An Interpersonal Communication Perspective on Resistance in Psychotherapy

Todd F. Van Denburg
*Transylvania University*

Donald J. Kiesler
*Virginia Commonwealth University*

This article discusses resistance in psychotherapy using the contemporary interpersonal communication model of psychotherapy. This perspective defines resistance as moments during sessions when the patient and therapist are interacting with one another in such a way that the patient is kept from becoming aware of any covert experiences or transactional patterns that are conflictual and anxiety provoking. The ways in which resistance may be conceptualized and worked with are discussed and applied to three patient vignettes, with an emphasis on working with resistances as they are manifested in the patient-therapist relationship. Some of the potential reactions of the therapist to resistance are discussed, including some relatively beneficial and some problematic instances. © 2002 John Wiley & Sons, Inc. J Clin Psychol/In Session 58: 195–205, 2002.

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Our orientation to psychotherapy is that of contemporary interpersonal communication psychotherapy (Anchin & Kiesler, 1982; Carson, 1969; Kiesler, 1988; Kiesler & Van Denburg, 1993; Leary, 1957). Central assessment and intervention procedures within psychotherapy are guided by two models: the *interpersonal circle*, including the con-
cept of complementarity (Kiesler, 1983), and the maladaptive transaction cycle (Kiesler, 1988).

In any interaction, individuals constantly are negotiating two relationship issues—how hostile or friendly they will be, and how much in control they will be in their relationship. The interpersonal circle is a conceptual–empirical model that summarizes the domain of interpersonal behavior by depicting interpersonal variables within a two-dimensional circular space formed by the axes of control and affiliation. Kiesler's (1983) 1982 Interpersonal Circle is shown in Figure 1.

A central concept in our model is that our interpersonal actions are designed to pull, draw, entice, or evoke restricted classes of reactions from persons with whom we interact, especially from significant others (including a therapist). This principle of complementarity is a major feature of the self-confirmational process wherein individuals attempt to influence others into confirming their familiar self-presentations. On the interpersonal circle, complementarity occurs on the basis of evoking the opposite or reciprocal response on the control axis (dominance pulls submission, submission pulls dominance) and a similar or corresponding response on the affiliation axis (hostility pulls hostility, friendliness pulls friendliness). Hence, friendly–dominant and friendly–submissive behaviors represent complementary sets of actions, as do hostile–dominant and hostile–submissive behaviors. In the therapy context, complementarity defines the situation in which the

Figure 1. The 1982 Interpersonal Circle.
patient and therapist’s interpersonal behaviors endorse and confirm each others’ self-presentation in regard to both control and affiliation.

Interpersonal complementarity addresses a component of the patient–therapist relationship that is distinct from the context-specific therapeutic alliance. The therapeutic alliance refers to a central feature of the conscious and realistic relationship between therapist and patient. In contrast, interpersonal complementarity conceptualizes the automatic and relatively unaware therapy relationship resulting primarily—but not exclusively—from the patient’s rigid and extreme transference patterns, referred to by Sullivan (1953) as parataxic distortions.

The recurrent pattern of covert and overt aspects of the patient’s behavior that are chained circularly to the covert and overt aspects of the individuals interacting with the patient (including the therapist) is referred to as the maladaptive transaction cycle. This conceptual guide, when combined with complementary predictions from the interpersonal circle, provides the framework to predict the specific components of the repetitive configuration of actions and reactions that define a patient’s self-defeating transactions with others (including the therapist).

Several therapeutic assumptions are central within the interpersonal communication framework. It is assumed that the maladaptive interpersonal difficulties in living of the patient are displayed to the therapist during the session. The therapist is pulled initially to provide the confirming complementary responses in reaction to the patient’s maladaptive interpersonal behavior. The therapist needs to disengage from this maladaptive—reinforcing complementary response and provide the patient a corrective experience through interventions that empathetically confront and challenge the patient’s maladaptive interpersonal pattern. The therapist needs to use his/her feelings and other covert reactions to assess the generalizable impact of the patient’s maladaptive style on others. Throughout their sessions, the therapist needs to give intervention priority to providing the patient verbal feedback that targets the central, repetitive, and thematic relationship issues occurring between them in their therapy sessions. This feedback often focuses on the therapist’s objective countertransference—the constricted feelings, attitudes, and reactions of the therapist that are induced primarily by the “actual personality and behavior of the patient, based on objective observation” (Winnicott, 1949, p. 195).

What Is Resistance?

Within our model, resistances are viewed as

(a) moments during sessions when the patient and therapist are interacting with one another in such a way that the patient is kept from becoming aware of any covert experiences or transactional patterns that are conflictual and anxiety provoking, and/or

(b) moments during or between sessions when the patient’s interpersonal behavior sabotage the therapeutic relationship and task.

During sessions, it takes both the patient and the therapist to create a barrier between the unaware anxiety-tinged components of the patient’s experience and the conscious components to which the patient and therapist currently are attending. We believe this conceptualization of resistance is a natural extension of construing the therapist’s role within the therapeutic dyad as a participant observer—the therapist is constantly contributing to, but also observing, how the patient is functioning during the session. Between sessions, the patient can enact interpersonal maneuvers that constitute a threat to the therapeutic
relationship—for example, the patient may cancel or reschedule appointments, avoid consideration of identified themes, forget to complete homework assignments, and the like. Whether live within the sessions, or present symbolically between sessions, the therapist conjointly participates in the patient’s interpersonal behaviors in his/her role as a participant observer.

We do not see resistance as an adversarial process, wherein sometimes the patient is being a good patient and sometimes being a bad patient. Instead, the patient is communicating constantly to the therapist, albeit indirectly, those aspects of him/herself that are anxiety provoking by interpersonally communicating how he/she is wanting the therapist to confirm the self-definitional bids by providing the complementary response.

Resistance can be realistic and conscious if the therapist has not provided clear structure and expectations as to what the therapy task is to be, or if the patient does not have the abilities or characteristics necessary to pursue the task after it has been structured clearly. Automatic or unconscious resistance can be manifestations of either temporary states of the patient or more long-standing traits. State resistances occur at specific moments within a session in which the patient experiences anxiety triggered by a threat to his/her sense of self-emanating during exploration with the therapist of a particular topic or issue. The momentary anxiety can be triggered as newly emerging thoughts or feelings begin to occur within the patient as a result of the patient’s concerns that the therapist will react negatively to the emerging contents, or from a particular relation matrix between the patient and therapist. Trait (or character) resistances occur repeatedly during therapy sessions at moments in which the patient’s maladaptive pattern of interpersonal behavior and the therapist’s response interfere with the task or process of therapy. At these moments, in reaction to the patient’s off-task maneuvers, the therapist experiences some level of negative emotion and cognition toward the patient that, if not identified and confronted through empathic or other interventions on the therapist’s part, cumulates and moves the patient–therapist interaction toward a state of impasse in which the therapy task clearly has bogged down.

Realistic and conscious resistance typically leads to unilateral premature termination of therapy by the patient. The patient sensibly realizes that what is being provided is not meeting his/her needs or is beyond his/her capacity.

State resistances are telegraphed primarily by momentary instances of patient overt anxiety displayed through the patient’s nonverbal behavior (facial expression, vocal changes in pitch, etc.). What occur are clear momentary deviations from the patient’s usual communication pattern during the sessions. At these moments, the patient has some level of awareness that the experience of anxiety is imminent and that some shift away from or avoidance of the therapy task is occurring. One shift that frequently occurs is an escalation in the intensity and rigidity of the patient’s typical interpersonal style in response to perceived threat or stress (Van Denburg & Kiesler, 1993). The function of this interpersonal maneuver is to put more pressure on the therapist (or other interactants) to provide the comforting complementary response, thereby decreasing anxiety by reinstating the familiar and relatively secure relational pattern. The therapist hopefully notices this escalation, begins to identify the precipitating circumstances and topics, and wonders if what the patient is feeling has any relationship to the patient’s experience of the therapist.

Trait or character resistances are displayed through the patient’s distinctive pattern of interpersonal behavior, through the patient’s typical pattern of communication with significant others, including the therapist. The possibilities are multiple depending on the patient’s particular form of personality organization and/or on the specific categorization of the patient’s interpersonal behavior on the interpersonal circle. A histrionic pattern, for example, recurrently interferes with the task of therapy by entertaining the therapist and
distracting the process away from threatening introspection. An obsessive-compulsive pattern, in contrast, consistently derails the therapy task by intellectual circumlocution, which distracts the therapist away from helping the patient to experience threatening clarity or action. Generally, trait resistances emanate from processes that, although mal-adaptive, are acceptable to the patient; hence, their recurrent manifestations tend to be automatic and less available to the patient’s awareness. These trait resistances pull complementary responses from the therapist in the form of restricted thoughts, feelings, action tendencies, and fantasies that similarly occur relatively automatically in the therapist’s experience and are less available to the therapist’s awareness. If undetected, these experiences gradually take on a negative emotional quality for the therapist (the aversive result of the patient’s maladaptive pattern) and cumulate as the therapist’s contribution to the therapy comes to an impasse.

Trait resistance, then, is an expression of the cumulative emotional relationship between the patient and therapist. A thread of negative feelings runs through instances of resistance, and these feelings are directed to and felt by the therapist in varying degrees. At these moments of resistance, the patient’s evoking messages to the therapist represent various combinations of dislike (anger, boredom, fear, disappointment, disrespect, etc.) on the affiliation axis of the interpersonal circle, and of dominance–submission struggles (competitiveness, rivalry, assertion, one-upmanship, passivity, etc.) on the control axis.

Conceptualizing and Working with Resistance

The three case presentations that are the focus of this issue exemplify instances of the various types of resistance we have just defined. Before discussing each of the patient vignettes provided, we would like to acknowledge the authors’ willingness to discuss their work with these patients. Also, we want to recognize the limitations inherent in reacting to only a very brief sample of clinical material from any course of treatment.

The Case of Julie

The first vignette we will discuss is that of Julie—the woman in long-term treatment who was struggling with issues related to autonomy. The patient is described as believing that, in her prepubescent relationship with her father, she “felt that she could do no wrong.” However, it appears this was the case only as long as she maintained the role of being a “good little girl.” Her consistent determination to maintain this familiar role in her current relationships (including with her therapist) leads to the hypothesis that variations from this interpersonal pattern during her early development led her to experience anxiety in her transactions. This seems to have been the case, particularly in her relationship with her father (as there is almost no information provided about her mother and their relationship, it is unclear how this relationship affected her personality organization and interpersonal functioning). Therefore, in order to maintain a sense of security, she learned to keep out of awareness (and/or not communicate) any authentic covert experiences or to avoid engagement in any transactional pattern that diverged from that of being a “good little girl.” We consider, then, moments of resistance to be those instances during sessions when she and her therapist are engaged in transactional patterns that are preserving this self-secure relational matrix.

It can be assumed that there are several experiences of her self and her relationships that are relatively more threatening to her sense of security. In the interpersonal model, one way to conceptualize the more dreaded aspects of experience is to infer about the
patient's "bad me" and "not me" (Sullivan, 1953). The bad me is that part of the patient's self-system that he/she can be aware of, but which is unacceptable and tinged with anxiety. The not me, on the other hand, is dissociated outside of awareness and, if alerted, initiates the most anxiety-filled experience of self and relationships. During sessions, one method of tracking when the bad me and not me are emerging into the patient's awareness is to look for periods of an escalation in typical interpersonal style.

There seem to be several occurrences of an escalation in her typical interpersonal behavior in the clinical material provided on Julie. The first occurred when, in reaction to the perceived disapproval of the office manager that her therapy sessions were scheduled during the day, she described an escalation in feeling unassured about her competence. In addition, while talking about her sexual fantasies, she intensifies her deferential pattern with the therapist, stating she will be whoever she thinks he wants her to be. Finally, there is an increase in unassuredness and inhibition when she is not sure what to discuss, and generally becomes more withholding. These illustrations, as well as others, all seem to involve Julie experiencing some perceived or anticipated rejection, with the consequence being that she cannot experience herself as a good little girl. These interpersonal interactions also demonstrate another form of resistance—Julie's tendency to attend selectively to the behaviors of others who she perceives to be rejecting or distancing. In other words, in her relationships with others, she is hypervigilant in detecting any indications that they are not confirming her sense of self; similarly, she selectively ignores those behaviors that are not congruent with her experience of being a "good little girl." This theme is illustrated when she insinuates that perhaps her father indeed had allowed and encouraged her growth, but that she had rejected these overtures, experiencing them instead as being "pushed out of the nest too early." It is likely that she engages in this process with her therapist as well.

Although the information Satten provides on this patient shows that she made substantial gains in treatment, there are, nevertheless, a number of ways our approach would have handled her resistances a bit differently. In general, the primary modification is that we would have attempted to work much more within the relationship; that is, we would have attempted to use the therapeutic relationship to explore and hopefully resolve her resistances and their underlying conflicts. On several occasions, the patient directly or indirectly addresses the therapeutic relationship, but the therapist does not respond directly. Some examples include her stating that she does not feel close to her therapist and her wanting him to see her as attractive and fun. A majority of our work within the relationship would focus on her need to maintain the role of a good little girl in the therapeutic relationship while resisting other relational matrixes and covert experiences. In addition, we might have explored earlier and more consistently how her wanting to decrease the frequency of sessions had implications for how she wanted the therapist to experience her, and she, in turn, experiences herself. Her therapist's agreement to decrease the frequency of their sessions without exploring what it means about the patient's experience of the therapeutic relationship allows the patient to act out the conflict rather than resolving it.

It also appears to us that Satten's assurance that he would be available to support her when she felt anxiety concerning the termination of treatment was an instance of providing Julie the complementary response, at which moment the therapist allowed himself to be pulled in, providing a confirmation of her maladaptive interpersonal presentation. We see this in her therapist's enactment of the benevolent, caring authority figure in response to her little-girl stance. Although it is necessary for the therapist occasionally to revert back to a complementary position in order to maintain the therapeutic alliance, particularly during times when the patient experiences a perceived empathic failure, this instance
in which the patient actively was experiencing old feelings about ending relationships appeared to be a fruitful place to explore a core conflict.

Another way we might have worked more within the relationship with Julie is through exploring how her maintenance of a rigid interpersonal style (good little girl) evokes negative interpersonal reactions within others. In her case, these interpersonal pulls within the therapist might have taken the form of overly controlling the sessions and a sense of gradual irritation and emotional withdrawal in reaction to her constant need for reassurance. Exploring this pattern with Julie would help her understand how she creates a self-fulfilling prophecy for herself by driving others away, which in turn triggers her sense of loneliness and reactivates the negative affect she experienced when she perceived her dad as rejecting. Her suicidal ideation likely was the consequence of re-enactment of this pattern.

The Case of Victoria

The second case is Victoria—the woman who entered treatment in reaction to her unexpected divorce. From an interpersonal perspective, this patient can be conceptualized as essentially lacking a stable, coherent sense of self. From her description of her developmental history, it seems that Victoria organized her interpersonal functioning around an attempt to figure out what others wanted from her, then trying, to the best of her ability, to provide it. This can be seen clearly in the poignant childhood memory around the age of four when she made anxious-ridden, worrisome attempts to feel confident that she was being viewed favorably by her mother.

Although a person with an unstable sense of self may appear to be mature and autonomous, these characteristics typically are more pseudomature and pseudoautonomous, representing inauthentic attempts to portray overtly the illusion. The result is a precarious and anxiety-filled existence in which the individual must work diligently to ensure that his/her incoherent, nonstable self remains unexposed. The primary maneuver by which this is accomplished is consistently to infer what others want and then provide it, thereby neglecting and negating one's own authentic experiences. In Victoria's case, this is illustrated by her unshakable support of her husband's many career moves, by her frantic attempts to save her marriage and cling to any hope that it might be resurrected, and by her recurrent compliance with her boss's many demands. She also describes her contacts with her father as leaving her feeling empty and as demonstrating that he does not want anything from her. In this context, her sense of self has been put on hold and, as a result, cannot be fulfilled.

The process of psychotherapy, with its inherent demand that the patient be introspective, paradoxically requires that Victoria do that which for her is most problematic—namely, to focus on and communicate about her inner self. She, in turn, cannot experience therapy as anything other than a dangerous situation that requires her to expose that which she constantly struggles to hide. The implicit demand that she explore her inner self traps her in a double-bind interpersonal situation. How can she give the therapist what he wants—in accordance with her long-standing interpersonal theme—when what he wants is that which she finds most anxiety provoking? Her resistance to this implicit expectation is to modulate contact with the therapist through frequent missed sessions (although promising to call, thereby giving the therapist part of what he wants), and through maintaining her pattern of pressured speech on multiple topics (thereby making it more difficult for the therapist to get her to focus with any depth on her inner self). In short, by decreasing the level of intensity and intimacy in the therapeutic relationship, she prevents the therapist from uncovering her incoherent and unstable self-concept.
We have found one intervention strategy to be particularly useful in dealing with this type of resistance. We would explore Victoria’s maladaptive interpersonal pattern, first by having her concentrate on her inferences about the covert experiences of significant others. We would start here for several reasons. First, this task requires that she begin with activity with which she is relatively facile; highlighting her relative strength, in turn, facilitates establishment of a positive therapeutic alliance. Second, although the inferential task requires introspection, it focuses on the inner experience of someone else, contributing to an atmosphere of safety in which she is not being asked directly to expose her own inner experiences. Third, it likely would be too anxiety provoking to ask initially that she make inferences about the covert experience of the therapist. It is only later that we would pursue this inferential task with a focus on the therapeutic relationship; however, we definitely would take this tack because we believe the greatest gains are to be made by analyzing how a patient’s interpersonal difficulties are present live within the session.

Application of this initial strategy ideally would follow a thorough, comprehensive inquiry (Sullivan, 1954). During that preparatory exploration, the patient would be asked to expand upon and clarify any descriptions that were vague. Further, the therapist would be primed to listen for missing pieces in her depictions. For example, in describing Paul’s (her current romantic interest) covert experience, it is likely that Victoria would leave out any negatively valenced depictions. Pointing out the contradiction between the absence of negative descriptions of Paul’s covert experience and Victoria’s reluctance to increase the intimacy in their relationship then might serve as a bridge to more direct probing of her own experiences. For instance, it is possible that her hypervigilant scanning for Paul’s problems serves the function of an interpersonal projection—that, if he were to truly know her, he would become bored or lose all interest. Only after these initial explorations would we begin to encourage her to explore directly her own covert experiences in reaction to others’ interpersonal behavior. Throughout this latter exploration, we would acknowledge empathetically how difficult it must be for her to focus on these painful experiences.

In exploring her relationship with Paul, it is possible that Victoria might reach a point where she felt stuck, not understanding why she needs to keep her distance in this relationship. At this point, we might make a connection between her relational stance with Paul and the type of relationship she had with her mother. She might come to see that, in order to maintain any sense of security with her mother, she had to figure out what her mother wanted of her; to accomplish this, she needed to hide from her mother certain experiences and to avoid certain relationship patterns with her mother. We would point out to her that, at the time, this maneuver likely was an adaptive solution, an effective way she could decrease her anxiety. We then might suggest that perhaps this same pattern is being enacted in her relationship with Paul, although—unlike with her mother—not leading to an adaptive conclusion; rather, it is denying her the adult experience of a satisfying intimate relationship. We have found that making developmental connections—pointing out etiological hook-ups to difficulties in living—builds a cognitive structure with which patients can understand their conflicts better.

The Case of Brian

The final vignette is that of Brian—the patient who met for only four sessions and then terminated prematurely. Our discussion will address the necessity of exploring resistance when it is related explicitly to the therapeutic relationship, the importance of trying to anticipate the type of resistance likely to be encountered, and the central concept of
counterresistance. In our view, counterresistances are those moments when the therapist, often unknowingly, engages conjointly with the patient to facilitate, exacerbate, or create resistance.

In our model, when resistance is related clearly to the therapeutic relationship, its appearance takes interventive priority. If this rule is ignored, establishment of a positive therapeutic alliance is unlikely and premature termination is probable. We believe Brian’s case illustrates how not addressing a conscious resistance related to the therapeutic relationship can lead to a therapy impasse or, in Brian’s case, to premature termination. Brian is described as being ambivalent about being in treatment; from our perspective, he is communicating to the therapist that he is not sure if he wants to have a relationship with him. Our ideal strategy would be to ask Brian immediately to talk about his ambivalence. Based on Newman’s descriptions of the case, it seems likely that Brian would construe his entering therapy as somewhat similar to accepting use of a crutch. In confronting an interpersonal issue such as this, we have found it useful first to agree with the patient’s analogy, but then highlight how it applies only to a temporary situation. Emphasis on the temporary nature of treatment often is soothing, particularly with a patient like Brian, whose difficulties in living are longstanding (i.e., patients with a personality disorder) and correspondingly are likely to be experienced as more permanent. This emphasis is also quite helpful with patients whose conflicts are related to dependency issues (as is likely the case with Brian, given his depressogenic developmental history), as they are individuals who are at an increased risk for terminating prematurely (Van Denburg & Van Denburg, 1992).

As mentioned earlier, a basic assumption of our model is that a patient interacts with the therapist in a way that mainly parallels the manner in which the patient interacts more generally. This principle helps the therapist predict the type of resistances the therapeutic dyad is likely to encounter. A major theme for Brian is that he remains on the periphery of life, especially in his relationships, and there is no reason to expect that this pattern should be any different in therapy. Accordingly, we would increase our efforts to try to ensure that Brian experienced the therapist as concerned, interested in him, and desiring to see him. When Brian called his therapist to cancel their sessions indefinitely because he did not want to have to leave work during the day, we would have offered to find an alternative meeting time, thereby sending a relationship message that the therapist wanted to continue to see him.

At times, all therapists will engage in counterresistances, and it appears that there are several instances of counterresistance in this third vignette. The therapist responded quite dominantly and somewhat hostilely when presented with Brian’s thoughts about quitting his new job. Soon after Brian introduced the topic, the therapist initiated a rather long monologue with the statement, “Let me know what you think about this when I’m done.” Our interpretation is that the therapist did not want Brian to talk at that moment, that the therapist felt he needed to take immediate control of the relationship because of the disruption precipitated by Brian’s passivity. Near the end of his discourse, the therapist queries, “Are there potential benefits to reserving judgment on the job until we can better ascertain exactly what is in your long-term best interest and what is not?” In our opinion, this question indirectly communicated to Brian that he is incompetent to direct his own life and that the therapist knows best. We believe these therapist counterresistances unfortunately exacerbated Brian’s anxiety and his need to flee treatment in order to keep secure his vulnerable sense of self.

In interventions targeting resistances, rather than pointing out to a patient his/her hesitation or avoidance related to topics filled with anxiety, we have found it more useful to put into words for the patient whatever it is they seem to be communicating indirectly.
For example, one way to conceptualize Brian’s discussion about quitting his new job is that his familiar self-concept was being threatened by this new group of people who he perceived as expecting him to be highly competent. Instead of exploring his pattern of passivity, lack of enthusiasm, and inhibitions, we first would have wanted to talk to Brian about how anxious this new job was making him.

Therapist Reactions to Patient Resistance

Obviously, a therapist’s experience of participation in given instances of resistance with patients will vary widely and invariably will include reactions that are outside the therapist’s own level of awareness. For a therapist to avoid or resolve moments of resistance requires that the therapist first notice and identify any negative impacts occurring toward the patient, as well as pinpoint the pattern of patient transactions that evoked these reactions. Through the labeling and disengagement process, the therapist regains the empathic freedom to respond subsequently to the patient with other interventions that can facilitate a return to productive therapeutic work. If successful, these interventions reinforce the patient’s gradual movements away from his/her erstwhile pattern of resistance.

If considerable complementarity exists between the interpersonal behavior of a patient during moments of resistance and the therapist’s preferred interpersonal behavior, it may be more difficult for the therapist to identify and disengage from the patient’s pull. This is the case because if the therapist is to interrupt the patient’s pattern of resistance, the therapist has to diverge from his/her own comfortable and preferred interpersonal pattern. At the other extreme, when little or no complementarity exists between the therapist’s typical interpersonal style and the interpersonal behavior of the patient during periods of resistance, one would expect the therapist to experience heightened anxiety during therapy inasmuch as the patient is pulling for reactions from the therapist that constitute the therapist’s not me, thereby considerably threatening the therapist’s own sense of self.

Finally, we believe that a therapist is more likely to engage in counterresistance when his/her psychological vulnerabilities match issues in the patient’s life that the patient is determined to avoid confronting. In these instances, if the therapist assists the patient to experience conflictual elements of the patient’s sense of self, the therapist risks experiencing his/her own vulnerabilities—horns of a dilemma indeed. For example, a therapist with narcissistic vulnerabilities may be less likely, with a narcissistic personality disorder, to help the patient explore and understand conflicts associated with bottom-line rage and entitlement.

Conclusions

We have found it useful in our therapeutic endeavors to conceptualize resistance as an occurrence in treatment in which the patient and the therapist both are engaged. This view of resistance is consistent with the interpersonal view that the therapeutic dyad functions according to reciprocal causality; that is, the patient and therapist are constantly, simultaneously influencing one another. From this perspective, resolving instances of resistance first requires that the therapist understand his/her own covert experiences and transactional patterns that are enacted during periods of resistance. Only then can the therapist assist the patient to become aware of those aspects of the patient’s experience that are anxiety provoking, creating the need to maintain a resistant stance within the therapeutic relationship.
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Select References/Recommended Readings


