Notes on Resistance in Addiction Counseling

Overview

In this work I will present the current state of my thinking about resistance in the context of addiction counseling. I'll also share my thoughts about the status of resistance as a concept across the current professional addiction counseling arena.

Very recently, new arrivals in the addiction counseling profession have replied, when I have asked them what is said of resistance in their graduate education, that they were literally told, "Resistance doesn't exist. Don't use the idea of resistance."

By contrast, my handling of this topic will be relatively broad. After the Introduction, the body of this document consists of separate areas of content, labeled Parts 1-12. Each of those sections begin with a key reference or major source upon which each respective portion of the paper is based. These are presented chronologically. The writing concludes with a Consolidation of the work with reflections, two Appendices (each from a different perspective), additional references, and then a list of suggested resources.

Some of the topics I address include:

- Transference
- The proof that resistance does not exist
- Improper perspectives, methods, relational systems, and language that evoke resistance
- How the idea of resistance has practical use even if resistance doesn't technically "exist"
- The impacts of ASAM and Motivational Interviewing
- Checking on therapeutic alliance as a remedy and as preventative maintenance
- How psychopathology, personality, and cognitive flexibility relate to this topic
- Psychodynamic considerations
- Stigma against stigma
- Factors in decision making
- What we can gain about resistance via analogy of physical materials and physics

My hope is that the reader discovers something new, and also something old.

Introduction

It seems to me we have now raised a generation of addiction counselors that know nothing of resistance.

- I can't remember the last time I heard resistance featured as a topic of a continuing education presentation.
- I can't remember the last time I heard a graduate intern mention resistance as a point of discussion or inquiry from a degree program-required checklist of competency or skill.

I'll say we've eliminated the word and idea of "resistance" so fully I can't remember the last time I heard a professional addiction counselor mention it – neither as an old-fashioned point of deviation from new best-practice thinking or method, nor as a point of complaining or of bragging given its lack.

From what I've seen over the last 20 years or so, the fight against the idea of resistance seems to be complete, and it has been driven from our profession. Even if I'm wrong about the extent of this banishment, the general abolition of resistance leaves me concerned.

Resistance during psychotherapy can be thought of as nothing more, or nothing more complex, than the old status-quo. It might take the form of a certain way of making meaning. Or it might take the form of a behavioral strategy to cope. In any case, resistance is likely to be, or embody, one's tried and true way of surviving and getting along in the world. And in its various forms it can be hard to detect. What might constitute resistance in the clinical instance?

- Example 1: Sometimes in the therapeutic process the clinician notices that the work has taken the form of a relatively continuous suspended animation. And this status has been avoiding detection for quite some time.
- Example 2: At a key point or juncture in the therapy, the old status quo suddenly asserts itself (with or without the awareness of the patient) in a way that is large and full.
- Example 3: Active compliance and cooperation that eventually prove to not be change-work, but a means of avoidance.

The world view found in the school of psychology known as radical behaviorism would argue there is no such thing as "resistance". It gets this view by arguing *all behavior is goal directed. And so, by definition, there is no such thing as "resistance" per se.*

But there is a view different from the view of behaviorism.

One could view any behavior as wholistically containing everything about the patient – as a hologram. In this way, any behavior is always seen to contain elements of both change-work and resistance. Thus, from this perspective, the claim that resistance does not exist depends upon the essential strategy of splitting apart and categorizing the concepts of "goal-directed" and "resistance", and then putting them in artificial conflict.

In this way, the mental gymnastics (splitting, categorizing, re-defining, etc.) required to claim resistance does not exist *could itself* be seen as resistance – of the idea of resistance. But I digress.

Rather than being any or all of objectively correct, exhaustively comprehensive, or sufficiently authoritative, this work will present the current condition of my thinking about resistance in an addiction counseling context. My hope is that the reader's resistance to the concept and reality of resistance will diminish, or that the reader will literally discover something old.

The other day I talked over the framework of this monograph, and some of the content, with a working master's level addiction counselor at my workplace. A new graduate, this person calmly remarked, "We were told resistance doesn't exist, and to not use the idea of resistance." And then they gladly started reading the 70% or so of this manuscript that I had completed by that point – with keen interest.

The framework of this writing will be seated in chronological order of publications and major initiatives.

Up next is a section concerning early clinical observations. I encourage the reader to try to be open, and to consider the material in that way during the reading.

Part 1: Early clinical observations

Freud, S. (1914). Observations on Transference-Love.

The novice or less experienced therapist might naively anticipate what it's like providing individual therapy. Such a therapist might not anticipate coming to a point in the work with a patient where both the patient and the clinician are totally stuck, even having come to irreconcilable odds. Or perhaps the therapist comes to find themselves in an insurmountable or unsolvable situation – a kind of labyrinth, or trap.

By contrast, the more experienced therapist can more often sense a therapeutic impasse for what it is – a key opportunity.

In his famous paper titled "Observations on Transference-Love" Sigmund Freud describes an analysand disclosing to the psychoanalyst the fact that they have fallen in love with the analyst. And Freud comments that this leaves the analyst, according to the layperson's average opinion, only one of three options:

1. Formalize the love, and legally marry?
2. End the therapy?
3. Carry on in an illicit love affair?

Freud mentions that many might choose to end the therapy out of an ethical obligation. And that in such an arrangement the patient would likely enter therapy with a different clinician, the pattern will repeat itself time and again, and nothing would be availed.

He does go on to propose an alternative view – an alternative clinical arrangement.

The paper describes how the analyst can note that the love being claimed signals the presence of an *agent provocateur* (a previously unknown feature of the person). And in the face of this behavioral display of love being put on by this provocateur, the clinician should remember:

- Don't turn away.
- Don't repulse it.
- Withhold a response.

Freud discusses how the resistance did not create the love, but adopts it for its purposes. And the therapist must take on a threefold battle:

1. In the therapist's own mind, against the forces that would drag the therapist down from the analytic level;
2. With those outside the analytic understanding, who would function as opponents and dispute the importance of the content;
3. Inside the analysis, with those patients who attempt to dominate the analyst and take the analyst captive to their difficulties.

In this work I will be addressing resistances, a variety of factors that can contribute to their formation, and a way of beginning to understand them. And I would like to point out that, as in the example above, I will not be sharing simple examples such as a patient who drinks alcohol in an out-of-control fashion and isn't ready, willing, or able to stop drinking altogether. And I won't be presenting a cartoon-like tug-of-war between an old-fashioned abstinence-based addiction counselor attempting to cajole a patient into a prohibitionist-style recovery, and a harm reduction peer support specialist or modern mental health counselor dually credentialed in SUD work, arguing in favor of safer substance use as the goal.

Rather, I'll be describing resistance.

But as those among us who have most recently completed graduate studies in clinical disciplines related to our work are likely to have been told, and as I have been told by newly graduated Master's degree therapists – today's professors proclaim, "Resistance does not exist. And we should not use that word, or that idea."

We now turn to Part 2: "The will and counterwill".

Part 2: The will and counterwill

Amundson, J. (1981). Will in the Psychology of Otto Rank: A Transpersonal Perspective. The Journal of Transpersonal Psychology. 13(2): 113-124.

Otto Rank, whom Freud call his successor and heir-apparent, eventually differed from Freud on grounds that were fundamental. Rank emphasized the *present, conscious, and willed*, instead of the past, unconscious, and wished. He held the notion that *warmth* was a duty of the analyst – as opposed to a distant, objective, expressionless professional artifice. Rank developed the idea that *empathy* was the primary therapeutic ingredient, as opposed to the truth delivered by the analyst as contained in interpretations. Further, Rank said the primary relationship impacting the child's development in life, and driving the extent of the person's problems or their lack, was the relationship *with the mother*, not the father.

One of Rank's analysands, Carl Rogers, attended some academic/professional lectures by Rank, and later made a career-length, giant contribution to psychotherapy based on Rank's notions (Stillpoint, 2016). Historians of this content (Amundson, 1981; Kramer, 1995) note that Otto Rank's theory and practice have left a legacy that includes the beginning of existential psychology, person-centered psychotherapy, inter-subjective counseling processes, Gestalt therapy, and what Rank called the "here-and-now" principle in psychotherapy. Other exponents of these methods, aside from Rogers, are Irving Yalom and Rollo May. Rank's influence is all around us in evidence-based models of care. And he is all but forgotten. But his ideas were also an important precursor to the research agendas found in the work of Harry Harlow and John Bowlby, for example, examining what came to be known as "attachment theory".

Rank coined the term "Counter-will". That term denotes "will in reaction to the will in others". It is the "instinctive resistance to any sense of coercion." Counterwill has been described as the "inferior function" of the will. That is to say, figuratively, the action of "counter-will" is

something analogous to the use of the left-hand by a right-hander. The will does have a primary function according to Rank, but the action of "counter-will" per se is not that primary function. For Rank, one can think of the counterwill as having a latent potential energy, and its action and force only being applied after it is awakened by another person's will. And that other person does not need to be a literal opponent for the counterwill to act.

By way of example, suppose a child of age 4 decides the family system is too dysfunctional, chaotic, emotionally unpredictable, emotionally hazardous, and energy-depleting to continue with the status quo. And as a response, while correctly predicting this pattern will not improve, this 4 year old moves into the cabinets beneath the kitchen sink, so to speak – using that space as something akin to an apartment or personal living quarters within the larger household. And further, imagine that at that time the child also decides to only speak and understand the native language of the home with their sibling – if and only if no adults are present. And if anyone other than, or in addition to, their sibling is present – to pretend to not understand their primary language, and to only speak gibberish as an imaginary, new and different (incomprehensible) language.

Now fast-forward 50 years in the life of that child. And imagine that after an important meal with a group of people who are socially significant in that person's life, the group is served a platter of delicious-looking and rather large cookies. And everyone takes one – except that now 50-something person who no longer lives in the kitchen cabinets. Further, months later, it is pointed out by one of those that did take a cookie, that this now 50 year old person noticeably declines the donuts brought to work for others to share. And that now 50 year old retorts that in this way they individuate and find "self" by exerting their counterwill – by not joining the game of the family system.

Consider this statement from Rank (1936, 1978):

> "Experience has taught, however, that as the therapist can only heal in his own way, the patient can only become well in his own way, that is *whenever* and *however* he wills, which moreover is already clear through his decision to take treatment and often enough through his ending of it."

As a mechanism, the "counterwill" is seen in every-day life, most commonly in the life of 2 year olds. The famous "terrible 2's" are well known by nearly everyone for consisting of a pattern of the same one reply to a very high percentage of opportunities and helpful instructions: "no".

Part 3: "The death of resistance"

de Shazer, S. (1984). The Death of Resistance. Family Process. 23:11-17.
doi.org/10.1111/j.1545-5300.1984.00011.x

In this landmark paper, Steve de Shazer makes 3 assertions concerning resistance:

1. It does not exist, per se
2. The conceptual structure commonly used by therapists evokes resistance
3. He offers a different system and language that don't evoke resistance

I'll address these three points in turn.

Resistance does not exist
The opening of the paper centers on the sequence of mental errors that make us think resistance exists.

1. The traditional thinking of therapists has been to observe some behaviors as countermanding the therapy.
2. They then elevate the fact of those behaviors into the concept of "resistance".
3. They finally make the mental leap of thinking resistance exists, per se, as a thing, and concretize it as real.

My assertion is that resistance does exist. So, alternatively, let's suppose for a moment that the idea of resistance *is false* – that resistance *does not* exist. This main objection to the idea of resistance *as a thing* presented by de Shazer is the notion that resistance is nothing but an idea that has been put together from phenomenological observation. And thus, according to this argument, even the *idea* of resistance is not a fact, but an error.

Well, to me, when I am faced with *that* particular argument I have a response.
To me it doesn't matter that resistance does not exist *according to that argument.* Why not? Because we use wholly inaccurate observations every day, *and they work.* Even though the sun does not literally "come up in the morning" (but rather, the earth spins and it merely *seems* to come up when in fact it does not) we live as if it does, and we organize our lives accordingly. What help or use is it to be literally correct at the level of a fact while being practically useless at the level of a goal?

Improper perspective and method evoke resistance
He explains that the early perspective within the discipline of family therapy viewed the patient as an organism that moved as a "figure" within the family system environment. And that the system was analogous to a kind of passive "ground".

He notes this view borrowed the notion of the family system as:

- preserving a kind of homeostasis (maintaining sickness within closed loops),
- on a random search for stability;
- like a machine with no memory and that cannot learn.

He compared that view of the family system to a structural mechanical system that is closed to information and open only to energy, searching for mechanical equilibrium.

de Shazer then goes on to say that in the family therapy context, to view the family as a system necessarily invokes *opposition* and *stuckness*, as the system is defined as *distinct* from the therapist. And he notes that the typical notion of "resistance" naturally nests within this arrangement.

The apparent inconsistency of this instruction on his part to me is large, as he already claimed resistance does not exist. I believe I barely need to point out that this dynamic description

identifies resistance as a problem, and identifies factors that help bring it about, or manifest it as active out of its latent or dormant potential.

A system that doesn't evoke resistance
de Shazer calls for an alternative view where a larger/macro supra-system is identified that envelops both the family and therapist as separate sub-systems into parts of one larger whole. And within that arrangement, as he argues, "morphogenesis" and "cooperating" are the organizing and clinical concepts respectively, replacing the "homeostasis" and "resistance" invoked by the original family system model.

He states, concerning the therapy situation and the traditional view he opposes, that the therapist is outside, not within, the methodological boundary of the clinical work. And that in his model this is not the case.

> "If the therapist is included in the description, however, then morphogenesis becomes the organizing concept, since the focus of therapy is changing. The openness of the subsystems, and their ability to change in order to survive, suggest the alternative label or clinical concept: cooperating."

He argues that in this context, *resistance, by definition, goes away*.

His claim that a therapist is traditionally seen as outside the methodological boundary of the therapy they provide seems odd to me. And I'll also note that the macro-system he prefers, whose boundary envelops and surrounds both the family and the therapist, was already a method of the first psychotherapeutic arrangement: psychoanalysis.

Language that doesn't evoke resistance
Later in his paper, de Shazer gives examples of how to formulate clinical probes (statements, questions, and so forth) for use in his model. This includes asking what might happen "when" rather than "if" a change happens. He emphasizes this kind of open and suggestive language, rather than the use of neutral or skeptical language. He argues that in this context, *resistance, by definition, goes away*.

If he is correct that within his proposed conceptual frame of the system and proposed therapeutic language resistance goes away, then it is my view that he is correct only in a conceptual and abstract sense. That is to say, in my opinion, no matter what concepts or language we use, we (the patient, family system, and therapist alike) all retain our humanness and therefore our proclivities that might at times work against therapeutic gains. And no conceptual framing or careful language can prevent or eliminate that. And I would go further and suggest that most clinicians are already aware of this.

To close I'll say that this paper is eye-opening and clarifying to me due to its irony. I wonder if de Shazer recognized his agreement about the existence of resistance in his attempts to ignore it and keep it dormant.

Thus, stay tuned for Part 4 covering de Shazer's follow up paper he published a few years later titled: "Resistance revisited".

Addendum:
I'll make a note concerning the existence of personality and relate it to de Shazer's paper.

As regular readers of *Recovery Review* will recall, and I'll stress again now, my academic preparation within psychology and clinical psychology was in a very rigorous form of scientific and empirical hardline skepticism. The applied clinical models we were trained in were behavior therapy and cognitive therapy.

We were literally taught that *personality does not exist*. And *the reasoning was the same*. We were taught that people might tend to behave in a certain way under certain circumstances, and differently in others. And that these trends *should not be confused* for being facets of the person, or anything stable over time or "real" that exists in a literal sense. To me this is the same kind of error described in de Shazer's paper where he concludes that resistance doesn't exist – because it is only phenomenologically observed and should not on that basis be turned into a thing that exists. But just as we all say, "the sun will come up in the morning" and are always literally wrong every time we say it, the experienced working clinician also knows personality, like resistance, *is there.*

Part 4: "Resistance revisited"

de Shazer, S. (1989). Resistance Revisited. Contemporary Family Therapy. 11(4): 227-233.

In his follow up paper to his initial publication on the topic titled, "The Death of Resistance", de Shazer writes, "I still insist that the concept of resistance was a bad idea for therapists to have in their heads."

And goes on to say, "…in 1979 I wrote a paper entitled 'The Death of Resistance' and I naively thought I was through with the whole concept when I mailed the paper in 1979. Of course, I was not: I have been haunted by the ghost of resistance ever since."

My considerations of the above include:

- The psychodynamic notion of *becoming the inverse* of something you oppose, and in that way, *carefully preserving* its image (like being the perfect opposite of one's most-hated parent, for example).
- How the psychoanalytic tradition might consider the notion that one can flush a topic once and for all, in one clean attempt, and be done with it.
- That de Shazer literally found resistance by opposing it – which he warned against in his earlier paper by teaching his way of proper wording within psychotherapy.
- Freud's paper titled *Negation* where he describes a common mental function that reveals our less accessible but true thinking, by what we claim to oppose. A common cartoon-like example of negation is as follows.
    - Therapist, pointing to a painting: "What do you see in that painting?"
    - Patient replies: "Well I don't see my mother. She's the furthest thing from my mind!"

de Shazer outlines mistaken thinking – how useful concepts become reified (taking something that is only abstract and turning it into something that is concrete or real), and rather than

remaining as explanatory metaphors they become facts. And that rather than saying it's "as if the client is resisting" they say, "the client is resisting". He notes how we almost never say the more accurate *"as if"*. But in my opinion his comments validate the notion of the usefulness of the concept, at least in part, even if it's literally inaccurate at the concrete level of science, and words.

de Shazer included in this second paper on the topic one most astounding passage. In it he literally uses both the concept of resistance and the literal word, to argue against its existence and usefulness. To me it's quite ironic. He states…

> "The concept of resistance was a bad idea: In fact, it is one of those ideas that actually handicap therapists. As therapists, we do not need an explanatory metaphor dealing with non-change or resistance to change."

One way of reading that passage might render the idea that he is speaking of resistance *in the "as-if"* and modeling the more proper use of the word as he instructs us to do. Another reading might render his phrasing as an example of what Freud called "parapraxis" – a "slip of the pen" or "slip of the tongue" that reveals our less accessible but true thinking. I'm not sure if it's both, either, or neither.

At another point in this follow up paper he writes, "Clinically speaking, non-change does not need to be explained or even described…"

- As someone originally trained in hardline CBT and who has done full time clinical work with more severely disturbed individuals for quite some time, I'm not sure what he's aiming at in a clinical-applied sense.
- He may be referring to a less disturbed population that is more amenable to a more fluid type of therapeutic encounter - one that can be more spontaneously derived.
- But if I'm even a little bit right, he's carefully managing resistance, working within the context it defines, and not waking it up unnecessarily, etc.

He also states in this follow up paper that after publishing his first paper on the death of resistance, "We have never given resistance another thought."

- And yet, here we are reading his follow up paper.
- To me, this seeming irony or paradox is both illuminating and instructive for early-career clinicians, even if we read de Shazer in the most generous way, understand his points, and agree with him.

In this article he quotes a paper that states, "…'there appears to be almost universal recognition that resistance exists'…" and he then adds his own notion that, "then, when a therapist looks for resistance in every knook and cranny he or she is sure to find it. This is known as a self-fulfilling prophecy which means that even a 'false' definition of the situation can lead to behaviors that change the false definition into a true one".

- My only response to this assertion is to ask the question, "How is it that this argument only applies against the idea that it does exist, and not against the idea that it doesn't?"

In the upcoming section, the material turns to two different sources for something closer to clinical pragmatism: Motivational Interviewing and the American Society of Addiction Medicine.

Part 5: Motivational Interviewing & The American Society of Addiction Medicine

In this portion of the work, I'll cover contributions from Motivational Interviewing and the American Society of Addiction Medicine.

Motivational Interviewing (MI)

Some might recall, in an earlier version of MI, the so-called "5 principles of Motivational Interviewing". They were:

1. Express empathy
2. Develop discrepancy
3. Avoid arguments
4. Roll with resistance
5. Support self efficacy

I'll say that "roll with resistance" essentially meant to identify either the patient's seeming opposition, or your own impulse to correct the patient on some level, and to not engage those directly. This could be construed as managing the difficulties of transference and countertransference. And it's an elementary principle in managing resistance, as Freud had instructed.

But my whole point is this. If there was any deeper therapeutic intent in MI concerning resistance, and I don't think there was, it was lost over the years. How so? By the promulgation of check-listed, surface-level fidelity to MI, that merely *hoped for no behavioral error* from the clinician in the resistance domain. Let me be clear – behavioral compliance with "rolling" is not the same as *understanding* what one is encountering.

In this way, in my opinion, the practical long term result of MI, as it was installed and enacted by our field, was to have our field slowly lose the concept of resistance, and the understanding of the patient that could be obtained through the lens of resistance, as a source of information.

As if that wasn't bad enough (wasn't enough of a loss), MI went even further and seems to have completely extinguished the notion of resistance at all, with its newer acronym OARS:

1. Open ended questions
2. Affirmations
3. Reflective listening
4. Summarizing listening

I see instructive irony in both of these formulations from MI. To me, both of these formulations:

- Highlight instructions for behavioral adaptation of the clinician to the presenting resistance of the patient;
- Instruct the clinician in how to maneuver around resistance while staying focused on movement forward;

- Address resistance from the perspective of behaviorism by emphasizing incremental changes in thinking;
- And are not insight-oriented, make no use of fuller interpretation, and in that way emphasize the meaning that is present – that the resistance signals. This final point is to say that this seems a clever way of paying attention to resistance.

We will have to see what the now new 4th Edition of the MI text has to say, and wait to see how our field operationalizes it. The way our field resisted resistance in its implementation of the previous editions of MI seems to have done its work.

The American Society of Addiction Medicine (ASAM)
ASAM characterizes addiction illness and substance use disorders on 6 dimensions. Dimension 4, in a previous version of ASAM's description, was called "Treatment Acceptance/Resistance". This simple notion was a continuum, with acceptance of treatment on one end, and resistance on the other. In that way, the scaling of this dimension could be called bipolar (consisting of two poles scaling opposite phenomena).

That formulation of Dimension 4 was later changed to "Readiness to Change". That conception, by contrast, is unipolar. That is to say, it starts with no or low readiness, and then demarcates incremental scaling of more and more readiness.

In the work-a-day world of clinical settings, most working clinicians I've been around memorize the names of the ASAM dimensions and operate within those 6 mental frameworks concurrently. They do not hold the detailed lines of demarcation (specific scaling) within each dimension in mind.

I wonder how much understanding has been lost over the last 20+years, as a generation or more of addiction counselors and their clinical supervisors know nothing more of this dimension than one unipolar scale of the amount of readiness.

In my opinion, *only scaling readiness* from none to full arbitrarily carves away the difficulties located in the entire range below "none". That is, content within the range of this dimension below "none" was previously included in the minds of working clinicians when the name of this dimension was "treatment acceptance/resistance". And in my opinion this has led to a loss for our field.

MI + ASAM + Person-Centered + Person-Driven = ?
Starting around the mid 1990's, as these perspectives and techniques from MI and ASAM were simultaneously gaining traction (to say nothing of the also-concurrent ascendancy of the "person-centered" movement and its "person-driven" variant within psychotherapy and addiction treatment), a message was engrained in our field. Across our field, the message (silently) took hold: "Anything that evokes resistance *is a clinical mistake*." Ironically, to me, that validates the existence of resistance.

Further, around the same time these forces were operating and **resistance was removed** as a sign within our services for addiction treatment, **pain was added** as a new vital sign within primary healthcare.

Now give that some thought: add pain as a major consideration, and remove resistance as a consideration. What has 20+ years of that combined methodology produced for us and our patients?

Are we in denial of resistance?

Regardless, why we are supposedly better off to ignore resistance and *only* scale levels of readiness eludes me.

In the next section, I'll discuss how systematically addressing the therapeutic alliance can be helpful in addressing resistance.

Part 6: A measure of therapeutic alliance

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J. & Johnson, L. D. (2003). The Session Rating Scale: Preliminary Psychometric Properties of a "Working" Alliance Measure. Journal of Brief Therapy. 3(1): 3-12.

The "Session Rating Scale" asks for the clinician to have the patient gauge the individual session on four indices:

1. I felt heard, understood, and respected (relationship)
2. We worked on and talked about what I wanted to work on and talk about (goals and topics)
3. The therapist's approach is a good fit for me (approach or method)
4. Overall, today's session was right for me (overall)

In my experience, taking a few minutes at the end of each session to have the patient go over these four items, scale them, use them as a point of feedback for the clinician, and promote discussion about improving the formulation of the work, is highly valuable.

One way to think about the real usefulness of building this into the end of each session is a principle from psychological testing: *assessment is reactive.* That is to say, the mere act of testing or assessing works in part as a *therapeutic intervention.* When one assesses, one is also intervening. It's a simple principle. Put the other way, one would say that one cannot assess without also intervening. Assessing has an impact, as interventions do.

In this way, the session rating scale is helpful – toward building therapeutic alliance, promoting the work of counseling (a shared responsibility that requires the work of both parties), and improving effectiveness session by session. It's an intervention. But does this alone *eliminate* resistance? I would say not.

For example…the patient might begin *a pattern* of: showing up late, forgetting assignments, not having much to say, or inert agreeability full of positive endorsements of the work. Worse, they might start a pattern of overtly disingenuous statements, purposeful subterfuge of the therapy or therapist, or increasing the use of minimizing. Alternatively, the patient might remain committed to the work in a positive way but begin to manifest major blind spots within a context of

immovability. What if the patient states, “I hate you” in the first five minutes of the first meeting? Or, what if the patient says, “I can’t. It’s just the way I am.” when not completing one piece of assigned work – after previously going well beyond the minimum of most challenges and assigned work for a long stretch of time?

Thus, the session rating scale can be thought of as a way to address resistance indirectly, and help it to manifest if it must.

Next, I’ll go beyond the therapeutic alliance and take a look at *psychopathology* in one dimension, and connect *that* to resistance.

Part 7: Psychopathology in one dimension

Caspi, A. & Moffitt, T. E. (2018). All for one and one for all: mental disorders in one dimension. American Journal of Psychiatry. 175: 831–844.

Imagine if it turned out, scientifically, that a single quantifiable factor marks the proclivity for, and presence of, psychopathology. In your mind, label that factor “p” for “psychopathology”. (Those that know the history of intelligence testing might recall such a single factor proposed for General Intelligence, known as “G”). Now imagine trying to roll the ball of that single factor up a hill called “improvement” – as either the patient, the therapist, or the “third” formed by the therapeutic dyad – as you read what follows.

In their 2018 paper, Caspi and Moffitt note,

> “In an ironic historical twist, we have learned that this idea was anticipated by Ernest Jones, the neurologist and psychoanalyst, as well as Freud’s biographer, who offered this prediction in his 1946 valedictory address to the British Psycho-Analytical Society: “… there may well be an innate factor akin to the General Intelligence G, the nature of which it still remains to elucidate, but which may be of cardinal importance in the final endeavor to master the deepest infantile anxieties, to tolerate painful ego-dystonic impulses or affects, and so to attain the balanced mentality that is our ideal… [I]f such a factor can ever be isolated it may prove to have a physiological basis which will bring us back to the often neglected problems of heredity. The capacity to endure the non-gratification of a wish without either reacting to the privation or renouncing the wish, holding it as it were in suspense, probably corresponds with a neurological capacity, perhaps of an electrical nature, to retain the stimulating effects of an afferent impulse without immediately discharging them in an efferent direction’”.

They then go on to say,

> “A second hypothesis, which echoes Ernest Jones, is that the core functional mechanism in p is poor impulse control over emotions. This subsumes a variety of deficits in response inhibition, ranging from impulsive speech and action in response to experienced emotions; cognitive impulsiveness as reflected in rumination about the causes and consequences of one’s distress; and impulsive overgeneralization from negative events. Research about the personality correlates of p supports this perspective; it is not just high neuroticism, but the toxic blend of antagonism, weak impulse control, and neuroticism

> that sets high p scores apart. Additional support for this hypothesis comes from longitudinal research which shows that poor childhood self-control, reflecting emotional dysregulation and executive deficits, cuts across all disorder liabilities and is a salient early developmental predictor of the p factor."

And then they state…

> "If p is quantitatively distributed in the population, with extreme scores signaling neuroticism, emotion dysregulation, intellectual impairments, and disordered thought, what marks its developmental progression? One possibility that we hypothesized is that many young children exhibit diffuse emotional and behavioral problems, fewer go on to manifest a brief episode of an individual disorder, still fewer progress to develop a persistent internalizing or persistent externalizing syndrome, while only a very few individuals progress to the extreme elevation of p, ultimately emerging with a psychotic condition most likely during late adolescence or adulthood."

To me, these authors seem to be implying the existence of specific genotypes and phenotypes of treatment-resistant psychiatric disorders – and a shared common factor that makes them so. How interesting. This would be another factor within, or a different specific kind, of treatment resistance.

We do know there are treatment resistant bacteria. And some depressive disorders require up to fourth-line medication interventions, or beyond, to avail clinically significant improvement. So why is the topic of addiction treatment resistance forbidden and seemingly banished in SUD treatment? Could it be that the phenomena of *resistance against recovery* is stigmatized by the advocates of ignoring resistance? If so, would this ironically promote stuckness within our field, and ironically hold us back from advancing our knowledge, skill, and ability to help – by not arranging for us to face and facilitate our way beyond our own barriers to our efficacy? If I'm onto something, I may have accidentally tripped into an area of resistance on our side of the desk. Our existing tools may not be sufficient for everyone – for the clinician as a clinician, or the patient as a patient.

But let's return to the paper itself. The authors note a corresponding convergence in the content of various therapies originally built separately to address different disorders. They describe thematic commonalities among these different therapies, and what those common elements seem to suggest. They state…

> "…a very large number of cognitive behavioral protocols for treating different disorders comprise the same evidence based modules: psychoeducation, setting treatment goals, cognitive restructuring, behavioral activation, recognizing physiological responses, emotion regulation, problem solving, exposure, identifying triggers, relapse prevention, motivation enhancement, social-skills training, and mindful emotion awareness. These elements appear in protocols tailored to eating disorders, anxiety disorders, depression, personality disorders, substance abuse, PTSD, aggression, and psychoses, suggesting they treat the constituents of p, and possibly p itself."

The therapy system this brings to mind for me is Acceptance and Commitment Therapy (ACT). The ACT model comes to mind for me because it targets the processes *that underlie* the

production of symptoms across and beneath many different categories of mental disturbance, instead of being another therapy that is only built for one specific kind of disorder or diagnosis.

As an aside, I'll say it strikes me that in addition to psychoanalysis anticipating the single factor of psychopathology (and operationalizing it, and describing its function), and being the first formal psychotherapy (that *does* also hold the family within the therapeutic system ala de Shazer), it is also the earliest example of a treatment aimed at the functional substrates of mental disturbance (rather than being one built for a specific disorder).

Regardless, I think these authors are onto something else that is important and don't quite identify it per se. To me, taking in the content of this paper, it seems that these notions condense to the idea that the *extent of progress and its limit* in the therapeutic moment points at what I will name the **"Single factor of therapy": *resistance.*** After all, in addressing serious psychopathology such as found in severe, complex, and chronic addiction illness, it's the factors that limit progress and the resulting level of function that are so key.

In the upcoming section I'll address fascinating findings in the area of cognitive flexibility.

Part 8: Cognitive flexibility

Watzek, J., Pope, S.M. & Brosnan, S.F. (2019). Capuchin and rhesus monkeys but not humans show cognitive flexibility in an optional-switch task. Scientific Reports. 9. doi.org/10.1038/s41598-019-49658-0

Do primates like monkeys and apes solve some problems better than humans?

It turns out that many primates give up on strategies that don't work faster than humans do. And it turns out that many primates don't stay committed to a strategy that previously worked but doesn't work now – whereas humans stay committed to such a strategy longer. This article is a fascinating read in spite of being quite technical.

The authors note, "In some cases, it can be beneficial to use learned rules even when they are suboptimal because constraints in our cognitive system can increase the cost and decrease the benefit of using alternative strategies."

They found this phenomena is even present in humans playing chess and also applies to "real life". They write,

> "Indeed, experts are not immune to cognitive set. For example, in a clever study using chess configurations, the availability of a well-known familiar solution prevented expert players from finding the more optimal strategy and lowered their problem-solving performance to that of players three standard deviations lower in skill…(an enormous decrease). This can affect important decisions we encounter in real life. Experts may make mistakes because they rely on well-learned procedures in seemingly familiar situations (in which it does typically result in good outcomes) even when others may be more adequate."

I would argue this dependence on our previously effective cognitive set, that is not working now, would apply to both the patient and the clinician – and thus resistance is "real" or "exists" at least in this sense.

The authors describe their own research by stating,

> "In this study, we assessed the ability of three primate species to break a cognitive set bias in order to use a shortcut. We found that capuchin and rhesus monkeys successfully used the shortcut at high rates, soon after it first became available. In doing so, they join the ranks of baboons and chimpanzees in outperforming humans, who tend to stick with the less efficient but familiar learned strategy (i.e., they show a cognitive set bias)."

Consider this research result the next time you find yourself pressing the same button over and over again on your computer keyboard or TV remote, during a moment of frustration that it's not working. And then ask yourself if it's correct that "resistance" simply "doesn't exist" and that further, addiction counselors "should not use the concept of resistance" as our graduate students are being taught.

The authors describe one source of the relative difficulty humans face in this regard. They state,

> "Humans' ability to encode the rule verbally may help them learn and use the strategy much more quickly than other primates can. However, such verbally encoded rules may be more firmly rooted and therefore less likely to be replaced by alternative strategies. Further, it is thought that more cognitive effort is required to switch to and from firmly encoded rules. In line with this interpretation, we found that humans, but neither of the two monkey species, exhibited switch costs in this study. They made more mistakes when using the learned strategy after just having used the shortcut."

Isn't it interesting that apparently, among humans with previous problem solving that involved words, the difficulty is increased, as the words associated with the previous solution seem to get in the way? (By the way, Freud's method of free association to help identify and dislodge words that are associated and get in the way without our realizing it is just too obviously relevant here. But I shall move on anyway).

The authors continue by saying,

> "…we suggest that this result highlights that cognitive flexibility is a balancing act between exploitation and exploration. On the one hand, if solution strategies are so entrenched that new information is ignored, they can lead us to make inefficient decisions and miss opportunities. On the other hand, if strategies are too susceptible to new input and easily replaced, we may get distracted by irrelevant or maladaptive information. Our results therefore fit nicely into the variability-stability-flexibility pattern of cognitive flexibility. According to this framework, initial strategy selection follows a variable pattern as a result of trial-and-error learning (e.g., the training phase in the present study), but is then replaced by a stable response strategy (e.g., the learned strategy was acquired and is being used consistently). Finally, people may enter a flexible state in which they can seek and adopt alternative strategies that better meet current demands."

This really reminds me of the aim of most psychotherapies – a flexible state for better meeting current demands. And if you were wondering if age in this respect is a complicating factor, you are right. Some "resistance" is a mere product of age…

> "…younger children outperformed adolescents and adults on a non-social task because they were more likely to try different strategies (variability) than older participants, who preferred a familiar solution (stability)."

Consider the idea *that resistance doesn't exist* and that addiction counselors *should not use the bad idea* of resistance as you read the authors' discussion of their findings.

> "Taken together, our results suggest that a lower working memory load may facilitate initial habitual strategy use to some extent (reflected in the monkeys' use of the switch strategy). However, working memory availability alone does not explain humans' initial inflexibility, nor does it explain why humans increasingly used the shortcut over time. We suggest that differences in how firmly the learned strategy may have been encoded better explains the observed inter-species variation in susceptibility to cognitive set. Further, it will be important to consider differences in the relative costs and benefits of exploiting a familiar strategy versus exploring alternative strategies, and how they may change over time or different contexts."

Perhaps this "firm encoding" and the entrenchment it naturally produces are a product of, among other things, adverse childhood experiences? I wonder.

Here's a more digestible and shorter overview from Psychology Today. It's interesting this super-short summary uses the word "resisted".

Why Do Humans Resist Change? | Psychology Today. Susan McQuillan, October 21, 2019
"The macaques and capuchins were significantly more likely to adopt new and more efficient shortcuts to attaining their goals than humans. When the benefits of using a simpler, more direct approach became apparent, however, humans were more likely to get on board.

Even when humans decided to use a shortcut, however, it took them much longer to accept and use the new strategy than the monkeys, and a significant number – almost one-third of participants – still resisted and used the old approach. Previous studies have shown that, given a choice, other primates, such as chimpanzees and baboons, are also more willing than humans to use shortcuts than humans."

As an aside, I can't help but remember I once asked a PhD clinical psychologist trained in the psychoanalytic tradition and psychodynamic psychotherapy, "…the goal of psychoanalysis". The reply was for the analysand "…to be relatively less reactive and relatively more nimble."

In the next installment, I'll examine the next relevant area humans face: personality.

Part 9: The general factor of personality

Dunkel, C. S., van der Linden, C., Kawamoto, T. & Oshio, A. (2021). The General Factor of Personality as Ego-Resiliency. Frontiers in Psychology. 12:741462. doi:10.3389/fpsyg.2021.741462.

What is the so-called "General Factor of Personality" and how is it relevant to the topic of this work?

Literature on the general factor of personality (GFP) "…begins with Galton's (1884) recognition that although individual personality descriptors may have different shades of meaning, their connotations largely overlap along a negative to positive gradient."

"GFP reflects the shared variance among personality traits in which individuals who possess one socially desirable characteristic are also more likely to possess another."

Dunkel notes that the GFP is essentially the same phenomenon as ego-resiliency/resilience and its existence has been mathematically substantiated time and time again. He states that the personality system aligned with the GFP and posited by Jack Block includes two fundamental dimensions: *ego-control* and *ego-resiliency.*

- ***Ego-control*** he describes as an individual's response to internal urges and external distractions. He states that an intermediate level of ego-control is associated with optimal psychosocial functioning. Too little ego-control results in impulsive behaviors (under-controllers). And at the opposite end of the spectrum are over-controllers who tend toward rigidity, restrictiveness, and fragility.
- ***Ego-resiliency*** is the other dimension. He states ego-resiliency represents the ability to adaptively modify the level of self-control to match the circumstances. Thus, it refers to flexibility in order to display adequate context-specific behavior. An individual who is high in ego-resiliency is appropriately versatile. Ego resiliency may have strong overlap with other well-known constructs like emotional intelligence and social-effectiveness.

The authors of the article state that the General Factor of Personality…

> "…overlaps with labels such as social effectiveness, emotional intelligence, and self-regulation. In addition, effective adaptation to, for instance, social situations does not only require adequate display of behavior but also the regulation of one's internal states. Such an ability to effectively adapt or regulate actions and internal states to the context is likely to have a broad effect on behavior: it can be expected to, at least partly, become manifest in many of the constructs measured in social science such as personality, self-confidence, social skills, emotional and cultural intelligence, grit, and many others. This may be the reason that, as Galton already noted, socially desirable or effective traits tend to go together (show a positive manifold)."

And so, I wonder, "Does the capacity to delay gratification inform our thinking here?" I think it does. And to me, an older psychoanalytic construct, "Ego strength", also seems to be a match.

A famous modern study illuminates these factors. Many know this study as "the marshmallow study." Young children are placed at a table, alone, and given a large marshmallow. They are

told if they do not eat it and wait until the adult returns to the room in several minutes, they will receive a second marshmallow and then they can eat both. But if they want to eat the one now, and not receive the second one, that is fine. Then the adult leaves the room to return later.

The alternative behaviors this manifests (delaying gratification for a longer term larger reward, or taking a smaller reward now and sacrificing the larger reward to be obtained later) are more predictive of life course than either of IQ or where one attends elementary school.

In that context, consider the definition of "ego strength" from the APA Dictionary of Psychology. Ego strength is…

> "…in psychoanalytic theory, the ability of the ego to maintain an effective balance between the inner impulses of the id, the superego, and outer reality. An individual with a **strong ego** is thus one who is able to tolerate frustration and stress, postpone gratification, modify selfish desires when necessary, and resolve internal conflicts and emotional problems before they lead to neurosis."

These research findings and clinical formulations align with some observations across my years of clinical experience and my resulting intuitions. And the general potential applicability to addiction counseling seems rational to deduce. As such, I posit that along with the native intelligence of the patient (the general factor of intelligence), the general factor of personality is a strong driver and rudder *of the course of counseling* and its results. To me, then it's as if the GFP is an ingredient that may help set an upper and lower limit on the benefits of counseling. And this could inform our understanding of the lack, presence, nature, and upper and lower limits of "resistance" among some individuals.

We will see more about how this plays out during therapy in the next portion of the work, focused on psychodynamic considerations.

Part 10: Psychodynamic considerations

The first two papers in a recent series of articles by Eric Plakun outline important considerations for most working clinicians, consistent with the theme of this work. Here, I've framed up some of those considerations that are particularly relevant to the notion that resistance does not exist, is a bad idea, and for now over 20 years the understanding resistance being lost among addiction counselors.

Plakun, E. (2023). Psychodynamic Therapy: An Overview for Trainees and Their Teachers: Part 1–The Basics. Journal of Psychiatric Practice. 29: 142–146.

Plakun writes,

> "It is probably easier to distinguish good feelings from bad (one's senses will achieve this easily) than it is to differentiate self from other."

The reason I highlight that sentence is the entire topic of functional difficulties in personality. This raises the topic of dimensions of clinically relevant and perhaps even diagnosable personality problems. This also raises the clinically relevant array of facets of personality

function (such as illuminated by the MCMI or the MMPI) that color and can complicate the lives of people. And it turns out that addiction treatment patients and addiction counselors alike, are people. This fact is so large and germane in every-day clinical work, it makes me wonder how long it's been since any academic who claims "resistance doesn't exist, and we shouldn't use that concept because it is bad" has seen a patient in clinical practice.

Plakun adds,

> "Our patients' imperfect solutions come at a price…people are suffering from their solutions."

I wish this would be a major topic of returning focus in the lifelong clinical supervision of every addiction counselor. And of every addiction counselor's clinical supervisor's clinical supervision they receive from their clinical supervisor of the clinical supervision they provide to counselors. Perhaps the combination of that arrangement and content would dislodge enough latent material and make enough stuckness evident that our field would resurrect the topic of resistance. My guess is it would.

I'll now turn to Plakun's other paper.

Plakun, E. M. (2023). Psychodynamic Therapy: An Overview for Trainees and Their Teachers: Part 2 – The Therapeutic Stance. Journal of Psychiatric Practice. 29: 314 – 318.

Here in Part 2, he adds…

> "Their problems are also their solutions…Although people may come to treatment with a conscious wish to change, the reality that their problems are also their solutions contributes to inevitable reluctance to change (which means giving up their best solution so far!) and to reluctance to allow unpleasant things that are unconscious to enter consciousness. They are unconscious for a reason. In (psychodynamic therapy), this avoidance of things that could lead to change is known as resistance. The resistance is to awareness of emotions and/or uncomfortable thoughts or memories."

Plakun identifies that within the therapeutic dyad there are "three relationships".

1. The real relationship (the patient and the counselor as people)
2. The transference relationship
3. The therapeutic alliance

In this sense, *the work of the therapy* itself becomes a "third" (an "object" different from the two people in the therapeutic dyad) to which each member of the dyad is committed. I really like that formulation, as it describes shared responsibility and concretizes the work of therapy as individuated from each of the two people. In that way, holding the work as "a third" also reminds us of the "self/other" differentiation that is so important in a healthy working relationship.

When the going gets tough
Plakun comments, concerning psychodynamic therapy (PDT),

> "Many patients struggle with achieving the capacity to be in a therapeutic alliance in outpatient PDT or other forms of therapy. For many of these individuals, intermediate levels of care (i.e., intensive outpatient programs, partial hospital programs, and residential treatment centers) are optimal because they add opportunities for social (aka epistemic) learning in addition to dyadic learning about themselves in individual therapy. Achievement of the capacity to be in a mutually trusting therapeutic alliance as a result of work in an intermediate level of care supports better use of post-discharge outpatient therapy."

He instructs us "…to listen from their perspective, with compassion and without judgment…" while noting that, "The combination of empathy and accountability offers opportunities for empathic confrontation and engagement of resistances and avoidance of the work."

In my opinion this shows us a starting place that might be helpful at some times with some patients.

To elucidate this he remarks, "The emotional stance of the therapist in PDT is referred to as 'technical neutrality.' This is an often misunderstood and unfairly maligned term that caricatures a long discarded psychoanalytic stance that was aloof, cold, uninvolved, and passive. Today, technical neutrality in PDT is a stance that is warm, available, empathic, and nonjudgmental." My aesthetic response to the dialect he presents (clinically professional and objective, while authentically warm) is positive. But that same aesthetic response might not be true of every patient or every counselor every day.

He goes further by describing the difficulties that emerge during the therapeutic process as *helpful*. He emphasizes this by stating "…co-creation of a viable therapeutic alliance is intended to construct a container within which the ruptures and repairs can be examined for the learning opportunities they offer."

It does strike me that many of our patients could benefit from counselors that were educated and clinically trained to be prepared for such an eventuality (that version of resistance), if only for the sake of the patient's improved social relations and wellbeing inside the social containers that are the framework of their own lives.

Next, I'll turn to "desirable stigma".

Part 11: Desirable stigma

Vanyukov, M. M. (2023): Stigmata that are desired: contradictions in addiction. Addiction Research & Theory. DOI: 10.1080/16066359.2023.2238603

This paper presents a commentary on the word "stigma" as it applies to our field – its definition, examples of use, proper use, and misuse. To me this article explores the *weltanschauung* (world

view) and *zeitgeist* (spirit of the age) that are currently in our field related to definitions and applications of "stigma".

The author includes examples of the lack of its use – for example, the lack of desirable stigma for "lethally dangerous behavior". Why should the disapproval of lethally dangerous behavior be stigmatized? And how does the active resistance of desirable stigma play out in the wider theater of our field (not just the counselor's office)?

I probably don't need to comment on the paper, but rather, the reader would be better off with a direct quotation to consider:

> "It is argued that the societal disapproval of substance use/addiction is inappropriate because it is a mental disorder, involving biological processes. Nonetheless, neither those processes nor negative attitudes towards substance use affirm the concept of stigmatization as currently applied. This concept conflates potential mistreatment and malpractice with the prosocial justified societal disapproval of a lethally dangerous behavior. Consequently, the stigmatization concept suffers from internal contradictions, is either misleading or redundant, and may do more harm than the supposed mistreatment of substance users that stigmatization connotes. On the contrary, the justified disapproval of harmful behavior may be a factor raising individual resistance to substance use. Instead of mitigating the effects of that disapproval, it may need to be capitalized on. If it is employed explicitly, conscientiously, and professionally, its internalization may be one of the resistance mechanisms needed to achieve any progress in the still elusive prevention of substance use and addiction."

To me, the idea of the stigmatization of lethal behavior as a source of *helpful resistance* against that lethal behavior, and viewing that stigma as a form of *capital for one's wellbeing*, is compelling.

In my opinion this paper is fertile ground for exploration of the topic of resistance as it relates to clinical work across our field *in the aggregate.* What is the impact of our collective stance?

- Why should the disapproval of lethally dangerous behavior be stigmatized?
- How does the active resistance of desirable stigma play out in the wider theater of our field (not just the counselor's office)?
- What patient resistance do we foster as we enact the worldview and spirit of the age that lethally dangerous behavior should not be stigmatized?

Further, and more simply, as a field we now generally *resist* even acknowledging the harms of use. For example, some versions of professional practices – even for those with severe SUDs – based in anti-stigma efforts, explicitly endorse *using safely, plus nothing* as a lifelong lifestyle. To me, one relevant entrance point for considering this in a more novel way, and challenging it, is the widespread ignoring and under-treating of cigarette smoking in clinical SUD services.

Part 12: Reward evaluation

Wu, M. & , Zheng, Y. (2023). Physical effort paradox during reward evaluation and links to perceived control. Cerebral Cortex. 33 (15): 9343 – 9353. doi.org/10.1093/cercor/bhad207

When I finished my graduate internship and got my first job as an addiction counselor, back in 1989, the program manager who hired me (and was my administrative and clinical supervisor) and I got together within only a few months of me starting – to develop a model of *what addiction is.* We finished the development of that model before the end of 1992 or so. He came from the same hardline, empirical, cognitive-behavioral clinical psychology department I graduated from.

One of the organizing concepts that we used to build our model was the notion of "hedonic calculus". That idea could be shown in the example of the routine process we all use to make quick calculations, seemingly without realizing it, about what is best to do. These decisions are rooted in simple principles, or even laws, of psychology – such as maximizing pleasure, while minimizing pain, at the lowest cost of effort.

You could imagine how delighted and intrigued I was then, when I recently came across this paper, focused on the physical effort paradox of reward evaluation.

The authors identify variables that to me are factors within the hedonic calculus concept. The factors the authors identify that mediate outcomes in their study include:

- Pros and cons
- Effort expenditure vs reward evaluation
- Perceived control
- Reward sensitivity vs effort discounting
- Affective significance of effort outcomes
- Appetitive reward vs aversive effort
- Effort enhancement by stage of effort vs type and timing of reward evaluation
- Retrospective effort discounting as a function of cognitive dissonance

It is interesting for me to consider that list, and the basic focus of this study, in the context of mid-20th century applications of even older learning theory (Pavlovian and Skinnerian) to phases of progression in addiction illness. This 3-stage model (Wikler) is an example of such work.

- **Pleasure.** For example, initial and early-stage use of heroin might largely involve pursuit of pleasure, but for some also have a second benefit of relief.
- **Escape.** Later use might largely involve escape from an aversive experience, like impending withdrawal, yet still provide some – albeit less, due to increasing tolerance – pleasure and relief as it did earlier. It's worth noting that non-human primates only progress this far in development of what we would call addiction.
- **Avoidance.** And an even later stage of illness is largely characterized by using to avoid withdrawal. Some people carry on a 'round-the-clock pattern of use for many years, successfully avoiding withdrawal, while obtaining very little if any pleasure as they did at the first. *Only the human* reaches a stage of progression in substance self-administration characterized by steady-state avoidant use; what might this suggest to us as clinicians?

My whole point in addressing the model my supervisor and I built, the aim of this paper, and the factors the authors identified is as follows. Couldn't it be that at times, some patients: stop, or are reluctant, or give up, or drop out, or don't show, or hold back, or "forget" their homework, or are dishonest, or minimize, or change the subject, or pretend to not understand, or repeat old behavior – because right now the change being proposed *just isn't worth it?* Like, at times the sum of the hedonic calculus is to *just say "no"* to the current clinical opportunity?

Why should our field resist resistance? Can't a clinician be broad-minded enough to consider resistance through the mere lens of hedonic calculus, the economic model of decision making, based on nothing more than effort vs reward?

Interestingly, Freud proposed just such a circuitry and impulse regulation (the economic model of the management of psychic energy he called "libido") in his theory of personality. And in this way, that part of his work resembled the work of his contemporaries in both psychophysics and in behaviorism.

Speaking for myself, if the radical behaviorists and psychoanalysts agree on something, I'm inclined to adjust my thinking in the direction of their agreement. "Resistance" might exist, and sometimes it might simply be nothing more than a product of hedonic calculus. Why should we necessarily resist that idea?

Consolidation and Reflections

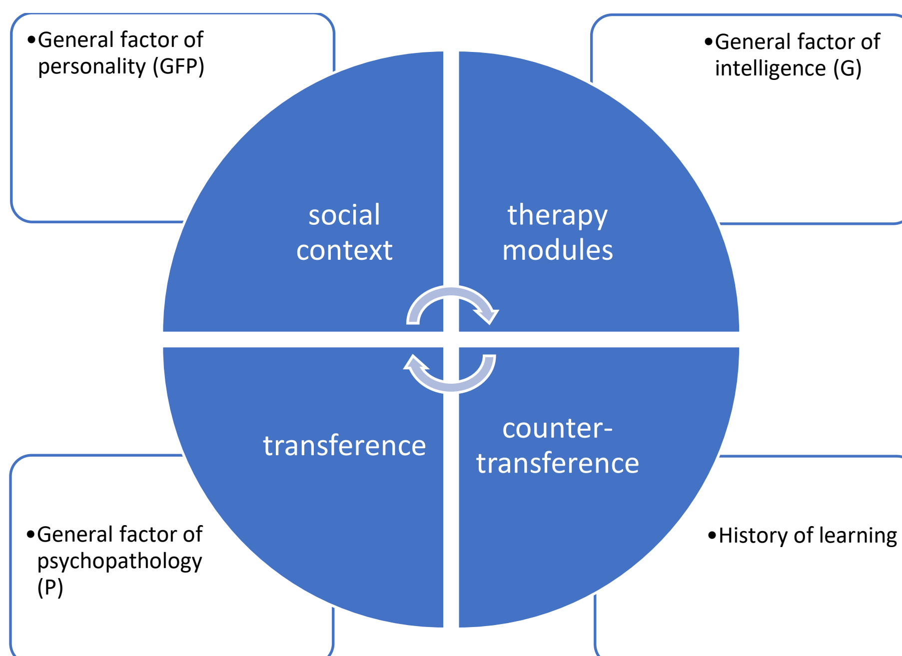
In this work I have endeavored to present a case for the existence of resistance in addiction counseling, and the importance of considering it. In doing so, I have presented resistance not as a particular or fixed phenomenon, but as a functional status within a relatively constant process of growth and its momentary limit – that might result from any number of different elements of human experience.

For example, resistance might result from any of, or blends of, the following:

1. Countertransference
2. Our theoretical framework
3. Our system of therapy
4. Psychodynamic responses to our theoretical and therapeutic systems
5. Cognitive inflexibility
6. Genotypic and phenotypic factors of
    a. Cognition
    b. Personality
    c. Psychopathology
7. The nature of the particular patient's addiction illness
8. Desirable stigma
9. Hedonic calculus

I have also presented the notion, first put forward by psychoanalysts, that the therapist too – not just the patient – can be in therapeutic resistance.

Below, I have attempted to picture my thinking on the topic of resistance in the form of a *visual diagram*. In this diagram I'm attempting to convey something like an outer contextual frame as part of an inner working mechanism, and a port at the bottom through which the resulting product is extruded.



1. The outermost four blocks (shown in white) are something like a large cone-shaped exterior of a funnel that holds material being put in. These blocks are also the factors related to the production of resistance that seem most fundamental to me. These operate simultaneously and synergistically in any person on any given occasion. From an addiction counseling perspective per se, these four factors are so fundamental to the person they resemble the contextual frame that therapy occurs in.
2. Within that set of four contextual factors are the working mechanisms of counseling (shown in blue).
    a. The therapist brings their therapy module (their statements, readings, therapeutic rationale, specific counseling statements, psychoeducational content, etc.), while the patient brings their social context (the famous "ghosts in the room") such as parents, friends, romantic partner, children, work colleagues, and so forth.
    b. Meanwhile, the patient and clinician will both enact transference responses.
3. Center-most in the diagram is the small port through which whatever comes out of a clinical instance emerges. The products of the process are extruded here. And in my opinion, any and all enactments – large or small, temporary or more static – are a hologram of the whole person and are a consolidation of both progress and resistance.

I've gone even further toward consolidating the material in this work, and now attempt to help render something practical, beginning with a grid. As you review the grid below, consider the separate columns. The columns list potential *ingredients* that form resistance, *rival formulations* against the notion of resistance, and *conceptual bridges* between the ingredients and rival formulations. Consider the material as columns, not as rows. The conceptual bridges might help

us identify opportunities within our field (as it currently operates) and fill them more creatively, flexibly, and from a starting point with a wider initial range of options.

Resistance		
Ingredients	**Conceptual bridges**	***Rival formulations***
Psychopathology on one dimension	Therapeutic impasse	Behaviorism (everything is goal directed)
General factor of personality	Psychodynamic considerations	Positive psychology (everything is strengths-based only)
General factor of intelligence	Measure therapeutic alliance	Motivational interviewing: "roll with resistance" then later "OARS"
Reward evaluation (flexibility vs entrenchment in ones learning history)	Motivational Enhancement Therapy (MET/FRAMES)	ASAM: "treatment acceptance/resistance" later changed to "readiness to change"
	Desirable stigma	

The practical use of these conceptual bridges

1. My first notion is that the ***therapeutic impasse*** occurs from time to time, in different forms, and might be a more palatable organizing construct than "resistance".
2. Next, exploring an impasse invites and requires opening one's mind, rather than ignoring the impasse or being compelled to reverse-engineer it, and perhaps implementing those opposites within a closed model.
3. Such a clinical exercise might help the counselor and clinical supervisor identify opportunities to improve clinical attunement and method.
4. In this way, "resistance" as a working construct should convey the notion that each existential moment and the constant process of intersubjective relating – can be thought of as always manifesting progress and its stopping point; resistance is a constant presence then, so to speak.

My thinking about ***psychodynamic considerations*** is similar, as that label tends to rule everything in as a starting point.

Measuring the therapeutic alliance to me sets up a helpful dichotomous tension between objectivity, quantification, and therapist-related outcomes on the one hand, and manifesting a context that demands intersubjective collaboration on the other.

Related to the therapeutic technique itself is the notion that ***MET and FRAMES*** are a relatively fertile conceptual or contextual framework as well as a starting structure from which to innovate choice in the therapeutic moment. Rooted in elements of both person centered MI and clinician-driven CBT, the MET/FRAMES methodology is maximally nimble compared to many schools

of thought and practice. If you can't recall "FRAMES" from memory, consider committing it to memory.

Meanwhile, the whole notion of ***desirable stigma*** produces enough paradox, initial confusion, and novel surprise to draw the clinician into real-original thinking and intentional open-minded thinking (vs an ethical center with nothing more than procedural reflexes).

Appendix 1: Considerations from physical materialism

One way I think about resistance relates to the simple physical properties of materials, and purely mechanical physics. The brute facts concerning the purely physical world (not organic, not living) that I will outline can help us back up, find an objective place outside our work, and get a fresh start on the topic of "resistance".

- **Properties of physical matter.** Consider the specific properties of various metals. One can use certain metals better for some purposes than others, based only on the inherent properties of the metals that are available. Must the same not also be true of the ***properties*** of counseling?
- **Trajectory of physical objects.** Consider track and field sports such as discus, shot-put or javelin. One can only toss an object so far. There are natural resistances that inherently limit our ability and there are natural resistances in the environmental factors that surround us. Must the same not also be true of the ***products*** of counseling?

To help elucidate these ideas, consider the following:

How mentally ***flexible*** is the patient? The clinician? The clinical supervisor?

- Physical materials differ in their ability to bend. Intrinsic properties establish the limit of flexibility. Further, a wire, rod, and plate all made of even the same metal will differ in their inherent ability to bend. Similarly, patients will differ in their level and extent of nimbleness. This general ability will have a general limit.
- But also, how flexible is the patient or clinician relative to a specific topic only?
- This capacity will have a specific limit that might be quite different from the related general limit.

How much ***effort/force/work*** is the patient (or clinician) applying to the therapy?

- This will have a general limit.
- How much effort are they applying to a specific topic or task?
- This will have a specific limit.
- Is "more" effort always better, or are there diminishing returns? Is less effort better in some instances?

How much resilient ***tensile strength*** does the patient (or counselor) seem to possess?

- This will have a general limit.
- How much tensile strength do they have relative to a specific topic?
- This will have a specific limit.

How ***permeable*** is the patient? How permeable is the clinician?

- Physical materials differ in their porousness. Iron, wood, and stone differ in this regard.
- Similarly, patients will differ in their openness. So will counselors.
- And this quality will have a general limit.
- Also – how permeable is the patient relative to a specific topic?
- This will have a specific limit.

How much ***absorbability*** is present?

- After permeability, I think about how greatly physical materials can differ in their *capacity to hold* a liquid.
- And this capacity can also be a function of the nature of the liquid, rather than the material holding it.
- The clinical instance (patient now x the content x the process) is like that.

How much ***endurance*** for change work do the patient and counselor possess?

- This will have a general limit.
- How much endurance does the patient possess relative to a specific task?
- This will have a specific limit.

What amount and direction of ***trajectory*** (forward or backward motion) occurs?

- At the most dry level of considering, as a pure matter of physics, any motion has at least a purely passive limit – a location of progress coming to a stop.
- Atmospheric pressure, relative humidity, wind direction, wind speed, and gravity all work against velocity. So might the layout of the terrain, if the object is on or near the ground.
- What would contextually impede progress if not considered and addressed?

In a way, to me, every existential moment of the patient in every therapeutic instance is an index of at least some of these factors in combination.

Furthermore, to me, the patient's current location always contains the extent of their progress (cumulative benefits) and its general, big picture limit (progress not yet made). That is to say, the patient locates themselves on a line of demarcation that combines the extent and natural limit of their progress. From the starting point forward, imagine an arrow in the positive direction showing their progress. And from their ultimate big picture goal backward, imagine an arrow showing their current position and remaining progress to make. Wherever that patient's position is, reflects the consolidation of both progress and natural resistance.

Not to slice too thin, but this is also true inside each and every existential moment, separately. The patient's current moment always contains their personal, small picture, in-the-moment equivalent of movement and its natural limit.

Overall, in this simple way, the patient could be thought of as always evidencing both progress and resistance, *as a whole* – if only from this kind of purely physics-type of consideration.

Does this have practical value for the clinician? For the clinical supervisor? Maybe this kind of ultra-dry, ultra-objective starting place can *help us* as addiction counselors *move forward*, past our mental and emotional blocks related to this topic.

Does this have practical value for the patient? In my view it behooves us to have a sense of these general and specific limits to help the patient specifically improve their capacities for:

- self-care,
- illness self-management,
- and autonomy and self-efficacy in looking after their own wellbeing.

Why would we want to shrink away from understanding their resistance at least in terms of simple limits? Why would we, as clinicians, adopt a counter-transference against understanding resistance, and discard the topic as though it does not exist?

The location of the current extent of progress, and its border with progress yet to be made, can serve as the definition of "resistance". It's the end, border, boundary, or edge of the progress vector. And yet, we have now grown a generation of addiction counselors without "resistance".

- What is the counselor without knowledge of limits?
- What is the counselor with unconscious resistance to resistance?

Toward answering those questions, it is interesting to consider that some clinical techniques in psychotherapy, especially some techniques from cognitive-behavioral therapy and short-term strategic therapy, require the presence of resistance. Stress inoculation, symptom prescription, and paradoxical interventions rely on the concept of resistance – even if unknowingly. They rely on it and function as a hinge against it, to ultimately promote self-efficacy.

Conversely, a counselor can be in resistance. Many of us have heard the axiom, "Don't work harder than the patient." At times, could this be an example of the therapist being in resistance? Or the clinical supervisor? I would suggest so. And it seems to me one very obvious and long-standing evidence of the possibility of the clinician being in resistance is all around us every day at the level of the whole field: *its resistance to the idea of resistance.*

Appendix 2: Considerations from Psychoanalysis

Psychoanalysis: discredited, misunderstood, and ignored. In those ways it resembles the concept of resistance itself, which it founded.

The "positivist" approach to understanding the world (utilizing scientific materialism and its related research methods and findings) rejected the claims and methods of psychoanalysis in total. Thus, behaviorism and the medical model of how to understand people have prevailed and left routine addiction counseling less fully equipped – abandoned in an "evidence-based", manualized, person-centered, or person-driven context that has lasted more than a generation.

The patient's seemingly automatic and unconscious reaction to the clinical situation, at times, contains historical information and its related affects; these might be foisted upon either or both of the clinician and the therapy being offered. This is the transference. The more experienced

clinician would probably follow Freud's advice (without realizing it was Freud's) to not turn away, and to not repulse the patient's reaction, but to withhold a response; 75 years later MI offers the same suggestions using different words. This is managing the countertransference. When faced with resistance, Freud advises us to retain our stance, view the resistance as important, and to not be swept away and taken captive by it. He tells us, rather, to understand resistance as signaling to us *a feature of the person we do not yet know, recognize, appreciate, or understand.* (I will point out that this method he outlines privileges the patient as the teacher.)

While doing so, we should avoid the beginner's error in clinical technique of simply enacting the exact opposite of the transference, or of the countertransference, in an attempt to undo them; we should understand and overcome our proclivity to engage that reflex of doing the inverse of the resistance as a method to use against the resistance. Alternatively, the clinician should remain cognizant that resistance may be covert and nested in the big picture while it avoids detection over the long haul. For example, the patient may be active in the little picture, with the resistance disguised as good-quality collaboration with the therapy.

The therapist and clinical supervisor could consider the possibility that the patient's movement, in any form, is a wholistic product of the whole person. And that any movement includes a natural limit at least partially resulting from natural countermanding forces. And the counselor-clinical supervisor dyad can also consider the possibility that "progress" and "resistance" might need not be artificially split off, put in tension, and taken captive to the clinician's desires. And while considering such possibilities, they could lightly hold and maintain the consideration that being "correct" in their judgment about the presence or lack of "progress" or "resistance" is perhaps *less important than being helpful in a practical way.* For example, measuring and attending to the accuracy and helpfulness of sessions, from the perspective of the patient, can include if the patient was able to talk about what they wanted to talk about. The manual-driven therapist should hear that, recall Freud's method of free association, and consider newer research identifying words that have become associated with old problem solving methods – words that entrench that method and now get in the way without our realizing it.

To the extent progress is seriously limited, we might consider widening the lens or method of our clinical system – from the individual patient level all the way to the program level. Have we encircled and included all the relevant needs, or excluded some of them? Might some of these be people? What influence do the previous generations have upon the patient now, and have we included them when they are available? Alternatively, if our clinical method never evokes any resistance, are we hiding from an important truth? Or have we even established rapport? Consider the warmth, empathy, here-and-now, present, conscious, willed, and counterwilled – as outlined by Rank.

Psychoanalysis aims at mental processes in general and the improvements it brings are broad compared to those of pre-packaged evidence-based manualized protocols that treat a specific disorder only. We might ask ourselves, then, if we are in resistance against adding therapeutic components or adjunctive supports that similarly bring broad benefits (e.g. suggesting opportunities within mutual aid societies of all kinds as well as religious communities, taking family system level actions, and development of dormant life domains and possible selves)? Are we using a narrowly limited clinical repertoire in a pattern of repetitive clinical actions and

circular operations while falling back on old theories and explanations, or perhaps check-list style clinical slogans to defend our limited methods? *Can the repetition compulsion be ours*, and not only the patient's? Do we keep trying solutions that literally don't work? And why? Have we considered activities that will raise the patient's ego control, ego resiliency, and ego strength?

And are we attending to the garden of the real relationship? The transference relationship? And the therapeutic alliance? *All three?* And while doing so what will it take to always listen openly and without judgment, while seeing difficulties that arise as helpful, rather than bothersome and countermanding the work? What stigma does the patient desire, and what stigma repulses the patient? What stigma does the counselor desire, and what stigma repulses the counselor?

How do these desires and revulsions align between the patient and the counselor?

And are these impulses a matter of our clinical supervision?

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About the Author

Brian Coon, MA, LCAS, CCS, MAC has been working full time in residential addiction treatment since 1988. This includes 19 years of service in a 9-12 month residential therapeutic community program specializing in gender-specific care and including a nursery component for 14 children from newborn through age 4 living with their mothers during residential treatment. 12 of those years he clinically supervised and administratively managed that program and an outpatient methadone maintenance program sharing the staff and physical plant. He spent 4 of those years managing a federal bureau of prisons halfway house, 1 year aftercare program, and an IOP located inside a 300-bed city/county work release detention facility. Since 2008 he has worked at a free-standing organization providing residential and outpatient programming with specialized services for young adults and public-safety-sensitive professionals (physicians, lawyers, etc.) and served as clinical director there for 10 years beginning in 2011. His bachelor's degree in psychology and master's degree in community-clinical psychology were obtained within a department deeply rooted in radical behaviorism and the scientist-practitioner model. His recent years have been marked by an interest in the psychoanalytic tradition, depth psychology, and the application of that information to addiction counseling, clinical supervision of counseling, clinical supervision of clinical supervision, and the function and leading of interdisciplinary clinical teams. In his spare time, he is a contributor at *recoveryreview.blog* and an affiliate of the *Addiction and Behavioral Health Alliance.*

"Philosophy is dead." Stephen Hawking, 2010. The Grand Design.

"It has often been said, and certainly not without justification, that the man of science is a poor philosopher." Albert Einstein, 1936. Physics and Reality.