How to Work with a Client's Resistance

How to Release the Deep-Rooted Resistance That's Blocking Your Client from Healing

Part 1: How to Help Clients Rebuild a Damaged Sense of Self

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How to Work with a Client's Resistance: Pat Ogden, PhD and Kelly McGonigal, PhD

Part 1: How to Help Clients Rebuild a Damaged Sense of Self

Dr. Buczynski: How do we work with a client's resistance when it's shielding them from pain?

Dr. Pat Ogden remembered one important lesson from a mentor that stuck with her for her entire life.

And it changed the way she approached the idea of resistance.

Here, she shares how this insight helped her lead one client through a radical breakthrough.

Dr. Ogden: Resistance is not a term I'm fond of.

When I first wanted to be a psychotherapist in the early 1970s, I met Ron Kurtz and everybody was talking about resistance even then.

He said that if you think a client is resistant, you need to look at how they're not feeling safe, and that really made an impression on me.

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When we call clients *resistant* or *difficult*, it's basically because our interventions aren't working and *we* feel incompetent.

With that said, there are clients that are challenging. They get into patterns of response that they can't get out of – they have internal conflicts that live in the way they think, that live in their emotions, and that live in their body.

They have impulses to grow and expand, but also impulses to pull in and retract.

All these conflicts are often named as *resistance*.

Sometimes there's such a tendency to blame clients for not responding to our interventions, so we need to be cautious with that word, *resistance.*

I have a client that I'd like to tell you about – we'll call him Stewart. He

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came to see me for a consultation session because he had been in therapy for about 15 years.

He'd switched therapists and had been with the same therapist for the last 10 years.

He was very successful in his life – had been at the top of his profession, but there came a time where, he said, he just decompensated.

He connected it to his mother's depression when he was about 18 months old until about three years old, which of course is a very critical time for a child.

He was just *stuck* in that timeframe. He was crying constantly – this had been going on for years and years and he had tried to work with that baby part.

He'd even built himself a whole room, like a primal scream room with big-size toys and furniture and all, to try and go into that baby and to heal, but it hadn't worked.

In this first consultation, in the first half of the session, *nothing* was effective. No matter how we tried to connect, he would just be sobbing – crying and crying and not able to really use any intervention in a way that would help him get through all those tears and all that loss.

He was currently in a relationship and he loved this woman very much – it was a new relationship, but he was so angry with her because she couldn't be there for him.

> "He ***wanted*** somebody to be there for him as a mother would a small child."

What he *wanted* was somebody to be there for him as a mother would a small child.

So what really helped him was working with his body.

I often think in terms of movement and movement vocabulary. His collapse and curling over in a depressive posture indicated a shortened rectus abdominis muscle, which can curl your body over like this – from your pubic bone to the top of the ribcage, and that was his posture.

When he was talking about his girlfriend, he said he was angry, and his fist came like this. I put a pillow there and he pushed out against it, and for a long time he said it was just neutral – nothing happened and he was still crying.

Then there came a moment where I could feel a shift in him where it wasn't an aggressive push of, "Keep away." It turned into a push of identity – just as when a child pushes up against the parent to find their sense

of self and their own identity.

Here was the turning point – he needed to be able to push in a variety of ways to be able to *feel* who he was – the self within.

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As he pushed, I asked him if he could just straighten up a little bit, which is also push – a push from the pelvic floor down and the top of the head up.

This is similar to when you see a little child who's learning/just beginning to sit up, and how they straighten their backs – they have that push, which says: *This is who I am. This is me*.

"They have the push that says: ***This is who I am. This is me***."

If you're collapsed as he was, you don't have that sense.

We worked with the sense of push in many, many ways: pushing with hands, pushing with the top of his head, pushing down with his pelvic floor, pushing with his feel as he stood up, and pushing against the wall.

He started to be able to notice his own boundaries – pushing like this activates your muscles, so you can feel where your body begins and ends.

The *pushing* started to shift his sense of self and how he lived in his body.

Now, what's important there is that we're not trying to override this part of him that's in pain – this little baby – but because he was stuck in that, he needed to develop a physically felt sense of self.

He could actually help the baby part grow up inside himself.

"The ***pushing*** started to shift his sense of self and how he lived in his body. He could actually help the baby part grow up inside himself."

That was an exciting session for me and an example of working with what I think most people would call resistance.

Dr. Buczynski: Did it happen all in one session?

Dr. Ogden: This was a consultation session, so yes. Then, he had to work with his therapist to practice this.

He'd been living with these procedural patterns in the body for years and it was going to take a lot of practice for him to live in his body in a different way.

Dr. Buczynski: I'd like to go back to what you said that Ron Kurtz was talking about – when people are resistant, it's a signal that they don't feel safe. If you saw that pattern, how would you respond?

Dr. Ogden: We see that constantly – and it's the task of the therapist and client working together to find out what's scary or what's not safe.

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For example, for him with that baby part, it was probably something like, "If I get better on my own, I will *never* get someone. I will never get the love I need."

This, of course, wasn't true, but it was true that this part of him would need some work and some reassurance.

It's just like the previous client – the shame client. She would go into this flat place where she could hardly respond. She was just cut off from her emotions – she was just operating from the surface of awareness.

A lot of people would say that this behavior was resistant, but I wouldn't call it resistance – she simple needed the safety of our relationship and my reaching to her for that part of her that was so ashamed – I was giving her safety.

She just needed to *feel* safe enough to come forward.

"I would approach both ways: talking verbally and using movement."

Dr. Buczynski: When you would think about that, would you talk to her about it verbally or would you move to make her feel safer? How would you approach it?

Dr. Ogden: I would approach both ways: talking verbally and using movement.

I'm thinking of one client who has DI, Dissociative Identity Disorder. Part of her feels very frightened of making any kind of assertive, aggressive action because that would have made the trauma in the past much worse.

So, we have to work with that part of her and use other internal parts to help that part understand that now things are different – she has to try out a little action and notice that nothing bad happens.

She has to see that she's OK – that she's not going to get hurt again. Each time, she makes the action a little stronger, and again nothing bad happens.

There was another client who would try a motion and then say, "OK, nothing bad happened there." She'd try

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it again, and again say, "OK, nothing bad happened there."

When people have had a childhood experience where a certain action has brought more abuse, *of course*, they're *terrified* to repeat that action.

Even though people know *consciously* that they're not in danger *now*, there is still that implicit part that's absolutely terrified.

Dr. Buczynski: When we're able to identify our clients' safety issues, it can help us become more targeted in our interventions.

For some further insight into this kind of resistance, let's hear now from Dr. Kelly McGonigal.

Dr. McGonigal: I'll share with you an exercise that I started using in my behavior-change workshops where it gets so much positive feedback. I'm sure that many people watching or listening will be familiar with this exercise.

It comes from acceptance and commitment therapy. For those who aren't, I have to describe it, because people tell me that they think about this all the time, once it's been demonstrated.

This is where people first identify what they feel or say to themselves that keeps them from doing something that they would like to commit to.

So when they think about doing it, they might say, "I'll make a fool of myself," "It will be too difficult," "I can't handle it," or whatever their experience is.

People come up with what the thought are, the emotions, and they write it out in a single sentence.

Then I will ask that person to come and stand up, often in front of a group so people can see this happening.

I might write on a piece of paper, "I cannot walk," then give that piece of paper to a person and say, "Can you read what's written on this?"

They'll say, "I cannot walk."

Then I ask them to close their eyes and repeat it in their own mind, "I cannot walk. I cannot walk," and even just sometimes embody what it feels like to be saying in their head, "I cannot walk. I cannot walk."

Then I say, "Now, this is so strange, but could you just walk around the room, while you continue to think, 'I cannot walk. I cannot walk.' You can say it out loud if you want, or it could just be in your head."

People get to watch someone walking around saying, "I cannot walk. I cannot walk," while clearly walking.

The person has that direct experience. Then we talk about what's it's like to have thoughts and feelings that say you can't keep going, or you can't do this, or you shouldn't do this. Yet isn't it amazing that you have the capacity to make a different choice, depending on your values and commitments?

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Then people can reflect back on their own resistance and say, "It seems to me that when I choose not to do what I say I want to do, what I say to myself is, 'I'm going to make a fool of myself,' and I don't want that."

So they could practice saying that in their head and imagining, "So what would I do that would be a step in that direction, even when they thought comes up?"

Then they could imagine doing that. When they actually do it in real life, it's like so many of the things, a great, concrete metaphor or visual experience that flips the light switch for a lot of people.

Dr. Buczynski: As Kelly showed, when we help clients challenge their own resistance, it can open the door to change.

In Part 2, we'll look at what keeps clients bound to their resistant patterns.

I'll see you then.