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Client Resistance as Predicted by Therapist Behavior: A Study of Sequential Dependence

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This study examined the relation of client resistant behavior to therapist directive behavior in a sample of 10 prominent archival therapy sessions. Client and therapist speaking turns were coded, with the behavior being aggregated into 1st-order 2 × 2 sequential frequency matrices for each dyad: one set with therapist behavior as antecedent and another set with client behavior as antecedent. The dependency of client and therapist behavior on the behavior of the other was considered across different dyads. The results indicated an overall trend, with therapist directive behavior slightly increasing the probability of subsequent client resistance. No similar effect of client behavior on subsequent therapist behavior was found. Implications of the findings with respect to research and practice are discussed.

High levels of client resistance have been found to be associated with negative outcome in therapy (Arizmendi, 1982; Gomez-Schwartz, 1978; Kolb, 1981; Tennen, Rohrbaugh, Press, & White, 1981) and premature termination (Arizmendi, 1982; Baekeland & Lundwall, 1975; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Kirtner & Cartwright, 1958; Kolb, 1981; Paradise & Wilder, 1979; Tracey, 1986). Despite consensus across theories that resistance is an important client communication, with implications toward outcome, there is little agreement about the meaning of resistance, the interactive nature of resistance, or the management of resistance in the therapy session. Although many theorists (e.g., Basch, 1982; S. S. Brehm, 1976; Horney, 1942; Jung, 1954; Redl, 1966; H. H. Strupp, 1973) view resistance as influenced by threats inherent in the therapeutic interaction (e.g., the relinquishment of control during a time of disequilibrium, loss of autonomy because of extra psychic influence, or a threat to the status quo), resistance is predominantly interpreted by researchers and practitioners alike as a client character issue, or as a manifestation of bad therapist practice (Dreikurs, 1967; Lazarus & Fay, 1982; Papp, 1981; Ruppel & Kaul, 1982; Strong, 1968). Only a few studies (Chamberlain et al., 1984; Hill, Corbett, Kanitz, Rios, Lightsey, & Gomez, 1992; Mahalik, 1994; Patterson & Forgatch, 1985) have considered resistance as a process variable, beyond a measure of immediate outcome.

Findings from the counseling process literature suggest a complicated relationship between resistance and outcome. Interactional determinants, such as therapist behavior (Hill et al., 1992; Mahalik, 1994; Patterson & Forgatch, 1985), client variables (Arizmendi, 1982; Beutler, 1979; Kolb, 1981), outcome (Tracey, 1986; Tracey & Ray, 1984), and stage of therapy (Chamberlain et al., 1984; Tracey, 1986; Tracey & Ray, 1984), have been found to play a determining role in the level of resistance and the therapeutic value of particular levels of resistance. The present study considers the interactive process in relation to resistance. Specifically, we are interested in the extent to which therapist directiveness fuels client resistance and the extent to which client resistance fuels therapist directiveness or nondirectiveness.

Although some theorists view resistance as an interactive process (e.g., Kell & Mueller, 1966; Strong, 1968; Sullivan, 1954), it has been infrequently examined as such. The most common focus on interactional determinants of client resistance has been therapist directiveness. Gillespie (1951) found a modest relation between therapist directive behavior and subsequent client resistance in a sample of nondirective therapy dyads. Using a more reliable and valid coding system and a stronger ABAB design, Patterson and Forgatch (1985) found that in a sample of behavioral interventions with mothers of problem children, therapist directive behavior did increase client resistance. Mahalik (1994) defined resistant behavior from a psychodynamic point of view and found that all types of resistance were found to be lower following nondirective therapist behavior.

Interpretations of findings (Gillespie, 1951; Patterson & Forgatch, 1985) regarding resistance seem to imply that resistance is to be avoided, discouraged, or minimized in the therapy process. Some findings (e.g., Hill et al., 1992; Tracey, 1986; Tracey & Ray, 1984), however, suggest that resistance is not only inevitable but may also be instrumental in the counseling process. Tracey and Ray (1984; using the categories of topic determination and topic following) found that successful dyads show increases in resistance level (represented as topic determination followed by topic determination) during the middle stage of therapy but unsuccessful dyads show no increase. Tracey (1986) similarly

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found that relative low resistance levels correspond with negative outcome. Given that there is general agreement that relatively high levels of client resistance are a negative indicator in therapy, these findings suggest that there may be an upper and lower threshold, wherein resistance, at certain levels, is a positive indicator in therapy. Tracey (1986) interpreted these findings as evidence that within certain parameters, resistance may be an indication that the work of therapy is occurring. Hill et al. (1992) also found evidence that the presence of client resistant behavior is not necessarily a prognosticator of poor outcome or an indication of bad therapeutic practice. They found that clients rated as most helpful therapist behavior that was subsequently followed by highly resistant client behavior. The findings of Hill et al. (1992), Tracey and Ray (1984), and Tracey (1986) call into question assumptions that client resistance is a negative indicator in therapy or an indicator of a poor therapist intervention. Developing models for thinking about resistance should in some way account for the essential and perhaps instrumental nature of resistance in the counseling interaction. We believe that resistance encompasses aspects of client experiencing above and beyond "noncompliance" and, in essence, may at times represent an enactment of healthy mechanisms (e.g., a boundary that differentiates self from other). We agree with Heppner and Claiborn (1989) that the client should be viewed as an active processor of information and not as a passive agent.

Definitions vary, but in general, the term client resistance has been operationalized 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. Without suggesting that progress in therapy requires the therapist to be in the lead, we also view resistance as occurring when the client does not follow the therapist's lead. Therefore, resistance is defined in the present study as any behavior that indicates overt or covert opposition to the therapist, the counseling process, or the therapist's agenda. This definition was selected because it is consistent with classical characterizations of how resistance manifests in therapy (e.g., Freud, 1946; Strean, 1990). Thus, use of this inclusive definition will provide some continuity between past and present discussions about resistance. Further, this definition is consistent with current conceptualizations of how clients negotiate for power and control in the therapy process (e.g., Tracey, 1985, 1986, 1987; Tracey & Ray, 1984).

The definitions and implications of directive versus nondirective behavior vary similarly from theory to theory and study to study. Patterson and Forgatch (1985) defined the behaviors *teach* and *confront* as directive and the behaviors *facilitate* and *support* as nondirective. These distinctions appear to represent extremes on several continuums, including therapist approval–disapproval. Furthermore, the behaviors support and facilitate are certainly less likely to be paired with therapist error (in timing, empathy, or interpretation) than the behaviors teach and confront. Gillispie (1951), adhering to a strict client-centered model, included therapist behaviors such as *encourage* and *approval* into the directive category. It is not clear that the behaviors encourage and approval should be considered directive. Even Snyder (1945), coming from a nondirective model, suggested that this characterization is an "extreme" interpretation of nondirective principles. Given the problems in using either definition of directive behavior as a guiding principle, we define therapist directive behavior as (a) any statement that leads, directs, or controls the verbal activity of therapy or (b) any statement that challenges or confronts the client. Therapist nondirective behavior is defined, in the present study, as (a) any statement that gives responsibility of decision for choice of area and direction of verbal activity to the client, (b) any statement that clarifies the client's previous statement or affect so that the therapist may increase his or her understanding of the client's frame of reference, or (c) any statement that indicates encouragement or support for the client.

The present study examines the verbal behavior sequence of the therapist–client interaction for the purpose of testing the sequential dependence of the client response (resistant vs. cooperative) on the preceding therapist behavior (directive vs. nondirective). It was hypothesized that an antecedent directive therapist behavior will increase the likelihood of a subsequent client resistant behavior and that a nondirective therapist behavior will increase the likelihood of a cooperative client behavior. A finding of this sort would support the earlier findings of Patterson and Forgatch (1985) and Gillespie (1951), provide evidence as to the interactional nature of the resistance phenomenon, and highlight a mechanism for therapists who have determined that lowering resistance levels is a priority in therapy.

Of additional interest in the present study is the dependence of the therapist behavior on the client's preceding behavior (resistant vs. cooperative). Some researchers (Alexander, 1948; S. S. Brehm, 1976; Horney, 1942; Jung, 1954) have speculated that resistance may serve a purpose in regulating the behavior of the therapist toward being less directive. Other researchers (e.g., Corrigan, Dell, Lewis, & Schmidt, 1980; Patterson & Forgatch, 1985; Strong, 1968) have suggested that the client's resistant behavior may trigger therapist directive behaviors. So, the effect of therapist directiveness on client resistance as well as client resistance on therapist directiveness was of concern in this study.

Method

Participants

The sample includes 10 dyads (8 therapists and 4 clients) in a single session. Three of the videotapes feature the therapists Pearls, Rogers, and Ellis with the same client "Gloria" (Shostrom, 1966). Three of the videotapes feature the three therapists Rogers, Shostrom, and Lazarus with the client "Kathy" (Shostrom, 1976). Three of the videotapes feature the therapists Strupp, Meichenbaum, and Beck with the client "Richard" (Shostrom, 1986). A single videotape featured Strupp with the client "Kelly" (Shostrom, 1989). These videotapes were made to demonstrate the various models of therapy to therapist trainees, with the therapists being considered expert in their respective models.

The decision to use these videotapes was based on both pragmatic and methodological reasons. These tapes are well know to researchers and psychotherapists, with the videotapes and transcripts being readily available for examination. In addition, a body of research (e.g., Hill, Thames, & Rardin, 1979; Kiesler & Goldston, 1988; Lichtenberg & Heck, 1986; Lichtenberg & Heider Barke, 1981; Lichtenberg & Hummel, 1976; Mahalik, 1994; Tracey & Guinee, 1990) has accumulated on various subsets of these tapes, making comparisons between studies feasible.

Process Measures

The Client Resistance Code. The Client Resistance Code (CRC; Chamberlain et al., 1984) was used in the present study to categorize client behaviors as resistant or nonresistant. The CRC consists of 11 categories of resistant behavior and 2 categories of nonresistant behavior. Resistant responses include challenging (confront, challenge, or complain), disagreeing (with therapist), expressing hopelessness (defeated or self-blaming), blaming (complain or tattle), defending others, defending self, pushing his or her own agenda, sidetracking (off topic), not responding (not responding to a question for 5 s or more), not answering (avoiding answering), and disqualifying (contradicting an earlier statement or making an extreme statement). Cooperative responses include nonresistant (all responses that are neutral, cooperative, or that follow flow) and facilitative (short utterances indicating attention or agreement) responses.

To determine face and content validity for the CRC, we had experts assess the degree to which the scale meets the specifications set by Hill et al. (1992) that the categories (a) are nominal and mutually exclusive, (b) represent the range of possible client behaviors from different theoretical perspectives, and (c) are at the same level of abstraction. In addition to Hill et al.'s (1992) guidelines, we considered whether the scale is economical, with the number of categories being no larger than is necessary to meet the above criteria. Sixteen doctors of philosophy in psychology from various theoretical perspectives with a mean of 13.94 (SD = 7.56) years of clinical experience rated the CRC using a 6-point response format with 1 (*strongly agree*) and 6 (*strongly disagree*). The raters found the CRC to be adequate on the dimensions of economy (M = 2.25, SD = 1.24), clarity (M = 2.31, SD = 1.20), and representativeness (M = 2.81, SD = 1.33). They generally agreed that the categories were mutually exclusive (M = 2.69, SD = 1.30), are at the same level of abstraction (M = 2.44, SD = 0.96), and are adequate for classifying resistant and nonresistant behaviors according to the definitions given (M = 2.56, SD = 1.09).

The predictive and construct validity of the CRC is supported in several studies. The CRC was used by Chamberlain et al. (1984) and Patterson and Forgatch (1985) to consider predictors of client resistance in the counseling session. Chamberlain et al. (1984) found resistance levels to be higher at midtreatment, a finding that was confirmed by Tracey and Ray (1984). Resistance levels were also found by Chamberlain et al. (1984) to be higher for dropouts as compared to completers and for agency as opposed to self-referred clients. Chamberlain et al. (1984) also found that clients tended to maintain their ordinal rankings in regard to level of resistance from early to midtreatment, a finding that was confirmed by Tracey and Ray (1984). In addition, a moderate and positive correlation was found between client resistance at the end of treatment and therapists' posttreatment ratings of outcome. Patterson and Forgatch (1985) found that directive therapist behaviors are associated with an increased probability of client resistance.

The Therapist Behavior Code. The Therapist Behavior Code (TBC; Forgatch & Chamberlain, 1982) was used to categorize therapist behavior into directive and nondirective units. The TBC describes in-session therapist behavior using eight exhaustive and mutually exclusive categories. Categories of the TBC include support (paraphrase, reinforce, agree, humor, empathy, self-disclose, supportive, joining, filling in, or apologetic), teach (instruction, commands, suggestions, providing rationale, or suggestions as questions), structure (structure, summarize, or modeling and role play), question and information seek (questions, information seek, rhetorical questions, or clarification), confront and challenge (disagreement, disbelief, disapproval, direct confrontation, challenge, sarcasm, indirect challenge, or confrontation), interpret and reframe (reframe, interpret, mind-read, speculate, normalize, or speak metaphorically), talk (coded when the therapist starts to say something but does not complete a codable behavior), and facilitate (coded when the therapist is basically listening to the client but making short utterances to indicate she or he is paying attention and the other person should keep on talking).

Additional subcodes were added to the TBC subcategories "question" and "interpret" to allow a dichotomous classification of behaviors into the directive and nondirective categories. If the therapist behaviors question or interpret were coded, the coder further determined whether the behavior was directive or nondirective according to the definitions provided. For example, if a question redirects the flow of conversation and requires information from the client, the question is given the additional code "directive." If a question seeks information only to clarify and therefore better understand the client's presentation, the question is identified as "nondirective." The TBC, along with the additional subcodes, will from here on be referred to as the Therapist Behavior Code–Revised (TBC-R).

In the present study the following behaviors were identified as directive: teach, structure, confront or challenge, question or information seek–directive, and interpret or reframe–directive. In the present study the following behaviors were identified as nondirective: support, question or information seek–nondirective, interpret or reframe–nondirective, talk, and facilitate.

To determine face and content validity for the TBC-R, we had experts assess the degree to which the scale meets the specifications set by Hill et al. (1992) that the categories (a) are nominal and mutually exclusive, (b) represent the range of possible therapist behaviors from different theoretical perspectives, and (c) are at the same level of abstraction. In addition to Hill et al.'s (1992) guidelines, we considered whether the scale is economical, with the number of categories being no larger than is necessary to meet the above criteria. Sixteen doctors of philosophy in psychology from various theoretical perspectives with a mean of 13.94 (SD = 7.56) years of clinical experience rated the categories using a 6-point response format of 1 (*strongly agree*) to 6 (*strongly disagree*). The raters found the TBC-R to be adequate in regard to economy (M = 2.31, SD = 1.08), clarity (M = 2.62, SD = 1.02), and representativeness (M = 2.50, SD = 1.10). They generally agreed that the categories were mutually exclusive (M = 2.94, SD = 1.0), are on the same level of abstraction (M = 2.38, SD = 0.89), and were adequate for classifying directive and nondirective behaviors according to the definitions given (M = 2.20, SD = 0.86). The predictive validity of the scale is supported by the findings of Patterson and Forgatch (1985).

Procedures

Coders (two graduate students in counseling psychology and two undergraduate psychology students) were trained for approx-

imately 16 hours in the use of the TBC-R and CRC, respectively. Training consisted of reading and discussing the manuals and practicing with training audio tapes and transcripts, until the raters attained a kappa $\geq .65$ (on collapsed categories) on a training tape. The 10 experimental videotapes were coded independently by the two coding teams, with one member of the team coding the client behavior and the other coding the therapist behavior. Client and therapist behaviors were coded separately to reduce the possibility of a coder guessing the hypothesis. The coders for client behavior did not know the categories for therapist behavior. The coders for therapist behavior did not know the categories for client behavior.

The unit of analysis used in the present study is the speaking turn, meaning the verbal response of one member of the dyad, which in all but the opening and closing statements will be preceded and followed by the verbal behavior of the other. The rules used to determine unit code when more than one codable behavior occurred in a speaking turn differed for therapist and client behavior. For the therapist behavior, the last codable behavior became the unit code. For the client behavior, a resistance unit was coded if any behavior was coded resistant in the speaking turn. This decision rule was based on the use of the first-order model in the present study and on the focus on the client's resistant versus cooperative response to the therapist's immediately preceding behavior.

Interobserver agreement was estimated using both point-for-point agreement indices and an interactional coding reliability (Bakeman & Gottman, 1986; Gottman, 1979; Wampold & Holloway, 1983). To consider point-for-point agreement, we generated a 2×2 agreement matrix for each session and each code (i.e., CRC and TBC-R). A kappa coefficient (Cohen, 1960) and percent agreement coefficient were derived for each agreement matrix. Percent agreement was calculated to provide perspective on the relative impact of the uneven distributions examined (e.g., high "percent chance agreement" values for the CRC, $M = 0.67$, $SD = 0.11$; and the TBC-R, $M = 0.59$, $SD = 0.17$) on the kappa coefficients. Second, using procedures advocated by Wampold and Holloway (1983) and Bakeman and Gottman (1986), an interactional coding reliability rating was calculated to compare the 2×2 sequential frequency matrices generated by the two rating teams. This reliability index is derived by correlating the paired scores of the two rating teams. For the present study, the interactional reliability is considered the more appropriate (e.g., less restrictive) of the indices of interobserver reliability, given our level of analyses (i.e., interactions aggregated over the course of the session) and focus (i.e., on patterns in the transition matrices, as opposed to specific moment by moment events or individual interactions).

The present study comes from an interpersonal point of view in which the focus is on how one member's behavior regulates the other's behavior in the therapeutic exchange. As such, a first-order sequential model was adopted (i.e., each person's behavior is dependent only on the preceding behavior of the other). Although higher order dependencies are possible (Hill, Carter, & O'Farrell, 1983; Howard, 1983), relationships beyond the first order have been found to revert to independence quite quickly (e.g., Cappella, 1981). Furthermore, the number of cells required to capture patterning beyond the first order increases exponentially with each lag position such that the power of the test may not be sufficient to detect the slight relationship that exists. For this reason, relationships beyond the first order are generally considered only when there is a theoretical interest in higher order dependencies and when there are sufficient data points to detect relationships that exist. It is, perhaps, for this reason that a first-order model predominates in the literature (e.g., Heppner & Claiborn, 1989; Lichtenberg & Heck, 1986; Tracey, 1985).

Client and therapist behavior was aggregated into 2×2 sequential frequency matrices for each dyad; one set with therapist behavior as antecedent (directive vs. nondirective) and client behavior (resistant vs. cooperative) as consequent; and another set with client behavior as antecedent and therapist behavior as consequent (see Table 1). These transition matrices served as the basic data of the analysis. In one matrix there was a cell of zero and, as recommended by Liebetrau (1983), a value of .5 was added to each of the cells in this table to enable analysis.

A beta weight (also known as a log odds ratio) was generated for each behavior transition matrix to determine the degree and direction of association between the consequent client behavior and the antecedent counselor behavior. The beta weight has a range from minus infinity to plus infinity and has a value of 0 in the case of independence. As was done by Tracey (1985), the beta weight for each transition matrix was transformed into a Yules' Q (Yules, 1900) to provide a more familiar and interpretable range of values for the measure of association. The Q statistic ranges from -1 to $+1$, with a value of 0 indicating independence. In the present study a positive value indicates a relationship in the direction of the hypothesis, that therapist nondirective behaviors tend to be followed by client cooperative behaviors and therapist directive behaviors tend to be followed by client resistant responses. A negative value indicates a relationship in the opposite direction. To test for the strength (or significance) of the association, we converted the beta for each table to a z score. A significance level of $p < .05$ was selected. Liebetrau (1983) and Allison and Liker (1982) provide formulas and working models for the above measures of association and tests of significance.

To determine whether the direction of association is significant across dyads (e.g., is there a trend?), a test was done using Cochran's (1954) Y statistic (Everitt, 1977). Cochran's Y is a method of combining the information from multiple 2×2 tables that does not rely on homogeneity or similar sample sizes. Cochran's Y is based on a weighted mean of the differences between proportions. Cochran's Y is distributed normally with zero mean and unit variance.

Results

Reliability

For the CRC ratings, a mean kappa of .51 ($SD = 0.17$) and a mean percent agreement of .80 ($SD = 0.14$) were obtained, which represent fair agreement (Fleiss, 1981; Landis & Koch, 1977). The percent agreement of .80 compares favorably to Chamberlain et al.'s (1984) percent agreement of .75 ($SD = 0.22$) for resistance and .89 ($SD = 0.08$) for cooperation.

For the collapsed categories (directive vs. nondirective) of the TBC-R, a pooled (over all 10 dyads) kappa of .55 and a percent agreement of .78 were obtained, suggesting fair agreement according to Fleiss (1981). To consider the impact of our additional subcodes on reliability, we calculated a kappa and percent agreement for the original TBC. The TBC kappa of .57 and percent agreement of .75 suggests that our additional codes did not substantially reduce the reliability of the TBC. These agreement ratios correspond to Patterson and Forgatch's (1985) mean percent agreement of .75.

The assessment of the interactional coding reliability yielded Pearson correlation coefficients of $r = .83$ ($p \leq .01$)

for the paired scores with the therapist behavior as antecedent and $r = .85$ ($p \leq .01$) for the paired scores with the client behavior as antecedent, suggesting that the patterns in the transition matrices (representing interactions aggregated over a session) are highly reliable across coding teams.

As recommended by Hill (1991), we increased the reliability of the data by averaging the cell frequencies generated by the rating teams for each session, thus deriving one 2×2 first-order sequential frequency matrix for each session, with cell values representing the averaged cell values from two independent ratings. These 2×2 first-order sequential frequency matrices were used for the analyses.

Intrarater reliability was considered by having the coders of the TBC recode a tape, coded earlier in the coding process, at the end of the coding period. The results were as follows: Coder A obtained a kappa of .56 on the TBC-R (percent agreement of .78) and .73 on the TBC (percent agreement of .89). Coder B obtained a kappa of .40 on the TBC-R (percent agreement of .71) and a kappa of .72 (percent agreement of .89) on the TBC. These ratings represent fair agreement according to Fleiss (1981). The disparity between agreement indices for Coder A and Coder B, and for the TBC and the TBC-R, however, may represent the fact that Coder B joined the team later than Coder A and that the use of the subcodes required additional clarification after the coding of experimental tapes began.

Measures of Association and Tests of Significance

The sequential frequency tables for therapist directive behavior and client resistance are presented in Table 1 and the resulting Q and z statistics for each dyad are reported in Table 2. Three of the 10 dyads were found to have a better than chance association between the therapist behavior and subsequent client behavior, with the relationship being in the predicted direction. Findings in this direction (though not significant) were also evident for five other dyads. The results of the Cochran test were significant ($Y = 1.74$, $p < .05$), indicating that the systematic variation observed across the 10 dyads (i.e., direction of association consistently in the positive direction) was significantly greater than would be expected by chance. The null hypothesis of independence for the therapist behavior and subsequent client behavior was rejected. Thus, the data provide modest support for the

Table 1
First-Order Behavior Transition Matrixes for the 10 Dyads and Two Sets of Analyses

Therapist behavior in dyad	Client behavior							
	Therapist behavior as antecedent				Client behavior as antecedent			
	Resistant		Nonresistant		Resistant		Nonresistant	
	f	*p*	*f*	*p*	*f*	*p*	*f*	*p*
Shostrum & Kathy								
Directive	28.0	.15	70.5	.37	21.5	.11	81.0	.42
Nondirective	22.5	.12	71.0	.37	30.0	.16	59.5	.31
Strupp & Richard								
Directive	4.0	.06	23.5	.38	5.0	.08	22.5	.37
Nondirective	7.5	.12	27.0	.44	6.5	.11	27.0	.44
Rogers & Kathy								
Directive	9.5	.10	15.0	.16	6.0	.06	19.5	.21
Nondirective	13.5	.14	57.0	.60	17.0	.18	52.5	.55
Beck & Richard								
Directive	2.5	.02	49.5	.42	0.5	.004	49.5	.42
Nondirective	1.5	.01	65.0	.55	3.5	.03	65.0	.55
Meichenbaum & Richard								
Directive	9.5	.14	20.0	.29	7.0	.10	24.0	.36
Nondirective	5.5	.08	32.0	.48	6.0	.09	30.0	.45
Lazarus & Kathy								
Directive	15.5	.10	65.5	.43	11.5	.08	70.5	.47
Nondirective	5.5	.04	65.5	.43	9.5	.06	59.5	.39
Perls & Gloria								
Directive	23.5	.19	49.5	.41	24.0	.20	48.5	.40
Nondirective	11.5	.10	36.5	.30	10.5	.09	39.0	.32
Ellis & Gloria								
Directive	10.0	.24	22.0	.54	10.0	.25	22.5	.56
Nondirective	0.5	.01	8.5	.21	1.0	.02	6.5	.16
Rogers & Gloria								
Directive	4.5	.06	5.5	.08	4.0	.06	5.0	.07
Nondirective	19.5	.28	39.5	.57	19.0	.28	40.0	.59
Strupp & Kelly								
Directive	5.0	.07	23.0	.30	6.0	.08	21.5	.29
Nondirective	10.0	.13	38.0	.50	9.0	.12	38.5	.51

Table 2
Dependence Indexes and Tests to Determine Statistical Significance

Dyads	Therapist as antecedent			Client behavior as antecedent		
	B	*Q*	*z*	*B*	*Q*	*z*
Ellis & Gloria	2.04	.77	1.35	1.06	.49	0.93
Lazarus & Kathy	1.04	.48	2.00*	0.02	.01	0.04
Rogers & Kathy	0.98	.46	1.88*	−0.05	−.03	−0.09
Meichenbaum & Richard	1.02	.64	1.65*	0.38	.19	0.61
Rogers & Gloria	0.51	.25	0.74	0.52	.25	0.60
Perls & Gloria	0.41	.20	0.98	0.61	.30	1.39*
Shostrum & Kathy	0.22	.11	0.68	−0.63	−.31	−1.90*
Beck & Richard	0.78	.37	0.74	−1.66	−.68	−1.08
Strupp & Richard	−0.49	−.24	−0.72	−0.08	−.04	0.28
Strupp & Kelly	−0.18	−.09	−0.30	0.17	.09	0.32

Note. Positive values indicate a positive relationship, with therapist directive behavior being predictive of increased levels of client resistance in the set of analyses with the therapist as antecedent and with resistance being followed by therapist directive behavior in the set of analyses with the client as antecedent. B = beta weight; Q = Yules' Q statistic.
* $p < .05$.

hypothesis that therapist directive behavior increases the probability that the client's subsequent behavior will be resistant and that therapist nondirective behavior increases the probability that subsequent client behavior will be cooperative.

The predictability of therapist behavior given the client's previous behavior was examined in an identical manner. The results of these analyses are also summarized in Table 2. The association between client behavior and subsequent therapist behavior was not significant for most dyads and was in opposite directions for the two dyads that showed a significant association. The other eight dyads showed a range of values in both directions. A nonsignificant Cochran's Y ($Y = .21$, $p > .05$) confirmed that no systematic variation was evident with respect to therapists' directiveness being related to previous client resistance.

Discussion

Findings of the present study indicate a relation in the predicted direction between client behavior (resistance vs. cooperative) and the preceding therapist behavior (directive vs. nondirective) when considering the systematic variation of the 10 dyads sampled. Thus support was generated (a) for the hypotheses and findings of Gillespie (1951) and Patterson and Forgatch (1985), (b) for the notion that resistance is an interactional phenomena, and (c) for the consideration of therapist behavior as a mechanism for managing resistance in the counseling session.

The present study suggests that the occurrence of client resistance is not random or independent of relationship events but rather is predicted, to a modest degree, by the therapist's antecedent behavior. The relationship between therapist directive behavior (defined by varying degrees of inclusion) and client resistance has been established in four studies including the present one (Gillespie, 1951; Mahalik, 1994; Patterson & Forgatch, 1985). Thus we can say with some confidence that resistance is, at least in part, a response to the therapist's previous directive behavior.

These findings support suggestions that therapists should measure, in relation to resistance level, the proportion of directive versus nondirective behaviors. The present study suggests that the therapist behaviors selected from the nondirective category will be less likely to be followed by a resistant response than behaviors selected from the directive category. Listening, encouraging, and supportive behaviors may be called for when a client's resistance level is unduly interfering with the development of an alliance or movement toward treatment goals. This idea has been used in practice for some time and is particularly emphasized by models that consider finesse, timing, client readiness, and relationship as instrumental in meeting the goals of therapy (e.g., H. H. Strupp & Binder, 1984). The work of the therapist is complicated here in that other interactional determinants may impact on the therapeutic value of a particular level of resistance. Furthermore, some studies (e.g., Jones & Gelso, 1988) are suggesting that the nature of the directive behavior (e.g., tentative vs. absolute) may influence the client's response. Future studies should consider the degree to which other therapist factors, such as relationship conditions and relative power, impact the client's experience of a therapist directive.

Unlike the relation of client resistance to preceding therapist directiveness, there was no similar relationship between therapist directiveness and preceding client resistance. This lack of a dependence of therapist behavior on client behavior is similar to the results of Tracey (1985, 1987). Taking a statistical dependency definition of control (Gottman, 1979; Tracey, 1985, 1987), the findings of the present study may suggest that therapists tend to act more independently than their clients on the dimensions studied. The joint finding of relative independence for the therapist and dependence for the client supports the notions that the therapist is dominant (Tracey, 1986) and the client's consequent resistant response is "reactant" (J. W. Brehm, 1966; Tracey, 1987), as opposed to independent or instrumental. Using a statistical dependency definition (Tracey, 1987), "reactance" is indicated when one member of the dyad's behavior is predicted by the behavior of the other member. The finding of dependence for the client and relative independence for the therapist certainly speaks to an imbalance of sorts (e.g., H. H. Strupp, 1973) that may be experienced differentially by clients with various interpersonal orientations.

Research (e.g., Chamberlain et al., 1984; Tracey, 1986) suggests that resistance level, and the implications for level of resistance, may differ among clients. Client variables have been proposed that relate to the client's experience of a therapist directive behavior. For instance, J. W. Brehm (1966) and S. S. Brehm (1976) suggest that *reactance* (a motivation to protect available freedoms when experiencing an influence attempt), will vary from person to person as a result of differing perceptions regarding interpersonal

freedoms and threats to freedom. Social psychology has proposed other client variables (e.g., locus of control; Rotter, 1966) that may have relevance to the client's experience of the therapist directive and to the motivation to select resistant versus nonresistant responses. In addition, some researchers (e.g., Messer & Meinster, 1980) suggest that variables such as gender, ethnicity, diagnosis, and the severity of illness may influence the client's response to a therapist directive. Future studies should consider the relationship between client variables such as reactance potential, locus of control, diagnosis, gender, and severity of mental illness to the interactional phenomenon of interest.

Limitations of the present study suggest further directions for research on resistance. The present study used an analog design, with the clients knowing at the outset that they would be seeing the therapists for one session only. It is likely that this translated into a lesser investment in the therapeutic relationship than would be expected from a client in the first session of an actual psychotherapy regimen. This might also translate to a lesser threat to freedom, given the temporary and relatively unimportant nature of the relationships in the analog study. Furthermore, 10 dyads representing four clients is a small sample. The session lengths of the demonstration sessions also tended to be short. The study should be replicated with a larger sample of clients and therapists in a naturalistic setting, with additional attention given to other process variables (e.g., client variables, outcome, and stage of therapy).

Despite our confidence in the interactional coding reliabilities for the present study, we defer to the ongoing debate about the importance of point-for-point agreement as a measure of construct validity, and we suggest that a longer training period than the one provided may be called for when constructs of this complexity are studied. We argue in favor of the use of interactional coding reliabilities, however, given that there are important constructs that are also difficult to detect in individual interactions. For instance, the constructs of resistance and therapist directive behavior require the coders to make a determination about the interactants preceding behavior as well as the target behavior. This compounds the possibility of error and thus the possibility of unreliability. The interactional coding reliability indices suggested by Gottman (1979), Wampold and Holloway (1983), and Bakeman and Gottman (1986) allow us to examine whether unreliability evident in the point-for-point agreement indices translates to unreliability in the data. We agree that point-for-point agreement continues to be important in the training of coders and the consideration of construct validity. We suggest, however, that the interactional coding reliability ratings provide an additional resource for determining interobserver reliability at the level of analysis.

An important implication of this study is that client behaviors must be understood in a context that includes the previous therapist behavior (e.g., the sequential unfolding of events). Furthermore, findings discussed in this article highlight the need to consider other client and process variables in relation to the interactional phenomenon of interest. Clearly, models are needed to capture the complexity of this interactional event and its determinants. Wholistic models such as Hill and O'Grady's (1985) process model or Shoham-Salomon's (1990) cyclical, ecologically oriented model, as well as statistical models such as structural equation modeling, are making it possible to consider variables such as resistance in a broader interactional context.

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P&C Board Appoints Editor for New Journal: *Psychological Methods*

The Publications and Communications Board of the American Psychological Association has appointed an editor for a new journal. In 1996, APA will begin publishing *Psychological Methods*. Mark I. Appelbaum, PhD, has been appointed as editor. Starting January 1, 1995, manuscripts should be directed to

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Psychological Methods will be devoted to the development and dissemination of methods for collecting, understanding, and interpreting psychological data. Its purpose is the dissemination of innovations in research design, measurement, methodology, and statistical analysis to the psychological community; its further purpose is to promote effective communication about related substantive and methodological issues. The audience is diverse and includes those who develop new procedures, those who are responsible for undergraduate and graduate training in design, measurement, and statistics, as well as those who employ those procedures in research. The journal solicits original theoretical, quantitative empirical, and methodological articles; reviews of important methodological issues; tutorials; articles illustrating innovative applications of new procedures to psychological problems; articles on the teaching of quantitative methods; and reviews of statistical software. Submissions should illustrate through concrete example how the procedures described or developed can enhance the quality of psychological research. The journal welcomes submissions that show the relevance to psychology of procedures developed in other fields. Empirical and theoretical articles on specific tests or test construction should have a broad thrust; otherwise, they may be more appropriate for *Psychological Assessment.*