

VIEWING AMBIVALENCE FROM A SOCIOLOGICAL PERSPECTIVE: IMPLICATIONS FOR PSYCHOTHERAPISTS

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*Ambivalence refers to the experience of simultaneous positive and negative affect toward the same person, object, or behavior that draws us in opposite directions and leads to some level of phenomenological discomfort. In psychology, ambivalence traditionally has been viewed as arising from intrapersonal conflict, that is conflict between dissonant cognitions or divided aspects of the self. Although reasonable, this explanation overlooks a larger factor. In sociology, ambivalence has been viewed as arising at the level of social structure when an individual in a particular social relation experiences contradictory demands or norms that cannot be simultaneously expressed in behavior. Sociologists have suggested that various structural attributes of the professional relationship itself can engender ambivalence on the part of clients. The present article reviews four of these structural attributes as they*

*pertain to the client-therapist relationship and outlines a number of strategies that clinicians can employ to ameliorate the adverse effects of the sociological ambivalence that can result.*

Human beings often experience coexistent positive and negative affect toward the same person, object, or behavior. This experience of being "of two minds," of bipolarity, of vacillation, of the dialectic push and pull of internal conflict is commonly referred to as ambivalence. Although the term was first coined by Blueler early in the 20th century (1910) and given conceptual force in Freud's work (e.g., 1922), the experience of being pulled in psychologically opposed directions is as old as recorded history and is addressed in both Eastern and Western philosophies.

The yin and yang of Taoistic philosophy have long been used to depict the essential bipolarity of existence, the interaction of opposites in nature as symbolized by a divided circle (Merloo, 1954). In Zen Buddhism, the vacillation and bipolarity of the human experience is understood according to the principle of samsara—the vicious cycle of existence, of getting caught up in worry and fear and hope, of wanting and not wanting, of trying to get away from pain by seeking pleasure (Chodron, 1991). In the Western tradition, theologians have long pointed to Jesus' sufferings in the garden of Gethsemane, where he wrestled with his decision whether to run away or face the anticipated death that awaited him, as a paradigmatic example of the emotional tug-of-war of ambivalence (Weigert, 1991). Seventeenth century secular philosophers and essayists such as Montaigne and Pascal also wrote extensively about a wide range of ambivalent experiences (Merton & Barber, 1963).

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Although musings on the nature of ambivalence are as old as human thinking and feeling, over the past 30 years, interest in ambivalence as a descriptive and explanatory construct has been largely absent in mainstream psychology. Few subject indices of contemporary textbooks on cognitive, social, industrial-organizational, or clinical psychology mention ambivalence, and it has faded from texts on motivation and judgment and decision-making. One likely reason that empirical and theoretical attention to the construct of ambivalence eroded over the past half century is that the field underwent significant, some would say, paradigmatic, shifts during this time period. The "behavioral revolution" of the 1950s and 1960s, and the "cognitive revolution" of the 1970s and 1980s shifted focus of the study of human behavior onto observable stimuli and responses, and later onto exploring the parallels between human cognition and computerized information processing.

Miller and Rollnick (1991) brought the construct of ambivalence back into the mainstream of psychological thinking in their seminal work on preparing people to change addictive behavior. They pointed out that the "oft-discussed problem of motivation" in addictions can best be understood as a manifestation of client ambivalence (cf. Davies, 1979). They developed Motivational Interviewing (MI), a brief intervention with the explicit goal of helping clients work through ambivalence about making a change (Miller & Rollnick, 1991). This type of motivational approach is readily adaptable for clients presenting for treatment for a variety of psychological problems other than substance abuse (e.g., Walitzer, Dermen, & Connors, 1999).

In the MI approach, as in classical psychoanalytic theory, ambivalence is hypothesized to stem from the level of individual intrapsychic processes. For example, Miller and Rollnick (1991) postulated that ambivalence can arise from approach-avoidance conflict, cognitive dissonance, or psychological reactance. Other theorists have developed the idea that ambivalence can arise from a divided sense of self. The following section briefly outlines each of these intrapersonal mechanisms by which the experience of ambivalence is thought to arise.

### **Intrapersonal Ambivalence**

#### *Approach-Avoidance Conflict*

Social psychologists define intrapersonal conflict as "a state that obtains for an individual when

he is motivated to make two or more mutually incompatible responses" (Jones & Gerard, 1967, p. 709), and these authors have devised a typology of different kinds of conflict that an individual might experience. Conflict may be between two desirable responses (approach-approach conflict), or two undesirable responses (avoidance-avoidance conflict). However, the type of conflict thought to engender ambivalence is known as the "approach-avoidance conflict," one in which a person is both attracted to and repelled by a single object (cf. Miller, 1944). As Orford (1985) and Miller and Rollnick (1991) pointed out, in this type of conflict, the individual alternately indulges in and resists the problematic behavior, resulting in the type of "yo-yo effect" or vacillation that is characteristic of the behavior of the ambivalent client.

#### *Cognitive Dissonance*

Festinger (1957) proposed that people strive for consistency between their cognitions, defined broadly as "pieces of knowledge," including their beliefs, attitudes, emotions, values, or behaviors. Cognitive dissonance theory postulates that individuals who discover inconsistency between cognitions experience a state of uncomfortable psychological tension (dissonance) that has drive-reduction effects similar to hunger or thirst. This unpleasant dissonance motivates the individual to restore consistency. From this perspective, ambivalence is a manifestation of cognitive dissonance; the ambivalent client simultaneously holds two contradictory cognitions and experiences phenomenological discomfort as he or she vacillates between the two.

#### *Divided Sense of Self*

Another intrapersonal mechanism that might give rise to the experience of ambivalence is conflict between different parts of the client's sense of self. Individuals often describe their phenomenological experience of ambivalence as the interaction between aspects of different selves, different minds, or more neutrally different interests (Elster & Skog, 1999). For example, a client may report that "part of me really loves my husband, but there is also a part of me that feels very hostile towards him," or that "on the one hand, I realize I need to stop drinking, but on the other hand, there is a part of me that really wants to go on a bender."

Classical psychoanalytic theory follows from this conceptualization; id, ego, and superego in-

teract within the individual to cause intrapsychic conflict that can be experienced as ambivalence. Contemporary psychodynamic theorists and practitioners also remain focally concerned with issues of internal conflict often discussed in terms of client resistance, namely "... the track of the patient's conflict about changing, the way in which the sincere desire to change confronts the fears, misconceptions, and prior adaptive strategies that make change difficult" (Wachtel, 1982, p. xix). Similarly, Perls (1969) embraced the notion of a divided sense of self as a source of ambivalence and psychological distress and saw the primary therapeutic task of gestalt therapy as one of first raising a client's awareness of and then integrating disparate parts of the self.

These mechanisms of approach-avoidance conflict, cognitive dissonance, and a divided sense of self all share one common feature; they are all thought to engender ambivalence at the intrapersonal level of analysis. However, as Lewin (1951) pointed out, human experience and behavior do not occur in a vacuum but rather in a "field of forces" that includes the influence of other individuals and society at large. It stands to reason then that ambivalence might be caused not only by process occurring within the individual but might also arise at the level of social structure. Over 30 years ago, sociologists Merton and Barber (1963) outlined an influential theory of sociological ambivalence that made just this assertion, proposing that ambivalence might arise not only from conflict internal to the individual, but also from conflict between various social roles and social statuses.

### Sociological Ambivalence

"In its most extended sense, sociological ambivalence refers to incompatible normative expectations of attitudes, beliefs, and behavior assigned to a status (i.e., a social position) or to a set of statuses in society" (Merton & Barber, 1963, p. 6). From this perspective, ambivalence arises when an individual in a particular social relation experiences contradictory demands or norms that cannot be simultaneously expressed in behavior. Consequently, the contradictory demands are expressed in an oscillation of behaviors. Merton and Barber's (1963) paradigmatic example of sociological ambivalence is the occupation of physician, one whose contradictory roles of objective scientist and empathic healer cause oscillation between the behaviors of detachment and compas-

sion, of discipline and permissiveness, and of personal and impersonal treatment.

Merton and Barber (1963) also suggested that there are essential characteristics of any institutionalized professional relationship that inherently cause clients to experience ambivalent feelings toward the profession. In their words, there are various sources of ambivalence "... located in the normative structure of the relations between client and professional that affect the role behavior of both" (p. 23). Attitudes about therapists by clients and about clients by therapists in terms of social norms are where sociological ambivalence may occur. Merton and Barber (1963) described the normative structure of the professional relationship in terms of different attributes that may engender ambivalence on the part of clients.

The first structural attribute they described is the *attribute of continuity*; "The relationship between a professional and a client is normatively presumed to be of indefinite duration, to involve enduring though intermittent interaction between the same people" (p. 24). This attribute of continuity is certainly well justified. After all, we would not want to see a physician who was not intimately familiar with our medical history, nor an attorney who did not know the facts of our case, not to mention a psychologist with whom we had not had the opportunity to build a productive therapeutic alliance. Although this norm prescribing a continued relationship can be advantageous, Merton and Barber (1963) pointed out that it also provides the basis for accumulation of client ambivalence toward the professional because it can serve to constrain the client to continue the relationship long after he or she has become dissatisfied with it.

This hypothesis nicely complements Smelser's (1998) more recent theory of sociological ambivalence. Smelser's general proposition is that dependence (i.e., situations in which choice is restricted because of political, ideological, or emotional costs) breeds ambivalence. He pointed out that an element of entrapment, be it found in romantic relationships, "total institutions" (e.g., military camps, boarding schools), or groups or organizations that demand commitment, adherence, and faithfulness from their members (e.g., churches, unions, minority groups) can engender feelings of ambivalence. This argument can be easily extended to the professional client-therapist relationship. As when one is in a long-term romantic relationship or is an active member

For a church or a labor union, clients in psychotherapy may not perceive themselves as having the freedom to leave. Clients may remain "enapped" in an ongoing therapeutic relationship because they are afraid of the emotional, psychological, or ideological cost that they would have to bear should they choose to leave. This element of entrapment may in turn engender feelings of ambivalence toward the therapist.

The *attribute of professional authority* also fosters the accumulation of client ambivalence toward the professional (Merton & Barber, 1963). Professionals clearly have a legitimate authority to prescribe action for their clients by virtue of their special competence. "But however great its legitimacy, authority is known to have a high potential for creating ambivalence among those subject to it. Authority generates a mixture of respect, love and admiration, and of fear, hatred, and sometimes contempt" (Merton & Barber, 1963, p. 26). However benevolent their intent, in medicine, law, and psychotherapy, the authority of the professional can be an agent of frustration; "The client may be required to abandon favored practices or values. He may be required to live a more limited version of his former life . . . He may be asked to change his eating habits or his work habits, to give up claims to property, or to turn his attention from interests that have long had meaning for him to new activities which he finds thoroughly uninteresting although they are said to be good for him" (Merton & Barber, 1963, p. 26). Thus, by virtue of their inherent authority, even when professionals are acting benevolently, appropriately, and within the bounds of behavior prescribed by their role, they can nevertheless engender client ambivalence.

A third attribute of the client-professional relationship that might engender ambivalence is thought to arise due to *perceptions of the professionals' self-interest*, the suspicion that the professional may be using his or her authority in their own interest to "live off" the troubles of their clients. Merton and Barber (1963) identified a number of factors thought to converge to produce this suspicion: "First, the client typically lacks specialized knowledge to judge the aptness of the professional's decisions. Second, anxiety about his or her fate tends to distort the client's appraisal of what is being done. Third, since it is often (not always) the case that a professional stands to gain from the continuation of the clients' troubles, the task of gauging the therapist's motivations is com-

plicated. Fourth, the frustrations imposed upon the client by the professional tend to skew the client's interpretation of even the most disinterested activities of the professional toward being seen as self-interested" (p. 27).

The fourth and final structural attribute that Merton and Barber (1963) proposed is ambivalence that arises from *differences in performance appraisal*, the fact that clients and professionals have different ways in which they appraise the professional's performance. Because laypeople typically lack any other reference point, they appraise professional performance in terms of whether it succeeds or fails to solve the problem that they present, that is, they appraise performance in terms of ideal outcomes. Professionals on the other hand, have a different appreciation of the context in which their work takes place, and thus judge their own performance in relative terms for example, comparing a particular client's progress relative to that of other clients with similar presenting problems. This status-based discrepancy in performance criteria may be another source of ambivalence toward the professional who may have failed to "fix" a client's problem, even though he or she may have done all that was possible under the circumstances.

#### **Addressing Sociological Ambivalence in the Therapeutic Relationship**

A number of psychotherapeutic approaches (e.g., MI and psychodynamic and humanistic theoretical orientations) outline strategies that are either explicitly or implicitly intended to address client ambivalence arising from intrapersonal conflict (e.g., Binder, 1999; Miller & Rollnick, 1991; Perls, 1969). To date, however, there have been no systematic attempts to articulate how best to work with client ambivalence that might arise from structural attributes of the professional relationship (i.e., the therapeutic relationship itself). The remainder of this article focuses on sociological ambivalence in the client-therapist relationship, and what can be done to ameliorate its adverse effects.

#### *The Attribute of Continuity*

Although psychologists have made much progress in recent years in developing brief interventions for the treatment of substance abuse and other psychiatric disorders (e.g., Cummings, Budman, & Thomas, 1998; Heather, 1989), psychotherapy is traditionally conducted in the con-

text of a long-term, ongoing relationship. Consequently, the attribute of continuity is a necessary ingredient in most psychotherapeutic relationships. The task at hand then is to identify steps that the clinician can take to prevent this attribute of continuity from causing an accumulation of client ambivalence toward the professional.

Generally speaking, the primary means of precluding the attribute of continuity from fostering the accumulation of client ambivalence is to nurture clients' feelings of autonomy and freedom of choice. Recall that the experience of ambivalence is understood by cognitive dissonance theorists as a manifestation of the uncomfortable state of tension that arises when individuals discover inconsistency in their beliefs, attitudes, emotions, values, or behaviors. Therefore, dissonance may arise when clients feel as if they are not getting what they want out of therapy, but nonetheless feel trapped in a continuing relationship with the therapist.

According to cognitive dissonance theorists (e.g., Brehm, 1962; Festinger, 1964), "a necessary condition for dissonance reduction is the decision maker's realization that he has made a choice freely . . ." (Janis & Mann, 1977, p. 247). A practicing clinician can do a number of things to help remind clients that they remain in therapy and with their chosen therapist of their own free will and for their own benefit. One is of course to explicitly remind clients that this is "their therapy," and to periodically invite client input about the experience, whether they think that their goals are being met, and so on. Another means of addressing the attribute of continuity is to process termination issues in an ongoing fashion. As therapists allow discussion of termination issues, the ongoing nature of the relationship is less likely to become a source of ambivalence for the client.

Making the relationship explicitly time limited can also be a useful strategy. Therapist and client may come to an agreement upon entering a relationship that it will be of a defined duration. The limited duration of the relationship may be motivated by economic reasons (e.g., an HMO indicates that it will only reimburse the client for six sessions) or theoretical reasons (e.g., Time-Limited Psychodynamic Therapy; Binder, 1999; Binder, Strupp, & Henry, 1995; Interpersonal Therapy; Markowitz, 1997). In either case, explicit agreement on the duration of the relationship at the beginning of therapy can preclude the accumulation of ambivalence by reducing uncer-

tainty about this aspect of the relationship. However, making the therapy explicitly time limited might also have the untoward effect of actually causing *more* client ambivalence. Unless this issue is processed thoroughly and openly, clients in time-limited therapy might feel ambivalence about trusting and working closely with their therapists because they know that they will be forced to end the relationship.

When entering relationships that are not explicitly time limited, a related means of precluding the accumulation of ambivalence toward the therapist is to suggest that the client agree to meet for a limited number of sessions, after which both therapist and client will discuss their perceptions of the progress that has been made, and the usefulness of continuing their relationship. The therapist might also address this issue directly during the intake session by asking the client to discuss what he or she expects to accomplish in therapy, indicating what the therapist as a professional is able to offer, and then deciding collectively at the end of the session whether it makes sense to continue the relationship.

#### *The Attribute of Authority*

Brehm's (1966) reactance theory offers one explanation of why authoritarian relationships might breed ambivalence. This extension of cognitive-dissonance theory posits that when individuals' freedom to perform certain behaviors is threatened or eliminated, they are motivated to regain their freedom and thus decrease their cognitive dissonance. Brehm (1966) and Wicklund (1974) found that when freedom is threatened, people do whatever they can to reinstate it, including openly refusing to comply despite pressure, behaving aggressively toward the agent of coercion, or subtly acting in ways that are contrary to what is demanded (Janis & Mann, 1977). This theory explains why using confrontational tactics in working with ambivalence (i.e., arguing with clients about their need for change and coming down strongly on one side of their ambivalence) is often ineffective and even counterproductive (see Miller & Rollnick, 1991).

Psychologists have long appreciated the deleterious effects that the attribute of professional authority can have on the therapeutic relationship. In fact, humanistic schools of psychotherapy, for example gestalt therapy (Perls, 1969), and client-centered psychotherapy (Rogers, 1951, 1961), have a profound appreciation of how authority

can generate a mixture of respect, love, fear, and hatred. It stands to reason that therapists who cultivate a relationship based on genuineness, empathy, and acceptance and treat their clients as persons of unconditional self-worth, engender far less ambivalence and frustration than therapists with a more authoritarian, directive, or prescriptive style. In fact, the importance of genuineness, acceptance, and empathy for a successful and productive therapeutic relationship have been supported by over 30 years of research (Bergin & Garfield, 1994).

However, regardless of how genuine, accepting, and empathic the client-therapist relationship can be, it remains at its core a professional relationship. Being humanistic or Rogerian does not make the therapeutic relationship an egalitarian one. After all, clients come to clinicians' offices and pay them for their services, not the other way around. Although nurturing a humanistic relationship with our clients can help mitigate the attribute of authority, our professional social role as therapists dictates that ambivalence arising from this source can never be completely eliminated.

In fact, the attribute of professional authority can prove quite useful at times, for example when conducting structured cognitive-behavioral interventions. Even then, however, it is wise to match the topic of conversation, the strategy used, and the therapeutic stance to the shifting needs of the client (see Rollnick, 1998). Being genuine, accepting, and empathic does not mean that one cannot sometimes be structured and directive. However, it does mean that one must be careful to tailor the therapeutic atmosphere and content to where the client is at the moment.

This process of matching therapeutic content and process to "where the client is at" can be understood from a number of theoretical perspectives. From the perspective of the transtheoretical model (cf. Prochaska & DiClemente, 1982), therapists should match their interventions to clients' momentary stage of change. For example, one might be more directive with a client in the "action" stage than with one who is in the "precontemplation" stage. From the psychodynamic perspective, the therapist might match intervention to "where the client is at" by attending to client resistance as it manifests itself in the transference relationship (see Basch, 1982; Gill, 1981). For example, if the therapist encounters significant resistance around a particular issue, he or she is wise to slow down and make an appropriate

interpretation, rather than forge ahead with other work.

Regardless of the therapist's theoretical orientation, clients are sometimes quite receptive to a structured intervention and, because of this receptivity, implementing such an intervention will not generate ambivalence because it is not perceived as authoritarian. Other times, however, when clients do evidence ambivalence in session, the clinician is wise to shift the focus of the session back to the relationship and to refrain from engaging in structured, directive work.

#### *Perceptions of Therapist Self-Interest*

The third attribute of the professional relationship that Merton and Barber (1963) suggested might engender client ambivalence is the suspicion that the professional may use the therapeutic relationship to "live off" the troubles of their clients. This suspicion is certainly understandable. Like any other professional, a psychotherapist without clients would not be able to remain in practice for long.

Although clients' perceptions that their therapists act in their own self-interest is understandable, it is not wholly accurate. Whether the goal of the therapy for the client is to achieve symptom reduction, eliminate or control addictive behavior, learn new skills, adapt to new life situations, or gain valuable insight into the etiology of current problems, most therapists want what is best for their clients. How then can practicing clinicians prevent clients' perceptions of them as being self-interested from causing an accumulation of ambivalence that could have an adverse impact on the therapeutic alliance?

One way to address this issue directly is by explicitly focusing the initial therapy sessions on the identification of mutually agreed-upon goals. By working with the client to identify the goals of therapy, the therapist can address a number of the factors that reduce suspicion that the therapist is acting in his or her own self interest. First, because clients know the direction in which the therapy is headed, they are better able to judge whether their therapists' actions are being taken in their own best interests, that is, whether each decision will take them closer or farther away from their own goals. Second, by having full knowledge of the goals of therapy, as well as information about the steps needed in order to achieve those goals, clients are likely to experience less anxiety about their fate. Third, by mak-

ing the goals of therapy explicit, clients are more likely to come to see how short-term demands and discomfort imposed upon them by their therapists are instrumental in helping them attain their own goals, rather than allowing these frustrations to skew their interpretation of their therapists' activities as being self-interested.

A second general approach to precluding the accumulation of ambivalence arising from this attribute of the professional relationship was outlined in the preceding discussion of the attribute of continuity; namely, making the therapeutic relationship explicitly time-limited. From the client's perspective, the primary manifestation of therapist self-interest is likely to be the continuing nature of the relationship, that is, that the therapist stands to gain financially from the continuation of the relationship beyond the point at which the client has received maximal benefit. By making an agreement to limit the therapy to a certain number of sessions, or to agree to discuss the progress that has been made after a certain number of sessions, this source of ambivalence is substantially reduced.

A third means of addressing this source of sociological ambivalence in the client-therapist relationship is to bring up the issue of therapist self-interest during therapy. Although this may be difficult to do artfully, bringing the issue up directly allows the client to express any ambivalence, frustration, or resentment toward the therapist that may have accumulated regarding actions perceived as being in the therapist's own self-interest. There are certainly clinicians whose theoretical orientation or individual therapeutic style makes this type of direct approach untenable. In such cases, the clinician is advised to simply be aware of how clients' perceptions of therapist self-interest might cause an accumulation of ambivalence and to intervene as appropriate. For example, those who work from a psychodynamic or psychoanalytic perspective might look for evidence of ambivalence in the transference relationship and make interpretations about it when appropriate.

#### *Differences in Performance Appraisal*

The fourth and final attribute of the professional relationship that Merton and Barber (1963) identified as a potential source of client ambivalence is that client and professional each appraise the professional's performance differently. Because they lack any other reference point, clients typi-

cally judge professionals' performance in terms of ideal outcomes: for example, "Did she make my depression go away?" or "Did she get my husband to stop nagging me so much?" In contrast, the clinical experience of professionals, as well as their access to the empirical literature, provides a different context in which to judge their own performance: for example, "Did his score on the Beck Depression Inventory improve over the past four sessions?" or "Has this couple demonstrated that they are learning the communication skills that I have been teaching them?" Furthermore, clinicians typically have had experience working with other clients who present similar problems and are thus able to compare a particular client's progress to that of previous clients: for example, "Has her depression improved as Mr. X's did after four sessions?" or "Has this couple acquired about the same level of communication skills as Mr. and Mrs. Y, whom I treated with the same intervention?"

Setting mutually agreed-upon therapeutic goals can preclude ambivalence that might arise due to differences in performance appraisal. When the goals of therapy are explicit and transparent, the client and therapist share criteria by which to judge whether the therapy is working for them and consequently whether they both think that the therapist is doing a good job. Goal-setting provides the client and therapist with a shared reference point so that the client is not forced to judge the therapist relative to some ideal outcome. Both long-term goals of the therapy and short-term goals that are necessary in order to achieve them can be explicitly discussed throughout the therapy as means of ensuring that this source of ambivalence does not compromise the therapeutic relationship.

#### *Ambivalence Arising from Other Sources*

An exploration of sources of ambivalence in the client-therapist relationship would not be complete without an open acknowledgment of the fact that clients can feel ambivalent about their therapists for entirely legitimate reasons having nothing to do with attributes of the client-therapist relationship. Therapists are human, and as such, have their own ego needs and genuine self-interest. Furthermore, as in any profession, there are good therapists and there are bad ones. Client ambivalence about being in therapy with a particular therapist can sometimes have less to do with structural attributes of the relationship than it has

to do with a therapist who may be unskilled, uncaring, self-interested, or simply not very good at working with particular types of clients who present themselves with particular types of problems.

### **Discussion**

The present article reviews the process by which various structural attributes of the professional psychotherapeutic relationship might cause an accumulation of client ambivalence toward therapists, and strategies that therapists can employ in order to preclude or mitigate ambivalence arising from these sources. The attributes of continuity, professional authority, perceptions of therapist self-interest, and differences in performance appraisal are hypothesized as having the potential for causing an accumulation of ambivalence toward therapists (cf. Merton & Barber, 1963).

Before summarizing the implications for clinical practice that follow from this analysis, it is important to point out some of the common pitfalls that one would be wise to avoid when ambivalence is encountered in the psychotherapeutic relationship. First and foremost, one should not interpret ambivalence as a sign of psychopathology on the part of the client. While it certainly does present a host of challenges for clinicians, ambivalence should be recognized as a normal and expected part of the process of behavior change. When ambivalence is normalized in this way, it can become a productive focus of therapy rather than an impediment to it. Second, it is important for clinicians not to be defensive about legitimate reservations that people may have about therapy in general, or even about working with an individual therapist. Although the structural attributes of the professional relationship described in this article may indeed engender client ambivalence toward therapists, it is important to remember that a particular client's reservations about his or her therapy might be caused by a whole host of other legitimate factors.

The strategies that have been proposed to address ambivalence arising from the various structural attributes of the psychotherapeutic relationship have a common unifying theme, and that is making the therapeutic relationship more open and transparent. This transparency can be achieved by making the relationship relatively more time limited and goal oriented while still cultivating a deep appreciation of the importance of the humanistic qualities of accurate empathy, genuineness, and unconditional positive regard.

By making the therapy explicitly time limited, clients are less likely to remain in a professional relationship long after they have become dissatisfied with it. By establishing mutually agreed-upon goals and periodically assessing the progress that has been made toward achieving those goals, uncertainty about the process and progress of therapy is likely to be substantially reduced. By nurturing and attending to the humanistic qualities of the therapeutic relationship, clients are less likely to experience ambivalence arising from the attribute of authority.

This set of strategies can be implemented by therapists working from a wide variety of theoretical orientations. A focus on goal-setting is obviously consistent with contemporary cognitive-behavioral therapy (CBT), as is explicitly agreeing upon the duration of the therapy. Although a focus on the humanistic aspects of the therapeutic relationship is not traditionally part of CBT, this focus is not pragmatically inconsistent with the principles of more structured cognitive-behavioral work. Other contemporary therapeutic approaches, particularly those that are explicitly time limited, clearly employ the strategies advocated in this article to help make the therapeutic relationship more transparent and thus less likely to foster the accumulation of client ambivalence. For example, in both interpersonal therapy and brief psychodynamic therapy, clear goals are set, a productive therapeutic alliance is formed, and of course, time limits are adhered to.

Before concluding, it should be acknowledged that these recommendations are not universally applicable. It may be the case, for example when working with individuals diagnosed with various personality disorders or those who suffer from chronic mental illness, that making the duration of therapy explicitly time limited is contraindicated. Along similar lines, when working with individuals who have been ordered by a court to receive psychological or psychiatric treatment, it may be necessary for therapists to exercise their professional authority to help clients continue to work toward goals that they may or may not perceive as being in their own best interest.

In sum, depending on the characteristics of their clients and their clinical setting, psychotherapists have various options available to them for working with the ambivalence that arises due to the structural attributes of the client-therapist relationship. Therapists who work in a managed-care setting, who already have substantial external

constraints on the number of sessions allowed for each client, will necessarily find it easier to follow the recommendations outlined in this article. Therapists who do supportive work with chronically mentally ill clients, or those who do long-term, in-depth psychoanalytic work with relatively high-functioning clients, might find these specific recommendations difficult to implement. Whatever one's theoretical orientation, clinical setting, or client population, it is important to keep in mind that client ambivalence may not be solely the product of the client's own intrapersonal conflict but may also arise due to structural attributes of the psychotherapeutic relationship.

### References

- BASCH, M. F. (1982). Dynamic psychotherapy and its frustrations. In P. L. Wachtel (Ed.), *Resistance: Psychodynamic and behavioral approaches* (pp. 3-25). New York: Plenum.
- BERGIN, A., & GARFIELD, S. (1994). Overview, trends and future issues. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 812-830). New York: Wiley.
- BINDER, J. L. (1999). Issues in teaching and learning time-limited psychodynamic psychotherapy. Special Issue: A research update on short-term dynamic psychotherapy. *Clinical Psychology Review*, 19(6), 705-719.
- BINDER, J. L., STRUPP, H. H., & HENRY, W. P. (1995). Psychodynamic therapies in practice: Time-limited dynamic psychotherapy. In B. M. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 48-63). New York: Oxford University Press.
- BLEULER, E. (1910). Vortrag über Ambivalenz, *Zentralblatt für Psychoanalyse*, 1910, p. 1; *Dementia Praecox, oder Gruppe Der Schizophrenien*, Leipzig: Deuticke.
- BREHM, J. W. (1962). *Explorations in cognitive dissonance*. New York: Wiley.
- BREHM, J. W. (1966). *A theory of psychological reactance*. New York: Academic.
- CHODRON, P. (1991). *The wisdom of no escape and the path of loving kindness*. Boston and London: Shambhala.
- CUMMINGS, N. A., BUDMAN, S. H., & THOMAS, J. L. (1998). Efficient psychotherapy as a viable response to scarce resources and rationing of treatment. *Professional Psychology: Research and Practice*, 29(5), 460-469.
- DAVIES, P. (1979). Motivation, responsibility and sickness in the psychiatric treatment of alcoholism. *British Journal of Psychiatry*, 134, 449-458.
- ELSTER, J., & SKOG, O.-J. (1999). *Getting hooked: Rationality and addiction*. Cambridge: Cambridge University Press.
- FESTINGER, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- FESTINGER, L. (1964). *Conflict, decision, and dissonance*. Stanford, CA: Stanford University Press.
- FREUD, S. (1922). *Beyond the pleasure principle*. Authorized translation from the 2nd German ed. by C. J. M. Hubback. New York: Boni and Liveright.
- GILL, M. (1981). Analysis of the transference. In H. J. Schlesinger (Ed.), *Psychological issues monograph series* (No. 53). New York: International Universities Press.
- HEATHER, N. (1989). Psychology and brief interventions. *British Journal of Addiction*, 84(4), 357-370.
- JANIS, I. L., & MANN, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment*. New York: The Free Press.
- JONES, E. E., & GERARD, H. (1967). *Foundations of social psychology*. New York: Wiley.
- LEWIN, K. (1951). *Field theory in social science*. New York: Harper & Row.
- MARKOWITZ, J. C. (1997). The future of interpersonal therapy. *Journal of Psychotherapy Practice and Research*, 6(4), 294-299.
- MERLOO, J. M. (1954). *The two faces of man: Two studies on the sense of time and on ambivalence*. New York: International Universities Press.
- MERTON, R. K., & BARBER, E. (1963). Sociological ambivalence. Reprinted in *Sociological ambivalence and other essays*. New York: The Free Press, 1977.
- MILLER, N. (1944). *Experimental studies of conflict, in personality and the behavior disorders* (J. Hunt, Ed.). New York: Ronald.
- MILLER, W. R., & ROLLNICK, S. (1991). *Motivational interviewing: Preparing people to change addictive behaviors*. New York: Guilford.
- ORFORD, J. (1985). *Excessive appetites: A psychological view of addictions*. New York: Wiley.
- PERLS, F. S. (1969). *Gestalt therapy verbatim*. New York: Real People Press.
- PROCHASKA, J. O., & DICLEMENTE, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice*, 19, 276-288.
- ROGERS, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.
- ROGERS, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- ROLLNICK, S. (1998). Readiness, importance and confidence: Critical conditions of change in treatment. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (pp. 49-60). New York: Plenum.
- SMELSER, N. J. (1998). The rational and the ambivalent in the social sciences. *American Sociological Review*, 63, 1-16.
- WACHTEL, P. L. (1982). *Resistance: Psychodynamic and behavioral approaches*. New York: Plenum.
- WALITZER, K. S., DERMAN, K. H., & CONNORS, G. J. (1999). Strategies for preparing clients for treatment: A review. *Behavior Modification*, 23, 129-151.
- WEIGERT, A. J. (1991). *Mixed emotions: Certain steps toward understanding ambivalence*. Albany: SUNY Press.
- WICKLUND, R. A. (1974). *Freedom and reactance*. Potomac, MD: Lawrence Erlbaum.