Resistance/Reactance Level

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Psychotherapists from all professions and perspectives periodically struggle to effectively manage a patient's resistance to change. This article provides definitions and examples of patient-treatment matching applied to patient resistance or reactance. We report the results from an original meta-analysis of 12 select studies ($N = 1,102$) on matching therapist directiveness to patient reactance. Our findings support the hypothesis that patients exhibiting low levels of trait-like resistance respond better to directive types of treatment, while patients with high levels of resistance respond best to nondirective treatments ($d = .82$). Limitations of the research reviewed are noted, and practice recommendations are advanced. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 67:133–142, 2011.

Keywords: resistance; reactance; treatment outcome; directiveness; meta-analysis; therapy relationships

Although resistance may be conceptualized in a variety of ways, it is generally well-accepted that a patient's resistance to change is one of the more challenging problems psychotherapists face. Seen as more than a failure to improve, resistance is often seen when a patient's behavior is directly or indirectly contrary to the recommendations of the therapist and/or to the health of the patient. This paradox of psychotherapy suggests that even the most well-intentioned patients may possess ambivalence about making beneficial changes and therefore fail to take action towards those changes.

Patients who do not comply with therapy procedures, even when believing that doing so will be helpful, are usually given the label of *resistant*. However, such a label implies that the problem lies solely with a characteristic of the patient and would disappear if he or she were more committed. Such an assumption may be unwarranted for a great number of patients and do little to help therapists improve the outcome of work with such patients. We believe it is more accurate to describe a patient's failure to respond favorably with therapy procedures as a problem of *reactance* rather than resistance.

Reactance implies that the psychotherapy environment, including the psychotherapist, plays a role in inducing noncompliance. By extension, a therapist has some control over the failure of therapy resulting from a patient's poor motivation or failure to change—it is also reflects a failure of the therapist to fit treatment to the receptivity of the patient. In consideration of this viewpoint, we have included a discussion of reactance in this article and use it interchangeably with the more usual term resistance. Our explicit objective is to consider how a patient's failure to thrive may be a reflection of poor fit between patient and treatment. We address the notion that by looking beyond the patient to the demands of the therapeutic environment, we can target processes that can facilitate better patient cooperation and improve outcomes.

The literature on patient resistance has arisen from two simple observations: (a) in every form of psychotherapy, some individuals don't change, no matter how skilled or

knowledgeable the therapist may be (Howard, Krause, & Lyons, 1993), and (b) in the end, most studied psychotherapies seem to achieve similar amounts of change to one another, a phenomenon characterized as the dodo bird verdict (e.g., Beutler, 2009; Budd & Hughes, 2009; Wampold et al., 1997; Wampold, 2001).

Since the mid-1970's, the preferred methodology of comparative psychotherapy research has been the randomized clinical trial (RCT). This methodology has been considered, in most circles, to be the "gold standard" for identifying research-supported treatments (aka, research-informed, evidence-based, empirically-supported; c.f., Norcross, Beutler, & Levant, 2006). This methodology compares two or more manualized treatments or employs a delayed or no-treatment control group as a comparison with a bona fide treatment. In actuality, none of these idealized treatments are homogeneous but are represented by clusters of interventions that may differ widely in intent. Typically, the discrete interventions within any treatment are aimed at multiple goals, reflecting efforts to create a therapeutic environment and to affect outcome. These treatments (or more accurately, clusters of strategic interventions bound together by a given theory) are applied by specially trained therapists to selected patient groups that share a common diagnosis and are randomly assigned to treatments. Therapists who depart too far from the ideal treatment behavior risk being dropped or are retrained to ensure fidelity in treatment delivery. The effects of therapist variability, the influence of the treatment relationship, therapy context and process variables, and all other factors thought to be extraneous to the specific treatment studied are ostensibly controlled through training, randomization, or the application of statistical controls.

Unfortunately, the effort to eliminate variance using RCT methodologies inadvertently eliminates from study the very aspects of psychotherapy that would allow us to understand and manage patient resistance. Limiting our study to what similarly trained therapists do in common to similarly diagnosed patients, rather than including the variations that exist among commonly trained therapists, the variability among patients within diagnostic groups, or the nature of the context in which psychotherapy is offered, tends to obscure important relational, patient, and therapist contributions to psychotherapy outcome (Beutler, 2009).

In response to the foregoing concerns, contemporary research has begun to examine aptitude by treatment interactions (ATIs). ATI research investigates how different classes of treatment methods interact with specifically defined (and often extra-diagnostic) character-istics of patients. It is increasingly thought that the match between various strategic interventions (rather than broader treatments) and patient characteristics (unique attributes of particular subgroups of patients who may or may not share a diagnosis) is what primarily instigates and maintains change (Castonguay & Beutler, 2006).

This article examines the value of this patient-treatment matching applied to the resistant patient. We report the results from an original meta-analysis on matching a nondiagnostic patient aptitude (resistance) to clusters of strategic interventions that share a common level of therapist directiveness. Our review assesses the prevailing hypothesis that treatment outcomes are enhanced by a good (inverse) fit between the patient's level of trait-like resistance and the therapist's level of directiveness (Beutler, Clarkin, & Bongar, 2000; Norcross, 2002).

Definitions and Measures

Patient Resistance/Reactance

In psychotherapy, the concept of resistance was introduced by psychoanalytic theory. Classic psychoanalytic theory characterized resistance as the patient's unconscious avoidance of unconscious threatening material that might be disclosed and threatened in analytic work (Arlow, 2000). Resistance was an inherent striving to avoid, repress, or control conflicted thoughts and feelings. For example, a patient with significant past trauma may feel threatened by an inquisitive therapist and protectively divert attention away from the threatening material through unconscious processes, or consciously attempt to withhold, falsify, or even refuse disclosure of relevant information.

Outside of psychotherapy, the concept of resistance achieved its greatest recognition within social psychology under the label, *reactance*. In 1966, J. W. Brehm proposed a theory of psychological reactance, defined as a "state of mind aroused by a threat to one's perceived legitimate freedom, motivating the individual to restore the thwarted freedom" (Brehm & Brehm, 1981, p. 4).

In spite of the similarity in the definitions of resistance and reactance, there are several distinguishing features. We have already mentioned that reactance invokes a consideration of the evoking environment, whereas resistance implies a problem contained within the skin of the patient. Beyond this important difference, resistance implies both a state-like and a trait-like quality associated with psychopathology, while reactance is more often confined to state-like behavior that occurs in normal personality expression. Once activated, resistance propensities can escalate to become reactant—oppositional, noncompliant, and rigid (Tennen et al., 1981). For example, an adolescent with high trait-like resistance may be particularly sensitive to threats to freedom (e.g., being disciplined by a parent) and consequently exhibit a reactant oppositional behavior that occurs in normal personality expression. Finally, reactance is expressed as directly oppositional behavior, while resistance can also include a failure to act (e.g., stubbornness, obstructionism, and rebellion).

Clients rarely attribute active opposition as a characteristic of their own behavior in psychotherapy (Kirmayer, 1990). Most ascribe their oppositional response to the effect of being a victim of circumstance, of disease, of others' malevolence, or of the therapy itself. It follows that a therapist may elicit resistant behavior from a client by assuming more control of the patient's behavior within and outside of the therapy sessions than is tolerable, by using confrontational techniques and creating and/or failing to mend alliance ruptures, etc. Thus, as we look for aspects of the therapeutic environment that may evoke resistance, therapist directiveness has become the major contender (e.g., Beutler, 1983; Rohrbaugh, Tennen, Press, & White, 1981; Shoham-Salomon & Hannah, 1991).

Therapist Directiveness

Therapist directiveness refers to the extent to which a therapist dictates the pace and direction of therapy and communicates a direction of needed change, as well as the overall predominance of control established by the therapist to elicit change. That is, directiveness refers to the degree to which the therapist is the primary agent of therapeutic process or change through the selection of specific techniques and/or the adoption of a specific interpersonal demeanor. As such, directiveness imposes a constraint on the recipient's available options, or his or her freedom—the very conditions that elicit reactance. Not surprisingly, therefore, research indicates that effective therapeutic change is greatest when the level of therapist directiveness corresponds inversely to patient level of resistance (e.g., Beutler & Harwood, 2000).

Measuring Resistance and Therapist Directiveness

The task of measuring resistance/reactance is made difficult by several factors. First, limiting the focus of measurement to state resistance displayed in session provides information about the frequency and context of such occurrences but makes it difficult to predict future resistance in different contexts. Conversely, measuring only trait levels of resistance limits one's ability to predict how state-mediating variables affect the variable expression of resistant behavior. Indirect resistance (i.e., passive resistance) or *degree* of compliance to therapy procedures may be less readily measurable than overt resistance or outright refusal to engage in therapy procedures. Furthermore, some expressions of resistance may not be isomorphic with broader psychopathology or even negatively affect outcome of therapy. Last, there is the question of what information is best observed by which party: the therapist, patient (through self-report), or a third-party.

Although there are no current measures that reliably predict the moment when a predisposition to resistance will translate into oppositional/reactant behavior, we can measure

the strength of resistance by assessing the likelihood of its being observed in different situations. That is, resistant traits can be identified by assessing a patient's *sensitivity* to external persuasion or social influence to change behavior, thoughts, and feelings that create a perception of limited choices or loss of control (e.g., Beutler, 1983; Brehm, 1966, 1976).

With the foregoing in mind, it follows that therapist directiveness is best measured at the level of individual therapists and interventions, with judgments based on the degree to which the interventions identified limit choice. Broad treatment orientations that emphasize interventions that require a direct role by the therapist as the catalyst for change (e.g., use of behavioral exposure, interpretations, role plays) can be considered more directive than interventions that emphasize the patient's role in creating his or her own pathways to change.

In the current review, we found that relatively few studies utilized a direct (patient level) measure of patient resistance and even fewer used a direct (therapist level) measure of therapist directiveness. In the rare instances in which the resistance of groups of individuals could be used to infer the presence of a shared level of resistance, such shared characteristics of the patient were considered to indirectly reflect resistance levels. Such group-level measures usually were based on descriptive diagnoses (e.g., borderline personality disorder, substance abuse, unipolar depression). Corresponding direct measures of the therapist's actions are even less frequently used than measures of individual patient behavior in research. Treatment type, as embodied in a manual, was used to infer the therapist's proclivities for directiveness, on some occasions to compare a treatment that dictated directive interventions with one that was explicitly less directive (e.g., behavior therapy vs. nondirective therapy, as per Beutler et al., 1991; Karno & Longabaugh, 2005b; or interpretive vs. insight-supportive therapy as per Piper, McCallum, Joyce, Azim, & Ogrodniczuk, 1999).

Clinical Examples

There are many examples of resistance in psychotherapy: The patient who consistently fails to complete homework assignments, the chronically late patient, the patient who agrees and then disagrees (''yes, but…''), and the patient who becomes angry and verbally attacks the therapist's skill or interventions. Although any patient may show some of these signs when the therapist moves too fast or makes a tactical error, patients who show consistent, cross-situational resistant behaviors may be spoken validly of as a ''resistant patient.'' Consider the case of ''Lisa,'' a 37-year-old European-American female in her third marriage. She sought psychotherapy because of mild depressive symptoms. She presented with a matter-of-fact and assertive style. She indicated that her primary goal was learning how to communicate in a more effective way with her husband. The client admitted that her husband was the one who told her to come to therapy, although he was unwilling to engage in couple therapy himself. Lisa defended her decision to undertake psychotherapy by describing the history of her symptoms in detail and reporting her background. She opened the third treatment session by asking, ''So, what do we do now?'' This was the client's first therapy experience, and she declared she wanted to move through the process and find a solution as quickly as possible. She expected to be through with therapy in a few sessions. This form of resistance may simply result from misunderstanding the nature of psychotherapy and the demands and time requirements associated with change. Such resistance can often be countered by providing education about the treatment process.

By contrast, ''Ray'' was a 34 year-old cocaine abuser who was sent to treatment by his lawyer. He openly expressed a lack of interest in participating and spent the first two sessions sitting quietly but sullenly. He failed to complete homework assignments or performed them in an obviously incorrect and antagonistic way. This ''reactant'' behavior exemplifies the conditions in which fear of losing face, control, or freedom, and a resulting open distrust of the process, can drive oppositionalism and avoidance. Working with this magnitude and type of resistance either requires a very slow and nondirective treatment, in which trust is developed gradually and painfully, or requires the use of paradoxical strategies, in which resistance is not only tolerated but also prescribed. In this latter tactic, the therapist attempts to gain the

patient's trust by acknowledging, agreeing with, or even encouraging the avoidance, with such assertions as, ''make sure you don't reveal more than you want to'' and ''it is not wise to rush into change.'' For example, the therapist suggested to Ray that he had failed to yet develop the strength to face aspects of his relationships and that until he developed this level of experience and maturity, the therapist would continue to encourage him to avoid discussing anything personal about himself. His resistance to being classified as weak helped move him toward greater self-disclosure.

Meta-Analytic Review

The objective of our meta-analysis was to investigate the hypothesis that an inverse fit between patient resistance and therapist directiveness is conducive to enhanced treatment benefit. To ensure an optimal and reliable test of this hypothesis, we began with the description of an ideal prototypic study that could best address the research question of fit. We used Beutler et al. (2003) as our template because it had the following methodological features.

- Three manualized treatments to ensure treatment breadth. Cognitive, narrative, and prescriptive therapies were designed to ensure variability of therapist actions across therapies.
- Patients with comorbid conditions of mild to moderate depression and substance abuse disorder.
- Patient *resistance* was measured before therapy using a self-report measure (the MMPI-2 TRT scale). This avoided the tendency to equate level of resistance with patient diagnosis. Likewise, *directiveness* was assessed through patient-level ratings of therapist actions using external raters applying a pretested scale (the Therapy Process Rating Scale; e.g., Malik, Beutler, Gallagher-Thompson, Thompson, & Alimohamed, 2003).
- Patients were randomly assigned to treatment type and then randomly assigned to therapist within treatment type.
- Directiveness of treatment was monitored in early and late sessions, and resistance was monitored after every five sessions to ensure constancy both of treatment and of fit.
- Outcome was assessed using standard scales for depression and drug abuse, including biological tests of use.
- Fit of treatment and patient was systematically measured and assessed against patient, treatment, and relationship contributors to outcome at the end of treatment and 6 months later.

The review of research literature began with the nearly 30 studies identified by Beutler, Harwood, Alimohamed, and Malik, in their (2002) qualitative review. To this list, we added articles extracted from a search of PsycNet, a computerized database of psychology and mental health publications, using various keywords related to resistance, matching, ATI, and treatment outcome. A final step was a hand search of major volumes that had emerged in the other steps of the search process.

Although the model study exemplifies the excellence desired for our analysis, it was not subjected to inclusion in this particular meta-analysis because the measure of fit was a composite variable that included the fit of resistance and directiveness along with two other measures of fit. Although a significant finding was obtained in the study, the fit of resistance and directives could not be teased out of the composite score from the published data.

Our meta-analysis was based on a carefully selected sample of studies that maintained a relatively uniform methodology and adequate description to ensure consistency in the calculation of ESs. All but one of the selected studies employed a manual-driven and randomized assignment to therapy. The 12 studies, involving 1,103 psychotherapy patients, are summarized in Table 1. (Beutler, Harwood, et al., 2011, present details of meta-analysis as well as a complete list of studies included in the analysis.) Several of these studies hailed from Project MATCH and associated publications (Karno & Longabaugh, 2004, 2005a,b).

Table 1
Resistance and Psychotherapy Directiveness

Study name	N	Design	Measure resistance	Measure directiveness	N ES/Study	M ES (Direct)	M ES (Resist)	M ES (Fit)	95% CI
Calvert et al. (1988)	108	RCT	D (FIRO-B)	D (TOQ)	1			0.52	0.42–0.61
Beutler, Engle et al. (1991)	62	RCT	D (MMPI)	I (CBT v FEP v S/Sd)	3	0.34		0.88	0.79–0.96
Beutler, Grawe et al. (1991)	63	RCT	D (9 Scales)	I (BEH Vs ND)	9			0.62	0.50–0.73
Beutler et al. (1993)	46	RCT	D (MMPI)	D (TPRS)	1	0.33		1.40	1.18–1.61
Piper et al. (1999)	98	RCT	D (QOR)	I (Interp v Insight)	4	0.31	0.43	0.64	0.54–0.58
Karno et al. (2002)	47	RCT	D (MMPI)	I (FST v CBT)	1	0.46	0.42	0.65	0.51–0.78
Karno and Longabaugh (2004)	140	RCT	D (anger)	D (TPRS)	3			1.16	1.04–1.33
	138	RCT	D (anger)	I (MET v CBT)	2			0.43	0.33–0.50
Karno and Longabaugh (2005a)	169	RCT	D (obs)	D (Obs)	4			1.21	1.12–1.29
Karno and Longabaugh (2005b)	139	RCT	D (self-re)	I (TPRS)	6			1.12	1.05–1.18
Clarkin et al. (2007)	62	RCT	I (BPD)	I (DBT v Pdyn v Support)	3			0.14	0.10–0.17
Gregory et al. (2008)	30	RCT	I (BPD)	I (Pdyn v TAU)	4			0.52	0.34–0.69
Total N	1102								
Summary weighted ESs						0.38		0.82	
95% CIs for summary weighted ESs =						0.32–0.43		0.81–0.86	

Note: For ease of interpretation, all effect sizes have been reported as positive values if they support the specified hypotheses. Negative values indicate a failure to support the hypothesized relationships. *Key*: Design = RCT (Randomized Clinical Trial); *Measures of Resistance and Directiveness* = Measure of Resistance and directiveness are either directly measured (D) or indirectly measured (I). Specifically, *D* indicates the use of direct observational ratings of directiveness [obs] or a standardized trait measure—e.g., the MMPI, QOR-Quality of Object Relationships, FIRO-B, or STS-Clinician Rating Form) applied to each individual. *I* indicates that an Indirect measure of Resistance was used based upon a grouping variable such as patient diagnosis—e.g., Borderline Personality Disorder [BPD] or Substance Abuse Disorder [SAD] to indicate resistant groups. Among measures of Directiveness, *D* indicates the use of a direct rating of therapist acts in treatment—e.g., using an observational rating like the Therapy Process Rating Form [TPRS], or a simple observational rating [obs]. *I* indicates the use of an Indirect measure of directiveness, based on the general directiveness of the treatment model used. Below are identifiers of the direct and indirect measures of the directive and non-directive treatments employed. TOQ = Therapist Orientation Questionnaire—a measure of therapist directiveness; Pdyn = psychodynamic treatment—moderately directive; TAU = treatment as usual-non-directive; BEH = behavioral Tx, directive; ND = non-directive or Reflective, non-directive; CBT = Cognitive Therapy, directive; FEP = Focused Expressive Therapy, low directive; Interp = Interpretive, highly directive; FST = Family Systems; NT = narrative therapy; MET = motivational interviewing, non-directive; DBT = dialectic behavior therapy, directive; Support = supportive therapy, non-directive. *N ES/Study* = Number of effect sizes calculated for this study. *M ES (Direct)* = the mean effect size attributable to the directiveness of the treatment—combining all treatments. *M ES (Fit)* = the mean difference between effect sizes for "good" and "poor" fit, estimated in MR/Nat studies from correlational data. All ESs are expressed as *d*. Total Effect size is weighted by the sample sizes of all studies. *M ES (Resist)* = the mean effect size attributable to the resistance variable—combining all varieties.

These analyses were included separately because they entailed different measures both of resistance and of directiveness and they varied in the samples used.

Results

Resistant patients are assumed to experience less benefit and are more prone to prematurely terminate from treatment than those who are cooperative. Unfortunately, although the preponderance of studies available in the literature is supportive of this claim, the reliability of the findings is less than optimal. For example, in our sample of randomly controlled studies, only two provided reliable data on which to calculate an effect size attributable to patient resistance (Piper et al., 1999; Karno, Beutler, & Harwood, 2002). These effect sizes were −.43 and −.42 (the signs are reversed in Table 1 to preserve consistency), suggesting that high resistance was related to low outcomes. Though meager, this finding is consistent with the evidence reported in our earlier review (Beutler et al., 2002). Thus, we tentatively reaffirm that our earlier recommendation, that psychotherapists avoid inciting patient resistance, may be valid.

In 10 of the 12 studies in our meta-analysis, we evaluated the fit of directiveness to patient resistance through individual, direct measure of the patient's resistance, the therapist's directiveness, or both. This assessment at the level of the person and session avoided equating treatment type with directiveness or patient resistance with diagnosis, and it assured independence of measurement.

Table 1 presents the mean ESs (*d*) associated with matching effects, summing across different measures across these studies. The resulting weighted *d* was .82, a large effect. A *d* of .82 suggests that approximately 15% of the variance in outcome may be reflective of the fit of directiveness and patient resistance.

However, the range of effect sizes was relatively wide, with.14 (Clarkin, Levy, Lezenweger, & Kernberg, 2007) being the low value and 1.40 (Beutler, Machado, Engle, & Mohr, 1993) marking the high value. Such variation suggests that the fit of treatment and patient is important, but that additional mediators also are at work and are not accounted for in the data.

Limitations of the Research

Because resistance, as a person trait, cannot be randomly assigned to patients, they are not subject to experimental designs that require direct random assignment. Randomized controlled trials are possible by randomly assigning patients (who vary in resistance) to treatments (which vary in amount of directiveness) and to therapists within treatments (whose differential proclivities to adopt directive interventions can be measured). Our meta-analysis relied heavily on such evidence and excluded studies that did not utilize randomized procedures for assigning patients to treatments and therapists.

Based on 12 studies that we believe are representative of the best available, we found that the evidence supports the hypotheses posed. However, we recognize that there is a particular weakness within this body of studies: they are not equally inclusive of the role of other potential mediators. The role of patient coping style, stage of change, cultural beliefs, and symptom severity are all cases where patient and treatment factors probably interact.

Another limitation in studying patient resistance is the absence of consensually accepted measures of trait-like resistance. Numerous measures have been developed, but they suffer from low or inconsistent intercorrelations. Another concern is the role played by different theories of psychotherapy in setting the level of therapist directiveness. Therapies deemed directive (behavioral, cognitive-behavioral) or nondirective (self-directed, evocative) are presumed advantageous for different patients, though directiveness alone seems to offer the better prospect of treatment outcome.

Summary and Therapeutic Practices

Collectively, the foregoing results provide strong evidence that, other things being equal, low levels of trait-like resistance serve as indicators for patients who respond to directive

interventions. We recommend the following therapeutic practices based on the research findings:

- Psychotherapists can recognize the manifestations of resistance as both a state and a trait. Cues for state-like manifestations of resistance include expressed anger at the treatment or therapist, ranging from simple dissatisfaction with therapeutic progress to overt expressions of resentment and anger.
- Therapeutic responses to such expressions of resistant states entail: acknowledgement and reflection of the patient's concerns and anger; discussion of the therapeutic relationship; and renegotiation of the therapeutic contract regarding goals and therapeutic roles. These responses are designed to defuse the immediate consequences of resistance and to infuse the patient with some sense of control, as suggested in formulations of reactance theory (Beutler & Harwood, 2000).
- Anticipate these reactions by initially assessing the level of patient reactance. Patterns are either assessed by standardized psychological tests that tap interpersonal suspiciousness and distrust or assessed by attending to the historical patterns that have characterized the patient's responses to authority. Patients with high-resistance traits typically manifest a history of difficulty taking direction, a tendency toward stubbornness and obstruction, and difficulty working cooperatively in groups.
- Match therapist directiveness to patient reactance. High reactance indicates a treatment that will de-emphasize therapist authority and guidance, employ tasks that are designed to bolster patient control and self-direction, and de-emphasize the use of rigid homework assignments. Homework assignments may be presented as experiments that require minimal overt action on the part of the patient to avoid failure and to reduce the likelihood of oppositional behavior. The relative amount of listening versus talking should shift more toward the patient, and fewer instructions should be used. Self-directed work and reading may replace the usual instructional activities of the therapist.
- Beware matching the level of therapist directiveness to the *therapist's* reactance level. This surfaces as a common occurrence among neophyte therapists who unwittingly project their own personality structure onto their clients. It is the patient's level of reactance, not the therapist's, that provides the optimal fit.
- Avoid stimulating the patient's level of resistance. Based on the research reviews, we conclude that there is strong and consistent support for a negative relationship between evoking patient resistance and therapeutic outcome. Although a causal chain cannot be certain, the consistency of the correlational evidence is persuasive.
- View some manifestations of client resistance as a signal that ineffective methods are being used. That is, resistance is best characterized as a problem of therapy delivery (not of the patient) and as such, becomes a problem for the therapist to solve. The skilled therapist can find a way to stimulate change and reduce fear of losing control or freedom.

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