

Current Behavioral Models of Client and Consultee Resistance: A Critical Review

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Abstract

Resistance is the phenomena that occurs in the therapeutic relationship when the patient refuses to complete tasks assigned by the therapist which would benefit the patient in improving their psychological situation. Resistance is also used to describe situations in the consulting relationship where the consultee does not do what the consultant suggests. Often resistance leads to poor treatment integrity and/or staff burn out. As a result, this resistance is a factor that warrants a behavioral interpretation and investigation. Currently several behavioral models of resistance exist. In this paper, we explore each of these models and critique the logical and empirical support. Future research directions will be discussed.

Keywords: Resistance, Behavioral Models, Functional Assessment, Consultation

Introduction

The functional analysis of verbal behavior began in 1945, with the publication of the Harvard Symposium on Operationalism in Psychological Review. In paper by B.F. Skinner entitled "The Operational Analysis of Psychological Terms" it was argued that by observing the contingencies and setting conditions under which a verbal community typically used the ordinary language terms, the interpreter could interpret the terms in a descriptive functional assessment. This approach is critical to the scientific investigation of events that on the surface may not appear to be readily available to a behavioral interpretation or behavioral research (Leigland, 1996). Leigland lamented that behaviorally oriented clinicians have done little research on terms that have been important to non-behavioral clinicians.

One term, which appears to have importance to traditional clinicians and consultants, is "resistance". Resistance can be defined as anything that a client or consultee does that impedes progress (Wickstrom & Witt, 1983). What is termed resistance in consultation can have serious implications for treatment integrity (Wickstrom, Jones, LaFleur & Witt, 1998). Resistance to change in verbal therapies and consultation is a phenomenon that has substantial representation (Cautilli & Santilli-Connor, 2000; Patterson & Chamberlain, 1994) with some early discussion within the behavioral literature (e.g., DeVoge & Beck, 1978; Skinner, 1957). Resistance appears to interest a broad spectrum of clinicians both behavioral (e.g., DeVoge & Beck, 1978; Lazurus & Fay, 1982) and non-behavioral (e.g., Mandanes, 1981) in orientation. However, supporting data are lacking to most of the theoretical conceptualizations including behavioral interpretations (Patterson & Chamberlain, 1994).

In deconstructing resistance or conducting an analysis of its use, behavioral psychologists find therapists and consultants use the word in the context of therapeutic failure. For example, Dougherty (2000) refers to resistance as a consultee's failure to participate constructively in the process of consultation. Resistance can occur in the treatment relationship, where the client does not improve or, in the consulting

relationship, where the consultee fails to implement the treatment. The clinical literature is replete with examples from different traditions of techniques to manage this problem if it arises in the therapeutic context (e.g., Spinks & Birchler, 1982). In one study using regression analysis, Patterson and Chamberlain (1994) showed that parental resistance to parent training reduced therapist effectiveness and these parents showed fewer improvements in discipline.

As pointed out by Cautilli and Santilli-Connor (2000), the term resistance is often used to describe a relationship in which the client, or in the case of consultation, the consultee, does not comply with the tasks that the therapist or consultant suggests. A review of the literature shows that many factors increase the probability that a consultee will be “resistant.” One of the important aspects of this suggestion is that resistance can affect treatment integrity. That is, when the consultee does not do what the consultant asks, the consultee is less likely to carry out treatment as designed.

Why Study the Effects of Resistance?

Resistance is common to practicing school psychologists (Hyman, Winchell, & Tillman, 2001; Tingstrom, & Edwards, 1989; Witt, 1986). Resistance can be either an overt or covert process (Butler, Weaver, Doggett, & Watson, 2002) but either way can result in poor treatment integrity (Gresham, MacMillian, Beebe-Frankburger, & Bocia, 2000; Sterling-Turner, Watson, Wildmon, Watkins, & Little, 2001). Thus, a comprehensive approach to increasing treatment integrity should include training school psychologists in methods to lessen resistance.

Treatment integrity, and hence resistance, is critical because the benefits of consultation is based on consultee’s ability to implement the selected intervention with integrity (Galloway & Sheridan, 1994). In addition, the ability to determine overall treatment efficacy and effectiveness depends largely on whether the consultee shows high treatment integrity. The question is “Do teachers do what the consultants suggest need to be completed?” If the consultee does not implement that intervention as intended, it is difficult to determine the cause of any resulting outcomes (Gresham, 1989; Gresham, Gansle, Noell, Cohen, & Rosenblum, 1993; Sterling-Turner et al., 2002).

This line of questioning has led to research to determine interventions that produce less resistance and greater treatment integrity. For example, Busse, Kratochwill, & Elliot (1999) provided evidence for the predictive validity of behavioral interviews and treatment outcomes. Using a series of multiple regressions, they looked at specific verbalizations on a behavioral consultation coding scale observing their affect on teachers’ perception of the consultant effectiveness, treatment outcomes, and single case effect sizes. They found that the behavioral consultation model accounted for about 30% to 34% of the variance in the consultation process. Providing more direct evidence, Bergan and Kratochwill (1990) and Sheridan, Dee, Morgan, McCormick, and Walker, (1996) found that the consultation process can produce high treatment integrity among consultees. Several researchers have tried to identify the specific techniques that promote high treatment integrity. Multiple suggestions have resulted from that line of study. These suggestions include the consultant: (a) making use of treatment scripts for the consultee

to follow (Erhardt, Barnett, Lentz, Stollar, & Reifin, 1996); (b) implementing consultee goal-setting and feedback procedures (Martens et al, 1997); (c) incorporating performance feedback interviews (Noell, Witt et al., 1997); (d) directly training teachers on treatment integrity for each intervention (Sterling-Turner, Watson, & Moore, 2002); and (e) making use of interventions that have high treatment acceptability for the teachers (Finn & Sladeczek, 2001; Riley-Tillman & Chafouleas; 2003; Rones & Hoagwood, 2000). Thus, resistance may function to lower treatment integrity and may influence the effective treatment of children's behavioral problems. If this is the case, then a functional analysis of resistance may lead to effective interventions, to lessen resistant behaviors, and to greater integrity of treatment.

Defining consultation

Behavioral consultation is a major role for school psychologists (Fagan & Wise, 2000) and behavior analysts. Traditionally, school psychologists define consultation as a relationship where the consultant works with the consultee to change the behavior of the client (Bergan & Kratochwill, 1990). As Erchul and Martens (1997) observed, consultation is an indirect service delivery model, where two people focus on the problem of a third. This contrasts with psychological therapy in which the therapist uses himself or herself as the instrument of behavior change. Consultation differs as a service delivery model from therapy in that in consultation, the consultant works with the consultee to change the behavior of the client, where in therapy the therapist serves as a direct instrument of behavior change (Bergan & Kratochwill, 1990).

Behavioral consultation is a problem solving process (Feldman & Kratochwill, 2003). The basis of the problem-solving interview is to gather information about functional variables (setting, antecedent, sequencing of behavior and environmental consequences of behavior) and skill levels (through curriculum based assessment and other methods) (Bergan & Kratochwill, 1990). In short, behavioral consultation is a problem solving process guided by a comprehensive functional assessment that attempts to generate evidenced based interventions based on the function of problem behaviors. Increasingly, professional support for behavioral consultation grows as federal legislation (IDEA, 2004) mandates the use of functional behavioral assessment and positive behavioral support for special education students with behavioral problems (Crone & Horner, 2003; Watson & Steege, 2003).\

Behavioral and Cognitive Behavioral Models of Resistance

Some argue that resistance may just be a reflection of the consultant's failure to give consultees the skills to perform the tasks requested by the consultant (Cautilli & Santilli-Connor, 2000; Watson & Robinson, 1996). Others argue that the consultee had "erroneous ideas" about consultation (Cautilli & Santilli-Connor, 2000; Watson & Robinson, 1996). These explanations, while being correct in some cases, tend to focus on skills deficits to the exclusion of potential motivational deficits. On the motivational end, Williams (2002), drawing on Goldiamond's (1974, 1975) constructional approach, argued that resistance is idiosyncratic and a useless concept. He argues that if the client is

not collaborating, then the therapist needs to determine the function that the client's behavior is serving. A comprehensive behavior analytic model should give an analytic account integrating both facets of motivation and skills deficits. If this analytic model has psychological reality, then synthesis of these behaviors should produce the phenomena (Catania, 1992).

As with other phenomena such as generalization (Riley-Tillman & Eckert, 2001; Tillman, 2001), conceptual models on resistance are important. Several models presently exist (e.g., Alford & Lantka, 2000; Cautilli & Santilli-Connor, 2000; Munjack & Ozial, 1978; Patterson & Fogatch, 1985; Skinner, 1957). Although some of these models are more comprehensive, considerable overlap exists between models. For example, Cautilli and Santilli-Connor (2000) drew on Daly, Witt, Martens & Dool's (1997) model of why academic behavior does not occur, as the basis for developing a competing behaviors' model for the functional analysis of resistance in clients. A competing behaviors model identifies the current performance level, as well as a desired behavior. The goal of the model is to make the alternative behavior functionally equivalent to the behavior that one seeks to replace, and then make the behavior that one wants to replace, less efficient. The authors hypothesized that resistance can come from establishing operations, history effects, and antecedent and consequence relations. They considered six factors critical to resistance. These were (a) consultant setting factors; (b) client motivation to perform the task; (c) the amount of practice to build fluency in skill; (d) assistance in implementing the skill under non-ideal environmental conditions; (e) retroactive interference in which old learning blocks the acquisition of new learning; and (f) complexity of the skill that is being required to be performed. The older Munjack and Oziel (1978) model draws on clinical experience of resistance to homework completion during sex therapy. This model proposed five reasons for resistance: (a) poor patient understanding of what is to be done, (b) specific patient skills deficits, which block performance, (c) lack of motivation or poor expectations for success, (d) anxiety or guilt mobilized from the treatment setting, and (e) secondary gain from positive reinforcement for displaying alternative behavior. Both of these models link interventions to the specific type of functions that resistance may serve. Both models place equal emphasis on relational as well as task factors. While these two models have several areas of overlap, only formal testing will determine if they are distinct. Two questions remain as to whether these models can be added or integrated into each other, or if they are really discussing the same issues. Unfortunately, to date neither of the two models has generated research to support or reject its basic tenets.

In his book, Verbal Behavior, Skinner (1957) discussed the historic factors that may lead to resistance. He links these factors to the psychotherapeutic techniques that a therapist might use to lessen resistance. For example, Skinner (1957) discusses that a history of punishment of various verbal "themes" is important. Due to this history of punishment, the client's expressions of those themes are less likely to occur and the client appears "resistant" to the therapist. For example, the client who may come from a strict religious background may have experienced punishment for discussing sexual matters and, thus, may be reluctant to discuss such matters with his or her therapist. Skinner (1957) discussed the importance of a psychotherapist's passive acceptance of client

verbal behavior to produce a “release,” which allows the client to become “more open” to their verbal behavior. While this form of intervention might be good for emotionally avoiding patients (Hayes, Strosahl, & Wislon, 1999; Kohlenberg & Tsai, 1991), it may not be beneficial to other types of clients. For example, as this author will discuss later, in parent training with conduct disorder children, Patterson and Chamberlain (1994) showed how the therapist becoming more accepting and supportive leads to unfavorable outcomes. This occurs because the therapist slows the teaching process and therapeutic process down. This slowing lessens the overall consultee progress and as a result, the consultee does not acquire adequate skills by the end of treatment. This differential use of support leading to drastically different outcomes, underscores the importance of interventions based on function when dealing with “resistance.”

Skinner (1957) discusses how the exploration of client “themes” in verbal behavior may be helpful in determining the historical consequential factors, which leads to resistant behavior. In addition, Skinner (1957) does not discuss within-session factors that might produce “resistance”; however, he does hypothesize that passivity on the part of the therapist will reduce resistance. This hypothesis, as will be later stated, has some support (see review of Patterson & Forgatch, 1985). As already noted however, sometimes passivity of the therapist, while reducing resistance, can lead to poor clinical outcomes (Chamberlain & Patterson, 1994).

In a somewhat different vein, Alford and Lantka (2000) in a study of resistance attempted to link behavioral processes with presumed cognitive functions. Thus, they attempted to link behavior from the behavior-environment scale of analysis with a presumed cognitive-affective underlying process. They identify two forms of resistance: (a) persevering when one should not, and (b) quitting when one should not. The former they exemplify by continuing to act in a manner that is dysfunctional over the long term but rewarding in the immediate. The latter, they hold as refusing to complete things like homework assignments, missing sessions or otherwise undermining treatment. These two forms of resistant actions would result in long-term consequences. This model sees resistance as a problem with task avoidance rather than a relational problem. This is different from the previous models discussed, where most of the focus of the model is on the nature of the instructions given and the role of the therapist in rendering consequences as the major role. Indeed, the only mention of resistance from this relational standpoint of the therapist’s role is in the form of collateral contingencies created by the therapist who is giving the instructions, or, as Cerutti (1989) would call it, “rule-governed behavior.” For example, if a therapist tells a client to complete a homework assignment confronting a task that the client is avoiding, the client is now under control of the aversive task but also under control of collateral relational contingencies of the therapist (i.e., therapist may be disappointed). To summarize, the Alford and Lantka (2000) model places primary focus on the task that the client is avoiding and less on the contingencies of the therapist-client relationship, which are central to the other models.

The Alford and Lantka (2000) model hypothesizes that the avoidance of therapist or consultant suggestions is immediately reinforced by escape from a difficult task. However, they point out that co-varying the tasks will produce long-term gain. The

inherent conflict is small immediate negative reinforcement or long-term positive rewards. Drawing on cognitive theory, the model holds that the patterns are primarily cognitive-affective-behavioral processes and are automatic in their functioning. For example, first, the person thinks, "I can't do this." Next, the person gets angry or afraid. Finally, the person avoids the task. While this model has appeal because of its greater focus on the types of tasks that produce resistance, the model has not received any research to this point to either confirm or reject its basic tenets (i.e., does task avoidance increase resistance in consultees). In addition, it remains unclear if the synthesis needs to remain for either of the two basic tenets to stand. For example, the cognitive-affective theorizing can stand independently of a behavioral explanation, and the explanation based on contingency history can stand independent of the cognitive description. Finally, while the authors view the model as more inclusive because it hypothesizes cognitive variables, one can question, "What is added by these variables to either explanation by the inclusion of the other?" The answer to this is not clearly stated.

In a similar model, Fuchs and Fuchs (1996) hypothesized resistance is often encountered by teachers based on rules they have developed about school reform. For example, if a teacher believes that s/he should not have a child in his or her class because s/he is a regular education teacher, then s/he is more likely to be resistant. In a related analysis of resistance, Hyman and colleagues (2001) found that matching teacher's rules about client misbehavior to intervention could lessen the amount of resistance experienced. The Hyman and colleagues (2001) study used only three teachers and results were variable.

Studying the rules, contingencies, meta-contingencies (Glenn, 1988) and their interlocking patterns (Cautilli & Hantula, 2002) acting on the teacher and the consultant could have a powerful impact on practical organizational behavior management (OBM) interventions to improve education for students, as it has in social services. For example, Ivancic, Reid, Iwata, Faw, and Page (1981) evaluated a behavioral supervision program designed to incorporate language training into the routine care of people with developmental disabilities to increase treatment integrity. The supervisor used prompts and feedback to train seven direct care staff to use four language-training techniques. They showed that increased use of the techniques occurred with six of the staff. Supervisory feedback was faded without decreases in staff performance during a maintenance condition. Yet, these types of interventions are outside the domain of intervention that a school psychologist can render. While this model does have some practical appeal and parallel literatures support this type of intervention, little research exists in this area, unlike the next model.

By far, the most explored position on resistance is that of Gerald Patterson and his colleagues at the Oregon Social Learning Institute (OSL). The OSL group developed its model in training parents of children with conduct problems. They acknowledge that the model that they developed might not generalize to other populations. Their model predicts that: (a) history of defeat in changing the child's behavior (b) parent traits such as depressed or antisocial, (c) contextual factors such as stress and social disadvantage and (d) therapist behavior such as teaching and confronting and the frequency and

intensity with which the teaching and confronting behavior was used, would all predict resistance.

Research on the OSLC model of Resistance

Patterson studied resistance as it occurred in parent training sessions. Parent training may be a good place to start a study of resistance because, according to O'Dell (1982), in parent training therapists only rate 25% of clients as "easy". In addition, experienced therapists are more successful in keeping families in parent training than novice therapists (Frankel & Simmons, 1992), as well as motivating, confronting and supporting parents through parent training (Barkley, 1997; McMahon & Wells, 1998). Readers can then conclude that parent training might be a therapeutic area that entails a lot of "resistance." In one study, Patterson and Forgatch (1985) explored the impact of therapist behavior (the independent variable) on client resistance (dependent variable). These researchers used an ABAB experimental design and observed the resistance displayed by parents in parent training for two conditions. The baseline involved the therapist using verbal behavior to convey "support" or "facilitate" (short statements indicating attention or agreement). In the treatment phase, the behavior of the therapist was "to confront" and "to teach." Resistance was measured by a coding system developed by Patterson and colleagues (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984) which identified as resistant such behaviors as talking over/interrupting, challenging/confronting, negative attitude, "own agenda," and "not tracking" as resistant. As the model predicted, "teaching" and "confronting" led to increases in resistant behavior, while "facilitate" and "support" led to decreases in resistant behavior.

In Patterson's model, resistance serves three main functions: (a) it reduces the amount of confrontation, teaching, or support that the consultee is given; (b) it increases the number of sessions needed to bring about therapeutic change; and (c) it reduces the therapists' "liking" for the consultee. The OSL group hypothesized that resistance would be lower in the beginning of therapy and then gradually increase as the therapist made more suggestions or attempts to teach techniques for change. As parents became more familiar with the techniques and began to experience some success with the interventions, resistance would gradually lessen. The model predicted an upside down U-shaped curve. Patterson and colleagues at OSL refer to the intervention, as the struggle-with-working-through hypothesis. Stoolmiller, Duncan, Bank, and Patterson (1993) set out to test this hypothesis by using a quadratic growth model formula. Stoolmiller and colleagues (1993) used the formula to test the goodness of fit of the model. Since their model predicts that resistance is low in the beginning of therapy, they looked for low resistance in the beginning of treatment as the therapist built rapport and began to understand the child's problems. In the second phase of their model, they predict that the therapist will begin to make demands. Thus, they hypothesized an increase in resistance. As parents became more successful with the techniques, a third phase would occur. In this third phase, the OSL group hypothesized a lowering of resistance due to the success the parents had with the interventions.

Drawing from a clinical sample of 68 mothers, Stoolmiller and colleagues (1993) studied whether resistance followed the quadratic model. They randomly assigned mothers to either a community eclectic treatment (n=14), which was a mixture of Adlerian therapy with structural family therapy, or to the behavioral parent-training group (n=53). Using latent growth curve modeling to test the hypotheses of the OSL model, Stoolmiller and colleagues (1993) reported the models predictions matched what they observed. They concluded that parent training tends to see sessions of increased resistance to a point in training, then a decrease in resistance, presumably, as the parents begin to achieve some success with the training. This model was predictive of therapy outcome as compared to a linear model of resistance. However, not all mothers followed this pattern. Indeed, some mothers stayed highly resistant or showed increasing resistance through the entire training series of sessions.

Patterson and Chamberlain (1994) followed up on these findings. They found in cases where the mother's resistance did decrease, greater gains were evident in parental discipline. In addition, regression analysis showed that decreasing "resistance" leads to more teaching of the parents and, in turn, decreases future arrests of the child. Patterson and Chamberlain (1994) correlated increases in parental resistance with contextual variables such as parental pathology and therapist interventions. Thus, through a decade of research, the OSL group has shown that therapist behavior can lead to an increase in client resistance (Chamberlain & Patterson, 1994; Patterson & Forgatch, 1985). This resistance follows a struggle-with-and-work-through pattern (Patterson & Chamberlain, 1994; Stoolmiller et al., 1993). That is, parents become resistant to using the techniques offered by the behavior therapist until they begin to experience the benefit of those techniques in the child's behavior. At the point of the technique's success, the parents begin to become more compliant.

Finally, Stoolmiller and colleagues (1993) found that resistance mediates parent training effectiveness in which parents, who do not experience a reduction in resistant behaviors, acquire less parenting skills. In addition to acquiring fewer skills, these parents' children experience more arrests in the future (Patterson & Chamberlain, 1994).

Summary and Conclusion

Many behavioral clinicians have studied resistance. Conceptual models exist and offer clinicians much in the lines of theoretical ways to pursue the problem. More research needs to be done to determine the effects of resistance on the consultant in the case of consultation as well as the effects on the therapist in the case of therapy. Future research needs to study the mechanisms of resistance and how they effect both the consultant as well as the consultee.

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