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Chapter 12 - Listening to Resistance

Robin Shohet

Editors' Introduction

Resistance does not just manifest in supervision, but in encounters with patients and colleagues. The author looks at how to reframe resistance so it does not become a battle of wills, but instead seeing it as feedback on something that has not yet been understood. This requires a certain humility in each of us, to recognise that there is a different but equally valid perspective to our own and others experiences. Realising this increases the likelihood of co-operation not just in supervision but any human relationship. In the context of this book this chapter explores how resistance can both serve the doctor and blind them to the possibility of different or new experiences There are times when resistance needs to be honoured and others when it needs to be challenged. In understanding more about what contributes to resistance, the decision whether to honour or challenge is made easier.

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Overview

Over the years of supervising, being supervised and training supervisors I have at different times and in different guises encountered resistance; resistance *to* supervision and resistance *in* supervision.. In this chapter my aim is to help understand the function of resistance, and while respecting its possible value, when appropriate, find skilful ways of moving beyond it. Although I am writing about resistance in the area of supervision, doctors often encounter resistance in their work with patients and many of the ideas discussed will be relevant for both situations.

Introduction

There is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes make change possible. (Rollnick et al 2008).

In this chapter, I would like to look at resistance from three different perspectives. First I would like to look at resistance *to* supervision. If you have got this far into the book, this is unlikely to apply to you, but you may have to deal with this in those you supervise. Their resistance may not be personal but part of a wider resistance to forms of reflective practice both in the medical profession and beyond.
Most of us can resist being vulnerable, and there are times when we feel vulnerable in supervision. So from that perspective resistance to supervision makes perfect sense.

The second perspective is looking at resistance *in* supervision, what it could mean and ways of reframing it to enable both parties to learn from it and move beyond it. I pay particular attention as to whether the resistance in supervision could be mirroring the resistance that comes from the patient. Finally, once we have understood the function of resistance a little more, we can move on to practical ways of moving beyond it for the benefit of all concerned – supervisors, supervisees and patients and perhaps even the profession as a whole.

On a personal level, having supervised and been in supervision for as long as I have and felt the benefits, I was puzzled as to why it was not widespread in the medical profession. However, the more I immersed myself in relation to the medical profession and supervision, the more I began to see how little I knew. In a dialogue with a colleague she pointed out how the medical profession has managed over generations without embracing the type of supervision we are talking about in this book. Doctors have been at the coal-face of life and death issues, they have had to compete to enter medical school, to perform at an extremely high level both academically and practically, they have to communicate with people from every strata of society and take huge responsibility on a daily basis. Why would someone with that level of experience or skill want to discuss their difficulties with a member of another profession? At this level supervision makes no sense and one would be right to resist it. But throughout the book, we have been looking at the benefits of a different approach to this one, and how there is value to all of us in sharing honestly and openly in order to solve problems. As well as anecdotal evidence, there is also empirical evidence that this can help us to perform better in our work – whoever we are (See Chapter 2 for a survey of the literature).

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Core beliefs

As I started to become interested in resistance, my own and other people's, I began to see that behind the resistance were certain belief systems, often not fully conscious. I have called these core beliefs, and my experience is that these have a very strong influence on our behaviour and choices. Often resistance to supervision and in supervision is based on core beliefs. These are beliefs that are considered so self evident that we encounter huge resistance when they are challenged. The person defending them usually does not realise they are assumptions. These beliefs determine what we see and how we process information, and can greatly contribute to the blind spots we all have. So we might have a core belief that it is rude to say what you think, which could hinder the supervisory relationship being an honest exchange. Or we encounter a core belief that our role in life is to take care of others. When it is suggested that doctors take care of themselves, this is seen as self indulgent. I have come to believe that resistance often points to a core belief and this could be a very fruitful area to explore together for both supervisor and supervisee.

Every profession has its own core beliefs and it might take someone from a different profession to question some of these values. This is why we encourage a mix of professionals on our training courses, and even go as far as to suggest that supervision from a different profession can be an advantage even though they do not know the profession from the inside. After an initial discomfort (we prefer to be with people who we consider like minded) trainees realise how much they have to learn from each others' worlds, and how things one profession takes for granted are not by

the other. So, for example, some practitioners had very strict time boundaries, whereas others were far more flexible and each could see the advantages in the other ways of working.

Some of the core beliefs I have found to be operating in the helping professions are

*It is my responsibility to cure the patient/client

*I am the strong/responsible one

*I need to know/have the answers

*Others must come first

*I must never make a mistake

Sometimes questioning the validity of these core beliefs can often invoke resistance, even antagonism. But if there is a willingness to explore these beliefs, we can see some of the drawbacks of holding on to them as described below.

*It is my responsibility to cure the patient. This denies the responsibility and resources of the patient.

*I am the strong/responsible one. This again denies the resources of the patient, and could stop appropriate asking for help.

*I need to know/have the answers. This is just not possible sometimes and is likely to contribute to stress.

*Others must come first. A doctor who does not take care of themselves will not be there to take care of others eventually. This is another of the core beliefs that contribute to burnout.

*I must never make a mistake. This is also not possible, but makes great demands on the doctor and could lead to hiding errors or unnecessary shame. This is a huge topic and is discussed in a recent book Being Wrong. (Schulz 2011). In relation to the medical profession, she quotes a policy of immediate acknowledging of mistakes by a hospital. The result was less mistakes, and perhaps unexpectedly, suing rates went down as patients most wanted acknowledgment more than compensation. The hospital CEO who introduced this policy said, "If you don't acknowledge that mistakes occurred, you'll never eliminate the likelihood they will occur again." (page 300).

Another core belief, and one which I think applies to many of the helping professions, centres around receiving. Helman (2006) quotes cancer specialist Rachel Naomi Remen. "One of the reason many physicians feel drained by their work is that they do not know how to make an opening to receive anything from their patients. The way we were trained, receiving is considered unprofessional. The way most of us were raised, receiving is considered a weakness."

Core beliefs are reinforced by the environment we find ourselves in (Realm 5 in chapter 5), and in the case of the medical profession there can be very high expectations of a cure put made by the anxious patient. If the doctor starts to believe in their omnipotence, this may hide a fear of powerlessness which may find no place for expression, and create internal tension. Supervision can help uncover such polarities as the impotent/omnipotent ones and the price we pay for swinging between them.

Part of the reason medicine has such a strong culture is that it is dealing with some of the deepest aspects of society – the relationship to our bodies and life and death. As such the doctor can lurch between impotence (in the face of death) and omnipotence (I can cure or at least postpone death). To deal with the impotence there could be a wish for more and more certainty as a way of compensating. Tolerating uncertainty and a willingness to accept not knowing can be explored in supervision, and perhaps after initial discomfort can be a great relief.

Of course there are many other reasons for resistance – time, money, finding a suitable person are just some. However what I have tried to do is explore some of the reasons that might relate to core beliefs in the belief that these often lie behind the more obviously rational reasons. I would like to now move on to looking at other factors that might be at play in resistance.

Contracting

The first place where we, as supervisors, might be able to work with any resistance is in the initial meeting. A clear and explicit contract can be of great value – the supervisor explaining how they work and what might be expected from the supervisee who can reciprocate with their expectations. The supervisor might start with something like this. "In our work together my wish is that we work collaboratively to explore issues that might get in the way of your fulfilling your potential and delivering the best service you can. This means that we can cover such topics as patients you might find difficult, relationships with colleagues and your practice, and work life balance. There are times when we might experience discomfort. This is

almost invariably part of any learning process. There is a period of unlearning as we go from unconscious incompetence to conscious incompetence (where we feel most lost) to conscious competence and finally unconscious competence. I hope we will be able to talk about difficulties as they arise. What can happen is that previous experiences of feeling put on the spot can be evoked, and I hope we will be able to explore these if they come up."

Consent

Consent is crucial to the supervisory relationship. Sometimes it appears that all is going well on the surface, but underneath the supervisee has not really given consent. The supervisee might say the right things, but has not fully accepted being in supervision. This is more likely to happen if the supervisee has not chosen to be in supervision or there is an assessment or managerial function involved. In many ways this subtle resistance is harder to work with than the more obvious attacking sort. The latter is sometimes a defence against real openness, and once the storm has been weathered, I have often found that the resistant supervisee is willing to learn the most, as the example of Mark later in the chapter shows.

I have become very interested in the topics of resistance and consent and have started to run workshops with another colleague called "Who do you bring to supervision?" This is a deliberate play on words. It is not only which patients, but how much of yourself do you feel able to bring? We explore the whole idea of a professional persona – when is it useful and when is it used to hide unnecessarily and therefore not useful. Professional distance is usually very necessary to stop over involvement, but

can be used automatically to justify a stance that is non-relational and a chronic form of protection. Learning to monitor how we use professional distance is a very important skill that can be enhanced by supervision. The supervisor can act as a role model in showing authenticity and vulnerability as a way of countering professional distance that is used as a defence.

Control

Sometimes there might be a conscious wish to be collaborative, but the supervisor may still have an unconscious need to be in control. A possible pointer to this is resistance in the supervisee. It is easy for the supervisor to label a supervisee as resistant or difficult, but if we take the approach that resistance could be meaningful and valuable, the supervisee's resistance could be unconscious supervision about control. Of course it could be many other things, but we might take an approach like this "I am noticing that you did not want to explore such and such. I wonder if you feel I am pushing you too hard or have I not understood something about you or this case, and your reluctance is a way of telling me this? What could I have missed?" This honours apparent resistance and models non defensiveness and a willingness to hear possible negative feedback and take responsibility for it. (see Casement 1991)

Picking up cues around resistance is a very useful skill, greatly helped if the supervisor does not feel threatened. I remember a very striking instance of giving a piece of advice about how to find out about some research. At the time this was gratefully received. At the following session, the supervisee was quite subdued even though he had acted on the advice with good results. I commented on the

supervisee's energy being low, and said that sometimes this means that something has happened in the previous session that contributes to this. Had I missed something perhaps or made a mistake? The supervisee paused for a moment and then said yes. Even though the advice was useful, it had stopped him discovering how to do the research himself.

An Appreciative Approach

I have found it useful at the initial session with each new supervisee to ask them about a good learning experience. I ask them to describe it in detail – why they thought it was good, and how we can bring some of that into our work together. This tells the supervisee that our focus is going to be on strengths and successes as much as problems and tells us about their learning style. It has the effect of lowering any resistance as the feelings from the positive experience carry over into the present situation. This is part of an approach called Appreciative Inquiry, (Watkins and Mohr 2001) and I will include a practical list of techniques in the summary. Many doctors might be unused to this approach, as their training involves learning to be aware of what could go wrong. Whilst focusing on what could go wrong is of great value in terms of treatment of illness, I think it is not a good model for human relationships, where recognising and building on strengths are of great value. Very often the key to the positive learning experience has been an important relationship, perhaps a teacher who took an interest when others didn't, and it is good to hear about this experience and learn lessons for the current relationship.

Most difficult

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In training supervisors with my colleagues, we also have an opposite approach to Appreciative Inquiry and ask trainees to write down what they would find most difficult to bring to supervision and why. In this exercise, the trainee supervisor, Tom, realised he was not bringing how anxious he felt about his forthcoming appraisal. His reason was that he did not want his new supervisor to think badly of him. Once he had allowed that reason into consciousness, he realised it was not valid, and was able to take the issue to supervision with considerable benefit, as it opened up the area of fear of judgment.

Revisiting core beliefs

We have looked at core beliefs as contributing to resistance to supervision, and here is an example of core beliefs operating in both supervisor and supervisee which were temporarily affecting their ability to work together.

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Ann is normally quite forthcoming in supervision. She has no problems being vulnerable, owning to uncertainty, and is very open to feedback. However, in this session, when she brings her patient Mr X, she blocks suggestions the supervisor makes. The supervisor, uncharacteristically, starts to feel irritated. He has a core belief about not sharing so called negative feelings as they could be damaging, but because of his respect of the supervisee and her usual openness, he overrides his resistance to challenge hers. He knows what is happening must mean something so says, "I notice that uncharacteristically you are blocking me today and even more

importantly I notice I am feeling irritated. I wonder if you can make sense of what is happening?" The supervisee has a lightbulb moment and replies, "Oh my goodness. I am behaving just like my patient who says he wants help, but resists all my suggestions and even if he says yes at the time, he does not act. I am very irritated by him." This leads to a very useful exploration of why the patient might be like that, given his family circumstances, and a compassion for him replaces her previous irritation.

The supervisor realised there was also a present time issue to explore. The supervisee had a core belief that she must like all her patients, and so it was hard for her to admit that she did not like this patient (although after the supervision this changed). The supervisor was able to overcome his resistance to sharing negative feelings and act as a role model. The supervisee was also able to recognise that having negative feelings was not something to be avoided, but a sign that could alert her to deepen her exploration of her relationship with her patients.

Understanding resistance as a form of mirroring

In this example, Ann realised that she was behaving in supervision how her patient was behaving with her. In other words whilst bringing a resistant patient, the supervisee becomes themselves resistant in supervision. This is known as mirroring or parallel process, and I have seen countless times supervisees take on their clients behaviour when they present in supervision. Knowing about this is a very useful theoretical tool for the supervisor and can help dissolve a lot of what appears or gets acted out as resistance.

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Resistance arising from differences in culture

Here is an example from general practice

Aziz was from a middle eastern culture and always asked about a patient's family, took great interest in them, and remembered their details. He was very popular with patients, but was seen as very inefficient by other doctors because he often overran. Core beliefs in the value of family context and taking time for this, was in conflict with the values of efficiency. These needed to be teased out in supervision so he could see more clearly his fellow practitioners' point of view and make more informed choices. This had benefits for all parties.

Reframing as a way of working with resistance.

What can sometimes happen, especially if the supervisee feels that they did not have a choice about their supervisor or having supervision, is that the supervisee might agree intellectually, but not change their behaviour. In this case the supervisor will need to listen carefully to the resistance. They could ask themselves and then their supervisees what they (the supervisor) have not yet understood, or check out if the supervisee feels they are being required to behave or think differently. In other words reframe the resistance of the supervisee in terms of what the supervisor might or might not be doing. To show this applies beyond supervision, those of us who have children can see this when we get apparent agreement to say tidy their rooms.

When this is not done, rather than be angry we can realise that the agreement was actually still our trying to control. A useful skill of the supervisor is to be able to reframe a situation as the following example will illustrate where the supervisor reframed a complaint into a commitment. The supervisor is using commitment in a particular way to illustrate a commitment to a belief that a feeling, in this case anger, might have been masking.

In a supervision group, John was often late and one of the group members in particular was gearing up to a confrontation. The supervisor said that perhaps the anger was pointing to a commitment and rather than expressing anger, what might the commitment be. The supervisee paused and then said, "This group is such a valuable resource for me. I want us all to be able to share it together." Once this had been elicited the supervisee was able to share this with the latecomer in a much softer way which was not resisted, whereas previous challenges had been met with resistance in the form of excuses.

An amusing example of reframing with patients is given by Helman (2006) The author describes working in a stockbroker belt with high powered patients who had very self destructive habits. They were driven, obsessed with deadlines, rushing tense. Telling them all of this and how it might damage their health simply didn't work….But phrase it in their language and their ears would prick up "Why don't you see your health, and your body as your capital. And see stopping smoking as an investment, a long term investment. One that in a few years will earn you a high rate of interest. Just think of all those dividends. It's an investment that is

bound to pay off. Invest in your body now and think of all those profits in years to come!"

In the following example the reframing was done by recognising a competing commitment which was inhibiting the supervisee from acting.

Amy, a junior doctor, felt she was being bullied by the senior partner, but resisted any suggestions as to what she might do about it. The supervisor wondered in a very non judgmental way if she could share what might be stopping her from taking the action she wanted to take, and challenging her boss. Perhaps there was something of real value that was even more important than challenging her boss (the competing commitment). Amy was puzzled and the supervisor hinted that perhaps the fear of being emotional and therefore weak could be present. There might be a commitment to her self respect that was greater than her need to challenge. Amy was able to resonate to this and together they explored whether being emotional was in fact weakness, however it was perceived. Finding the competing commitment ie seeing there was a conflict between wanting to challenge and fearing being vulnerable, helped to dissolve the resistance. Simply giving strategies for tackling the senior partner might not have worked as well.

Finding the commitment in the complaint/resistance.

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Many of us when faced with a complaint are likely to become defensive. In the following example the supervisor was able to model a different way of working with a complaint by finding the commitment in the complaint.

Mark makes it clear that he thinks supervision is a waste of time. He has managed very well for the last fifteen years without it. He says that the last group, especially, was a complete waste of time. People just talked and talked about themselves mainly, and even when they did talk about the patient, it was mostly speculation instead of sticking to the facts. The supervisor, at this point, could have become defensive around the complaint, but sees the commitment in the resistance. She says that she hears that he is committed to making good use of time, with which he agrees. She adds that she knows that the welfare of the patient is important to him, to which he impatiently replies of course. So, she continues, bringing these together, a group that really focusses on the wellbeing of the patient in an efficient way might be useful? He agrees and adds that a training group where he could learn up to date methods and the latest research would be a far better use of his time. The supervisor says she can well understand this, but would he be willing to present a case to the group and see how it felt to be on the receiving end of the supervision? He doubtfully agrees and the group uses a technique of all asking one question which could take the work further which he was not to answer then, but write down and think about. The supervisee is quite surprised at how useful it has been, giving perspectives he had not thought about. He says that he had been taught that when he had difficulties to get on with things and put it all to the back of his mind, and that he was too old to change now. The following week he brings the case of a woman patient who had been getting on his nerves and says with a smile and don't go telling me she reminds me of my

mother. The group role plays different ways of approaching her while the supervisee watches quite thoughtfully and says how useful it has been. Here the skill of recognising the commitment in the complaint and the apparent competing commitments (efficiency and welfare of patients) was important in overcoming the resistance. In this way she was able to reframe how the group could work for Mark.

Resistance protecting vulnerability and the courage to go beyond

In supervision there can often be resistance to feeling vulnerable, the core belief being that it is a sign of weakness. The supervisor might feel frustrated when they see signs of not coping which the supervisee adamantly denies. Understanding that there might be core beliefs operating around not appearing weak will help the supervisor come alongside the supervisee more easily.

A supervisor can often forget how vulnerable it is to go to supervision and talk about issues that are difficult – whether it be patients or colleagues or difficulties at home that are leaking into work. In my supervision work I encounter a real fear in supervisees of being shamed to which the supervisor needs to be sensitive. This is especially true of group situations and a group supervisor needs to know a lot about group dynamics (the Balint groups are well structured to help minimise the less co-operative side of groups and bring in the co-operative see chapter 8). I believe it is important that supervisors themselves be willing to experience their own vulnerability, and if appropriate, share it with the supervisee.

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There is a school of thought that says that people with whom we are uncomfortable can be our teachers, showing us aspects of ourselves that we might not normally encounter. If we can't accept they have something to offer us, however, we will avoid, blame and try and find others to collude with our negative opinions of those who seem to create our discomfort. Supervision can help us learn to go past our natural resistance to sticking with uncomfortable feelings which make us feel vulnerable, and I have been witness to this process of potential transformation many times. (Shohet 2011 Ch. 11)

A model I have found useful in mapping out the levels of helping which I found in a book called The Courage to Teach (Palmer 1998), is to distinguish the what, the how, the why and the who of a profession. Applying this to medicine, the what is the disease and diagnosis, the how is the treatment (Realm 1 Chapter 5), the why is questioning some of the norms and core beliefs around medicine (Realm 5 Chapter 5), and the who is looking at the person of the doctor and what he or she brings with them into the consultation (Realm 3 Chapter 5). It is the last two that are the real focus of supervision we are writing about in this book. I regularly witness in supervision the courage to examine core beliefs and blind spots, and a willingness in supervisees to look at themselves, but can also empathise with the resistance to doing this. In our training groups we do an exercise looking at how participants might sabotage their learning, for example by withdrawing or feeling critical or not good enough. It is very interesting to share these, a way of anticipating the resistance, as we all have at least some of these behaviours or scripts. This exercise can be done in the supervisory relationship, too, looking at and naming the potential pitfalls. Once

the possibility of resistance occurring has been named, it seems to make it less likely to happen, or for it to happen without awareness.

To challenge or not

At this stage we need to ask ourselves when is it useful to go along with resistance until the relationship is on a more secure footing, and can be challenged later; when is it a sign that something is wrong and the resistance is a healthy refusal to go along with that, the psychic equivalent of the immune system; and when does it need to be pushed through; and how do we recognise the difference? I have no ready answers to such questions, but would remind you of the technique mentioned earlier of the supervisor asking if there is something they have missed or not understood. As well as showing a non defensive stance, it gives an opportunity for the supervisee to share what they might not have consciously realised was bothering them.

Hawkins and Shohet (2006 pp212-213) in their chapter on developing supervision policy and practice in organisations, look at resistance to change in organisations. They quote many reasons that apply personally as well as organisationally such as fear of the unknown, lack of information, no perceived benefits, threat to status, reluctance to experiment. They quote the work of Kurt Lewin (1952) who adapted from physics into the field of human relations the law that says: "Every force creates its equal and opposite force." Hawkins and Shohet write, "If the resistance can be

honoured and redirected, the change will happen without having to use greater effort." (p.213).

In the following example the group tried to push through the resistance which only increased it, and the supervisor was able to recognise this and redirect it.

In a group supervision, the members were challenging a group member quite forcibly about an issue about breaking confidentiality. The supervisor agreed with their challenge, but not the way they were doing it, as the supervisee was getting more and more uncomfortable. He said, "I notice that the group is being very challenging to you, Beth. When this happens it sometimes means that the group is not taking responsibility for how they might have done, or could do, what you have done. You are reminding them that at some stage they might have done what you did, or fear that they might do in the future." The group agreed and apologised to Beth who was then able to explain her competing commitment to confidentiality but also what she considered to the welfare of the family and that she had in fact made a mistake.

Wilful Blindness. Resisting group norms

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Resistance does not only apply to supervision as we can all find areas of our lives where we resist. In a book called Wilful Blindness (Hefferman 2011) the author describes how we do not want to see anything which threatens our world view, what I

have called our core beliefs in this chapter. We may consciously think we can appreciate difference, but she quotes evidence to show that we choose friends, partners, neighbourhoods where our comfort around similarity is not threatened. Where this gets dangerous or dysfunctional is when we choose to ignore the evidence in order to manage a competing commitment to belong. There are classic psychological experiments (starting with the classic experiments of Asch 1951) that show people will report seeing lines longer than they are because the rest of the group appear to think the same (the other members of the group are stooges). The need to belong, not rock the boat is very strong, so we have to make a conscious commitment to go for truth rather than comfort. Supervision, if it is going to be valuable, will help us uncover blind spots, and this may not always feel comfortable, especially when it means not going along with the group norms. As such, it may be useful for supervisors to be in a different profession because they have an outside perspective and may not be party to the same core beliefs. There are arguments for and against a supervisor coming from the same profession, but the outsider position does have something to offer as they can question the norms and core beliefs of the profession more easily.

Summary

Resistance can potentially provide both supervisor and supervisee with very useful information. It can point to unhelpful core beliefs on a personal and professional level, and these can be explored in supervision. I believe it plays an important part in

the medical profession from the patient upwards, and as such is worthy of attention. There are no easy answers as to when to honour the resistance and when to challenge it, but my approach has been that listening carefully to the resistance can deepen the learning for both parties.

My wish is not just to give ways of listening and insight, but also practical tools and I have summarised them below.

*Clear contracting to explain the purpose of supervision, the way of working and sharing expectations.

* Sharing positive experiences of supervision and learning

* When noticing resistance, the supervisor being willing to check themselves out to see if they have missed something rather than blame the supervisee

*Eliciting and making explicit core beliefs

*Reframing – seeing the commitment behind the complaint.

*Noticing competing commitments and making them explicit

*Recognising parallel process whereby the supervisee begins to present in the same way as their patient has presented to them. In other words recognising that the resistance can go from patient, to supervisee, to supervisor.

*Naming the potential for sabotage right at the beginning.

My belief is that resistance, like the immune system, is there for a purpose and we need to understand it and work with it, especially in those instances where it can put the body on false alert. Extending the analogy, supervision can be seen as a way of enhancing the body's immune system, with similar great benefits in helping to stop, or at least reduce, the prevalence of the ‘dis-ease’ of stress and burnout and help to

promote a healthier life style.

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