How to Work with a Client's Resistance

How to Safely Approach the Vulnerable Parts That Are Resisting Change

Part 2: 5 Harmful Strategies That Lead to Resistance (And How to Deal With Them)

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Dr. Buczynski: Resistance is the result of an inner conflict between openness and self-protection.

At least that's how Dr. Terry Real sees it.

And when a client puts up these barriers, Terry believes there is often one protective part at play.

Here, Terry shares how this part developed and the five ways it can keep your client from healing.

Dr. Real: I heard a story about the great psychoanalyst, Elvin Semrad, who was working with this schizophrenic young man who lived on the streets. He was going a big demonstration interview but he was going to follow him after the interview.

I'll never forget this. Semrad said to this man, "If you choose to stay in treatment and stay on the medicine that helps you, and do the day program and get yourself better, I will be with you while you do that. If you choose to stay on the streets, get off your medicine, start taking drugs and die, I want you to know I will be with you as you do that. No matter what you choose – life or death – I will be your witness and companion. I'm your guy."

That's detachment from the outcome. It's an extremely powerful therapeutic tool.

Dr. Buczynski: When you think about people being resistant, how do you conceptualize what's going on?

Dr. Real: As a relational therapist, which is how I conceive of myself, my plum line is intimacy. Intimacy looks like this meets this. The clients that I see look like this meets this. I call it *rational deformity*.

My job is to straighten out the deformities and allow for true, authentic connection between the two parties. As I'm going along, I'm asking myself, what's moving us towards increased intimacy and what's moving us away from increased intimacy?

One of the things that consistently moves people away from increased intimacy, or into resistance, is that it's damn scary! Vulnerability and intimacy is frightening. It's what we long for; it's what completes us – but, to the degree to which you've been hurt, or had trauma in your childhood, or seen intimacy do not good things for people.

While we long for it, there are other parts of us that are protective; there are parts of us that get triggered and don't long for the vulnerability of intimacy – instead, we long for shielding and self-protection.

> "There's a tri-part system of the psyche: **the functional adult** part of the self (the pre-frontal cortex); **the wounded child** (the limbic system); and ***the adaptive child***—the part *between* the two spheres."

In the system I work with, which I've inherited from Pia Mellody, there's a tri-part system of the psyche – similar to Dick Schwartz, actually: there's the functional adult part of the self – prefrontal cortex, present-based, thoughtful, here and now, adult; there's the famous 'wounded child' – the limbic system, the very young and overwhelmed part of us; and between these spheres Is the 'adaptive child' part of us – the part of us that adapted.

The bitter pill that I ask the people I work with to swallow is that it's only the functional adult part of us that *wants* to be intimate. The adaptive child part of us wants to be right, wants to control things, wants unbridled self-expression, retaliation, or withdrawal. These are the five losing strategies that I name.

> "The functional adult part of us is the only part that ***wants*** to be intimate. The adaptive child part wants us to be *right*."

If you are in your adaptive child part, or your partner is in his or her adaptive child part all bets are off. They don't want to use the skills. They don't want to be intimate.

I have a saying, "You can be right or you can be married – what's more important to you?" That adaptive child part of you would say, "*Right* is more important down the line."

If I'm dealing with resistance, I'm probably dealing with the adaptive child part of the person, not the adult part of the person. It's my job to get to know that part of them, make friends with that part of them, and ultimately take care of and demote that part of them: "You're not running my relationship – I am."

One of the critical questions in relational life therapy is, "Which part of you am I speaking to? Am I speaking to the adult part of you that wants to get closer to your partner? Or am I speaking to one of the triggered parts of you that's running for cover?" The art is helping you get re-centered in the adult place inside of you that wants to be close, in order for you to be able to access the skill.

Dr. Buczynski: Could you go over those five . . .

Dr. Real: Losing strategies?

Dr. Buczynski: Yes.

Dr. Real: Sure.

Your particular losing strategy are the things the adaptive child part of you runs on.

> "The five losing strategies are: a desire to **be right**, to have **control** , to have **unbridled self-expression**, to **retaliate**, and to **withdrawal**."

Being right: trying to determine who's right and who's wrong, and solve your differences by figuring out who's 'more valid' – good luck with that one.

Controlling your partner: *I would be so happy if only you did…*

Unbridled self-expression: in regards to the kitchen sink, *You did it last week, you did it 10 years ago, your sister does it, you're just like your father who does it, you're just a big slob.*

Retaliation: *I'm going to hurt you the way you hurt me.*

Withdrawal: *I'm out of here. We're not talking about it. Leave me alone.*

You get caught by any one of those or any combination of those, and you're done. You'll never get more of what you want when you're in that place, because you're not *about* getting more of what you want – you're about having wider control or one of those agendas.

Dr. Buczynski: When your client's in that place, how do you respond to them?

Dr. Real: I teach them about the difference between the adaptive child, the functional adult, and the wounded child. I go back in the family or origin.

Here's a classic dysfunctional stance – angry pursuit is a dysfunctional stance. It's a dysfunctional relational stance. Angry pursuit is an oxymoron. There's nothing seductive or attractive about angry pursuit. It's a self-defeating strategy.

Once I identify the patient's dysfunctional stance, I go up a generation: "Who was the complainer in your family, growing up?" *Oh, my god – my mother!*

"And where were you in this?" *I felt sorry for my mother.*

"Well, you still do. Even though she's dead, you're carrying on the family business." *What do you mean?*

"What was your mother's name?" *Stephanie.*

"Okay, 'Stephanie and Ruth – Complaint R Us' – this is the family business. Your mother taught you how to park in the 'complaint position,' and now you're carrying on the legacy. Is this how you want to live your life, or will you let me help you get out of this?"

Dr. Buczynski: As Terry showed, intimacy can feel like a very risky proposition.

At the beginning of his talk, Terry shared a story about a practitioner offering unconditional positive regard for his client.

Dr. Ron Siegel had a further thought on that—

Dr. Siegel: There's a tradition in many mental health circles that if somebody comes in, and they're actively drinking or actually using some other drug, we say, "Well, first you have to be abstinent, and once your abstinent, once you gain abstinence through AA or something like that, then I'll work with you."

I once had a colleague of mine who worked a lot with substance abuse problems saying it's a little bit like having a depressed person come into our office and saying, "As soon as you cheer up, I'm happy to be your psychotherapist, but I don't want to see you with all of this morose business."

There's something a little peculiar about it in a sense, not accepting the person even when they're making a maladaptive choice.

"There's something peculiar about not accepting the person even when they're making a maladaptive choice."

But of course, we have the opposite problem which is all the people who maybe spent years in psychoanalysis or some other kind of treatment, never dealing with their substance problem, and they later said, "Gosh, it wasn't until I found AA and found all these other people who had had failed psychotherapies that I thought my therapist really did me a disservice by doing this for all these years."

So what do we do with this tension? I don't think there's an easy one-reliable answer each time.

I think that we need some kind of a middle road in which we maintain the relationship – let the person know we're with them, we're going to love them, and be with them, whatever the choice is, but we don't stop

looking at the consequences of the behavior.

We don't stop helping them to see that a given maladaptive pattern is going to keep them trapped.

> "There is something very, ***very*** important about an ***unconditional positive regard***."

In fact, the fellow who I mentioned just being who turned to substances in adolescence, I was working with him as an adult, and he was still using substances at the beginning.

And we did a lot of work to try to develop greater affect tolerance, to be able to use the skills, to be able to be with the feelings that I was just discussing before. Then he was able to use those other programs to get sober.

And he was so grateful for having stayed for my having stayed with him, because he had the sense that without sobriety, I was going to drop him at some point, because that's what he had heard from others.

So, it's just a very complicated balance. But there is something very, very important about this unconditional positive regard.

Dr. Buczynski: As Ron suggested, it's a tricky balance between giving unqualified support and promoting behavior change.

In the next module, we'll look at one overlooked reason why some clients stay resistant.