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Aesthetic Attunement to Client Resistance: The Art Therapist's Hand

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Abstract

The topic of client resistance in therapy has garnered significant attention over time across various theoretical orientations. However, within art therapy, there remains a notable gap in the comprehensive consideration of client resistance and the effectiveness of art therapy interventions in addressing this phenomenon. This capstone thesis aims to identify that gap by conducting a brief literature review concerning (a) the multifaceted underpinnings of client resistance, (b) the psychological functions of client resistance in therapy, and (c) competencies specific to art therapy training that are beneficial in addressing client resistance. The following review uses information from the existing literature to fill the research gap to understand how to approach client resistance.

Keywords

resistance, empathy, art therapy, therapeutic alliance, therapeutic change, mirroring, response art

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Introduction

Various theories have attempted to offer explanations for why clients exhibit resistant behaviors. This capstone thesis is a research inquiry into utilizing art therapy competencies and techniques as attunement tools in the treatment of resistant clients. The inspiration for this area of study was conceptualized from the capstone author's previous internship experiences with child clients who struggled with behavioral issues. It was challenging for the author to drop in and attune to clients when they presented resistant behaviors. The author wanted to understand the underpinnings of their clients' resistant actions and reactions in a way that would help them master their countertransference and adjust their art therapy practice so that they could approach their clients' process in the most beneficial way possible. This research inquiry will synthesize the existing literature around client resistance and the competencies in art therapy, to provide insight for future art therapy practitioners addressing resistance.

This capstone thesis proposes that utilizing art therapy techniques can enhance the therapeutic alliance and mitigate client resistance in therapy (Blum, 2015; Franklin, 2010; Franklin, 1990; Nash & Zentner, 2023; Robbins & Cooper, 1994). The questions that will help to guide this inquiry include: How can addressing the existing literature on client resistance help current practitioners understand the varied foundations of client resistance? And moreover, how can the core competencies, training, and strategies employed by art therapists assist in developing therapeutic alliances with resistant clients, in a way that enhances therapeutic outcomes?

These research objectives attempt to ascertain a comprehensive understanding of the challenges posed by client resistance in therapy and seek strategies to address them.

Method

This capstone thesis reviewed 22 peer-reviewed articles, all exploring client resistance to therapy. A meta-analytic approach was employed to synthesize existing qualitative, quantitative, and arts-based research articles pertaining to client resistance in therapy, and considered the areas of; historical aspects of client resistance, current and past psychological theories regarding client resistance, and the capacities of art therapy in addressing resistance. Each diverse article has been systematically reviewed and integrated to offer a nuanced understanding of the multifaceted nature of client resistance and the efficacy of art therapy competencies and interventions in addressing it. Search terms for collecting data included; client resistance to therapy, client resistance to change, psychological stages of change, empathy, attunement, the therapeutic alliance, attachment and the therapeutic alliance, art therapy and resistance, and attachment security and resistance.

Literature Review

Resistance Pathology

Classic psychoanalytic theory was the first to coin the term “resistance” in psychotherapy. It defined resistance as the client's “avoidance of unconscious threatening material that might be disclosed and threatened in analytic work” and suggested that even the most well-intentioned clients may harbor ambivalence to change, regardless of what stage of therapeutic change they are in (Beutler et al., 2011, p. 135; Vickberg, 1999). This ambivalence to change could be evidenced in client behavior as avoidance of therapy sessions, refusal to engage in therapeutic work, or in complex manifestations like aggressive or confrontative behavior.

Through the years, other theories and theorists have adopted interpretations of the underpinnings of client resistance to therapy. Internal family systems (IFS) followed a similar

vein to psychoanalytic theory, as they both highlight unconscious processes and defense mechanisms; in IFS, resistant behaviors are contextualized as a protective measure against negative symptoms that are created by internal 'managers' (Beutler et al. 2011; Schwartz & Sweezy, 2019). Similarly, drive psychology conceptualized resistance as a defense mechanism that protects against internal processes. In drive psychology, "drives" are internal "energetic expressions of sexual and aggressive tensions" (Cooper & Robbins, 1994, p.64). When clients feel overwhelmed and frightened by their internal drives, resistance functions as the psychological protection of the ego, which is often exhibited through defensiveness to keep themselves from feeling vulnerable.

While some theoretical orientations postulated that resistance is a defense against internal material, other theories contextualized resistance by investigating both the internal processes of the client *and* their interactive dynamics in the therapeutic space. Ego-psychology's view of resistance focused on any misguided presumptions of the therapeutic space and any unrealistic expectations that are imposed on the behavior of the client (Robbins & Cooper, 1994). Some clients may feel more "in control" when verbally combating with their therapists. Combativeness may help them balance the perception that their therapist is trying to control them, or give them a feeling of control over the space. Emotion-Focused therapy was similarly focused on the therapeutic interplay between the client and therapist, and conceptualized resistance as 'pursue' and 'withdraw' behaviors related to negative interaction cycles, suggesting the influence of transference and countertransference on resistance in the therapeutic interplay (Johnson, 2012; Ryland et al., 2022). Similarly, Object-Relations theory emphasized the concept of "internalized relationships" regarding attachment security, where the therapist is meant to create a holding environment for the client, and claimed that resistance arose from the client's fears of abandonment (Robbins & Cooper, 1994). Building upon this idea, Self-Psychology is organized

around supporting the client's sense of Self. Its conceptualization of resistance considers the therapist's negative contribution to the client's dissociated parts of Self (Robbins & Cooper, 1994). Each of these theories contributed to a collective knowledge that client resistance is not solely influenced by the internal world of the client, nor is it solely influenced by external conditions and expectations. Rather, each theory considers that client resistance is influenced by a collection of varied and nuanced internal unconscious processes and reactions to external dynamics with the space and the therapist.

Reorienting Pathology of Resistance

However resistance is conceptualized or pathologized, it takes on different forms in different individuals. It might manifest as a failure to follow through with therapeutic homework, a reaction to objective improvement with skepticism, high levels of expressed emotion towards the therapist, purposeful concealment of emotional content, client criticism to distance themselves, defensiveness, contempt, stonewalling, or subtle avoidances like "I don't know" statements (Cooper et al., 2022; Gottman, 1999; Newman, 1994). The therapist must consider these factors closely to understand if the resistant behaviors stem from unconscious internal or external dynamics (Newman, 1994). To do so, the varied manifestations of client resistance must be reconceptualized within the greater systems of psychotherapeutic practice in a way that both investigates the etiology of resistant behaviors and validates the client's experience; something that none of the existing theories are able to completely achieve.

Johnstone & Boyle (2018) offered a detailed conceptualization of an alternative diagnostic system that highlighted the conceptual and empirical imitations of the "disease model" of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Instead, they proposed a diagnostic system that incorporated social, psychological, and biological elements of client experience into the diagnostic understanding of client distress. In the discussion regarding

client resistance, this shift away from the current DSM-V classification system of symptomology echoed earlier theories which emphasized both internal and external precipitants for client resistance, and supported a more organic understanding of psychological distress that is informed by how the client reacts to their environment (external stimulants) and to their experiences (internal stimulants) (Johnstone & Boyle, 2018; Ryland et al., 2022; Schwartz & Sweezy, 2019).

While resistance has been framed by some earlier theories as an unwillingness to change, clients who exhibit resistant behavior in therapy should not be written off as "not being 'ready' for therapy" or "not *wanting* to get well." When client resistance is framed as an unwillingness to change or the lack of a "want" to get well, the therapeutic alliance and therapeutic work are undermined. Their resistance becomes just some bothersome behavior that needs to be corrected rather than understood and empathized with, which weakens the therapeutic work. The factors that contribute to any aspect of human behavior are multiple, complex, and "always shaped by personal meaning and agency," meaning that it is difficult to "categorize" or "predict" human experience and reactions to environmental events (Johnstone & Boyle, 2018, p.6).

The new framework proposed by Johnstone & Boyle invited practitioners to discard the outdated question, *what is wrong with you?* and ask instead the alternative questions, *what happened to you* and *how did you make sense of it*, shifting from a pathologizing mindset to one that validates the power and threat dynamic in the client's experience that often can fuel psychological distress and resistance in therapy (Johnstone & Boyle, 2018). Just as there is no one way that client resistance can be expressed, there is not one correct way for the therapist to conceptualize resistance; there is rather a collective understanding of what may be undermining healthy connection in the therapy space (Robbins & Cooper, 1994). With this understanding, this capstone thesis is attempting to understand resistance not as a conscious reaction or something

wrong with the client, but one that is informed by the multiple and varied experiences that influence how resistant a client might be to the therapeutic space.

Protective Responses to Threats

While in theory, most of the literature posited diverse psychological motives for resistance, multiple theories advocate for a more eclectic understanding of resistance that focuses less on a singular theory of human behavior and more on how clients respond to the myriad of internal and external influences affecting them (Beutler, et al. 2011; Mahrer et al., 1994; Robbins & Cooper, 1994; Ryland et al., 2022; Yotsidi et al., 2019). The most contemporary views of resistance have shifted to conceptualizing resistance as a "protective and affirmative role" that informs the therapeutic interplay between therapist and client, rather than simply the client's unwillingness to move forward (Yotsidi et al., 2019).

The therapeutic space, as well as therapists themselves, represent change. Although therapeutic change is intended for the client's benefit, it can evoke significant perceptions of threat and induce stress, leading to resistance even among the most well-intentioned clients. Newman (1994) posited that when clients are expected to relinquish their "protective systems" they often feel vulnerable and uncomfortable. Similarly, Cooper et al. (2023) described resistance as client ambivalence to change due to fear of the relinquishment of old maladaptive patterns, exhibited by purposeful concealment of feelings from the clinician. When clients are unable to be vulnerable or relinquish control of old patterns, it can hinder their therapeutic progress. It is important to consider that clients do not resist merely because they want to. The therapist must understand that clients' resistance is not solely a matter of choice. Even if their reluctance to change seems deliberate, the prospect of change can be intimidating and elicit unconscious protective instincts (Beutler et al., 2011).

As a result of this line of thinking, Beutler et al. (2011) proposed that the term *reactance* was more fitting for a client's aversion to change than resistance, as it acknowledges the involvement of unconscious processes within the client, which interact with external stressors to shape resistance. Reactance, in contrast to resistance, defined averse behaviors in therapy as internal reactions to external stimuli. The researchers posited that the preconceived demands and expectations of the therapeutic environment (the external stimuli) may unconsciously induce reactance in clients (the internalized material) that can become resistant behaviors like noncompliance (the resulting externalized reaction) (Beutler, et al., 2011; Ryland et al., 2022). Hence, research corroborates that resistance can be impacted by the coupling of unconscious processes in clients with unsuitable environments and/or expectations within the therapeutic setting.

One contemporary theory further extended the concept of resistance/reactance beyond a mere emotional reaction, reframing it as a somatic process. Through the lens of polyvagal theory, which reconceptualized resistant behaviors as preconscious and driven by the human nervous system, client resistance was understood as a protective response emerging from the autonomic nervous system (Ryland et al., 2022). Polyvagal theory noted that the nervous system activated defensively in response to perceived threats; a system called “neuroception.” This mechanism serves as the client's protective response to perceived dangers, and it can be triggered within the therapy setting based on the client's perception of a threat. Mentally threatening material in therapy can be the danger of facing avoided feelings, of being pushed outside one’s comfort zone, or the danger of abandoning old behavioral or cognitive patterns. All these things can elicit a fight or flight response in client’s nervous system (Ryland et al., 2022). The attunement rupture between the client and the therapist that results from the threat of perceived danger is what

polyvagal theory noted as the fuel for the vicious cycle of defensiveness and disengagement (Ryland et al., 2022).

The Therapist's Role in Client Resistance

Most sources have described client resistance as energy or behaviors that originate unconsciously within the client, which can be a reaction to their environment or to internal processes (or both). Mahrer et al. (1994) shifted the focus to the specific role that the therapist plays in the client's manifestation of resistance. Mental health clinicians come in all shapes and sizes, with different manners and theoretical orientations to therapy. Mahrer highlights that with their variability, mental health clinicians have the capacity to enact or enforce innate roles of power that accompany their individual positionalities. Mahrer et al. (1994) posited that client resistance might originate from the way the clinician approaches the client. The untrained, unaware, or uncurious clinician might inadvertently inspire resistance within the client. This can be due to ignorance of the power dynamic within the therapeutic setting, a lack of attunement to the client, or by becoming distracted by their own emotional content (Regev, Kurt, & Snir 2016). Similarly, Beutler et al. (2011) claimed that the therapeutic environment, including the therapist, plays an active role in inducing noncompliance. Within this understanding, there are three major ways in which the therapist can inadvertently cause client resistance.

Counselor expectations and demands on behavior often exacerbate resistant tendencies in clients (Mahrer et al., 1994). The therapist's expectation that the client be ready for change and show up determined and engaged for sessions can often inspire resistance. Another contributor was counselor-imposed client roles, including the counselor's expectation that the client performs in a complementary role to the one that the therapist is filling. Unfitting expectations create a disconnect between the client and counselor; the counselor does not show up for the client empathetically which can cause the client to become defensive and withdraw from the

therapeutic alliance. Furthermore, when a clinician is predisposed to look for resistance, they can unconsciously cause it to manifest in their clients (Mahrer et al, 1994; Ryland et al, 2022). Counselors who have the entrenched belief that resistance is a normal, unavoidable element of the client experience oftentimes misunderstand client cues that could be alluding to a different psychological process. Thus, therapists must comprehend their own energetic impact on client resistance and address any preconceived attitudes toward resistance. Only then can they accurately evaluate all potential factors that underpin client resistance.

A Need for Resistance Intervention Training

Much of the literature is focused on the pathology rather than the etiology of resistance, which suggests that there is an increasing need for more clinician training when it comes to addressing client resistance; both due to the lack of awareness regarding the clinician's role in causing it, and because of a lack of awareness around its management. Cooper et al. (2023) explored the capacity of both therapists and non-therapists to identify process errors in psychotherapy, particularly those associated with client resistance patterns and behaviors. The study positioned that the therapist's empathic response and validation were more adaptive to client resistance than responding to resistance with directness. The authors of this study argued that "management of client resistance has a significant impact on therapy outcomes" and stressed the need for an update to psychotherapist training regarding resistance for that very reason (Cooper et al, 2023, pg. 1097). The authors noted that through the years, psychotherapy training has "emphasized intervention over observation," resulting in the underdevelopment of clinicians' ability to detect negative client reactions and intervene accordingly. It was found that this impacted the therapeutic process so negatively that in a clinical study, untrained individuals had higher attunement rates to clients' negative responses to therapy, and therefore greater outcomes, than trained clinicians (Cooper et al, 2023, pg. 1098-1099). To gain skills in appropriately

addressing client resistance, the authors argued that a therapist in training must first obtain an understanding of how to detect client resistance in its many forms. They argued that “clients' negative reactions tend to be subtle and often embedded in seemingly affiliative behavior” suggesting a need for a deeper level of acuity towards the client's in-process behaviors, rather than the swiftness with which the clinicians were with their interventions (Cooper et al., 2023, pg. 1099). This idea is in direct opposition to the earlier argument that being keen to the manifestations of resistance could support the premature fabrication of resistance, which suggests that perhaps there is a middle ground balance in which therapists can be aware of the client’s in-process behaviors, while not allowing their preexisting views of resistance overshadow the context of those behaviors (Cooper et al., 2023; Mahrer et al, 1994; Ryland et al, 2022).

Empathic Competencies & Art Therapy

The evident need for more process-oriented training in client resistance necessitates a collection of empathic strategies and tools across therapeutic practice. These resources can then be employed effectively in the therapeutic setting when working with resistant clients. Although client resistance has been addressed in many ways by many different sources, it has been unanimously agreed across the literature that empathic response and validation is the most effective therapist response to client resistance (Cooper, et al., 2023; Newman, 1994; Robins & Cooper, 1994; Beutler et al., 2011). To cultivate appropriate empathetic mechanisms for attuning to client resistance, therapists need to grasp the fundamental components of therapeutic empathy and its diverse applications throughout the therapeutic process.

Therapeutic Curiosity

Cultivating a therapeutic practice that remains organically engaged with observing and attuning to client resistance warrants a firm grounding in inquisitive observational questions

(Cooper et al., 2023). Therapeutic curiosity must flow from a place of genuine inquiry with consideration for the client's experience. The language that therapists use around this inquiry is integral and could mean the difference between truly understanding client resistance and defaulting to the outdated pathological understanding of resistance. Newman (1994) initiated the discussion by asking "What purpose is the client's resistance serving for them?" This question provides a valuable starting point for the consideration of client resistance as it originates from a myriad of varied factors. Connecting this questioning approach to the Johnstone & Boyle's (2018) query "How are you making sense of this?" places the client's experience at the center of comprehension, rather than focusing solely on the resistance itself. Newman (1994) also considers how the client's resistance fits into their developmental/historical patterns, and what idiosyncratic beliefs might underpin their resistance, which continues the line of inquiry around the client's experience rather than pathologizing the resistant behaviors themselves.

The Dilemma of Directiveness

There is some dissent among the existing literature regarding the efficacy of directiveness as an intervention for client resistance. Both the therapist's directiveness and the directiveness of treatment have been scrutinized by various sources. Robins & Cooper (1994) believed that the confrontation of one's defenses was a method that provides a richer ego integration for the client and noted that firm structure and support are the foundations of treatment (intervention concepts taken from drive psychology). But Cooper et al. (2023) posited that therapist directiveness can more often aggravate client resistance than alleviate it, as directiveness without a strong trustworthy rapport can provide a platform for the "acting out" of the client's ambivalence. Yotsidi et al. (2019) emphasized the role of security in psychotherapy and supported addressing resistance directly as a method to increase security in the therapeutic space, though the researchers acknowledged that resistance can often be associated with low alliance levels.

Instead, the therapist may avoid the cyclical trap of resistance by meeting the client's opposition to change with empathetic interventions that create a less threatening platform for therapeutic connection. Cooper et al. (2023) claimed that empathic response and validation was a more viable and adaptive therapist response to client resistance. Beutler et al. (2011) supported that, specifically when working with clients who exhibited higher levels of resistance. Conversely, they also noted that clients who exhibit low levels of resistance will often respond more effectively to directive types of treatment, while clients with elevated levels of resistance respond best to non-directive treatments, like empathetic and validative interventions rather than challenging ones. They found in their research that "effective therapeutic change is greatest when the level of therapist directiveness corresponds inversely" to the client's level of resistance (Beutler, et al. 2011, p. 135). All sources assume that the level of directiveness used in treatment should relate directly to the level of trust within the relationship, and all sources agree on its successful use within the appropriate context (Cooper et al., 2023; Yotsidi et al., 2019; Beutler et al., 2011).

So, while directiveness may be a valid and reliable intervention for some resistant clients, there is little evidence to support a ubiquitous application, and it must be handled delicately and deliberately if directive interventions to resistance are used in treatment. Most of the literature is in support of non-threatening approaches for addressing resistance, which for the art therapist can include the use of approaches such as working alongside, parallel artmaking, or artistic response (Nash & Zentner, 2023). The use of nonverbal connective mechanisms like artmaking can foster attunement between the client and therapist without directly addressing the client's resistance.

Therapeutic Silence

When we think of "client resistance," we may picture a client who is sitting in the therapy space, refusing to speak or engage, and that client-initiated silence may be a source of great stress for clinicians. Regev, Kurt, & Snir (2016) conducted several semi-structured interviews of art therapists to broaden the conversation around the use of silence in therapeutic settings as a tool for therapeutic connection. Through the lens of these fifteen interviewees, the article framed silence as a misinterpreted resistance mechanism, and it helped to deconstruct what therapists currently view as "resistant behavior." Three types of client-initiated silence were identified; emotional, reflective, and expressive silence. All types of silence are indicative of some sort of therapeutic shift happening within the client, whether it is introspection, regression, avoidance, or a taking of control. There were also two types of silence that the authors noted that are initiated by the therapist; client-focused silence, known as "silent listening," and the silence that may occur when therapists become distracted by their own emotional content, which can be detrimental to the emotional state of the client (Regev et al., 2016). The authors accentuated the entry-point for art therapy in moments of resistance-initiated silence; asking a client to create something, or the art therapist's creation of something, has been found to give the occupants of the space creative and expressive permission to communicate non-verbally. In sessions with one such silent client, Nash & Zentner (2023) expressed feelings of discomfort about their client's withdrawal while making artwork alongside one another and raised the issue in a discussion with their supervisor. Together, the authors and their supervisor contextualized the silence as the client's wish to enjoy the flow of creativity, paired with the client's comfort in the quietness with the therapist, which demonstrated that they were building therapeutic rapport in an energetic, nonverbal manner.

Resistance and The Therapeutic Alliance

How therapists perceive, conceptualize, process, and orient themselves to the resistant behaviors of their clients can profoundly affect the therapeutic relationship, just as the therapeutic relationship can profoundly affect resistant behaviors in clients. The inverse relationship between the level of resistance in clients and the strength of the therapeutic alliance places the therapists' approach to client resistance in a pivotal spot in the process and work of building the therapeutic relationship (Ryland et al., 2022, p. 267). Kazdin, et. al (2006) explored how the therapeutic alliance relates to therapeutic change in oppositional resistant clients. The study participants included 77 school-age children referred for treatment to outpatient services for oppositional, aggressive, and antisocial behaviors. The measures of the study were the Therapeutic Alliance Scale for Children (used for the therapist-client alliance), the Working Alliance Inventory (used for the therapist-caregiver alliance), and the Treatment Improvement Scale (used to evaluate client improvement). In chorus, these were used to study the therapeutic alliance prospectively throughout treatment and included a series of surveys and interviews completed before, during, and after treatment. Conclusions showed that the child–therapist alliances were related to therapeutic changes in the children and that the better the quality of these alliances during treatment, the greater the therapeutic outcomes relating to the mitigation of resistance (Kazdin et. al., 2006).

Process Acuity. Cooper et al. (2023) highlighted the significance of *process acuity* – the therapist's keenness to where the client is in their process – as being a vital clinical skill for therapists to cultivate. This process relies on the "therapist's personal inventory of the client's many cues", which helps the therapist create fluency in the subtle verbal and nonverbal communications of the client, and results in the strengthening of the therapeutic alliance (Franklin, 2010 p. 163). In other words, the therapist must have an empathetic awareness of the internal state of the client's processes to empathize, build security, and move the therapeutic

alliance forward. When the therapist can attune to the client's subtle cues, they can better navigate adverse therapeutic dynamics like resistance, miscommunications, or therapeutic ruptures.

The rupture and repair process can be insurmountably beneficial to growing the therapeutic alliance and to the process of ameliorating client resistance. Disagreement or rupture often necessitates powerful empathy deliverance, which is therefore "substantially more powerful than empathy delivered at randomly selected times" (Cooper et al 2023, p. 1098). In other words, empathy delivered at precise moments can be an integral tool in addressing client resistance and can also be used to manage a deeper therapeutic alliance. It's important to note that the efficacy of this "beneficial disagreement" warrants a firm foundational therapeutic alliance and the establishment of a safe therapeutic space, to avoid damaging the client's feeling of safety during the rupture and repair process (Kossak, 2009).

Attachment Security. Recent research into client resistance concerning interpersonal elements of security in therapy suggests that client resistance is significantly correlated with attachment security (Yotsidi et al., 2019). Clients will often enact their maladaptive attachment patterns with their therapists either as learned relational behavior, as a manifestation of transference, or as a defense mechanism (Paley, 2018; Wallin, 2007). When the client's maladaptive attachment pattern disrupts the therapeutic interplay, the therapeutic alliance may be similarly disrupted due to how the attachment patterns are approached by the therapist. As the therapeutic relationship is often regarded as being the therapy itself, a resistance-induced rupture of the relationship can be critical for treatment, and the process-oriented therapist can rely on the rupture to reveal the underlying attachment pattern, in order to help the client create a new understanding of a secure relationship (Shilkret & Shilkret, 2011; Wallin, 2007). Malchiodi (2017) and Urquhart et al. (2020) both supported the use of haptic artistic mediums to foster

attunement and attachment in therapeutic settings. Art materials that foster the sense of touch are believed by some researchers to be supportive of reparative processes like attunement and attachment in clients because touch is very widely considered to be the most primal sense that humans first learn to connect through in infancy (Urquhart et al., 2020).

The Art Therapist's Attunement Capacities

Attunement is an integral skill for any practicing clinician when building a therapeutic relationship and involves asynchronous and responsive attention to energetic and embodied shifts in the client in order to read the communicated needs of the client (Kossak, 2009; Perry, 2013). According to Kossak, the efficacy of the therapeutic encounter is sculpted by the clinician's ability to remain aligned, present, and alert to "cultivate a mutual resonance" between themselves and the client (2009, p. 13). When centered alignment (in other words, the therapist's authenticity) is established, they can engage with clients on a deeper and more connected level, which helps them enter a therapeutic attunement (Kossak 2009, pp. 13-14). Research suggests that art therapists possess specific learned attunement and engagement skills through creation because of their aesthetic training, proficient attentiveness to empathy, and attention to their authentic presence and how it functions in the therapeutic space (Franklin, 2010; Franklin, 1990; Robbins & Cooper, 1994). The following literature overview regards the art therapists' specific capacity to attune to client needs.

Mirroring

According to Blum (2015), the brain's mirror neurons are the building blocks for empathy. When watching others perform gestures, facial expressions, or movements, mirror neurons located in the brain's motor cortex are activated both in the individual performing the movements and in the observer; a communication that has its roots in mother-infant relationships (Blum, 2015; Urquhart et al., 2020). When an individual imitates the movements of another, the

mirror neurons are activated at higher rates, providing a richer experience of understanding the other person's intentions, feelings, and motivations. "By mirroring, we reflect to the client the dissociated parts of the client's self" through the conscious embodiment of the client experience, which works both to help the therapist better understand the client's internal, unconscious experience and also to help clients feel seen or heard on a deeper emotional level (Blum, 2015; Robbins & Cooper, 1994, p. 65). Mirroring could be the actual physical embodiment of facial expressions, gestures, body movements, and languages of the client, or it could be the intentional use of therapist artmaking that mirrors the art or movements that the client is engaged with. Mirroring serves to enhance the therapist's comprehension of the client's internal world and as a gesture that validates the client's embodied experience.

Visual Empathy: Artistic Responses

Art therapists undergo training in both psychotherapy and artistic practice, shaping a therapeutic identity that embodies both the roles of clinician and artist. This dual identity provides art therapists with intrinsic tools for attunement and empathy, which allows them avenues to access and understand the client's internal world. Art therapists may do so through the act of empathetic witnessing and artistic response, which is a form of mirroring. Artistic response is typically elicited in response to resistant, avoidant, or otherwise nonverbal communication preferences in the client (Nash & Zetner, 2023).

Franklin (1990) utilized an artistic response technique to attune to an adolescent inpatient client who had made various drawings surrounding her experience of depression. After working with the therapist for some time, the client was discharged and then admitted again quickly after for a suicide attempt. In their initial meeting back, the client was very withdrawn and silent. In the silence, the therapist empathically recalled one of the client's drawings of a tunnel from when she had last been in the unit and began to render a sculpture of a tunnel with a woman walking in

it. Slowly, the client began to engage with the therapist's art, which effectively opened an avenue for conversation. At the same time, the therapist began to understand the internal processes of their client on a deeper emotional level and was therefore better equipped for the emotional exchange.

Franklin (2010) broadened the conversation around the importance of artistic response in an arts-based research exploration. The researcher explored therapist response art as an attunement tool by investigating the emerging research on mirror neurons as they pertain to human connectedness. The research consisted of a case study of visual empathy in session with an art therapy group of male adolescents in a locked inpatient unit. The participants were described as difficult to engage with and exhibited "oppositional antagonism" in the therapeutic space when the sessions began. In an effort to garner curiosity and attention from the group members, the therapist responded to their antagonism by creating an image of a "well-defended fortress" which included barbed wire over thick walls, and intentionally phallic cannons which helped to draw the participants to ask questions and engage with the therapist and the art (Franklin, 2010). The researcher reported that using their own artwork with the group members created a "congruence with the group's formative process" and validated everyone's reservations about coming to the group while opening avenues for connection and communication (Franklin, 2010). In making a conscious empathetic effort to interpret the core themes of the group by creating art and inviting inquiry, the therapist helped to evolve a new level of group participation, thereby underlining the efficacy of utilizing empathic art responses as a way to notice, honor, and offer back "expressions of deflected affect to their clients" (Franklin, 2010 p. 166; Robbins & Cooper, 1994).

The Aesthetic Attitude. In 1990, Franklin defined the term *esthetic attitude* in art therapy practice as the "sympathetic attention to and contemplation of any object of awareness

whatsoever, for its own sake alone" (Franklin, 1990). In essence, this notion underscores the intrinsic value of artistic responses in therapy. The art therapist's response artwork not only communicates empathy with the client's experience nonverbally but also redirects focus to the art itself. This shift in attention may help alleviate any discomfort the client feels about being the center of attention, which may be contributing to resistant behaviors (Nash & Zetner, 2023).

Franklin examined the case of a client with a history of community conduct issues who would come to therapy and fall asleep instead of engaging with the therapist (1990). Rather than use the time for themself, the therapist utilized the time that the client slept by maintaining sympathetic aesthetic attention to him and drawing him while he slept. By sharing those drawings with the client afterward, the therapist could engage with the client in a way that moved toward "an exploration of emotionally loaded material that was previously avoided," while maintaining a non-confrontational dynamic (Franklin, 1990; Nash & Zetner, 2023). The case examples illustrate the efficacy of empathic artmaking and maintaining an aesthetic mindset in sessions with resistant clients. Consequently, the importance of aesthetic engagement with resistant clients is implicated. To reach the client's internal world, the art therapist may use a culmination of aesthetics, mirroring, and empathy to respond accurately (attune) to the unspoken needs of their clients. When the art therapist can accurately attune to the resistant communications of the client appropriately, resistance can be ameliorated (Robins & Cooper, 1994).

Discussion

Resistance is not born from just one element but is a culmination of detrimental environments and client coping strategies to maintain their psychological equilibrium. Though it can originate from anywhere depending on the individual needs and struggles of the client, resistance to therapy is most often understood as a protective mechanism against unfamiliar and

uncomfortable experiences, such as therapeutic change or relinquishment of old patterns. Resistance is essentially a reaction rather than a predisposition.

For some individuals, the notion of change can evoke deep-seated fear. Whether it involves psychological or physical shifts, change often entails relinquishing familiar patterns or embracing new ones. Patterns which, for various reasons, serve a purpose for individuals. Therefore, it is understandable that any clash between maladaptive psychological patterns and a catalyst for change – be it the clinician's embodiment of change or the discussion of change in the therapeutic context – could hinder therapeutic progress. In some cases, a client's averse reactivity to change could be exhibited by deliberate processes such as the vocalization that the client does not need or want therapy. Conversely, their reactivity may be buried in the unconscious and manifest as subliminal avoidance of psychological material. Invariably, resistance to change appears to be the primary motivator behind most instances of client resistance, and it is evident that for client resistance to be ameliorated, it must be approached by the therapist with empathy and validation.

At the heart of most contemporary therapeutic practices is empathy; it is arguably the most important quality in a psychotherapist. Empathy is one of the most influential tools for addressing resistance and is essential for the therapist to garner attunement to the client's inner world. Specifically, the trained art therapist possesses specific skills for fostering verbal, non-verbal, and artistic engagement with clients who otherwise would be unable to address their maintaining factors of resistance. In art therapy, artistic empathy plays an extremely significant role and is often paired with the concept of mirroring and the concept of attachment. The author of this capstone thesis was inspired by the various case studies within the literature that investigated the effects of therapist response art, and would be interested in further exploring the merits of response art on a wider scale.

Recommendations

This research reviewed the literature specific to art therapy and client resistance to therapy. The literature noted several suggestions for working with resistant clients in a way that is both respectful and efficient. The author of this capstone thesis found that empathy and curiosity are the most beneficial therapeutic approaches to client resistance, as they foster the therapeutic alliance. Integrating nonverbal attunement tools such as response art – art that is created by the therapist in response to the client's presence – can stimulate mirror neurons in the brain that foster human connection and increase therapeutic and intrapersonal engagement.

Specifically for research, the author hopes to stimulate more interest in working with client resistance to produce more investigations that employ artistic response to the client's presence, modeling Franklin's (2010) study. Subsequent actions may involve the development of a methodology that extensively tests the validity and reliability of utilizing nonverbal artistic attunement interventions such as empathic therapist response art with resistant clients. This research could potentially support the development of understanding how client resistance to therapy affects the therapeutic process, and how therapist response art may carefully cater to the therapeutic alliance by providing clients with nonverbal validation.

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