Treatment resistance in corrections

by ***Denise L. Preston***[1]
Research Branch, Correctional Service of Canada

Treatment resistance, while ubiquitous, has a negative impact on treatment outcome, in terms of poorer compliance regarding attendance and performance and reduced treatment gains. Given that the primary outcome anticipated from correctional intervention is the protection of the public, efforts to reduce treatment resistance are paramount.

This article discusses sources of resistance, presents strategies to reduce resistance,[2] and describes treatment engagement strategies employed in a specific Correctional Service of Canada intervention, the Persistently Violent Offender treatment program.[3]

Reasons for resistance

Resistance can stem from the following five sources: the client, the treatment or techniques employed, the environment, the clinician, and the client-clinician relationship.

Client variables

Scores of client variables have been related to resistance. They can be classified into the following subgroups:

- disorder;
- personality;
- behavioural;
- client fears; and
- client self-serving.

Disorder variables — The very nature of certain disorders often predisposes clients to be resistant to treatment efforts. Most often, this is related to how the disorder affects clients' abilities to trust. These disorders include borderline, anti-social, narcissistic, and paranoid personality disorders, psychopathy, schizophrenia, organic or neurological disorders, intellectual deficits, and substance abuse.

Personality variables — Clients who are hostile, defensive, demanding, and rebellious are resistant to intervention. So are those who reject authority, have an extreme sense of entitlement, and an excessive need for control. Finally, those with an eternal locus of control, such that they deny, minimize, or externalize blame are also resistant to intervention.

Behavioural variables — Numerous client behaviours contribute to resistance. These include lack of motivation to change and failure to see personal problems as serious. These also include various skills deficits, anger, aggression, and violence, and being suicidal.

Client fears variables — A variety of client fears are related to resistance. Some reflect a lack of understanding of the nature of therapy while some serve a self-protective function. For example, clients may fear a lack of confidentiality in the therapeutic relationship. Or, they may feel hopeless about their ability to change.

Client self-serving variables — Clients may be resistant for various self-serving reasons. For example, they may experience secondary gains from the dysfunctional behaviour that is being targeted in treatment. Or, they may have other hidden agendas to justify continuing to behave the way they do.

Treatment variables

Various treatment variables can have an impact on resistance. Most obviously, a poor match between type of treatment or treatment techniques and clients does not bode well for behaviour change. For example, verbal therapies, abstract concepts, and written homework would likely lead to resistance on the part of low functioning, illiterate, inarticulate clients. Group size can also affect client resistance and treatment outcome.

Treatments of shorter duration tend to result in less client resistance and, although there is no significant difference in the amount of resistance encountered by various types of therapies, behavioural therapies seem to engender slightly less resistance than others.

Environment variables

Cultural disparities between clients and clinicians can have a negative impact on resistance as can clinicians' failure to understand culturally-defined client behaviours. Low socio-economic status can also have a negative effect on client resistance, primarily due to lowered client expectations of their need for and ability to change. As well, poor social support systems can serve to maintain client resistance. The setting in which treatment is

provided can also engender client resistance. This is particularly true if the setting is a negative one or if clients are institutionalized and possibly attending treatment involuntarily.

Clinician variables

There has been little systematic research looking at the impact of clinician qualities on the therapeutic process and client resistance. Lack of research notwithstanding, several clinician qualities have been suggested to contribute to client resistance. These can be divided into the following two sets.

The first set of clinician qualities contributing to resistance is independent of the existence of client resistance. That is, in such cases, clients may or may not demonstrate resistance, but clinicians may erroneously conclude that they are due to their own cognitive or perceptual distortions.

The second set of clinician qualities has a negative impact on client resistance. In these cases, client resistance is evident, but clinicians respond in ways that exacerbate the situation. A confrontational approach is one example while providing little guidance or feedback to clients is another.

Client-clinician relationship

In some respects, it is difficult to separate the client-clinician relationship variables from client variables and clinician variables as, ultimately, both sets of factors have their impact on the client-clinician relationship. Nevertheless this relationship, hereafter referred to as the therapeutic alliance, and variables affecting it are considered separately because of the importance of the therapeutic alliance to client resistance and therapeutic outcome.

Clinical researchers have written extensively about therapeutic alliance. They have noted that therapeutic alliance is likely to be the most important factor related to compliance with treatment. It accounts for most of the variance in treatment outcome, and is the strongest predictor of outcome in brief dynamic and client-centred therapies.[4]

The development of a therapeutic alliance is contingent upon both client and clinician variables. Related to clients, therapeutic alliance depends upon clients' commitment to treatment, working capacity, and ability to establish healthy interpersonal relationships.

Related to clinicians, therapeutic alliance depends upon qualities such as competence, empathy, sincerity, and acceptance of clients. It also depends upon the degree to which clinicians can motivate clients and the type and quality of communication with clients. Also important are negative clinician attributes such as highly moralistic and judgmental attitudes toward clients, clinician interpersonal or relationship problems, erroneous clinician perceptions of clients as resistant, and counter-transference issues.

Strategies to reduce resistance

Clinicians should select intervention strategies only after careful analysis of the form of resistance clients are demonstrating. Due to the sheer number of combinations this level of analysis can potentially yield, it is impossible to prescribe specific techniques for every possible manifestation of resistance. Often, it will be necessary to employ several techniques, either concurrently or successively. In all cases, however, two things should be kept in mind. First, the ultimate goal of the selected strategy is to reduce resistance, enhance motivation, and facilitate treatment gains. Second, it is important to work with rather than against resistance.

The ultimate goal of the selected strategy is to reduce resistance, enhance motivation, and facilitate treatment gains. Second, it is important to work with rather than against resistance.

Strategies for reducing client-related resistance

Given the relationship of resistance to dropout rates, it is important to effectively address it early on. One possibility is to provide treatment priming or pre-therapy sessions prior to the commencement of a particular course of treatment. This could be provided on an individual or group basis.

If priming sessions are not a possibility, resistance will have to be addressed early in treatment. It is best not to address resistance directly in the first session as that should be a non-threatening opportunity for clients and clinicians to formulate initial, hopefully positive, impressions of each other.

When resistance is ongoing, as in repeated statements challenging clinician credibility or program integrity, therapists have several options as to how to address it, either individually or in-group sessions. They can attempt to respond specifically to the content of what clients are saying. While this may be helpful in certain circumstances, it can also exacerbate the situation as clients may then resist

what the clinician has said. They can respond to the process of the challenge, either by labelling the comments as resistance and using this as a forum for discussion or making observations such as "I have noticed when we discuss X, you do Y" and then ask clients for explanation.

Finally, if resistance is ongoing and repeated attempts have failed to reduce it, it may be necessary to terminate clients from treatment. This is particularly true if the ongoing resistance is interfering with the progress of other clients. Termination from treatment should be carefully considered, however, as it may create other unforseen problems.

Strategies for reducing treatment-related resistance

Clients should be actively involved in developing their treatment plan, setting treatment goals, and selecting treatment techniques to achieve their goals. Plans, goals, and techniques imposed by clinicians will likely engender client resistance with the end result of limiting treatment outcome. The agreed-upon goals must be reasonable, attainable, and pro-social and clinicians should provide regular feedback concerning clients' attempts to achieve their goals.

Strategies for reducing environment-related resistance

Some environmental factors, such as cultural background and socio-economic status, are beyond the control of clients and clinicians. Clinicians should ask clients directly about the impact of their cultural background on their beliefs, attitudes, and behaviours and they should take these factors into consideration in treatment planning. With respect to socio-economic status, clinicians should strive to encourage clients about their potential for and ability to change. As with cultural factors, they should take socio-economic status into account in treatment planning.

Resistance due to the setting in which treatment is offered may have to be addressed similarly to cultural and socio-economic factors. That is, in many cases clients and clinicians may not be able to control where treatment is delivered. This is particularly true if treatment is delivered in an institutional setting. Where possible, selecting the best possible location to foster a therapeutic atmosphere within the institutional setting can be helpful. So can reminding clients that, despite the negative atmosphere, they can maintain a positive attitude and change their behaviour for the better.

Strategies for reducing clinician-related resistance

It is incumbent on clinicians to determine their contribution to client resistance and to modify their behaviour accordingly.[5] In addition to accurately assessing client resistance and skillfully employing the strategies above, the following qualities seem essential. Clinicians should be perceptive, sensitive, empathic, friendly, and trustworthy. They should also be flexible and tolerant. They should demonstrate acceptance of clients, despite their behaviour, good communication skills, and a sense of humour. They should be supportive of and encouraging to client, at all times emphasizing client readiness and willingness to make behaviour changes. This is consistent with motivational interviewing techniques suggested by Miller and Rollnick.[6] They should use self-disclosure carefully as the utility of clinician self-disclosure depends on the type of therapy, the purpose of the self-disclosure, the particular client, and the amount that is disclosed. They should minimize their use of confrontational approaches as these only serve to increase resistance and attrition rates. As well, aggressive confrontation exemplifies clinicians taking responsibility for bringing about behaviour change in clients.[7]

Finally, clinicians should critically evaluate the source of any counter-transference reactions they may have to clients. For example, in the event that they feel anger toward clients, they should try to discern whether or not their anger stems from provocative client behaviours or from their own frustration with recalcitrant clients. After having identified the source of their counter-transference reactions, clinicians must then manage them appropriately.

Strategies for reducing client-clinician relationship resistance

Just as ensuring a good match between clients and treatment is important to reduce treatment-related resistance, so too is ensuring a good match between clients and clinicians. This entails consideration of factors such as cultural background and sensitivity, gender, personality, and interpersonal style.

Clinicians should attempt to maintain an empathic and consistently positive attitude towards resistant clients and must establish and maintain clear professional roles and boundaries from the outset. This is distinct from clinicians making a deep personal commitment to clients as is often implied in client-centred therapies.

Forensic populations and settings

While many of the issues and suggestions likely apply to forensic populations, some issues are particularly germane while other additional ones must be considered.

Just as resistance was identified as ubiquitous and predictable in all forms of psychotherapy, it is

inevitable with forensic populations. Numerous client-related reasons for resistance were identified; forensic clients demonstrate most, if not all of these factors simultaneously and in greater severity than non-forensic clients. That is, the majority of forensic clients are diagnosed with one or more disorders that seriously impair their ability to effectively engage in treatment, demonstrate hostile, defensive, and aggressive personalities, skills deficits, lack of motivation, a number of fears and insecurities, and numerous self-serving behaviours. Moreover, forensic populations tend to be less motivated for treatment, more resistant or non-compliant while in treatment, have higher attrition rates, demonstrate fewer positive behavioural changes while in treatment, and, possibly, demonstrate higher recidivism rates after participating in treatment.[8]

In addition to the strategies suggested for non-specific client populations, clinicians working with forensic populations must take the clients' legal dilemmas into account. For example, forensic clients may appear resistant when they are actually trying to protect themselves from further legal consequences.

Andrews and Bonta[9] state that correctional treatment should be delivered to higher risk offenders, target criminogenic needs, be based upon cognitive-behavioural or social learning theories as opposed to non-directive, insight-oriented, or evocative approaches, and take into consideration the principles of risk, need, and responsivity. Relating to the process of treatment, they specify several clinician and therapy variables such as the relationship and contingency principles. The relationship principle presents that a positive therapeutic alliance between clinicians and offenders has the potential to facilitate learning. The contingency principle holds that clinicians must, as part of their relationship with offenders, set and enforce agreed upon limits to physical and emotional intimacy as well as clear anti-criminal contingencies. The latter includes effective reinforcement for pro-social behaviour and effective disapproval for anti-social behaviour.

This indicates, then, that the development of a therapeutic alliance or a positive interpersonal relationship between clinicians and clients is of primary importance with both non-forensic and forensic populations. This may not be the case, however, for psychopaths.[10]

Persistently Violent Offender Treatment Program

The Persistently Violent Offender Treatment Program is a demonstration project developed and funded by the Research Branch of the Correctional Service of Canada. It is a multi-year, multi-site non-residential treatment program currently offered in two medium-security institutions in Canada. The program targets persistently violent offenders, defined as those having at least three convictions for violent (non-sexual) offences. It is based upon a social problem-solving theoretical framework and is delivered according to cognitive-behavioural principles. It involves 16 weeks of half-time participation.[11]

Given the population in question, most are treatment-resistant. For this reason, the first section of the program is a motivational module designed to facilitate participant interaction, commitment, and trust. The module begins with two weeks of individual therapy as a form of priming. This allows clients and clinicians a non-threatening opportunity to begin to get to know each other. Clinicians can address any concerns clients may have and to begin to explore clients' goals for the treatment program. At all times, clinicians are respectful, empathic, and supportive.

The motivational module also includes one week of group sessions. During this week, violence is rarely discussed. Instead, clients and clinicians generate group rules, discuss obstacles to treatment such as on-going substance use, impulsivity, and aggressive beliefs and how to minimize their impact on treatment outcome, and complete a cost-benefit analysis of program completion. In all of these exercises, the short-term and long-term positive and negative impact of various behaviours on clients and others are considered.

The second and third sections of the program are the problem-definition and skills-building modules, respectively. While specific resistance-reducing strategies have not been incorporated into these modules as they have been in the motivational module, other factors facilitate the reduction of resistance. On occasion, a peer tutor is hired to serve as a positive role model for resistant clients. As well, clinicians encourage the use of problem-solving and conflict resolution skills in each group such that clients feel more empowered and take more ownership over how the group progresses.

Finally, clinicians selected for the program are screened for personal suitability factors. Preferably, they are competent, confident, sensitive individuals who ascribe to a "firm but fair" approach in dealing with offenders. The perception of self-confidence is particularly important with this population of offenders as they have a tendency to prey upon staff that appear to be lacking in confidence. They must have a strong sense of their professional identities and boundaries and be intrinsically motivated. They must also work together co-operatively and

supportively, to model appropriate behaviours to clients, to reduce potential manipulation by clients, and to sustain each other through inevitable difficulties.

Measurement of motivation in the Persistent Violent Offender program

Clients who participate in the Persistently Violent Offender treatment program complete a comprehensive assessment battery before and after the treatment program.[12] Self-report measures of responsivity and motivation for treatment are included in the assessment battery. Given the lack of correlation between offender self-reports of motivation and behaviour change and outcome, clinicians also complete weekly behavioural ratings of client motivation and behaviour change, as indicated by attendance, participation, behaviour, and attitude. Future analyses will examine the correlation between the two methods of assessment and the relationship of each one to treatment outcome.

Conclusion

Given the number of reasons for and forms of treatment resistance, it is impossible to prescribe exactly what to do with any client in any given situation. Careful analysis by clinicians is a prerequisite to employing the most efficacious means to reduce treatment resistance. These efforts are essential given that treatment outcome is contingent upon the reduction of treatment resistance and that the primary anticipated treatment outcome of correctional interventions is the protection of public safety. ■

[1] Collins Bay Institution, Box 190, Kingston, Ontario K7L 4V9.

[2] For comprehensive coverage of resistance and strategies for the reduction of resistance, see Anderson, C.M. and Stewarts, S. (1983). *Mastering resistance: A practical guide to family therapy*. New York, NY: Guilford Press. See also Cullari, S. (1996). *Treatment resistance: A guide for practitioners*. Massachusetts: Allyn & Bacon.

[3] Serin, R. (1995). *Persistently violent (non-sexual) offenders: A program proposal*. Research Report R-42. Ottawa, ON: Correctional Service of Canada.

[4] Horvath, A. O. and Symonds, B. D. (1991). "Relation between working alliance and outcome in psychotherapy: A meta-analysis". *Journal of Counseling Psychology*, 38, p. 139-149.

[5] Mahrer, A. R., Murphy, L., Gagnon, R. and Gingras, N. (1994). "The counsellor as a cause and cure of client resistance". *Canadian Journal of Counselling*, 28, p. 125-134.

[6] Miller, W. R. and Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.

[7] Jenkins, A. (1990). *Invitations to responsibility: The therapeutic engagement of men who are violent and abusive*. Adelaide, Australia: Dulwich Centre Publications.

[8] Gerstley, L., McLellan, A. T., Alterman, A. I., Woody, G. E., Luborsky, L. and Prout, M. (1989). "Ability to form an alliance with the therapist: A possible marker of prognosis for patients with antisocial personality disorder". *American Journal of Psychiatry*, 146, p. 508-512. See also Rice, M. E., Harris, G. T. and Cormier, C. A. (1992). "An evaluation of a maximum-security therapeutic community for psychopaths and other mentally disordered offenders". *Law and Human Behavior*, 16, p. 399-412.

[9] Andrews, D. A. and Bonta, J. (1994). *The psychology of criminal conduct*. Cincinnati, OH: Anderson Publishing.

[10] See Preston, D. L. and Murphy, S. (1997). "Motivating treatment-resistant clients in therapy". *Forum on Corrections Research*, 9, (2), p. 39-43, for a more detailed description of strategies to consider with psychopaths.

[11] Preston, D. L., Murphy, S., Serin, R. C. and Bettman, M. (1999). *Persistently violent (non-sexual) offender treatment program: Therapist manual*. Ottawa, ON: Correctional Service of Canada.

[12] Serin, R. and Kennedy, S. (1997), *Treatment readiness and responsivity: Contributing to effective correctional programming*. Research Report R-54. Ottawa, ON: Correctional Service of Canada.