

Non-compliance and Resistance in Psychiatry and Psychotherapy

Thomas Abel^{1,*}

¹Psychotherapist, Psychoanalyst, Trauma Therapist, ISTFP-certified Therapist in Transference-Focused Psychotherapy (TFP), Group Analyst, Supervisor and Training Analyst, Germany

*Correspondence should be addressed to Thomas Abel, info@praxis-abel.de

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Commentary

Non-compliance is a frequently underestimated phenomenon in medicine. Compliance means adherence to therapy, cooperation and participation of patients and their human environment in medical treatment and refers to taking medication, adhering to diets or lifestyle changes, such as reducing risk factors, for example smoking, obesity or lack of exercise [1]. According to a report by the World Health Organization [2], only 50% of patients have sufficient compliance. This means that only half of patients implement what they have discussed with their doctor, while the other half implement it only partially or not at all. Intentional or unintentional non-compliance, or insufficient implementation of the treatment plan, can be associated with an increased risk of mortality, more symptoms of the disease and a lower quality of life, depending on the underlying disease. Some hospital admissions are caused by inadequate implementation of treatment plans. Studies have identified poor communication between doctor and patient as an important factor in inadequate treatment adherence. For this reason, the term compliance is increasingly being replaced by adherence, which refers more to joint decision-making between patients and practitioners [1].

In the field of psychiatry, Halkjaer-Lassen *et al.* [3] show a non-adherence rate of 42% for antidepressants, while meta-studies, such as that by Addisu *et al.* [4], found a rate of as high as 45% for neuroleptics. There are three clusters of reasons for this:

1. Medication-related reasons are primarily related to side effects, e.g. weight, sexual function, sedation, emotional blunting, and, in the case of antipsychotics, additional extrapyramidal and metabolic side effects.

2. In terms of disease-related factors, a lack of insight into the illness is particularly prominent in psychoses, but also generally in cases of shame and denial: 'I'm not ill!' or 'I'm not crazy!'

3. In terms of treatment and system factors, the therapeutic relationship plays an important role, especially insufficient information about effects and side effects, a lack of joint decision-making, poor accessibility of the doctor, or external hurdles such as trips to the chemist.

When psychotropic drugs work well and quickly, they can sometimes lead to undesirable results. Depressive patients are often only prevented from acting on suicidal impulses, which are part of their symptoms, by a reduced drive. Antidepressants sometimes improve drive first, while mood remains depressed. The danger is that patients now have the energy to act on their suicidal fantasies. However, some also stop taking the medication without consulting their doctor because they are frightened by the intensity of the suicidal impulses they suddenly notice within themselves and by the power to act on these impulses. When neuroleptics quickly and successfully reduce hallucinatory or paranoid psychotic symptoms, patients often react with post-psychotic depression. For example, one of my patients felt that his neighbors were watching and eavesdropping on him through the pipes in his small flat in a 25-storey high-rise building. In the hallway, he heard their voices talking maliciously and disparagingly about everything he did in his flat. For a short time, he felt relieved and liberated when the symptoms quickly disappeared thanks to a neuroleptic. But when he realized that no one in the huge high-rise building was interested in him and his life, he felt deeply lonely and depressed. He stopped taking the medication, soon heard the familiar voices in the hallway again and felt the observations in his flat. That was

easier to bear than the objectless emptiness of his loneliness. This made the reason for his non-adherence understandable. An effective medication alone would not be able to help him in the long term. It was just as important to support him in finding and maintaining contacts, for example by moving into a shared flat, finding friends, a wife and later also starting a career. Group psychotherapy was very important for him.

In psychotherapy, non-adherence is a long-known and well-researched phenomenon known as resistance [1]. People suffer from mental or physical problems, seek treatment, long for change, but at the same time do everything they can from the outset to slow down or completely prevent any change.

Some end therapy as soon as the first improvements are achieved or the problem is understood. Psychotherapy means interfering with mental homeostasis. This causes uncertainty, self-doubt and anxiety and jeopardizes the patient's previous self-image. After all, the adjustment they had found was the best possible solution to their conflicts. It is now under threat. The patient primarily seeks help from the therapist. The resistance is secondary, the result of serious anxiety: the balance once achieved guaranteed the patient's security and stability. The resistance is intended to maintain it. In psychodynamic therapy approaches, there is the assumption of the unconscious and the conscious as the tip of the iceberg. Cognitive scientists do not speak of the unconscious, but of implicit mental processes [1]. Both mean that the patient usually does not carry out the defense operations consciously, intentionally and purposefully, and that she often does not even know or feel what she is trying to avoid.

Sigmund Freud dealt with this contradictory phenomenon as early as 1895 in his 'Studies on Hysteria' [5]. He coined the term 'resistance' to describe this phenomenon. He first used it in his description of the treatment of his patient Elisabeth von R. in 1892. He understood her ignorance as a desire not to know about inner, unbearable ideas. Later, he explained that memory is opposed by a force that corresponds to the force that originally led to repression, i.e. to the formation of symptoms. This force is supposed to keep the repressed material unconscious. Defense and resistance are related phenomena in this respect: resistance is the defense that manifests itself in the therapeutic process. Ultimately, the discovery of resistance led to the abandonment of hypnosis, as Freud found that the communication of repressed, unconscious memories brought to light under hypnosis often could not be accepted by patients after the hypnosis was lifted and they were fully conscious, and in most cases reinforced the resistance. Hypnosis was therefore replaced by working with and on resistance.

Freud coined the term psychoanalysis: the Greek word 'lyse' or 'lysis' means decay or dissolution in the sense of being dissolved. Aná stands for up, apart, or again. Analysis

is therefore about dissolving a laboriously tamed chaos. In psychoanalysis, we use interpretations to systematically dissect 'Ana', the defense mechanisms that hold together the chaos of 'lysis', of impulses and feelings in the unconscious id, as well as possible. However, defense mechanisms cannot simply be broken down, but rather encounter us as resistance to our systematic attempts at dissection [cf. 1].

In psychotherapy, an optimal level of resistance is important: too much or too little resistance can slow down, complicate or even prevent therapy.

In 'Inhibition, Symptom and Anxiety', Freud [6] divided resistance into five categories according to the ego, id and superego, with the first two categories being classified as ego resistance.

Over the last 100 years, many authors have addressed this topic. Today, we distinguish between eight forms of resistance. In Abel [1], I describe these eight forms in great detail with illustrative case studies:

1. Framework resistance: On the one hand, this refers to resistance to the external framework of the treatment, such as missing sessions, arriving late, discontinuing therapy, or even destructive behavior that jeopardizes the treatment, such as suicidal tendencies or substance abuse. On the other hand, this resistance concerns the internal framework, the regulatory system that dictates to the patient what they should and should not do in therapy. In addition to the prohibition of violent outbursts in the therapy room, this primarily involves phenomena such as silence, falling asleep or not following the basic rules, such as free association in psychodynamic procedures or dealing with exercises in behavioral therapy.
2. Resistance through defense mechanisms: Every person has defense mechanisms that are considered ego functions. Mentally healthy or only slightly disturbed, neurotic people have many and more mature defense mechanisms, while people with personality disorders and psychotic individuals tend to have few and immature defense mechanisms. One example is the displacement of fears of human closeness onto an elevator or bus, which leads to claustrophobia. Another example is projection, in which one's own desires, but also undesirable aspects of one's own self, are projected onto another person, like a film onto a screen. In the other person, they can then be fulfilled or combated. For example, one of my patients suspected that a saleswoman in a bakery loved him and that other passengers on the bus hated him. It later turned out that he loved the beautiful baker's wife and that fellow passengers on the bus who took his favorite seat made him angry. Defense mechanisms protect us from fears and thus from internal or external dangers. They are activated

to regulate conflicts. Conflicts exist between desires, needs and instinctual impulses on the one hand, and the closely related feelings of shame, guilt, fear, disgust, grief, hurt, powerlessness, internal prohibitions or ego ideals on the other. Defense mechanisms lead to unconscious compromises being found between both sides, so that desires are partially and distortedly fulfilled, but at the same time feelings of shame or guilt do not become too great. They therefore stand in the way of processes of awareness, insight and change, so that in therapy we encounter them as resistance to therapeutic progress.

3. **Transference resistance:** The inner images of people with whom the patient has had conflictual relationships in her life, in which she was unable to fulfil her central needs, either in whole or in part, because the other person reacted with shame or rejection, or in which she was not allowed to show feelings such as love or aggression because they were met with prohibition, are transferred to other people. Personality traits of parents, siblings, teachers, friends, partners, superiors, but also of her own children can be relived in the therapist. This can help to make unconscious conflicts accessible to consciousness. However, it can also lead to resistance because the patient develops the feeling that even here, in front of her therapist, she is not allowed to name, let alone experience or express, important feelings or needs. From the patient's perspective, we are then no longer mildly positive, friendly companions, but critical, prohibitive or shameful in relation to important feelings and impulses, even if we do not experience ourselves in this way. It is therefore important to recognize and address such transference at an early stage so that conflicts can be made conscious instead of blocking the therapeutic relationship.
4. **Guilt and shame – superego resistance:** Our patients' conscience, their superego, is often much stricter, more prohibitive or disparaging than that of other people. It then prohibits any kind of positive change, joy, pride or free will. As soon as the patient achieves a small improvement, the superego intervenes and prohibits it. The superego primarily triggers feelings of guilt. The ego ideal contains the image of how we would like to be in order to be recognized and perhaps even admired by ourselves and others. If the patient's image of herself is very far from the ego ideal, she experiences shame and feelings of inferiority. For many patients, the ego ideal is so exaggerated that it would be unattainable even with the greatest effort. It then ridicules any change as small, insignificant and laughable, so that the patient ultimately refrains from making any effort to change.
5. **The familiar – id resistance:** In addition to taking medication, adherence primarily concerns lifestyle changes, such as a healthier diet, more exercise or giving up tobacco, alcohol and other addictive substances. Here, but also in our relationship with ourselves and in our relationships with others, we often cling to the familiar and familiar for a very long time, even when it has long been clear to us that some things are not good for us or others. Almost all fairy tales deal with this theme, because despite their initial insights, the protagonists try the same thing twice, four times, sometimes even six times without success, before finally, on the third, fifth or seventh attempt, they abandon the usual path and try a new pattern.
6. **Resistance due to secondary gains:** A secondary gain refers to the objective or subjective advantages that a patient or their environment derives from their illness. Recovery through medication or psychotherapy calls this gain into question, which is why it leads to non-adherence to treatment measures or resistance to improvement of the illness. The primary gain from illness is the internal benefit that the patient derives from their illness, such as protection from experiencing loneliness through hallucinatory voices from neighbors, as in the example above. 2. The secondary gain from illness is the external benefit that patients derive from their illness, on the one hand within their relationships, such as being allowed to stay in bed, being cared for or spared by others. On the other hand, it is about work-related or financial gain for patients, such as being on sick leave or receiving a pension. With an average of 48 days, mental illnesses result in the longest work absences due to illness. The tertiary gain from illness is about advantages for the patient's environment. Relatives who care for bedridden depression patients, provide legal or personal support to schizophrenics, or accompany phobic individuals feel needed, useful, and that they have a special function or competence without which the person they are supporting could not live, or at least not in the same way. It increases their self-esteem, gives them power, and sometimes even gives their lives meaning. Changes in the patient often mean that they need their relatives less or in a different way, which can be very confusing and unsettling for them, so that they consciously or unconsciously do something to suppress the patient's positive developments. For this reason, among others, systemic therapy works not only on changes in the index patient, the one who comes to the practice first, but on the entire family system. We call quaternary gain ideological or social attitudes about what is considered mentally ill, what is not, and how the community deals with it. For example, when Germany was reunified in 1989, two very different perspectives collided: In the authoritarian, dictatorial regime of East Germany, conformist, submissive people were highly desirable, so that phobic, aggressively inhibited or mildly depressed

individuals were less noticeable, while people with a desire for autonomy and openly aggressive behavior were more likely to cause offence. Completely different values applied in the democratic, free West German society, which set self-realization as its highest goal.

7. Personality structure-specific resistance: Our personality is shaped by the way we learn to deal with different conflicts in our life history. This results in a typical way of experiencing and behaving. As adults, we are all driven by something: some want to create order, others want to be on stage and show themselves off, and still others want to care for other people. All of this is related to central relationship desires. In psychiatric or psychotherapeutic treatments, people with very similar symptoms therefore show very different levels of motivation and adherence.

8. Countertransference resistance: Countertransference encompasses all the therapist's mental, emotional, visual, physical and behavioral reactions that the patient triggers in her through her way of forming relationships, i.e. through her transference. Half of these reactions are triggered by the patient's stories, feelings and behavior in the therapist, who is empathetic, contains the patient's feelings and senses the roles assigned to her. The other half consists of the therapist's own inner reactions to the patient, who enters the therapeutic encounter as her own subject with her own personal life and relationship experiences, her current life situation, her age, gender, social position and all her own feelings of love, joy, fear, anger, shame and guilt. Both halves are equally important. They can promote or block treatment in very different ways.

Even though it is a very complex topic, it is worth exploring.

Treatment discontinuation, non-adherence and resistance that delays change can be avoided or at least reduced. Unrecognized and unaddressed resistance leads to protracted treatment processes that are unsatisfactory for both sides. Therefore, the rule is to address the resistance first, and only then the content at hand.

Abel [1] is the first to summarize all known forms of resistance that relate to psychotherapy in an individual setting. The forms of resistance for group therapies and treatments of couples or families are missing. This can be addressed further in future publications.

The Author

Thomas Abel is a licensed psychotherapist, psychoanalyst, trauma therapist, ISTFP-certified therapist in Transference-Focused Psychotherapy (TFP), group analyst, supervisor and training analyst. He is based in Berlin, where he works in

private practice within the German public health system. He also teaches at several psychotherapy and psychoanalytic training institutes.

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