Pause]

*Hester:* All the same, they don't usually blind their wives, do they?

*Dysart:* Oh, come on!

*Hester:* Well, do they?

*Dysart:* [sarcastically]: You mean he's dangerous? A violent, dangerous madman who's going to run around the country doing it again and again?

*Hester:* I mean he's in pain, Martin. He's been in pain for most of his life. That much, at least you *know*.

*Dysart:* Possibly.

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Hester: *Possibly!* . . . That cut-off little finger you just described must have been in pain for years.

Dysart: [*doggedly*]: Possibly.

Hester: And you can take it away.

Dysart: Still—possibly.

Hester: Then that's enough. That simply has to be enough for you, surely?

Dysart: No!

Hester: Why not?

Dysart: Because it is his.

Hester: I don't understand.

Dysart: His pain. His own. He made it.

[*Pause*]

[*Earnestly.*] Look . . . to go through life and call it yours—*your* life—you first have to get your own pain. Pain that is unique to you. You can't just dip into the common bin and say 'That's enough!'. . . He's done that. Alright, he's sick. He's full of misery and fear. He was dangerous, and could be again, though I doubt it. But that boy has known a passion more ferocious that I have felt in any second of my life. And let me tell you something I envy it.

Hester: You can't.

Dysart: [*vehemently*]: Don't you see? That the Accusation! That's what his stare has been saying to me all this time. '*At least I galloped! When did you?*' . . . [*Simply.*] I'm jealous. Hester. Jealous of Alan Strang.

Hester: That's absurd.

Hester Solomon's reaction is not surprising. When one is not personally involved in the throes of a countertransference reaction of his or her own, then the intense countertransferences experienced by others can be easily perceived as "absurd." However, Dr. Dysart finds himself in the midst of a difficult dilemma. On the one hand, he has the unique ability to help his patient by virtue of possessing remarkable clinical talent and a personal understanding of the patient's problem. On the other hand, he is at risk for not being able to control his own feelings of envy of the patient and of losing adequate objectivity to properly conduct treatment.

In this particular example, the possibility of maintaining objectivity seems unlikely given the above dialogue. As a result, Dr. Dysart faces a second dilemma surrounding his countertransference concerning this patient:



Does the therapist *keep* or *refer* such a patient (Scaturro & McPeak, 1998)? Although it seems prudent in the above example to strongly consider referral given the intensity, an alternative might be for the therapist to obtain formal consultation, initially, to decide whether or not keeping or referring the case would be most beneficial to the patient. However, even a straightforward referral may have substantial and varied meanings and impact for the patient within the context of transference (Gill, 1984). One patient-oriented reason as to why the decision to refer a given case should never be taken lightly concerns the potential for patients to view a referral out to another professional as a rejection by the therapist, even if the reasons are valid. Carrying the case with ongoing consultation may be an option, but only if the countertransference reactions of the therapist are openly acknowledged and well articulated with the consultant with a view toward providing the patient the best possible treatment.

Although discussions of countertransference traditionally have been relegated to therapists utilizing a psychoanalytic or psychodynamic method of treatment, there has been an increasing acknowledgment of the universality of this concept in cognitive-behavioral (e.g., Safran, 1998) and family systems treatment modalities (e.g., Framo, 1968). In a now-classic article frequently assigned in clinical training settings, Framo (1968) candidly, eloquently, and sometimes poignantly illustrates the range of the therapist's reactions to the patient in light of the resonance in the therapist's own life and family history, ranging from the benign internal response or reflection to the clearly problematic, inappropriate, and countertransference response to the patient that has the potential for negative impact on the patient. Consider the following rather moving example of a statement made by the therapist during a family therapy session, followed by an internal reflection of the therapist in parentheses:

Me to son: "While your mother was crying I noticed you looked very upset. It's hard for you to deal with her unhappiness, isn't it? You feel you have to do something, don't you?" (Only if parents are happy can children be. Me to mom at age of five: "Mom, don't cry . . . I love you; you still have me. When I grow up I'm going to buy you a washing machine, so you won't have to work so hard.") (Framo, 1968, p. 19)

Now, alternatively, consider the following intense, overdetermined statement made to the parents by the therapist stemming from a strong countertransference overidentification with the parentified children, followed by the countertransference recognition by the therapist in parentheses:

Me to parents: "You exploit, make parents out of, and psychologically murder your children." (How much of my anger rides on the back of old angers? With which of my undigested introjects was I dealing? Who was I trying to rescue? On whom, really, was I wreaking revenge?) (Framo, 1968, p. 20)

The potential for all therapists, regardless of their own family history, to react with strong countertransference to emotion-laden patient scenarios is well exemplified by J. S. Wallerstein's (1990) work on the range of countertransferential responses associated with conducting therapy with family members who are undergoing divorce. Wallerstein's observations concerning therapists' countertransferences over grappling with this family crisis are predicated on her longitudinal outcome study of the long-term effects of the children of divorce at 10-year (J. S. Wallerstein & Blakeslee, 1989) and 25-year (J. S. Wallerstein, Lewis, & Blakeslee, 2000) follow-up periods. The outcome of these studies has, in particular, challenged two of what Wallerstein referred to as our society's "cherished myths" about divorce. The first myth holds that if parents are happier, even if the price of their happiness entails the dissolution of the marriage and family, then the children will be inevitably happier as well. On the contrary, the results of Wallerstein's landmark study show that the children, on the whole, do not look emotionally happier and more well adjusted even if one or both parents are happier. These children have shown more aggressiveness in school, increased difficulties in learning, more depression, more likelihood of being referred for psychological services, earlier onset of sexual activity, more children born out of wedlock, less marriages, and more divorces than peers from intact families. According to J. S. Wallerstein et al. (2000, p. xxix): "Indeed, many adults who were trapped in very unhappy marriages would be surprised to learn that their children are relatively content. They don't care if Mom or Dad sleep in different beds as long as the family is together."

The second cherished myth about divorce in our society is the belief that divorce is merely a temporary crisis that wields its most harmful effect at the actual time of the breakup. In other words, it is believed that if the parents do not fight, particularly not in front of the children, and are "rational" about the disbanding of the family, that the short-term crisis will resolve itself rather quickly. Rather, the reports from the children of divorce reveal that, unless there was domestic violence in the family, it is the many years of living in a divorced or remarried family that matter the most. What is of more importance to the children of divorce is the sense of loss, abandonment, and betrayal of childhood and the acute anxiety experienced when one reaches adulthood. These children enter adulthood with myriad unsettled questions regarding commitment, trust, and allegiance in intimate relationships. In essence, the life stories reported by Wallerstein and her colleagues (J. S. Wallerstein & Blakeslee, 1989; J. S. Wallerstein et al., 2000) belie the myths about divorce that our society has come to embrace.

Given the fervor with which these collective myths have been created and maintained in our society, it is no surprise that psychotherapists are not immune from intense countertransferential emotions when confronted by the often-denied reality of a dissolving family in the clinical context. Powerful countertransferences may occur not only as "countertransference proper"

(i.e., reactions to the divorcing patient's rageful and seductive transferences to the therapist) but also as a normative response to marital breakdown and the diminished parenting of the children (J. S. Wallerstein, 1990). The collapse of the once-loved partner into the now-hated adversary can be frightening for a clinician to witness at close range. Such clinical experiences inevitably evoke anxiety in the psychotherapist and ultimately obscure objectivity and therapeutic neutrality. The divorcing individual brings to the psychotherapist the dilemmas that confront both clinician and nonclinician in his or her daily life: issues of love and hate, dependence and independence, and the myriad of bipolar problems of living in relationships with men and women. The psychotherapist is brought "up close" to not only the frequent impermanence of marital partnerships but also the enactment by a parent of the threat to abandon his or her children. The potential for the clinician to become lost in ambiguity is, perhaps, best exemplified by the unsettling perception that "There but for the grace of God go I" (J. S. Wallerstein, 1990, p. 339). Thus, it seems that regardless of the therapist's own family background, the possibility of a simply "neutral" response to such primitive emotions seems unlikely. That is to say, whether the psychotherapist originates from a family in which the parents loved one another for a lifetime, terminated their marriage in a bitter divorce, or stayed together in a lifeless marriage "for the sake of the children," the countertransference reactions of the therapist are likely to be substantial. Furthermore, the dilemmas of countertransference are likely to occur whether the psychotherapist is carrying out divorce therapy and mediation with the couple and family, providing cognitive-behavioral coping strategies, or conducting psychodynamically oriented object relations reconstructive therapy on an individual basis with one or the other of the marital partners. As Gill (1984, p. 213) observed, "a transference relationship develops in every therapy, whatever the approach." Thus, the previous illustrations serve to point out the ubiquity of transference and countertransference in the psychotherapeutic context.

### DILEMMAS OF RESISTANCE

A similar permeation exists for the phenomenon of resistance in the psychotherapeutic environment. To consider why this is, it is first important to consider exactly what the process of resistance is and what it is not. According to Auld and Hyman (1991, p. 114),

[Resistance] is a force within the patient that acts against the therapeutic process, against the task of uncovering and dissolving the neurotic conflict. It is a force that works to maintain repression even at the cost of perpetuation, or even the expansion, of neurotic symptoms. . . . Resistance results from the patient's attempt to avoid the anxiety evoked in

the therapy when repressed feelings, wishes, thoughts, and experiences threaten to return to awareness.

The clinical dilemmas of resistance arise from the ambiguity of the patient wanting symptom relief and behavioral changes in his or her life, on the one hand, while feeling the safety of familiarity with the status quo, on the other. This ambivalence in the patient about psychotherapy and behavior change has given rise to several misconceptions about the nature of the patient's resistance. Auld and Hyman (1991) attempted to rectify some of these misconceptions by clarifying what resistance is not: Resistance is not an acting out of anger, resentment, or hostility against the psychotherapist. Resistance is not a refusal or oppositionality of the patient to accept the psychotherapist's ideas or suggestions. And, finally, resistance is not an attempt on the part of the patient to make his or her interactions with the therapist to be perplexing.

These clarifications point out an important distinction between the psychodynamic conceptualization of resistance and the behavior therapy models of resistance as noncompliance to therapeutic instructions (Leahy, 2001). Twenty years ago, P. L. Wachtel (1982, p. xiv) observed the following:

In the behavioral literature, references to resistance are scant. If one only reads about behavior therapy, one is likely to conclude either that behavior therapists do not understand or do not notice resistance or that their methods overcome resistance or make it irrelevant.

According to the behavioral model, the failure of a patient to comply with therapeutic recommendations may be attributed to the therapist's selecting reinforcements that are not salient to the patient (e.g., teacher's praise for an oppositional adolescent) or noncontingent, or perceived as noncontingent, on the outcomes desired (Leahy, 2001). Accordingly, it becomes the therapist's job to construct ways in which to get the patient to comply with the treatment objectives (e.g., Lazarus & Fay, 1982). In this way, the behavior therapist's approach to the patient is strongly allied with the role of a teacher, instructor, or scientist.

For therapists who view the process of psychotherapy as being embedded within the broader context of an interpersonal relationship, the inherent ambiguity of resistance is more readily acknowledged and more broadly understood. In contrast to the behavioral approach, the role functions of the psychotherapist are viewed as that of the compassionate listener and the empathic observer (Blatt & Erlich, 1982). The perceived differences in professional role functions have corresponding effects on how the patient's resistances are viewed. Thus, Blatt and Erlich, for example, believed alternatively that the psychotherapist's job is to assist the patient in recognizing his or her resistance when it occurs and assess its various possible meanings for the patient, particularly with respect to the patient's fear or apprehension about the anticipation of change.

Rather than viewing the patient's resistances in potentially critical or pejorative terms, as many patients themselves are prone to do, it may be important to assist patients in discovering the positive function of their resistance to change and the maintenance of their symptomatology (e.g., avoiding overwhelming anxiety or panic). K. Adler (1972) offered the metaphor of the "symptom as a friend" to the patient. In other words, the symptom behaves as a good friend might to prevent the patient from making a premature and disorganizing life decision that the patient might not yet be ready to undertake (e.g., an impending marriage, divorce, or job change; Mozdierz et al., 1976). Thus, the continuance of the symptom, or resistance to change, serves the positive function of giving the patient more time to prepare and achieve a greater readiness for important life changes. The dilemma in therapy, of course, is how much of a "friend" is the symptom in its resistance to change, versus the deleterious effects (i.e., the emotional cost) of maintaining the status quo of the symptomatology? This view of resistance and symptomatology is predicated on Freud's (1926/1959a) concept of *signal anxiety*. Thus, the anxiety serves as a signal or warning to protect the patient against the disorganization of an even greater traumatic anxiety or move that might threaten danger and throw the patient into a state of disequilibrium. Recent examinations of the concept from the standpoints of cognitive psychology, learning theory, psychophysiology, and behavioral neuroscience, as well as psychoanalytic theory, have shown some convergence of thought on the function of resistance anxiety (Wong, 1999).

The cognitive-behavioral and psychoanalytic perspectives on resistance need not be, however, diametrically opposed for the integrative therapist who is willing to entertain the elements of both in treatment. Rhoads (1984), for example, considered multiple ways in which aspects of the two approaches can be integrated and enhance one another. He believed that a psychodynamically oriented understanding of resistance and approach to intervention can be exceedingly useful when encountering resistance in the form of noncompliance in behavior therapy. Although behavioral noncompliance is far from being the only form of resistance, certainly behavior therapy patients have innumerable reasons for not counting baseline behaviors, not constructing charts and graphs, and not completing behavioral homework assignments in general. Rhoads recommended that, in such instances, the behavior therapist may shift to a more exploratory therapy with the patient concerning his or her feelings about having been asked to undertake such assignments and, perhaps, relate this to any similar reactions to such requests in earlier times of the patient's life, especially involving others who might have served as the relational prototypes in dealing with authority figures and their various requests or demands (i.e., to interpret the patient's transference resistance to the behavior therapist) in an effort to increase compliance.

Rhoads (1984; Feather & Rhoads, 1972) also suggested that target behaviors for such behavioral approaches be predicated on a more comprehen-

sive psychodynamic understanding of the patient's psychopathology. For example, it has been proposed that one of the early sources for panic disorder and agoraphobia is the very real experience of some form of abandonment in the developmental history of such a patient (e.g., Friedman, 1985; Sable 1994, 2000; Scaturo, 1994). Once a psychodynamic connection to panic has been established in the treatment of a given patient, then it may be possible to tailor behaviorally oriented exposure therapy through systematic desensitization (Wolpe, 1992) to address both loci of the patient's anxiety (i.e., the fear of panic attacks in the present and the abandonment fears of the past). That is to say, rather than constructing a single hierarchy pertaining to the patient's fear of panic in only current contexts (e.g., a restaurant, grocery store, or a shopping mall), it may be possible to construct two separate hierarchies, one related to the above-noted anxiety-associated contexts of the present and one as a hierarchy of fears leading up to certain historical abandonment experiences of the past (e.g., the loss of a parent at an early age). It may also be possible for the therapist to construct a combined, overlapping hierarchy with graduated steps from both of the separate hierarchies moving up the hierarchy in an alternating fashion jointly desensitizing the patient to both sets of psychologically related fears, thereby providing a truer integration of past and present within a single behavior therapy regimen.

In cognitive therapy, resistance has been defined as anything in the patient's thoughts, feelings, or behavior that interferes with the demand characteristics (Orne, 1962; Whitehouse et al., 2002) or subtle situational expectations of the cognitive therapy approach. These demand characteristics include

emphasis on the here-and-now, structured sessions, continuity across sessions, problem-solving orientation, rational thinking, collaboration with the therapist, psychoeducation and information sharing, an active role for both patient and therapist, accountability as evidenced by identifying and measuring goals and attainment of goals, and compliance with self-help assignments. (Leahy, 2001, p. 11)

Yet, even within this highly structured approach, resistance is seen as multifaceted and multidetermined. Leahy (2001) outlined several dimensions of resistance within a cognitive therapy model. First, a patient with depression, for example, may require a sense of validation for his or her feelings or perspective such that he or she truly believes that the therapist can understand the perceived helplessness and demoralization felt by the patient before the patient entrusts the therapist with a belief in the therapist's ability to help. Second, the patient may be resistant to change because of a need for *self-consistency* and the belief that he or she has been steadily committing him- or herself to a given course of action and is, thereby, reluctant to consider an alternative course (i.e., the discomfort associated with cognitive dissonance; Festinger, 1957). A third source of resistance to change might be

the patient's personal need to view his or her past behavior as consistent with the view of his or her own sense of self or identity, that is to say, the patient's *self-schema* (Horowitz, 1988). A fourth impediment to behavioral change may be a type of *moral resistance* in which the patient may feel an obligation to significant others in his or her life to maintain the status quo and not disrupt the equilibrium in the family. A fifth dimension of resistance might be the secondary gain or reinforcement that a given patient may receive from significant others or provide to him- or herself in assuming the social role offered by victimization. Sixth, the patient may feel unable to assume the risk and responsibility associated with making changes in one's life, providing for oneself, and the fear of losing what little one gets from a familiar coping strategy in life. And, finally, resistance may take the form of a *self-handicapping strategy* by the patient in which the "designated problem" by the patient is in fact a solution (i.e., an excuse) by which the patient is able to avoid making other, more substantial changes in his or her life.

By recognizing the multifaceted nature of resistance, Leahy (2001) proposed the use of an *integrative social-cognitive model of resistance*. Accordingly, an "integrated social-cognitive model of resistance recognizes that resistance is often the result of emotional dysregulation (or overregulation), early (and later) childhood experiences, and unconscious processes" (Leahy, 2001, p. 20). This multidimensional model of resistance borrows heavily from its psychoanalytic predecessors that emphasize the self-protective mechanisms of psychological defenses and unapologetically acknowledges that many of these processes may lie outside of the patient's conscious awareness at given points in time. Even the staunch adherents of a psychoanalytic framework might find little to argue with in such a multidimensional approach to resistance.

#### CONCLUDING REMARKS: FROM ORTHODOXY TO INTEGRATION IN THE NOVICE AND SEASONED CLINICIAN

The clinical dilemmas that arise from the interpersonal ambiguities of transference, countertransference, and resistance to change span the major theoretical perspectives on psychotherapy regardless of whether the clinician believes or assumes that some of these resistances may be operative at an unconscious level of psychological functioning. Although adherents to other approaches that do not consider unconscious processes to be operative may view their clinical work purely from a cognitive or behavioral theoretical level of explanation, Leahy (2001, p. 14) observed that the notion of "theoretical purity" tends to be more common among novice clinicians. The more experienced and seasoned clinician generally shows a greater willingness to borrow concepts and methods from other modalities in an effort to enhance therapeutic effectiveness. Even the admonishment by P. L. Wachtel (1982) noted earlier concerning the limited understanding of the concept of resis-

tance in the early behavior therapy literature was tempered by his observation that this is an illusion that disappears rapidly when one speaks with experienced behavior therapists about case material. In this respect, the movement toward integrative psychotherapy may well be an outcome or product of the maturation that has taken place in the field of psychotherapy. Reciprocally, advances in psychotherapy integration may also serve as a *maturing force* within the profession. The next chapter addresses the more consciously determined dilemmas that occur in the psychotherapeutic process related to the difficulty involved in the interpersonal negotiation of the therapeutic boundary between the neutrality of the therapist, on the one hand, and therapeutic engagement (and the therapist's self-disclosure) with the patient, on the other.