Resistance, Reactance, and the Difficult Client

E. Thomas Dowd
Daniel Sanders
Kent State University

Abstract

This article describes the effect of client resistance and reactance in the counselling process and methods for assessing these phenomena. In addition, client symptoms are conceptualized as either ego-syntonic, where the symptom is consonant with the client's self-image, or as ego-dystonic, where the symptom is dissonant from the client's self-image. These concepts are then used in deriving counselling strategies for working with difficult clients according to a model that crosses high and low reactance with ego syntonicity-dystonicity. According to this model, the least difficult clients are those whose reactance is low and whose symptoms are ego-dystonic. The most difficult clients are those whose reactance is high and whose symptoms are ego-syntonic. Clients whose reactance is low and whose symptoms are ego-syntonic or whose reactance is high and whose symptoms are ego-dystonic are moderately difficult. Counselling interventions designed for clients in each of the four categories are described.

Résumé

Cet article décrit l'effet de la résistance et de la "réactance" du client à l'intérieur du processus de counseling et les méthodes pour évaluer ces phénomènes. De plus, les symptômes des clients sont conceptualisés comme étant soit syntonique au moi, dans le sens où le symptôme est consonnant avec l'image de soi du client, ou comme étant dystonique au moi, dans le sens où le symptôme est dissonnant de l'image de soi du client. Ces concepts sont par la suite utilisés pour dériver des stratégies de counseling pour travailler avec des clients difficiles selon un modèle qui croise la "réactance" élevé ou basse avec la syntonique-dystonique au moi. Selon ce modèle, les clients les moins difficiles sont ceux dont la "réactance" est basse et dont les symptômes sont dystoniques au moi. Les clients les plus difficiles sont ceux dont la "réactance" est élevée et dont les symptômes sont syntoniques au moi. Les clients dont la "réactance" est basse et dont les symptômes sont syntoniques au moi ou bien la "réactance" est haute et dont les symptômes sont dystoniques au moi sont modérément difficiles. Des interventions en counseling, s'appliquant à chacune des quatre catégories, sont décrites.

Interference in the counselling process can be seen as arising from two sources; those external to the client and those found within the client. Strong and Matross (1973) allude to this distinction when they speak of client change as the relative strength of forces impelling compliance (counsellor social power) and those restraining compliance (client resistance and opposition). Resistance is the client's nonacceptance of counsellor influence due to the perceived illegitimacy of counsellor power, role, and influence attempt. Opposition is the client's disagreement with the content of the counsellor's communication or the implications of the change advocated. The purpose of this article is to focus on the dynamics within the client which often interfere with the client-counsellor relationship, or opposition as defined by Strong and Matross.

RESISTANCE

Most counsellors are familiar with the concept of resistance, although it has been defined differently in different theoretical systems. Psychodynamic theory has traditionally viewed resistance as a problem which must be overcome by whatever techniques therapists have at their disposal. Cognitive behavioural (Meichenbaum & Gilmore, 1982), social influence (Dixon, 1986), and systems theories (Anderson & Stewart, 1983) of psychological change, in contrast, generally espouse the position that resistance is a natural and often necessary concomitant of the change process. It should therefore be worked with, rather than opposed.

Constructivism, however, offers a new look at resistance within the counselling context (Mahoney, 1988a; 1988b; Liotti, 1989). According to constructivism, people actively organize and construct their perceptions of the world into meaning systems known as cognitive schemata. These schemata are organizing frameworks that both are created by and, in turn, create the individual's view of reality. Mahoney (1988a; 1988b) states that resistance is self-protective and often adaptive. He stresses that "resistance to change serves as a natural and often healthy function in protecting core organizing processes (and hence systemic integrity) from rapid or sweeping reconstructive assault" (1988b, p. 300). Mahoney has argued that tacit structures are difficult for the individual to explicate and are resistant to change, because they are embedded in the person's meaning structures. For example, automatic cognitive rules involving interpersonal trust are difficult to talk about. People simply do not know at a conscious level what their assumptions are, about who to trust and when to trust. While they may feel mistrustful, they cannot state consciously that a tacit rule may be, "I can never trust people to be there for me."

Similarly, Liotti (1987; 1989) states that psychotherapeutic resistance arises primarily from the individual's natural resistance to the displacement of old meaning structures by new ones. The resistance to change by a construct is a function of its past ability to predict events along with its centrality to the individual's experience and personal identity. Those self-schemata which have been highly predictive and/or very central to an individual's meaning system are more resistant to change. Thus, a self-schema of oneself as a noble, self-sacrificing person will be resistant to data indicating that one can often behave very selfishly.

This view of resistance is confirmed by Meichenbaum and Gilmore (1982) who state that resistance is a reluctance to consider data that does not confirm one's pre-existing view of the world. Festinger (1957) as well states that people strive for cognitive consistency and attempt to avoid dissonance. However, this viewpoint implies that resistance is situation-specific—that is, it is generated from a particular life situation (Dowd,

1989). According to this view, for example, a woman who does not trust men will tend to interpret men's behaviour towards her as untrustworthy —but not necessarily the same behaviour of women.

The experimental psychology literature on implicit learning and tacit knowledge can also contribute to our understanding of resistance (Dowd & Courchaine, 1992). Implicit learning has been shown to occur through the tacit, or unconscious, detection of covariation, where previously unrelated events are now associated because they have occurred together. In so doing, they form tacit cognitive rules. For example, fear learned in a specific situation may be repeatedly evoked in that or in similar situations in the future, without the individual ever being able to say exactly what about the situation is fearful. In the process, a tacit rule is formed such that, "One must always be afraid of 'X'." Indeed, it has been shown that, when faced with ambiguous stimulus events, individuals tend to impose their preexisting interpretive categories on these events, even if the events and categories do not objectively match. In other words, we see what we have been taught in the past to see, and these perceptions then colour our future interpretation of similar events. The self-perpetuating nature of these tacit interpretive categories suggests that they will be very resistant to change.

REACTANCE

In contrast to resistance, psychological reactance, as described by Brehm and Brehm (1981), is a motivational force to restore lost or threatened freedoms. Where the cognitive theory of resistance focuses on meaning structures, the cognitive theory of reactance focuses on a sense of personal control in people's lives. Brehm and Brehm (1981) state that a perceived loss of previous control intrinsically motivates the person to restore that control. For example, if a counsellor suggests that a client no longer engage in a certain behaviour, the client may seek to restore that freedom by opposing the counsellor's interventions. These attempts to restore freedom may occur in a variety of ways: by directly engaging in the prohibited behaviour, by watching others engage in the prohibited behaviour, by engaging in a similar behaviour, or by experiencing an increased attraction to the prohibited behaviour. The individual may fight back for a time but, after experiencing repeated failure to control events, may give up and succumb to feelings of helplessness and subsequently exhibit decreased motivation for control (Brehm & Brehm, 1981). The motivation to restore or protect threatened freedoms is potentially very powerful, involving significant tacit core assumptions about the way people should act in the world. Such an assumption may be especially powerful in the individualistic North American and Western European cultures, where cultural assumptions regarding the desir-

ability of individual control are strong (Dowd, 1989). Conversely, this tacit assumption may not be as powerful in other cultures that place the welfare of society over the welfare of the individual or where cultural ideas such as "fate" or the "will of God" are stronger. Thus, the counsellor should be aware of the possibility of strong tacit schemata for personal control in their clients, such as, "I must be in control at all times" or "My welfare should supersede that of others."

DEVELOPMENTAL ANTECEDENTS

Just as normal opposition in small children may be seen as a positive developmental event indicating the child's increasing autonomy, Brehm and Brehm (1981) also suggest that a variety of positive maternal actions, such as expressions of approval, acceptance, hugging, and smiling correlate with infants' compliance with maternal requests. Brehm and Brehm (1981) state that deviant oppositional behaviour may be the result of certain parenting styles, such as physical and psychological punishment, reliance on physical control, material reward, and number of verbal commands issued.

Dowd and Seibel (1990) have integrated the formulations of Brehm and Brehm (1981) with the developmental psychopathology theory of Vittorio Guidano (1987). Critical to the emerging sense of personal identity is the development of a flexible autonomy. This autonomy is fostered by an intermediate level of reactance. Without autonomy there is no identity and no reactance. For example, a child lacking in autonomy would lack a sense of identity and would display no reactance. Identity can develop only when the child feels autonomous from others; likewise, without autonomy there can be no loss of freedom to react against. There was never freedom to begin with. Autonomy is best developed when the parental figure fosters unconditional acceptance and safe separation, with a safe base of support when necessary. However, the likelihood of abnormal levels of either compliance or reactance is increased when the child experiences the frequent use of physical punishment, coercive control instead of reasoning, an inconsistent reward and punishment system, and excessive criticism. In these situations the child could become overly reactant or overly compliant.

In the case of extreme and indiscriminant reactance, children may be seeking to establish autonomy. However, paradoxically they develop no true sense of identity. They become simply the inverse of the identity of the parental figure against whom they are reacting. Parental figures who punish autonomy and do not provide a safe base of support may have a child who has an unusually low level of reactance, which does not aid either the development of adult autonomy or true identity.

HIGH REACTANT CHARACTERISTICS

Dowd and Seibel (1990) suggest that if reactance were to be measured and normally distributed, we might describe those individuals at one extreme of the distribution as abnormally nonreactant whereas those at the other extreme might be described as abnormally reactant. The former may be described as helpless whereas the latter may be described as oppositional.

Brehm and Brehm (1981) cite evidence indicating that there is a significant correlation between reactance and internal locus of control, between reactance and Type A personality behaviour (among men), and between reactance and a high level of private self-consciousness. More specifically, Dowd and Wallbrown (1993) have shown that highly reactant people tend to be aggressive, dominant, defensive, easily offended and autonomous. Dowd, Yesenosky, Wallbrown and Sanders (1992) found that highly reactant individuals, according to the revised California Personality Inventory (CPI-R), are characterized by the following descriptors: unconcernred about making a good impression; intolerant and dominant; and more concerned with achieving through independence, where freedom and individual initiative are valued, than achieving in settings where there are strict rules and expectations.

Dowd and Wallbrown (1993) caution that, although many of the descriptors may convey a negative image of clients, one can speculate that such people would be forceful and effective leaders in many circumstances. They would likely be confident and not easily disuaded from goals seen as important. They may display strength and character and seek to take control of events rather than allowing events to take control of them. Loucka (1991) found that men were significantly more reactant than women.

Dowd (1993), combining the developmental theory of reactance with the results of the above studies, has speculated that the abnormally high reactant individual may be low on a sense of identity and high on autonomy, whereas the abnormally low reactant client may be low on both. If this were to be true, then different counselling strategies and interventions may well be needed for high and low reactant clients.

ASSESSMENT

Resistance and reactance have always been difficult to assess. Until recently, they were assessed by *post hoc* behavioural measures such as non-compliance with homework or by counsellor judgement as a result of client behaviour in the interview session. Thus, counsellors would describe clients as "resistant" if they did not complete homework assignments, were late to sessions, or consistently did not accept the counsellor's interpretations. There are several problems with this type of assessment. First, insofar as they are *post hoc*, they risk being tautological,

i.e. non-compliance is subsequently labeled resistance even though it explains nothing. Second, the counsellor's ideas are assumed to be correct by definition, and the client's ideas are discounted and labeled "resistant" if they are different from the counsellor's. Third, they are based on counsellor judgement only and therefore are fraught with potential unreliability. Fourth, such labeling leads to no differential counsellor behaviour and in practice often results in the client being dismissed as "unmotivated."

Recently, however, there have been several paper and pencil measures of psychological reactance developed that allow the counsellor to assess this construct *a priori*. This allows the counsellor to measure the level of client reactance potential before counselling begins. Furthermore, new theoretical concepts have been developed that can help the counsellor decide which techniques to use for clients of different levels of reactance. Dowd and his colleagues (Dowd, Milne & Wise, 1991) constructed the Therapeutic Reactance Scale (TRS) to measure characterological reactance. This 28-item scale is easily administered and Dowd et al. have provided normative data as well as reliability and validity data. Hong and Page (1989) developed a similar 14-item scale that shows good reliability.

Counsellors can also use a variety of behavioural data to assess level of reactance. These include assigning homework and monitoring compliance or noncompliance, observing no-show rates and late arrivals, as well as observing such in-session behaviour as repeated objections to counsellor statements or consistent hostile comments. Frequent use of the term "yes, but" can indicate client reactance as well. Counsellors can also monitor their own feelings of anger and frustration towards clients, since highly reactant clients often arouse just these feelings in their counsellors. Finally, counsellor feelings that, "I'm working harder than my client!" or "I'm spinning my wheels!" are often the sign of a highly reactant client.

INTERVENTIONS

According to Rohrbaugh, Tennen, Press and White (1981), there are two classes of interventions to consider when exploring the counselling techniques that might be used with a reactant client. When reactance is low, a compliance-based approach where the client changes by attempting to comply with the counsellor's directives may be the most effective approach. For example, a low reactant or compliant client is likely to carry out homework assignments that are designed to help solve the problem, whereas a reactant or defiant client is likely not to complete these assignments. On the other hand, when the client is high on reactance, the counsellor may wish to use a defiance-based approach, where the client changes as he or she seeks to defy the counsellor's directives. In this situation, for example, the counsellor may instruct the

client to come to the next session with a high level of anxiety so that this anxiety can be examined more clearly. A highly reactant client would be more likely to come with reduced anxiety.

The second factor discussed by Rohrbaugh, et al. (1981) is the relative freedom of the behaviour. Behavioural freedom refers to the degree of understanding of and control over the problem behaviour that the client feels. For example, anxiety is typically experienced as nonvolitional and out of control; therefore it would rank low on behavioural freedom. Conversely, such habit disorders as smoking or overeating are clearly free behaviours, in that the client knows what to do to reduce or eliminate the problem; avoid putting either cigarettes or food in the mouth! The problem is the lack of motivation or control, not the lack of knowledge. However, as Dowd and Trutt (1988) have noted, there are conceptual problems with this second dimension. First, the reactance dimension much more clearly separates different counselling strategies than does the behavioural freedom dimension. Second, all problems are perceived at least to some extent as unfree or the client would not seek counselling at all. He or she would simply lose weight, for example. Therefore, in an attempt to rectify the conceptual problems with the compliance-defiance model, we have reconceptualized the second dimension. A central factor to consider in working with the difficult client is the level of emotional distress felt by the client regarding the problem. It is important to determine if the problem is experienced by the client as being either an integral part of the self-concept (ego-syntonic) or as alien to the self-concept (ego-dystonic). If the problem is ego-dystonic, then the client will more likely be distressed and therefore more highly motivated to change. However, if the problem is ego-syntonic, then the motivation for change is likely to be lower. In this case, the client enters counselling mainly because he or she is being pressured by external forces (i.e. significant others, employers, courts, etc.) to do so.

There are four possible categories of reactance level and ego syntonic or dystonic behaviour. In the first category, the easiest to treat, problems are more likely to be seen as dissonant with the self-image by the client, he or she is not reactant, and is therefore likely to comply with the counsellor's directives. Motivation to change is likely to be high. Indeed, Dowd and Trutt (1988) suggest that in this situation conventional techniques may be adequate for change to occur and that unconventional strategies such as paradoxical interventions may not be necessary at all. Reframing or positive connotation, a quasi-paradoxical technique which involves interpreting in a positive light that which the client interprets in a negative light, may be particularly useful here. Otherwise, the usual armamentarium of counsellor interventions should be appropriate and sufficient. For example, a compliant client who comes in with a personally distressing problem such as speech anxiety is likely to be receptive to

the counsellor's interventions. Reframing situational anxiety in the workplace as concern with doing a good job may help in the short run. Or, as one client stated, "I want my anxiety to work *for* me."

In the second category, clients are low on reactance and their problematic behaviour is not contrary to their self-concept. Here, the task is to turn ego-syntonic behaviour into ego-dystonic behaviour. This can be accomplished in several ways. First, the counsellor can present the problem to the client as thematic (i.e. pervasive throughout the client's life) rather than situationally specific. Second, the counsellor can explore the external forces that have led to the client seeking, or being placed in, counselling. These forces, as they are explored with the client, are then used as "leverage" in the treatment process. Third, it can be helpful to work with the client to discover the underlying motivators of the behaviour and to assist the client in discovering more appropriate ways to satisfy his or her desires. This technique may also reduce reactance, since the client is helped to find an alternative way of achieving the same goal. In this situation the client is able to maintain and perhaps even enhance his or her self-esteem. For example, a client who has obtained much gratification in the past from being a depressed person or an invalid can be helped to examine both the reasons for this choice of a coping strategy and alternative methods of achieving the same goals.

Clients in the third category may represent a higher lever of difficulty than those in the first two because of the higher level of reactance, although their problem is ego-syntonic. In this situation, the therapeutic task is to reduce the level of reactance so that the motivational pressure inherent in the ego-dystonic state may be allowed to motivate the client to change. Clients may not be happy with themselves; however, they may also be threatened by the prospect of losing a number of "free" behaviours. For example, a client may want to give up cigarette smoking but may be resistant to accepting counsellor suggestions for a smoking reduction plan. According to Brehm and Brehm (1981) the perceived or actual loss of freedom of action is a loss of control. In such situations, clients will seek to prevent the loss of free behaviours or to restore lost free behaviours, and hence are motivated not to change. Clients with high reactance potential may need a therapeutic approach which affirms their sense of freedom of action and does not push them too hard, yet provides definite information. There is evidence that reactant individuals may respond better to decisive rather than tentative counsellor interpretations (Dowd, Trutt & Watkins, 1992) and that highly reactant clients may reduce a problem behaviour, such as cigarette smoking, more readily when a low amount of negatively-toned advice is given (Graybar, Antonuccio, Boutlier & Varble, 1989). There is also evidence that highly reactant individuals may respond better to low discrepancy interpretations (discrepant from the individual's preexisting viewpoint) than

moderate discrepancy interpretations (Loucka, 1991) and that reactant counsellor trainees prefer unstructured supervision, at least in noncrisis situations (Tracy, Ellickson & Sherry, 1989).

The use of paradoxical interventions may also be appropriate in this situation. There are a number of paradoxical interventions which are useful for highly reactant clients. Dowd and Trutt (1988) stated that paradoxical interventions do not form a therapy of their own, but are rather a class of techniques that should be incorporated into the counsellor's armamentarium and used as appropriate. Symptom prescription is a paradoxical intervention which directs the client to deliberately experience the problematic behaviour. The client is thus placed in a double-bind. An inability to experience the symptom implies the problem is solved, whereas an ability to deliberately experience the symptom implies that one has control over it and can choose not to experience it as well. Restraining involves directing the client to change slowly or not to change at all. Highly reactant clients will tend to defy the counsellor, thus changing faster than they might otherwise. This strategy has been used extensively in sex therapy and is known in lay terms as "reverse psychology." Positioning, in which the counsellor agrees with, or even exaggerates, the client's negative view of self may also be useful with highly reactant clients. This strategy is most useful when the negative comments are designed to elicit positive comments from others in order to put oneself in a "one down" position. For example, a client may describe, in florid terms, all the dreadful things he or she has done and what an evil person he or she is as a result, in order to get the counsellor to disagree and point out what a worthwhile person he or she really is. Counsellor agreement with the client's viewpoint can effectively terminate this power tactic and the oppositional client has no choice but to become more positive about self. Dowd and Trutt (1988) suggest that this technique must be used cautiously, as it can be perceived as sarcastic or can increase such problems as depression.

Clients in the fourth category are the most difficult to treat, not only because they are highly reactant, but because the symptomatic behaviour supports their self-concept. The counsellor is faced with the dual necessity of not only changing ego-syntonic behaviour into ego-dystonic behaviour, but also of reducing client reactance. These are the truculant, oppositional clients, seeing their symptoms as someone else's problem, who have bedeviled generations of counsellors. For example, it is not uncommon for couples undergoing marriage counselling to attribute all the problems in the marriage to their spouse, leaving themselves as the much maligned and long-suffering martyr. The tacit assumption may be, "It is my destiny to suffer for the sins of others!" In such situations it may become necessary for the counsellor to use multiple strategies. The interventions described above for working with highly reactant clients

may be useful. In addition, the methods described above for turning ego-syntonic behaviour into ego-dystonic behaviour may also be helpful. Since the client is resistant to change and sees the behaviour as consonant with his or her self-image, it is easy to derogate the counsellor as a credible change agent. Multiple sources of change-producing agents, such as group counselling, or interventions involving family members, may also be useful here. For example, the involvement of other people, such as family members or other members of a counselling group, all presenting the consistent viewpoint that the client's behaviour is his or her own problem and not someone else's, may eventually cause the client to see his or her symptoms as ego-dystonic. Such efforts at overcoming denial are commonly practiced in substance abuse counselling. Likewise, the use of defiance-based interventions may help in reducing reactance, as well as providing alternative ways for the client to meet his or her needs. Whenever possible, these alternatives should be presented as the client's own ideas, to enable him or her to "save face." However, counselling with clients in this situation is, at best, a slow and uneven process.

CONCLUSIONS

Psychological reactance is a key variable in understanding and working with difficult clients. The psychological defense system assembled over the years by clients to protect and enhance their self-concept can only be penetrated with their cooperation, and they will not cooperate in a healthy manner unless the counsellor is viewed as non-threatening. We have attempted in this article to describe a conceptual framework and some interventions derived from that framework to assist counsellors in being seen by difficult clients as allies rather than enemies. For highly reactant clients, it is important that the counsellor not threaten too much "free" behaviour, provide a relatively unstructured counselling session, and not provide interpretations of the client's behaviour that are too different from existing client ideas. Nevertheless, highly reactant clients may appreciate, and respond positively to, a direct, no-nonsense counsellor style. The use of defiance-based interventions, in which the client's reactant posture is used in the service of change, may be useful. Helping the client to find alternative ways of satisfying his or her needs may also be helpful.

Changing a consonant (ego-syntonic) behaviour into a dissonant (ego-dystonic) behaviour may be accomplished by repeatedly pointing out how the client's problem is thematically pervasive throughout life, rather than situation-specific. The use of other important people in the client's life may help, since it is more difficult to deny the same point of view coming from multiple sources. Again, helping the client to find alternative, more socially acceptable ways of meeting his or her needs may be helpful.

An important principle in working with difficult clients is repetition. Clients who are either highly reactant, whose symptoms are seen as ego-syntonic, or both, are not likely to change rapidly. The counsellor must have the patience and the ability to repeatedly provide the same interventions and interpretations, often in the face of hostility and denial, and to be satisfied with small gains at first. However, the rewards of helping a difficult client to overcome his or her long-entrenched problems can be truly rewarding.

References

Anderson, C. M. & Stewart, S. (1983). *Mastering resistance: A practical guide to family therapy.* New York: Guilford.

Brehm, S. S. & Brehm, J. W. (1981). *Psychological reactance: A theory of freedom and control.* Orlando, FL: Academic Press.

Dixon, D. N. (1986). Client resistance and social influence. In F. J. Dorn (ed.), *The social influence process in counseling and psychotherapy.* Springfield, IL: Thomas.

Dowd, E. T. (1989). Stasis and change in cognitive psychotherapy: Client resistance and reactance as client mediating variables. In W. Dryden & P. Tower (eds.), *Cognitive psychotherapy: Stasis and change* (pp. 123-38). London: Cassell.

———. (1993). Motivational and personality correlates of psychological reactance and implications for cognitive therapy. *Psicologia Conductual (Behavioural Psychology), 1,* 145-56.

Dowd, E. T. & Courchaine, K. (1992). Implicit learning, tacit knowledge, and implications for stasis and change in cognitive psychotherapy. Paper presented at the annual convention of the Association for Advancement of Behavior Therapy, Boston.

Dowd, E. T. & Seibel, C. (1990). A cognitive theory of resistance and reactance: Implications for treatment. *Journal of Mental Health Counseling, 12,* 458-69.

Dowd, E. T. & Trutt, S. D. (1988). Paradoxical interventions in behaviour modification. In M. Hersen, R. M. Eisler & P. M. Miller (eds.), *Progress in behavior modification,* Vol. 23 (pp. 96-130). Sage.

Dowd, E. T. & Wallbrown, F. (1993). Motivational components of psychological reactance. *Journal of Counseling and Development, 71,* 533-38.

Dowd, E. T., Milne, C. R. & Wise, S. L. (1991). The Therapeutic Reactance Scale: A measure of psychological reactance. *Journal of Counseling and Development, 69,* 541-45.

Dowd, E. T., Trutt, S. D. & Watkins, C. E. (1992). Interpretation style and reactance in counselor's social influence. *Psychological Reports, 70,* 247-54.

Dowd, E. T., Yesenosky, J. M., Wallbrown, F. & Sanders, D. (1992). Psychological reactance and its relationship to normal personality variables. Unpublished manuscript, Kent State University.

Festinger, L. (1957). *A theory of cognitive dissonance.* Stanford, CA: Stanford University Press.

Graybar, S. R., Antonuccio, Boutlier, L. R. & Varble, D. L. (1989). Psychological reactance as a factor affecting patient compliance to physician advice. *Scandinavian Journal of Behavior Therapy, 18,* 43-51.

Guidano, V. F. (1987). *Complexity of the self: A developmental approach to psychopathology and therapy.* New York: Guilford.

Hong, S. & Page, S. (1989). A psychological reactance scale: Development, factor structure, and reliability. *Psychological Reports, 64,* 1323-26.

Liotti, G. (1987). The resistance to change of cognitive structures: A counterproposal to psychoanalytic metapsychology. *Journal of Cognitive Psychotherapy: An International Quarterly, 1,* 87-104.

———. (1989). Resistance to change in cognitive psychotherapy: Theoretical remarks from a constructivistic point of view. In W. Dryden & P. Trower (eds.), *Cognitive psychotherapy: Stasis and change* (pp. 28-56). New York: Plenum.

Loucka, P. A. (1991). Client reactance and counselor interpretations: Do they make a difference? (Doctoral Dissertation, Kent State University, 1990), *Dissertation Abstracts International*, 52-01B, 522.

Mahoney, M. J. (1988a). Constructive metatheory: I. Basic features and historical foundations. *International Journal of Personal Construct Psychology, 1*, 1-35.

———. (1988b). Constructive metatheory: II. Implications for psychotherapy. *International Journal of Personal Construct Psychology, 1*, 299-316.

Meichenbaum, D. & Gilmore, B. (1982). Resistance: From a cognitive-behavioral perspective. In P. Wachtel (ed.), *Resistance in psychodynamic and behavioral therapies*. New York: Plenum.

Rohrbaugh, M., Tennen, H., Press, S. & White, L. (1981). Compliance, defiance, and therapeutic paradox: Guidelines for strategic use of paradox interventions. *American Journal of Orthopsychiatry, 51*, 454-67.

Strong, S. R. & Matross, R. P. (1973). Change processes in counseling and psychotherapy. *Journal of Counseling Psychology, 26*, 98-107.

Tracey, T. J., Ellickson, J. L. & Sherry, P. (1989). Reactance in relation to different supervisory environments. *Journal of Counseling Psychology, 36*, 336-44.

About the Authors

E. Thomas Dowd, Ph.d. is Professor of Counseling Psychology at Kent State University and Adjunct Professor of Psychology in Psychiatry at the Northeast Ohio Universities College of Medicine. He is a Fellow of the American Psychological Association and holds Diplomates in Counseling Psychology and Behavioral Psychology from the American Board of Professional Psychology, Inc. His professional and research interests are in cognitive behaviour therapy, paradoxical interventions, and psychological reactance.

Daniel Sanders, Ph.D. is Assistant Professor of Counseling Psychology at Kent State University. His professional and research interests are in career counselling, assessment in rehabilitation counselling, and minority affairs.

Address correspondence to: E. Thomas Dowd, 316 White Hall, Kent State University, Kent, Ohio 44242, USA.