Practitioner Perspective

# Managing Client Resistance in Clinical Practice: Utilising a Cognitive Behavioural Formulation for Non-Compliance to Change with Personality Schemas

*By Clive Rooney*

*Accurate case conceptualisation can be used to inform therapists in managing client resistance to change. Narcissistic Personality Disorder typifies the developmental and transferential challenges that are frequently encountered in therapy and the underlying motivation for the client to resist personality modification*

**Introduction**

During the 19th century, psychopathology was viewed principally in terms of resistance by neurologists. The psychiatric observation of such behaviour was attributed to the practice of malingering or feigning psychological symptoms for the purposes of social or financial benefit (Shorter, 1997). Breur (1895) & Freud (1955) attribute this phenomenon to conflicts in the psyche that are out of the remit of consciousness.

Psychoanalysis understands client resistance from the perspective of ego defences – a symbolic representation of the true inner conflict. The practicing analyst proposes, that only a working through of the client's resistance using the transference relationship can the conflict be resolved (Kernberg, 1975, 1978). This article will emphasise the utility of cognitive behavioural approaches to client non-compliance in clinical practice. Aaron Beck's Schema Model (1990) will be utilised to stress the importance of avoidance and compensation strategies employed by clients to resist therapeutic change. To illustrate this, the clinical presentation of Narcissistic Personality Disorder (NPD) will be examined.

**Cognitive models of resistance**

Ellis's (1985) model of resistance emphasises the dysfunctionality of client's thinking. His model explains the client's tendency to be resistant in terms of absolute thinking and 'irrational beliefs'. Ellis stresses the importance of client's global statements about themselves, stating that such terms are meaningless. According to Leahy (2001), Ellis "indicates that concepts such as 'worthlessness' are not empirically verifiable" (p.18).

Similarly, Burns (1989) underscores the existence of cognitive distortions and how they operate to impede compliance

with self-help exercises. Burns further addresses this through the identification of specific client strategies used to evade progress in therapy such as perfectionism, emotional reasoning, sense of entitlement and reactance all being prominent in deflecting from therapeutic compliance.

Beck & Freeman (1990) enhanced the Schema model traditionally employed to understand depression and anxiety (Beck, 1967; Beck, Rush, Shaw & Emery, 1979) to comprehend the intricate processes involved in personality disorders. Recurrent problems are attributed to the existence of core and rigid cognitive processes developed from early childhood. These 'schemas' direct the selection to and recall of information in the client's current and past life that is consistent with their ideas about the self and others (Beck, Emery, & Greenberg, 1985). Personality schemas correspond to specific patterns and themes arising from specific vulnerabilities triggered by current environmental stressors (Beck, et al, 1985).

Beck (1990) stresses the importance of avoidance and compensation as strategies used by clients who have inflexible personality schemas. The strategy of avoidance relates to the client's tendency to evade situational and environmental stressors that could trigger their schematic processes. Compensation relates to the practice of adopting behaviours that aim to counter the activation of their schema in a variety of interpersonal and social situations.

Leahy (2001) emphasised the concept of 'extra-adaptive behaviours' in the clinical setting, such as being overly pleasing, overly attached, and even overly critical of the therapist. Young, Klosko & Weishaar (2003) speak about the concept of early maladaptive schemas arising from unmet developmental needs. The disruptive attachment patterns of such clients are compensated by overdeveloped strategies: "Certain overdeveloped and repetitive strategies are used to compensate a distorted view of self and others that have emerged as a response to negative developmental experiences," (Beck, Davis & Freeman, 2015, p. 43).

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**Narcissistic Personality Disorder**

According to the *DSM-V* (American Psychiatric Association, 2013) NPD is a "pervasive, inflexible, and maladaptive pattern of inner experience and behaviour" (p. 300). Beck et al (2015) speak about the self-aggrandizing and competitive expectations of being given special treatment in therapy. Self- esteem for the narcissistic client equates to positive self-evaluation and admiration from others (Neff, 2011). Beck et al (2015) discusses the personality structure of NPD as typifying "overcompensating schema modes" in their self and other schemas (p. 304).

Milton (1996) offers an interesting perspective on NPD based on Social Learning theory. Due to the anticipation of the child's needs by the parent, the child has been denied the skill of obtaining gratification, as no effort has been expended by the child. He further adds that this pattern is continued into adolescence and early adulthood, culminating in the formation of the narcissistic personality structure. I have personally observed in clinical practice this transference phenomenon of the expectation of therapist-led 'cure' without any active participation of the client. As discussed, Milton (1996) describes this personality formulation as "passive-dominant" (p. 243). From a clinical perspective, more often than not narcissistic clients tend toward depression when the environment does not provide the gratification to which the individual feels entitled (Wessler, Hankin & Stern, 2001, p. 244).

**Clinical presentation of narcissistic resistance**

As we have seen with Milton's (1996) Social Learning Theory, the clinical presentation of an NPD client typically resembles a passive-dominant personality style. It is prudent to expect such a personality-disordered client to expect others to fulfil their needs without any purposeful or active behaviour on their own part, hence the passive aspect of the personality circumplex.

From an interpersonal perspective, the NPD client will attempt to procure a dominant stance in any given interaction. Such intersubjective vacillation between these two styles confers a sense of entitlement without any instrumental act or behaviour on the part of the client to earn this gratification.

Beck, Davis and Freeman (2015) speak about the threatening imbalance in relationship dynamics that therapy provides for the client. Not infrequently, the NPD client will view themselves in a subordinate or weaker position due to the 'educated' status of the therapist and this would typically evoke a sense of humiliation on the part of the client. It is worth mentioning that when conceptualising a case formulation for a NPD client, Wessler, Hankin and Stern (2001) classify the NPD personality presentation as either a 'true narcissist' or a 'defensive narcissist'. The former presents as lacking any form of empathy in the transference relationship; the latter will habitually overcompensate for perceived lack of confidence by projecting a polar opposite

version of self that has the effect of portraying a highly self-centred personality style.

The true narcissist seldom, if ever, requires such a compensatory style as they genuinely believe themselves to be superior. In the words of Wessler, Hankin and Stern (2001): "The true narcissist already has more than enough self-regard" (p. 244).

It is worth noting that the overriding behavioural indicator characteristic of this personality mode is the abundant paucity of social reciprocity – an almost compulsive yearning for appreciation in the absence of appreciating others.

**Cognitive consistency with NPD**

When we discuss personality schemas it is more often the case that familiarity does not breed contempt. Swann, Stein-Seroussi & Giesler (1992) discuss a self-verification model when conceptualising clients who actively seek out, attend to, and cognitively recall confirmation of their self and other schemas. Indeed, this serves an internal motivational vehicle to procure and maintain an internalised familiarity that is consistent and predictable, and it is this consistency that Helder (1958) called a 'cognitive balance'.

Cognitive behavioural therapy in the tradition of Socratic questioning would collaboratively and scientifically address any inconsistency in beliefs as a therapeutic conduit to guide the client to belief change. Conversely, however, Leahy (2001) underscores the motivational desire of certain clients to reject and vehemently repudiate such inconsistent discoveries to preserve the omni-presence of certain hypertrophied early maladaptive schemas, "rather than change the negative belief, the patient may reject the positive evidence – and perhaps even the therapist" (Leahy, 2001, p. 58).

**NPD self-justification and cognitive dissonance**

When understanding the complexity of the cross-sectional and developmental formulation of the NPD client, it is worth considering the undeniable role that cognitive dissonance plays in the maintenance of such long-standing mental structures. Festinger (1957) identified the elaborate task of individual's efforts to justify their hypertrophied cognitive schemas – even in the face of contradictory evidence:

"Individuals are motivated to reconcile their psychologically inconsistent beliefs" (p. 90). This is typically a personality constant for NPD clients in therapy, owing to their unfaltering belief that the 'problem' resides outside of themselves. As is often the case when clients present in my practice with characterological difficulties, I fail to recall a single occasion where the initial presenting issue was one that was attributed to the actions of the client or to the modest acceptance that it could be their own behaviours as the genesis of the problem.

**Clinical treatment of narcissistic resistance**

To illustrate this dissonance effect in my experience with NPD clients, it is useful to provide some clinical examples. Several years ago in the opening initial assessment, an NPD client remarked that he was not sure if I could help him in any beneficial way. The client repeatedly probed into my skills and abilities to help him with his difficulties engaging and interacting with colleagues in a new job. I hypothesised at the time that this was an initial 'test' to empirically confirm his underlying schema of superiority and entitlement on his part and weakness and inferiority on mine.

In this situation I was careful not to be provoked into re-enacting this cognitive interpersonal cycle, but to neutralise the client's expectations by offering an anti-complementary, disconfirming interactive style. It was crucial for therapeutic success that I came across as equally strong, competent and confident, as to not do so would recruit me in the service of his cognitive-interpersonal schema cycle, i.e. weak and someone to be dominated interpersonally. To my recollection I retorted with the following: "Thank you so much for asking me this very important question. I believe that after listening to your difficulties and concerns I might be the most appropriate therapist to help you. I also believe that I am the most qualified to assist you in what clearly are very special struggles over all the other therapists that I think would not really appreciate the special nature of these recent stressors."

This was a timed choice intervention that conveyed to the NPD client that I was technically qualified and self-assured in my abilities to handle the client's 'special' problems. This is one of the few occasions in the practice of CBT with personality disorders, and especially NPD, that an immodest approach is optimal in laying the foundation for therapeutic success.

This strategy precipitated over the course of therapy – a series of put-downs and deliberate condemnations of my character, my expertise, qualifications and personality to provoke a schema-confirming response. The client had experienced an anti-complimentary interpersonal style, which created dissonance between what was expected (a timid, modest and acquiescent therapist) and what was experienced (a confident equal with capable skill). In this example, the client's condemnations acted as a defensive strategy to reduce this unfamiliar scenario – hoping to re-establish the more familiar interpersonal schema of the dominant, superior client and the frail, feeble psychotherapist. Over time, these caustic put-downs

diminished in frequency as the transference relationship became increasingly of a correctional emotional and social experience. From here, a less directive approach was utilised to point out for the client the gulf of difference between his private constructed version or reality and my own socially-attuned version.

This was demonstrated in one session where the client's self-aggrandizing stories, with no other motive, but to impress and pull adulating responses from me, were met by timed observations and remarks on my part of the client's obvious lack of empathy. On one occasion the client manifested what appeared to be a vain, glorious boast of having verbally accosted a flight attendant for not coming to his service immediately when he pressed the button for assistance. Despite the fact that the flight attendant was occupied with another issue on the plane at the time, this was seen by the client as a conscious and direct attempt to deny him gratification. I retorted with an alternative version of reality, with the aim of illuminating his own private version. "You know, if that were me in that situation, I would feel quite upset, or even hurt, that I wasn't being appreciated. I might also feel angry that I was being demeaned by someone for actually doing my job. I would also wish in that situation that someone would understand the demand of my job and be more respectful to me." Predictably, this strategy was met with counter rationalisations to maintain the cognitive consistency that people should cater to his every need when he wants it.

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In my own clinical practice, I have found it therapeutically useful to

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'impress' the narcissistic client from the onset when inevitable reassurances for optimal therapeutic performance are made. Wessler, Hankin and Stern, (2001) state that narcissistic clients 'expect' only the best. Not surprisingly, this 'demand' will also extend to "the best therapist" (p. 244). Novice therapists or therapists in training might find this position difficult to adopt, owing to covert confidence issues of their own, leading to provocative counter-transferential reactions.

According to Milton (1996), the passive-dominant cognitive-interpersonal cycle adopted by the narcissistic client would mandate on their part a transference-related test. Leahy (1991, 1995) refers to these as 'life scripts' and I have observed such life scripts unfold in the transference relationship.

Safran and Siegal (1990) discussed the concept of the Cognitive Behavioural Cycle to be utilised *in vitro* (in session). They go on to state that such a cycle can be examined with regards to the transference relationship – "an experiential disconfirmation of the client's cognitive interpersonal cycle" (Wessler et al, 2001, p. 160). Recently, a client in practice started to belittle my professional approach to treatment and elevated this to inappropriate remarks of the therapeutic office. The cognitive-interpersonal cycle of the client was clearly operational. In an attempt to model a non- defensive way of reacting, I provided a schema incongruent response that provided a form of dissonance in what clearly was not the 'typical' reaction that the client expected from others *in vivo* or other significant relationships outside of therapy. I decided to use humour, indicating that perhaps the client is right and that "I should have gone on to get my Doctoral to get better furnishings". From the perspective of the avoidance/compensation strategies that were formulated through accurate case conceptualisation, the therapeutic relationship assumed a shift in trajectory. This strategy and many more like it during treatment obviated the schema-driven protective strategy to 'defend' his 'superior status'.

Gilbert (2010) adds to the feelings of superiority by the narcissistic client to include reward- seeking behaviour as part of the overdeveloped strategies employed by clients with NPD. Such clients develop an illusory bias in self-image (Colvin, Block, & Funder, 1995), which has implications for clinical treatment. This is another example of providing dissonance between the narcissistic client's illusory self-image and the therapist's socially appropriate concept of reality and conventional social behaviour. Typical remarks on my behalf would draw attention to how I would feel in a similar position. This strategy could also be utilised as a specific form of empathy training to demonstrate in session the effects of the client's remarks and behaviour on myself the therapist. Such in-session transference observations can then be related to the client's outside therapy affect, on other significant people and interpersonal relationships. Neff (2011) outlines how these techniques can be used as alternatives to the grandiosity and competitive comparisons made all too frequently by narcissistic clients. In therapy, the use of empathy training can strategically neutralize these self-aggrandizing image preoccupations by clinically connecting the client to his developmental maladaptive patterns.

An example of this can be seen when my client typically monopolised the session with unending yarns about his triumphs in sport and business. When it was brought to his attention that such exuberant overinforming was learnt in childhood to procure acceptance and love and that in the transference relationship it confers no special condition for care, such transference configurations can be explored leading to corrective and latent learning.

**Conclusion**

This article highlighted the existence of schema resistance to change and addressed the specific overdeveloped strategies employed by NPD clients that are demonstrated and presented in clinical practice. The cognitive and behavioural profile of clients presenting with personality disorders provides the essential backdrop to optimising the effectiveness of an accurate case conceptualisation approach to understanding and treating client resistance to change in the therapeutic process.

Becks' (1990) avoidance and compensation overdeveloped strategies employed by clients provide the instruments to deflecting positive change in treatment. Clients who present with NPD typically adopt extra adaptive behaviours to protect their surface schemas of entitlement and superiority (Leahy, 2001). Building on the early maladaptive schemas formed in childhood (Young, 1990), the narcissistic client typically learned to compensate for unmet developmental needs and a lack of reinforcement for obtaining gratification (Young, Klosko & Weishaar 2003). The clinical implications of this for treatment have been observed in the transference relationship whereby the learned strategies are manifested in a passive-dominant personality style, (Milton 1996).

As a mental health practitioner, I have observed this resistance working with both syndromal and characterological presenting issues. I believe that client resistance is all too often a secondary problem that counsellors and psychotherapists need to embrace fully and comprehensively in their approach to therapy and their overall treatment plan. Once the transference phenomenon is denied its 'clandestine' quality and brought to the attention of the client, only then, I believe, can this potentiate the invitation for a mindful discussion in treatment on negotiating the conflict between change and familiarity. This is our responsibility as therapists. However, the issue of change is always the responsibility of the client.


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