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**LA THÈSE A ÉTÉ
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Progressive Changes in Clients' Responses
to Active-Directive Interventions
in Rational-Emotive Therapy

CATHERINE A. PINK

Dissertation presented to the School of Graduate Studies,
University of Ottawa,
as partial fulfillment of the requirements
for the degree of Doctor of Philosophy

Ottawa, Canada
1986

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Curriculum Studorum

Catherine A. Rink was born in Ottawa, March 6, 1948. She received the Bachelor of Household Science from Macdonald Institute, University of Guelph in 1969, the Bachelor of Arts (Honours Psychology) and the Master of Arts (Psychology) from the University of Ottawa in 1976 and 1979 respectively.

Abstract

This was a first study of client responses to active-directive interventions in a directive therapy.

Audiotaped series of RET sessions conducted by Albert Ellis and Lucien Auger were analysed for progressive changes in clients' responses to several active-directive interventions.

The results showed that clients' responded with increasing opposition/resistance to those active-directive interventions specific to RET (cognitive disputation) but with increasing acceptance/compliance to more general active-directive interventions.

In addition, each component of cognitive disputation (challenging questions, directive interpretation, and didactic presentations) led to a unique pattern of client responding over the series of sessions. It was suggested that clients' progressive changes towards increasing acceptance or increasing opposition could be accounted for by the degree of direct personal challenge implied by each intervention.

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Introduction to the Problem

One area of psychotherapy research has as its focus client in-session responses to therapeutic interventions. The aims of such research have been both to test theories of therapy (Kiesler, 1973) and theories of change (Strupp, 1973), and, on a pragmatic level, to assess the contribution, usefulness, and impact of particular interventions on the therapeutic process (Bergin & Strupp, 1972; Ehrlich, D'Augelli & Danish, 1979; Goldstein, Heller & Sechrest, 1966; Gormally & Hill, 1974). The present investigation falls within this domain of psychotherapy process research. In particular, the focus is on progressive changes in client in-session responses to certain interventions over a series of treatment sessions.

The focus of the research is the progressive change in client in-therapy responses to cognitive disputations as they are used in Rational-Emotive Therapy (RET). Cognitive disputation is a central and fundamental RET technique of exposing and challenging clients' irrational beliefs, with the aim of persuading them to give these up in favor of a healthier system of rational beliefs. A number of specific interventions comprise cognitive disputation including direct interpretations, challenging questions, and didactic presentations.

These target interventions belong within the family of active-directive interventions. This larger family, which has been the focus of considerable psychotherapy research and clinical concern, has been given a number of different labels in the psychotherapy literature. Some common labels include: leading

interventions (Ashby, Ford, Guernsey & Guernsey, 1957), authoritarian interventions (Lorr, 1965), active interventions (Butcher & Koss, 1978; Finesinger, 1948; Howe & Pope, 1961), directive interventions (Rogers, 1942; Snyder, 1945; Thorne, 1950), and expert interventions (Schmidt & Strong, 1970; Strupp, 1957).

For purposes of the present study, this family of interventions will be called active-directive. The label *directive*, while being perhaps the most common, has been deliberately avoided since it is predominantly associated with a single theoretical framework; that is, the client-centered. Within client-centered therapy the term *directive* carries a negative connotation which the present research wishes to avoid. The label *active-directive*, on the other hand, reflects the spirit of a wide range of clinical and research writings without suggesting an unfavorable evaluation of the interventions it describes.

The active-directive family of interventions may be found to some extent in virtually all approaches to psychotherapy. Certain approaches, however, are more cordial to its use. In general, it is the more directive therapies that tend to value active-directive interventions. Among the most prominent, contemporary therapies that incorporate active-directive responses is Rational-Emotive Therapy (RET). It is the choice of the present research to study active-directive interventions as used in this well-known, high-profile directive approach. Accordingly, the focus is those active-directive interventions that form an integral part of RET theory and practice, while acknowledging that a variety of other active-directive interventions are no doubt used

in many contemporary directive therapies. While the focus here is those active-directive interventions central to RET, it should be noted that recent reports suggest that the target interventions are being used increasingly by therapists who are not RET practitioners due to the widespread popularity of RET and the other contemporary directive therapies (Grieger & Boyd, 1980). Consequently, the research results have implications for both RET practitioners as well as others who incorporate cognitive disputation into their practice.

The present research constitutes an initial study of client responses to vigorous active-directive interventions as they are used in RET, a prominent, contemporary therapy congruent with the use of such interventions. As such, the study also contributes to RET theory. Specifically, the purpose is to examine progressive changes over a series of sessions in clients' in-therapy responses to the target interventions as they are used by two exemplars of RET, Albert Ellis and Lucien Auger. As suggested by clinical theory, progressive client changes will be investigated in regard to a dimension from client compliance to client opposition.

In general form, the main research question may be framed as follows: In several series of RET sessions, conducted by two exemplars of RET, Albert Ellis and Lucien Auger, when vigorous active-directive interventions are examined, and when client responses are categorized as falling along a dimension of acceptance/compliance and opposition/resistance, will clients' tendencies toward acceptance/compliance and opposition/resistance increase, decrease, or remain the same over a series of sessions?

This is the major question to be investigated. Directional predictions and specific hypotheses will be presented at the end of the Review of the Literature, based on careful examination of clinical theory and related research.

Chapter I

REVIEW OF THE LITERATURE

While the specific focus of the present research is progressive changes in clients' in-therapy responses to particular active-directive interventions central to RET, the Review of the Literature will cover the broader active-directive family of interventions. The aim is to review the literature concerned with active-directive interventions in general, being the larger group incorporating the interventions targeted for this study.

Historical Review of Active-Directive Interventions in Psychotherapy

The purpose of the historical review is twofold. First, the emergence and presence of the family of active-directive interventions will be traced through the development of psychotherapy practice. The goal is to see where these interventions are found in historical context and in contemporary practice. Second, the theoretical context with which the use of active-directive interventions is congruent will be examined, for while these responses might well be found at least occasionally in most approaches to therapy, their use has become especially congruent with and central to particular theories of psychotherapy that have evolved over the years of therapy practice.

Emergence and Presence of Active-Directive Interventions in Psychotherapy Practice

Dubois' Rational Therapy.

The first use of active-directive interventions was around the turn of the century as part of the first directive therapy. This therapy was developed as part of the movement amongst clinicians away from hypnotic suggestion (then the foremost psychological treatment) towards newer forms of psychotherapy (Ellenberger, 1970). Directive therapy was one of two major emerging therapies at that time; the other was psychoanalysis.

The directive approach favored working with the fully conscious patient (rather than the hypnotized one) using a highly persuasive, educational approach and relied substantially on the influential authority of the psychotherapist to sway the patient in the direction of a healthier philosophy of living (Thorne, 1950). Therapy was viewed more as a persuasive, logical appeal to the client to change his or her erroneous, unhealthy ideas than as an opportunity for the client's abreaction of repressed memories and the therapist's giving therapeutic suggestions (as seen in hypnosis). The directive interventions employed to bring about client change included persuasion, advice, suggestion, exhortation, reassurance and direct regulation of the client's life (Thorne, 1950).

This directive approach was pioneered by Paul Dubois, a Swiss physician prominent in Bern. Dubois called his method Moral or Rational Therapy (1909). Because of his cognitive theory, Dubois is regarded as one of the first cognitive therapists (Raimy, 1975). He is also credited with developing persua-

sion, one of the oldest therapeutic techniques (Wolberg, 1967) and with being the first to systematize the influential authority role of the therapist (Thorne, 1950).

Although Dubois was apparently very successful and one of the foremost therapists between 1880 and 1910 (Ellenberger, 1970), he was rather isolated from the two major centers of psychotherapy development, Janet in Paris and Freud in Vienna. No formal school of therapy formed around him. Despite this, his directive techniques survived him and became part of early psychiatric counseling as it developed outside of psychoanalysis (Thorne, 1950).

Directive Trends in Psychoanalysis

Trends toward therapist directiveness and the use of active-directive interventions are also found within the development of psychoanalysis (Butcher & Koss, 1978; Fiedler, 1950; Stone, 1980; Thorne, 1950; Wells, 1982). The theory of psychoanalysis is of course not at all similar to Dubois' theory of therapy, but there were some developments in psychoanalytic techniques in the early days that were along more directive lines. As a result, a controversy of technique and therapist role ensued, ending in part with the formulation of more directive, psychoanalytically-based therapies (e.g., supportive therapy and psychoanalytically-oriented psychotherapy), and with a distinction being drawn between directive and nondirective approaches and interventions.

In the early days of psychoanalysis, the treatment was, in contrast to Dubois' therapy, predominantly nondirective. That is, when Freud abandoned hypnosis, he changed his view of the therapist from that of the traditionally dominant doctor to that

of the neutral, nonintrusive listener (Coltrera & Ross, 1967). He warned against guiding patients' lives, instructing them in daily living or trying to change their philosophy of living, interventions characteristic of directive therapy. Analysis was not considered educational, nor a place for gratifying the patient's needs or focusing on symptom removal (Ellenberger, 1970). Freud's rule for therapists was one of abstinence in these matters.

Freud insisted then, as classical analysts do now, that the therapist's main stance was passive, nondirective, an observer and an interpreter. The only directiveness or activity was in structuring the business details of therapy, such as appointment times, and payment of fees, and in invoking the rules of therapy (e.g., free association and no major decision-making during treatment) (Dollard & Miller, 1950; Kanzer & Blum, 1976). The sole exception to the passive stance was in the treatment of certain phobic patients who at one point in therapy were directed to face the fearful situation. This therapist directive was backed up by the therapist's power as an authority-figure and by threat of termination of treatment (Dollard & Miller, 1950; Bergmann, 1976).

Within the psychoanalytic family, it was Ferenczi who first experimented with and advocated a more active therapist role (Kanzer & Blum, 1976). His innovations created the first psychoanalytic technique dispute and initiated a "creative, vigorous and highly controversial period in the field of technique, which continued until the outbreak of World War II" (Bergmann, 1976, p. 32). Ferenczi himself insisted that his promotion of an active

therapist role did not mean that the therapist should take either the tutorial or authoritarian role generally adopted by physicians, (Ferenczi, 1976), nor Dubois' stance (Glover, 1976). However, his critics maintained that the success of his active methods depended on making use of his position of authority.

They especially objected to his directive technique of exhorting clients not to use their customary defenses during or outside the session (Glover, 1976). These direct behavioral prescriptions were matched by equally directive control of the therapy process. Ferenczi set a termination date for treatment, interrupted free associations when they were being used as a defense, suggested fantasies for clients to follow when they appeared blocked, and insisted that talk be concrete rather than abstract.

Ferenczi, like Dubois and unlike accepted psychoanalytic technique, made use of the therapist's influential authority role as a deliberate lever of change. He directed the process of therapy and insisted on certain client behavior outside the session. Just before his death, he introduced the notion that perhaps the therapist should indulge the needs of the client. This idea was taken up by Alexander and French and was a forerunner of supportive therapy in which the therapist plays a much more active-directive role than in classic psychoanalytic technique.

After Ferenczi, the next major challenge to the classic technique in terms of therapist directiveness came from Alexander and French. In their revision of the psychoanalytic method, the therapist was very active in directing the process of therapy, manipulating the patient-therapist relationship and in using

supportive techniques such as guidance and advice concerning the patient's issues of daily living (Alexander and French, 1946).

They saw the more active-directive, supportive techniques as being on a continuum with the classic technique and a necessary part of every analysis when the patient's ego strength was waning.

In Alexander and French's method, the therapist was more like Dubois' authority-figure than Freud's passive observer/interpreter. What was most like Dubois in terms of technique was the therapist's offering emotional support and encouragement as well as actively intervening in the outside life of the patient.

The active-directive trends introduced by Ferenczi and taken up by Alexander and French contributed to the crisis of technique in psychoanalysis that became evident by the late 1940's and early 1950's. Other contributing factors were: (a) the proliferation of new psychoanalytic theories and attendant therapeutic techniques after Freud's death, along with the growth of psychoanalysis in North America; (b) the attempt by analysts to find techniques that were more effective in treating the standard neurotic patient and to discover means of treating patients not suited to classic technique (e.g., children, psychotics, the elderly) (Bergmann & Hartmann, 1976); (c) the absence of a comprehensive treatise on technique by Freud (Coltrera & Ross, 1967; Bergmann & Hartmann, 1976). One important outcome of this crisis was for the various camps to define more clearly their positions on therapist activity and directiveness (Kanzer & Blum, 1976).

When the classical analysts formulated their position, the

therapist's role was clearly the way Freud saw it: nondirective, passive and neutral. The therapist did not engage in a reeducative type of therapy, nor try to sway the patient's philosophy of living, nor engage in supportive or dependency-gratifying techniques (Kanzler & Blum, 1967). The so-called rational techniques or directive therapy methods such as reassurance, advice, ego-strengthening, and palliative prescriptions were not considered to be part of psychoanalysis proper (Fenichel, 1945). The effectiveness of these methods was considered limited to producing perhaps a transference cure or creating a positive transference that might prepare the patient for a true analysis. Active-directive methods were not seen to promote change of the underlying dynamic structure of personality (the goal of psychoanalysis).

The therapy approaches that used more active-directive techniques were relegated, by the classical analysts, to a place outside of analysis proper. These included, for example, psychoanalytic psychotherapy, supportive therapy, short-term dynamic therapy, and counseling.

In one sense, there appeared to be two groups of analysts: one defining themselves as classical or standard analysts who followed Freud's original nondirective technique with little variation, and another which preferred to expand the original passive, neutral stance to include some more active-directive interventions (Wolman, 1967). However, there is a continuing debate in the psychoanalytic literature concerning the difference or lack of difference between psychoanalysis proper and its more directive offshoots. According to Paolino (1981), who reviewed

the debate, there has been no agreement amongst the experts on this issue. One group holds that there is a sharp difference in technique between psychoanalysis proper and the other psychoanalytically-based therapies. The other believes that there is a blurred difference and that all analysis includes at some point some of the more active-directive, supportive techniques.

Despite this debate, it is clear that within the psychoanalytically-oriented therapies some approaches use interventions that are considerably more active-directive than the standard technique and invite therapists to be more openly and actively the influential authority.

Rogers' Objections and the Client-Centered Position

About the same time that the analysts were defining their concepts of the role and techniques of the therapist in relation to directiveness, therapist directiveness and the use of active-directive interventions became a major issue for psychotherapy and counseling practice in general.

Rogers' (1942) objections to directiveness are a landmark in the history of the use of the family of active-directive interventions. He pointed to implicit theoretical assumptions underlying the use of active-directive interventions and offered an evaluation of their clinical consequences. His strong stance against directiveness on theoretical and empirical grounds allowed related theoretical issues to be brought into the open for the first time. Up to the time of his contribution, the major theoretical issue dealt with was the deleterious effect of active-directive interventions on the development of the transfer-

ence within a psychoanalytic framework.

In contrast, Rogers' primary objection was to an assumption he felt lay behind the use of active-directive interventions; viz., that the client is incapable of assuming responsibility for setting his/her own goals. As a consequence, the therapist/authority had to take on the job of guiding and directing clients towards appropriate, socially-sanctioned goals. Rogers strongly rejected the assumption of client dependence on the authority of the therapist.

He also rejected the client-therapist relationship fostered by these assumptions of the client's state. He particularly criticized psychoanalysis for establishing a parent/child kind of therapeutic relationship but was equally critical of the medical model's physician/patient relationship and the educational model's teacher/student relationship. Rogers believed, instead, that the client needed an accepting, nondirective therapist who could provide unthreatening conditions in which the client could discover his/her own answers, solutions and directions.

Rogers also criticized the older active-directive techniques on empirical grounds. His experience was that interventions such as ordering and forbidding, exhortation, suggestion, reassurance, advice and intellectualized interpretation simply did not work. At best they brought about a superficial or short-term change, but no lasting personality change. This objection is similar to that the classical analysts had to active-directive interventions.

Rogers' position, then, was in opposition to Dubois' theory and practice of therapy, and to the standard psychiatric counsel-

ing of his day. He also opposed at least some aspects of psychoanalysis, particularly its therapist/client relationship and the use of intellectualized interpretation as the means of change.

The issues of theory that Rogers' objections brought to light included questions about the nature of client pathology and needs in therapy, the role of the therapist and the nature of the therapist-client relationship.

At this point in time, the directiveness/nondirectiveness issue seemed to crystallize into a client-centered therapy versus psychoanalysis debate as evidenced by the psychotherapy research literature (Pope, 1977). In the process there was a shift in the meaning of directiveness.

For Dubois, at the turn of the century, directiveness meant the use of interventions such as advice, suggestion and exhortation in a persuasive attempt to change the client's attitudes. For the classical analysts, the meaning was much the same. Any attempt by the analyst to advise, reeducate or indulge the needs of the client was active-directive. Any deviation from the role of neutral observer/interpreter was considered directive, as were techniques that altered the client's unique process of transference development and pattern of free association. For the analysts, staying within the bounds of interpretation and a transference relationship was defined as the correct nondirective position.

For the client-centered therapists, however, therapist directiveness encompassed the Dubois-type interventions as well as precisely those elements considered nondirective by the classi-

cal analysts. For Rogers and his followers the analyst was directive in assuming the role of the authority who unraveled the client's problems through interpretation of the transference. What was considered nondirective by the analysts was included in the directive category by the client-centered group.

Thorne's Directive Therapy

In response to the growing debate concerning directiveness, Frederick Thorne designed a directive therapy (1950) expressly to counteract what he considered to be widespread, uncritical acceptance of the client-centered approach. His idea was to reclaim the older active-directive methods that were being devalued, and to do so within a nonpsychoanalytic theory based on the findings of psychological science.

Thorne is credited with being the developer of directive interviewing (Matarazzo, 1965) and is considered to represent the "authoritarian position par excellence" (Benjamin, 1981).

Thorne (1950) himself felt that he and only a few others, notably Ellis (Rational-Emotive Therapy) and Glasser (Reality Therapy) had been responsible for establishing the basics of directive interviewing. In fact, Thorne did not originate directive interviewing which had its beginnings much earlier in Dubois as well as considerable development in early psychological treatment both within and outside of psychoanalysis. It is perhaps more accurate to say that Thorne clearly established the techniques and underlying theoretical assumptions of directive therapy in more recent psychotherapy practice.

Thorne identified those therapeutic techniques or interventions central to the directive approach. They included reassur-

ance, persuasion, advice, suggestion, information-giving, directions for behavior outside the session, strong directive/authoritative interpretations and confrontation. These were the techniques of the older traditional counseling approaches (Thorne, 1950) and the ones incorporated into the directive offshoots of psychoanalysis.

Thorne's emphasis was on therapy as a learning or relearning situation with the therapist as a sort of paternal authority figure who took firm control of the direction of therapy and even of the client's life until such time as the client demonstrated ability to cope on his/her own. The goal of therapy was for the client to learn, from the therapist, more effective coping methods and adaptations to reality. Therapy did not concern itself with unconscious instincts as it did in the psychoanalytic school nor on releasing emotional blocks to growth as in the client-centered approach.

Like Thorne, Ellis (1962) and Glasser (1965) developed psychotherapies that adhere to the psychoeducational model in which the therapist is active-directive. Both therapists were trained in conventional psychiatric, psychoanalytically-based therapy, which they quickly found to be ineffective and too passive.

Ellis' Rational-Emotive Therapy is a highly cognitive approach in which the client is guided to evolve a philosophy which stresses rational thinking, a scientific approach to life and responsible hedonism (Walen, DiGiuseppe & Wessler, 1980). Clients are taught to stop evaluating themselves and basing their self-worth on the judgments of others.

In Glasser's Reality Therapy, which was developed independently of Ellis' work, the focus is much more on the client's current maladaptive, irresponsible behaviors. Therapy stresses setting goals for better behavior and developing a plan for successfully achieving these goals responsibly, within the limits of society's values and standards. Reality Therapy promotes development of the client's self-esteem through experiences of successfully meeting his/her needs within the demands of reality.

In both Rational-Emotive Therapy and Reality Therapy, the therapist is actively involved, confrontational, and persuasive, making the most of the influential authority role. Both stress the importance of therapy as a learning and relearning process and the role of the therapist as a teacher.

Directive Trends in Contemporary Psychotherapy

In the mainstream of contemporary psychotherapy practice, the use of active-directive interventions is found within two major areas. These are the family of brief or short-term therapies, and the developing cognitive or cognitive/behavioral therapies (of which RET is a prominent member). In addition to these leading members of the psychotherapies, there are also several individual miscellaneous methods of therapy that stress a directive approach (see Jurjevich, 1973).

Brief Therapy: Although the brief therapies encompass a variety of theoretical approaches, e.g., psychodynamic, behavioral and crisis intervention (Butcher & Koss, 1978), the common characteristics include the use of active-directive interventions and a directive role of the therapist.

The actual interventions characteristic of the brief thera-

pies are the same ones noted by Thorne (1950) as central to directive therapy, i.e., support, reassurance, guidance, concrete direction for extra-therapy action, information, suggestion, persuasion, advice, bold interpretation, and direct, aggressive confrontation (Butcher & Koss, 1978; Butcher & Maudal, 1976; Wells, 1982; Wolberg, 1965).

The therapist in brief therapy makes full use of the role of the competent, benevolent authority and parent-figure (Butcher & Koss, 1978; Butcher & Maudal, 1976; Korchin, 1976; Wells, 1982; Wolberg, 1965). The focus and goal of therapy is on the client learning new skills and strategies for coping and adaptation (Wells, 1982). It is a problem-solving, present-oriented focus (Wolberg, 1965) in which the therapist explicitly instructs the client in a healthier philosophy of living, offering his or her values as better or more effective (Butcher & Koss, 1978; Wolberg, 1965).

Cognitive-Behavior Therapy: Also among the mainstream contemporary therapies that use active-directive interventions are the cognitive-behavior approaches. Cognitive therapy is perhaps the latest development in psychotherapy practice (Hoffmann, 1984) and is rapidly becoming the one of the most popular (Mahoney, 1977). The development of the cognitive approaches, their somewhat paradoxical marriage with behavior therapy and their theoretical foundations have been reviewed and analysed by a number of authors including Mahoney (1977), Mahoney and Arnkoff (1978), Stone (1980), and Wilson (1978). The importance of cognitive psychology in personality change has been brought to

psychotherapy practice by theorists, researchers, and clinicians such as Kelly, Rotter, Jerome Frank, Bandura, Mahoney, Mischel, and Goldfried (Rimm & Masters, 1979; Stone, 1980; Wilson, 1978). The most influential therapists in the development of cognitive and cognitive-behavior therapy are Ellis, Beck, and Meichenbaum (Stone, 1980), the most senior and most prominent being Ellis (McMullin & Giles, 1981; Wilson, 1978). Ellis (1979) himself has noted that a number of modern systems of cognitive-behavior therapy overlap theoretically with RET. These include Beck's Cognitive Therapy (1976), Goldfried and Davison's Cognitive-Behavior Therapy (1976), Lazarus' Multimodal Therapy (1971, 1976), Mahoney's Personal Science (1974, 1977), and Meichenbaum's Self-Instruction Training (1974).

Beck (1976) and Ellis (1955) were the pioneers in cognitive approaches to therapy. Starting in the 1950s, they independently developed theories of psychopathology and methods of treatment based on the notion that one's evaluation and interpretation of events preceded emotional responses. They found that in psychological distress, clients' faulty evaluations, misinterpretations, and irrational thinking caused emotional problems, such as depression and anxiety.

Beck and his research team have intensively studied and developed the cognitive therapy of depression (Beck, Rush, Shaw & Emery, 1979). Their focus has been on the distorted cognitions of depressed and suicidal clients as well as on cognitive methods of treatment. More recently, Beck's cognitive model has been applied to the treatment of anxiety and other major psychological disorders (Beck, Emery & Greenberg, 1985).

Ellis' theory of Rational-Emotive Therapy has been mentioned briefly above and is described in detail in a later section.

As the third prominent figure in cognitive-behavior therapy, Meichenbaum has contributed important research on the use of self-statements or talking to oneself as a vehicle of personality/behavior change (1974) and, more recently, has developed a stress-innocation program using the cognitive approach (1975).

Identifying specific active-directive interventions used in the cognitive-behavior therapies is difficult, since there have been few attempts to specify what actually transpires between therapist and client in a cognitive-behavior session (Harrell, Beiman & Lapointe, 1981). Attempts to define or analyse techniques have focused primarily on RET (e.g., Mahoney, 1974; Walen, DiGiuseppe & Wessler, 1980) and to a lesser extent on Meichenbaum's Self-Instruction Training (Mahoney, 1974). The results of attempts to identify the active-directive interventions central to RET will be detailed in a later section.

Some of the interventions characteristic of cognitive-behavioral approaches include didactic persuasion, directive interpretation, assertive confrontation, giving directions for behavior outside the session, mini-lectures and formal argument. The therapist is more active-directive in the cognitive approaches than in other therapies (Beck, 1970) and uses the influential authority position to promote client change (Arnkoff, 1980).

Some authors (e.g., Arnkoff, 1980) suggest that as in the brief therapies, the therapist's values, or ones approved of by the therapist are offered as appropriate for the client. Others

(e.g., Beck et al., 1979) stress that the therapist stays within the client's value system, focusing on more realistic thinking and behaving within the client's frame of reference.

Summary

Active-directive interventions were introduced by Dubois (1909) at the turn of the century as part of his Rational Therapy and were used outside of psychoanalysis in the early psychiatric counseling. Directive trends and ~~active~~-directive interventions are also found within the development of fundamentally non-directive psychoanalysis. In the 1940's and 1950's, the issue of directiveness became a focal point of debate both within psychoanalysis and outside of it. With Rogers' (1942) formulation of nondirective theory and therapy, theoretical issues underlying the use of active-directive interventions were identified. These included assumptions about client psychopathology, the role of the therapist, and the nature of the therapist-client relationship. The use of active-directive interventions was reclaimed by Thorne (1950) in his Directive Therapy and by the directive treatments developed by Glasser (1965) and Ellis (1973). The use of active-directive interventions has been maintained in the mainstream of contemporary psychotherapy practice by two major groups of therapies, the short-term or brief therapies and the cognitive/behavioral. Of these, Ellis' RET is considered to be the most senior and most prominent of the cognitive/behavioral (Mahoney & Arnkoff, 1978; Wilson, 1978) and has been the focus of the majority of the psychotherapy research on cognitive/behavioral methods.

Theoretical Context for the Use of Active-Directive Interventions

The purpose of this section is to review the theoretical context within which the use of the family of active-directive interventions is congruent. A later section will deal specifically with RET theory and rationale for the use of active-directive interventions in that approach.

While there is no formal school of directive therapy, active-directive interventions are found as a central component of approaches that take a common stance on three important issues of psychotherapy theory: the model of therapy, the role of the therapist and the nature of the therapist-client relationship.

Model of Therapy

Approaches that value the use of active-directive interventions share a common model of therapy, including (a) assumptions regarding the nature of psychopathology, (b) the goals of therapy, and (c) the means of therapeutic change.

In general, these approaches hold an adjustment or coping model of therapy (D'Augelli, D'Augelli and Danish, 1981; Thorne, 1950). That is, the focus of therapy is on helping the client adjust and adapt to the demands of reality, society, the environment, and to develop effective coping strategies (Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980). The theory is that the client needs (and comes to therapy to get) the information, knowledge and skills necessary for effective living (Wells, 1982; Wolberg, 1965).

Assumptions Regarding Psychopathology: The assumptions about psychopathology underlying the adjustment model of therapy

include variations on two main themes. One theme is that the client is suffering from loss of, or weak, ego-strength (Thorne, 1950; Wolberg, 1954), or from a loss of control or breakdown, or ineffective efforts to control thoughts, feelings and behaviors (Dubois, 1909; Frank, 1975; Korchin, 1976). The result for the client is vulnerability and less effective coping (Korchin, 1976), irrationality (Thorne, 1950) and reduced ability to regulate behavior along socially acceptable lines (Thorne, 1950). The second theme of psychopathology is that clients' problems stem from faulty thinking (Dubois, 1909; Wolpe, 1973; Young, 1974), an inaccurate view of reality (Glasser, 1965; Young, 1974), maladaptive cognitive processes (Mahoney & Arnkoff, 1978) or irrational beliefs (Goldfried, Decentecio & Weinberg, 1974). These problems of cognition lead to ineffective behavior patterns (Mahoney & Arnkoff, 1978) and emotional distress (Ellis, 1973).

Goals of Therapy: In view of these two themes of psychopathology, there seem to be two categories of therapeutic goals in the directive approaches. Both tend to be more circumscribed than the open-ended goals for the nondirective therapies (Beck, 1970). The first category of goals is related to the issue of loss of control and weak ego strength. It includes symptom removal (Beck, 1970; Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980), regaining the pre-stress level of functioning (Wolberg, 1965), specific problem-solving (Young, 1979), solving behavioral problems (Beck, 1970) and skills training (Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980). A more recent development in this line of therapeutic goals comes from the cognitive-behavioral approaches. Clients are taught higher-order

rules of successful living (rather than circumscribed skills training) (Rathjen, Rathjen & Hiniker, 1978). These general principles of adaptive behavior can be applied to a variety of problematic situations by the client.

The second category of goals relates to the psychopathology issue of faulty beliefs and is, consequently, changing the client's patterns of belief and philosophy of living (Beck, 1970; Dubois, 1909; Ellis, 1973; Strong, 1968; Wolpe, 1973).

Means of Therapeutic Change: In light of the adjustment theory of therapy and the two psychopathology themes, how does change come about? In the directive approaches, change is viewed primarily as a learning process; that is, therapy is an educational endeavour (Dubois, 1909; Ellis, 1973; Frank, 1975; Grieger & Boyd, 1980; Thorne, 1950; Wells, 1982; Wolpe, 1973). The view is that the client has either learned faulty or ineffective patterns of living, or has a deficient repertoire of life skills. Effective skills can be learned or relearned through the therapist's planning and direction. The focus of therapy, consequently, is on the present, on specific problem areas (Beck, 1970) and more on cognition than emotion (Matarazzo, 1965). Areas of concern of other approaches such as the past, childhood experiences and defense mechanisms are not the central part of directive treatment (Beck, 1970).

To summarize, the model of therapy congruent with the use of active-directive interventions is a coping model of therapy in which the client's problems represent a loss of control or faulty belief system. Directive treatment is a learning process with

the goals of helping the client regain control and/or learn a new, healthier philosophy of living.

Role of the Therapist

There are two prevailing views of the role of the directive therapist. In the first, the therapist is seen as the active-directive expert and authority. The therapist consciously, deliberately, and actively uses his/her position of authority to bring about client change (Frank, 1975; Strong, 1968; Thorne, 1950; Wolberg, 1965). In fact, the goals of therapy and direction of change, in this view, come largely from the therapist rather than from the client (Benjamin, 1981; Wolberg, 1954). It is the therapist who evaluates the client, plans and directs treatment (Thorne, 1950), urging the client to move in a direction the therapist believes to be more satisfying and effective (Snygg & Combs, 1949). The therapist candidly interprets reality and guides the client to more acceptable adaptation (Arnkoff, 1980; Benjamin, 1981; Dubois, 1909; Glasser, 1965; Strong, 1968; Wolberg, 1965).

Typical descriptions of this view of the therapist include being an authority figure (Benjamin, 1981; Dollard & Miller, 1950), a benevolent authority (Andrews, 1966; Butcher & Koss, 1978), and a constructive authority (Thorne, 1950). He or she is viewed as being in the superior or dominant position (Benjamin, 1981; Thorne, 1950), akin to the traditional role of the physician (Wolpe, 1973). Others compare the therapist to a parent, or the ideal parent (Dollard & Miller, 1950; Wolberg, 1965). It is from this position that the therapist wields the power of persuasion to promote client change. The therapist is someone to look

up to, a provider of rewards and punishments, someone to be obeyed or acquiesced to (Dollard & Miller, 1950; Fenichel, 1945; Wolpe, 1973).

In addition to being an authority-figure, the directive therapist, in this view, is also an influential expert. He or she is the fully competent expert (Blake, 1973) and diagnostician (Mahoney & Arnkoff, 1978) who has the knowledge to help (Butcher & Koss, 1976), to provide answers and information (Grieger & Boyd, 1980). The therapist takes charge, plans & directs treatment (Butcher & Koss, 1978; Frank, 1975; Korchin, 1976; Thorpe, 1950).

The second prevailing view of the role of the directive therapist reflects a more humanistic, softer, empathic approach. While the therapist's inherent position of power or authority is not denied, the stance is more of the therapist as a teacher, educator, guide, and competent professional (Benjamin, 1981; Glasser, 1965; Mahoney & Arnkoff, 1978; Wells, 1982; Wolberg, 1965). The therapist works together with the client toward goals that both have agreed upon (Beck & Greenberg, 1984; Goldfried & Davison, 1976). The therapist's role is to provide the expertise to help the client reach his/her goals. Occasionally the therapist takes a more active role in establishing appropriate goals for the client, especially with depressed clients who may be initially confused and distracted (Beck et al., 1979), but whenever possible the therapist follows the client's goals (Goldfried & Davison, 1976). Even when the therapist must be more directive, an attempt is made to engage the client's collaboration in the process (Beck et al., 1979). Directive therapists following

this second model of their role limit the use of their authority position to being a lever of social influence and reinforcement as a means of getting clients to try new behaviors and do homework assignments. They also act as role models for displaying behaviors, attitudes, and emotions that are likely to enhance the client's progress (Goldfried & Davison, 1976).

Both views of the therapist share the notion that the directive therapist is an active, involved participant in the session (Beck et al., 1979; Wolberg, 1965). The therapist is a real person responding with personal interest, vigor, and encouragement, in contrast to other models of therapy in which the therapist is more passive, neutral, and detached.

The Nature of the Therapist-Client Relationship

When the therapist actively assumes the authority role, as in the first view of the directive therapist's role noted above, the therapist-client relationship takes on certain characteristics. In this type of relationship, the client is seen as cooperating with the lead of the therapist, the therapist's direction rather than having a collaborative relationship with the therapist as a partner in the process. Frank (1975) describes the relationship as one of guidance and cooperation rather than the collaborative relationship of the nondirective, evocative approaches. "The therapist uses the patient's dependence on him - his 'transference' - as a means to gain the necessary leverage, rather than as a potential source of increased self-understanding" (Frank, p. 237).

Others have described this kind of relationship as one of dominance and dependence (Benjamin, 1981; Matarazzo, 1965; Thorne,

1950), like a parent and child (Strupp, 1973; Wolberg, 1965) or like a physician and patient (Thorne, 1950; Wolpe, 1973). In other frameworks the client is likened to a student willing to learn adaptive behaviors from the therapist/teacher (Mahoney & Arnkoff, 1978; Thorne, 1950; Wells, 1982). The therapist in this view of the relationship accepts, encourages and actively utilizes his or her authority position in relation to the more dependent client in order to promote change.

In the second view of the therapist role as an educator, guide, and competent professional, the relationship with the client is more collaborative, like team work. The client may be initially somewhat dependent on the therapist, and this fact might be used at first to get him/her to follow the therapist's direction, but the aim is an independent client as soon as possible (Goldfried & Davison, 1976). Beck et al. (1979) stress that the therapist is not, and does not present him/herself as, an all-powerful figure with magical procedures to be worked on a passive client. Instead, the roles are presented as both parties working together in an open, responsible way toward shared goals for the client (Beck & Greenberg, 1984). Beck has labeled this relationship "collaborative empiricism" (1979, p. 6).

Other authors stress the importance of an empathic relationship and the therapist's staying within the framework of the client's value system (e.g., Beck et al., 1979; Goldfried & Davison, 1976; Ladouceur, Bouchard & Granger, 1977; Wessler, 1984). They note that while the conditions of warmth, genuineness, and empathy do not constitute the process of therapy, they are con-

sidered to be necessary elements of a relationship of trust with the client.

Summary

While there is no clearly delineated school of directive therapy, the literature concerned with active-directive interventions reveals a common, general theoretical position that could be labeled *directive*. The diverse proponents of active-directive interventions share a similar stance on the model of therapy. They differ in the degree to which the therapist uses the influential authority position as a means of change and on the importance of establishing an empathic, collaborative relationship with the client. The directive therapies adopt a coping model of treatment in which the therapist is clearly an active, involved participant who instructs and guides the client to a more effective social adjustment. This is the theoretical context within which active-directive interventions are valued as therapeutic techniques.

Active-Directive Interventions in Psychotherapy Practice

While it is possible to trace active-directive interventions through the development of psychotherapy practice, and to construct a theoretical context within which they fit, it is not always clear what specific kinds of therapist statements are included in the active-directive category. Typically, authors make no mention of actual active-directive interventions. In other situations, some interventions are referred to but not

operationally defined and it is evident that labels have no consistent meaning across authors. To date there has been no comprehensive inventory of active-directive interventions.

The purpose of this section is to survey the clinical and research literatures for the specific interventions considered to belong to the active-directive family, and to describe them. The aim is to answer the question, What actual therapist interventions belong in the active-directive category? Description of active-directive interventions central to RET theory and practice follows in a later section.

Clinical Literature

From a review of the clinical literature concerned with active-directive approaches, it is possible to construct a constellation of therapeutic interventions that are consistently associated with directive psychotherapies. While not all authors mention all interventions, and while labels are used differently, there is considerable overlap in the writings so that a group of active-directive interventions emerges.

The following interventions are those that emerge in the active-directive group:

1. Persuasion. Persuasion is one of the oldest therapeutic techniques (Brammer & Schostrom, 1960; Thorne, 1950; Wolberg, 1954), dating back to Dubois (1909). His meaning of persuasion was for the therapist to inform the client about the dangers of his or her present beliefs and actions and then give "lessons on rational morality" (p.243). The central characteristic of the modern definition (Thorne, 1950) is the therapist's use of logi-

cal argument, to influence client attitude change and to correct faulty thinking or illogical beliefs (Ellis, 1959, 1973; Wolpe, 1973).

Persuasion is an umbrella label consistently found in the directive literature. It describes the therapist's intention of changing clients' opinions, convincing them to adopt more effective behaviors and even indoctrinating them in the therapist's own philosophy of living (Thorne, 1950; Wolberg, 1954). The general label *persuasion*, therefore, can refer to a variety of specific therapist behaviors, including exhortation, giving advice or instruction, modeling more adaptive thinking (Frank, 1975), telling the client the facts of the disorder (Thorne, 1950), describing the consequences of not changing (Dubois, 1909; Harrell, Beiman & Lapointe, 1981; Mahoney, 1974) and giving information about the theory of therapy (Harrell, Beiman & Lapointe, 1981; Mahoney, 1974). Other interventions called persuasion include confrontation, challenge or disputation of client illogical beliefs, and giving mini-lectures (Ellis, 1973; Harrell, Beiman & Lapointe, 1981; Walen, DiGiuseppe & Wessler, 1980).

2. Advice. Giving advice is often mentioned in the literature in connection with persuasion. Frequently the terms are used interchangeably (Brammer & Schostrom, 1960; Dubois, 1909; Ellis, 1973). Thorne (1950), however, makes a clear distinction between the two. While persuasion is argumentation appealing to the client's intellect, advice-giving refers to the therapist's presenting an opinion on the best course of action for the client to follow.

3. Suggestion. Suggestion, along with persuasion, is one of the oldest therapeutic techniques (Thorne, 1950). Its modern use began with Mesmer and its development is intertwined with that of hypnosis. Thorne (1950) and Wolberg (1954), for example, define suggestion as an attempt to influence the ideas, feelings and behaviors of the client by circumventing his or her intellectual functions. There is no logical argument or appeal to reason as there is in persuasion. The therapist simply makes pronouncements (for example, about expected improvements in the client) on the strength of his or her authority (Platinov, 1967; Wolberg, 1954).

A second, different meaning of suggestion refers to the therapist's recommending or suggesting certain activities for the client to follow (Dollar & Miller, 1950; Glasser, 1965; Young, 1974), or offering solutions to the clients' problems of daily living (Glasser, 1965). In this meaning, suggestion is mild advice offered in a way that does not demand compliance (Benjamin, 1981).

4. Directions for behavior. Another characteristic intervention of the active-directive therapist is giving instructions, directives or injunctions regarding the client's behavior outside of the therapy session. The therapist, in effect, says *do this or that* or *don't do this or that*, in telling the client how to conduct him- or herself outside the session. For example, directions might be given in the form of setting limits for client behavior regarding possible acting out, suicide and homicide (Butcher & Maudal, 1976).

In giving directions for behavior, the therapist may assume varying degrees of control over the client's life and behavior. In the extreme, the therapist plans and directs the major aspects of the client's life and relationships (Garner, 1973; Thorne, 1950). For example, the therapist in the following excerpt decides where the client will live and how her family members will interact:

Certain rules were laid down for their relations in the immediate future. In the future, each is to try not to express negative feelings and attitudes. If they can't say something pleasant, nothing is to be said. They are to exchange Christmas presents as usual, and arrange occasional dinners. For the time being, Dottie is to live with Mrs. Z. However, if she stays there she must agree to be in at a reasonable hour, and not to entertain men in the apartment. (Thorne, 1950, p. 114)

In another kind of directive, the therapist urges the client to carry in-therapy behavior changes to life outside of the session (Alexander & French, 1946). In other words, the client may have made changes apparent within the session and in relation to the therapist but has not manifested the new behaviors in everyday life and extra-therapy relationships. In directive therapies the client is told to try out new behaviors outside the session.

In a third kind of directions for behavior, the therapist teaches the client new behaviors or skills and requires that they be carried out between sessions. The most common examples come from behavior therapy and the cognitive-behavioral approaches. The client might be taught assertiveness or relaxation (Andrews, 1966; Wolpe, 1973), and other interpersonal coping skills (Ellis, 1959; Goldstein & Stein, 1976). The cognitive-behavior therapist

often requires clients to challenge their own irrational beliefs by following specific steps of self-confrontation as homework between sessions (Ellis, 1973).

While the therapist may assume varying degrees of control over the client's life, all of the clinical examples of this intervention are similar in that the client is given quite specific directions on how to behave outside of the therapy session.

5. Giving Information. Another active-directive technique is giving factual information. The therapist might give the client information about the client in the form of test results (Dollard & Miller, 1950; Thorne, 1950) or by defining the problem (Blake, 1973; Butcher & Maudal, 1976; Young, 1974). Therapists also give information on the process of therapy, what to expect, how it works, the principles of therapy (Dollard & Miller, 1950, Glasser & Zunin, 1973; Wolpe, 1973). The facts might be about psychopathology, what it is, how it comes about, what can be done about it (Blake, 1973; Ellis, 1973; Glasser & Zunin, 1973; Walen, DiGiuseppe & Wessler, 1980; Wolpe, 1973). Finally, therapists tell clients the facts of life, about "universal life realities" (Fromm-Reichmann, 1950; Ellis, 1973; Wolpe, 1973; Young, 1974).

The informing is frequently done in the form of mini-lectures and brief, authoritative explanations (Butcher & Maudal, 1976; Walen, DiGiuseppe & Wessler, 1980).

In the clinical literature, giving information is sometimes labelled reassurance or persuasion, depending on the therapist's intention.

6. Reassurance. Thorne (1950) defines reassurance as a support-

tive technique intended to increase the client's sense of security, courage and confidence. Once again, the therapist's intention to make the client feel better is manifested in a variety of actual interventions. For example, the therapist might want to allay distress by assuring clients that they will be taken care of, that treatment is available, they will recover (Benjamin, 1981; Thorne, 1950). The client might be given information about therapy, the therapist and psychopathology (Thorne, 1950; Wolberg, 1954). The therapist could encourage the client to keep trying, not to give up (Dollard & Miller, 1950; Wolberg, 1954; Young, 1974). The label *reassurance* is occasionally used interchangeably with *positive encouragement* (Young, 1974), *positive reinforcement* (Butcher & Maudal, 1976; Thorne, 1950), and *assurance* (Benjamin, 1981).

7. Approval/Agreement. In directive treatments the therapist does not hesitate to offer approval of client behaviors and ideas or to show agreement with the client when appropriate (Benjamin, 1981; D'Augelli, D'Augelli & Danish, 1981). In giving these positive evaluations the therapist clearly places him/herself in the authoritative position of one who judges client behavior.

8. Disapproval. From the same authoritative position, directive therapists make negative evaluatory statements regarding client behavior. These include disapproval, opposition, criticism, rejection, scolding, threats and punishment (Benjamin, 1981; D'Augelli, D'Augelli & Danish, 1981; Thorne, 1950). They all imply a negative evaluation of the client by the therapist. In some cases, directive therapists use statements of disapproval as injunctions against reoccurrence of some unproductive client

behavior. For example, a therapist might express strong disapproval with the client's aggressive behavior. The assumption is that the therapist is an authority-figure on whom the client depends and disapproval functions as a form of punishment.

9. Interpretation/Confrontation. Another active-directive intervention referred to in the clinical literature is the use of a particular kind of interpretation. The definition of interpretation in the literature dealing with active-directive approaches is not necessarily a psychoanalytic one in the sense of pointing out unconscious motivation. Interpretation, in the active-directive literature, more often refers to the therapist telling clients about their behavior or personality according to the theoretical position of the therapist (Brammer & Schostrom, 1960), or the therapist's offering the client an alternate view of his or her feelings or behavior (Hammer, 1968).

In the literature on directiveness, interpretations are described as falling at the directive end of a continuum with tentative formulations at one end and authoritative interpretations at the directive end (Abt, 1968; Brammer & Schostrom, 1960; Wolberg, 1954). Rather than being a cautious hypothesis offered to the client for consideration, the type of interpretation referred to in the active-directive literature is strong and challenging (Wolberg, 1954), strong and authoritarian (Abt, 1978), confronting and frank (Thorne, 1950) and exceptionally direct (Ellis, 1968).

Active-directive interpretation is not made following the generally accepted practice of being cautious and attentive to

timing. In contrast, it is made at any time in therapy without consideration for the state of the therapist-client relationship or other preparation of the client (Ellis, 1968; 1973; Rosen; 1953).

Active-directive interpretation is also viewed as being more interviewer-centered; that is, rather than staying strictly within the client's world or frame of reference, the therapist interprets according to his/her own view of events using the therapist's reality as the touch stone instead of the client's.

Since the active-directive interpretation is direct, blunt, therapist-centered, and often focused on present behavior, it is difficult to differentiate from confrontation. Indeed, there is no convention in the clinical literature for separating the two (Garduk & Haggard, 1972). Authoritative interpretations are often described as confrontative (Ellis, 1968; Wolberg, 1954), or confrontational and challenging (D'Augelli, D'Augelli and Danish, 1981). Confrontations are sometimes placed at the directive end of the directiveness continuum of interpretation (Brammer & Schostrom, 1960). The terms *interpretation* and *confrontation* are used interchangeably to refer to the therapist's rather bluntly telling the client what he or she is like.

Confrontation, as an active-directive intervention separate from interpretation, refers to a direct and sometimes aggressive challenge of client beliefs and behaviors (Butcher & Maudal, 1976). The therapist typically pits himself or herself as the authority (interpreter of reality, representative of societal norms and values) against the client's misconceptions, illogical or inaccurate beliefs, and irresponsible behaviors (Andrews.

1966; Glasser, 1965; Glasser & Zunin, 1973; Rosen, 1953; Thorne, 1950). In a confrontation the therapist disputes the client's belief system, interpretation of reality and intrapersonal inconsistencies (Ellis, 1973).

In summary, active-directive interpretation is strong, blunt, challenging, made at any time, usually with a focus on present behavior. For many authors, active-directive interpretations are the same as confrontations since they conceptualize interpretation along a continuum with active-directive ones at the strong, confrontational end. Others consider confrontation a separate intervention characterized by the therapist's pointing out inconsistencies between his/her beliefs and those of the client or intra-client inconsistencies.

10. Structuring the Session. This intervention refers to the therapist's directing the session, leading the interview and structuring therapy (Brammer & Schostrom, 1960; Thorne, 1950; Wolberg, 1967). The therapist actively sets the agenda for the session, directs topics of discussion and steers the client into areas judged important by the therapist. The therapist does not sit back passively allowing clients to talk about whatever comes to mind, or waiting for clients to come to important issues on their own.

Structuring also means that the therapist informs clients about the process of therapy. Particularly in the beginning sessions, he/she introduces the model of therapy and its rationale (Dollard & Miller, 1950; Mahoney, 1974; Walen, DiGiuseppe & Wessler, 1980) and advises the client about respective therapist-

client roles (Pope, 1979; Thorne, 1950; Walen, DiGiuseppe & Wessler, 1980).

11. Questioning. Questioning is an active-directive intervention refers to three types of interventions used with different intentions. First, questioning is used for information gathering to aid the therapist in making an assessment and diagnosis (Butcher & Koss, 1978; Walen, DiGiuseppe & Wessler, 1980; Young, 1979). Second, during the middle phase of the therapeutic process questions can be used in a rhetorical, challenging way to make clients aware of their irrational beliefs, to dispute irrational ideas and to quiz clients on what they have learned thus far (Walen, DiGiuseppe & Wessler, 1980; Young, 1979). Finally, questioning is used later in therapy as part of the process of planning life/behavior changes (D'Augelli, D'Augelli & Danish, 1981). For example, the therapist might question clients about how they intend to integrate what they've learned in therapy into daily living. What changes are they prepared to make now that they've explored their difficulties?

In summary, a review of the clinical psychotherapy literature reveals a group of eleven active-directive interventions that are consistently identified as being characteristic of directive approaches to therapy. In an effort to be thorough in identifying these interventions that belong to the active-directive family, the psychotherapy research literature was also reviewed. The findings are presented in the following section.

Research Literature

Research literature is helpful in two ways in the search for interventions that belong in the active-directive family.

First, members of the active-directive group are identified in the results of factor analytic studies of actual psychotherapy sessions. These studies analysed therapists' statements and found that certain interventions seemed to group together in an active-directive response category. In the Mintz, Luborsky and Auerback research (1971) the group of active-directive interventions is called the *directive mode* of responding. McNair and Lorr (1964) label them *directive-active therapeutic methods*, and Lorr (1965) uses the term *authoritarian interpersonal behavior pattern*.

The specific interventions comprising the directive, directive-active and authoritarian modes include structuring, directing and leading the interview (Lorr, 1965; McNair & Lorr, 1964; Mintz et al., 1971), advising (Lorr, 1965; Mintz et al., 1971), persuading (Lorr, 1965; Mintz et al., 1971), being active (McNair & Lorr, 1964; Mintz et al., 1971), telling the client what to do or how to solve a problem (Lorr, 1965) and hostility/intrusiveness (Mintz et al., 1971). These are the same interventions mentioned in the clinical literature in association with active-directiveness. In addition, two new interventions not found in the clinical literature clustered with the directive style in the Mintz et al. study (1971). They were creative self-expression and attempting to elicit affect from an inactive client. These two refer to the therapist's using an active, creative intervention to stimulate an emotional response in a passive client.

The second way that the research literature helps in identifying interventions that belong to the active-directive family is through category systems developed to analyse psychotherapy process. That is, the category systems themselves, as research tools, contain information concerning which interventions belong in the active-directive group. The information comes not from results of research, but from the instruments used to conduct psychotherapy process research.

Certain category systems include an active-directive category, for example, "directive behavior" (Bohn, 1965; Porter, 1943; Snyder, 1945), "leading behavior" (Ashby, Ford, Guernsey & Guernsey, 1957), "the therapist as an expert" (Strupp, 1957; Schmidt & Strong, 1970), and "therapist initiative" (Strupp, 1957).

On the whole, these category systems are older ones from the era of psychotherapy process research concerned with the comparison of directive and nondirective interventions. More recent category systems (e.g., Goodman & Dooley, 1976; Hill, 1978; O'Mally, Suh & Strupp, 1983; Stiles, 1979) that aim to encompass a wide variety of therapeutic interventions used across different therapeutic approaches tend not to include an active-directive therapist category.

The interventions to be categorized as active-directive in the older content systems include: leading the session, forcing topic choice (Porter, 1943; Bohn, 1965; Ashby et al., 1957), test interpretation/evaluation (Porter, 1943), giving information (Porter, 1943; Ashby, 1957; Strupp, 1957), approval/encouragement (Porter, 1943; Strupp, 1957; Snyder, 1945; Ashby et al., 1957).

proposing client activity (Porter, 1943); persuading (Porter, 1943; Bohn, 1965; Ashby et al., 1957), reassurance (Porter, 1943; Bohn, 1965; Strupp, 1957), disapproval/criticism (Porter, 1943; Strupp, 1957; Snyder, 1945), structuring (Snyder, 1945; Ashby et al., 1957), directive questions (Bohn, 1965; Snyder, 1945; Strupp, 1957), interpretation (Ashby et al., 1957; Snyder, 1945; Strupp, 1957), suggestion and advice (Ashby et al., 1957), answering direct questions and making authoritative statements (Strupp, 1957).

Summary

A review of the clinical psychotherapy literature indicates that a group of eleven therapeutic interventions is consistently identified with directiveness and can be considered the components of the active-directive family of interventions. The same interventions are considered to belong to various directive categories of therapist statements in content analysis systems developed for psychotherapy process research and emerge as components of the active-directive therapeutic mode in factor analysis studies of therapeutic interventions. They are: persuasion, advice, suggestion, directions for behavior, information, reassurance, approval, disapproval, interpretation/confrontation, directing the session, and questioning.

It is against this background of the active-directive family of interventions within the context of directive therapy approaches that the RET interventions of interest to the present research will be investigated.

Client Responses to Active-Directive Interventions

The general aim of the present research is to study clients' verbal responses to active-directive interventions in actual therapy sessions and particularly changes in responses over several sessions.

Alternative research options for studying client response to active-directive interventions might be, for example, to investigate the outcome of therapy in which active-directive interventions are used or to measure client recall of in-therapy experiences through post-session interviews or tests. While other strategies offer valid questions for study, the choice for the present research is to focus on the process of a series of sessions, particularly on client verbal responses to target active-directive interventions as the sessions progress. The research will focus on a few selected interventions as they are used within RET, a directive therapy approach.

The purpose of this section is to review the psychotherapy clinical and research literatures dealing with clients' responses in the session to the active-directive family of interventions identified in the previous section. The purpose is also to investigate progressive client changes in response over a series of sessions. This general review will serve as a backdrop for a review of client responses to the active-directive responses characteristic of RET.

Clinical Literature

The clinical literature addressing in-session client response to active-directive interventions in general is sparse but relatively consistent and deals almost exclusively with responses in any given session as opposed to possible changes in response over several sessions. There is agreement in this literature that active-directive interventions as a family elicit various forms of opposition, for example, rejection (D'Augelli, D'Augelli & Danish, 1981; Thorne, 1950; Wolberg, 1954), rebellion (Benjamin, 1981), defensiveness (Snygg & Combs, 1949) and suspicion or skepticism (Beck, 1976). There is also an expectation that some clients will passively comply, accept unthinkingly, or swallow whole active-directive interventions (Beck, 1976; Benjamin, 1981; Snygg & Combs, 1949; Wolberg, 1954). Other clients will be drawn into a Yes ... but type of response; that is, superficial agreement followed by rejection or debate (Beck, 1976; Bedrosian & Beck, 1980; Butcher & Maudal, 1976).

Snygg and Combs (1949), Rogers (1942) and more recently Benjamin (1981) have suggested that active-directive interventions in fact restrict clients' possible responses to two opposite categories: submission or rebellion. Benjamin (1981) found that

Confronted by a facade of superiority, the interviewee must defend himself as best he can. If he perceives it as the expression of the interviewer's values, he may either submit or emerge with a shield to defend his own values (p. 101).

In other words, when the therapist makes an active-directive intervention clients have little leeway in responding and tend either to agree, comply and accept passively, or, alternatively,

oppose, argue and reject. "The only responsibility of the counsellor is the decision as to how far she will cooperate" (Rogers, 1942, p. 117).

Clients' responses are expected to fall within one of the two categories due to the supposed effects of active-directive interventions on clients' senses of autonomy (or lack thereof). That is, active-directive interventions are considered to push, challenge and pressure the client into accepting directives originating largely in the frame of reference of the therapist as authority-figure (Benjamin, 1981; Combs, Richards & Richards, 1976; Platinov, 1967; Snygg & Combs, 1949; Wolberg, 1954). This may result in feelings of threat to autonomy, and subsequent rejection or rebellion. On the other hand, active-directive interventions also tend to put the client in an inferior position, appealing to dependency needs and eliciting deference or the compliant responses (Benjamin, 1981; D'Augelli, D'Augelli & Danish, 1981; Dollard & Miller, 1950; Finesinger, 1948; Snygg & Combs, 1949; Wolberg, 1954).

The individual who has a good deal of independence necessarily rejects such suggestion in order to retain his own integrity. On the other hand, the person who already has a tendency to be dependent and to allow others to make his decisions is driven deeper into dependency. (Rogers, 1942, p.25).

In addition to discussion of client response to active-directive interventions as a family, the clinical literature also comments on client response to a few specific active-directive interventions. Advice and information-giving are thought to interrupt the flow of the session (Benjamin, 1981; Butcher &

Maudal, 1976), elicit rejection (Rogers, 1942) and initiate a game in which the client asks for advice and then rejects it (Benjamin, 1981). The therapist's giving directions for behavior is expected to elicit defiance or debate (Davis, 1971; Wright & Strong, 1982). Challenging *Why* questions, including Socratic questioning, create defensiveness, withdrawal, silence, defiance and noncompliance (Benjamin, 1981; D'Augelli, D'Augelli & Danish, 1981; Walen, DiGiuseppe & Wessler, 1980). The clinical predictions of response to these specific active-directive interventions are consistent with those found for active-directive interventions as a family.

Given that, according to the clinical literature, clients' responses to active-directive interventions tend to be either oppositional or compliant, what is expected to occur over a series of therapy sessions? The clinical literature does not directly address this question. There are mild suggestions from two proponents of active-directive interventions that clients are expected to be oppositional and rejecting in the beginning of therapy but that they become more accepting after some unspecified course of therapeutic work (Grieger & Boyd, 1980; Thorne, 1950). No mention is made as to how initially compliant clients respond after several sessions.

The clinical literature predicts almost exclusively that clients will respond negatively to the active-directive family of interventions and yet these interventions seem to be increasingly popular considering the trend amongst clinicians toward the use of the contemporary directive approaches (Smith, 1982). This discrepancy between current practice and the clinical predictions

indicates that data is clearly needed on clients' responses to these interventions and particularly on how responses might change over treatment. If the initial client response is indeed negative, is there evidence of more positive response over a series of sessions? There is a real gap in the knowledge in this regard that has definite implications for clinical practice.

Research Literature

This section reviews the psychotherapy research literature concerning client in-therapy responses to the active-directive interventions and changes in response over a series of sessions.

There is no psychotherapy research that directly addresses the question, How do clients respond in-therapy to active-directive interventions as they are used in directive therapy approaches and how do responses change over a series of sessions? There is no detailed evaluation of client response to active-directive interventions within the context of therapies congruent with their use. Instead, the information available comes from research done 20 to 40 years ago at a time when many psychotherapist researchers were interested in answering the global question, Which is more effective, directive or nondirective therapy? It was also a time predominated by client-centered research. As a consequence, the research tends to be limited to general, global studies such as comparisons of client responses to active-directive and nondirective therapeutic styles, or analyses of client-centered therapy. Clearly, a detailed study of client responses to active-directive interventions within an appropriate therapy context does not emerge from the early global comparison studies.

dominated by client-centered theory.

Despite their limitations, these early studies will be reviewed since they are the sole source of information on client responses in-therapy to active-directive interventions and, as such, offer at least suggestive data.

The research provides two types of data. First, there are studies looking at client in-therapy responses to overall active-directive therapeutic approach or style compared to nondirective. Second, a few studies analysed client responses to particular active-directive interventions. Within these two types of research there is data hinting at how clients' responses might change over a number of sessions.

First, several studies of actual psychotherapy sessions have compared clients' in-therapy responses to active-directive styles of therapy with responses to nondirective styles. In the majority of cases, the findings for active-directive styles of therapy were interpreted as being less favorable regardless of the client variable measured. The active-directive styles resulted in less client talk (Carnes & Robinson, 1948), in more guarded, resistant, dependent responses with more blocking and interrupting the therapist (Ashby, Ford, Guernsey & Guernsey, 1957; Rottschaffer & Ranzaglia, 1962), and in less personal, problem-relevant talk (Pallone & Grande, 1965). Clients also responded to active-directive styles with more hostility, silence and anxiety (Tourney, Bloom, Lowinger, Schorer, Auld & Grisell, 1966) and with fewer information-seeking responses (Samaan & Parker, 1973). In one study there was a trend toward increased client resistance in active-directive interviews (Gillespie, 1953). In

a single study there was no difference in client responses to active-directive and nondirective therapeutic styles, on a measure of client self-exploration (Kaul, Kaul & Bednar, 1973). On a variety of measures, then, client in-therapy responses to active-directive therapeutic styles in actual psychotherapy sessions appear to be less favorable than in-therapy responses to nondirective styles, with the possible exception of client self-exploration.

Two more recent experimental analogue studies of psychotherapy process have produced conflicting results concerning client in-therapy response to active-directive styles. In one study, when therapists used a single form of response throughout the interview, the active-directive responses produced less desirable client responses than nondirective responses (Ehrlich, D'Augelli & Danish, 1979). Clients in this research responded with less talk, less use of affect words, the present tense and self-referent pronouns when therapists used advice-giving, influencing, or closed question modes of intervention. More desirable responses followed the nondirective modes (open questions, content and affective responses). A second study using different therapist modes found no difference in client production of affect words, self-referent pronouns or verb tense in response to therapist modes of reflection, probe, confrontation or free-style (Barnabei, Cormier & Nye, 1974).

These two experimental analogue studies seem to mirror the naturalistic research in that active-directive response modes produce either negative client responses or are not different

from nondirective modes.

These studies represent efforts to discover which therapeutic mode is better, active-directive or nondirective. While the active-directive mode appears to lose out in the comparative research, it is not clear that the client variables measured are equally relevant and appropriate to both therapeutic modes. For example, having clients talk a lot, self-explore, use affect words and be nonresistant may be responses valued more by nondirective than active-directive approaches. The research results may be more appropriately viewed within the context of nondirective therapy goals and values. While perhaps valid in this regard, they fail to provide information on client response to active-directive interventions within a therapeutic context that values their use.

Second, other research investigated clients' responses in the session to active-directive interventions. Two studies suggest that client responses directly following interventions classified as active-directive are less desirable than those following nondirective interventions (Frank, 1964; Snyder, 1945). Snyder (1945) concluded that to the group of active-directive interventions analysed in his research, client response was unfavorable. Frank (1964) found that when therapist interventions were classified as either directive or nondirective, clients responded to the directive ones with less exploration of meaning, less insight, but more talk about problems and symptoms.

Four studies reported client responses to several specific active-directive interventions. Clients responded to persuasion with rejection, with statements about their problems and symptoms

(Snyder, 1945) and with more resistance than they showed to all other therapeutic interventions, both active-directive or non-directive (Gillespie, 1953). Information-giving was followed by client statements that indicated progress or uncertainty (Frank & Sweetland, 1962). When therapists asked direct questions, clients responded with rejection (Snyder, 1945) and when they made structuring interventions clients abandoned self-exploration or rejected the structuring (Bergman, 1951; Snyder, 1945). The interventions disapproval and criticism elicited rejection, resistance and talk about symptoms (Gillespie, 1953; Snyder, 1945) while approval and encouragement were followed by insight and understanding (Snyder, 1945).

Two experimental studies focused on clients' in-session response to a particular active-directive intervention, confrontation. Anderson (1968 & 1969) found that subjects responded with significantly greater self-exploration following confrontations made by high-functioning therapists than they did with low-functioning therapists (therapists were rated according to level of empathic functioning on Carkhuff and Berenson's 1968 scale). This study did not compare client responses to confrontation with responses to other interventions.

These data suggest that the majority of the active-directive interventions investigated in actual psychotherapy sessions are responded to in a variety of negative ways, e.g., rejection, resistance, and abandoning self-exploration. The sole positive client response seems to follow approval and encouragement. In addition, experimental research suggests that client responses to

confrontation are more favorable when therapists are high-functioning on a measure of empathy. Of the eleven interventions that have been identified as active-directive, the research reviewed above reports on client in-therapy response to seven: persuasion, information-giving, direct questions, structuring, disapproval/criticism, approval/encouragement and confrontation. There is no research on client response to the remaining four: advice, suggestion, directions for behavior or reassurance.

There are several major limitations on these studies of client responses to active-directive interventions in view of the present research. The first and perhaps most important is that most of the naturalistic studies analysed sessions of client-centered therapy (in fact, all research that reported the kind of therapy studied was of the client-centered approach; one study, Frank (1964), did not report the theoretical orientation of its sessions). This means that the results we have for client responses to active-directive interventions come exclusively from a few reports of client-centered therapy, an approach that rarely uses the active-directive interventions and in fact considers them errors in technique.

A second limitation is that all of the studies of actual psychotherapy used Snyder's 1945 category system or modifications of it. This was one of the original content analysis systems developed at the beginning of psychotherapy process research. Since it was designed within the context of client-centered theory, the research results are limited to addressing a question of how active-directive interventions can be evaluated according to client-centered theory of therapy. An offshoot of these two

limitations is that the client variables investigated tend to be more relevant within nondirective than directive approaches.

Of final interest to the present research is how client responses to active-directive interventions might change over a series of sessions. Two studies report change in client response to active-directive style and interventions over several sessions. Ashby, Ford, Guernsey and Guernsey (1957) found that there was a trend for clients of leading therapy (who were more defensive at the beginning of therapy than clients of reflective therapy) to become less defensive by the fourth interview (the trend was statistically nonsignificant). This result lends some support to the clinical literature in suggesting that clients may resist active-directive interventions initially, but accept them later in treatment. Anderson (1969), in the experimental study of confrontation, found that while clients' gains in self-exploration were greater following confrontation by a therapist rated as high-functioning in empathy, compared to a low-functioning therapist, clients of both groups of therapists had greater gains in self-exploration following confrontation in session 4 than they did in session 1. This finding also suggests that clients' responses may be more positive in later sessions.

Conclusions

To conclude, no research directly addresses the question of interest to the present study; that is, how do clients respond in-therapy to active-directive interventions as they are used in directive therapy, and how might responses change over treatment? The only related research focuses on either global comparisons of

client responses to active-directive and nondirective modes of therapy, or on responses to active-directive interventions used in client-centered therapy. A review of this research indicated that client responses to active-directive modes of therapist intervention and to active-directive interventions used in client-centered therapy are less favorable on a variety of client measures than responses to nondirective modes and interventions. In terms of how clients' responses to active-directive interventions might change over a series of sessions, the research gives a very tentative suggestion that responses might be negative at first and more positive after several sessions. There has been no research support for the clinical prediction that some clients start out in a passive/compliant manner.

The limited research available, at first glance, seems to support the clinical literature predictions that active-directive interventions elicit negative client responses. A careful review of the research studies, however, shows that the data have been collected from sessions of client-centered therapy in which the use of active-directive interventions is both infrequent and an error in technique. In addition, the client variables measured may be more relevant to a client-centered theory of therapy than to a directive theory. In essence, active-directive interventions have been evaluated primarily against nondirective theory and values. As such, the research results do answer a valid research question, that is, How do clients' responses to nondirective and active-directive interventions differ in client-centered sessions? Clearly, the data do not provide information on clients' responses to active-directive interventions within

the context of directive therapy theory and values. What is missing in the research is this very evaluation of active-directive techniques within therapies that provide a rationale and a theoretical basis for their use. It would seem important now to have this kind of study both to assess theories of directive therapy better and, from a clinician's point of view, to have data bearing on the process of therapy when active-directive interventions are used as central and frequent techniques.

Active-Directive Interventions

In Rational-Emotive Therapy

The preceding sections of the review of the literature have dealt with active-directive interventions in general and client responses to their use in therapy. It is striking that there has been no research investigating client responses, and particularly progressive changes in responses, to active-directive interventions in therapies congruent with their use. The present research focuses on the use of these interventions within a directive therapy, RET, and especially on client responses over a series of sessions.

Rational-Emotive Therapy is not only one of the three major representatives of the development of modern directive therapy, along with Thorne's Directive Therapy and Glasser's Reality Therapy (Thorne, 1950), but also continues to be perhaps the most prominent of the contemporary directive approaches in terms of clinical writings and research (Grieger & Boyd, 1980). There are

several recent texts for teaching RET to therapists (e.g., Grieger & Boyd, 1980; Tosi, 1974; Walen, DiGiuseppe & Wessler, 1980; and Wessler & Wessler, 1980). There is an RET training institute, The Institute for Rational-Emotive Therapy, and an RET journal *Journal of Rational-Emotive Therapy* (previously known as *Rational Living*). Moreover, there is a base of some twenty years of psychotherapy research (see reviews by DiGiuseppe, Miller & Trexler, 1977; Mahoney, 1974; McGovern & Silverman, 1984; and Wilson, 1978) and a continuing emphasis on testing RET theory and practice through research (Ellis, 1980). It should be noted that while RET is practiced by a substantial number of certified RET practitioners, there are indications that RET methods are increasingly being used by therapists of other persuasions due to the widespread popularity and high profile of RET (Grieger & Boyd, 1980). All of these factors suggest that RET provides one appropriate context for the study of client responses to active-directive interventions. Within the RET research literature alone, study of client responses appears to be overdue. It is noted, however, that since there has been no study of client responses over a series of directive therapy sessions, virtually any directive therapy could be investigated. The choice of RET is, therefore, a somewhat arbitrary but clearly appropriate one.

Accordingly, the purpose of this section is to review the literature concerning the use of active-directive interventions in RET. Particular attention will be paid to clients' in-therapy responses and changes in responses over a number of sessions.

Brief Overview of RET

RET was founded in 1955 by Albert Ellis. Ellis was initially a marital and family therapist who trained in psychoanalysis. As a young therapist he became dissatisfied with client progress and disenchanted with psychoanalytic theory (Ellis, 1962). He developed Rational-Emotive Therapy as a directive, cognitive-behavioral approach with philosophic roots in stoicism and with ties to the modern ideas and concepts of Dubois, Thorne and certain of the analysts who took a more active approach to therapy, for example, Alexander and French, Adler, Horney and Sullivan (Ellis & Grieger, 1977). Ellis notes that others, notably Beck, independently developed similar therapies about the same time (Ellis, 1962). RET, however, is distinctive amongst cognitive-behavior therapies for its strongly active-directive style and focus on cognition (Wessler & Wessler, 1980).

When Ellis first introduced RET, his emphasis was largely on the cognitive aspects of the theory and treatment. In the 1970s, he focused on the humanistic nature of RET philosophy of living (Ellis, 1973) and then on RET as a cognitive-behavioral approach (e.g., Ellis & Grieger, 1977). Presently, Ellis (1984) contends that RET has been, from its inception, a comprehensive cognitive-emotive-behavioral therapeutic approach but that at different times in its history he has stressed various components of the theory and/or practice.

The basic RET tenet is that emotions spring from ideas and that to control one's disruptive feelings, ideas or beliefs must change. Emotional disturbance is a result of dysfunctional or irrational thought processes (Ellis, 1962; Walen, DiGiuseppe &

Wessler, 1980). Ellis has theorized that humans are biologically predisposed to hold several strong irrational beliefs which are learned in early life but more importantly are actively rehearsed and reinforced in adult life (Ellis, 1973). They are varieties of three main types of musts, or in RET terms, musturbation (Ellis, 1979a):

1. I must be competent, adequate and achieving, and I must win approval of all the important people in my life.
 2. Others must always treat me fairly and kindly when I want them to.
 3. I must have and need the things I really want.
- (p. 3)

Humans are also uniquely rational and unusually teachable relative to other animals so that irrational beliefs such as these can be changed. The preferred, or elegant, therapeutic goal in RET is to have the client examine and give up the irrational beliefs and replace them with a healthier philosophy of living, particularly the RET philosophy of responsible hedonism.

Theoretical Rationale for the Use of Active-Directive Interventions in Ret

In an earlier section, it was suggested that directive therapy approaches that value active-directive interventions have common theoretical positions on the model of therapy, the role of the therapist and the nature of the therapist-client relationship. Rational-Emotive Therapy, as a directive approach that explicitly promotes the use of vigorous active-directive interventions, shares most of these positions with one or two important exceptions.

While most directive therapies subscribe to an adjustment or coping model of therapy, Ellis contends (in the face of criticism

to the contrary) that RET in its elegant or specific form aims for substantive personality change through radical restructuring of the client's personality (Ellis, 1979a). It is true, however, that inelegant or general RET is synonymous with other forms of cognitive-behavioral therapy that follow the adjustment model, e.g., cognitive-behavior modification, cognitive therapy, and multimodal therapy (Ellis, 1979b). Ellis also stresses that the therapist-client relationship is one of collaboration (Ellis, 1984) rather than cooperation, thereby differing from some other directive approaches.

With these two exceptions, RET theory is in agreement with the theoretical positions taken by directive therapies as a group. Psychopathology is viewed as stemming from faulty cognitions (Ellis, 1962; Walen, DiGiuseppe & Wessler, 1980) as it is in many directive approaches. Change comes about through a learning process in therapy (Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980; Tosi, 1974). The therapist takes the position of the expert educator (Ellis, 1962; Tosi, 1974; Walen, DiGiuseppe & Wessler, 1980) who aims preferably for teaching the client a healthier philosophy of living and scientific approach to self-change, or, failing that, more effective skills and strategies for happy living (Ellis, 1979b).

In addition to the general theoretical position of directive therapies, RET theory postulates specific reasons for using its characteristic vigorous active-directive responses. These are explained below.

According to RET theory, irrational thoughts are deeply

ingrained and difficult to change. An inherent predisposition to think irrationally coupled with early training in crooked thinking lead to a very solid but dysfunctional philosophy of living (Ellis, 1962). A strong active-directive approach is needed to uproot and challenge persistent patterns of thinking (Ellis, 1962; Tosi, 1974) and as a model for clients to follow in vigorously challenging their own beliefs (Ellis, 1979a). In the words of Ellis (1962), the therapist is a "frank counter-propagandist who directly contradicts and denies the self-defeating propaganda and superstitions which the patient has originally learned" (p. 95).

Another assumption of RET that supports a strong active-directive approach is that clients are typically lazy and slow to change. They constantly and very actively perpetuate their pathologies, reindoctrinating themselves with their irrational beliefs. The only way to break the cycle is for therapists to interrupt actively and challenge the client's belief system (Grieger & Boyd, 1980). An inactive or passive listening style is believed to be, at best, slow and inefficient, or, at worst, completely ineffective in promoting client change. In RET the therapist is urged to attack vigorously the client's unrealistic ideas and present didactically a healthier set of beliefs and values (Ellis, 1973). According to Ellis (1962), "active encouragement, persuasion and upward pushing on the part of the therapist is usually required to counteract some of the pernicious effects of self-sabotaging" (p. 193).

RET theory holds that the active-directive style prevents clients from slipping into unproductive, repetitive ventilating

of negative feelings. Active-directive interventions aim immediately to cut through emoting to challenge the irrational beliefs underlying bad feelings. Catharsis and continued expression of emotion are thought either to help clients adjust to their distress or aggravate it. According to RET, change occurs not as a result of expression of feeling but by forceful pounding away at irrational beliefs (Ellis, 1962).

Active-directive interventions are also believed to be more efficient in counteracting clients' feelings of anxiety and inadequacy since they include the therapist's very persuasively instructing the client to undertake homework assignments to build self-confidence (Ellis, 1973).

While many other theoretical approaches warn against active confrontation and strong interpretation unless the therapist-client relationship is well-established and therapy is advanced, RET theory allows for directive challenges and blunt interpretations immediately, even in the first session (Ellis, 1973). RET therapists

do not hesitate, even during the first session, to directly confront people with evidence of their irrational thinking and behavior. They actively interpret many of the things clients say and do without being too concerned about possible resistances and defensiveness. (Ellis, 1977, p. 195)

According to RET, there is no unconscious where deeply buried conflicts reside, but merely ideas marginally out of awareness. These pose no threat to the client and can easily be brought into awareness through straight-forward interpretation. In addition, the therapeutic process is not thought to depend on the state of

the client-therapist relationship beyond basic rapport, so that there is no need for development of a special relationship before confrontations and vigorous interpretations are made (Walen, DiGiuseppe & Wessler, 1980).

The use of active-directive interventions is also consistent with the educational, didactic thrust of RET. RET is, in fact, described as being "unusually didactic" and "explicatory" (Ellis, 1973; Ellis & Grieger, 1977). The theory states that emotionally disturbed people need to be told directly how and why they became distressed and actively taught new attitudes and approaches to living (Ellis, 1973).

It is clear from Rational-Emotive theory that an active-directive approach is believed to be the most effective in helping clients relieve their distress. What stands out is that RET promotes particularly vigorous or strong active-directive interventions. Ellis (1962) says of RET that it is "distinctly more assertive and frankly counter-propagandistic than are the therapies with which it most significantly seems to overlap" (p. 329), and that RET therapists go beyond the usual passive and indirect approach "to make a forthright, unequivocal attack on his [the client's] general and specific irrational ideas and try to induce him to adopt more rational views" (p. 94).

RET is typically described by its proponents in ways that point to a very forceful approach: for example, it is held as highly active-directive, highly rational, persuasive and interpretive, exceptionally hard-headed (Ellis, 1962; Grieger & Boyd, 1980). RET therapists are portrayed as vigorous, exceptionally active-directive and outgoing (Ellis, 1973); as ruthlessly urging

the client into better behavior, and as exerting consistent philosophical and interpretive pressure on clients to change irrational beliefs (Ellis, 1962). They "actively, hopefully [keep] blasting away at the patient's defenses" (p. 195). The following therapy excerpt from Ellis (1962) illustrates the strong active-directive style of an RET therapist in response to a client who failed to do a between-sessions homework assignment.

So you didn't feel like doing the assignment. Tough! Well you're goddamn well going to have to do it if you want to overcome the nonsense you keep telling yourself. And you didn't like me for giving you the assignment. Well, I don't give a shit whether you like me or not. We're not here to have a lovey-dovey relationship and thereby to gratify you for the moment so that you don't have to work to get better - but to convince you that unless you get off your ass and do that assignment I gave you, and many more equivalent assignments, you're going to stew in your own neurotic juices forever. (p. 198)

Ellis is quite clear that the preferred and most effective therapist style is strongly active-directive. After all, it is this style as well as the emphasis on challenging or disputing client's irrational beliefs that distinguish RET from other cognitive-behavioral therapies (Ellis, 1979c). However, there has been some debate within the RET family concerning the necessity for a strong active-directive approach and stress on disputing irrational ideas. Eschenroeder (1979) and Wessler and Wessler (1980) suggest that RET can be practiced using a variety of therapist styles including, but not limited to, a forceful active-directive approach. Johnson (1980) more specifically suggests that a better method is to combine the logic and persistence of Ellis with the warmth and understanding of Rogers. Wes-

sler and Wessler (1980), probably more than other RET authors, like to point to the well-roundedness of RET in terms of both style and technique, suggesting that RET practice is not limited to Ellis' hard-headedness nor to the technique of challenging client beliefs.

Given that a strong active-directive style is a distinguishing characteristic of RET and recognizing the debate on this point, it is surprising that no research has investigated typical RET interventions. Ellis and others have noted both the lack of research and the need for it, particularly investigation of the hard-sell, rational-persuasive interventions (Ellis, 1979a; Ellis & Grieger, 1977; Grieger & Boyd, 1980). Accordingly, the aim of this study is an initial investigation of client in-therapy responses and especially changes in responses over a series of sessions to characteristic RET vigorous active-directive interventions.

Cognitive Disputation as a Major Active-Directive Intervention in RET

In an earlier section, it was noted that there has been no comprehensive inventory of interventions characteristic of active-directive therapy approaches in general. Similarly, there has been no definitive categorization or articulation of therapeutic techniques for RET (Ellis & Grieger, 1977; Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980). In fact, "the literature does not provide enough detail for therapists to apply cognitive techniques properly" (McMullin & Giles, 1981, p. 2). Clinicians have just recently begun to describe the RET process by looking at the typical interventions therapists use (e.g.,

Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980; Wessler & Wessler, 1980).

Ellis (1979c) and others (Grieger & Boyd, 1980; Wessler & Wessler, 1980) have lately emphasized that RET is a comprehensive method of cognitive-behavioral-emotive therapy. As such it uses a wide range of therapeutic techniques including behavioral ones such as systematic desensitization, self-management, biofeedback, skill training and especially homework, as well as emotive methods like humorous songs, risk-taking exercises and Rational-Emotive Imagery (REI). However, the cognitive techniques, and particularly cognitive disputation, form the active core of RET work and distinguish it from other cognitive-behavioral therapies (Bard, 1980; Ellis, 1973; Ellis, 1979b; Tosi, 1974; Wessler & Wessler, 1980). Consequently, the present study will focus on cognitive disputation as a central active-directive intervention characteristic of a contemporary active-directive approach to psychotherapy.

Cognitive disputation, the challenging of clients' irrational beliefs, is perhaps the major RET technique, at the heart of the therapeutic change process (Ellis, 1979b; Grieger & Boyd, 1980). Ellis has stated that if there is a fundamental RET method it is disputation (Ellis, 1979b). This intervention is perhaps the most frequent and typical one used with virtually all clients (while other interventions may be used only selectively in particular cases). (Bard, 1980; Ellis, 1979b; 1980). Cognitive disputation is the unique contribution of RET to psychotherapy practice, and is a manifestation of the fundamental theory that irrational beliefs underly psychological distress (Ellis, 1973;

Wessler & Wessler, 1980); that is, the cognitive disputation intervention is designed to challenge and change the beliefs that cause problems.

The present research, as a first study of client in-therapy responses to the RET process will focus on responses over a series of sessions to this primary intervention, cognitive disputation, while it is acknowledged that RET therapists may indeed use many other interventions in the course of treatment. It is also noted that while cognitive disputation is only one of many active-directive interventions, it has been selected for examination here due to its central importance in RET and widespread use elsewhere.

In cognitive disputation, the therapist directly and actively challenges the client's irrational beliefs. Clients are confronted with the illogic of their ideas and persuaded to adopt healthier, rational beliefs (Ellis, 1979a; Walen, DiGiuseppe & Wessler, 1980). From descriptions of cognitive disputation in the RET clinical literature, it is clear that the thrust of this intervention is twofold: (a) to confront clients with their irrational beliefs, challenging the logic of them and (b) to persuade clients actively to give up irrational beliefs in favor of healthier rational ones (Ellis, 1973).

What is not clear from the literature is which specific therapist interventions are classified as cognitive disputation. Since there has been no definitive analysis and description of RET interventions, authors use individual systems of classifying interventions. For example, Walen, DiGiuseppe and Wessler (1980)

include the use of humor or exaggeration as a typical cognitive disputation intervention whereas Ellis (1979c) notes that humor would only be used with selected clients under special circumstances, and Grieger and Boyd classify humor as one of the RET emotive techniques (rather than as a cognitive method). Likewise, the most recent handbooks for practitioners of RET (Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980) do not refer to interpretation as a disputational intervention while Ellis (1973) is quite clear that active-directive interpretation is a key intervention to make clients aware of the irrational ideas they keep telling themselves.

For purposes of the present research, three cognitive disputation interventions have been chosen for study on the basis that they have been described in some detail in the RET clinical literature and conform to the basic thrust and essence of the cognitive disputation technique. They are: challenging questions, direct interpretation and didactic presentations. Recent analyses of Ellis' therapy sessions and demonstration sessions suggest that these three are among the interventions he uses most frequently (Becker & Rosenfeld, 1976; Hill, Thames & Rardin, 1979; Zimmer & Pepyne, 1971). Forceful questions and interpretations aim to confront and challenge clients on their irrational beliefs while didactic presentations give factual, reality-based educational information and alternative rational beliefs to help clients adopt a new belief system.

The present research will consider clients' progressive changes in response over a series of sessions to these three cognitive disputation interventions. It is acknowledged that the

study does not aim to include all the possible cognitive disputation interventions as independent variables. The choice has been to select a few cognitive disputation interventions that have been relatively well described in the RET clinical literature and to use these in a first study of clients' in-therapy responses to a central RET technique.

Of the three cognitive disputation interventions chosen for inclusion in this research, challenging or disputational questions have been perhaps most clearly defined in the RET clinical literature. This is a specific kind of questioning that requires clients to prove or justify their irrational beliefs to the therapist. Through a series of *Why?* and *How is that so?* questions, the client sees that irrational beliefs cannot be logically defended. RET theory maintains that if clients can recognise the lack of logic in their ideas and the negative emotional consequences of irrational thinking they will be able to change them. In addition, challenging questioning done by the therapist provides a model of how clients can eventually question and challenge their beliefs by themselves.

Challenging questions as used in RET cognitive disputation are distinct from other forms of questioning that might be used in RET as well as in other therapies. Challenging questions are not information-gathering questions like *How old are you?* *What is your problem?* *When did your symptoms begin?* Likewise, they are not gentle leading questions like *Can you tell me more about that?* They are active challenges, probing the client's belief system.

Walen, DiGiuseppe and Wessler (1980) have described three kinds of challenging questions used by Ellis and others at the Institute for Rational-Emotive Therapy:

1: Questions that ask for evidence to support beliefs and for demonstration of logical consistency in thinking. These questions would take the following general forms: What is the proof? Where's the evidence? Why is that so? How do you know? What would that mean about you as a person? How would you be destroyed if that were the case?

The following clinical examples show how these questions might be formulated in a session:

T- So you're different from other people, what are you concluding from that?

T- Where is the evidence that you must have enjoyment easily and quickly?

T- Where's the proof that you need other people?

2. Questions that require clients to evaluate the logic of their expectations of future catastrophies; for example, What would happen if _____? If that's true, what's the worst thing that can happen? How would that be so terrible? Why would you have to be destroyed by that?

The following clinical examples further illustrate this kind of questioning:

T- Why is it terrible when life doesn't give you the pleasure that it must give you?

T- Let's suppose people do say you're unstable, What's the horror of that?

T- Where is it written that you can't stand this kind of

frustration?

3. Questions that urge clients to evaluate the hedonistic value of their beliefs, for example, *As long as you believe that, how will you feel? Where will that belief get you? What is the point in that belief?* In a session, these questions might take the following forms:

T- *If you really believe you need someone, and you can't have anyone, how will you feel?*

T- *If you keep believing that you'll never be likeable, how will you feel?*

T- *What's the point in thinking that you're inferior?*

One way of getting clients to see the illogic of their beliefs is through these challenging, disputational questions. Another is by active-directive interpretation, the second cognitive disputation intervention chosen for study. Active-directive interpretations confront clients with their irrational beliefs and the damaging consequences in terms of emotional distress and behavior problems (Grieger & Boyd, 1980; Wilson, 1978; Young, 1974). The therapist directly, bluntly tells clients what their problem beliefs are and how they result in distress.

These active-directive interpretations differ both in content and delivery from the usual cautious, indirect interpretations made by many other therapists. In RET, interpretations do not focus on the past, the unconscious or repressed material, nor do they deal with transference, dreams or nonverbal behavior. Instead, they focus on the present cognitive, philosophical system of the client (Ellis, 1973). In contrast to the typical

tentative interpretations offered with respect to appropriate timing, RET interpretations are made at any time in therapy in a forthright, vigorous and persuasive manner (Ellis, 1973). The therapist confronts clients with their irrational beliefs, and proves that they keep indoctrinating themselves with these beliefs that result in psychological difficulties (Ellis, 1973). The following examples illustrate the RET active-directive interpretation. In Ellis (1973):

T- Yeah. So that's good that you see that. But there's another magical element in this catastrophizing about airplanes. Not only are you saying, sort of, that "I might have some power over the airplane, etc to let it fall or not." But you're really saying, "If I were dead, - let's suppose that this really occurred - "it would be awful for me." (p. 206)

In Grieger and Boyd (1980):

T- Right. A shit like me will blow it again and again, so what's the use. So what we're saying then, in relation to this emotional problem, is that you really down yourself, you start calling yourself names. And then what happens is you get into feeling really rotten about you and really helpless and hopeless and small and ineffective and so forth in relation to eating. So you then give up and start eating, because how can someone so low do something so hard. So it has a circular effect upon eating. (p.199)

T- Your thinking is getting circular right there. I want to intercept it, because the reason you get yourself so miserable is because you tell yourself, "I'm such a shitty person for blowing it," and we're attacking that fundamental belief. Your flaw is that you stupidly don't stick to diets: and I'm asking you to show me why you, as a totality, are a shitty person because you have that particular flaw or stupid habit. (p. 203)

The third cognitive disputation intervention to be studied is didactic presentations. The didactic interventions form an integral part of the disputation process by providing clients

with information they need, by teaching a new way of thinking (the RET way), and by presenting healthy rational ideas that take the place of the client's irrational ones. In didactic interventions RET therapists teach RET theory and rationale, sometimes using analogies and parables (Walen, DiGiuseppe & Wessler, 1980). They give mini-lectures about the causes and cures of psychopathology, and give information on the facts of life and objective reality (Ellis, 1959; 1973; Grieger & Boyd, 1980; Wilson, 1978; Young, 1974). Therapists also teach the RET method of logically challenging one's own beliefs and they offer rational alternatives that can form a healthier philosophy of living for the client (Ellis, 1973). The following examples from RET sessions show how therapists use didactic interventions in cognitive disputation. In Walen, DiGiuseppe and Wessler (1980):

T- Let's first take a look at whether your anger is working for you or against you. What does rage do? It sets the stage for a fight!. Also, it isn't good for you; it sets your juices flowing, makes you feel more irritated and so forth. Now concern or annoyance, on the other hand, serve as sensible cues for you to say, "How can I change this? What can I do to help the situation? Perhaps if I explain to him ...". See, now we're talking about strategies. And if a strategy doesn't work, what would you do? You'd go back to the drawing board and try another. You see, you can do that kind of problem solving once you're not in a rage. (p. 107)

In Ellis (1973):

T- All right. So we'll call C, the Consequence, anxiety. And we'll call A, the Activating event, the fact that you're going to take this plane trip - or you're taking it. Let's assume that - to Memphis. Now the question is: "What really causes C? Is it A, the trip, or is it something else?" And we know it can't be A, because sometimes you might not think of these worst things; and other times you might think of them really, continually, etc. It isn't any event that causes

the Consequence. So it must be B - your Belief System. Now let's get you to see the rational Belief that causes that is implicated in C. It doesn't exactly cause C, the anxiety, but it causes another emotion. Now that rational Belief - it's a negative belief, prediction of something negative, but still pretty rational. (p. 202)

In Grieger and Boyd (1980):

T- Good. Because there's a real connection between calling yourself names like shitty and feeling really bad about you. If you said to yourself - "Hey, I'm sitting here doing something that's shitty, but who doesn't; I'm just like everybody else and that's ok." - you wouldn't have felt so bad, would you? But when you call yourself things like a really shitty person, how else can you feel besides bad? Right? See that connection? There's no other way you could feel and that's the basis for your emotion upset. (p. 198)

Client Responses to Active-Directive Interventions in RET

Rational-Emotive Therapy theory presents a clear rationale for the use of active-directive interventions as key therapeutic tools. How then are clients expected to respond to these central techniques in the session? How does client response change over a number of sessions? There is virtually no RET clinical literature addressing this question and there has been no research.

The RET clinical literature has not addressed the issue of how clients actually respond to typical interventions as a session or series of sessions progresses, except to note common problems encountered in the process of a single session. The literature therefore indicates what problematic client responses might be, but not what could be expected in an unproblematic session.

Interestingly, the expected problematic responses correspond closely to those the general literature predicts will follow active-directive interventions, namely, either passive accept-

ance/compliance or resistance/opposition. For example, in RET, the active-directive style is recognized as having the potential to elicit either client dependency or hostility (Wessler & Wessler, 1980). Clients may argue, give Yes, ... but responses, intellectualize, refuse homework assignments and resist rational analysis (Walen, DiGiuseppe & Wessler, 1980). The specific intervention of didactic lecturing may elicit either unthinking acceptance, or denial and debate (Walen, DiGiuseppe & Wessler, 1980), while Socratic questioning can be followed by silence, distress, compliance, or the client persisting with irrational statements (Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980). Overuse of the questioning and lecturing interventions has also been seen to result in a passive or argumentative client (Walen, DiGiuseppe & Wessler, 1980). So it seems that RET practitioners commonly encounter either compliant or oppositional responses to the active-directive style in general and particularly to didactic interventions and challenging questions. What is not clear is how clients respond in a positive manner to typical RET interventions.

In terms of how client responses to RET active-directive interventions might change over a series of sessions, RET practitioners suggest that it is fairly common for clients at the beginning of therapy to argue with and resist the therapist's disputations, but they give this up when they can see his/her point of view, sometimes only after a lot of therapeutic work (Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980). This suggests that an initial resistance may be followed by acceptance

after some period of time. As noted above, it seems that clients not only respond to active-directive interventions with initial resistance or opposition, but also with compliant acceptance. There is no mention in the RET clinical literature of changes in client response over a series of sessions when they begin responding in a compliant way.

The RET clinical literature is very spotty concerning client responses in the session to typical active-directive interventions. There are soft suggestions that problematic responses are quite commonly encountered and that if clients start out in a resistance mode they may be more accepting after a period of time. However, in view of the clinical predictions that the family of active-directive interventions elicits a variety of negative responses, and the mention of similar problematic responses to RET active-directive methods, there is a real gap in the knowledge regarding an important aspect of the use of active-directive therapeutic interventions, i.e. client in-session responses.

This gap becomes more apparent considering that there has been no research study of client responses in the RET process. Consequently, there is no empirical evidence either to support or reject the soft suggestions regarding client response in the clinical writings.

Since active-directive therapies and interventions are becoming increasingly popular, it would appear that initial research is needed to begin assessment of the effects of active-directive interventions on client behavior. Such research is particularly timely within the context of Rational-Emotive Thera-

py since RET not only provides a popular model of the use of active-directive interventions in contemporary therapy, but also encourages and promotes research investigation of psychotherapy.

Conclusions

Although active-directive interventions have been the topic of considerable clinical concern and some research for many years, there has been no study of clients' in-therapy responses to their use in directive therapies which value such interventions. Rational-Emotive Therapy is a prominent, contemporary directive therapy that promotes the use of active-directive interventions. It has a growing following, part of a recent trend amongst therapists to adopt more active-directive treatment techniques. To date, there has been no study of client responses to typical RET active-directive interventions. The general psychotherapy clinical literature dealing with active-directive interventions and to some extent the RET clinical literature suggest that clients' responses to active-directive interventions will fall into two contrasting categories: compliance/acceptance or resistance/opposition. There has been no research investigation of this suggestion for client responses in directive therapies. Likewise, there has been no study of a tentative suggestion that initial oppositional responses become accepting ones over several sessions.

The present research, as a first study of client in-session responses to active-directive interventions within the context of

contemporary directive therapy, will focus on Rational-Emotive Therapy. Specifically, the aim is to study client responses over a series of sessions to a central RET intervention, cognitive-disputation. As such, the research results have a bearing specifically on the RET theory of therapy as well as on the practice of RET. In a more general way, the research also contributes to the psychotherapy theoretical literature concerning active-directive therapies and interventions and provides clinicians with initial information regarding client responses over time to a particular set of popular active-directive interventions.

Research Hypothesis

The purpose of the present research is to study clients' in-therapy responses and changes in responses over a series of sessions to a primary RET active-directive intervention, cognitive disputation. For this research, cognitive disputation comprises three interventions: challenging questions, directive interpretations and didactic presentations.

In general form, the research question and hypothesis may be framed as follows:

In a series of RET sessions, when clients' responses are categorized as either acceptance/compliance or opposition/resistance, and when clients' responses to cognitive disputations are compared with responses to other active-directive interventions and non-active-directive interventions, then the following question and hypothesis may be studied:

1. Will clients' tendencies toward compliance/acceptance or opposition/resistance increase, decrease or remain the same over a series of sessions?

There is no research on this question. However, theories of directive therapies, including RET, suggest the following hypothesis:

1. Clients' responses to cognitive disputations and other active-directive interventions will progressively change towards increasing acceptance/compliance and decreasing opposition/resistance over a series of sessions.

This is the major question and hypothesis of the research. The research strategy also allows for examination of client

responses to each of the three interventions comprising cognitive disputation. Given that for the present research cognitive disputation comprises challenging questions, directive interpretations, and didactic presentations, the following question may be studied as an auxiliary to the major hypothesis:

1.a Will there be significant differences among the three cognitive disputation interventions in clients' tendencies toward compliance/acceptance or opposition/resistance; and will these tendencies increase, decrease, or remain the same over a series of sessions?

This question is not specifically addressed in either the clinical or research literatures, nor do the theories of directive therapies generate a clear expectation. However, on the basis of the suggestion that client responses to active-directive interventions in general will change toward increasing compliance, the following hypothesis will be investigated:

1.a Clients' responses to each of the specific interventions comprising cognitive disputation will progressively change toward increasing acceptance/compliance and decreasing opposition/resistance over a series of sessions.

Implications of the Findings

It was concluded from the review of the clinical and research literatures that client responses to active-directive interventions have been studied primarily within the context of client-centered therapy. That is, active-directive interventions have been evaluated against nondirective therapy theory and values. The present research, in contrast, is a first study of

client responses over time to certain common active-directive interventions as used within the framework of RET directive therapy theory and values.

There is virtually no clinical literature and no research on how clients respond in RET sessions. There are suggestions that clients respond with either passive, superficial acceptance or opposition. There is also an expectation that clients will start out in an argumentative, resistant stance but change in the direction of acceptance over the process of therapy.

If the results of the present study indicate that clients do indeed respond initially with opposition and then change towards more responses of acceptance, the general expectations of RET theory of therapy will be confirmed. That is, clients start out oppositional but eventually do show agreement with the therapist's position. If this is the finding, the clinical hunches and expectations generated from the clinical experience of a number of RET authors will be supported (e.g., Grieger & Boyd, 1980; Walen, DiGiuseppe & Wessler, 1980), as well those of other active-directive therapists like Thorne (1950). In addition, some tentative hints from research suggesting change in a positive direction would find support (e.g., Anderson, 1969; Ashby et al., 1957).

If clients tend to remain oppositional, then the predictions of the critics of active-directive interventions, as well as the findings of the early research on active-directive versus non-active-directive interventions may have some support, that is, that active-directive interventions tend to elicit negative responses (e.g., Ashby et al., 1957; Benjamin, 1981; D'Augelli.

D'Augelli & Danish, 1981; Gillespie, 1953; Rogers, 1942; Rottschaffer & Renzaglia, 1962; Synder, 1945; Tourney et al, 1966).

On the other hand, if the results do not show change in client responses in the direction of acceptance from opposition, it could also be concluded that simply more therapeutic work was needed and that change might be evident later in therapy. This conclusion would support the RET position that irrational ideas are strongly entrenched and difficult to change.

The research results also have implications for RET theory of personality and personality change. The theory states that irrational beliefs are firmly entrenched and slow to change (Ellis, 1962), that clients stubbornly hold on to their dysfunctional ideas, and that a concerted attack by the therapist is necessary to uproot them (Ellis, 1962; 1979; Grieger & Boyd, 1980). If the results show clients being oppositional, argumentative, and resistant, then this theory will receive some support whether or not clients' responses change over the sessions. Of course, change in the direction of more acceptance and agreement is also predicted by RET theory in that active-directive interventions are expected to uproot irrational beliefs.

For practicing therapists, whether RET followers or others who use cognitive disputation, the results will be a first indication of how clients may be expected to respond over time to these active-directive interventions. Therapists will be able to note if their clients do respond along an acceptance/opposition dimension and decide if this is a response pattern they value as

therapeutically productive. They can use the results to decide whether cognitive disputation provides client consequences that they intend to elicit during the session. Particularly if the results show clients to be oppositional only initially, therapists may conclude that they have to persist with disputing until clients begin to respond with more agreement and not discontinue disputation thinking that it is not working. Whatever the results, they will provide the first empirical data for therapists wishing to consider the client consequences of cognitive disputation.

Chapter 2

METHODOLOGY

The purpose of this chapter is to present a method for investigating the research questions posed at the end of the Review of the Literature. The presentation of the research design is followed by a statement of the specific research hypotheses.

Research Design

Description of the Data

The source of the data is three series of RET sessions contributed by Albert Ellis and Lucien Auger, two exemplars of RET practice. The Ellis series comprises sessions 2, 3, and 4 with a male client and sessions 2, 3, and 4 with a female client. Both Ellis clients presented problems of procrastination and overweight. Auger contributed a complete therapy, sessions 1 through 8 with a female client who presented interpersonal and family problems. This series was conducted in French. Sessions 2, 3, and 4 were chosen for inclusion in this study. All three clients were in their thirties.

Major Characteristics of the Research Design

The research design allows for the study of changes in client responses to the target interventions over a series of early sessions. The design focuses on the changes client by client so that it is a single case study with replication.

The research is a naturalistic study. Since the aim is to look at the target therapist interventions and their client consequences under conditions experienced in daily clinical prac-

tice, the raw data are audiotapes of a series of actual psychotherapy sessions conducted by real therapists with real clients. In addition, the therapists are RET experts. Albert Ellis, who conducted therapy series 1 and 2, is the founder and chief spokesperson of RET. Lucien Auger, the therapist in series 3, has written widely on the topic of RET (e.g., 1972; 1974; 1977; 1979a; 1979b; 1980a; 1981a; 1981b), including one book with Ellis (1980b). The use of recognized practitioners and real clients ensures that the target therapist's interventions are studied as they occur in actual therapy by experienced, competent therapists. The client responses come from adult clients typical of those any therapist might encounter in the practice of psychotherapy.

Given the design using naturalistic data, a number of research considerations arise. These include: (a) how to measure the therapist and client variables, (b) the form of the raw data, (c) the sample of data to be analysed, (d) choice of scoring unit, (e) identification of therapist target statements, (f) classification of client responses, (g) choice of judges, (h) procedures for rating, and (i) statistical procedures for analysis of the data. The remainder of the chapter will address these methodological issues.

Measurement of Therapist and Client Variables

The data consist of the actual therapist statements and client responses made in the sessions as rated by trained judges.

Data Form

Psychotherapy process research typically uses audiovisual recordings, audiotapes and/or transcripts of audiotaped sessions as data (Bergin & Garfield, 1971; Garfield & Bergin, 1978; Kiesler, 1973). Kiesler (1973) points out the advantages of using the audio dimension to pick up extra- and paralinguistic variables, like voice pitch, tempo, and volume change, if these provide information needed to answer the research question.

Audiotapes were the choice of data form for this research so that judges would have voice quality available to help make accurate identifications of the active-directive therapist target statements and judgments of clients' compliance/opposition.

Data Sample

Related psychotherapy process research has analysed entire sessions, that is, each therapist and client statement, as well as portions of sessions using a variety of sampling procedures. Sampling is necessary and appropriate for large amounts of raw data but otherwise runs the risk of losing valuable information from sections excluded. Given that the present study is confined to only three series of therapy sessions and that the aim is to identify possible progressive changes in clients' responses over several sessions, the data include each therapist and client statement.

Scoring Unit

Kiesler (1973) lists the units proposed in the literature as suitable scoring units in psychotherapy process research. They include single words, phrases, sentences, the utterance, topic areas, the typescript page, and various time samples. The choice

depends upon the view of the session desired, that is, close-up or more general, and the type of variables. For the present study, the utterance or statement (everything one participant says between two successive productions of the other) gives a suitably detailed view of both therapist and client behavior. The statement also makes conceptual sense given that the goal is to measure clients' compliance/opposition with target therapist interventions.

Identification of Therapist Target Statements

The focus of the present research is three kinds of cognitive disputations used in RET: challenging questions, directive interpretations, and didactic presentations. These form the three major categories of therapist interventions investigated. In the Review of the Literature, it was concluded that there is no existing set of clearly defined and widely accepted operational definitions of RET interventions. Accordingly, for this study, descriptions of the three target interventions were carefully collected from the clinical RET literature using a variety of RET writers who describe what they do in therapy and who provide training handbooks for therapists wishing to learn RET interventions (e.g., Grieger & Boyd, 1980; Tosi, 1974; Walen, DiGiuseppe & Wessler, 1980; Wessler & Wessler, 1980). In brief, the three interventions have been defined as follows:

- (1) Challenging Questions. These require clients to prove or justify their beliefs by asking for logical evidence, for the logic behind their expectations of horrible future events and for assessments of the hedonistic value of their beliefs. Challeng-

ing questions are distinct from other kinds of questions used in psychotherapy. They are not information-gathering inquiries like "How old are you?" or "What is your problem?" or "When did your symptoms start?" Similarly, they are not gentle leading questions like "Can you tell me more about that?" They are active challenges that probe the client's belief system.

The following clinical examples show how these challenging questions might occur in a session:

T- So you're different from other people. What are you concluding from that?

T- Where is the evidence that you must have enjoyment easily and quickly?

T- Where's the proof that you need other people?

(2) Directive Interpretations. Directive interpretations are forthright, vigorous, and persuasive statements that tell clients what they are like, what their problems are, how they are behaving, what their beliefs are, etc. The interventions are firm, unhesitant, and sometimes outspoken and provocative.

Directive interpretations are characterized by bluntness and the straightforward manner in which they are delivered. They are not tentative suggestions or gentle hypotheses.

The following examples are therapist statements that would be rated in category 2:

T- Not only are you saying, that "I might have some power over the airplane, etc., to let it fall or not." But you're saying, "If I were dead," - let's suppose that this really occurred - "it would be awful for me."

T- So what we're really saying then, in relation to this emotional problem, is that you really down yourself, you start calling yourself names. And then you feel really rotten about you, and hopeless, and then you give up and start eating.

(3) Didactic Presentations. Didactic presentations are statements that seem like little lectures or information about reality that the therapist gives the client. The therapist might be teaching the client about RET theory, or giving examples of better ways of thinking or behaving. Therapists might explain how emotional problems start and what can be done to help, or how other people have changed. The key characteristic is the lecturing or informational aspect of the intervention.

The following are examples of interventions that belong in Category 3:

- T- No, no, it's not back when you were 5. It's what we would more accurately call preconscious. In other words, it's not that deeply repressed so much as it's going on in the back of your mind, but you don't easily, and most of us don't, virtually nobody puts his finger right away on those thoughts that are at the back of your mind.
- T- Look, there isn't a parent in the world who hasn't felt he could just take the kid when he was whining and throw him out the window. This is an impulse, you know. Children are very demanding. We have to get up in the middle of the night for them. We're tired. They think Mama's going to be there Johnny-on-the-spot.

A detailed description of the three target categories is found in Appendix 1, Instructions to Judges for Rating Therapist Statements. The detailed definitions in the Appendix are illustrated with actual clinical examples of the interventions as they have been used in real therapy sessions. The examples were taken from published transcripts of RET sessions conducted by certified RET practitioners.

In addition to the three target cognitive disputation categories, two additional categories of therapist statements were included to take into account, first, other active-directive interventions that may be used in RET sessions and, second, non-

active-directive interventions. The fourth category, Other Active-Directive Interventions, allows comparison of clients' responses to the three target disputational interventions with responses to other active-directive statements. The fourth category acts as a check on possible differential client responses to cognitive disputation and other active-directive interventions.

As noted in the Review of the Literature, there is no existing category system for classifying therapist statements as active-directive. However, in the Review, a number of interventions were identified in the clinical and research literatures as belonging to the active-directive family of interventions. It is these interventions that make up the fourth category. Briefly, they include persuasion, giving advice, suggestions, directions on what to do, reassurance, encouragement, disapproval, criticism, confrontation, direct questions, and structuring or leading statements. Category four includes statements that are leading, directive, authoritarian, expert, and/or active. In these interventions the therapist is in the role of the expert, influential professional, wise teacher. For example:

T- When did your anxieties begin?

(direct question)

T- Now, let's look at this example for instance. There was nothing you could do at the hotel. It was not the best place to have your temper tantrum, and maybe an intellectual approach would have been better under the circumstances.

(criticism and a suggestion of what the client should have done instead)

T- You should not bare your soul without evidence of

reciprocity. Also, before you plunge too deep there should be a feeling of a fairly broad base of common interest.

(directions on how the client should behave)

There is a detailed description of category four interventions in Appendix 1.

The fifth category of therapist interventions, Non-Active-Directive Interventions, allows comparison of client responses to the target cognitive disputation interventions with non-active-directive statements. Category five includes any therapist statement that cannot be categorized as either one of the three cognitive disputation interventions or category four. The following interventions would be given a category 5 rating:

T- Uh hum.

T- I see.

C- I really hate him.

T- You really can't stand him.

T- Would you like to talk about it now?

T- It seems as if you might be afraid when you have to meet people.

Classification of Client Responses

According to the Review of the Literature, clients are expected to respond to active-directive interventions along a dimension from acceptance to opposition. The clinical literature suggests that clients respond with strong and mild acceptance or compliance, with rejection and opposition, or with acceptance followed by rejection.

There is no existing category system for rating client responses along a dimension from acceptance to opposition. The few related studies that have incorporated client response categories, such as acceptance, agreement, openness, rejection, re-

sistance, and defensiveness (e.g., Ashby et al., 1957; Auld & White, 1959; Gillespie, 1953; Snyder, 1945; Speisman, 1959; Tourney et al., 1966) are related conceptually to either client-centered therapy or psychoanalytic therapies (e.g., Snyder, 1945; Gillespie, 1953), or designed to allow study of specific therapist interventions, such as, depth of interpretation (Speisman, 1959). There is no scheme for studying client responses to the active-directive interventions used in directive therapies or for investigating the predictions in the clinical literature. Accordingly, a three-category system was designed for the present research to take into account the acceptance and opposition responses mentioned in the clinical literature and an Other category for client responses that cannot be placed in one or other of the acceptance/opposition categories. Briefly, the client response categories are:

- (1) Acceptance/Compliance
- (2) Opposition/Resistance
- (3) Other

The categories have been defined using the descriptions found in the clinical literature for each type of response. That is, whenever an author mentioned a response that would constitute, for example, strong acceptance, this was noted and included in the definition of client acceptance/compliance.

In category 1, the client accepts, agrees with, or complies with the previous therapist statement. This acceptance can range from strong, unconditional acceptance, such as: "Yes!" "That's it!," to mild or reluctant agreement, such as: "Uh, huh, you're

right," or "Yeah, I know." Client statements are rated in category 1 when the client's response indicates acceptance or agreement, whether mild or strong.

In category 2, the client rejects, disagrees with, or argues with the previous therapist statement. It is clear that the client opposes what the therapist has just said. The client may also show opposition by putting the therapist on the spot with questions or by not complying with the therapist's leads and questions.

In some cases, the client's responses may not fit either category 1 or 2, that is, either agreement/compliance or opposition/resistance. Any other client response is placed in the third client category "Other."

A detailed description of each client category is found in Appendix 2, Instructions to Judges for Rating Client Responses. The category definitions are supplemented by a large number of clinical examples of each response. These were taken from the same pool of published transcripts of RET sessions used to illustrate the therapist categories. Therefore, the examples represent responses made by real clients in actual RET sessions.

Judges

Like the majority of psychotherapy process research that uses two to four judges (e.g., Edwards, Boulet, Mahrer, Chagnon, & Mook, 1982; Hill, 1978; Hill et al., 1979; Strupp, 1957), the present study uses four judges, two English-speaking judges for the Ellis data and two French-speaking judges for the Auger data. Judges had graduate training in counseling/psychotherapy, since some degree of clinical expertise is required in making both

therapist and client ratings.

Procedures for Rating Therapist and Client Variables

The original audiotaped sessions were re-recorded to facilitate the rating procedure. A pause of 8 seconds was inserted after each therapist and client statement, and statements were labeled consecutively, just before the pause, e.g., 'therapist statement,' 'T 1,' (pause, 8 sec), 'client statement,' 'C 1,' (pause, 8 sec).... This procedure allows judges to make their decision and record their rating during the pause, eliminating the need to stop, rewind, and restart the tape after each statement.

Judges are trained to rate therapist and client statements using a commercially available demonstration session by Ellis. The four judges independently rate therapist statements and client responses. When agreement between judges reaches 80%, training is considered complete.

The rating of the raw data comprises several steps. Initially, English-speaking judges for the Ellis data independently rates each therapist statement into one of the five therapist categories, and the following client response into one of the three client response categories. French-speaking judges follows the same procedure for the Auger data. On the basis of the initial ratings, interjudge reliability is calculated separately for the Ellis and Auger data using the kappa statistic (Cohen, 1960). Kappa assesses the proportion of agreement between two judges after chance agreement has been removed (Hill, 1978).

At the second step, judges meet to discuss and re-rate those

therapist statements and client responses for which there is disagreement (Hill, 1978). At the third step, an independent arbitrator makes a final decision if there is disagreement at the second step. This procedure minimizes the loss of data so that the only information rejected consists of those therapist or client statements that are unintelligible.

Statistical Procedure for Data Analysis

Given that the raw data are the classification of therapist statements into five target categories and the following client responses into three client categories, what statistical procedure will allow assessment of progressive changes in clients' responses over the series of three sessions? One possibility is to calculate for each target therapist intervention the proportion of client responses falling into each of the three client categories (acceptance/compliance, opposition/resistance, and other). For example, following Challenging Questions in session 1, there might be .65 acceptance/compliance, .25 opposition/resistance, and .10 other client responses. These proportions can be determined for each client over the three therapy sessions.

In this manner, the progressive changes in proportions of client acceptance/compliance and opposition/resistance from session 2 to sessions 3 and 4 can be determined. (It should be noted that the third client category, *other*, is not included in the data analysis for purposes of testing the research hypotheses.)

For an analysis dealing with proportions and changes in proportions from session to session, the appropriate statistic is calculation of z . z , a deviate of the normal curve, is used to

assess the significance of the difference between two proportions. To assess progressive changes in clients' responses over the sessions, z can be calculated between sessions 2 and 3, 3 and 4, and 2 and 4 for proportions of client acceptance/compliance and opposition/resistance following each target therapist intervention. As an example, z can be determined for client proportions of acceptance/compliance to Challenging Questions in sessions 2 and 3 to indicate whether there is more acceptance in session 3 than session 2.

z is found by dividing the observed difference between proportions by the standard error of the difference. Ferguson (1971) gives the following formula:

$$z = \frac{p_1 - p_2}{\sqrt{p_1 - p_2}} = \frac{p_1 - p_2}{\sqrt{pq[(1/N_1) + (1/N_2)]}}$$

and where:

p_1 and p_2 are the two proportions being compared

$$p = (f_1 + f_2) / (N_1 + N_2)$$

$$q = 1 - p$$

f_1 , f_2 , N_1 , and N_2 are the raw frequencies and totals.

z is interpreted as a deviate of the normal curve when the N s are reasonably large and p is neither very small nor very large. Ferguson (1971) gives the formula for determining whether the raw data meet this requirement. In the present analysis, z is calculated whenever the raw data conform to this requirement so that the normal curve can be used as the point of reference.

The values of z used to assess significance depend upon whether a one- or two-tailed test is used. Ferguson (1971)

recommends the use of one-tailed or directional tests of significance since psychological research is more interested in the direction of change rather than simply the magnitude of the difference between two values or observations. For the present study, the one-tailed test is especially appropriate since the hypotheses predict directional changes, i.e., progressive increases and decreases in proportions of client acceptance/compliance and opposition/resistance over three sessions. For a one-tailed test, z values of 1.28, 1.65, 2.33, and 3.09 are required for significance at the .1, .05, .01, and .001 levels respectively.

Ferguson (1971) cautions that when small samples are used (as in the present case) and a very stringent α is set, there is greater danger of making a type β error (failing to reject the null hypothesis when there is a significant difference). To diminish this possibility, z s reaching the .1 level of significance or above will be reported as indicating a significant difference between proportions in this analysis.

To summarize, proportions of clients' responses falling into the three client categories will be determined for each therapist target category. Changes in proportions of client acceptance/compliance and opposition/resistance over the sessions will be determined by calculating the statistic z for two proportions and referring the z value to the normal curve for assessment of significance.

The research design includes five target therapist categories (Challenging Questions, Directive Interpretation, Didactic Presentations, Other Active-directive Interventions, and Non-

active-directive Interventions). The first four are active-directive interventions while the fifth is comprised of non-active-directive statements. These are the two major groupings of therapist interventions. In addition, Active-directive Interventions may be divided into Cognitive Disputation (specific to RET) and Other Active-directive Interventions (which may be used by many psychotherapeutic orientations). Finally, Cognitive Disputation, for the present research, is composed of Challenging Questions, Directive Interpretation, and Didactic Interventions. The following table illustrates the grouping of the target therapist interventions and is the layout used for the presentation of the research results.

Table 1

Grouping of Target Therapist Interventions

I. Active-directive interventions

A. Cognitive disputation

1. Challenging questions
2. Directive interpretations
3. Didactic presentations

B. Other active-directive interventions

II. Non-active-directive interventions

In this research, clients' responses to the active-directive categories of therapist interventions are of primary interest, particularly to those specific to RET. Responses to non-active-directive statements are included as a point of comparison.

Research Hypotheses

Given that there are three series of early RET sessions conducted by exemplars of RET,

Given that each series represents therapy with one adult client,

Given that two series are conducted by Albert Ellis and one series by Lucien Auger,

Given that therapist statements are categorized as falling into cognitive disputation (including challenging questions, directive interpretations, and didactic presentations), other active-directive interventions and non-active-directive interventions,

And given that clients' responses are categorized as acceptance/compliance, opposition/resistance, or other,

Then it is predicted that:

- (1) Proportions of client acceptance/compliance to Active-directive interventions will increase significantly over three sessions. This increase will be significantly greater than that for Non-active-directive interventions; and
- (2) Proportions of client opposition/resistance to Active-directive interventions will decrease significantly over three sessions. This decrease will be significantly greater than that for Non-active-directive interventions.

These are the main research hypotheses. The following five auxiliary hypotheses follow from the major two.

- (1a) Proportions of client acceptance/compliance to Cognitive Disputation interventions will increase significantly over three

sessions. This increase will be significantly greater than that for Non-active-directive interventions.

(2a) Proportions of client opposition/resistance to Cognitive Disputation interventions will decrease significantly over three sessions. This decrease will be significantly greater than that for Non-active-directive interventions.

(1b) Proportions of client acceptance/compliance to Other Active-directive interventions will increase significantly over three sessions. This increase will be significantly greater than that for Non-active-directive interventions.

(2b) Proportions of client opposition/resistance to Other Active-directive interventions will decrease significantly over three sessions. This decrease will be significantly greater than that for non-active-directive interventions.

(1c) Proportions of client acceptance/compliance to Challenging Questions will increase significantly over three sessions. This increase will be significantly greater than that for Non-active-directive interventions.

(2c) Proportions of client opposition/resistance to Challenging Questions will decrease significantly over three sessions. This decrease will be significantly greater than that for Non-active-directive interventions.

(1d) Proportions of client acceptance/compliance to Directive Interpretations will increase significantly over three sessions. This increase will be significantly greater than that for Non-active-directive interventions.

(2d) Proportions of client opposition/resistance to Directive

Interpretations will decrease significantly over three sessions. This decrease will be significantly greater than that for Non-active-directive interventions.

(1e) Proportions of client acceptance/compliance to Didactic Presentations will increase significantly over three sessions. This increase will be significantly greater than that for Non-active-directive interventions.

(2e) Proportions of client opposition/resistance to Didactic Presentations will decrease significantly over three sessions. This decrease will be significantly greater than that for Non-active-directive interventions.

Chapter Three

Results

The purpose of this chapter is to report the research findings related to the major hypotheses as well as data on interrater reliability. Other findings bearing on the use of active-directive interventions within directive therapy will also be noted.

Data Collection and Interrater Agreement

During the training period, judges independently studied the therapist and client category systems and practiced rating a commercially available audiotaped session with Albert Ellis as therapist. The practice ratings were divided into three segments, giving judges the opportunity to consult with the experimenter and check their ratings after each segment. Training ended when the interrater agreement reached 80%, a level arbitrarily selected to indicate acceptable agreement.

The data collection proceeded in three steps. During step one, two judges independently rated the English audiotapes and two others the French audiotapes.

Interrater agreement was determined from this initial rating of therapist statements and client responses. The Kappa statistic was calculated separately for the English and French data. For the English data interrater reliability reached .74 for the therapist categories and .74 for the client categories. For the French therapy sessions, Kappas of .79 and .77 were found for the

therapist and client categories respectively. These levels indicated acceptable agreement across judges for both categories and for English and French data.

The Main Hypotheses

There were two main hypotheses (1 and 2) along with five auxiliary hypotheses to each main hypothesis. Each hypothesis tested changes in proportions of either client acceptance/compliance or opposition/resistance over three sessions to active-directive interventions as a whole and specifically to cognitive disputation and its components. Progressive changes in clients' responses to the active-directive interventions were compared with changes in responses to non-active-directive interventions.

The distribution of client responses following each therapist target intervention is shown in Tables 2, 3, and 4. The majority of therapist interventions fell into the active-directive category for all clients and all sessions. Non-active-directive interventions accounted for only 2-23% of therapist interventions.

The number of client responses in some cells was low. While results are reported for each client individually, in some cases client responses are combined and additional results for grouped data are provided with statistical analysis.

Hypothesis 1 stated that proportions of client acceptance/compliance to active-directive interventions would increase

Table 2

Distribution of Client Responses
Following Therapist Target Interventions

Client 1

Session 2

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	43	10	3	56
A Cognitive disputation	26	5	1	32
1 Challenging questions	12	1	0	13
2 Directive interpretation	7	2	0	9
3 Didactic presentations	7	2	1	10
B Other active-directive	16	5	2	23
II Non-active-directive	1	0	0	1
			Total	57

Session 3

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	42	14	0	56
A Cognitive disputation	17	11	0	28
1 Challenging questions	5	1	0	6
2 Directive interpretation	6	5	0	11
3 Didactic presentations	6	5	0	11
B Other active-directive	25	3	0	28
II Non-active-directive	2	3	1	6
			Total	62

Session 4

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	49	16	2	67
A Cognitive disputation	34	12	1	47
1 Challenging questions	12	7	0	19
2 Directive interpretation	6	3	0	9
3 Didactic presentations	16	2	1	19
B Other active-directive	15	4	1	20
II Non-active-directive	7	1	0	8
			Total	75

Table 3

Distribution of Client Responses
Following Therapist Target Interventions

Client 2

Session 2

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	47	23	9	79
A Cognitive disputation	21	17	8	46
1 Challenging questions	7	2	0	9
2 Directive interpretation	6	3	5	14
3 Didactic presentations	8	12	3	23
B Other active-directive	6	0	3	9
II Non-active-directive	6	0	3	9
			Total	88

Session 3

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	49	7	6	62
A Cognitive disputation	34	6	4	44
1 Challenging questions	4	2	0	6
2 Directive interpretation	18	2	1	21
3 Didactic presentations	12	2	3	17
B Other active-directive	14	1	2	17
II Non-active-directive	4	0	5	9
			Total	71

Session 4

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	32	2	8	42
A Cognitive disputation	20	2	7	29
1 Challenging questions	1	0	1	2
2 Directive interpretation	6	1	3	10
3 Didactic presentations	13	1	3	17
B Other active-directive	12	0	1	13
II Non-active-directive	10	1	2	13
			Total	55

Table 4

Distribution of Client Responses
Following Therapist Target Interventions

Client 3

Session 2

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	86	19	8	113
A Cognitive disputation	56	13	3	72
1 Challenging questions	43	7	2	52
2 Directive interpretation	8	4	0	12
3 Didactic presentations	5	2	1	8
B Other active-directive	29	6	5	40
II Non-active-directive	8	2	4	14
			Total	127

Session 3

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	47	26	6	79
A Cognitive disputation	29	22	4	55
1 Challenging questions	18	15	2	35
2 Directive interpretation	5	5	0	10
3 Didactic presentations	6	2	2	10
B Other active-directive	18	4	2	24
II Non-active-directive	7	5	2	14
			Total	93

Session 4

Therapist Target Intervention	Client Response			N
	Acceptance/ Compliance	Opposition/ Resistance	Other	
I Active-directive	39	29	4	72
A Cognitive disputation	25	26	4	55
1 Challenging questions	6	11	0	17
2 Directive interpretation	14	9	3	26
3 Didactic presentations	5	6	1	12
B Other active-directive	14	3	0	17
II Non-active-directive	14	2	5	21
			Total	93

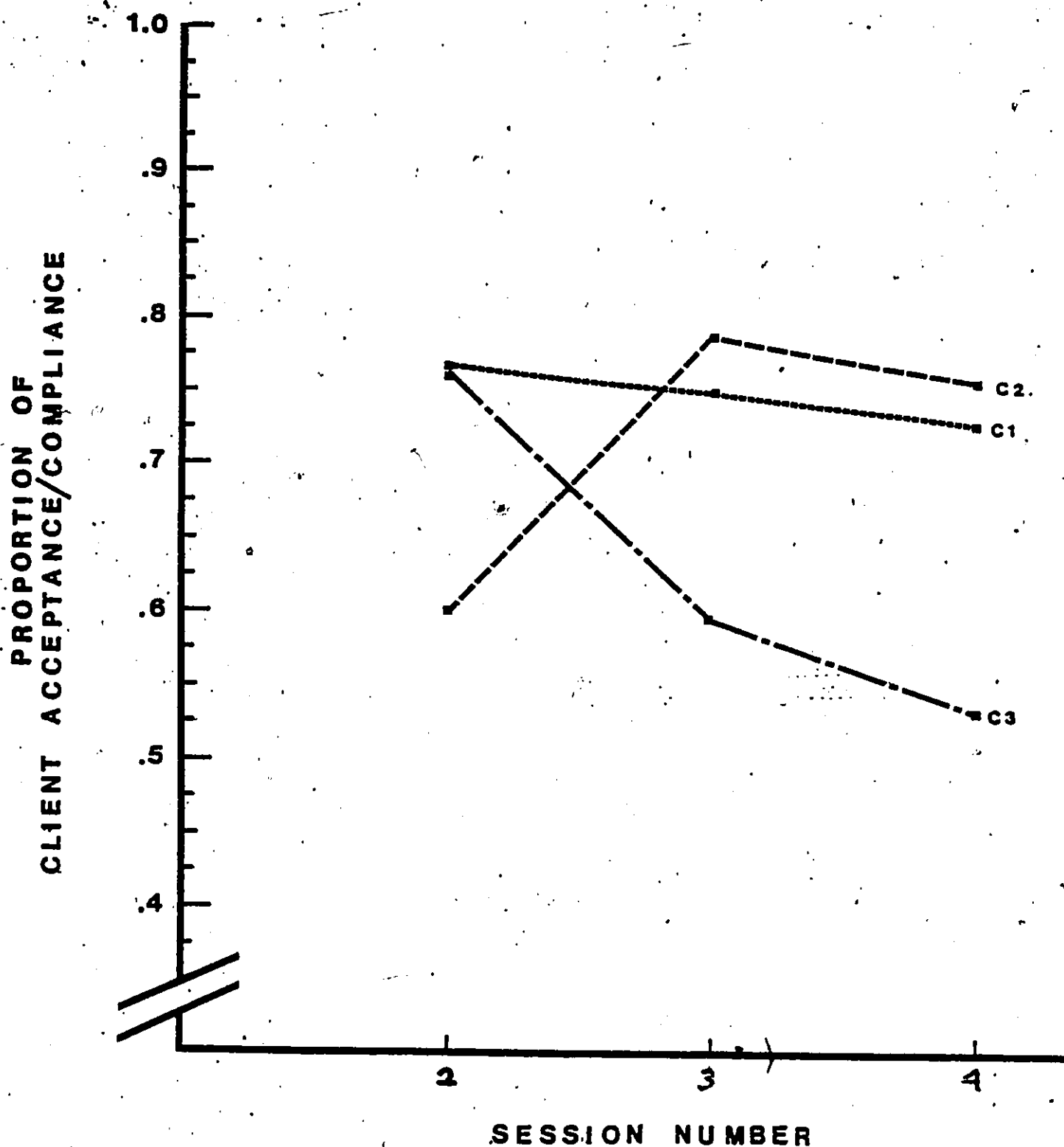


Figure 1. Proportions of client acceptance/compliance to active-directive interventions over 3 sessions for 3 clients separately (C1, C2, C3).

significantly over three sessions and that the increase would be significantly greater than that for non-active-directive interventions.

Figure 1 shows the patterns for the three clients. Client 1 showed no significant change in acceptance/compliance to active-directive interventions over three sessions ($z = .464$, $\alpha > .1$ between sessions 2 and 4). Client 2 showed a significant increase in acceptance/compliance from session 2 to session 3 ($z = -2.470$, $\alpha \leq .01$), and from session 2 to session 4 ($z = -1.837$, $\alpha \leq .05$). Client 3, on the other hand, had significant decreases in proportions of acceptance/compliance from sessions 2 to 3 ($z = 2.455$, $\alpha \leq .01$), and from sessions 2 to 4 ($z = 3.108$, $\alpha \leq .001$). The three clients showed different patterns of response, with client 2 following the hypothesized change.

Figure 2 illustrates a surprising and unexpected pattern in clients' responses to non-active-directive interventions over the three sessions. There was a decrease in acceptance/compliance to non-active-directive interventions in session 3 and then an increase between sessions 3 and 4, although N s were not sufficiently large to make a statistical confirmation. Based on grouped data, there was a significant decrease in proportions of client acceptance/compliance to non-active-directive interventions in session 3 ($z = 1.283$, $\alpha \leq .1$). In session 4, the proportions of acceptance/compliance returned to the session 2 level (there was no significant difference between sessions 2 and 4, with $z = .962$, $\alpha > .1$). (Figure 3).

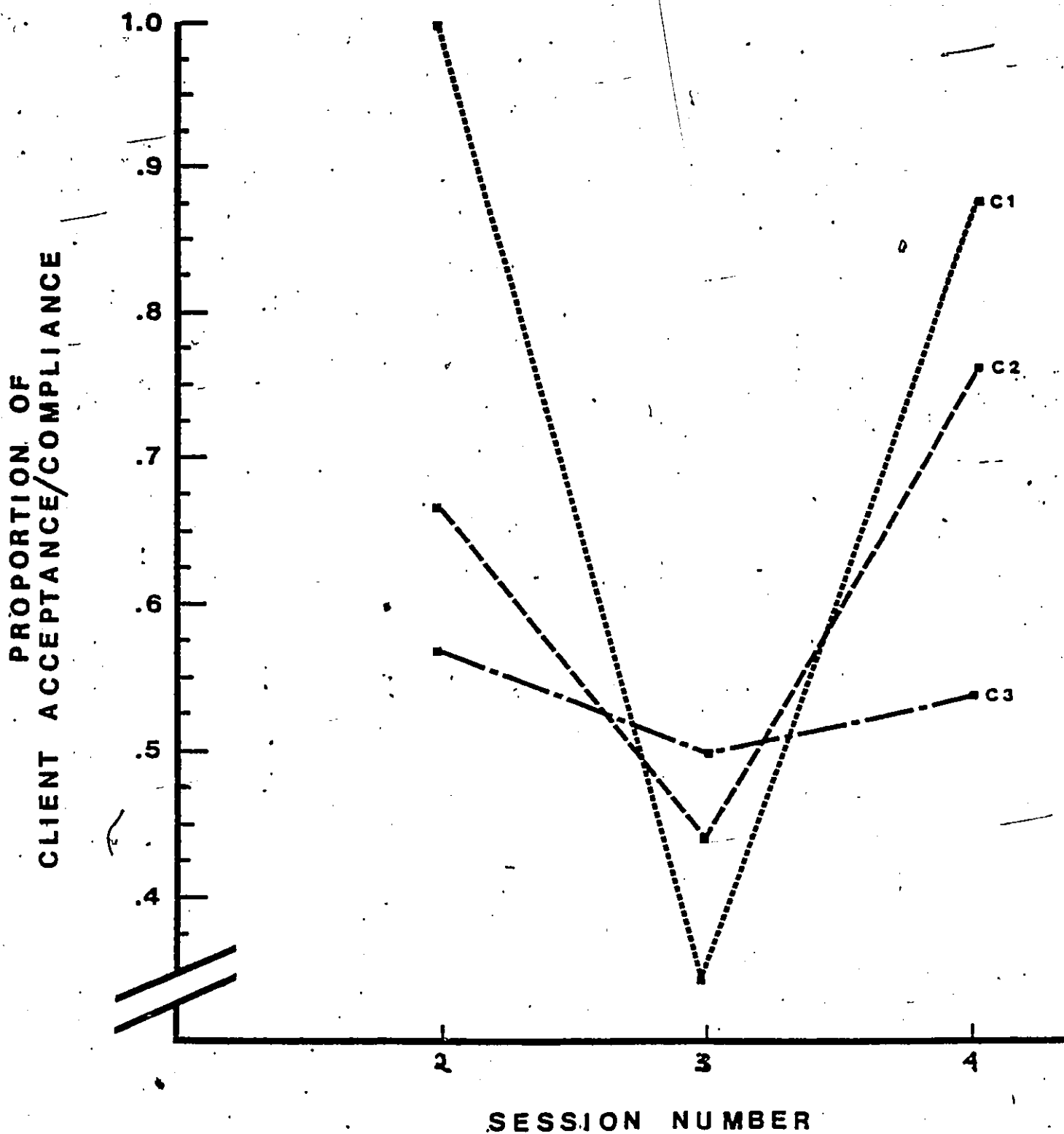


Figure 2. Proportions of client acceptance/compliance to non-active-directive interventions over 3 sessions, for 3 clients separately (C1, C2, C3).

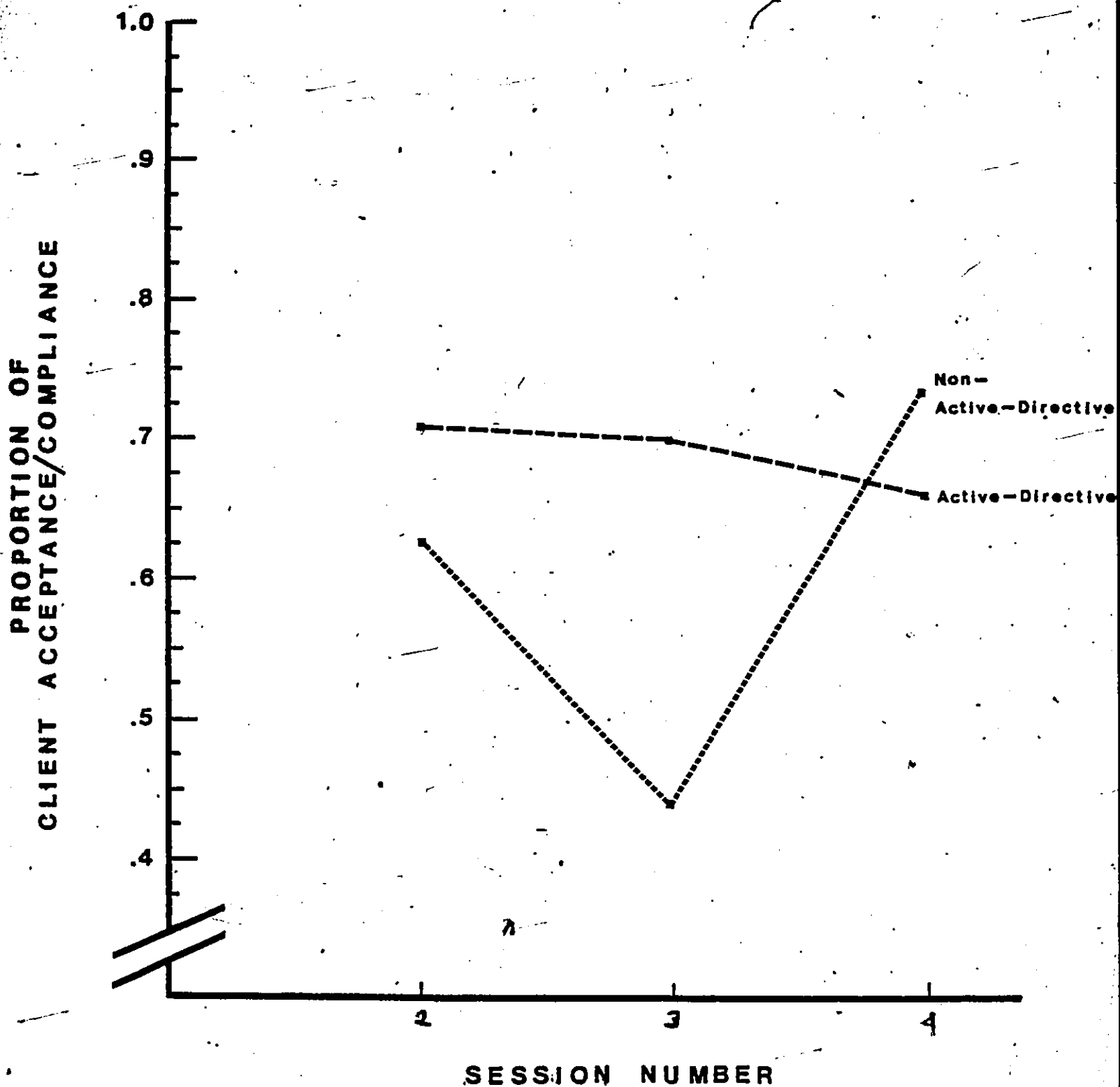


Figure 3. Proportions of client acceptance/compliance to active-directive and non-active-directive interventions over 3 sessions (all clients combined).

Hypothesis 2 stated that the proportions of client opposition/resistance to active-directive interventions would decrease significantly over three sessions and that this decrease would be significantly greater than that for non-active-directive interventions. Figure 4 indicates that for Client 1 there was no significant change in proportions of opposition/resistance over the three sessions ($z = -.815$, $\alpha > .1$ between proportions for sessions 2 and 4). Client 2 showed a significant decrease in opposition/resistance between sessions 2 and 3 ($z = 2.567$, $\alpha \leq .01$) and 2 and 4 ($z = 3.150$, $\alpha \leq .001$). Client 3's pattern was the reverse, with a significant increase in opposition/resistance between sessions 2 and 3 ($z = -2.591$, $\alpha \leq .01$) and 2 and 4 ($z = -3.550$, $\alpha \leq .001$). Again, Client 2 followed the hypothesized pattern. /

Clients' proportions of opposition/resistance to non-active-directive interventions are shown in Figure 5. Once again, session 3 stands out in that there was an apparent increase in opposition/resistance to non-active-directive interventions for 2 clients. While there was insufficient data to confirm a statistically significant change for individual clients, there was a significant decrease between sessions 3 and 4 ($z = 1.996$, $\alpha \leq .05$) when clients' responses were grouped together. (Figure 6).

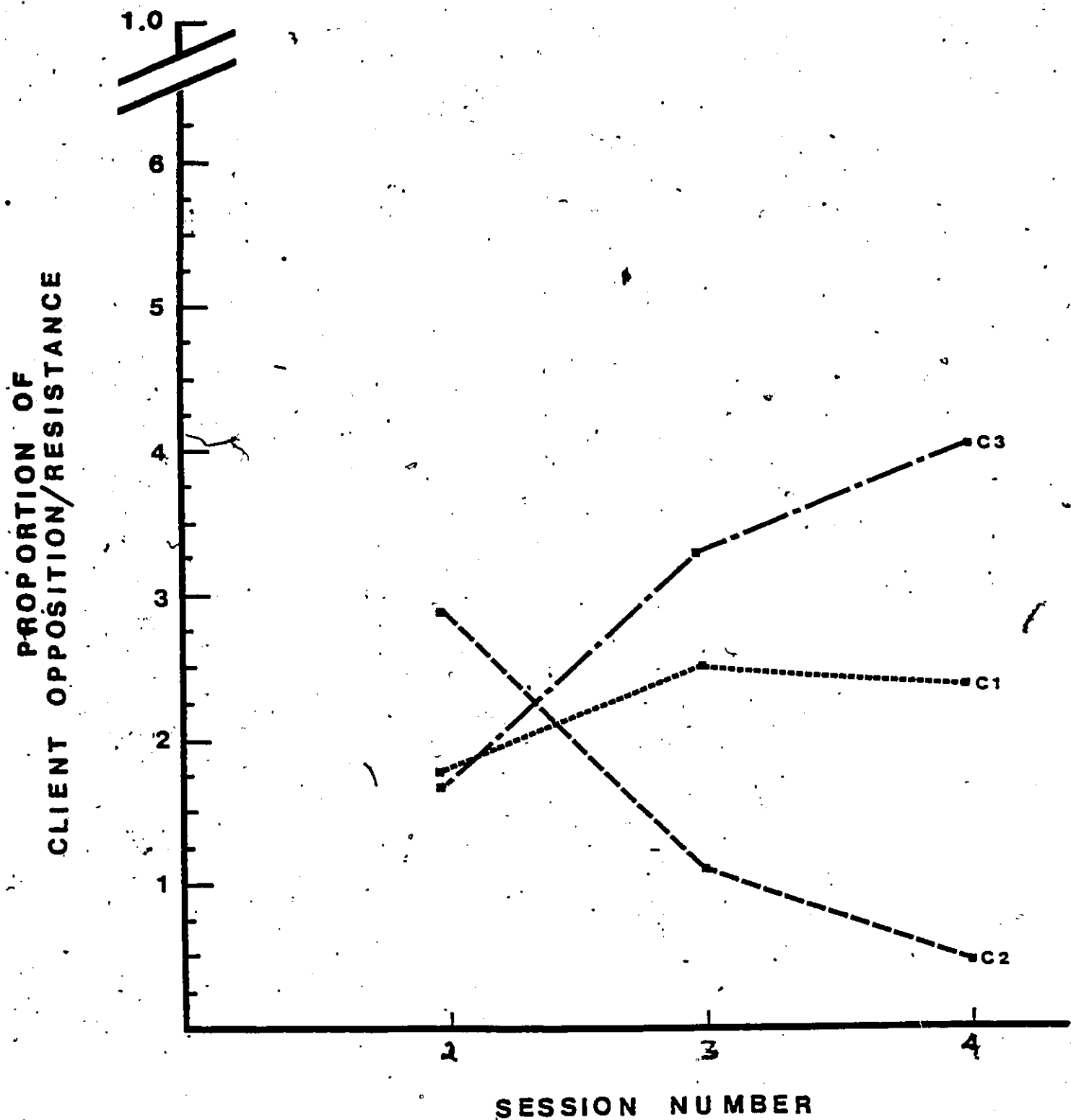


Figure 4. Proportions of client opposition/resistance to active-directive interventions over 3 sessions for 3 clients separately (C1, C2, C3).

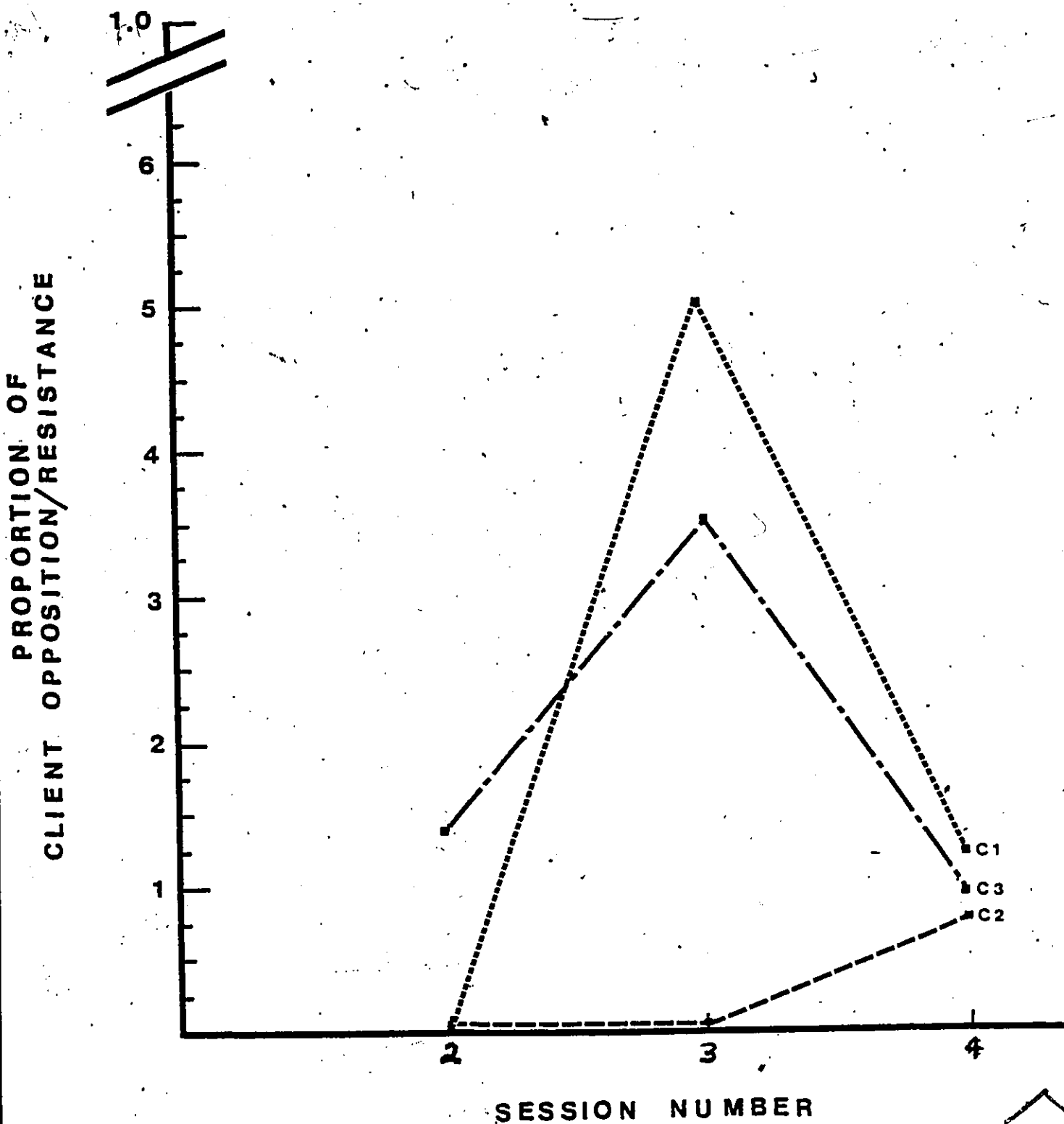


Figure 5. Proportions of client opposition/resistance to non-active-directive interventions over 3 sessions for 3 clients separately (C1, C2, C3).

PROPORTION OF
CLIENT OPPOSITION/RESISTANCE

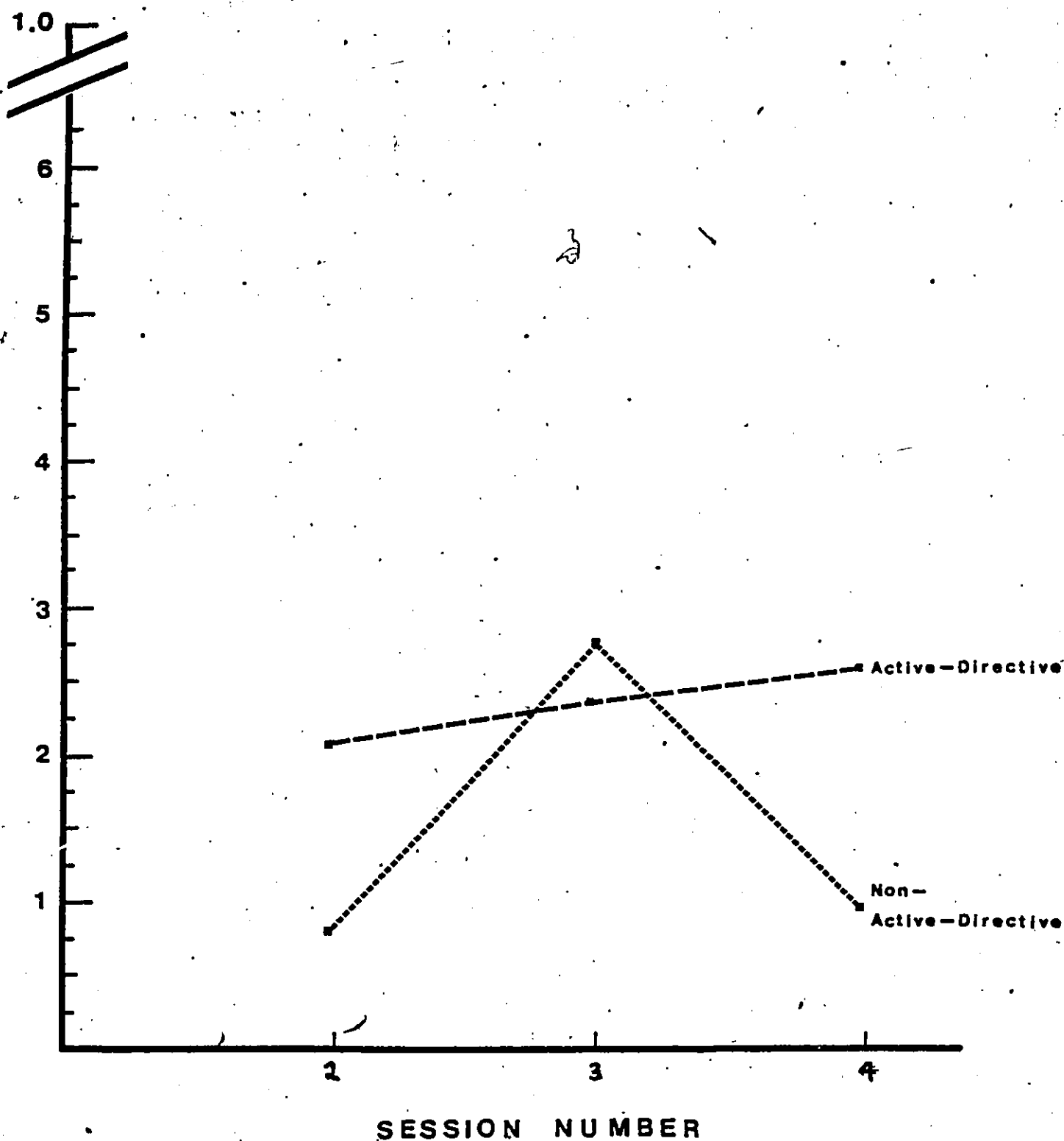


Figure 6. Proportions of client opposition/resistance to active-directive and non-active-directive interventions over 3 sessions (all clients combined).

To summarize the results for non-active-directive interventions, all three clients appeared to have a decrease in acceptance/compliance in session 3 and then an increase to session 2 levels by session 4. This pattern was confirmed statistically for the grouped data. Likewise, a concomitant increase in opposition/resistance was significant for the grouped data.

Hypotheses 1a and 2a relate to clients' proportions of acceptance/compliance and opposition/resistance to the group of cognitive disputation interventions (challenging questions, directive interpretations, and didactic presentations). Specifically, hypothesis 1a stated that proportions of client acceptance/compliance to cognitive disputation would increase significantly over three sessions and that this increase would be significantly greater than that for non-active-directive interventions.

Figure 7 indicates the patterns of acceptance/compliance to cognitive disputation for individual clients. Client 1 had a significant decrease in proportions of acceptance/compliance between sessions 2 and 3 ($z = 1.761, \alpha \leq .05$) as did Client 3 between sessions 2 and 3 ($z = 2.973, \alpha \leq .01$) and 2 and 4 ($z = 3.755, \alpha \leq .001$). Client 2, in contrast, showed a significant increase in proportions of acceptance/compliance between sessions 2 and 3 ($z = -3.076, \alpha \leq .01$) and 1 and 3 ($z = -1.975, \alpha \leq .05$). Client 2 again followed the predicted change.

Hypothesis 2a stated that proportions of client opposition/resistance to cognitive disputation would decrease significantly over three sessions and that the decrease would be significantly greater than that for non-active-directive interven-

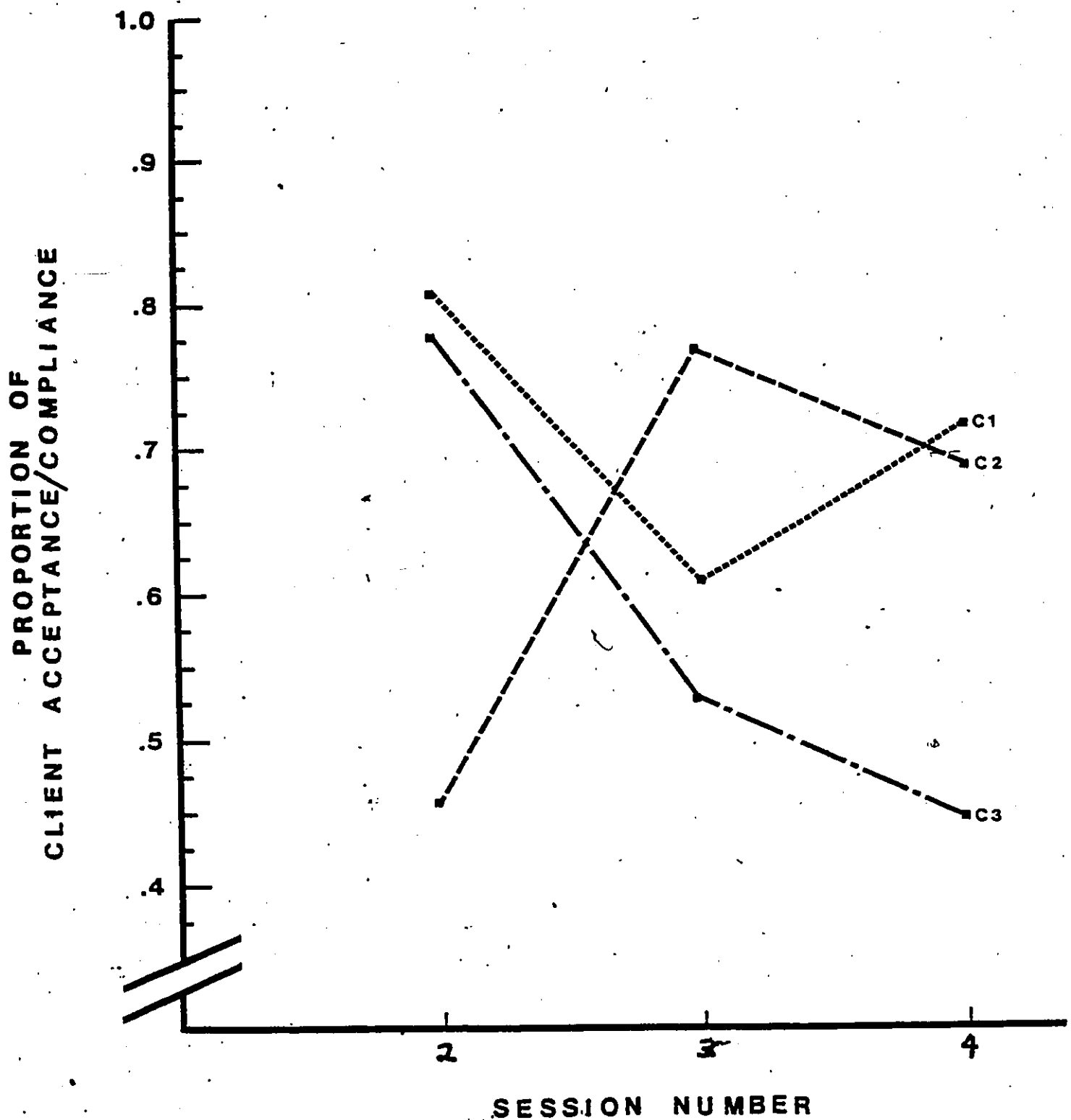


Figure 7. Proportions of client acceptance/compliance to cognitive disputation interventions (challenging questions, directive interpretations, and didactic presentations) over 3 sessions for 3 clients separately (C1, C2, C3).

tions.

Figure 8 shows the patterns for individual clients. Client 1 had a significant increase in opposition/resistance to cognitive disputation between sessions 2 and 3 ($z = -2.068$, $\alpha \leq .05$) and then returned to session 2 level in the fourth session ($z = -1.052$ does not reach the .1 level of significance). Client 3 also showed a significant increase in opposition/resistance in session 3 ($z = -2.742$, $\alpha \leq .01$) and again between session 2 and 4 ($z = -3.537$, $\alpha \leq .001$). The graph indicates a progressive decrease in opposition/resistance for Client 2 which is significant between the second and third ($z = 2.535$, $\alpha \leq .01$) and second and fourth ($z = 2.915$, $\alpha \leq .01$) sessions. Once again, Client 2 followed the predicted pattern.

Hypotheses 1b and 2b were concerned with clients' proportions of acceptance/compliance and opposition/resistance following all other active-directive interventions (exclusive of cognitive disputation). Hypothesis 1b stated that proportions of client acceptance/compliance to all other active-directive interventions would increase significantly over three sessions and that the increase would be significantly greater than that for non-active-directive interventions.

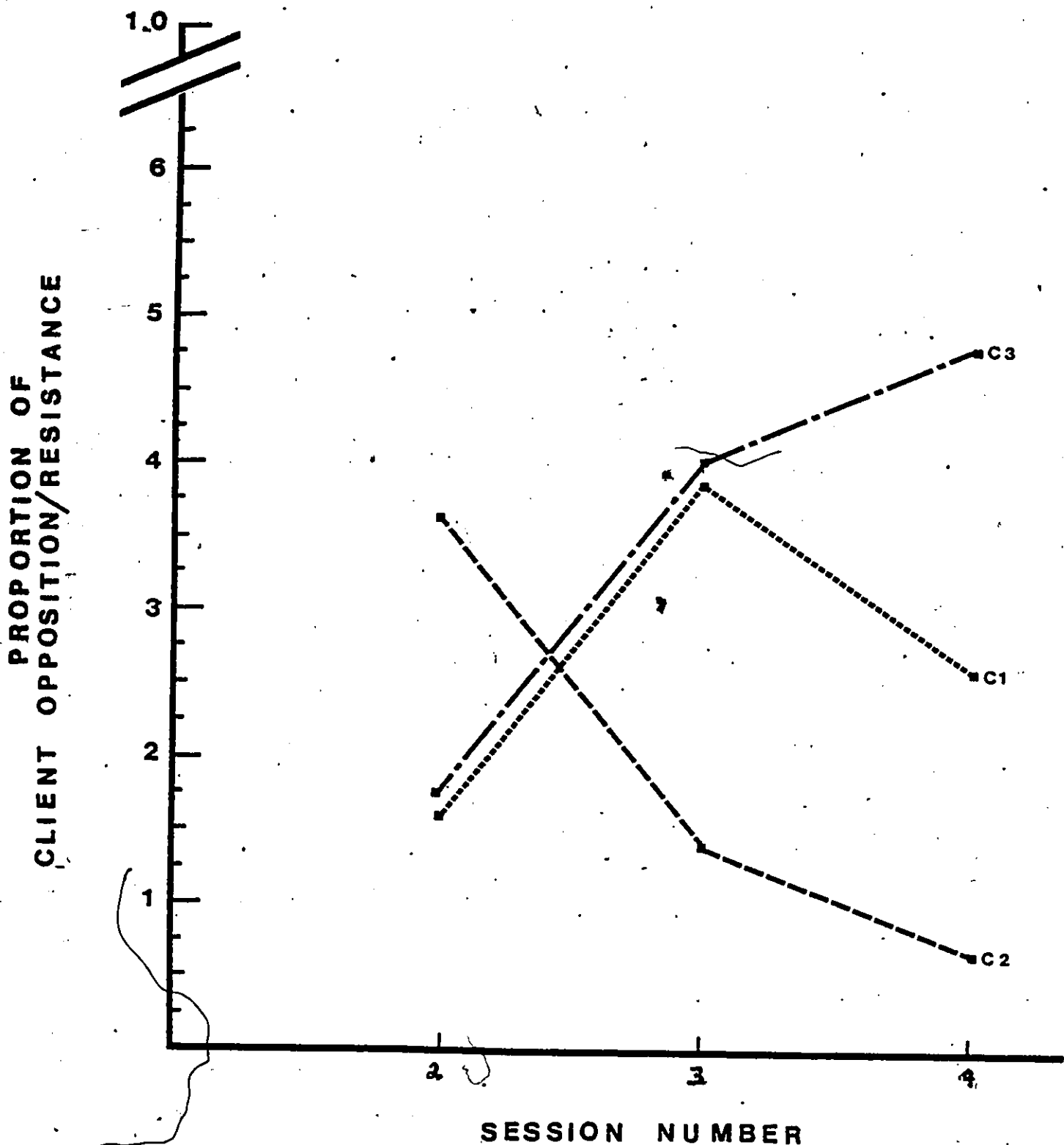


Figure 3. Proportions of client opposition/resistance to cognitive disputation (challenging questions, directive interpretation, and didactic presentations) over 3 sessions for 3 clients separately (C1, C2, C3).

The patterns of acceptance/compliance to other active-directive interventions for individual clients are shown in Figure 9. While the individual data did not allow for statistical analysis, inspection of the graphs suggests that for all clients there was an increase in proportions of acceptance/compliance by the third session. This was confirmed by grouping the data ($z = -1.350$, $\alpha \leq .1$ between sessions 2 and 3). (Figure 10).

A combination of individual and grouped data suggest confirmation of hypothesis 1b.

Hypothesis 2b stated that proportions of client opposition/resistance to all other active-directive interventions would decrease significantly over three sessions and that the decrease would be significantly greater than that for non-active-directive interventions. Results are indicated in Figure 11.

The data did not warrant statistical analysis, but by inspection it appears the Clients 1 and 3 may have remained relatively stable in proportions of opposition/resistance to other active-directive interventions over the sessions while proportions for Client 2 may have decreased. Results for the grouped data indicated no significant decrease in opposition/resistance between sessions 2 and 4 ($z = .600$, $\alpha \geq .1$). (Figure 12).

The remaining hypotheses were concerned with client acceptance/compliance and opposition/resistance to the three separate components of cognitive disputation. They were challenging questions, directive interpretations, and didactic presentations.

Beginning with challenging questions, hypothesis 1c stated that proportions of client acceptance/compliance to challenging questions would increase significantly over three sessions and

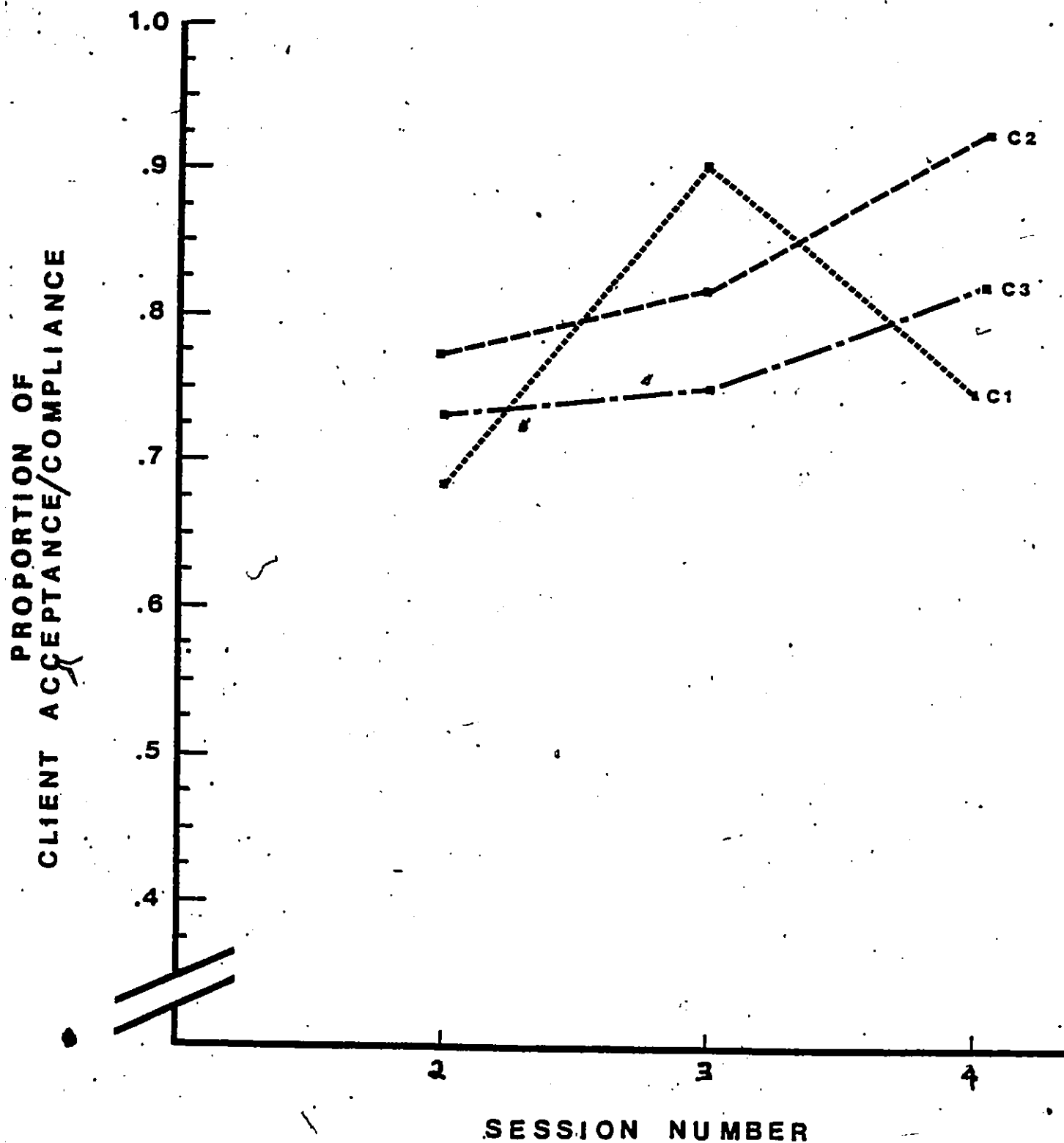


Figure 9. Proportions of client acceptance/compliance to other active-directive interventions over 3 sessions for 3 clients separately (C1, C2, C3).

PROPORTION OF
CLIENT ACCEPTANCE/COMPLIANCE

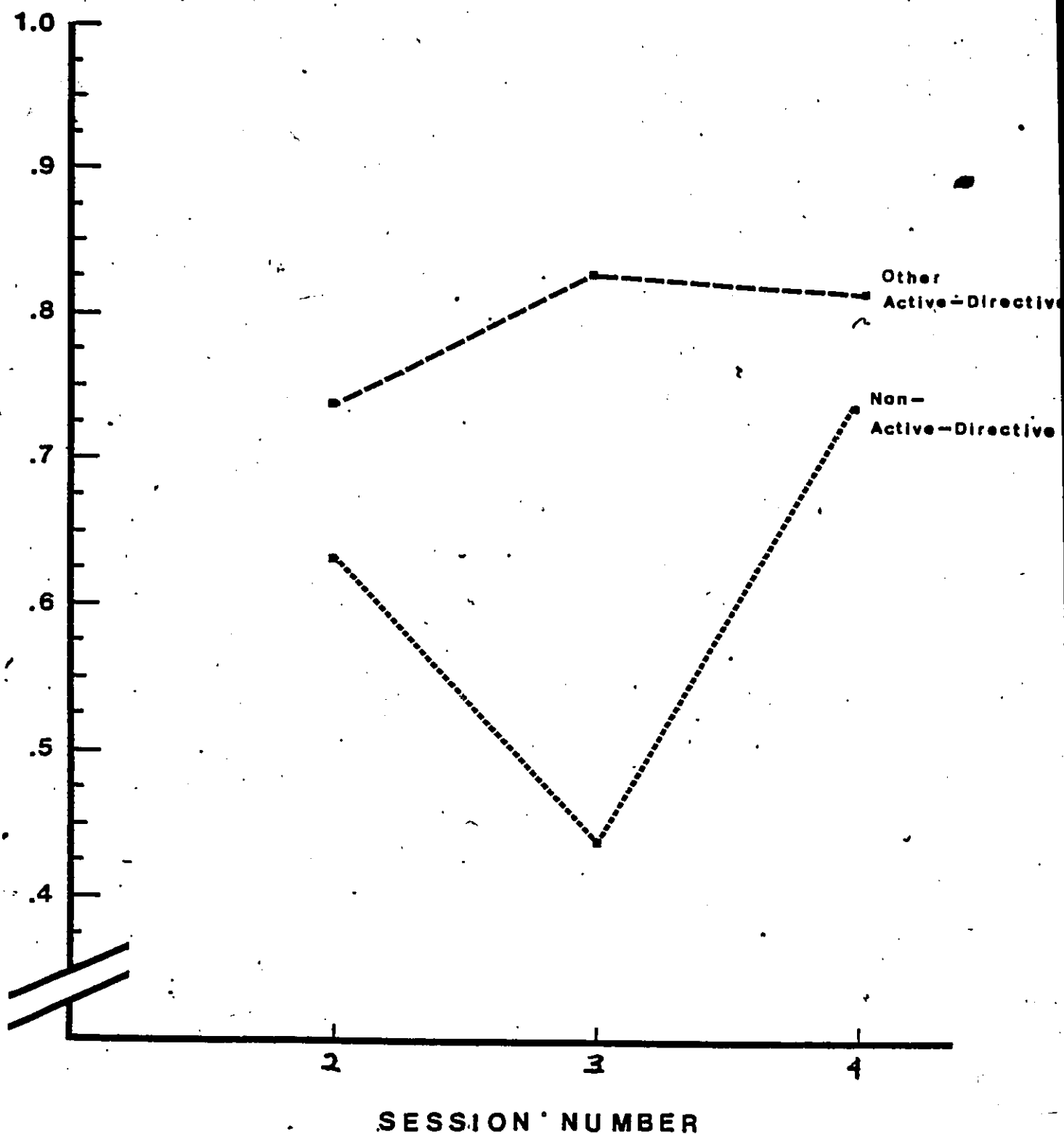


Figure 10. Proportions of client acceptance/compliance to other active-directive and non-active-directive interventions over 3 sessions (for all clients combined).

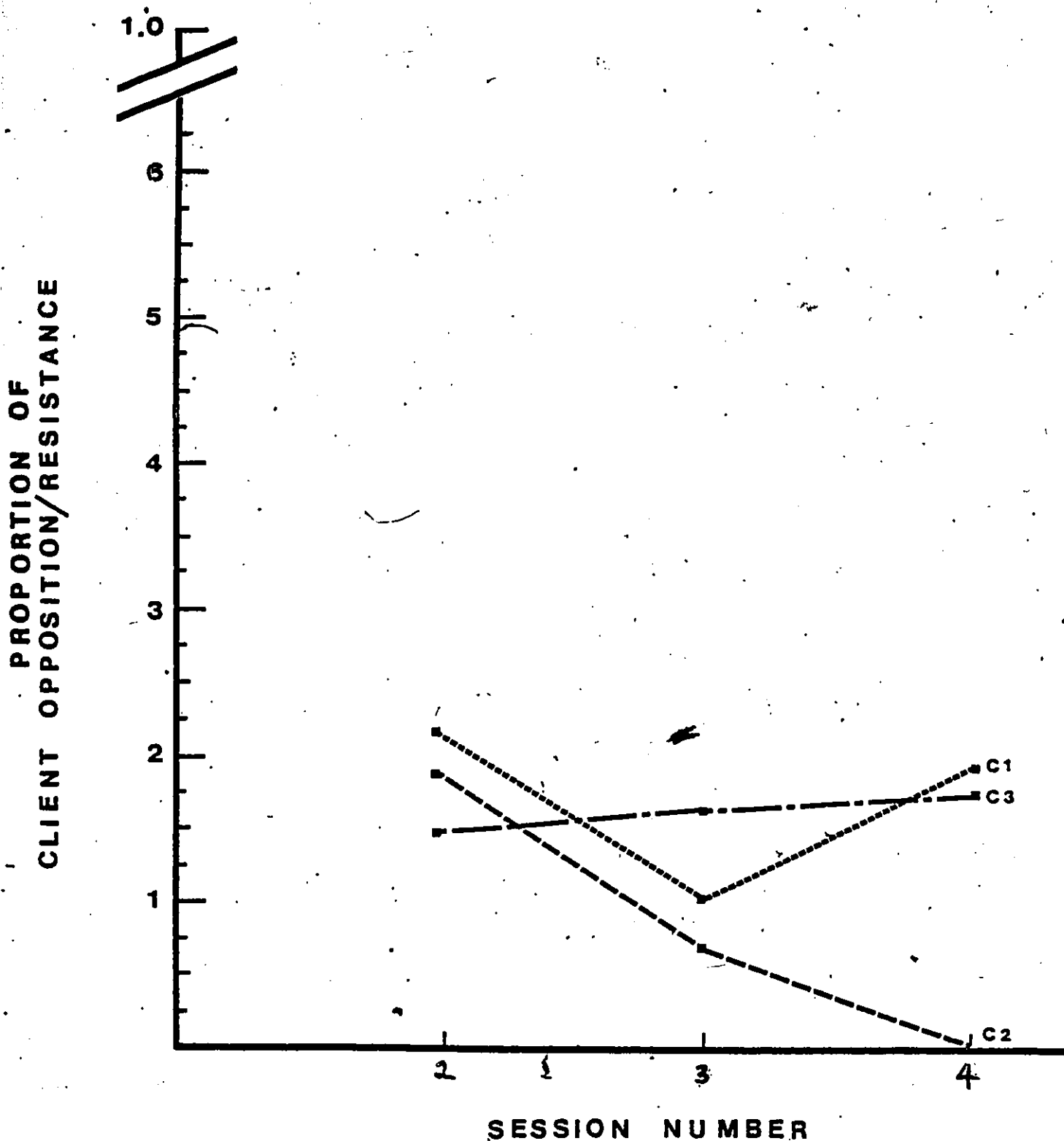


Figure 11. Proportions of client opposition/resistance to other active-directive interventions over 3 sessions for 3 clients separately (C1, C2, C3).

that the increase would be significantly greater than that for non-active-directive interventions. The results are illustrated in Figure 13.

Although, in the main, data for individuals did not allow for statistical analysis, the graph suggests that all three clients followed the same pattern of decreasing acceptance/compliance. There was sufficient data to confirm a significant decrease for Client 3 between sessions 1 and 2 ($z = 3.124$, $\alpha \leq .001$) and 1 and 3 ($z = 3.794$, $\alpha \leq .001$). When the data were grouped, there was a significant decrease in acceptance/compliance between sessions 2 and 3 ($z = 3.784$, $\alpha \leq .001$). (Figure 14). The results suggest lack of confirmation of hypothesis 1c.

Hypothesis 2c stated that proportions of client opposition/resistance to challenging questions would decrease significantly over three sessions and that the decrease would be significantly greater than that for non-active-directive interventions. Results for separate clients are illustrated in Figure 15. Clients 1 and 3 appeared to follow the same pattern, showing an increase in opposition/resistance to challenging questions over the three sessions. This was confirmed statistically for Client 3 between the second and third sessions ($z = -3.093$, $\alpha \leq .001$) and the third and fourth ($z = -1.478$, $\alpha \leq .1$). Client 2, on the other hand, appeared to increase in proportion of opposition/resistance in session 3 and then decrease in session 4 although there were not sufficient data to confirm that pattern statistically. Once again, Client 2 may have followed the hypothesized pattern.

PROPORTION OF
CLIENT OPPOSITION/RESISTANCE

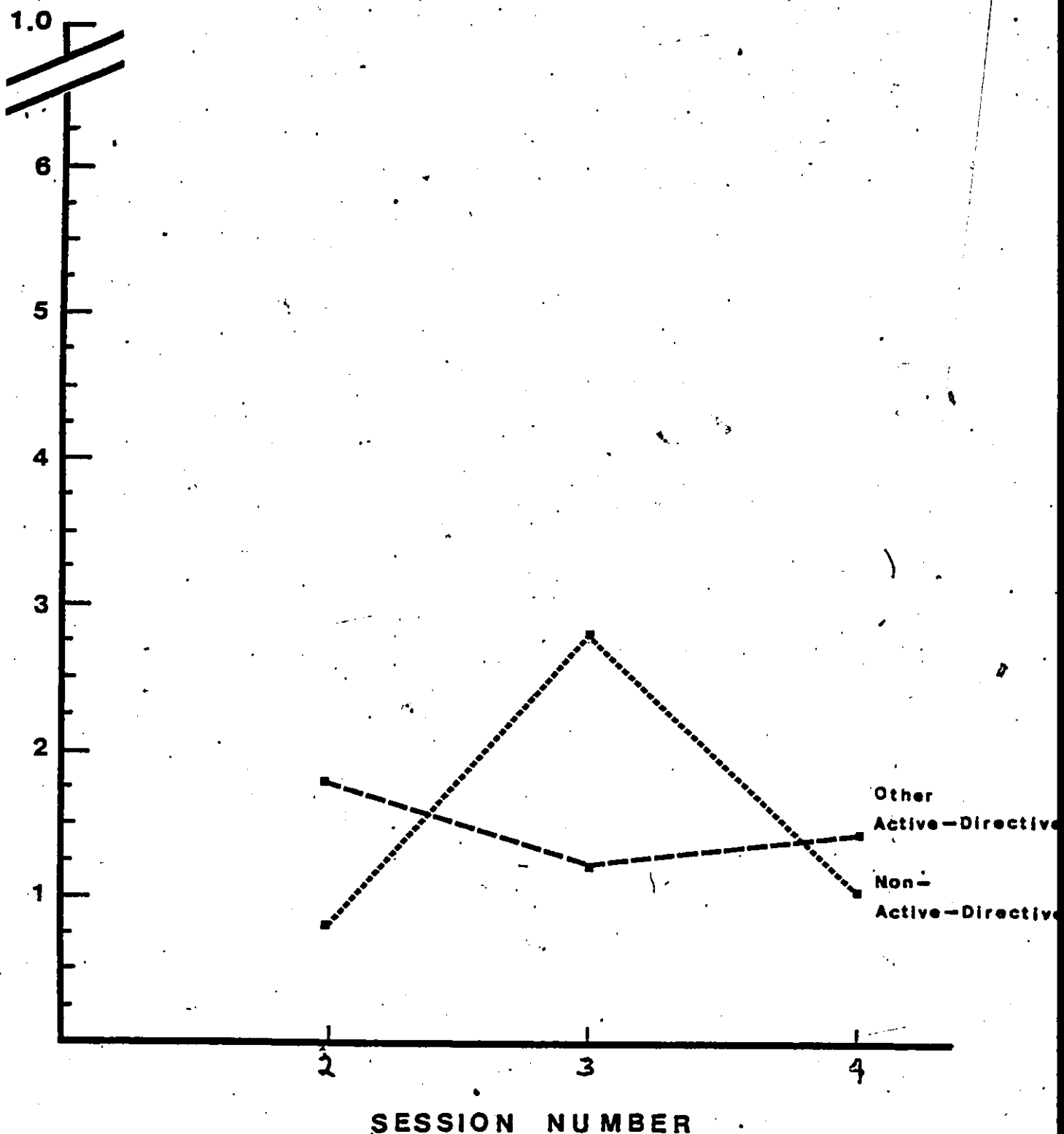


Figure 12. Proportions of client opposition/resistance to other active-directive and non-active-directive interventions over 3 sessions (all clients combined).

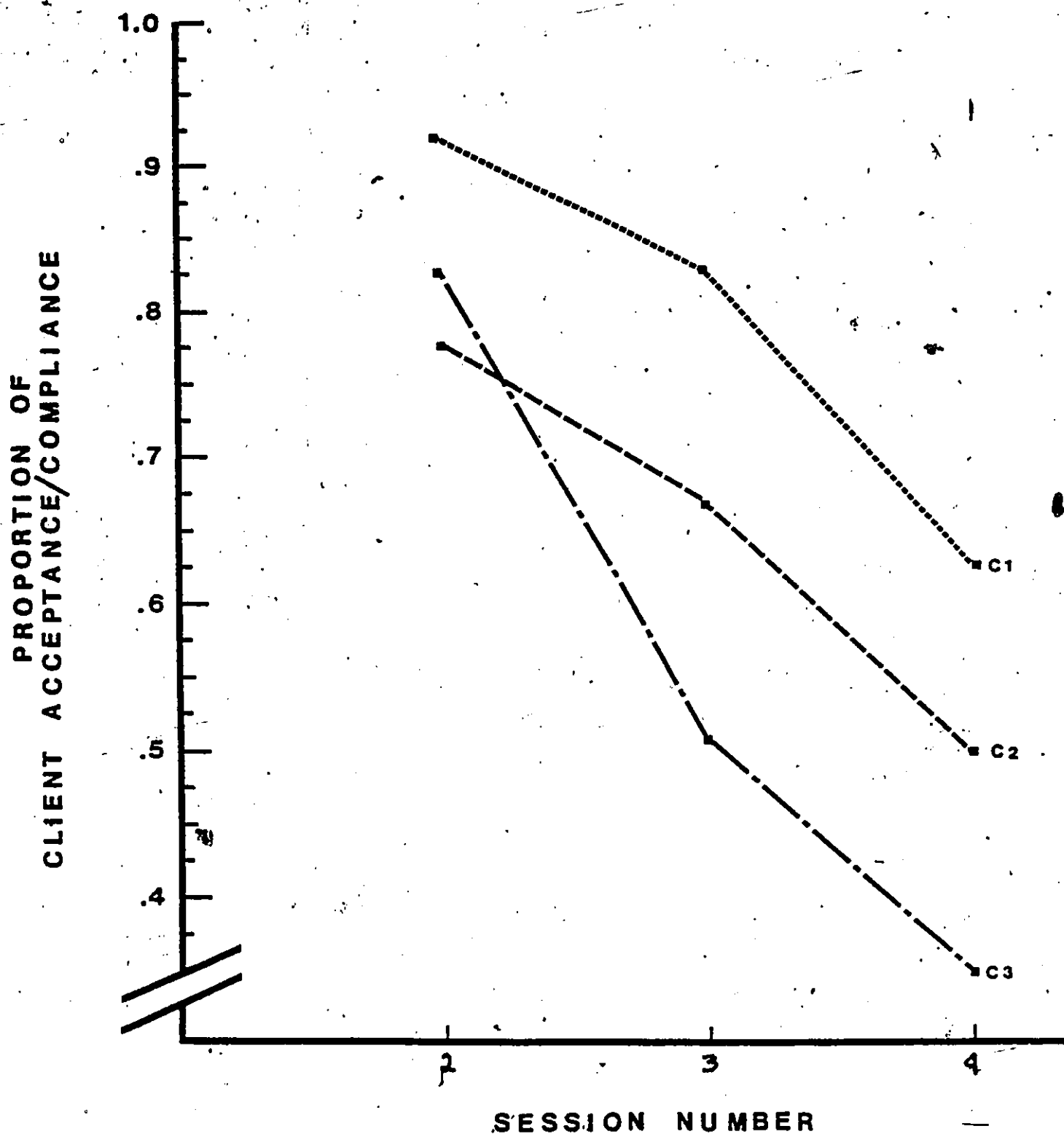


Figure 13. Proportions of client acceptance/compliance to challenging questions over 3 sessions for 3 clients separately (C1, C2, C3).

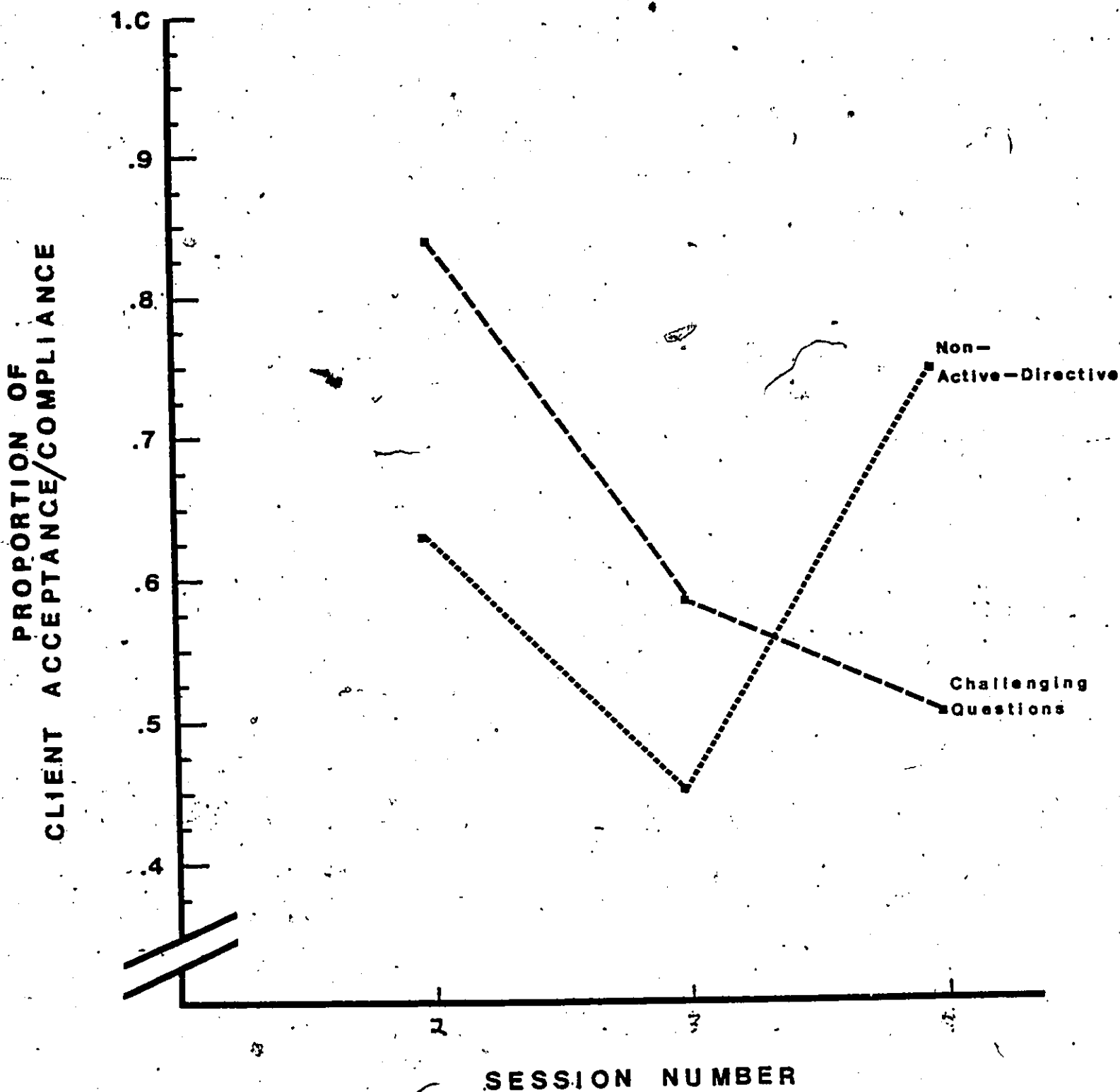


Figure 14. Proportions of client acceptance/compliance to challenging questions and non-active-directive interventions over 3 sessions (all clients combined).

For the cognitive disputation intervention, directive interpretation, hypothesis 1d stated that proportions of client acceptance/compliance would increase significantly over three sessions and that the increase would be significantly greater than that for non-active-directive interventions. The results are shown in Figure 16. Patterns for each client showed that there was no significant difference in proportions of acceptance/compliance between sessions 2 and 4 for either Client 2 or 3. Z-scores of $-.828$ and $.744$ did not reach significance at or above the $.1$ level. There was insufficient data to analyse the pattern for Client 1 and the apparent peak in acceptance/compliance for Client 2 in the third session.

Hypothesis 2d for directive interpretation stated that proportions of client opposition/resistance would decrease significantly over three sessions and that the decrease would be significantly greater than that for non-active-directive interventions.

Inspection of the graphs for individual clients (Figure 17) again indicated that Clients 1 and 3 seemed to follow the same pattern while Client 2 may have behaved according to the prediction. However, the data did not allow for statistical confirmation of individual patterns. Figure 18 indicates that when the data were grouped, there was no significant difference in proportions of opposition/resistance between sessions 2 and 4 ($z = -.315, \alpha > .1$). Results suggest that hypotheses 1d and 2d were not confirmed.

Finally, hypotheses 1e and 2e focused on clients' responses to the cognitive disputation intervention, didactic presentations.

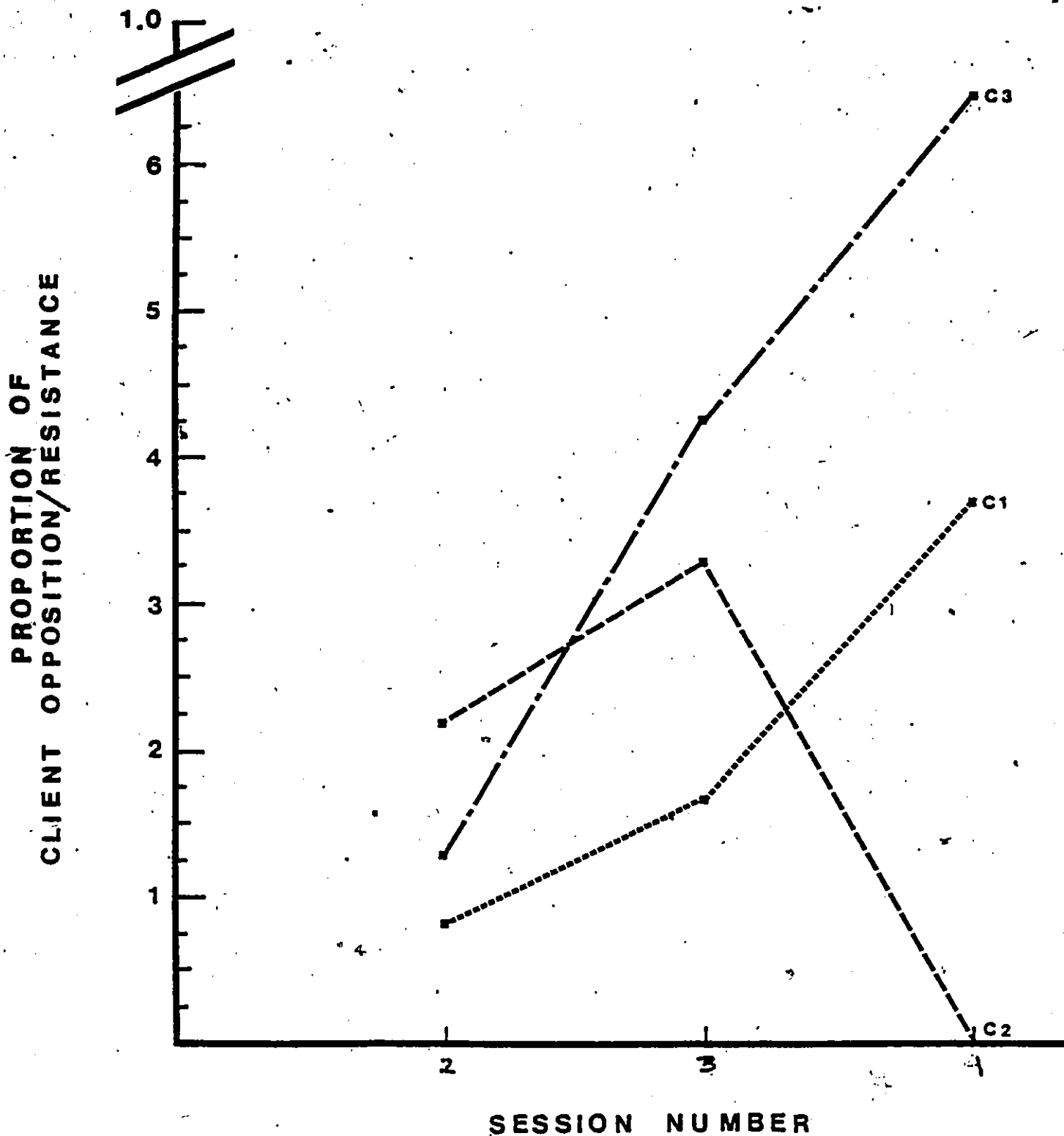


Figure 15. Proportions of client opposition/resistance to challenging questions over 3 sessions for 3 clients separately (C1, C2, C3).

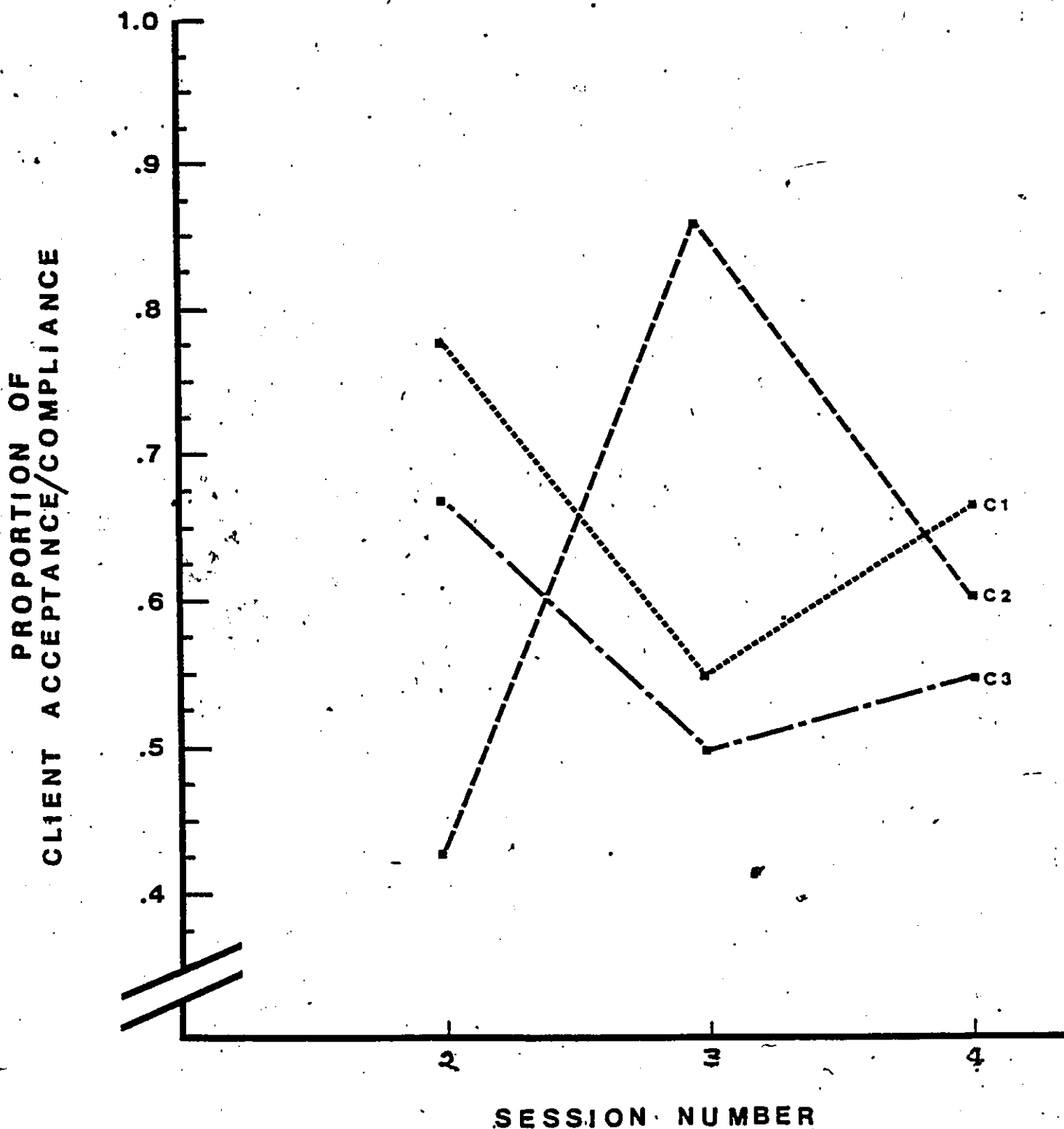


Figure 16. Proportions of client acceptance/compliance to directive interpretation over 3 sessions for 3 clients separately (C1, C2, C3).

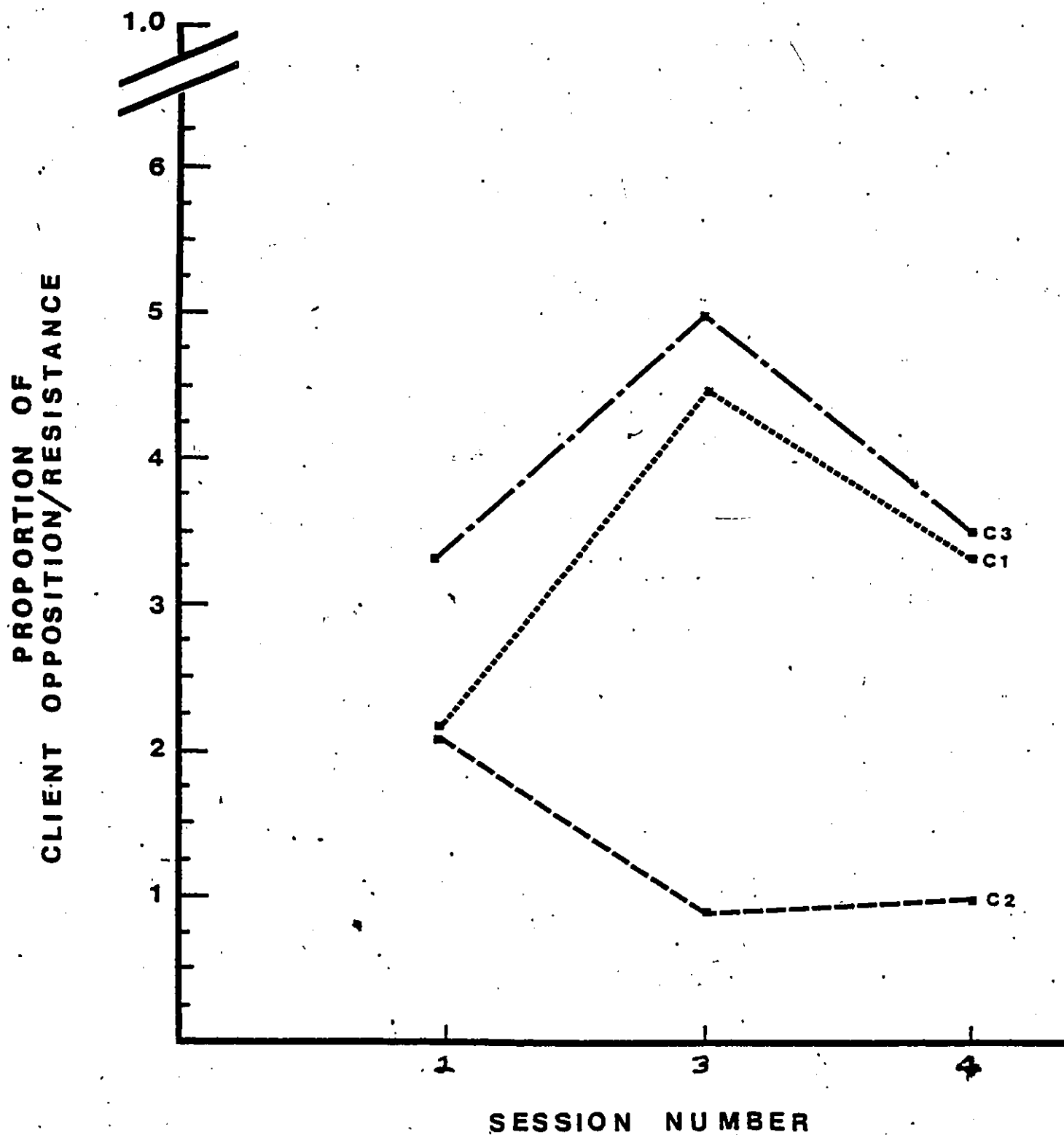


Figure 17. Proportions of client opposition/resistance to directive interpretation over 3 sessions for 3 clients separately (C1, C2, C3).

PROPORTION OF
CLIENT OPPOSITION/RESISTANCE

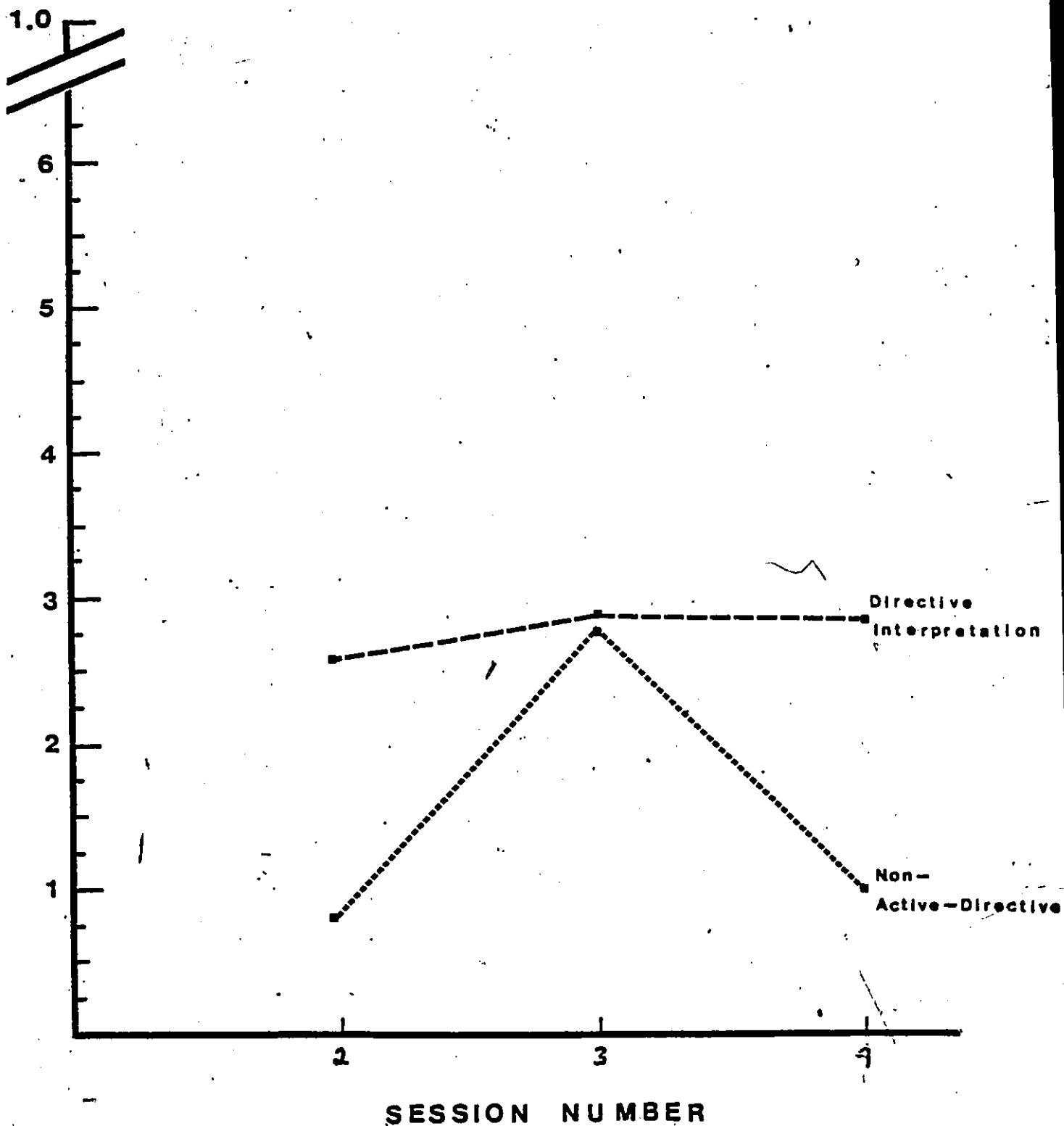


Figure 18. Proportions of client opposition/resistance to directive interpretation and non-active-directive interventions over 3 sessions (all clients combined).

Specifically, hypothesis 1e stated that proportions of client acceptance/compliance to didactic presentations would increase significantly over three sessions and that the increase would be significantly greater than that for non-active-directive interventions.

Patterns for the individual clients are indicated in Figure 19. Analysis of Client 2 data confirmed a significant increase in proportions of acceptance/compliance between sessions 2 and 3 ($z = -2.239$, $\alpha \leq .05$) and 2 and 4 ($z = -2.610$, $\alpha \leq .01$). While Client 3 appeared to drop in acceptance/compliance between the third and fourth sessions, this change was not significant ($z = .856$, $\alpha > .1$). Finally, the apparent increase in proportions of acceptance/compliance for Client 1 by the fourth session could not be confirmed statistically. On the basis of grouped data (Figure 20), there was a significant increase in acceptance/compliance to didactic presentations between sessions 2 and 3 ($z = -1.285$, $\alpha \leq .1$), and 2 and 4 ($z = -2.123$, $\alpha \leq .05$). The grouped data suggest confirmation of hypothesis 1e.

In terms of client opposition/resistance to didactic presentations, hypothesis 2e stated that proportions of opposition/resistance would decrease significantly over three sessions and that the decrease would be significantly greater than that for non-active-directive interventions.

Individual patterns seemed to indicate that both Clients 1 and 2 had a net decrease in opposition/resistance over the three sessions (Figure 21), although Client 1 appeared to peak in session 3. The net decrease was confirmed for Client 2 between

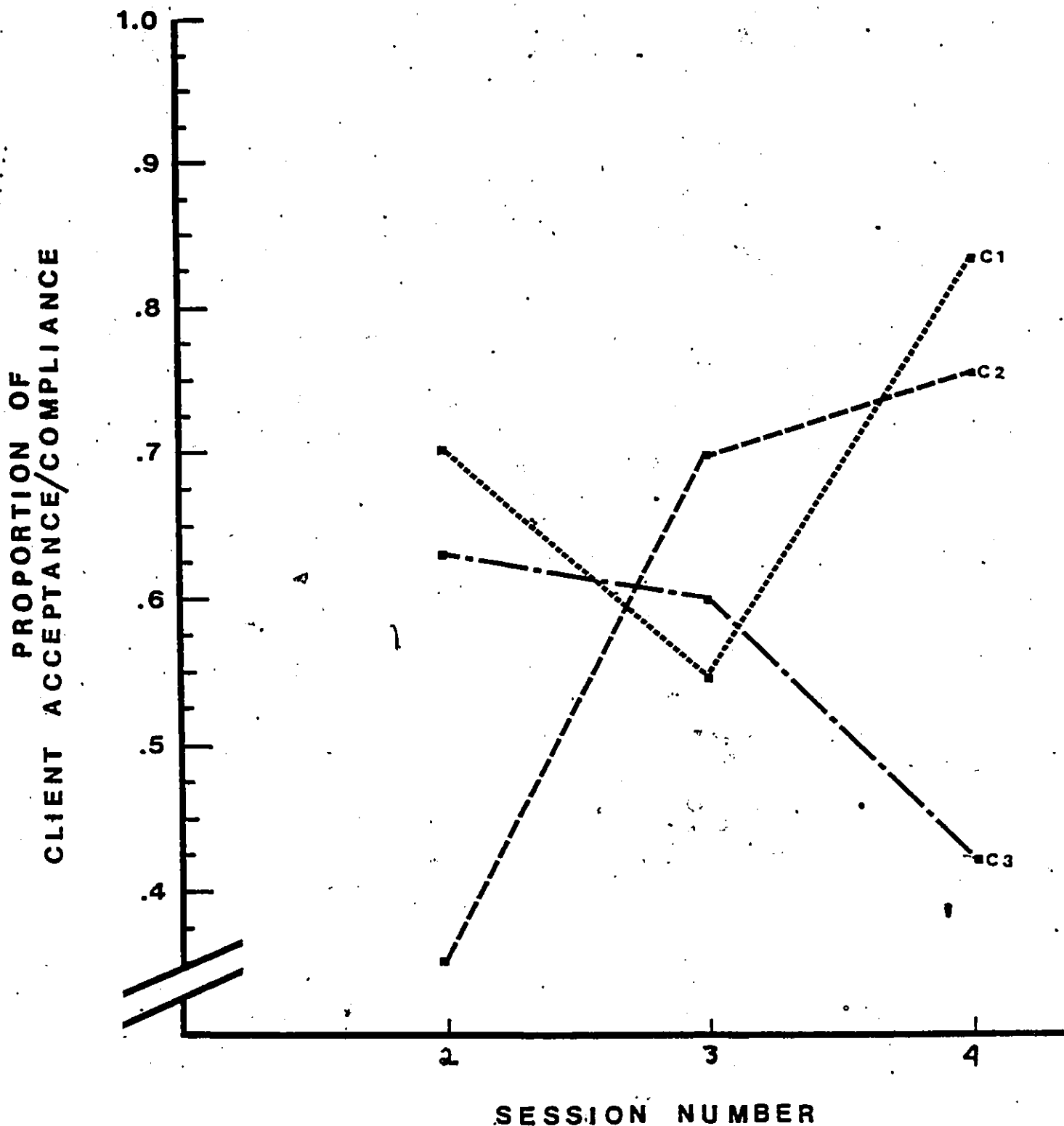


Figure 19. Proportions of client acceptance/compliance to didactic presentations over 3 sessions for 3 clients separately (C1, C2, C3).

PROPORTION OF
CLIENT ACCEPTANCE/COMPLIANCE

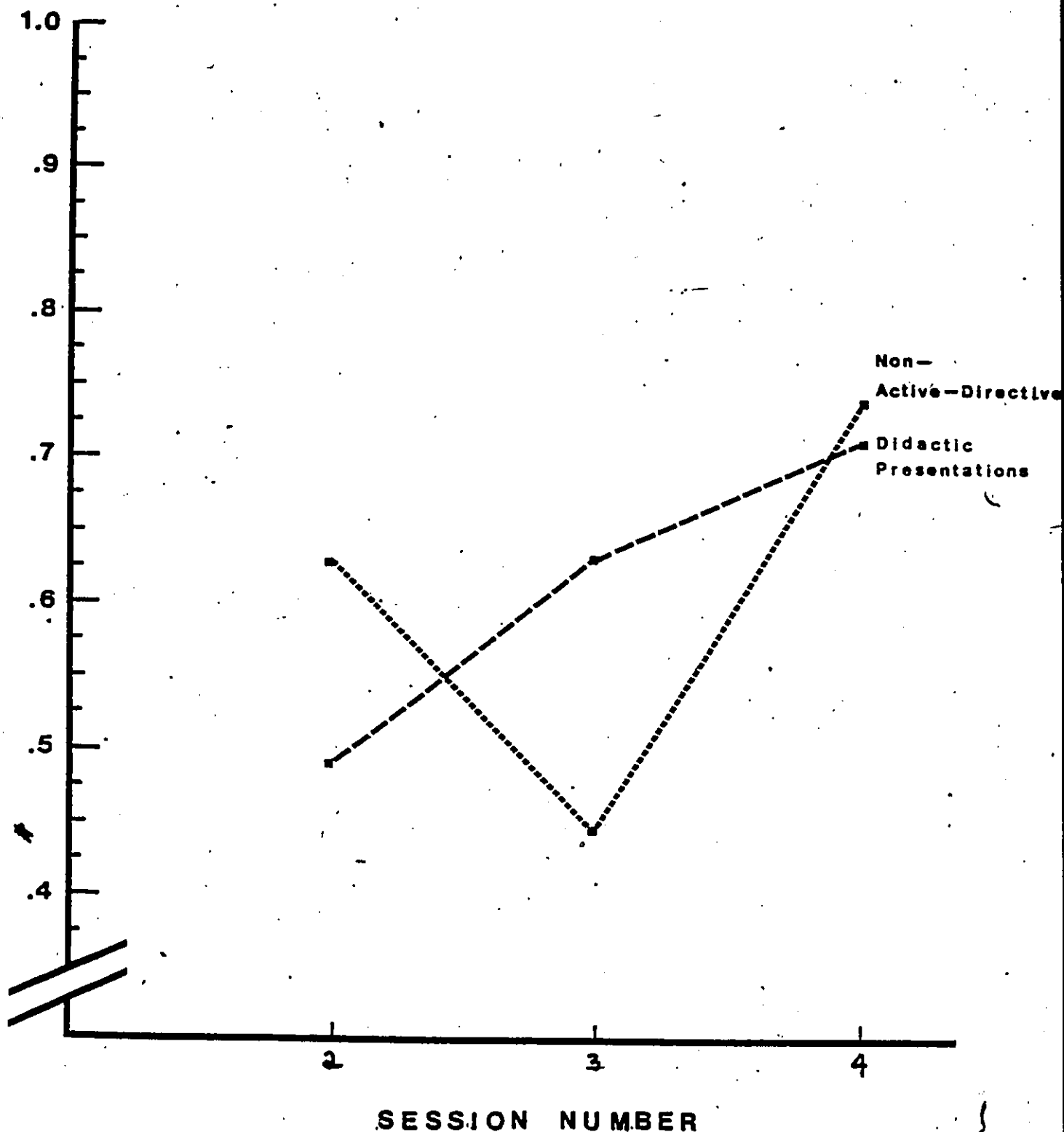


Figure 20. Proportions of client acceptance/compliance to didactic presentations and non-active-directive interventions over 3 sessions (all clients combined).

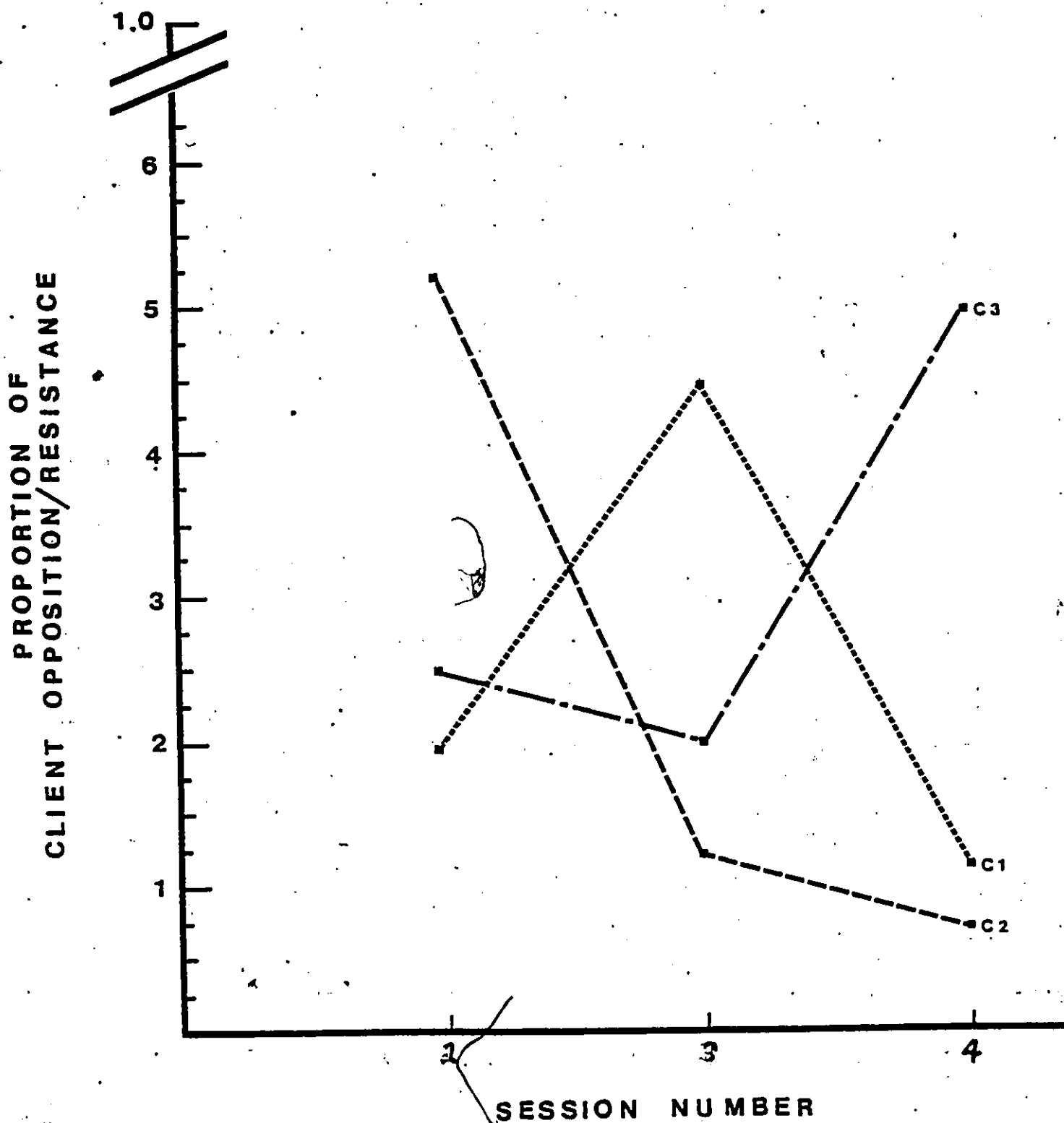


Figure 21. Proportions of client opposition/resistance to didactic presentations over 3 sessions for 3 clients separately (C1, C2, C3).

Figure 21. Proportions of client opposition/resistance to didactic presentations over 3 sessions for 3 clients separately (C1, C2, C3).

sessions 2 and 3 ($z = 2.649$, $\alpha \leq .01$) and 2 and 4 ($z = 3.090$, $\alpha \leq .001$). The apparent net increase in proportions of opposition/resistance for Client 3 could not be tested statistically.

When the data was grouped (Figure 22), there was a significant decrease in opposition/resistance from session 2 to session 3 ($z = 1.465$, $\alpha \leq .1$) and from session 2 to session 4 ($z = 2.121$, $\alpha \leq .05$), suggesting confirmation of the last hypothesis.

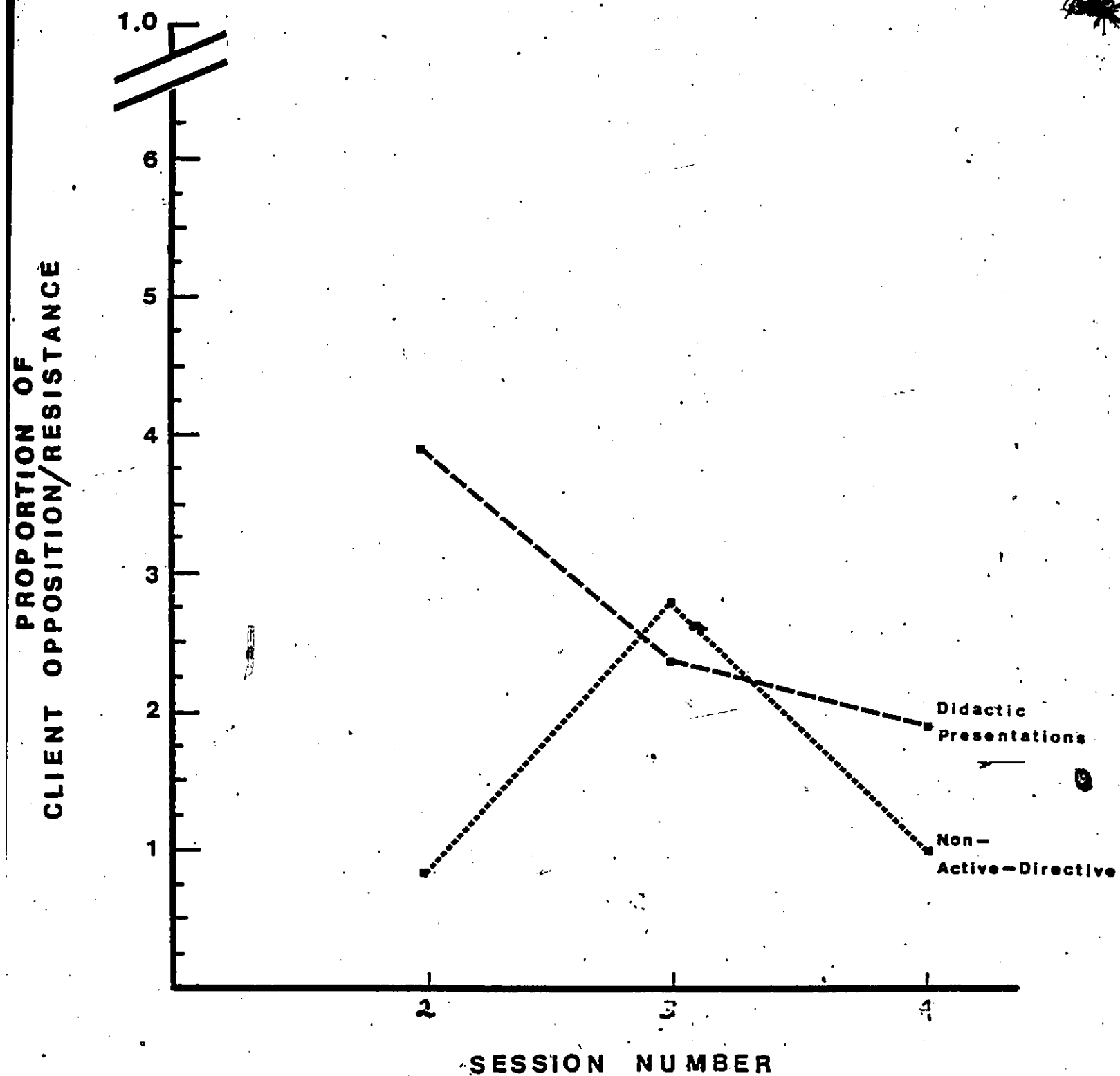


Figure 24. Proportions of client opposition/resistance to didactic presentations and non-active-directive interventions over 3 sessions (all clients combined).

Summary of Results for the Main Hypotheses

The main hypotheses tested clients' changes in proportions of acceptance/compliance and opposition/resistance over three early RET sessions to active-directive interventions as a group and specifically to cognitive disputation and its component interventions. These changes were compared to those following non-active-directive interventions. For all active-directive interventions, the hypothesis was that proportions of acceptance/compliance would increase over three sessions and that proportions of opposition/resistance would decrease. These respective changes were expected to be greater than those found for non-active-directive interventions.

Results showed that while each of the three clients had individual patterns of responding over the three sessions, two cognitive disputation interventions (challenging questions and directive interpretation) were followed by the same pattern for all clients.

Client 1's pattern appeared to be characterized by no overall change in acceptance or opposition over the three sessions to active-directive interventions as a group, to cognitive disputation and to directive interpretation. Challenging questions were followed by increasing opposition and decreasing acceptance. Didactic presentations elicited increasing acceptance and decreasing opposition. Other active-directive interventions were increasingly accepted.

Client 2, on the other hand, appeared to follow the hypothesized patterns of change more closely. This client showed increasing acceptance and decreasing opposition to active-directive

interventions as a group, to cognitive disputation, didactic presentations and other active-directive interventions. The notable exceptions to this pattern were responses to challenging questions which became less accepting as well as more oppositional responses to directive interpretation which showed no change.

Client 3's pattern showed decreasing acceptance and increasing opposition to active-directive interventions as a group, to cognitive disputation, challenging questions and didactic presentations. There was no overall change following directive interpretation and other active-directive interventions elicited increasing acceptance.

One interesting finding when looking at individual differences in patterns of response over time was that challenging questions uniformly elicited decreasing acceptance and more opposition. The directive interpretation intervention showed no change in either acceptance or opposition over the three sessions for all clients.

A second notable finding was client responses to the non-active-directive interventions. It appeared that all three clients decreased their acceptance responses in the third session and that two increased their opposition. By the fourth session, acceptance and opposition had returned to the levels found in session 2.

A summary of the results for the data when grouped is shown in Table 5. Results indicated that for all active-directive interventions combined, there was no significant change in pro-

portions of acceptance/compliance or opposition/resistance over the three sessions. When the group of active-directive interventions was broken down into the interventions specific to RET, i.e., cognitive disputation and all other active-directive interventions (not specific to RET), the two groups produced different results. Cognitive disputation interventions led to decreasing proportions of client acceptance/compliance and increasing opposition/resistance over three sessions. All other active-directive interventions in contrast, were followed by increasing proportions of acceptance/compliance and stable proportions of opposition/resistance. Clients were progressively less accepting and more oppositional to RET active-directive interventions than to the general active-directive type of therapist statement.

When clients' responses to individual cognitive disputation interventions were analysed, the three interventions were observed to lead to different response patterns. Challenging questions were followed by decreasing proportions of acceptance/compliance and increasing opposition/resistance. Directive interpretation was followed by unchanging proportions of acceptance/compliance and opposition/resistance. In contrast, didactic presentations led to increasing proportions of acceptance/compliance and decreasing opposition/resistance over the three sessions.

In conclusion, two categories of active-directive interventions showed the expected pattern of increasing acceptance/compliance over three sessions, i.e., other active-directive (those not specific to RET) and didactic presentations. Didactic presentation was the only active-directive category to follow the

Table 5

Summary of Research Results
for Grouped Data

Intervention

Progressive Changes in Client
Responses over Three Sessions

I. Active-directive

No change in proportions of
acceptance/compliance or
opposition/resistance

A. Cognitive disputation

Decreasing acceptance/
compliance and increasing
opposition/resistance

1. Challenging questions

Decreasing acceptance/
compliance and increasing
opposition/resistance

2. Directive interpretation

No change in proportions of
acceptance/compliance or
opposition/resistance

3. Didactic presentations

Increasing acceptance/
compliance and decreasing
opposition/resistance

B. Other active-directive

Increasing acceptance/
compliance. No change in
proportions of opposition
resistance.

II. Non-active-directive

Decreased acceptance/
compliance and increased
opposition/resistance in
session 2. No net change
in proportions of either
response from session 1
to session 3.

predicted progressive decrease in proportions of opposition/resistance. Patterns opposite to those expected were found for cognitive disputation interventions as a group, and for challenging questions specifically. The remaining categories showed no significant change over three sessions (active-directive interventions as a group and directive interpretation).

Other Findings

The results summarized above represent findings related to the main hypotheses of the research. There were several other results of interest that address some of the concerns expressed about the use of active-directive interventions and noted in the literature review.

For example, the clinical literature suggests that active-directive interventions will elicit more oppositional responses than non-active-directive interventions. While this suggestion was not part of the present research hypotheses, the grouped data indicate that proportions of opposition/resistance to active-directive interventions as a group indeed were significantly higher than those for non-active-directive interventions in the first and third sessions ($z = 1.482$, $\alpha \leq .1$; and $z = 2.286$, $\alpha \leq .05$ respectively). In session 2, there was no significant difference, since opposition/resistance to the non-active-directive interventions increased significantly, bringing it up to the level of the active-directive group.

This finding, of greater opposition to the active-directive

interventions was also true for cognitive disputation. That is, cognitive disputation was followed by significantly higher proportions of opposition/resistance than non-active-directive interventions in sessions 1 ($z = 1.629$, $\alpha \leq .05$) and 3 ($z = 2.721$, $\alpha \leq .01$). In contrast, other active-directive interventions (not specific to RET) appeared not to differ from non-active-directive interventions in eliciting oppositional responses. Statistical analysis, possible only for the third session, indicated no significant difference between the two groups ($z = .659$, $\alpha > .1$). It appeared that the RET interventions elicited greater opposition whereas the other active-directive interventions did not. This held true for two of the three individual cognitive disputation interventions. By session 3, both challenging questions and directive interpretations showed significantly higher proportions of opposition/resistance than the non-active-directive interventions ($z = 3.786$, $\alpha \leq .001$; and $z = 2.276$, $\alpha \leq .05$, respectively). Didactic presentations, as well, did not differ in proportions of opposition/resistance from non-active-directive interventions by session 3 ($z = 1.242$, $\alpha > .1$).

The present results tend to support the clinical expectation that active-directive interventions elicit more opposition than non-active-directive. However, this did not hold true in the RET sessions for active-directive interventions other than those specific to RET, nor for didactic presentations.

The clinical prediction discussed above would also suggest that active-directive interventions may be followed by correspondingly lower proportions of acceptance/compliance than non-active-directive interventions. The present results show that

this was true for cognitive disputation, challenging questions and directive interpretations. By session 3, they all had significantly lower proportions of acceptance/compliance than the non-active-directive interventions ($z = -1.538$, $\alpha \leq .1$; $z = -2.197$, $\alpha \leq .05$; and $z = -1.572$, $\alpha \leq .1$, respectively). In contrast, all active-directive interventions taken as a whole, other active-directive (exclusive of RET) and didactic presentations were not significantly different from non-active-directive interventions in proportions of acceptance/compliance ($z = -.938$, $\alpha > .1$; $z = .949$, $\alpha > .1$; and $z = -.314$, $\alpha > .1$, respectively).

Another suggestion from the clinical literature is that active-directive interventions will be most frequently followed by oppositional responses. That is, there will be a greater proportion of oppositional than accepting responses. The present results do not tend to support that prediction. Inspection of the graphs shows that proportions of opposition/resistance responses range from approximately .15 to .5. Proportions of acceptance/compliance responses are higher, ranging from approximately .5 to .85. These findings suggest that in the RET sessions, active-directive interventions were followed most often by acceptance/compliance responses, with opposition/resistance occurring at most 50% of the time. Challenging questions appeared to elicit the highest proportion of oppositional responses.

Finally, the literature suggests that active-directive interventions will tend to restrict clients' responses to either agreement or disagreement, thereby limiting the range of client talk. The present results seem to support this expectation.

Inspection of the graphs revealed that 93% of responses to active-directive interventions were either acceptance/compliance or oppositional/resistance, with only 7% other kinds of responses. Non-active-directive interventions were followed 77% of the time by either acceptance/compliance or oppositional/resistance, allowing 23% other kinds of responses. This difference was significant at the .001 level ($z = 5.517$). Active-directive interventions in this study did restrict client responses to predominantly acceptance or opposition and did so to a significantly greater degree than did non-active-directive interventions.

Chapter 4

Discussion and Conclusions

The purpose of this chapter is to present the discussion points related to the main findings of the research as well as the conclusions drawn from the study and their implications for clinical practice and further research.

Discussion

Main Hypotheses

The main hypotheses predicted that clients' responses to the target active-directive interventions would become increasingly accepting and decreasingly oppositional over the three sessions studied. In fact, each client had a unique pattern of responding. Client 2 tended to follow the hypothesized changes. Client 1's pattern was a mixture of no change, decreasing acceptance/increasing opposition and increasing acceptance/decreasing opposition, depending upon the intervention. Client 3, in contrast, showed a predominance of decreasing acceptance and increasing opposition.

Although there are no hard research data with which to compare these findings, the clinical literature (e.g., Grieger & Boyd, 1980; Thorne, 1950) and two research studies (Anderson, 1969; Ashby et al., 1957) do tentatively suggest that clients' initial negative responses to active-directive interventions will become more positive/accepting after about four sessions. It is

possible that this study of the first four sessions was not extensive enough to notice a shift in responding for all clients. The pattern for Client 2 cannot be accounted for simply by therapist or client variables. Ellis was the therapist for both Clients 2 and 1, and both had similar presenting problems of procrastination and overweight. The only obvious difference was that Client 2 was male and Clients 1 and 3 were female. It would be difficult to account for the pattern of Client 2 on the basis of gender alone, with the male client becoming progressively more accepting and compliant over three sessions and the female clients doing the opposite.

Despite individual differences in response patterns, two of the cognitive disputation interventions (challenging questions and directive interpretation) elicited the same response pattern for all clients. Cognitive disputation was uniformly followed by increasing opposition and decreasing acceptance over the three sessions. Directive interpretation was followed by unchanging patterns of acceptance and opposition.

In addition to these uniform patterns in the individual data, the grouped data indicated that didactic presentations were followed by increasing acceptance and decreasing opposition over the three sessions.

There is nothing in the clinical or research literatures to suggest how clients respond over time to specific RET interventions. In general, challenging questions and didactic presentations are expected to elicit various oppositional responses (e.g., Benjamin, 1981; Rogers, 1942; Walen, DiGiuseppe, & Wes-

slar, 1980). This expectation was noted in both the general and RET literatures. The present results, then, are the first data showing clients' response patterns over time to specific RET interventions.

The response patterns are understandable according to RET theory, which suggests that the stronger interventions may result in initial client defensiveness (Wessler & Wessler, 1980). Clients' responses seen here may be an indicator of how powerful (provocative, challenging) the three cognitive disputation interventions are. Of the three, challenging questions may be the most overtly provocative and personally threatening to the client. According to RET theory of therapy, challenging questions are used to forcefully attack clients' irrational beliefs. It could be expected, then, that clients would resist such attacks, at least at first. To continue this line of reasoning, the present research results suggest that clients may not have found directive interpretations as threatening, since they maintained stable proportions of acceptance and opposition over the three sessions. Likewise, clients may have been increasingly ready to accept didactic presentations as the sessions progressed. Since didactic presentations are most often mini-lectures, informational statements or an alternative view of reality (the therapist's), they are not focused as intensely on the client's personal shortcomings. As such, didactic interventions might more easily elicit increasing client acceptance.

This research is the first to provide empirical data showing clients' differential responses to three major components of cognitive disputation. The results tend to be understandable

according to RET theory of therapy.

Client Responses to Non-Active-Directive Interventions

Another major finding of the research was the unexpected pattern of responses to non-active-directive interventions. In session 3, there were significant increases in opposition/resistance and decreases in acceptance/compliance. This result seems remarkable in that it held true for all three clients in response to the non-active-directive interventions of two different therapists. There is no information in the literature to suggest how clients in directive therapy respond to non-active-directive interventions. The psychotherapy research literature indicates that clients respond in a variety of positive/accepting ways to non-active-directive interventions in nondirective therapy (e.g., Ehrlich, D'Augelli, & Danish, 1979; Gillespie, 1953; Tournay et al., 1966). Clients in this study of RET sessions responded to non-active-directive interventions in session 3 as if the interventions were challenging questions (which led to decreasing acceptance and increasing opposition in the second session). It is difficult to account for such a result and impossible to say, within the limits of this research, what the pattern would look like over ten or twenty sessions. What is known is that in directive therapies, non-active-directive are not frequently used (Ellis, 1977; Hill et al., 1979). What is more, they are not considered to be central, powerful interventions used as a primary means to promote change (Ellis, 1977). It would seem that in directive therapy, non-active-directive statements would be infrequent, rather inconsequential interventions. In the present

study, while infrequent, they appeared to have a clear, dramatic effect in the third session. If clients had responded to all the active-directive interventions in session 3 with increased opposition and decreased acceptance, it could be suggested that perhaps a general oppositional response mode was responsible for the responses to non-active-directive interventions. This was not the case. In the absence of other data or clinical hunches with which to compare the present finding, it seems possible at the present time simply to report the observation.

Other Research Observations

The final discussion points relate to other observations of the impact of active-directive interventions used in the context of directive therapy. As suggested in the clinical and research literatures (e.g., Benjamin, 1981; Combs, Richards, & Richards, 1976; Gillespie, 1953; Tournay et al., 1966), active-directive interventions as a group were followed by higher proportions of opposition/resistance than were non-active-directive. The new finding in this regard was that active-directive statements not specific to RET were no different than non-active-directive in eliciting opposition and neither were RET didactic presentations. This suggests, first, that it may be only the stronger, most active interventions that lead to more oppositional responses in RET and, second, that didactic presentations may be much less threatening than other cognitive disputations, a point mentioned earlier.

It was also noted that in these directive therapy sessions, all active-directive interventions were still followed more frequently by accepting responses than by oppositional ones or other

responses. This finding was contrary to the general expectation voiced in the clinical literature (e.g., Benjamin, 1981; Rogers, 1942). This result would tend to support RET theory, which holds that active-directive interventions do not particularly frighten clients or produce a negative effect on the therapeutic process (Ellis, 1973).

Finally, it was observed that active-directive interventions did restrict clients' responses to predominantly two categories: acceptance or opposition. This finding supports the prediction in the clinical literature (Benjamin, 1981; Rogers, 1942; Syngg and Combs, 1949). This prediction, from the nondirective literature, is intended as a criticism of active-directive interventions. From the point of view of RET theory, however, the finding could be viewed positively. Active-directive interventions could be seen as successfully keeping clients on track, preventing digressions into storytelling, historical information, accounts of negative feelings and other nonproductive discussion. RET therapists do not particularly value, as therapeutic, extensive client self-exploration as do the nondirective therapists.

Research Design Issues

In view of the study's results, it is clear that a major limitation of the design was to restrict the analysis to early RET sessions. While it is perfectly legitimate to study early sessions and a strength of the design was to look at clients' progressive changes in responses over a series, a more comprehensive picture would have emerged with a longer series of sessions (or inclusion of later sessions). The early pattern of respond-

ing to both cognitive disputation (especially challenging questions) and non-active-directive interventions raised questions that could only be answered by analysing later therapy sessions.

A second limitation was the small sample of therapists and clients. Given that it was very unusual and special to solicit a series of sessions from RET experts (including the founder), from a research point of view a larger sample would have allowed broader generalization.

In terms of the measurement of client responses, the client categories provided a fairly gross assessment. The three categories could have been more finely divided so that superficial or mild acceptance and mixed acceptance/opposition were separate categories.

In terms of measurement of therapist interventions, aspects of voice quality could have been assessed in order to quantify the strong active-directive RET style.

Finally, informal observation of therapist statements indicated that many were phrased in question form. Since the client acceptance category included compliance (i.e., going along with the therapist's directive, answering the question), there may have been some confounding of agreement and compliance. The proportions of acceptance/compliance may have been elevated due to the frequency of interrogative remarks. It may have been useful to classify therapist statements according to both content and form to avoid this possibility.

Suggestions for Further Research

There has been no research in the area of client responses to active-directive interventions in directive therapy, so that the field is open to study. Possible studies opened up by the present investigation include analysis of either a longer series of sessions, or later therapy sessions, inclusion of client gender as a variable, and extending the research to include more clients and other therapists. It would be particularly interesting to focus on client response to the use of non-active-directive interventions in directive therapy.

Further research could use either analogue procedures or naturalistic study. The need to analyse longer series of sessions and to replicate the unusual drop in client acceptance to non-active-directive interventions in session 2 would best be met with naturalistic data. Other questions, such as the impact of client gender or the response patterns of many clients to more therapists, could be addressed within an analogue format.

Implications for Theory and Clinical Practice

Given that the present research was a first study of client responses to certain active-directive interventions in a directive therapy, and given that the sample was small, any implications for theory and clinical practice must be phrased rather tentatively. Inasmuch as the sessions analysed were sessions of Rational-Emotive Therapy with exemplars of RET as therapists, the implications of the findings apply primarily to RET theory and to therapists trained in RET who conduct standard RET sessions. In a general way, the findings are also of interest to directive therapy theory and to any therapists who use the target active-

directive interventions as well as to other practitioners of directive therapy. The results also speak to some issues raised by nondirective therapies.

Implications for RET and Directive Therapies

The results tend to support RET theory in the following manner:

(1) RET theory holds that irrational beliefs are deeply engrained and resistant to change. Challenging questions are forcefully directed at the irrational statements clients make to themselves and in this research were followed by increasing opposition/resistance over three sessions. It is probable that clients became more defensive precisely because the challenges focus on central, strongly held beliefs. RET therapists are usually advised of the need to persist with challenges until the client sees the illogic of his/her thinking. The present results indicate that therapists may not notice this change within the early sessions. This study may indicate, in addition, that resistance to challenging questions is a common response found in most clients rather than a response to poor technique or found only in problem clients. It is important to note that the resistance to challenging questions in the early sessions is therapeutically valued in RET as an indication that the client is actively engaged with the therapist in the process of giving up irrational beliefs.

(2) RET theory also suggests that cognitive disputation is a powerful technique that attacks clients' problems head-on.

more forcefully than other interventions. This would seem to be true considering the defensiveness that followed cognitive disputation compared to client responses to other active-directive interventions.

(3) According to RET theory, clients need to be taught a rational approach to living, a rational philosophy. The expectation is that they will quite quickly see the problems with their own thinking if the therapist clearly models and teaches healthier ideas. The present results would suggest that clients do increasingly accept therapists' didactic presentations, even within the first four sessions.

(4) Ellis has stated that directive interpretations can be made without hesitation at any time during therapy without threat to the client. The research results lend support to this notion in that clients did not change their patterns of responding to directive interpretations over the series of sessions and most frequently indicated acceptance.

The results also tend to support and/or address issues of the family of directive therapies. Directive therapies in general do not expect that active-directive interventions will meet with overall opposition/resistance (as do the nondirective therapies). In this research, clients responded more frequently with acceptance than with opposition to all of the active-directive interventions studied. On the other hand, active-directive statements did elicit proportionately more opposition than the non-active-directive.

In the Review of the Literature it was noted that the directive therapies stress the learning process as the means of thera-

peutic change. The present results suggest that in the early sessions, clients may become increasingly agreeable to the therapist's teachings about healthier ways of thinking, feeling, and behaving. On the other hand, when the therapist's focus is more directly a challenge to the client's specific irrational attitudes, the response may be increasingly resistant.

The Review also indicated that there were characteristic directive therapist roles and consequent therapist/client relationships. While the present study did not specifically look at these elements of the directive approach, it was evident from observation of the audiotapes that both therapists were very active and tutorial throughout. It would seem that clients responded not so much to the overall directive style of the therapists but to specific interventions, since each intervention was followed by a unique response pattern. In terms of the therapist/client relationship, it was clear that the therapists provided a powerful structure to the sessions, especially when using active-directive interventions, since client responses were so highly restricted to an acceptance/opposition dimension.

Implications for Nondirective Therapies

The research results tend both to refute and to support nondirective criticism of directive therapy. Active-directive interventions were not followed by wholesale rejection in the RET sessions studied. Overall, active-directive interventions elicited acceptance responses more frequently than resistance responses. Active-directive interventions not specific to RET were no different than non-active-directive interventions in

terms of clients' patterns of response in the first and third sessions. In session two, it was the non-active-directive interventions that elicited greater opposition.

In favor of nondirective criticism were the findings that (1) active-directive interventions were followed by proportionately more opposition than were the non-active-directive and (2) active-directive restricted clients' range of responses to primarily the acceptance/opposition dimension. While these forms of client response may not be desirable within the context of non-directive approaches, they are not necessarily unfavorable in directive approaches. While nondirective therapy values the clients' unhampered self-exploration, directive therapy wants to confront clients and have them debate and argue their beliefs against the therapist's. Within this latter framework, oppositional responses and staying within the acceptance/opposition dimension would indicate an effective therapeutic process with the client actively struggling to change. While nondirective therapists may want to avoid using active-directive interventions given their consequences, the process engendered by such interventions is consistent with the theory and goals of directive approaches.

Likewise, the therapist/client relationship may not be the one deemed therapeutic according to nondirective theory. Rogers criticized the teacher/learner relationship that appears to be present in the RET sessions analysed. However, the strong didactic and structuring style seen here is accepted by directive therapies.

Implications for Clinical Practice

For the clinician, in a directive therapy context, the results imply that cognitive disputation, and especially challenging questions, may lead to increasing opposition/resistance, at least in the early sessions. In line with RET theory, the recommendation would be for therapists to persist despite client defensiveness. Therapists might also expect to see early acceptance of didactic presentations and an overall tendency for clients to be more frequently accepting than resisting of active-directive interventions. In addition, clients' responses may be more restricted to the acceptance/opposition dimension following active-directive statements than non-active-directive.

Conclusions

In this first study of client responses to active-directive interventions in a directive therapy, progressive changes in clients' acceptance/compliance and opposition/resistance to several active-directive interventions in Rational-Emotive Therapy were studied over a series of three early sessions. The following conclusions are drawn:

From the Main Hypotheses

- (1) Clients showed individual patterns of responding to the target interventions over the three sessions.
- (2) Despite individual differences, clients responded to two key RET interventions in the same way. Challenging questions were followed by increasing opposition and decreasing acceptance. Directive interpretation was followed by unchanging patterns of acceptance and opposition over three sessions. In addition, the grouped data suggested that clients increasingly accepted didactic presentations.
- (3) Although non-active-directive interventions are neither frequent nor central techniques in directive therapies such as RET, they appeared to have a very definite, though unexplained, impact on clients' responses in the second session. These were a marked decrease in acceptance/compliance and corresponding increase in opposition/resistance following non-active-directive statements in that session.

From Other Observations

(4) Active-directive interventions were as a group followed by higher proportions of opposition than were non-active-directive interventions. By session three, both challenging questions and directive interpretation showed significantly higher proportions of opposition than non-active-directive interventions. In contrast, active-directive interventions other than those specific to RET and didactic presentations did not differ from non-active-directive interventions in eliciting oppositional responses. —

(5) The most frequent response following active-directive interventions was acceptance/compliance, accounting for 50% - 85% of responses. Opposition/resistance accounted for 10% - 50%.

(6) Active-directive interventions restricted clients' responses predominantly to acceptance or opposition and did so to a greater degree than non-active-directive interventions.

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Appendix 1

Instructions to Judges for Rating Therapist Statements

1. Each therapist statement is to be rated individually into one of the following five categories.
2. There is an 8-second pause on the tape after each therapist statement. Use this interval to make your decision and record your rating.
3. Give each therapist statement one rating only.

Therapist Statement Categories

Category 1. Challenging Question

This is a specific kind of question that requires clients to prove or justify their ideas and beliefs to the therapist. Challenging questions are distinct from other kinds of questions used in psychotherapy. They are not information-gathering inquiries like "How old are you?" or "What is your problem?" or "When did your symptoms start?" Similarly, they are not gentle leading questions like "Can you tell me more about that?" They are active challenges that probe the client's belief system. There are three main forms of challenging questions:

(1) Questions that ask for evidence to support beliefs and for demonstration of logical thinking. These questions take the general form: "What is the proof?" "Where's the evidence?" "Why is that so?" "How do you know?" "What would that mean about you as a person?" "How would you be destroyed if that were the case?"

The following clinical examples show how these challenging questions might occur in a session:

T- So you're different from other people. What are you concluding from that?

T- Where is the evidence that you must have enjoyment easily and quickly?

T- Where's the proof that you need other people?

(2) Questions that require clients to evaluate the logic of their expectations of future catastrophies, for example, "What

would happen if?" "If that's true, what's the worst thing that could happen?" "How would that be so terrible?" "Why would you have to be destroyed by that?"

The following clinical examples would be classified as challenging questions:

T- Why is it terrible when life doesn't give you the pleasure that it must give you?

T- Let's suppose that people do say you're unstable. What's the horror of that?

T- Where is it written that you can't stand this kind of frustration?

(3) Questions that ask clients to evaluate the point of their beliefs, for example, "As long as you believe that, how will you feel?" "Where will that belief get you?" "What is the point in believing that?" In a session, these questions might look like the following:

T- If you really believe that you need someone, and you don't have anyone, how will you feel?

T- If you keep believing that you'll never be likeable. How will you feel?

T- What's the point in believing that you're inferior?

Rate as Category 1 any question that you judge to be challenging even if there is no example above to match it.

Category 2. Directive Interpretation

Directive interpretations are forthright, vigorous, and persuasive statements that tell clients what they are like, what their problems are, how they are behaving, what their beliefs are, what they are saying, etc. Directive interpretations are characterized by bluntness and the straightforward manner in which they are delivered. They are not tentative suggestions or gentle hypotheses. In contrast, directive interpretations are firm and unhesitant. They can also seem outspoken and provocative.

The following examples are therapist statements that would be rated in category 2:

T- Not only are you saying, that "I might have some power over the airplane, etc., to let it fall or not." But you're saying, "If I were dead," - let's suppose that this really occurred. - "it would be awful for me."

T- So what we're really saying then, in relation to this emotional problem, is that you really down yourself, you

start calling yourself names. And then you feel really rotten about you, and hopeless, and then you give up and start eating.

T- Your thinking is getting circular right there. I want to intercept it, because the reason that you get yourself so miserable is because you tell yourself, "I'm such a shitty person," and we're attacking that fundamental belief. Your flaw is that you stupidly don't stick to diets.

T- Well, sounds to me, Jill, that you have two problems here, not one. First, you have a problem with dieting, a thyroid problem, bad eating habits, etc., that prevent you from staying on a diet. And second, you get upset about eating badly and then eat when you don't want to eat.

T- So your feeling bad and your drinking go hand in hand. What begins as drinking too much quickly turns into bad feelings.

Rate as Category 2 any therapist statement that straightforwardly tells the client about the client. These directive interpretations can be firm, unhesitant, blunt, and even vigorous and provocative or confrontational.

Category 3. Didactic Presentation

Didactic interventions are statements that seem like little lectures or information about reality that the therapist is giving the client. The therapist might be teaching the client about RET theory, or giving examples of better ways of thinking or behaving. Therapists might explain how emotional problems start and what can be done to help, or how other people have changed. The key characteristic is the lecturing or informational aspect of the intervention.

The following are examples of interventions that belong in Category 3:

T- No, no, it's not back when you were 5. It's what we would more accurately call preconscious. In other words, it's not that deeply repressed so much as it's going on in the back of your mind, but you don't easily, and most

of us don't, virtually nobody puts his finger right away on those thoughts that are at the back of your mind.

T- Look, there isn't a parent in the world who hasn't felt he could just take the kid when he was whining and throw him out the window. This is an impulse, you know. Children are very demanding. We have to get up in the middle of the night for them. We're tired. They think Mama's going to be there Johnny-on-the-spot.

T- You should stop worrying about them. Don't try to make food you think they'll like. Give them what they want. Kids can grow up into healthy human beings with just peanut butter sandwiches and milk.

T- Let's first take a look at whether your anger is working for you or against you. What does rage do? It sets the stage for a fight! Also, it isn't good for you; it sets your juices flowing, makes you feel more irritated and so forth. Now concern or annoyance, on the other hand, serve as sensible cues for you to say, "How can I change this? What can I do to help the situation? Perhaps if I explain to him ..." See, now we're talking about strategies. And if a strategy doesn't work, what would you do? You'd go back to the drawing board and try another. You see, you can do that kind of problem solving once you're not in a rage.

T- All right. So we'll call C, the Consequence, anxiety. And we'll call A, the Activating event, the fact that you're going to take this plane trip - or you're taking it. Let's assume that - to Memphis. Now the question is: "What really causes C? Is it A, the trip, or is it something else?" And we know it can't be A, because sometimes you might not think of these worst things; and other times you might think of them really, continually, etc. It isn't any event that causes the consequence. So it must be B - your Belief System. Now let's get you to see the rational Belief that causes, that is implicated, in C. It doesn't exactly cause C, the anxiety, but it causes another emotion. Now that rational Belief - it's a negative belief, prediction of something negative, but still pretty rational.

T- Good. Because there's a real connection between calling yourself names like shitty and feeling really bad about you. If you said to yourself - "Hey, I'm sitting here doing something that's shitty, but who doesn't; I'm just like everybody else and that's ok." - you wouldn't have felt so bad, would you? But when you call yourself things like a really shitty person, how else can you feel besides bad? Right? See that connection? There's no other way you could feel and that's the basis for your emotional upset.

Rate as Category 3 any therapist intervention in which the therapist is teaching, informing, lecturing the client.

Category 4. Other Active-Directive Interventions

Category 4 is to be used for any therapist statement that is active-directive but does not fall into Categories 1, 2, or 3. Use Category 4 for other interventions that come from the therapist's position of authority. They include statements that are leading, directive, authoritarian, expert, and/or active. In these interventions the therapist is in the role of the expert, influential professional, wise teacher. Active-directive statements include persuasion, giving advice and suggestions and directions on what the client should do. Reassurance and encouragement as well as disapproval and criticism are also active-directive interventions. Confrontation and direct questions would be rated in Category 4 as would statements that structure or lead the interview.

The following are Category 4 active-directive interventions:

T- When did your anxieties begin?

(direct question)

T- Now, let's look at this example for instance. There was nothing you could do at the hotel. It was not the best place to have your temper tantrum, and maybe an intellectual approach would have been better under the circumstances.

(criticism and a suggestions of what the client should have done instead)

T- You should not bare your soul without evidence of reciprocity. Also, before you plunge too deep there should be a feeling of a fairly broad base of common interest.

(directions on how the client should behave)

T- It is possible for you to find many things in your life

that you don't like. All people do things that they're ashamed of. You can catalogue all of your shameful things, but when you compare them to anyone else's, your sins will probably compare to theirs. I don't think you've been so blameworthy.

(reassurance)

T- No, you're not stupid, just a little confused.

(reassurance)

T- Now, as I remember, you told me last week that you had some suicidal thoughts and where are you with that?

(direct question, therapist is leading the session)

T- And do you know when you feel somebody is attractive?

(direct, confrontational question)

T- What was your feeling about that situation?

(direct question)

T- Give me an example of this problem.

(a leading statement)

T- What are you saying to get those fearful feelings?

(direct question)

T- How much have you been sleeping?

(direct question)

T- You'll really have to stop blaming yourself, until you really work at changing that, you'll keep feeling miserable.

(persuasion, telling the client how to behave)

T- You know, you could go and ask her directly what she wants.

(suggestion)

T- I would strongly advise speaking to the attending physician about that incident.

(advice)

Rate as Category 4 any therapist statement that is clearly

active-directive and authoritative but does not fit one of categories 1, 2, or 3.

Category 5. Non-Active-Directive Intervention

Rate as Category 5 any therapist statement that does not belong in categories 1 through 4. The following interventions would be given a category 5 rating:

T- Uh hum.

T- I see.

C- I really hate him.

T- You really can't stand him.

T- Would you like to talk about it now?

T- It seems as if you might be afraid when you have to meet people.

Appendix 2

Instructions to Judges
Rating of Client Statements

1. Each client statement is to be rated as a response to the therapist statement immediately preceding it. Listen carefully to each therapist statement and then rate the client response that follows. Consider only how the client's statement relates to the therapist statement immediately preceding it.
2. There is an eight-second pause on the tape after each client statement. Use this interval to make your decision and record your rating.
3. Give each client response one rating only.

Client Response Categories

The client responses are to be judged according to whether the client expresses agreement or disagreement with the previous therapist statement. There are three (3) categories:

Category 1. Acceptance/Compliance

In category 1, the client accepts, agrees with, or complies with the previous therapist statement. This acceptance can range from strong, unconditional acceptance, such as: "Yes! That's it!," to mild or reluctant agreement, such as: "Uh, huh, you're right," or "Yeah, I know." Client statements are rated in category 1 when the client's response indicates acceptance or agree-

ment, whether mild or strong. Client statements that show compliance with the therapist remark, that is, that answer a therapist question or follow a leading intervention are also rated in category 1.

Category 2. Opposition/Resistance

In category 2, the client rejects, disagrees with, or argues with the previous therapist statement. It is clear that the client opposes what the therapist has just said. The client may also show opposition by putting the therapist on the spot with questions or by not complying with the therapist's leads and questions. Included in category 2 are the "Yes,... but" type of client responses in which the client may initially agree with the therapist but end by disagreeing.

Category 3. Other

In some cases, the client's responses may not fit one either category 1 or 2, that is, either agreement/compliance or opposition/resistance. Rate as 3 any client statement that cannot be rated in categories 1 or 2.

Examples of Ratings of Client Statements

The following are examples of actual client statements and how they would be rated according to the Agreement/Disagreement scale. These examples do not exhaust the possibilities for types of client responses that would be rated in each category. They are presented as examples of correct use of the categories.

Category 1. Acceptance/Compliance

T- And, a person who engages in these behaviors who doesn't know better is okay, but a person who does things she doesn't like and knows they are bad for her and stupid is a shit.

C- Right!

T- You see, they say that once a person is an alcoholic, and you would be called that, then he can't ever touch a drink. I've seen several people whom I've gotten to give up drinking and they do drink socially from time to time. So, A.A. is wrong.

C- Oh, I think they are too. I - I think that A.A. doesn't provide the basis for a solution.

T- Yeah, right. "It could happen. And I could more likely get hit by a car, or something like that."

C- I'm more likely to get killed in a taxi on the way.

T- Which I should be able to ...

C- Which I should be able to do! (laughs)

T- You see, that is grandiose. You're, you're also saying a magical thing, I believe, because most people do under these circumstances.

C- That's a very interesting word that you've got, magical. For that's the magical thing.

T- Right. But there are two other things you could have done which would have added to this - and what you did was good - and, third, you could have said, "Look, if I protect them, really, by stopping them from swinging, etc., then it's a dubious aid to their lives.

C- Right. Well, I've gone over this with myself many times, and, you know, I know the ridiculousness of frustrating their lives or preventing their development and their happiness by restricting their freedom.

T- And that's what gamblers really think. "If I win the race, then I've done this."

C- Somehow forced that horse to move faster!

T- Intellectual insight means, "Once in a while I believe it, and I wish I always believed it, but I really don't. I go back to the magic - the horseshit.

C- Well, I, uh, ... I have, uh, that's precisely it. Because I have these periods of time when I'm really in gear with it, with the intellectual concept.

T- So what would you insanely be telling yourself at the irrational belief, B?

C- Oh, I'd be saying that "I must have a cigarette, or I can't get along without one, or I shouldn't be deprived."

T- Concern, caution. Something like that. Right?

C- Um-huh.

T- Because you'd say, "Well, since that could occur, and since I wouldn't want it, maybe I shouldn't take the trip, maybe I should go by train instead. You certainly wouldn't feel happy about that thought. So you would be sad or regretful or frustrated. But that's all. And then you'd say to yourself, "Now what are the chances of a dreadful accident happening?" You'd probably conclude very few.

C- They'd be low.

T- But you're really saying, "If I were dead, it would be awful for me."

C- Yeah.

T- You would be at the end of your life but you wouldn't know it. Right now, you're seeing yourself as both dead and alive.

C- Uh-huh.

T- So your feeling bad and your getting off your diet goes hand in hand. What begins as bad eating quickly turns into bad feelings.

C- Right.

T- OK. Now do you see how thinking those kinds of thoughts can only lead to feeling really bad and really bad about you?

C- Yeah, I do.

T- Is there something fundamentally wrong with them?

C- I guess not. (softly)

T- Yes, and no matter what you do, you can't fill up that thing you call ego.

C- Right.

T- The fact of the matter is you're probably telling yourself, "If she finds out that I went out, she would condemn me, and I couldn't stand being condemned. That makes more sense than what you originally said."

C- I guess that's right.

Category 2. Opposition/Resistance

T- You did the Behavioral work, the homework assignment. You didn't smoke. But you didn't do very much attacking the magical thinking. Now, if we can get you to do it again and fight and actively dispute the magical thinking, then not only would you stay off cigarettes but do yourself a great deal of philosophic and general good.

C- How do you do it, besides simply ...? I haven't been doing very well at precisely parsing the, uh, thoughts.

T- But you'd better dispute at the D, "Why should the world be such that I ought to get away with smoking and not get the respiratory disorders? Why is it awful that I have to give them up?" You see, you're not disputing the magic. The other client went through 2 or 3 weeks of real pain. He was habituated for thirty years.

C- Actually, I don't have anything like that kind of discomfort. In fact, when I quit in the past it was simple. I just quit. I didn't see any irrational ideas.

T- No, no, no. You're only going to continue to be miserable if you believe that idea - if you tell yourself you're a shitty person.

C- Can't I just be plain old miserable about being fat?

T- But it almost appears as if you're saying, "Look - I really don't have an ego and I'm trying to get one."

C- I don't know. I never approached it that way. I just assumed I had one.

T- Can you remember a recent incident when you had that feeling?

C- Nothing happened today ...

T- But many of my friends call me all kinds of names continually and they disagree with me - it doesn't bother me at all.

C- I'd tell them I didn't like it. It would bother me.

T- You're saying they're ignorant.

C- No - no - I'm saying that they aren't ignorant.

T- In my terminology I would say that these are people who are very disturbed, who really don't know what they're doing and therefore they commit these wrongs.

C- Well, I don't know. When my father hit me, I think he knew what he was doing.

T- But you just said that the force is sort of outside them and it's forcing them to do things.

C- No, no, no. I said there was a motivating force over here.

T- You were taught these crazy ideas by your father, your mother, your church.

C- No - my mother and father never taught me anything when I was young.

T- Let's suppose you were lusting after him, what's the hassle?

C- I don't know.

T- Wouldn't people show it if they're really upset, really disturbed?

C- Ah, no, I'm not sure they would, they might just be silent.

T- You don't want to lose her, but you're not very happy with her behavior towards you. You're really saying, "I need more than she's ready to give. But if I go out and get it elsewhere and she found out, it would be horrible and I couldn't live with the guilt."

C- That's right except for one thing. It's not her. I'm not putting the blame on her.

T- OK, that's true and you might be annoyed at that fact.

C- Yeah, but the reason I can't work this out knowing what I do is that the condemnation half of this comes from other people.

T- In other words, they don't accept the fact that the universe doesn't give a shit about them.

C- (laughs) We all know it, even though we don't accept it. I think, well, I've accepted this intellectually, but it doesn't seem to help.

T- Your problem actually is the fact that you have a lot of what I call *shoulds*, *oughts*, and *musts*, and as soon as you believe that anything ought to be, you're going to be disturbed and will get into trouble with other people. Why? Because as soon as you think a thing ought to be, there's a good chance that it won't. In this world, lots of things that you believe ought to be aren't.

C- Yes, but they have come true. Lots of things I believe have come true.

T- But you know a lot of people die young.

C- I know, but a lot die in their 70s and 80s and I say to myself, "Gee, maybe I could accept it when I'm 70 or 80 when I would have lived a full life."

T- So far, we agree that you're saying (a) "I refuse to accept that life isn't always fair" and (b) "I refuse to accept the idea that I might die young. I know other people do, but I won't believe it could happen to me."

C- I can objectively agree with you. But I have a hard time really accepting it for my own.

Category 3. Other

T- Okay. Here's what I hear you saying. You say, "I don't want to give in; I want to define my situation for myself, not the way she is defining it for me."

C- I'm not sure I've got a line on where this all started. When I was playing in the jazz group, she resented my playing. She had all kinds of reasons ...

T- But you're preoccupying yourself with these thoughts. That's what you're doing. You're dwelling on it.

C- (sighs) Let me explain an event that may have some relevance here.

T- Self-put-down is depression. But those cognitions, those very helpful thoughts are not going to help in anger because there is a different set of irrational things which are going on - different from depression. So, it's like taking the wrong medicine.

C- Do you think that it fits into this kind of therapy - the idea that anger suppressed becomes depression? Because I've heard that said.

T- I don't think you believe that.

C- One thing that helps me is to think; "Well, it's not my fault, the fact that she's like that."

T- If you don't work really hard at giving up that "she should" you're going to be continually disappointed in her, trying to control her ...

C- In terms of acting every day, once in despair I talked to my father about this and he said the best way to deal with her is to submit.