Increasing Client Truthfulness and Openness in Cognitive-Behavioral Therapy

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****These are notes that will provide more information than the slides during this presentation. There are also references listed here that will not be on the slides. There will be more details in the presentation but it will generally follow what is in these notes*****

INTRODUCTION

This is a presentation to address what stands in the way of clients making progress in CBT

Just because a person says they want to change does not mean that they really want to change or are ready to change

Main factors creating obstacles to therapeutic change are resistance and denial (Vitousek, Watson & Wilson, 1998)

All three relate to truthfulness and openness in CBT

Discussion of resistance and denial has been limited in CBT research (Haugard, 2008)

- Resistance and denial often viewed as domain of psychodynamic therapy
- Seen as unconscious process discussed primarily in psychodynamic therapy
- Therapists newer practicing CBT often may attribute to fact person is in therapy as evidence they are not resistant or in denial
- These therapists may see evidence of resistance and denial reflected more in the number of people who do not seek out therapy

Interesting to note that when limiting literature search on resistance, ambivalence and denial to past three years articles on these constructs become very limited

- “resistance” used primarily in more recent articles to refer to “treatment-resistant” depression and schizophrenia
- Mainly referring in those recent articles to resistance to medication
- Reference to constructs addressed here largely from 2008-2018

Earlier theories of resistance and denial had them “residing” in clients

More recent theories have them resulting from negative interpersonal dynamics between therapy and client (Mitchell, 2013)

DEFINITIONS—main terms referenced throughout presentation

- Truthfulness-being honest and forthright about problems and challenges
- Openness—being receptive to therapeutic change and the work it involves
- Denial—both the thought process and behavior behind not being truthful in therapy
- Resistance—behaviors behind not being receptive and open to change
- Ambivalence—thought process behind not wanting to change
- In CBT ambivalence is the thinking behind not being open to change, resistance is the behavioral part (Button, Westra, Hana & Aviram, 2014)

SIGNS OF RESISTANCE, AMBIVALENCE AND DENIAL

Therapists found to not be very proficient without training in terms of identifying signs of resistance, ambivalence and denial (Hara et al, 2015)

Open hostility towards therapy (Schwartz, Chambless, McCarthy, Milrod & Barber, 2019)

- Person shows up but makes it very clear they are angry towards therapy
- Often comes along with person stating therapist does not really care or understand them

Hesitant to discussion of specific goals (Watson & McMullen, 2005)

Inconsistency between recent problems person identifies and experiences they report

- Example would be someone gets multiple DUIs but insists problem is stress management
- Another would be person reports spouse telling them they have problems with anger but they insist problem is social difficulties

SOURCES OF RESISTANCE AND DENIAL

Cognitive-behavior therapy often focuses on solving practical problems

Resistance often arises due to difficulties with psychological problems rather than practical problems (Leahy, 2012)

These psychological problems include:

- Need to feel validated
- Difficulties handling emotional intensity
- Challenges handling vagueness of emotions, person not being able to identify specifically how they feel emotionally
- Cognitive dissonance—change making person feel they are incompetent at making decisions (Newby-Clark, McGregor & Zanna, 2002)
- Need for self-consistency—“if making this change makes so much sense why didn’t I do it years ago?”, leads to person seeing themselves as being unable to change
- Personal schemas—once we form a concept of who we are then we tend to seek out information consistent with those identities, makes therapeutic change difficult
- “Just world” thinking—belief that bad things happen to bad people, distress is evidence of unworthiness, reinforces to person that they do not deserve to change
- Person feels entitled to their emotional suffering
- Change seen as too risky—may be more problems associated with changing than with not changing
- Person keeps from changes as part of “self-handicapping”—if person keeps problems in one area than they do not have to change in other areas
- Client may have unrealistic expectations regarding the pace of change (Davis, 1999)
- Could also be due to cognitive therapy model of problem being not taking into account all relevant factors

- Becoming attached to the problems and fearing what change could bring—example would be person who knows they need to change drinking patterns but not want to lose social aspects of drinking and/or may fear withdrawal symptoms (Kane, 2004)

EFFECTIVE INTERVENTIONS FOR RESISTANCE, AMBIVALENCE AND DENIAL

Supportive interventions more effective than direct responses and confrontation (Westra & Norouzian, 2018)

Motivational interviewing interventions helps address resistance, ambivalence and denial

Monitoring progress over time and identifying patterns of when symptoms tend to improve and when person experiences other change can reduce resistance over time in longer-term therapy (Hayes, Abel & Kuylan, 2020)

Therapist factors associated with decreasing resistance, ambivalence and denial include (Westra, Avirom, Connors, Kertes & Ahmed, 2012):

- Positive reactions to clients
- Therapist showing positive reaction to engaging in therapy

SUPPORTIVE INTERVENTIONS THAT HELP REDUCE RESISTANCE AND DENIAL

Supportive therapy approaches based on positive psychology research (Carr et al, 2021):

- Helping client verbalize their values and finding ways to specifically fit therapy with their values
- Discussing how client sees their best self – allowing therapy to be focused on who the person wants to be and not who they are told to be
- Starting therapy by asking client to identify strengths and what is positive about themselves
- Working on challenging whether the negative things others say about client and entirely true or may be only part (or none) of the story
- Identifying with client what parts of their past have been more positive—making clear therapist is looking for “real” positives and not just negatives
- Addressing what positive experiences client is grateful for—focuses on what is positive about the person and not just what is negative
- Presenting optimistic view of what therapy can do for person that is in line with what changes they want to make

PROVIDING VALIDATION

Particular form of supportive therapy where the client is “heard” in terms of problems they see

Good early step to lessen resistance even if it means putting off addressing problems that might be more impactful to help client see therapist accepting what client identifies

Another issue here is validating that the therapist sees the client as a “whole person” and not just a diagnosis

- Consistent with research for diagnostic labels like “autism” where individuals with the diagnosis respond more to therapist not defining them just based on diagnostic “labeling” (Maroney & Horne, 2022)

- Focusing on what person wants to change even if not consistent with what their diagnosis would suggest
- Can still focus on areas consistent with diagnosis but may need to “come at it from a different direction”
- Example might be working with person who has autism on finding ways to feel comfortable in social situations and do more socially without necessarily labeling it as problem related to autism diagnosis

My experience has also been the clients feel more validated and more receptive to interventions if I provide explanation of more technical aspects of therapy

- Do not necessarily want to know all the details but seem to respond to therapy being something with complexities
- One example I see often is clients responding well to the idea of something being “subconscious”
- Consistent with neurological research on idea of “non-conscious”
- Idea that material may be out of consciousness but still impacting us is consistent with CBT and neurological research
- Clients do not necessarily want technicalities but respond well when I validate that I recognize them as someone who could understand some of the complexities related to therapy

- Challenges handling vagueness of emotions, person not being able to identify specifically how they feel emotionally
- Cognitive dissonance—change making person feel they are incompetent at making decisions (Newby-Clark, McGregor & Zanna, 2002)
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POSITIVE REACTIONS TO CLIENTS

Therapists taking more positive approach in talking about what therapy can offer

Focused on making changes the person wants to make

Can start with what client wants even if later it switches to what client seems to need more

“Hello. I am Dr. _____ and I can help” is good introduction to lessen resistance

Therapy “gift” is older term referring to therapist helping patient make small gain within first few session in line with what they report wanting—helps increase receptiveness to therapy over time

MONITORING PROGRESS OVER TIME

Addresses the issue of clients have unrealistic expectations of how long therapy change should take

Helps reduce resistance over time—this is an issue that can come up as client starts therapy with positive reaction to change but becomes more resistant when it takes too long

Focus is on identifying patterns and showing client that the change they wanted and the change they needed can occur but it may follow different path

Important to not see it as argumentative but rather just pointing out the facts about what is actually happening in therapy

EMOTION REGULATION SKILLS

These are skills that can be addressed over time

Focus in CBT is on helping to make cognitive “side of the brain” and emotional “side of the brain” work in congruence

This is not something that can be addressed quickly in therapy but clients knowing that the goal is to help them learn that getting emotional and cognitive sides of their brains to work together can help decrease resistance

Even if they know it will take time making the clear can help reduce resistance and denial due to discomfort with vagueness of emotions

Can also address how clients will often “feel” that their negative responses work even if they “know” they are not effective or healthy

Difference here in addressing resistance is that the focus is on making clear it is on getting thoughts and feeling working together rather than giving one priority

This can be helpful for preventing resistance that may be due to person feeling they are entitled to their emotional suffering

Therapy approaches not designed to take away emotional experiences (even the negative ones) but to make them more manageable by getting both parts of brain working together

Find it useful to incorporate Freud’s quote that goal of therapy was to turn unbearable “misery into common unhappiness” (use different term than his original term “hysterical” because “unbearable” is term more familiar to people)

Shows goal is to not take away emotional pain but to make it less painful

MOTIVATIONAL INTERVIEWING

Therapists who used approaches consistent with motivational interviewing helped reduce resistance throughout therapy process (Aviram, Westra, Constantine & Antony, 2016)

Motivational interviewing helps lessen resistance, ambivalence and denial in CBT (Westra, 2010)

Adding motivational interviewing interventions can help reduce resistance even in middle of treatment (Muir et al, 2021)

Major aspects of motivational interventions found effective for reducing resistance and denial in CBT (Fairburn et al, 2009)

- Supporting client self-efficacy
- Rolling with resistance
- Expressing empahy
- Reinforcing “Change-talk”

Factors specific to motivational interviewing that help with resistance and denial (Madson & Loignan, 2009):

- Collaboration—therapy addressed in partner-like fashion, both therapist and client are equals
- Evocative relationship—Positive reasons for change are drawn from within the client rather than presented directly by therapist
- Autonomy—ability and decision to work on change entirely under client’s control
- Respecting autonomy for reducing resistance and denial is very important for adolescents as well as for adults (Sommers-Flanagan, Richardson & Sommers-Flanagan, 2011)

CASE EXAMPLES OF FAILURES ADDRESSING RESISTANCE, AMBIVALENCE AND DENIAL IN CBT

CASE EXAMPLES OF SUCCESSES ADDRESSING RESISTANCE, AMBIVALENCE AND DENIAL IN CBT

REFERENCES

Andrews, L. A., Hayes, A. M., Abel, A., & Kuyken, W. (2020). Sudden gains and patterns of symptom change in cognitive–behavioral therapy for treatment-resistant depression. *Journal of Consulting and Clinical Psychology*, *88*(2), 106-118.

Aviram, A., Westra, H. A., Constantino, M. J., & Antony, M. M. (2016). Responsive management of early resistance in cognitive–behavioral therapy for generalized anxiety disorder. *Journal of Consulting and Clinical Psychology*, *84*(9), 783-794.

Button, M. L., Westra, H. A., Hara, K. M., & Aviram, A. (2015). Disentangling the impact of resistance and ambivalence on therapy outcomes in cognitive behavioural therapy for generalized anxiety disorder. *Cognitive Behaviour Therapy*, *44*(1), 44-53.

Carr, A., Cullen, K., Keeney, C., Canning, C., Mooney, O., Chinseallaigh, E., & O'Dowd, A. (2021). Effectiveness of positive psychology interventions: a systematic review and meta-analysis. *The Journal of Positive Psychology*, *16*(6), 749-769.

Davis, D. (1999). Refraining resistance and noncompliance in cognitive therapy. *Journal of Psychotherapy Integration*, *9*, 33-55.

Fairburn, C. G., Cooper, Z., Doll, H. A. O'Connor, M. E., Bohn, K., Hawker, D. M., & Palmer, R. L. (2009). Transdiagnostic cognitive behavioral therapy for patients with eating disorders: A two-site clinical trial with 60-week follow-up. American Journal of Psychiatry, 166, 311-319.

Hara, K. M., Westra, H. A., Aviram, A., Button, M. L., Constantino, M. J., & Antony, M. M. (2015). Therapist awareness of client resistance in cognitive-behavioral therapy for generalized anxiety disorder. *Cognitive Behaviour Therapy*, *44*(2), 162-174.

Haugaard, C., & Sandberg, K. (2008). Resistance in cognitive therapy: An analysis of paradigm and contemporary practice. *Nordic Psychology*, *60*(1), 24-42.

Kane, S. (2004). Ambivalence and resistance to change. *Mental Health Nursing*, *24*(3), 11-13.

Leahy, R. L. (2012). *Overcoming resistance in cognitive therapy*. Guilford Press.

Madson, M. B., Loignon, A. C., & Lane, C. (2009). Training in motivational interviewing: A systematic review. *Journal of substance abuse treatment*, *36*(1), 101-109.

Maroney, M. R., & Horne, S. G. (2022). "Tuned into a different channel": Autistic transgender adults' experiences of intersectional stigma. *Journal of Counseling Psychology*, *69*(6), 761-774.

Mitchell, C. W. (2013). Reducing resistance in psychotherapy. In G. P. Koocher, J. C. Norcross, & B. A. Greene (Eds.), *Psychologists' desk reference* (pp. 258–262). Oxford University Press. https://doi.org/10.1093/med:psych/9780199845491.003.0053

Newby-Clark, I. R., McGregor, I., & Zanna, M. P. (2002). Thinking and caring about cognitive inconsistency: When and for whom does attitudinal ambivalence feel uncomfortable?. *Journal of personality and social psychology*, *82*(2), 157-166.

Muir, H. J., Constantino, M. J., Coyne, A. E., Westra, H. A., & Antony, M. M. (2021). Integrating responsive motivational interviewing with cognitive–behavioral therapy (CBT) for generalized anxiety disorder: Direct and indirect effects on interpersonal outcomes. Journal of Psychotherapy Integration, 31(1), 54–69. https://doi.org/10.1037/int0000194.supp

Schwartz, R. A., Chambless, D. L., McCarthy, K. S., Milrod, B., & Barber, J. P. (2019). Client resistance predicts outcomes in cognitive–behavioral therapy for panic disorder. *Psychotherapy research*, *29*(8), 1020-1032.

Sommers-Flanagan, J., Richardson, B. G., & Sommers-Flanagan, R. (2011). A multi-theoretical, evidence-based approach for understanding and managing adolescent resistance to psychotherapy. *Journal of Contemporary Psychotherapy*, *41*, 69-80.

Vitousek, K., Watson, S., & Wilson, G. T. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical psychology review*, *18*(4), 391-420.

Watson, J. C., & McMullen, E. J. (2005). An Examination of Therapist and Client Behavior in High-and Low-Alliance Sessions In Cognitive-Behavioral Therapy and Process Experiential Therapy. *Psychotherapy: Theory, Research, Practice, Training*, *42*(3), 297.

Westra, H. (2004). Managing resistance in cognitive behavioural therapy: The application of motivational interviewing in mixed anxiety and depression. *Cognitive Behaviour Therapy*, *33*(4), 161-175.

Westra, H. A., Aviram, A., Connors, L., Kertes, A., & Ahmed, M. (2012). Therapist emotional reactions and client resistance in cognitive behavioral therapy. *Psychotherapy*, *49*(2), 163-172.

Westra, H. A., & Norouzian, N. (2018). Using motivational interviewing to manage process markers of ambivalence and resistance in cognitive behavioral therapy. *Cognitive Therapy and Research*, *42*, 193-203.