Lazar Pejović[1]
Faculty of Legal
and Business Studies
Dr. Lazar Vrkatić

The Relationship Between Attachment Patterns and Resistance in Psychotherapy

Abstract

The primary aim of this study was to explore the relationship between patterns of attachment and the manifestation of resistance in the psychotherapeutic process, as well as their influence on the therapeutic dyad between therapist and client. The study involved a single therapist–client pair; however, standardized questionnaires were administered only to the client. A phenomenological research approach was employed, focusing on phenomenological description of the client's lived experience within the therapeutic process. Data were collected through a semi-structured interview, as well as through the use of the ECR-R and the Relationship Questionnaire (RQ), which were used to assess the client's attachment style and patterns of behavior in close relationships. The findings suggest that specific attachment patterns may influence the form and expression of resistance during psychotherapy. These observations are consistent with several psychological theories that emphasize the relational and affective dimensions of resistance within therapeutic work. The study may serve as a preliminary basis for future research employing more detailed and direct methodological approaches in the exploration of attachment dynamics and resistance in psychotherapy.

Keywords: resistance, attachment model, interview, psychotherapy.

1 lazar_pejovic@yahoo.com

1. INTRODUCTION

1.1 Resistance

In this paper, resistance is primarily examined within the framework of psychoanalytic theory. Other perspectives on the phenomenon of resistance will also be considered, including the early psychoanalytic followers and critics (Reich, 1933), as well as later humanistic continuations (Fromm, 2015). In addition, resistance will be viewed through the perspectives of transactional analysis, cognitive-behavioral therapy, existential psychotherapy, and constructivist psychology.

Historically, resistance initially emerged as a reaction of the client to certain techniques used in psychoanalysis. Over time, psychoanalysis itself evolved through the process of working through resistance. One of the major contributions of psychoanalysis lies in demonstrating that the human intellect is deeply dependent on affective life.

Resistance is viewed as a distinct segment of client behavior consisting of a series of unconscious diversions that influence the ego. Its primary function is to halt the process of change and obstruct the continuation of therapeutic work. Freud (1933), in developing the theory of resistance, identified three primary forms of resistance to which the analyst responds through interpretation, potentially leading to abreaction and relief from symptoms through which resistance had been expressed, thereby freeing the individual from an infantile view of the world. These three forms include:

1. When the patient is instructed to follow the flow of consciousness and not allow any motive to divert the stream of thought, the patient often violates this rule, providing various excuses such as claiming that nothing comes to mind, that certain topics are irrelevant to the session, or that discussing specific past situations is uncomfortable.

2. The second form manifests as intellectual resistance, often through rationalization, directed toward perceived danger, namely the psychoanalyst.

3. The third form appears through the phenomenon of transference, in which the individual places an authority figure, most often a parent, onto the position of the analyst, toward whom ambivalent emotions are directed.

The mechanism at the core of resistance is repression. Psychoanalytic theory assumes that the forces preventing change in the client are the same forces that originally produced the psychological conflict (Freud, 1933). A strong opposition emerges against allowing certain mental contents, represented as memories of particular events, to reach consciousness. This opposition is expressed through resistance, often appearing in behavior that contradicts the therapist's suggestions, through forgetting, or through the inability to find sufficient time to complete therapeutic tasks. Resistance therefore often manifests through the blocking or redirection of voluntary processes via specific psychological mechanisms, diverting the individual from the goals necessary for progress in the therapeutic relationship. Repression produces the symptoms about which the client complains and which bring them to psychotherapy. It disrupts the coherence of the client's thoughts and creates psychological gaps that the individual attempts to fill in various ways. Repression rarely occurs alone; it is usually accompanied by regression toward a specific event preserved in memory, to which the individual remains fixated, because the individual lacked the cognitive capacity to adequately process the information coming from either the external or internal world.

In the study of resistance, from a psychoanalytic perspective, it has been established that it arises from the ego itself, that is, from manifest or latent traits or character features. And these same forces of character, which influenced such structuring of the ego itself, have taken care of repression and also affect the manifest behavior itself, which we designate as resistance.

Reich (1933), in *Character Analysis*, explains that the ego often identifies with the authority figure who imposes deprivation, typically a parent. Aggression originally directed toward this authority figure is turned inward against the individual's own character structure. Neurotic character structure therefore emerges as a compromise between instinctual demands and defenses against them, which differ precisely only in terms of the degree of development. And it is precisely that infantile demand that has been transformed into attitudes in a certain shape or form, as an automatic way of responding. In that, we find a similarity between the affective attachment and the infantile demand that arose from it, which we want to examine, and the way it manifests itself through resistance.

Childhood experience, or a psychological childhood situation, which existed in reality, or was falsified, and we learn about it through the analysis of resistance, has remained "preserved" in two ways.

1. With regard to content, as unconscious thoughts or ideas
2. With regard to form or shape, as character attitudes of the Ego, or automatic reactions.

Obviously, the same element from the unconscious infantile structure is preserved and made evident in two ways, which present themselves to us through behavior during the session, as resistance:

1. In what the individual does, thinks, and says
2. In the way they react or act

There must always be certain relationships between the outward appearance of character, which we perceive, the internal mechanisms, and the particular history of their understanding of both reality and the Self. (Reich, 1933)

Based on his observations, Reich suggests that resistance will naturally emerge in response to perceived threats, but its intensity is reduced if the patient's negative attitude which arose at an earlier stage when positive emotional responses toward the object of need gratification were withheld is addressed first. Once the patient becomes aware of this attitude, the accumulated negative energy or aggression is released, preventing it from later manifesting as depression or disrupting the continuity of behavior. The second approach is to refrain from analyzing positive expressions of love, or the client's confident acceptance of tasks and authoritarian attitudes, as forms of resistance, until these have transformed into hatred; that is, until they manifest as reactions of disappointment.

We believe that at the core of every personality dynamic lies the nucleus that drives actions, attitudes, thoughts, or ideas, namely antagonism, or conflict. In the antagonism and the struggle for control over the body, conceived as an object moving within a given space and time and within conditions necessary for any potential development or success, we must take this fact as the starting point for our investigation. From there, we can advance our understanding of resistance as a natural response of the organism, and subsequently observe the client's conscious reactions, which occur under the influence of defense mechanisms that, at specific times, have only facilitated developmental movement. On this basis, the core of resistance can be identified and reassessed, and the client can be gradually acquainted with the changes that may occur and prepared for them accordingly. The client continuously processes, cognitively, to the extent permitted by their intellect. Psychoanalysis has shown that human intellect is strongly influenced by affective states. Based on this conditioned perception, the client analyzes the relationship itself, and if it is positive, if trust in the psychotherapist develops, resistance will be present but at a lower intensity; conversely, if trust is lacking, the intensity of resistance will be greater. We believe that only after analyzing and reconciling relational dynamics, or constructing a personality moving toward coherence of thought, can resistance be overcome, or at least sufficiently understood in terms of its mechanisms. Only after clearing the channels of communication, or reducing the affect shaped by the parent–child relationship, can we continue to build a trusting relationship, which will serve as the foundation for positive change.

Depending on the duration of therapy and the continuity of improvement, this process can lead to consistent or lasting changes in the individual's character structure.

Perhaps the most important aspect during analysis is recognizing resistance (Fromm, 1991). Resistance is a phenomenon that exists and emerges within the interaction or relationship between therapist and client. It is not limited to the analytic setting but occurs in the life of anyone who is attempting to change, develop, or truly live.

It appears that humans possess two strong tendencies. One is the drive to move forward, beginning from birth, while simultaneously harboring a profound fear of the unknown, the hidden, and the repressed, essentially, a fear of freedom, risk, and novelty. At the same time, there is an equally strong tendency to withdraw, to retreat, and to resist moving forward (Fromm, 1951). This fear of the new, of what we are unaccustomed to, of uncertainty and the external world, is expressed as resistance. It manifests through various defensive maneuvers that prevent the individual from progressing and achieving meaningful outcomes.

Through his humanistic psychoanalysis, Fromm identified three types of resistance and noted that the patient behaves most problematically when they rationalize their resistance. Starting from the premise that we resist improvement in our own lives, he concluded that individuals who resist their own progress view it with suspicion rather than with pleasure or joy. Therefore, any improvement in their condition serves as the starting point for a compromise, a compromise that inherently contains a form of symptom, which the psychotherapist approaches through interpretations of resistance. Success itself, when perceived as positive, can lead to a compromise whereby the efforts invested in healing are diminished to the extent that the patient rationalizes that very success. Resistance changes in form and intensity throughout the course of therapy. Among the forms observed in psychoanalytically oriented therapists are, for example, the patient overwhelming the therapist with dreams, or engaging in trivial conversations that do not pertain to the structure of the problem but rather to the minutiae of everyday life. These forms of resistance relate specifically to the work with the psychoanalyst and are not tied to the past in which the root of the problem lies; in other words, they are expressions of resistance. Above all, resistance is a completely natural human reaction, and it is the therapist's responsibility to determine how to work through it and how to gradually acquaint the patient with the underlying problem.

Supporting these ideas from researchers are the findings we gathered through a review of the fundamentals of Transactional Analysis, Cognitive Behavioral Therapy, and, finally, the Psychology of Personal Constructs. Sometimes, when an agreement is reached between therapist and client regarding "homework assignments," clients, often under a veil of doubt, may perceive even a carefully planned work schedule as counterproductive. The very term "homework assignment" can trigger strong reactions or abreaktions in the Child ego state, eliciting rebellious responses that the individual has retained from childhood and that were originally directed toward authorities or teachers. These responses are linked to a series of experiences the person may have had in relation to such figures (Voudson, 2011). Different types of behaviors commonly referred to as "resistance" are, in constructivist psychotherapy, primarily viewed as the client's *active choice* to continue behaviors that make more sense to them personally, while resisting behaviors that are more meaningful from the therapist's perspective (Fransella, 1991). A client who drives the therapist to frustration through their failure to do what the therapist desires, or through their refusal to see things in the way the therapist clearly perceives, is not necessarily rejecting the therapist as a person. It is far more likely that they are demonstrating that their system of constructs does not encompass what the therapist believes the client's system should include (Kelly, 1955:1101). According to Mark Voudson, there is undoubtedly a part of the self that strives for change, which we can observe in the client, as well as a part of the self that, drawing on the energy of the Ego which, as noted, also generates resistance, opposes change. Such ambivalence can be confusing, but

when understood in a certain way, it directs us to relevant information and provides a basis for intervention. If we consider that the entire script referred to here as the person's scenario, develops within the context of relationships, and acknowledge that only an understanding of this context can illuminate the meaning of the client's reactions, and that the script represents a form of internal continuity with early relational experiences, then we have a framework for more clearly understanding this ambivalence toward changeIn this context,emphasizing that we are working around this idea, the client may fear change on an unconscious level, as it threatens to disrupt the bond or established relationship with internal objects, namely the parents. Resistance can thus be understood as a "battle for loyalty." Furthermore, it is important to note that the existential approach to therapy teaches that taking responsibility for one's life and embracing freedom inevitably brings a degree of anxiety (Yalom, 1980; 2005). In conclusion, an individual striving for success must learn to live with the ultimate dual outcome: personal growth toward which they aspire, alongside the tension that arises from the responsibility for the development of their character and themselves as a conscious person.

In constructivist therapy, resistance is considered in a specific way. This type of therapy focuses on constructs mediated through language, recognizing that an idea which serves as a driving force, or energy halted by a particular concept, can be constructed and understood through examining the meanings of the client's terms. Resistance itself is not viewed as a separate type of behavior requiring special attention. If the client does not construct change in the same way as the therapist, or fails to perceive the possibility for change, this indicates insufficient coherence of thought to guide and direct movement toward a particular understanding of the information they receive. As a result, the client cannot continue therapy along the path encouraged by the therapist and fails to progress in that direction, which implies two key consequences.

First, such a change may be too difficult for the client, and they simply do not dare to allow it for themselves. Second, the therapist may not have sufficiently understood the client.

Therefore, these client behaviors can be understood in several ways, specifically, three ways:

1. The client may resist change because they assume it is accompanied by excessive anxiety, which arises when the change occurs in the direction of a psychological void, that is, when the change holds no meaning for the client.

2. The individual may resist due to an overwhelming perceived threat; in other words, the conscious system of constructs is simply not usable in the context of the proposed change.

3. Finally, the individual may resist the desired change because of hostility, or because they are unable to confront their other shortcomings

Accordingly, for constructivist therapists, resistance is understood as a form of the client's strategy to protect themselves from external influences. It is not viewed as a disruptive force in the session; rather, the therapist works with resistance, not against it.

Other perspectives, in contrast to psychoanalysis, adopt different positions within the cognitive framework.

Assigning significance to oppositional behavior, it is referred to as reactance, a form of lower-intensity resistance. As a stable trait in these studies, such noncompliance, expressed through reactance, originates from a history of interactions in which this behavior was either reinforced by the environment or at least elicited by it (Beutler, 2002). We propose that reactance can be understood as the reactivation of past experiences that occurred in reality, particularly within the dynamics of Self/authority, Self/environment, and Self itself. In this form of resistance, the affective component of reactions toward authority figures, including the psychotherapist, is particularly heightened (Cautilli,2000,2005).

However, resistance expressed through noncompliance, which appears to be transferred from the parents to the psychotherapist, originates from specific situations, most often the actions of the therapist or their demands. This is another indication, we suggest, that when an individual experiences or assigns a construct/meaning to a particular feeling as positive/negative or true/false, ambivalence toward the parent, particularly the father as authority, the mother as support during upbringing and as the primary object of the individual's existence will, through the process of transference, increasingly manifest in behaviors that we identify as resistance.

1.2 Primary affective attachment

The relationship a child establishes with the mother in early childhood is of crucial importance for both personality formation and the development of relationships in adulthood. This relationship is referred to as affective attachment and, according to various authors, is formed by approximately the age of five.

From a developmental perspective, one of the earliest fears is the fear of separation. According to Freud (1933), this fear represents the ego's response to the danger of complete helplessness and emerges during the stage of absolute dependence on the parents. For the purposes of our research, particularly relevant is the aforementioned and developmentally later fear, the fear of loss of love, which arises in situations involving the threat of losing support and objects of love (and/or identification). The fear of loss of love represents a feeling of threat arising from the withdrawal of love by a significant other. This fear originates from the earlier fear of separation. Freud writes in *New Introductory Lectures on Psychoanalysis* (1933) that the adult fear of losing love is a derivative of the infant's primordial panic experienced when the mother is absent.

Fonagy (Fonagy et al., 2002) argues that attachment relationships are of primary evolutionary importance because they provide the conditions necessary for the development of reflective functioning and the development of the self. The understanding of the biological function and purpose of affective attachment has changed considerably over the past three decades. Sroufe and Waters maintain that the goal of the attachment system is the achievement and maintenance of a sense of security, rather than merely the attainment of physical proximity to the attachment figure (Sroufe & Waters, 1977). Schore (2003) argues that the formation of attachment relationships during the first year of life represents a crucial event for subsequent socio-emotional development. Furthermore, within a secure attachment relationship, optimal conditions are established for the maturation of specific neural structures responsible for affect regulation, which mediate both interpersonal and intrapsychic aspects of later socio-emotional functioning.

According to Mary Ainsworth's (1963) research conducted with infants in Uganda, attachment behavior is already clearly present by six months of age and is differentially directed toward one or more caregivers responsible for the child's care.

Attachment theory represents one of the most widely used theoretical frameworks for understanding personality development and, more recently, psychotherapeutic processes.

According to Bowlby (1972), different behaviors are organized into systems, with each behavioral system consisting of functionally equivalent behaviors that produce the same predictable effect or outcome. At the same time, any given behavior may serve more than one behavioral system. Research has identified four distinct attachment styles that develop in childhood, as well as their reflections and influence on an individual's later life.

1. Secure attachment - As the term itself suggests, these children are accustomed to having a caregiver who consistently responds to their needs and demands, later becoming an important figure of support and authority. As a result, the child does not experience significant anxiety or negative

emotions during the caregiver's absence, as they are confident in the caregiver's return. The infant develops an internal working model based on such affective interactions, forming a self-image as worthy of love and attention, while perceiving others as trustworthy and reliable.

Individuals who develop secure attachment in infancy tend to grow into adults characterized by strong self-esteem and a sense of security. They are typically marked by openness in communication, an exploratory orientation toward life, and a tendency toward growth and development. The capacities associated with this personality structure are considerable; such individuals generally adapt more easily and cope more effectively with life's challenges than others.

2. Anxious/Ambivalent (Preoccupied) Attachment - In this attachment pattern, the mother is perceived as inconsistent in responsiveness, failing to meet the infant's needs in a continuous and reliable manner. The caregiver responds only intermittently or selectively, leaving the child without consistent emotional availability. As a result, the child seeks the caregiver's attention even more intensely, leading to preoccupation with the attachment figure. Children with this insecure attachment pattern often grow into adults who continue to experience feelings of helplessness without a primary attachment figure. This ambivalent behavioral model tends to persist throughout much of life unless therapeutic intervention occurs. Individuals with this attachment style typically enter romantic relationships with pre-established expectations of inconsistency in their partners, believing that only a symbiotic bond can provide a sense of complete love, often experienced, in practice, as a need for control.

3. Avoidant Attachment - In this distant pattern of early affective bonding, the mother fails to respond consistently to the child's signals. From this relationship emerges a triad of behavioral responses: protest, despair, and eventual withdrawal. It is through this final phase that the child forms their internal working model. This pattern leads to the development of behaviors and traits that later influence the individual's personality structure and character. Early in life, a part of the self develops the belief that one is not worthy of having their signals responded to, while distrust toward others becomes a central relational stance. Individuals with this self-perception tend to develop a defensive, emotionally distant personality. They approach relationships with caution, reluctance, and skepticism. In romantic relationships, they often engage in occasional, non-committal partnerships, lacking trust toward their partner and maintaining emotional distance and guardedness.

4. Disorganized/Insecure Attachment - In this attachment pattern, children do not develop a consistent self-image. Parental responses are chaotic, which the child, affectively perceiving the world, quickly recognizes. Children exhibiting this pattern also develop a general distrust of the world, perceiving it as dangerous. Consequently, due to fear, the cognitive component of their personality, which should normally process information from the external environment, fails to function properly, with persistent anxiety shaping cognition. These individuals carry experiences of rejection and neglect from childhood. As adults, they are typically anxious, fearful, and emotionally guarded. Their style of thinking can be inferred indirectly through observation of their way of life, which is often confused, irrational, and lacking coherent meaning. Given their pervasive anxiety, which frames reality as threatening, they tend to be inadequate and highly indecisive in romantic relationships.

It is important to emphasize that internal working models of attachment do not merely represent the nature of past experiences; they also serve as prototypes for the formation of future relationships. There exists a set of conscious and unconscious rules that shape the expression of the attachment system, primarily by guiding cognition, emotional responses, and behavioral patterns.

2. METHODOLOGY

The study was conducted as a case study with the aim of examining the relationship between basic affective attachment and the experience of resistance within the psychotherapeutic relationship. Based on the assumption that there is a connection between the way an individual perceives and interprets past experiences and their current functioning in therapy (Vilig, 2016), a single client was investigated using a semi-structured interview and standardized instruments for assessing affective attachment. Additional data were collected through an interview with the therapist to assess the level of resistance, affective style, and the quality of the therapeutic relationship. The instruments used included the Experiences in Close Relationships – Revised (ECR-R) scale and the Relationship Questionnaire (RQ), while a semi-structured interview on resistance in therapy was specifically developed for the purposes of this study. The data were analyzed using a descriptive phenomenological method, with a focus on understanding the subjective experience of resistance and the therapeutic relationship. ECR-R results were processed in SPSS 26 through recoding and calculation of summative scores. The study was conducted over the course of one week, across two sessions (first, administration of questionnaires and interview with the therapist; second, interview with the client). The aim of the study was to examine how patterns of affective attachment influence the manifestation of resistance and the therapist's experience, thereby contributing to a better understanding of the relationship between early experiences and the psychotherapeutic process.

3. ANALYSIS

3.1 Interview analysis

In the following section, we present the transcripts of interviews conducted with the therapist and the client using a semi-structured interview format. Questions are displayed on the left, with participants' responses on the right. The therapist interview is presented first, followed by the client interview. During the client interview, attention was also paid to nonverbal communication. Questions were formulated in the same manner for both the client and the therapist; the only difference being that the client also completed questionnaires to aid in the interpretation of their responses. The aim was to gather as much information as possible about pre-existing beliefs in the present, which are closely associated with the individual's characteristic pattern of affective attachment.

Tabela 1

1. What does resistance in therapeutic work mean to you?	- Well, a process that helps me change a part of myself that has been forgotten or left unfinished, which will most likely, by addressing it, allow me to approach the client's problem more effectively
2. How do you experience it? Through your body? Emotions? Thoughts? Behavior?	- Through thoughts.

3. How do you know when you are experiencing resistance? Through which signs or experiences?	- Rapid shifts in associations and the flow of thoughts, rational thinking in difficult situations, as if I lack empathy; behaviorally, I do not show major changes because I am careful that the client does not notice any agitation or insecurity.
4 What is the dominant source of knowledge about resistance within yourself?	- Fear.
5. What caused the greatest resistance in working with this client? Did you communicate it? If not, what prevented you from saying it? What, if any, was a specific resistance in working with this particular client?	- A problem we could not resolve on multiple occasions. I did not communicate it, as the thought that doing so would not help her overcome the problem prevented me. The specific resistance in this work was that I could not accept that she could not overcome the mentioned problem.
6. Did you associate the experience of resistance in working with this client with any of your personal previous processes, such as childhood images or experiences, relationships with your father or mother?	- Yes, with some childhood stubbornness. With my mother on several occasions, because I behaved similarly toward her at times.
7. Did you relate the experience of resistance to your personal political, ethical, or socially influenced attitudes?	- Yes.
8. Did you relate the experience of resistance to an understanding of social position, and in that context, the acceptance/non-acceptance of your client (e.g., homosexuality, lesbianism, sex work, macro-level issues, abuse of women or men, domestic or street violence)?	- No.

In the therapist interview presented in Table 1, it is evident that the therapist openly discusses her own resistance toward the client, demonstrating a high level of self-awareness and conscientiousness. She understands the process of resistance and uses it as an opportunity to gain deeper insight into herself. Furthermore, she references personal childhood experiences, revealing the roots of her resistance. The therapist perceives resistance primarily cognitively, noting a reduction in psychological space for understanding the other person, or for empathy. When describing her experience of resistance, she highlights behavioral patterns from her own childhood, particularly instances of stubbornness in her relationship with her mother. She identifies the source of her resistance as frustration over the client's repeated inability to resolve a particular problem. Additionally, the therapist notes that resistance is connected to certain personal attitudes, whether political, ethical, or social-though she does not elaborate in detail. Overall, the therapist demonstrates a secure and consistent behavioral pattern.

Tabela 2

1. What does resistance in therapy mean to you?	- Currently, it is everything I do not have the courage to talk about with the therapist.
2. How do you experience it? Through your body? Emotions? Thoughts? Behavior?	- Most often, I experience it physically through my body.
3. How do you know when you are experiencing resistance? Through which signs or experiences?	- The upper part of my body begins to bend and contract; I feel as though I am creating a protective "membrane" that prevents my resistance from disappearing, since it always serves some purpose.
4. What do you consider the dominant source of knowledge about resistance within yourself?	-Shame.
5. What caused the greatest resistance in working with this client? Did you communicate it? If not, what prevented you from saying it? What, if any, was a specific resistance in working with this particular client?	- I do NOT wish to discuss it here, but I always try, once I become aware of it, to inform the therapist that it exists, even though I currently do not want to address it.
6. Did you associate the experience of resistance with your personal previous processes, such as childhood images or experiences, relationships with your father or mother?	-Yes.
7. Did you relate the experience of resistance to your personal political, ethical, or socially influenced attitudes?	-Yes.
8. Did you relate the experience of resistance to your social identity or experiences of acceptance/rejection (e.g., gender, sexuality, social status, exposure to abuse)?	-Yes.

The client responded positively to the invitation to participate in the study. However, during the interview, the participant appeared reserved, providing laconic answers while displaying anxiety nonverbally. The dominant emotion associated with the client's resistance is shame, which manifests as withdrawal in the therapeutic process and may impede progress, a fact of which the client is aware. In experiencing resistance, the client responds physically, curling into a fetal position as a defense against both the surge of uncomfortable emotions and the therapist. The secondary benefit

of resistance is recognized by the client, yet despite this awareness, they are unable to overcome it. The client acknowledges the resistance and associates it with childhood experiences, although the precise nature of these relationships remains unclear from the responses. Furthermore, the client perceives that personal attitudes and social position play a significant role in the therapeutic relationship and thus influence the experience of resistance.

.3.2 Psychological Questionnaires

In order to provide a more detailed explanation of the relationship between the variable of affective attachment and resistance in therapeutic work, we administered the ECR-R and RQ assessments.

ECR-R

Table 3 presents the results obtained using the ECR-R, calculated by dividing the raw scores by 18 for each respective subscale. Based on these scores, the client was classified into one of four affective attachment patterns (Bartholomew & Horowitz, 1991) - secure, preoccupied, avoiding, or disorganized, according to the parameters described earlier (see Section 2.3: Interview and Psychological Tests). Given that the participant is female, normative values for this subgroup were applied: Anxiety: M = 3.56, SD = 1.13; Avoidance: M = 2.92, SD = 1.21.

Tabela 3

Dimension	Score
Anxiety	4.05
Avoidance	2.66

According to the results presented in Table 3, the client demonstrated an elevated score on the Anxiety subscale compared to the normative group, while the score on the Avoidance subscale was slightly below the average for the female subsample. Accordingly, the client can be provisionally classified within the affective attachment pattern known as “anxious/ambivalent” or “preoccupied” attachment.

RQ

This questionnaire provides indications of the extent to which the participant identifies with the descriptions of the four affective attachment patterns (Bartholomew & Horowitz, 1991). On a scale from 1 to 7, the client’s responses ranged between 3 and 6, reflecting personality insecurity alongside a tendency toward security. The client rated the secure attachment style highest (6), followed by the preoccupied attachment style (5). The avoidant attachment style received a score of 4, while the disorganized attachment style was rated lowest (3). These results reflect the client’s self-assessment, which may not necessarily correspond to her actual attachment pattern but rather to her subjective perception of herself.

4. DISCUSSION

This study aimed to investigate whether and how basic affective attachment influences the client’s experience of resistance, the therapist, and the therapeutic relationship. More specifically, it examined how relationships formed in the primary environment, primarily within the family, affect the nature of resistance that emerges during the therapeutic process. The theoretical framework employed in this study was primarily psychoanalytic theory, along with related theoretical approaches.

The client is a 25-year-old female who has been engaged in an active psychotherapeutic relationship for nearly two years. The primary reason for selecting this client was the long-term nature of her therapy, which allowed for the development of a deeper therapeutic relationship in which the emergence of psychological resistance, as a natural byproduct of the therapeutic process, was to be expected.

To obtain answers to these questions, we employed interviews and psychological questionnaires as the primary analytical techniques. The interview used in this study focused on resistance in psychotherapy, while two questionnaires were administered: the Experiences in Close Relationships-Revised (ECR-R) and the Relationship Questionnaire (RQ). The interview and questionnaires were administered to the client in a single session, and the same procedure was followed for the therapist. The sessions took place in private settings: the client's session was conducted in the researcher's apartment, while the therapist's session took place in their office.

During the assessment, no major difficulties or ambiguities arose, and the process proceeded without significant difficulties. The client appeared visibly anxious when responding to questions, which contributed to the laconic answers presented in Table 1. The researcher primarily observed nonverbal signs of anxiety, such as gaze aversion and foot tapping. In contrast, the therapist was open to communication, confident in providing responses, and highly assertive. By analyzing the responses from the client and therapist interviews, we can unequivocally conclude that mutual resistance was present at the time of assessment, although the nature and intensity of resistance differed considerably. On one hand, the therapist exhibited resistance patterns reflecting childhood experiences, drawing a parallel with affective attachment in the primary group. On the other hand, such information regarding the client could not be fully obtained due to her reservedness, despite her positive response to the specific question on this topic. In psychoanalytic terms, the therapist exhibited the third form of resistance (Freud, 1914), which manifested as a behavioral pattern originating in childhood toward parental authority and now directed toward the client. Freud (1914) characterizes the pattern of resistance observed in the client as a form of avoidance in confronting unpleasant content. In the case of the client, resistance manifests in multiple ways: a) through refusal to discuss the topic with the therapist, perceiving it as intimidating, and b) through a physiological response to feelings of shame arising from resistance, expressed as muscle spasms and curling into a fetal position. This type of client response evoked in the therapist the sense that the problem was too overwhelming to be resolved through conversation alone, leading the therapist to avoid it, which in turn reinforced the resistance within their relationship. Given that the central emotion was shame, we consider that the client required an open approach with a high degree of empathy. However, this was not fully achievable, as the therapist's resistance resulted in a diminished capacity for empathy toward the client. Although the client indicated that their resistance is related to patterns formed in childhood, they did not elaborate on the reasons for this perspective. Nevertheless, as we will see later, we believe that this question can be addressed through analysis of the data obtained from the ECR-R and RQ questionnaires, which support a preoccupied affective attachment pattern. It is important to note that the client's behavioral patterns are consistent with Reich's (Reich, 1933) assertions, more precisely with the observation that resistance emerges in the form of behavioral reactions representing residues of inadequate relationships with figures from the primary group (familyIn light of transactional theory, we emphasize that the client's pattern of resistance resonates with the first form outlined in the Introduction, as we observe that the participant demonstrated a high level of anxiety (also reflected in the findings of the ECR-R scale). Furthermore, the feeling of reluctance to openly discuss the source of resistance with the therapist may be interpreted as the client's position that the potential benefits of change do not lead to psychological fulfillment but rather, as suggested in the theoretical framework, to a sense of psychological emptiness.

According to the ECR-R questionnaire results presented in the Analysis section of this study, the client falls within the anxious/ambivalent attachment pattern. A characteristic description of this attachment style is that individuals tend to form symbiotic relationships in order to reduce feelings of discomfort caused by the unpredictability of others, achieve a sense of perceived control, and ensure that their partner will not abandon them. As individuals tend to maintain such an attachment pattern into adulthood, we may assume that it has also influenced the relationship the client in this study has developed with her therapist. Within this framework, we identify possible reasons for the experience of shame and the reduced motivation to overcome resistance, as resistance may provide psychological benefits by allowing the client to remain in a symbiotic relationship with the therapist. Specifically, the client remains in a submissive position in relation to the therapist, which, in turn, places the therapist in the role of a parental figure supervising the client. In this way, the client secures an illusion of control similar to that achieved by a child in relation to their parents. Although the client expresses a desire to open up to the therapist, she also reports experiencing certain benefits from resistance and indicates a lack of willingness to change in this domain. This constitutes the primary basis for the argumentation presented earlier.

Regarding the results obtained from the RQ scale, the participant identified primarily with a secure attachment style. The fundamental characteristic of this pattern is the absence of anxiety, as the primary caregiver was consistently available to the child, allowing the development of trust and the expectation that the caregiver would not abandon them even during temporary separations. At the very beginning of the analysis, a contradiction becomes evident in the client's responses, as two diametrically opposed attachment styles were rated with nearly identical scores: the secure style received a rating of 6, while the preoccupied style was rated 5. This suggests the presence of a conscious tendency toward a secure attachment style, or a conscious self-perception aligned with security, alongside an acknowledgment of the preoccupied pattern, which represents the primary finding of the ECR-R scale. As this reflects a conflict between the conscious aspect of the Self and the client's actual behavioral patterns, the rating of the secure attachment style will be interpreted as the client's aspiration, while the preoccupied style will be treated as the dominant behavioral pattern. Consequently, there is partial convergence between the findings of these two scales, which meaningfully correspond with the results obtained through the semi-structured interview. Unfortunately, we did not obtain a more elaborate explanation of the client's views regarding her conscious perception of attachment styles. Nevertheless, there are strong indications that the client will primarily rely on the preoccupied attachment pattern as a prototype for future relationships and, most relevant to this study, within the therapeutic relationship itself.

Divergent behavioral patterns - resistances, were unequivocally observed within the dyadic space between the therapist and the client. As previously noted, their nature and underlying causes were, as expected, entirely different. In the therapist, resistance emerged from a personal sense of incompetence projected onto the client, manifested as the client's perceived inability to overcome the problem, which further evoked stubbornness and corresponding emotional reactions in the therapist. However, the therapist does not exhibit behavioral reactions (a claim based solely on self-report, not verified within the therapeutic setting), which in this case is advantageous, as such behavior could have triggered a negative spiral within the already sensitive relationship. Conversely, the client behaves consistently with her attachment pattern, applying it within the therapeutic relationship, which ultimately also shapes the nature of the resistance observed. The preoccupied type of attachment develops within the primary group, indicating that the client, due to inconsistent parental behavior, developed a form of insecurity manifested through anxious symptoms. This attachment pattern was also applied within the therapeutic relationship, resulting in the therapist assuming a parental role, with whom the client seeks to establish a symbiotic bond. In this context, resistance serves to maintain the relationship, and the client herself

recognizes its secondary benefits. Simply informing the therapist that the resistance exists, followed by a lack of willingness to overcome it, evokes in the therapist a sense of frustration and, according to the therapist, stubbornness, which can be interpreted as an infantilized form of manipulation on the part of the client. In this "stalemate position," it becomes clear how the client uses resistance as a means of maintaining a symbiotic relationship with the therapist. The secondary benefits of resistance, whether consciously or unconsciously experienced by the client, include a sense of control over the situation and affirmation of self-worth within the relationship. The therapist, on the other hand, reacts with frustration and stubbornness, which further reinforces the interaction pattern and reflects previously described patterns of attachment and psychodynamic theories of resistance.

4.1 Critical reflection

The qualitative nature of this study allowed us to take an analytical approach to the issue of resistance and to capture the essence of this phenomenon within a concrete case study. We believe that we have adequately addressed the research questions posed and that, through this study, we have deepened existing knowledge about the phenomenology of resistance in the psychotherapeutic relationship. A reflection on the study itself highlights several limitations.

Primarily, our understanding of resistance is obtained indirectly, through a semi-structured interview that was not validated and was developed specifically for this research. Additionally, we consider that the small number of questions left certain gaps in explaining the very causes of resistance; however, for the purposes of this study, we still had sufficient material to draw justified conclusions. The freedom of interpretation is a fundamental aspect of the qualitative approach, and we endeavored to rely as much as possible on the theoretical framework of psychoanalytic and related theories. We consider that attachment styles permeate all therapeutic relationships and represent a critical construct in analyzing any therapeutic process, particularly the phenomenon of resistance. We believe that it would be desirable for future research to focus on the direct analysis of resistance, within the psychotherapy process itself, and to connect it with the construct of attachment, in order to gain a deeper understanding of their interrelations.

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