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Honoring Protective Responses: Reframing Resistance in Therapy Using Polyvagal Theory

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Abstract

Therapists often conceptualize resistance as client behaviors that impede progress; this perspective threatens the therapeutic alliance, especially in couple and family therapy where increased resistance and multiple alliances are present. Polyvagal theory reframes and normalizes resistant behaviors as preconscious, protective responses emerging from our autonomic nervous system. The theory also explains how humans reciprocate safety cues to connect with each other; therapists can use concepts of polyvagal theory to manage their own emotional regulation and foster safety and connection in therapy. Polyvagal concepts deepen our understanding of protective behaviors presenting in couple and family therapy; therapists can help couple and family clients to recognize protective behaviors in their own relationships and facilitate safer connection and engagement. Clinical implications are presented: psychoeducation can help clients normalize and understand their protective processes; therapist presence and immediacy acknowledges and normalizes protective behaviors as they arise; therapist and client self-regulation skills support connection; therapist genuineness is a precondition to client safety; and understanding of polyvagal theory enhances assessment of conflict and enactments in couple and family therapy.

Keywords Polyvagal theory · Resistance · Couple and family therapy

Honoring and Normalizing Protective Responses

Resistance is often recounted as an unfortunate but inevitable byproduct of therapy, laying blame primarily with the client (Seligman & Gaaserud, 1994). This framing is reinforced when therapists maintain expectations of how their clients are supposed to engage and progress in therapy. These phenomena are most conspicuous in mandated treatment programs (Snyder & Anderson, 2009), but even motivated clients who choose to attend therapy will at times demonstrate disagreement, non-compliance or avoidance at some points in their therapy experience (Teyber & Teyber, 2017). How we, as therapists, perceive, conceptualize, process and respond to these behaviors will profoundly affect our therapeutic relationships.

The problematic effects of resistance may become more pronounced in couple and family therapy, where multiple clients present with differing levels of engagement and competing alliances (Escudero & Friedlander, 2017; Shamoon et al., 2017). Systemic models encourage therapists to acknowledge and explore the motivations behind these behaviors (Fleming & Morrill, 2017); emerging research in neurobiology supports these validating approaches and helps us understand how they increase safety and strengthen the therapeutic alliance.

Polyvagal theory explains how the nervous system responds to our external environment, activating defensiveness or social engagement where appropriate (Porges, 2011). This theory has particular relevance to the therapy environment: as clients approach vulnerable emotions and related memories, subliminal processes may refer to perceived or remembered threats which can preconsciously activate protective behaviors associated with the sympathetic nervous system (SNS) that align with descriptions of therapeutic resistance. Conversely, the perception of safety and positive

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regard activates the parasympathetic nervous system (PNS) encouraging engagement and connection, the key ingredients of a strong therapeutic alliance (Dana, 2018). Therapists who incorporate polyvagal theory into their framework of practice will be less likely to blame or resent their clients for their preconscious activation of protective behaviors in a vulnerable setting. This understanding can also help therapists perceive, normalize, and explain conflict patterns demonstrated by couple and family clients, and facilitate coregulation and connection where appropriate.

The therapist's ability to create safety and facilitate coregulation, however, is dependent on their ability to self-regulate and their genuine positive regard of the client (Dana, 2018). As polyvagal theory demonstrates, cues for threats and safety are perceived subliminally via a multitude of subtle manifestations and perceptions—they cannot be simulated or 'faked' (Porges, 2011). In this way, polyvagal theory aligns with the core components of person-centered theory: genuineness, empathy, and unconditional positive regard (Rogers, 1995).

Recent neuroscience research is uncovering many findings that help us understand human behavior, yet many clinicians convey difficulty converting neuroscience research into practice. This paper will explain how polyvagal theory can reframe common resistant behaviors as preconscious protective responses arising from the autonomic nervous system. We will discuss and describe how this reframing generates clear and practical applications for improving alliances and interventions in individual and systemic therapy.

Literature Review

Resistance

The concept of resistance in psychotherapy has generally focused on the client's perceived inability or refusal to engage, limiting the effectiveness of therapy. The term was initially developed by Freud, who defined resistance as a patient's unwillingness to talk about unwanted memories, leading to painful symptoms (Jones et al., 1961). Resistance was later conventionally defined by Bischoff & Tracey as "any client behavior that exhibits a reluctance, on the part of the client, to participate in the tasks of therapy as set forward by the therapist" (1995, p. 488). In a survey conducted by Seligman and Gaaserud (published in an article titled "Difficult Clients"), most therapists saw resistance as counterproductive to change in therapy; only 8% of respondents saw resistance as a "universal process, caused by unconscious factors" (1994, p. 34). Common behaviors framed as resistance included: arguments with the therapist, refusing correction of misinterpretation, homework noncompliance, avoidance, silence, and opposition to therapeutic reframes (Seligman & Gaaserud, 1994; Westra et al., 2012).

This framing of resistance may align with and be reinforced by rigid therapist expectations (Beutler et al., 2011; Mahrer et al., 1994; Rautalinko, 2017). When the concept of resistance is entrenched in the therapist's ongoing assessment of their clients, they may find it in any behavior or response that strays from the therapist's expectations (de Shazer, 1989; Ellis, 1984; Westra et al., 2012). Novice therapists—holding preconceived notions of the nature of the therapeutic relationship—are often surprised to encounter disagreement, reluctance or non-compliance from their 'help-seeking' clients (Teyber & Teyber, 2017). A negative framing of resistance assigns blame to the client, or to the therapist for being unable to help the client. Perceptions of blame and defensiveness create unspoken relationship ruptures that increase the likelihood of early termination and poor outcomes (Beutler et al., 2011; Henkelman & Paulson, 2006; Regan & Hill, 1992; Westra et al., 2012).

These implications are even more pronounced in couple and family therapy, where multiple clients present with differing levels of engagement and increased sensitivity to blaming (Escudero & Friedlander, 2017). It is more common in couple and family therapy for some clients to be unwilling or less willing participants, or to shut down or be less involved in therapy when certain topics are raised in session (Friedlander et al., 2006b). With multiple clients in session, therapists must also manage additional resistant behaviors, an increase in alliance ruptures, and competing configurations of alliances (Benson et al., 2012; Escudero & Friedlander, 2017; Hardy et al., 2020). For example, an individual attending couple therapy may feel resistance towards the therapist, especially if they are less motivated than their partner to attend or feel that they are being blamed for the current problems. Preexisting conflict in the couple relationship will also likely manifest in session as resistant behaviors between partners—including defensiveness, criticism, and disengagement—which may intensify under the perceived pressure of the therapy environment (Escudero & Friedlander, 2017). Negative reactions to these pervasive resistant behaviors could drastically deteriorate perceptions of safety and alliance in couple and family therapy.

Perhaps as a necessary reaction to the complexity and escalation of resistant behaviors in relationship therapy settings, systemic models have historically normalized client resistance and framed it within assessments and interventions. Bowen encouraged attention to resistant behaviors as manifestations of unresolved conflicts within a family (Bowen, 1978), while structural approaches to family therapy identified resistant behaviors as homeostatic processes used to maintain dysfunctional hierarchies (Minuchin, 2012). Emotion-Focused Therapy conceptualizes resistance within the relationship as 'pursue' and 'withdraw' behaviors

related to negative interaction cycles (Johnson, 2012). Gottman Method Couples Therapy strongly emphasizes aspects of resistance in their conceptualization of the 'four horsemen': criticism, defensiveness, contempt, and stonewalling (Gottman, 1999). Internal family systems (IFS) theory frames resistant behaviors as protection from suffering and other negative symptoms emerging from internal 'managers'; IFS therapy honors these 'managers', and attempts to develop collaborative relationships with them as they progress through therapy (Schwartz & Sweezy, 2019).

Experts and researchers have also challenged traditional conceptions of resistance in more general therapy settings. De Shazer (1989) famously called for a "death to resistance", arguing that exploring and identifying resistance distracted the therapist and harmed the alliance. Mahrer et al. (1994) reframed resistant behaviors as manifestations of client strength and autonomy, to be respected and validated instead of confronted and resolved. Teyber and Teyber (2017) also identify the utility of client resistance, noting that resistance may represent an acquired functional coping strategy for the client, and having the option of applying resistance may make therapy feel less threatening. In a detailed study of resistance in therapy, Tursi (2016) found that clients saw resistance as empowering, and an important way to establish safety while they developed a relationship with the therapist. Viewing resistance as a valuable, protective behavior has clear implications for the therapeutic alliance, and is supported by emerging research in neurobiology and the autonomic nervous system.

Polyvagal Theory

Polyvagal theory describes how the nervous system defensively activates in response to perceived threats, or downregulates these defenses to encourage openness and connection (Porges, 2011). According to polyvagal theory, we employ a hierarchy of three autonomic states to assess environmental threats and mediate our behavior (Porges, 2001, 2003, 2011). The primary (less common) state responds to perceptions of extreme threat by shutting down or feigning death. The secondary state is popularly known as 'fight or flight'; this state is related to activation of the SNS which activates protective behaviors and mechanisms in response to perceived threats. The tertiary state, most recently developed in the evolutionary timeline, relates to activation of the PNS. This autonomic stance has also been referred to as the 'rest and digest' and connect state, where social engagement and relationship interaction is more likely to occur (Gilbert, 2017; Porges, 2011). Ideally, humans should spend most of their time in the tertiary, connective state, and only activate the secondary protective state when confronted with genuine threats.

According to polyvagal theory, the nervous system preconsciously perceives threats, a process that has been termed 'neuroception' (Porges, 2009). As these systems operate on subcortical levels and are informed by past experiences, polyvagal theory offers important insights into the otherwise confusing activation of anxiety, stress and other 'fight or flight' reactions to seemingly safe environments and events. A therapist may carefully foster a safe therapeutic environment, but any cues that relate to a traumatic memory or competing anxiety may preconsciously perceive a threat and activate the protective features of the SNS (Dana, 2018; Geller & Porges, 2014). This preconscious, protective mechanism offers a useful reframe for client resistance.

Resistance vs Protection

Through the lens of polyvagal theory, we understand that resistant behaviors, including avoidance, non-compliance, disengagement or disagreement may stem from the protective, preconscious functioning of the SNS. Traditional conceptions of resistance identify these behaviors as inconvenient therapeutic barriers, but polyvagal theory frames this resistance as the client's protective mechanism to achieve safety, which has evolved and adapted as a result of their lived experiences. In other words, a therapist could change their perception of the client by honoring and validating their in-built protective mechanisms, rather than blaming them for their resistant behaviors. Badenoch (2018) frames this defense system as an "inner guardian", blending our memories with our current perceptions to help us adapt and feel safe. We cannot blame clients for the subliminal activation of a system evolved and designed to protect them: "by learning to … honor the ways the autonomic nervous system listens and acts in service of safety and survival, therapists bring a different level of understanding to their clients' actions and experiences" (Dana, 2018, p. 38).

This reframe has important implications for clients who present at therapy with an 'attunement mismatch', immediately perceiving or anticipating danger in the setting; which is especially prevalent when relationship-based trauma is a part of their history (van der Kolk, 2018). These clients are likely to perceive threats from the therapist and disengage. Attunement mismatch may also be evident in other relationships, perpetuating a vicious cycle of defensiveness and disengagement from others (Dana, 2018). Couple and family therapy clients may demonstrate attunement mismatches with each other due to trauma in the presenting relationship or previous relationships (Dana, 2018; van der Kolk, 2018). A therapist who recognizes and validates these natural protective stances can acknowledge and respond to client safety needs, identify the unintended effects of these protective behaviors, and model regulation and connecting behaviors.

We might consider again the common example of an unwilling partner attending couple therapy. Many clients present to couple therapy harboring pre-existing trauma or anxiety about their safety, which increases their sensitivity to threats and risk of disengagement (Anderson et al., 2020). This client may become defensive or critical towards the therapist and their partner or threaten to disengage entirely. Reframing resistant behaviors as emerging from a protective system allows the therapist to witness and normalize these behaviors in the context of the client's history and current relationships. The therapist is then empowered to address the client's perceptions of safety in therapy and in the couple relationship by moderating the impact of these protective behaviors and facilitating behaviors that promote connection.

Enhancing Connection Through Coregulation

Polyvagal theory offers insight into how safety and connection can be fostered via cultivation of the social engagement system and coregulation. The social engagement system relates to the projection and reception of cues of safety between humans (and other mammals) that signal a lack of threat and presence of safety (Porges, 2011). This is accomplished in a complicated interaction between the heart and facial muscles that coordinates the expression of calm-indicating behaviors related to our own state of functioning. In other words, "how we look, listen, and vocalize conveys information about whether we are safe to approach" (Porges, 2017, p. 8). These cues are also interpreted subconsciously via neuroception; subtle eye movements, posturing, breathing and other factors combine to indicate downregulation of the self and provide safety cues to others, which can then be reciprocated in a process of coregulation (Porges, 2011).

The well-established concepts of therapeutic presence, empathic listening behaviors, and the therapy alliance are highly related to the perception of safety in the relationship via activation of the PNS. Polyvagal theorists further identify some of the specific behaviors related to establishing safety, including interested and caring facial gestures, soft eye contact, warmth and prosody of voice, and an open posture (Geller, 2018; Geller & Porges, 2014). However, applying the principles of polyvagal theory requires more than a simple replication of listening behaviors. The implications of neuroception demand genuine engagement, empathy and positive regard from the therapist to create the perception of safety (Rogers, 1995). In couple and family therapy, the therapist will often identify and nurture genuine compassion and care between clients, and facilitate the enactment of these feelings into connecting, coregulating behaviors (Dana, 2018; Gottman, 1999; Greenberg, 2015; Johnson, 2012).

However, the therapist cannot facilitate coregulation until they are in a state of safety and connection supported by their own PNS. As we have discussed, resistance has traditionally been identified as a client problem, but therapists also experience (and often internalize) resistant behaviors. Regan and Hill (1992) discovered that therapists were more likely than clients to refrain from voicing their own negative therapeutic experiences, which contributed to their own internalized frustration and disconnection. In a seminal commentary on resistance, Albert Ellis identified the therapist as their own most difficult client, often maintaining irrational self-pressure to be respected by receptive clients: holding these expectations, they may be reluctant to admit to their own anxieties and frustrations and project these on to the client (1984). Failure to recognize and appropriately process our own anxiety or frustration via supervision and reflection will likely cause us to project it on to our clients instead (Espinoza & Kovarkizi, 2017; McDaniel, 2016), who will perceive safety threats and remain in a protective stance (Porges, 2011; Westra et al., 2012). A polyvagal framing of resistant behaviors as a valid, protective mechanism may reduce the therapist's own anxiety and frustration, further encouraging activation of their own PNS to help the therapist maintain a supportive stance that encourages coregulation (Geller & Porges, 2014).

Once again, these implications become more prominent in couple and family therapy settings, where the increased complexity can intensively challenge the relationship therapist's perceptions of safety and comfortability engaging with clients (Escudero & Friedlander, 2017; Shamoon et al., 2017). The therapist's ability to self-regulate not only increases their alliance with the clients, but also encourages safety and connection between clients in session (Karvonen et al., 2016). Attuned therapists can gauge client perceptions of safety with the therapist and with each other and modify interventions accordingly. Many relationship therapy models encourage the therapist to identify and normalize these protective mechanisms as they occur between clients, creating opportunities for insight and behavior adjustment (Gottman, 1999; Greenberg, 2015; Johnson, 2012; Lebow et al., 2019).

Clinical Implications

Miller and Rolnick (1991) suggest that "the true art of therapy is tested in the recognition and handling of resistance. It is on this stage that the drama of change unfolds" (p. 112). Reframing resistance as a protective behavior can help us refine our clinical interventions to promote safety and increase the client's awareness of the impact of these behaviors in their own relationships. Here we offer five general principles of clinical application, drawing on compatible models and interventions.

Psychoeducation

Psychoeducation is a critical step in normalizing the experience of resistance. Therapists may prioritize a discussion about polyvagal theory and automatic protective behaviors in their initial meetings with clients as they lay the foundation for the therapeutic alliance. When clients understand that their physiological reactions are a functional and adaptive part of their biology, and that it is normal for them to feel those in the therapy process, at best it may create more willingness to engage with honesty about their experience and at worst it normalizes their experience. There is a growing movement to incorporate neurobiology education into psychotherapy practice (Beeson & Field, 2017). For example, a popular trauma treatment model incorporates polyvagal theory to help clients understand the impact of relationship trauma on relationships in the present and learn how to consciously engage while acknowledging anxious avoidance stemming from prior abuse (Vogt, 2018).

Normalization of subliminal protection behaviors in relationships might also reduce pressure and blaming among couple and family clients. Psychoeducation on dysregulation and subsequent disconnecting behaviors is common in many models of couple and family therapy (Fishbane, 2013; Gottman, 1999; Greenberg, 2015; Johnson, 2012). This can increase mutual compassion and insight, addressing the underlying sources of conflict interactions.

Psychoeducation should be tailored to provide insight into the client's specific presenting problems. For example, if relationship trauma is evident, a therapist can help the client understand that their autonomic nervous system has evolved to keep them safe from painful experiences, and that it is natural for this defense system to activate when discussing private thoughts and feelings. Badenoch (2018) cites the experience of a client with explosive anger issues: connecting his anger to fear of his violent father and reframing it as a protective mechanism reduced the client's shame and allowed for mindful activation of the social engagement system in therapy, which then allowed processing of the deeper underlying trauma.

Presence and Immediacy

Therapists who acknowledge protective behaviors as they arise create opportunities for education, normalization and regulation. When the client or the therapist internalizes a negative event in therapy, subliminal perceptions of threat are likely to occur; Dana (2018) recommends naming these instances and taking responsibility for them to avoid unconsciously projecting criticism towards the client.

Therapists should regularly check in with how the client is feeling, noting or carefully guessing at any potential protective reactions (resistance) they perceive (including their own protective reactions). This might be framed as a conscious recognition of neuroceptive processes, voiced as "it feels like you don't like that question that I just asked, am I right?", or "it feels like something has changed between us in the last few moments, but I'm not sure what it is", or even, "I felt a little offended at what you said just a moment ago, but I'd like to better understand what that means to you". In a metacommunicative process, regularly checking in—even when resistance isn't immediately detected—can further normalize discussions about protective reactions and create more opportunities for engagement (Miller et al., 2006).

In couple and family therapy settings, the therapist may use their observations, intuition and neuroception to perceive and identify protective behaviors between clients. Gottman, for example, recommends a quantitative approach utilizing video review to identify predefined behaviors and expressions indicating defensiveness, criticism, contempt and stonewalling (Gottman, 1999). Emotion-focused theorists encourage therapists to use their intuition to sense protective stances and behaviors and relate their impressions to clients (Greenberg, 2015; Johnson, 2012). Couple and family therapists help clients identify and process their protective behaviors with each other, creating increased opportunities for connection and coregulation (Bradford & Bar-Kalifa, 2020).

Self-Regulation

The therapist's ability to self-regulate and remain in a connective stance is a necessary precursor to coregulation and client safety. Practicing self-regulation techniques outside of sessions can help the therapist become more adept at drawing upon these when needed. Self-regulation processes can also be practiced collaboratively in sessions with the client, to normalize the experience of resistance and model emotional regulation. There are a myriad of published techniques and interventions supporting self-regulation that can be practiced both in and outside of therapy settings, and we encourage therapists to practice and become proficient at using these individually and with clients.

Emotion regulation is a key component of several systemic theories (Bradford & Bar-Kalifa, 2020). Emerging research related to polyvagal theory identifies numerous interventions that individuals, couples, and families can use to increase their capacity to process and respond to distress—including enhancing sleep hygiene, cardiovascular exercise, meditation and mindfulness, breathing exercises, and expressions of gratitude (Johnson et al., 2021). Systemic models also specify many interventions to regulate intense emotional distress related to trauma (Blow et al., 2020). A well-known example is Gottman's "Diffuse Physiological Arousal" intervention, which encourages the measurement of both partner's physiology in session, followed by

prescribed self-regulation exercises when measurements indicate that one or both clients are 'flooded'. Couples are encouraged to learn to self-regulate, and to coregulate by supporting each other through the exercise. This intervention clearly identifies and normalizes activation of the SNS and its associated protective behaviors, as well as the benefits of self-regulation in promoting connection (Gottman, 1999).

The need for self-regulation in therapy also highlights the importance of self-care for practicing therapists. Careful attention to physical and mental health can cultivate a 'ventral baseline', where social engagement becomes a default behavior and the need for self-regulation is reduced (Badenoch, 2018). Mindfulness practice and other self-care behaviors can expand the therapist's 'window of tolerance', which describes the intensity of input they can process before the SNS becomes activated (Baldini et al., 2014). In addition to learning and practicing self-regulation behaviors, careful attention to personal mental health is critical to the therapist's ability to broadcast and maintain a sense of safety and stability in the therapy setting (Badenoch, 2018).

Genuineness

The concept of neuroception from polyvagal theory implies that safety cues must emanate from a place of being genuine. This implication aligns with Rogers's person-centered theory, which promotes genuine curiosity and positive regard towards clients, applied consistently so that clients can rely on a safe therapeutic environment (Rogers, 1995). It is not enough to recommend that a therapist expresses gratitude and respect for their client; polyvagal theory aligns with person-centered theory to encourage the therapist to develop and consistently apply genuine appreciation and respect for all clients (Dana, 2018; Geller & Porges, 2014). Neuroception suggests that our distractions, defensiveness, and negative appraisals will be subliminally perceived by the client. For example, when a couple therapist feels less compassion or positive regard for one partner, that partner is likely to perceive this and disengage (Janusz et al., 2021). Though shifting alliances are inevitable (and sometimes prescribed) in systemic therapy (Friedlander et al., 2006a; Minuchin, 2012), honoring protective behaviors and cultivating genuine positive regard for each client will help repair ruptures and manage alliances when necessary.

We have heard anecdotal evidence of therapists checking their phone and working on puzzles in therapy. Any therapist who believes that they can divide their attention without affecting the relationship is mistaken; even if the client is not consciously aware of the distraction, their sensitive neuroceptive processes will perceive some distancing and activate defenses accordingly (Geller & Porges, 2014). In an intimate conversation, the listener's diversion of attention can feel painful and rejecting (Geller, 2018).

Within this frame, we can make the argument that the relationship is more important than the intervention, a position supported by common factors research (Norcross & Lambert, 2011) and polyvagal theory (Geller, 2018). Indeed, a preoccupation with models and interventions can hurt the alliance: Badenoch (2018) suggests, "if I open the door to greet my patient with my own idea about which techniques will best help this person, my ventral vagal parasympathetic will most likely be offline, a condition that will communicate lack of safety to my client" (p. 81).

Couple and Family Therapy

Communication difficulties and conflict are frequently reasons couples and families attend therapy (Doss et al., 2004). Systemic models recognize that persistent conflict patterns invoke defensiveness, criticism, and withdrawal (Diamond et al., 2014; Gottman, 1999; Greenberg, 2015; Johnson, 2012), common protective behaviors stemming from activation of the SNS. A therapist may apply their understanding of polyvagal theory to recognize these protective behaviors and openly acknowledge them as part of the therapy process. Collaborating with clients, the therapist can build recognition of how protective behaviors are enacted and perceived and their impact on the couple or family system. By normalizing and validating the existence of these behaviors, therapists can reduce blame and pressure and start to unfold the primary emotional experiences contributing to conflict (Gottman, 1999; Greenberg, 2015; Johnson, 2012).

A therapist can apply their understanding of connecting behaviors and the social engagement system via enactments, a common intervention across most forms of systemic therapy. A therapist applies an enactment by encouraging a client to turn to a partner or family member and coaching them to safely listen to or express internal experiences. The therapist may simultaneously process the enactment with multiple clients, using their intuition to acknowledge and process protective impulses as they arise, and invoking the client's genuine compassion and interest for their partner or family member to facilitate safe communication and connection (Gottman, 1999; Greenberg, 2015; Johnson, 2012).

We acknowledge that these clinical implications for couple and family therapy contribute no new interventions or approaches. Instead, insights from polyvagal theory confirm the efficacy and appropriateness of systemic approaches that have normalized and adaptively responded to protective behaviors. In addition, polyvagal theory offers couple and family therapists a greater depth of language and understanding to identify and normalize protective behaviors between clients and develop adaptive responses that promote safety and connection (Bradford & Bar-Kalifa, 2020). By understanding and consciously recognizing their own neuroceptive processes, therapists can better attune to each clients' experience of safety

and identify protective behaviors as they are manifested in session. In other words, while the manualized interventions may remain largely unchanged, a therapist's intuition and decision-making are enhanced by a more complete understanding of the underlying processes related to protective behaviors emerging in therapy.

Polyvagal theory may also support teaching and supervision processes for couple and family therapists. Although systemic models generally espouse adaptive responses to protective behaviors, therapists who utilize these models are still subject to anxiety and other factors previously discussed that may contribute to a negative framing of resistance. Therapists can be invited to attend to the client's and their own autonomic experience when framing resistant behaviors. Many systemic therapists also subscribe to individual therapy approaches that negatively frame protective behaviors. Polyvagal theory supports normalization of protective behaviors across all forms of therapy, offering a consistent approach amenable to integrative practice.

Limitations and Future Directions

Neurobiology and polyvagal theory are evolving fields of study. We recognize that some of polyvagal theory's fundamental assumptions of how neurobiology impacts behavior are not proven, and further empirical research is warranted to better establish these relationships. However, if the autonomic nervous system does not indeed function exactly as described in polyvagal theory, behaviors related to perception, protection and engagement have been observed and correlating patterns established in observational research (Porges, 2011). Even as a metaphor, polyvagal theory offers an illustration of human behavior that supports previous research and heuristic practice.

The present usefulness of polyvagal theory does not obviate the need for additional research to further refine, test and illustrate its application in clinical settings. Process and qualitative research are well-suited to test the assumptions of polyvagal theory, especially as physiological measurement in clinical settings becomes more accessible. Carefully analyzing the moment-by-moment process of therapy using observation and physiology could greatly increase our understanding of the temporal impact of clinical interventions on client perceptions of safety. Furthermore, these implications could also be studied in supervisory relationships, where resistance is also frequently conceptualized (Abernethy & Cook, 2011).

Conclusion

Resistance has traditionally been perceived as an unwanted barrier to change in therapy. Polyvagal theory suggests that resistant behaviors emerge from an adaptive, preconscious system that seeks to protect us. Acknowledging and normalizing protective responses in therapy strengthens perceptions of safety and the therapeutic alliances in individual and systemic therapy. These core conditions make up a critical foundation for engagement and positive outcomes; in other words, "safety is the treatment" (Badenoch, 2018). We recommend therapists use polyvagal theory to normalize and explain protective behaviors as they arise in therapy, and to cultivate their own self-regulation, mental health, and genuine way of being with clients.

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