Working with Resistant Clients

"I wanted to try adding one vegetable a day, but my wife was busy with the kids and my boss gave me a lot of work to do so I just couldn't get to the store."

You listen to this story with a sinking feeling. This is the third session in a row in which Jack has told you he couldn't try the goal he'd set with you in the previous session. His excuses are reasonable, but show a pattern of setting small, manageable goals then not attempting to meet them. He is polite but obviously resistant. You are beginning to dread his visits. What do you do?

Resistance is a natural part of the process of change. We all embody it to one degree or another, and if we didn't, we would change with every new influence, like kites in a breeze. Often, the clients with the greatest motivation to change are initially the most resistant, almost as though mobilizing themselves in some way before plunging into unknown waters. Change is letting go of the familiar and opening into uncertainty. As counselors, we can maximize our client's motivation to make positive change and diminish their resistance.

Expectations

To begin with, we need to consider our own, and others, expectations of ourselves. Dietitians are often the screens for the projections of our clients. Deservedly or not, we are often perceived as rigid, perfectionistic judges who will humiliate our clients while taking away all their pleasure in eating. One of my clients described her initial impression of me, *before we actually had met*, as "a stern, skinny woman with pointy breasts in a buttoned up white coat." This after her referring therapist had told her I was a warm, accepting person, skilled to help her meet her eating goals. We have to consider that our clients may see us as bad mothers who are going to shame them into doing things they don't want to do. The time it takes to create good rapport is never wasted. And if, after a few sessions you feel you and your client haven't "clicked," it would be kind to refer them to another dietitian.

In addition, we have to consider that eating behavior is notoriously difficult to change. It is complex web of many small habit-driven behaviors, most of which have powerful emotional underpinnings. We have historically been expected to create miracles—getting people to make complex changes in their eating habits after one short session in their hospital room. Although that has changed and we do see people for follow-up visits, our own expectations, those of the public, and other health professionals, are high. And in case that weren't difficult enough, unlike other counselors, we seldom have much counseling training included in our dietetics curricula. Unless we seek out additional training, consultation, and supervision, we are unskilled as counselors, yet are expecting ourselves to help people make very difficult changes.

And we can have unrealistic expectations of our clients as well. Those of us who choose to work in health related professions often place a much higher value on good health than most people, and would be willing to make bigger sacrifices to promote it. Our clients may have many priorities that come before

their health, which might be almost unthinkable to us. Many people never think about health until they are facing illness. For example, perhaps Jack has been told he has risk factors for heart disease and should lower his cholesterol. He obeys his physician and comes to see you, but feels fine, and secretly, perhaps unconsciously, cannot imagine why he should give up any food he enjoys to change a number that has little real meaning to him. Whereas, we ourselves, having been attracted to a health profession, might have the ability to vividly imagine the state of arteries subjected to poor genes and diet, and the terrible future that might await him.

In the Beginning…

So we need to ask, before we begin an assessment, "What made you decide to come see a dietitian at this time?" People who have come because of health care provider, family, or friend's pressure are unlikely to make changes. We need to educate our clients, but also help them sort out what is important to them, even if it means ending the sessions at that time. It is also useful in the initial sessions to ask clients what they have been told about their condition, and what it means to them. We need to listen carefully, without judgment, and be willing to hear that their idea of how to be happy is different from our own. We can help our clients see health as a priority, making our sessions interesting and fun, but we can't expect our clients to view their situation as we do. We also need to help our clients discover where they are in the process of change. Prochaska and others delineated a cycle, beginning with pre-contemplation moving through a progression of change (1). If we try to convince our clients to change before they are ready, it is disrespectful and likely to create a sense of failure for both.

If we want to do more than educate a client, that is, if we want to do more than impart information in a way that is retained, we need to learn how to help people change their behavior. As a minimum, this means that we need to be skilled in active or reflexive listening and behavioral therapy. Learning to listen well is skill that ordinary life does not teach us. We need to be trained in the skills of listening, but more than that, we need hours of practice to do it well. If we do most of the talking in a session, something is wrong. Or, if we are half listening while we are thinking of what we want to say next, we are missing valuable clues of how to help our client. And we need training to be able to help our clients assess and monitor their own eating behavior; set small, achievable goals; and to do meaningful follow-up sessions that keep clients coming back while they gradually reach their long term goals. Therefore, the behavior based therapies that were first developed in the 1970's (2) are still essential for changing eating behavior.

And, should we find ourselves working with clients with psychologically based problems with eating such as eating disorders, disordered eating, substance abuse, chronic illness, etc., we need still more training in counseling skills. Psychotherapists and other counselors receive at least two years academic training in counseling, and then accumulate a thousand or more hours of supervised experience under a seasoned counselor. We as a profession have

been slow to recognize our need for better training. We would never expect ourselves to be able to sit down and play complex music on a piano with no training, yet we somehow expect it of ourselves as counselors. No book or classroom learning is complete without ongoing consultation and supervision, ideally from an experienced counselor who is a dietitian, or if one is not available, a psychotherapist who understands our needs in helping our clients change their eating and who is open to learning from us.

Yes, But Then What?

But sometimes, despite our efforts and training, we find ourselves faced with someone like Jack, who shows up and does little else. We always need to notice who is doing most of the work in the session, or as one of my trainers described it, "who is rowing the boat." Some clients, like Jack, play the "yes, but" game. "I'd like to try a leaner cut of meat, but…I wanted to eat one meal at home last week but…That's a good idea but…" If you find your self exhausted and frustrated in a session, it's a good sign that you are rowing the boat, not your client. It is time to lean back, put down the oars, and ask the client, "Can you remind me why it is important to you to make this change in your eating?" Allowing the client to revisit their original reasons for changing can help remind them. The next question might be, "What is a small change you are ready to make that would help you reach your goal?"

However, sometimes a client will have good reasons to change, but still spin their wheels. It is helpful to take the other side, saying, "I know you really want to make this change, but with all the other priorities you have right now, perhaps it isn't the best time." Or, "You know, making this change might seem to be a good idea, but there is always a downside, even to what would seem to be a positive change. What do you think some of the problems might be for you were you to change your diet?" Clients who don't seem to be working are often dumbfounded by such an inquiry, and might take a while to answer. But often, as they search for what the negative consequences might be to changing, some profound truths become apparent. It is common for people to attach great meaning to eating, food, and weight. For example, anyone who has helped people who want to lose weight has seen that sometimes people who perceive themselves as overweight feel protected by their size—from sexuality, from success or failure in careers, or from taking risks. Or sometimes the balance of power in a relationship is threatened when one partner begins to change. We have seen partners sabotage our client's attempts to change, and sometimes the sabotage comes from within. Bringing these issues to light helps people examine them and sometimes let them go.

Generally clients are much more motivated to try their own ideas than yours. Being a fountain of ideas, suggestions, and recommendations robs your client of finding their inner resources. In the initial assessment, ask your client "Do you know how you are keeping your weight higher than you want it to be?" Or, "What is it you do that makes it easier to eat the way you want to?" "What do you know about the recommendations for this condition?" It is amazing how

much information people already have about what they need to do, and why they are not doing it. Once your client has told you what they need to do to change, your job becomes helping them to break it down into small enough steps to be successful. If you give the suggestions for what change to make, it is much less powerful.

However, if a client comes up with a goal that you think would be counter-productive, such as going on a fad diet, rather than telling them 50 reasons why the diet is scientifically invalid, ask them what is attracting them. When we criticize our client's ideas we diminish our relationship with him or her. See if you can help the client incorporate those features of the plan they admire into their diet. If it is impossible to find a compromise, suggest that they try "their idea." By being clear that the is their idea, and being open to their experimenting with it, you stay with them. Later should they find it is impossible to follow the diet as a way of life, you can help them discover what was useful about it, and what made it impractical, without ever having provoked resistance.

And it is the same with information. Dietitians are prodigious learners, or we could never navigate our education. We expect our clients to be able to take in large amounts of information and be able to act on it. We need to keep it simple--one or two new facts or ideas in a session are plenty. So it is reasonable to expect that the client may already know enough to begin to change. Rather than saying, "Why don't you try reducing the fat in your salad at lunch by reducing the amount of cheese, nuts, and dressing," you might better say, "What do you think you could do to reduce the amount of fat in one meal?" Your client will find the resources within to change, and will learn that they know what they need better than you can. Occasionally a client honestly won't know what would help. It is then useful to give two or three suggestions and let them chose the one they want to try, so that the power still rests in their hands.

Some people are by nature oppositional. Automatically they say "yes" if you say "no," "black" if you say white. It becomes obvious quickly when we use clarifying statements to understand what they are telling us. Lisa is describing her problems with eating in an assessment visit, and I am actively listening, restating her language to be certain I've understood. Lisa tells me, "Every night when I come home, I start eating and don't stop until I fall asleep."

"You find that you can't stop eating for the entire evening when you are at home?" I want to be certain I've understood.

"No, it's not like that," says Lisa. "Sometimes I stop after dinner but then I go in the kitchen and eat everything I can find."

"So you mean you aren't necessarily eating non-stop, but you will start eating again at some point and keep going?"

"No, I don't keep going, it's like…well," she hesitates in frustration. "I just eat, that's all!"

This is an example of a person who is oppositional. She isn't doing it deliberately; it is the way she unconsciously defends herself from feeling controlled. It means, however, that anything you suggest she try, or any goal you help her set, *even if it is her idea*, will be resisted. Often people with this pattern will most resist the suggestions they make to themselves. The best way to get

around this defense is to suggest the opposite of what you would like to see the client do. So for example, if you have suggested he or she read a certain book and after several sessions they haven't, you say, "I think that it would be a bad idea for you to read this book at this time. In fact, I never should have recommended it, I'm sorry. Even if you get curious about it, don't read it." Or, with a pattern of not bringing in food records: "You have too much going on to expect yourself to keep food records right now. Even if you think you would benefit from doing it, I don't want you to do it now." This approach might sound manipulative, but people feel relieved because often their inability to change is frustrating them. Sometimes by "taking back" a suggestion, or pulling back from making any recommendations, you free the client from their reaction, and they are able to make the change in spite of you, and move forward.

There are many, probably hundreds, of psychotherapeutic approaches and probably thousands of techniques. Many of these are aimed at changing behavior and can be used in nutrition counseling. Some of the most powerful approaches we can use come from the brief therapies known as solution focused or solution oriented. Solution oriented strategies diminish resistance and enhance motivation by focusing on the clients' strengths. Examples of questions we might ask our clients using a solution-focused approach are, "What would it look like if you were successful with the change you want to make? Are you aware of how it is you were able to succeed in this goal that you set? Can you help me understand how you are able to succeed some of the time with this?" This kind of focus asks the client to look within at their own resources and strength and by describing them to you, make it more real in his or her own mind. These approaches and others like them are described in a number of books, (3, 4) but must be practiced to be effective, ideally in supervision with a more experienced counselor.

Finally, for a well-trained counselor with the support of regular consultation and supervision, working with resistant clients can be enjoyable. Rather than finding ourselves burning out as we exhaust our creativity and compassion, we can see these clients as a challenge, a puzzle to be understood. All people want to be happy, and most would be happier if their bodies felt healthier. Our job isn't to convince people to do something they don't want to do. Rather, our job is to help people discern what they need and want to do to feel better, help them break it down into manageable steps, and especially, to help them move through the internal obstacles that we all find ourselves facing sometimes. Resistant clients aren't our enemies. They are people like us encountering natural barriers to change. It is our job to join them, not fight them. And we will enjoy our work and find it much more fulfilling when we do.

(1.) Prochaska, J, DiClemente, C. *Toward a Comprehensive Model of Change.* In Miller, W.R and Heather N (Eds) Treating Addictive Behaviors: Processes of Change. Plenum, New York. 1986.

(2.) Holli, Betsy B. Ed.D., R.D. *Using Behavior Modification in Nutrition Counseling*. Journal of the American Dietetic Assoc. December 1988, Vol. 88.

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(3.) Mathew D. Selekman, *Solution-Focused Therapy With Children*, 1997, Guilford, ISBN, 1-57230-230-5.

(4.) Barbara McFarland *Brief Therapy and Eating Disorders*, 1995, Jossey Bass ISBN, 0-7879-0053-2.