Integrating Three Approaches to Counter Resistance in a Noncompliant Elderly Client

By Cheryl Puntil, RNC, MN

When elderly clients are depressed and have an underlying personality disorder, resistance to change becomes a key element that must be addressed for therapy to be effective and for change to occur.

Change is attributed to many factors. According to Lewin, a social psychologist, motivational and perceptual processes are influenced by internal and external factors. Behavior, then, is a function of both environmental and personal characteristics (Shortell, 1988). Although change is perhaps the most sought after goal in psychotherapy, it is met with continued resistance. "Resistance to change or resistance to being influenced in particular ways occurs when systems are required by certain circumstances to alter their established behaviors" (Anderson, 1983). Resistance occurs even when clients are high-functioning, self-motivated, and insightful.

Resistance is one of the major phenomena analyzed and worked through in psychoanalysis. In relation to the treatment of personality disorders, use of the psychoanalytic theories in treatment of resistance dominates the literature (Gottschalk, 1988). Although nonpsychoanalytic therapies gear themselves toward the treatment of symptoms, such as depression and anxiety, and behaviors stemming from personality disorders, there is a place for them when addressing the broad concept of resistance.

For psychiatric nurses to deal effectively with resistive clients, they must have appropriate resources. This article will focus on the concept of resistance in therapy and its definitions and functions according to psychoanalytic and nonpsychoanalytic theories underlying the behavioral and cognitive therapies. A case presentation of a hospitalized, elderly depressed woman with an underlying personality disorder will illustrate an integrated approach to resistance. Resistance and change encountered in therapy with the elderly will be explored, and countertransference of the nursing staff will also be discussed.

Resistance: Definitions and Origins

The resistance that will be discussed is exemplified by the client who re-
fuses to comply with suggested treatment. Nurses can deal with resistance more effectively if they are aware of its multiple functions, its relationship to defenses in general, and the particular purpose it has in each particular instance.

Resistance, in psychoanalytic terms, means "the reactivation, outside the patient’s awareness, of the motivating powers which were responsible for the mental patients’ original pathogenic dissociative and repressive processes" (Fromm-Reichmann, 1950). In other words, resistance is anything the client does to avoid or prevent the progression of the analytic work. There are many ways a client can resist. A client can be silent, or not feel like talking. He can be fixated on trivia or on external events, avoid uncomfortable topics, be late, miss appointments, or keep secrets from the therapist.

Freud believed that the purpose of resistance, "like defense mechanisms, serves to protect clients from intense anxiety inherent in becoming aware of their unresolved intrapsychic conflicts or unacceptable thoughts and impulses" (Anderson, 1983). Resistance is a way for the client to hold on to her symptoms to guard against an intrapsychic disequilibrium. Fromm-Reichmann (1950) said that the same source that motivated the patient’s original dissociative and repressive processes, that is, her anxiety, is also the main reason for the resistance. The psychiatric nurse can best help the client if she is aware of the function of resistance and how, when, where, and why it serves the individual.

Behaviorists believe that behavior is learned and maintained by contingencies in an individuals' social environment (Shelton, 1974). Resistance is spoken of in terms of it being noncompliance resulting from a learned inadequate social skill. The client resists carrying out assigned tasks designed to facilitate the change process.

Resistance has not been studied by behaviorists in the way that it has by psychoanalysts because it is not congruent with their notion of what sustains human behavior. Behaviorists think that clients are rational beings who, when given the proper set of contingencies, will change. When clients do not change, even after proper behavioral interventions have been established, they are said to be irrational (Anderson, 1983). Resistance is therefore a result of the scarcity of implicit instructions and a lack of relevance of the task to the client’s needs (Shelton, 1974). When a psychiatric nurse understands resistance from a behavioral perspective, she can manipulate the milieu and identify the appropriate set of contingencies to assist the client in changing behavior.

Cognitive therapy teaches people how to change the way in which they think about and perceive their current reality. Resistance is conceptualized as negative cognitions about therapy. Cognitive therapists counterbalance these negative cognitions by anticipating potential sources of noncompliance and emphasizing empathy, acceptance, and careful indoctrination of interventions. A collaborative relationship is sought in which the therapist engages the client and structures therapy, but the client carries out much of the therapeutic work between sessions, thus engaging in a cooperative mode. Cognitive therapists believe that if they fail to engage the client in therapy, the therapy will fail (Beck, 1973).

If a nurse understands resistance from a cognitive approach, she will be motivated to work with the client towards encouraging positive thoughts about the client’s treatment and mental health. As stated earlier, the client resists because he has negative cognitions about treatment. This indicates how the client feels about the treatment itself and the caretaker. Resistance is reflected by statements such as "this will never work," or "this treatment is nonsense." Nurses need to be aware that the issue of resistance needs to be dealt with before anything else.

Resistance and Its Functions
Resistance does have certain positive functions. It provides social systems with insurance against chaos and confusion, provides stability, and is a sign of health and good judgment (Anderson, 1983). Resistance also can be useful. According to Greenson (1968), resistance is an expected and necessary activity of the client. The detection and the working through of resistance is an important, worthy, and respectable part of analysis. Resistance not only facilitates the development of a working alliance, but it also needs to be addressed throughout the psychotherapeutic process.

Dealing with resistance in clients with personality disorders is difficult because the resistance is ego-syntonic to the client. Syntonic resistances are usually well-established, habitual patterns of behavior or character traits, sometimes of social value. This means that the client is unaware that what she is doing is counterproductive to the progression of her psychiatric treatment. The behavior the client exhibits (the resistance) is felt as familiar, rational, and purposeful, and the client does not sense her own resistive behavior. Even for the professional, this type of resistance is difficult to recognize and results in some difficulty in establishing a working alliance with the client. In the character neurosis, the resistances are rigid, ego-syntonic, "silent" habits, traits, or attitudes (Greenson, 1968). When the resistance is
identified by the therapist, it needs to be worked through for the therapy to be productive.

Clients with a personality disorder typically do not seek treatment for psychological insight or characterological change, but rather for manipulation of their environment or relief from internal distress. In the following case, Mrs. B. entered the hospital after her second suicide attempt of an overdose of antidepressants. Her first attempt at suicide was to jump out of a moving car, which resulted in no injuries.

Case Presentation

Mrs. B. is a 82-year-old divorcée, who up until a year ago was living independently in her own apartment. One of Mrs. B.’s children “coerced” her into moving in with her. After this occurred and Mrs. B. had given up everything to make the move, Mrs. B. said her daughter and son-in-law “took all my money, beat me up, and sent me back here. I don’t know where they are or care, they are somewhere gallivanting around the country with my money.” Although the events of this story are vague, this is a true story according to Mrs. B.’s son, who is now her primary caretaker.

In lieu of Mrs. B.’s symptoms and psychiatric history, she was diagnosed with an Axis I diagnosis of major depression and Axis II diagnosis of a personality disorder (American Psychiatric Association, 1987). Because of Mrs. B.’s lack of insight, her inpatient status, and estimated length of stay between 4 and 6 weeks, treatment consisted of a behavioral cognitive approach, antidepressants, and eventually electroconvulsive therapy (ECT). Family care conferences were initiated and implemented by Mrs. B.’s primary nurse, physician, and social worker to ensure the support of Mrs. B.’s family.

The beginning phase of her hospitalization and treatment was predominantly met with resistance to the diagnostic and assessment procedure. Nursing staff spent most of their time and effort just getting Mrs. B. to cooperate. She was very resistant to the treatment plan as evidenced by a lack of cooperation with tests, x-rays, hospital policies such as eating in the dining room, ingestion of medications, and by her attempts to be as independent as she was capable. She had “every excuse in the book” as to why she could not take a certain pill, test, or why she needed the wheelchair instead of walking. Nothing the nursing staff could do would satisfy her or decrease her discomfort.

She was told at what time she would have her appointment for a test, but when it came time for the escort service to take her, she was in the shower. When confronted with this situation, she claimed she had misunderstood the time she was to be ready. Mrs. B. refused all trials of medications, including antidepressants. She would try them at first but then claimed they had upset her stomach. She claimed that they were of no use to her.

Mrs. B. had complained of pain due to osteoarthritis, but every attempt to assist her in dealing with the pain was discarded. The staff ordered an air mattress for her bed, a heating pad, special pillows, and chairs, but every attempt was chastised. The staff could not get past the assessment phase to determine the degree of her pain or other hypochondriacal symptoms and, therefore, they became frustrated in dealing with Mrs. B.

She had engaged the staff in splitting, where there were “good” and “bad” staff, “nice” nurses and “incompetent” nurses. When the attending physician would make rounds, Mrs. B. acted like the perfect patient and told the physician that the nurses were “out to get her,” that the staff didn’t believe how much pain she was in, and that she was disliked by the staff. Mrs. B. would frequently express skeptical or hostile remarks and direct challenges of the staff’s competence, saying “there is nothing you can do for me. You really don’t know what you are doing, do you? That other nurse I had last night was an idiot, how could she have helped me?”

She then began to refuse to come to the dining room for meals because she could not walk, even though she was walking the day before. A wheelchair was not given to her because it was felt that there was no organic basis for her inability to walk and that if provided, it would feed into her sick role and secondary gain. Her manner was irritable, negative, challenging, and blaming. Thus, she alienated the people who possibly could help her.

Something had to be done to help Mrs. B. because the treatment of her depression was not progressing and she had stopped eating. The attention of the staff was valued by Mrs. B., and from this a behavioral program was set up to deal with this noncompliance. Mrs. B. was to receive 15 minutes of staff attention if she left her room and if she ate in the dining room. If she did not comply, she would only get custodial care with little interaction from staff, i.e., taking vital signs, blood, and making environmental rounds. The program was explained to Mrs. B. in detail and began after she had agreed to follow the program.

Mrs. B. refused to eat for 4 days and only drank water and the nutritional drink, Ensure, creating considerable anxiety for the medical staff. Mrs. B.’s care had to be documented clearly in the medical charts because of the unconventional nursing approach to her treatment. Mrs. B. finally walked out of her room on the fifth day and stated that she had been acting foolish and that she wanted to eat in the dining room. The behavioral program had worked.

The cognitive intervention was to deal with Mrs. B.’s feelings towards treatment itself and to help her understand her need for follow-up therapy. Mrs. B. was unable to give up old expectations and behaviors, had little insight into the causes of her depression and suicidality, and was unable to understand interpretations from the staff. The staff focused on being supportive and reality-oriented. It was important for the staff to elicit a positive transference and therapeutic alliance. The importance and helpfulness of the treatment and psychotherapy in help-
ing Mrs. B.’s depression was stressed. A consistent number of staff work with Mrs. B. and were available to her when reasonably needed. Staff avoided her manipulative behavior by setting limits, and allowed her to take responsibility for her own decisions. The staff was neutral, yet empathic towards any behavior or feeling Mrs. B. displayed. Negative countertransference responses were avoided by open recognition of personal limitations and frequent case conferences about Mrs. B. The reality focus and the importance of treatment were of primary consideration in Mrs. B.’s case. Because Mrs. B. refused all medication and any insight-oriented therapy, ECT was felt to be the treatment of choice for her major depression.

The staff had worked with Mrs. B. this far in developing a therapeutic alliance and working relationship; ECT was the last suggestion to treat her depression. Mrs. B.‘s family provided enough leverage for Mrs. B. to consent to ECT. During her first ECT treatment, she looked up at the nurse as the nurse was preparing her temples for the electrodes and said, ‘You are torturing me now. Are you happy that you are doing this to me?’ The staff had to be neutral once again to this comment, empathic, and understanding as to the purpose behind the resistances. Mrs. B. did get better with the course of ECT and her depression lifted to where she was walking, eating very well, concerned with how she looked, wearing makeup and fixing her hair, attending occupational therapy, and socializing with other clients. She was less self-ruminative, somatic, and now more satisfied with herself. Although she continued to make no connection that the inpatient hospital treatment and ECT had helped her in any way, she did form a positive relationship with the staff and her doctor. The cognitive approach had assisted Mrs. B. in developing a therapeutic alliance, enabling her to cooperate with the treatment of her depression. Mrs. B. was to have follow-up appointments and psychotherapy with her intern, was placed in a board and care facility, and was taking antidepressant medication.

Many clients in the inpatient hospital program cannot tolerate a psychoanalytic perspective because of their level of adaptive function or ego structure, lack of basic trust, motivation, or intellect. Mrs. B. had chronic maladaptive behavioral patterns and periodic diffuse atypical depressions with destructive impulses. During this hospitalization, it was important to establish a climate that would eventually allow her to return to treatment without a loss of self-esteem.

In Response to Resistance
Nursing staff can deal with resistance more effectively if they are aware of the multiple functions of resistance, its relationship to defenses in general, and the purpose in a particular instance of resistance. The task of the treatment team is to distinguish the fact that the client is resisting, how he does it, what he is warding off, and why he does so. Freud felt that his clients were resisting him when they were unable to be hypnotized, not considering that he may have had something to do with their unresponsiveness. In a realistic image, resistance has been thought to be the client responding to the professional caretaker’s error (Greensoen, 1968).

When resistance is encountered, it feels personal. Nurses can feel hostile, frustrated, angry, and insecure, and they can interpret the resistance as rejection and thus feel unskilled in their work. When a client is resisting, caretakers tend to feel it is their job to do something about it (Nurnberg, 1984). The nursing staff needs supervision or support from co-workers. Negative countertransference will occur if the staff members do not deal with their own narcissistic needs. When the staff begins to feel bored, lacks involvement, or is too emotionally involved with the client or there begins to be moralizing and value judgments, then a negative countertransference has been established and must be addressed. Nurses can understand the resistance and work with it effectively if they consider the client’s vulnerability and how aggression serves as a narcissistic defense against it.

Clients with personality disorders will settle into a longer course of treatment when they are no longer able to deny the impact of repeated confrontation with reality or rage (Gottschalk, 1988). In the meantime, it is likely that some of the nonpsychoanalytic psychotherapies are capable of developing techniques and approaches that can favorably influence personality disorder conflicts and problems. Whichever therapy is used, it is more effective if the goals are defined and sought after rather than hoped for on a laissez faire basis.

Psychotherapy with the Elderly
There has been an abundance of literature on the treatment of the depressed geriatric client (Beck, 1973). A client with a diagnosis of major depression with an underlying diagnosis of a personality disorder becomes much more complicated to treat; there has been little documentation on psychotherapy with the elderly client with a personality disorder. Freud was pessimistic about psychoanalysis with the elderly because of their lack of “elasticity of mental processes” necessary for psychodynamic change, the rigidity of their characterological defenses, and their limited anticipation of the future (Freud, 1904/1950).

In the later years, people experience significant losses in the body, ego, and family structure, as well as changes to self-object constancy. Anxieties are now realistically related to shifts in the realm of safety; therefore, this may be the catalyst for self-improvement whereby an elderly person would consider treatment (Cath, 1987). Elderly clients with longstanding personality disorders do get depressed, many with suicidal ideation or attempts. With the combination of a cognitive behavioral approach, psychopharmacology, and a psychotherapeutic understanding of resistance behavior, elderly clients can experience symptom relief, eventually affecting their lives in a positive manner.

In a study done with an elderly group of clients undergoing psychotherapy, it was found that psychotherapy had a positive effect on symptom relief (Lazarus, 1987). It was common that on entering treatment, clients felt alienated from their historical image of
Resistance

themselves as competent, independent adults. Many suffered low self-esteem because developmental issues of aging, potential biopsychosocial losses, and narcissistic injuries threatened their sense of mastery.

According to Lazarus and Groves (1987), four factors within the psychotherapist-client relationship contributed to a positive outcome and to restoring the elder’s self-esteem and sense of mastery. Positive feelings toward the psychotherapist allowed the client to feel comfortable in expressing thoughts and feelings. Clients used the defense mechanisms of externalization and projection to attribute the cause of their problems onto someone or something outside themselves, permitting them to avoid exploring intrapsychic and interpersonal contributions to their problems. The therapist explored with clients how to be more assertive and how to separate themselves from the identified cause of conflict. The supportive therapeutic approach of reassurance, encouragement, and suggestion helped them reaffirm their views of themselves as psychologically healthy and to re-establish continuity with their previous positive sense of self. It was found that the elderly had the potential for psychodynamic change. responded more sensitively to their therapist’s empathy, and were able to re-establish continuity with their previously positive sense of self.

Conclusion

Life seems to be a continuing adaptation to change. Change is difficult for anyone, but it can be accomplished at any age if resistance to change is assessed, understood, and addressed both by the psychiatric nurse and the client. The basic ingredients of therapeutic change continue to be important when dealing with the therapeutic context (Strupp, 1976). Professionals create and maintain a helping relationship, characterized by respect, interest, understanding, tact, maturity, and a firm belief in their ability to help. The professional influences the client through suggestions and encourages openness of communication, self-scrutiny, and honesty. Interpretations are made of unconscious material and self-defeating or harmful behavior, strategies in interpersonal relations and fantasies are explored, and distorted beliefs about realities are clarified.

The impressions held today by therapists and analysts are that the elderly can experience effective psychotherapy, and that the motivation for change may increase as one grows older (Cath, 1987). There is clear evidence that the elderly have the capacity and willingness to profit from a psychotherapeutic experience.

References


