THE IMPACT OF RESISTANCE ON EMPATHY IN COGNITIVE-BEHAVIOURAL THERAPY

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Abstract

Given existing observational research suggesting that therapist empathy tends to decrease during moments of resistance (e.g., Ahmed, Westra, & Constantino, 2012; Francis et al., 2005), the present study sought to: (1) explore the impact of resistance on client perceptions of therapist empathy, and (2) examine client-rated empathy as a mediator of the impact of resistance on therapy outcomes in the context of 44 therapist-client dyads receiving 15 sessions of cognitive-behavioural therapy for generalized anxiety disorder. Trained observer ratings of resistance were utilized to identify the level of resistance present in an early therapy session, and the corresponding client post-session ratings of therapist empathy were extracted for that session. Treatment outcome was measured via client-rated worry severity at posttreatment and one-year posttreatment. Higher levels of resistance were found to be significantly associated with lower client post-session ratings of therapist empathy, above and beyond clients' baseline empathy ratings. Client post-session ratings of therapist empathy did not mediate the relationship between resistance and treatment outcomes. This is the first study to examine the relationship between observed resistance and client perceived empathy by using client ratings of empathy. The current study underscores the important link between resistance and client perceived empathy, and highlights the critical need to enhance therapist in-session responsivity to resistance in psychotherapy research and training.

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The Impact of Resistance on Empathy in Cognitive-Behavioural Therapy

Client resistance, or opposition to the direction set by the therapist (Westra, Aviram, Kertes, Ahmed, & Connors, 2009), has been increasingly identified as a clinically important phenomenon in psychotherapy (Miller & Rollnick, 2002; Westra, 2012). Client resistance can be expressed either directly (e.g., disagreeing or interrupting) or indirectly (e.g., withdrawing, ignoring, or side-tracking), and includes resistance toward the therapist or the treatment (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Westra et al., 2009). Resistance may be particularly apparent in action-oriented treatments such as Cognitive-Behavioural Therapy (CBT), where higher levels of therapist direction can promote resistance among clients who are ambivalent about change (e.g., Leahy, 2001; Sanderson & Bruce, 2007; Westra, 2012). Client resistance has been shown to strongly and reliably predict reduced engagement and poorer treatment outcome, and has been consistently related to the early termination of treatment (Aviram & Westra, 2011; Beutler, Harwood, Michelson, Song, & Holman, 2011; Gomes-Schwartz, 1978; Jungbluth & Shirk, 2009; Miller & Rollnick, 1991; Piper et al., 1999; Strupp, 1980).

Although resistance has been found to have a highly detrimental impact on therapy outcomes, little is known about *how* resistance exerts such a toxic effect. That is, no study to date has investigated the potential pathways through which resistance negatively impacts treatment outcomes. It may be that resistance (e.g., opposition, argument, disagreement) directly negatively impacts treatment outcomes and/or it is possible that resistance disrupts or negatively influences other important therapy processes as well. One reasonable candidate that could be disrupted by the presence of resistance is client perceived empathy – that is, the presence of resistance may disrupt therapist empathy, which in turn might negatively influence treatment outcomes. Existing

observational research has provided preliminary support for this assertion, demonstrating that therapist behaviour becomes less supportive/empathic and more directive during moments of resistance (e.g., Ahmed, Westra, & Constantino, 2012; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Francis et al., 2005).

The purpose of the current study is to explore the impact of resistance on client perceptions of therapist empathy in the context of CBT, and then to examine empathy as a mediator of the impact of resistance on therapy outcomes. Given previous research showing that resistance can be especially salient in the context of high therapist direction (e.g., Francis et al., 2005), the current study sought to examine the impact of resistance on client perceptions of therapist empathy within the CBT context. In this introduction, I will first consider resistance in CBT and delineate the ways in which resistance can arise within the context of CBT, followed by a discussion of the negative effect of resistance on treatment outcomes. Next, I will discuss the importance of therapist empathy in psychotherapy, and consider the ways in which empathy is impacted during moments of resistance. Finally, I will provide an outline of the specific aims of the present study.

What is Resistance?

Resistance can be defined as any behaviour that opposes, blocks, diverts, or impedes the direction set by the therapist (e.g., Client Resistance Code, Chamberlain et al., 1984). In a therapy session, the therapist nearly always sets a direction by either asking a question, making a reflection, or offering the client a suggestion or feedback, and the client typically follows the lead of the therapist. Resistance to therapist direction may be expressed either directly (i.e., verbal statements such as “I do the relaxation exercises and they help but don’t fix it,” or “I just hate writing my thoughts down”) or indirectly (i.e., in process, such as disagreeing, ignoring,

interrupting). Newman (1994) outlines several forms that resistance can take in CBT, including homework noncompliance, behaving in ways that go against what was agreed upon in session, in-session avoidance such as silence or repeated use of "I don't know," high levels of expressed emotion toward the therapist, gratuitous debates with the therapist, and misinterpretation of the therapist's comments, among others.

While it is tempting to consider opposition to the therapist or treatment to be a sole client characteristic, it is more typically a reflection of interpersonal process gone awry. Often, such resistance arises from the therapist's directive, rather than supportive, management of client ambivalence (and the conditions giving rise to resistance are discussed further below) (Westra, 2012). The presence of resistance reflects a lack of collaboration between the client and therapist, and manifestations of resistance in CBT (e.g., lack of collaboration on tasks and goals, clients' disagreement with the therapist's interpretation of their problems) have also been found to represent strains or ruptures in the therapeutic alliance (Watson & McMullen, 2005).

Relatedly, the work of Safran and Muran (1996) on alliance ruptures is a very similar construct to resistance, and essentially describes similar, if not identical phenomena. Safran and Muran (2000) describe two types of alliance ruptures, including confrontation and withdrawal types. These two types of ruptures have been found to differentially impact therapeutic progress and client and therapist experiences (Coutinho, Ribeiro, Hill, & Safran, 2011). In confrontation ruptures, the client directly communicates resentment, anger, or dissatisfaction with the therapist or process of therapy (e.g., the client criticizes the therapist's interpersonal style). In withdrawal ruptures, the client withdraws or becomes partially disengaged from the therapist, his or her own emotions, or the process of therapy (e.g., the client avoids the therapist's interpretations of his or her problems by providing minimal responses) (Eubanks-Carter, Mitchell, Muran, & Safran,

2009; Safran & Muran, 1996, 2000). Further, ruptures in the therapeutic alliance, like resistance, indicate deteriorations in the relationship between the client and therapist that can go on to negatively impact psychotherapy progress and treatment outcome, particularly when unacknowledged or left unmanaged (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder & Strupp, 1997; Coutinho et al., 2011; Rhodes, Hill, Thompson, & Elliot, 1994; Safran & Muran, 1996).

Noncompliance in Cognitive-Behavioural Therapy

Although CBT is widely regarded and utilized as an effective treatment for anxiety (e.g., Chambless et al., 1996; DiMauro, Domingues, Fernandez, & Tolin, 2013), treatment non-response is common, with approximately 60% of individuals with anxiety only partly responding or not responding to treatment (Westen & Morrison, 2001). In the case of generalized anxiety disorder (GAD) specifically, up to 50% of clients are non-responders to treatment (Hunot, Churchill, Texeira, & Silva de Lima, 2007). In a survey of expert CBT practitioners treating panic disorder, "lack of engagement in behavioural experiments" and "noncompliance" were the most commonly identified reasons for insufficient response to CBT (Sanderson & Bruce, 2007). Further, surveys of practicing CBT therapists demonstrate that noncompliance with key aspects of treatment, such as homework, is a common occurrence (Helbig & Fehm, 2004), with only a minority of clients being identified as complying fully with the treatment (Kazantzis, Lampropoulos, & Deane, 2005; Sanderson & Bruce, 2007; Westra, 2012).

Client ambivalence or "resistance to treatment," and the accompanying tensions this creates on the therapeutic alliance, has been identified as a major factor limiting treatment response in CBT (Antony, Ledley, & Heimberg, 2005; Leahy, 2001; Sanderson & Bruce, 2007; Westra, 2012). That is, many clients entering psychotherapy are uncertain or undecided about

change (i.e., they want to change, but also fear it) and thus, are unlikely to use action-oriented strategies (O'Hare, 1996; Westra, 2012). Individuals with GAD for example have been found to be commonly ambivalent about change, holding both positive (e.g., "worry helps me to prepare for negative events") and negative (e.g., "worry interferes with my life") beliefs about worry (Borkovec & Roemer, 1995; Westra, 2004, 2012). This ambivalence is often expressed indirectly when clients are expected to comply with the requirements of CBT, and resistance may then arise in the form of homework noncompliance, arguing with the therapist, or reluctance to take an active role in sessions (Newman, 2002; Westra, 2012).

Not surprisingly, the active involvement of clients with the treatment process has been consistently related to better treatment outcomes, and has been identified as among the most important contributors to therapy outcome (Orlinsky, Grawe, & Parks, 1994). In their review, Orlinsky and colleagues (1994) found that client engagement in therapy was significantly associated with positive outcomes in 65% of the 54 studies reviewed. Moreover, client cooperation, as opposed to resistance, was found to relate to positive outcomes in 69% of the studies. These results suggest that the cooperation between client and therapist, in addition to the active engagement of the client with the treatment, is instrumental in further facilitating the attainment of positive outcomes in psychotherapy (Button & Westra, 2013).

The Development of Resistance

While resistance has been traditionally considered to be a client characteristic, a more interpersonal or relational interpretation of resistance has emerged in recent years (e.g., Beutler, Moleiro, & Talebi, 2002; Moyers & Rollnick, 2002; Westra, 2012). That is, resistance may be considered the product of a client's ambivalence about change (i.e., the degree of internal conflict about change) and the way in which a therapist responds to that ambivalence (Miller &

Rollnick, 2002; Moyers & Rollnick, 2002). Thus, in order for resistance to occur, the client must have something or someone to resist or oppose, and the therapist plays a critical role in either exacerbating or diminishing the resistance depending on his or her response to it (Moyers & Rollnick, 2002; Westra, 2012). Prolonged episodes of resistance occur when the therapist persuades or continues to advise, direct, or make suggestions when the client is not ready for change (Westra, 2012).

Indeed, research reliably demonstrates that directive therapeutic approaches tend to elicit greater resistance than supportive styles (e.g., Bischoff & Tracey, 1995; Moyers & Martin, 2006; Patterson & Chamberlain, 1994). For example, in a study conducted by Patterson and Forgatch (1985), researchers found that when therapists alternated within a session between "teach and confront" and "facilitate and support," therapist behaviours of "teaching and confronting" were found to increase resistance, while facilitative and supportive therapist behaviours were observed to promote greater cooperation between client and therapist. Similarly, Miller, Benefield, and Tonigan (1993) showed that when problem drinkers received feedback on alcohol use in a directive style, clients were increasingly defensive and elicited greater post-intervention drinking, compared with the same feedback delivered in a supportive style. Karno and Longabaugh (2005) corroborated these early findings in their study examining the effect of clients' trait reactance and therapist directiveness on the effectiveness of psychotherapy for alcoholism. Findings demonstrated that increased therapist directiveness (i.e., confrontation, interpretation, and introduction of topics) had a negative effect on clients with medium or high levels of trait reactance, and was associated with increased drinking among reactant clients.

Together, these findings suggest that while directiveness may be appropriate in situations when the client is cooperative or motivated for change, it is particularly contraindicated when

clients are resistant or ambivalent about change (Beutler et al., 2002, 2011; Ilgen, McKellar, Moos, & Finney, 2006). Researchers have suggested that continuing to be highly directive in the context of client noncompliance or strong ambivalence may enable the therapist and client to "act out" this ambivalence, and may in turn exacerbate the resistance rather than diminish it (Arkowitz & Westra, 2004; Burns & Auerbach, 1996).

The Impact of Resistance on Outcomes

Research strongly and consistently demonstrates that resistance can be detrimental to maintaining a strong sense of collaboration in therapy and to treatment outcomes (Gomes-Schwartz, 1978; Miller & Rollnick, 1991; Westra, 2012). In a study conducted by Watson and McMullen (2005), significantly higher levels of resistance were observed in sessions that were rated by clients as being low in the therapeutic alliance compared to those sessions rated by clients as being high in the therapy alliance. Moreover, higher levels of resistance have been reliably associated with reduced engagement, poorer treatment outcomes, and with the early termination of therapy (e.g., Beutler et al., 2011; Gomes-Schwartz, 1978; Jungbluth & Shirk, 2009; Miller & Rollnick, 1991; Piper et al., 1999; Strupp, 1980). And while resistance may be rare compared to cooperation, it has a robust capacity to predict client engagement and treatment outcomes. In a review by Beutler and colleagues (2001) exploring the predictive capacity of resistance, 82% of the studies showed that client resistance correlates negatively with treatment outcomes.

In more recent work investigating the effectiveness of CBT for GAD, Aviram and Westra (2011) showed that as early as the first session of psychotherapy, higher levels of resistance were strongly and consistently associated with poorer outcome up to one-year post-CBT, reflecting a lack of collaboration between therapist and client. In this study, researchers found resistance to

also predict subsequent engagement in therapy sessions and reduced homework compliance (Aviram & Westra, 2011). Similarly, in a study conducted by Jungbluth and Shirk (2009) examining CBT for depressed adolescents, higher levels of in-session resistance were found to predict the total number of sessions completed. Results of this study also found resistance to substantively predict CBT task involvement in subsequent sessions, accounting for 33% of the variance in subsequent involvement.

These findings support reviews of the literature on resistance demonstrating that the effectiveness of psychotherapy is associated with the relative absence of resistance (e.g., Beutler et al., 2002, 2011; Westra, 2011), and that the quality of the client's engagement with therapy is one of the most potent predictors of treatment outcomes (Orlinsky et al., 1994). Given the research corroborating the negative impact of resistance on treatment outcomes, exploring the pathways through which resistance may negatively impact treatment outcome is vital to understanding this important phenomena, and ultimately to facilitating higher levels of engagement in psychotherapy. Therapist empathy has been identified as a critical ingredient to successful psychotherapy (e.g., Greenberg, Rice, & Elliott, 1993; Watson, 2002), and is hypothesized in the current study to be one such pathway through which resistance negatively impacts therapy outcomes.

Empathy in Psychotherapy

According to Rogers (1980), empathy is best understood as "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view. It is the ability to see completely through the client's eyes, to adopt his frame of reference…" (p. 85). This "perspective taking" has been described to encompass the accurate understanding and attunement to both the cognitive and affective processes underlying

the client's experience in therapy (Elliott, Bohart, Watson, & Greenberg, 2011; Moyers & Miller, 2013). A review of the literature on empathy demonstrates that empathy is a critical ingredient to successful psychotherapy irrespective of the therapeutic approach used (e.g., Greenberg et al., 1993; Linehan, 1997; Mahoney, 1995; Watson, 2002). Numerous researchers consider empathy to be a basic relationship skill (Bohart & Greenberg, 1997; Rogers, 1975; Watson, Goldman, & Vanaerschot, 1998), and to be a key component for building a positive working relationship with clients (Watson, 2002). Empathy has been widely regarded to serve several key functions in psychotherapy (Angus & Kagan, 2007; Watson et al., 1998; Watson, Steckly, & McMullen, 2014), and high levels of empathy have been consistently shown to be among the most potent predictors of treatment outcome (Elliott et al., 2011; Orlinsky et al., 1994; Watson, 2002).

Research suggests that empathy is an active ingredient and consistent predictor of client change (Rogers, 1975; Taylor, 1990; Westra, 2012). In her work, Watson (2002) identifies at least three important functions of empathy in psychotherapy: (1) enabling a positive working alliance, (2) deconstructing clients' assumptions or world-views, and (3) enhancing clients' affect regulation. Further, empathy has been described as facilitating clients' self-reflection in therapy and to underscore their innate ability to know themselves, to evaluate their beliefs, and to make choices regarding change and how to best enhance their lives (Rogers, 1975; Taylor, 1990; Westra, 2012). As argued by early researchers including Rogers (1957), Barrett-Lennard (1981), and Horvath and Greenberg (1989), therapist empathy facilitates the development of self-empathy in clients, helps clients moderate their conditions of worth, and facilitates and maintains a positive therapeutic alliance. In a recent study investigating *how* empathy predicts client change within the context of 16 weeks of psychotherapy for depression, Watson, Steckly, and McMullen (2014) found that clients' perceptions of therapist empathy relate to significant

improvements in attachment insecurity and significant decreases in negative self-treatment. Researchers concluded that client perceived empathy is a key mechanism of change worth investigating further.

In addition to serving many complex functions, therapist empathy has been consistently shown to be a powerful predictor of therapy outcome, with higher levels of therapist empathy predicting more positive treatment outcomes (e.g., Bohart, Elliott, Greenberg, & Watson, 2002; Duan & Hill, 1996; Horvath & Bedi, 2002; Martin, Graske & Davis, 2000; Orlinsky et al., 1994; Patterson, 1984). In a meta-analysis examining the relationship between empathy and psychotherapy outcome, with study dates ranging from 1961 to 2000, Greenberg, Watson, Elliott, and Bohart (2001) found empathy, in its entirety, to contribute to almost 10% of the outcome variance in the studies reviewed. Researchers concluded that empathy accounts for as much (if not more) outcome variance than any specific intervention. Elliott, Bohart, Watson and Greenberg (2011) replicated these findings in a more recent meta-analysis demonstrating that empathy is a moderately strong predictor of outcome (mean weighted $r = .31$). Interestingly, results of this study showed that client and observer perceptions of empathy predict outcomes better than therapist perceptions of empathy. Relatedly, in a recent review of empathy in addictions treatment, Moyers and Miller (2013) noted that irrespective of the theoretical orientation, high-empathy counselors have higher success rates compared to low-empathy or confrontational counseling, which has been found to be significantly related to higher drop-out, client relapse rates, weaker therapeutic alliance, and less client change. This set of findings suggests that client perceptions of therapist empathy may be critical to their experiences and outcomes in therapy.

Empathy and Resistance

As previously discussed, resistance is most often encountered within the context of high therapist direction (i.e., when the therapist advises, directs, or makes suggestions, and the client opposes moving in that direction; Miller & Rollnick, 2002; Westra, 2012). Particularly in action-oriented treatments such as CBT, increased therapist direction can promote resistance among clients who are ambivalent about change (e.g., Leahy, 2001; Sanderson & Bruce, 2007; Westra, 2012). Despite research suggesting that supportive strategies are indicated during resistance (e.g., Beutler et al., 2002; Miller & Rollnick, 2002), a number of studies have demonstrated that therapist behaviour tends to become markedly *less* supportive at these times.

Using descriptive analyses to examine the paradoxical negative correlation found between increased use of cognitive therapy techniques and outcomes in CBT for depression, Castonguay and colleagues (1996) found that therapists tended to increase their adherence to cognitive rationales and techniques (e.g., challenging or persuading) during moments of resistance, or of tension in the therapeutic alliance. Notably, researchers found that among sessions identified by clients as low in the therapeutic alliance, therapists focused more rigidly on their own agendas (e.g., stressing their own thoughts about the client's problems, convincing the client about the validity of the CBT intervention, persuading the client in the face of opposition), rather than exploring the client's experience. This pattern of therapist response was observed to be *especially salient* during moments of client hostility toward the therapist or opposition towards the therapy, and to exacerbate tensions in the alliance and interfere with therapeutic change. Among sessions rated by clients as high in the therapeutic alliance, therapists were observed to focus more on the client's beliefs and their impact on the client's emotions, which did not result in lower alliance ratings despite moments of disagreement between the

therapist and client. Given research on the nature of therapist empathy, there is strong theoretical and empirical reason to suspect that this dismissing of the client's position (in pursuit of one's own agenda) during moments of opposition is synonymous with a *lack* of therapist empathy. That is, by virtue of responding to resistance by becoming increasingly directive, the therapist communicates a disinterest in listening to the client and in understanding "his or her thoughts, feelings, and struggles from the client's point of view" (Rogers, 1980, p. 85).

Similarly, using a qualitative approach to examine alliance ruptures and their resolution in CBT, Aspland and colleagues (2008) observed that ruptures tended to occur when therapists persisted with the application of a technique in spite of client concern. Specifically, researchers found that during moments of increased client withdrawal or disengagement (i.e., resistance), therapists tended to become more persuasive, defensive and controlling and less overtly validating. Consistent with the findings of Castonguay and colleagues (1996), this pattern of therapist response was found to perpetuate ruptures in the therapeutic alliance. Moreover, successful rupture resolution was only found to occur when therapists attended to ruptures by being increasingly collaborative and by focusing on concerns pertinent to the client. This involved therapists' changing their behaviours and encouraging clients to engage by being more collaborative and by summarizing, exploring and validating clients' experiences (i.e., increased therapist empathy). In keeping with recommendations by Rhodes and colleagues (1994), Newman (1998, 2002) and Watson and Greenberg (2000), Aspland and colleagues (2008) concluded that upon noticing an alliance rupture, therapists should become increasingly empathic and responsive, and use reflection and non-defensive exploration to encourage clients to express their concerns, rather than continuing with standard technical intervention.

More recently, research by Ribeiro and colleagues (2014) provided further theoretical and empirical support for the interconnectedness of client resistance and therapist empathy. In their study, researchers used the Therapeutic Collaboration Coding System (Ribeiro, Ribeiro, Gonçlaves, Horvath, & Stiles, 2013) to examine therapist responses during moments of client ambivalence in a poor outcome case of narrative therapy. As noted previously, resistance can often develop in the context of directive management of client ambivalence about change. Similar to findings specific to resistance and therapist response in CBT, the results of this study demonstrated that therapeutic challenging (as opposed to supportive intervention) was the most common response preceding *and* following client ambivalence in a case of narrative therapy. In keeping with previous research, this study also found that when the therapist responded to the client's ambivalence by challenging the client, the client was more likely to invalidate the therapist's intervention, contributing to deterioration in the quality of therapeutic collaboration. In contrast, when the therapist responded to the client's ambivalence using a more supportive strategy, the client tended to validate the therapist's intervention, which researchers interpreted as the client's willingness to work at the level proposed by the therapist. Researchers concluded that by responding to client ambivalence by challenging or increasing direction, therapists might unintentionally contribute to client ambivalence, and perpetuate client feelings of being misunderstood.

Finally, in the only experimental study linking client resistance and practitioner confrontational behaviour to date, Francis and colleagues (2005) randomly assigned practitioners to interview *the same actor* who was portraying an individual either high or low in resistance to quitting smoking. Practitioners in the high-resistance condition were found to increase their confrontational behaviour (e.g., Practitioner: "[Interrupting] Smoking starves your body from

oxygen!" p. 1179), offer significantly less praise and encouragement, and ask fewer open-ended questions that sought to understand the patient's perspective, compared to those in the low resistance condition. Practitioners in the high-resistance condition were also found to use blaming statements more often (e.g., implying that if the patient did not take on the responsibility of changing, there was nothing more that could be done for them), and to express empathic statements that were identified by researchers as negative or as "hollow-empathy," compared to practitioners in the low-resistance condition (p. 1180). Confrontational statements were also found to occur most commonly when the therapist and client agendas were in conflict. These findings are consistent with previous research and experimentally demonstrate that when clinicians encounter moments of high resistance/opposition, this can pull for increasingly directive and even negative, highly unsupportive therapist behaviour, which is clearly unempathic. That is, such directive, controlling behaviours emerge from the clinician's imposition of his or her own perspective rather than attempting to understand the client's position or experience.

Indeed, research shows that clients, in addition to observers, tend to perceive more controlling, persuasive or dismissing therapist behaviours as unempathic (Henry, Schacht, & Strupp, 1986; Lorr, 1965; Watson, Enright, & Kalogerakos, 1998). In a qualitative study investigating clients' experiences of empathy in client-centered therapy, Myers (2000) found that failing to maintain eye-contact, interrupting, and dismissing the client's position while pushing the therapist's own agenda were all perceived by clients as being unempathic. In contrast, in this same study, clients perceived therapists as empathic when therapists were open to discussing any topic, non-judgmental, and attentive to details.

Taken together, these findings demonstrate that during moments of increased client opposition or ambivalence, therapists may become increasingly directive and controlling, and by extension, increasingly dismissive of the client's position. And while resistance may be particularly likely in CBT, given its highly directive focus, these patterns appear to be evident in *any* directive form of counseling when client ambivalence is encountered. Given the plethora of research delineating the nature of therapist empathy, there is strong theoretical and empirical reason to suspect that this ignoring of the client's position during moments of opposition may be experienced by clients as a lack of therapist empathy. It also seems that moments of resistance are particularly associated with unsupportive, directive therapist behaviour, compared to moments when the client is cooperative; thus further supporting a possible important link between resistance and client perceptions of empathy. Episodes of resistance, and their accompanying decline in therapist supportive behaviour, may be particularly important influences on client experiences of therapist empathy.

Why Would Therapist Empathy Decrease During Resistance?

In their review of research on negative process**,** Binder and Strupp (1997) observe and describe that human beings, even highly trained therapists, have difficulty in responding to interpersonal conflict in which they are participants. That is, as human beings, therapists commonly experience negative reactions to potentially difficult or provocative behaviours such as disagreement, opposition, challenging of the therapist or therapy, criticism, or even hostility (e.g., Fremont & Anderson, 1988; Henry & Strupp, 1994; Strupp & Williams, 1960). Moreover, during such moments, therapists have been observed to make attributions (i.e., blaming) to the motivational or interpersonal deficiencies of their clients (e.g., Binder & Strupp, 1997; Strupp & Williams, 1960). This is consistent with work by Coutinho, Ribeiro, Hill and Safran (2011)

examining therapist and client experiences of alliance ruptures. At these times, therapists were found to report many negative experiences including not knowing what to do in the moment, feeling ambivalent and confused, feeling guilty and incompetent, and feeling tense. Given this, Binder and Strupp (1997) contend that the therapist's ability to establish and maintain a positive therapeutic alliance when he or she inevitably encounters such behaviours has been vastly overestimated.

In addition to experiencing a natural difficulty dealing with interpersonal conflict, therapist negative reactions, and consequently directive, controlling responses to client resistance or opposition, may be particularly likely when working within the context of the CBT model. Within the CBT framework, opposition (e.g., homework noncompliance, disagreement with therapist advice, challenging the therapist/therapy) is regarded as a problem and an obstacle or "barrier" to successful treatment (e.g., Beck, 1995; Garland & Scott, 2007; Goldfried, 1982; Kazantzis & Shinkfield, 2007), and therefore would be highly susceptible to eliciting therapist behaviours (e.g., convincing, persuading, educating, etc.) intended to *overcome* or remove the obstacle. This conceptualization of resistance is in contrast to other models of therapy such as Psychodynamic Therapy (e.g., Messer, 2002) or Motivational Interviewing (MI; Miller & Rollnick, 2002; Westra, 2012) for example, in which client resistance and ambivalence are seen as containing important, even vital information in the change process.

As a result of the tendency to view resistance as problematic, CBT practitioners are trained to challenge resistance, with the ultimate goal of eradicating it in order to regain client adherence with the treatment procedures that are thought to be responsible for positive CBT outcomes. For example, CBT therapists facing resistance are often encouraged to persist with the standard application of cognitive-behavioural techniques, including challenging irrational beliefs or

cognitive distortions (Burns, 1989; Ellis, 1985; Leahy, 2001; Stevens, Muran, & Safran, 2003). Raue and Goldfried (1994) explain that when clients are reluctant to engage in particular tasks, such as homework, it is the CBT therapist's role to convince the client that complying with the task is in his or her best interest, thereby encouraging an attitude of friendly submission. They also suggest that it is paramount for the therapist to provide a clear rationale for his or her approach during moments of client reluctance or disengagement, and to strategize with the clients as to how they may overcome such "problems."

Given this, it is not surprising that CBT therapists have been found to become increasingly adherent to CBT protocol (even at the expense of appearing overly rigid or unempathic) during moments of sustained client resistance (e.g., Aspland et al., 2008; Castonguay et al., 1996; Ribeiro et al., 2014). Further, given that resistance in CBT (e.g., noncompliance, disengagement, withdrawal etc.), is seen as an impediment to treatment progress, engaging in behaviours such as "hearing," exploring, or empathizing with the client's opposition, might be perceived as encouraging or reinforcing these impediments, and consequently, a threat to effective CBT. As a result, when resistance is present, the CBT therapist tends to work hard to diminish this resistance, and his or her focus is to challenge the client at these times rather than providing increased empathy.

Aims of the Present Study

Previous research has consistently found that high levels of resistance are detrimental to therapeutic outcomes (e.g., Aviram & Westra, 2011; Beutler et al., 2011; Jungbluth & Shirk, 2009 etc.). Yet no previous study has explored precisely how resistance negatively impacts outcomes. Given research showing that therapist empathy tends to decrease during moments of client resistance or opposition (e.g., Aspland et al., 2008; Francis et al., 2005), the empirical

basis for investigating client perceived empathy as a potential mediator in the relationship between resistance and treatment outcome is strong. Importantly, *client* (rather than observer or therapist) ratings of empathy were used in the present study, since it is client perceptions of empathy that are the most strongly associated with outcomes in previous research (Barrett-Lennard, 1981; Bohart et al., 2002; Gurman, 1977; Orlinsky et al., 1994).

Data were collected from a recently completed randomized controlled trial (RCT) comparing CBT alone with Motivational Interviewing (MI) integrated with CBT, for severe GAD (Westra, Constantino, & Antony, 2015). Trained observer ratings of resistance were utilized to identify the level of resistance present in an early (i.e., prior to session 5) therapy session. Given previous research demonstrating that the coding of one early treatment session provides adequate information on which to base outcome predictions (Aviram & Westra, 2011; Westra & Arkowitz, 2010; Hara et al., 2015), together with findings showing that resistance levels tend to be highly correlated over time in therapy (e.g., early resistance with midtreatment resistance; Button, Westra, Hara, & Aviram, 2015), one *early* therapy session was coded for each client. Client immediate post-session ratings of therapist empathy for the coded session were utilized (e.g., if session 3 was coded for resistance, then the post-session 3 ratings of empathy were utilized etc.). Treatment outcome was assessed through client-rated worry severity at posttreatment and at one-year posttreatment. Since empathy was measured at every other session, and session 1 ratings were used as a control for baseline levels of client perceived empathy, only sessions 3 or 5 were utilized in the present study. It was hypothesized that:

(1) Higher levels of resistance within a session would be negatively associated with post-session client-rated empathy, even when accounting for baseline levels of client-rated empathy.

(2) Client-rated empathy would mediate the relationship between higher levels of resistance and poorer treatment outcomes.

Method

Data for the present study were derived from a larger RCT investigating an integrated treatment of MI and CBT with CBT alone for severe GAD (Westra et al., 2015). Given that levels of resistance have been shown to systematically differ between MI and CBT groups (Aviram & Westra, 2011) and was virtually absent in the MI-CBT group of the larger trial (Westra, personal communication, January 5, 2015), only therapist-client dyads in the CBT alone group ($N = 44$) were analyzed for this study. The low levels of resistance in MI-CBT are likely due to the systematic training in the recognition and minimization of resistance as a key therapy goal (Westra, 2012).

Participants

Participants were recruited from community advertisements in the greater Toronto area. All participants were enrolled in the study for an 18-month period from February 2012 to July 2013. In order to participate in the study, participants were required to pass the initial telephone screen, which emphasized the criteria for GAD. Those who scored above a cutoff for high severity GAD during the phone screen, as assessed by a *Penn State Worry Questionnaire* (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) score of 68 or higher (out of a possible 80), were invited to complete a Structured Clinical Interview for Diagnosis IV (SCID IV; First, Spitzer, Gibbon, & Williams, 1996). The proposed criteria for the diagnosis of GAD in Version V of the Diagnostic and Statistical Manual of Mental Disorders (DSM) were also utilized in the interview to ensure that all participants met both DSM-IV and DSM-V criteria for a principal diagnosis of GAD (American Psychiatric Association, 1994). The PSWQ was re-administered

during the diagnostic interview, and only those participants scoring above the cutoff for high severity GAD were considered eligible to participate in the study. Given the high rate of comorbidity between GAD and depression, participants with other comorbid disorders were also considered eligible for the study provided that GAD was their principal diagnosis based on level of impairment. The inter-rater reliability of a random sample of 25% of audiotaped interviews for those participants who were successfully enrolled in the study indicates good consistency, with an overall kappa for all diagnoses of .87 and .95 for GAD specifically.

Participants were excluded from the study if there was evidence of substance dependence within the past six months, a neurological problem, major cognitive impairment, learning disability, significant current suicidal ideation, history of a psychotic or bipolar mood disorder, or below criterion proficiency in English language. Clients agreed to refrain from receiving any concurrent psychotherapy during the acute treatment phase of the study or from taking benzodiazepine medications. If clients were concurrently using antidepressant medications (n = 15), they were required to be on a stable dose at study entry (i.e., at least three months) and to remain on that dosage throughout the study. Individuals who recently discontinued an anti-depressant medication were required to be off of the medication for at least three months. Those who were unmedicated were required to remain unmedicated for the duration of their treatment.

Therapists. There were a total of 13 CBT therapists (all female) in the present study, including 12 doctoral candidates in clinical psychology and one postdoctoral psychologist. Each therapist saw between one and seven clients, with a median number of three clients per therapist. In order to control for allegiance effects and to ensure that therapists did not deliver a treatment in which they did not believe, therapists were nested within treatment group in the larger RCT

(Westra et al., 2015). Thus, CBT therapists exclusively delivered CBT. In the larger RCT, therapists also self-selected into treatment condition (MI-CBT or CBT alone).

Therapists' training involved readings and a four daylong workshop including role-play and discussion, followed by one practice case with extensive feedback and video supervision. All therapists were deemed competent in the delivery of CBT. Therapists also received supervision for all study cases, which consisted of videotape review and weekly individual meetings with one senior CBT psychologist and one postdoctoral fellow.

CBT Treatment

Treatment involved 15 weekly sessions of CBT. The treatment manual was constructed from several evidence-based protocols (e.g., Coté & Barlow, 1992; Craske & Barlow, 2006; Zinbarg, Craske, & Barlow, 2006), and consisted of psychoeducation regarding anxiety and worry, training in self-monitoring, progressive muscle relaxation, cognitive restructuring (e.g., probability overestimation and catastrophic thinking), and one or more additional behavioural strategies (e.g., behavioural experiments, reduction of worry behaviours, imaginal exposure to feared outcomes). Sleep strategies were also discussed in session based on work by Carney and Edinger (2010). Relapse prevention was discussed and a relapse plan was developed at session 14. All therapists were required to implement treatment in a particular order, with progressive muscle relaxation first, cognitive restructuring second, and behavioural strategies third. The length of time therapists spent delivering each component, however, was left to their discretion based on the client's needs and responsiveness to each element of treatment. Homework was routinely determined and common homework activities included self-monitoring, relaxation practice, thought-records, and eliminating worry behaviours, among others. In order to ensure consistency in the management of homework noncompliance, procedures for managing this in a

CBT-consistent manner were explicitly utilized (e.g., Beck, 2005; Kazantzis & Shinkfield, 2007; Tompkins, 2004; Waters & Craske, 2005). This included integrating strategies that would help in the prevention of homework noncompliance (e.g., working collaboratively to develop homework, anticipating obstacles to homework completion etc.), and responding to noncompliance (e.g., validating the difficulty of completing homework, empathizing with the reasons for noncompliance, providing psychoeducation about the utility of homework, problem-solving obstacles etc.).

Measures

Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990). The PSWQ is a widely used 16-item measure assessing trait worry on a 5-point likert scale, employed in the larger RCT and in the current study as the principal outcome measure. The PSWQ demonstrates high internal consistency (Cronbach's α of .93 for all anxiety disorders, and .86 for GAD) and temporal stability, as well as good convergent and discriminant validity (Brown, Antony, & Barlow, 1992; Meyer et al., 1990). This instrument has been found to effectively differentiate individuals with GAD from those with other anxiety disorders and healthy controls (Brown et al., 1992). Total scores on the PSWQ range from 16 to 80, with higher scores reflecting greater worry. The average Cronbach's α for the current study was .62 at baseline, and ranged from .95 to .96 at posttreatment and follow-up assessments.

Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962). The BLRI is an extensively used relationship measure, which served as the primary measure of client-rated therapist empathy in the present study. This pantheoretical instrument is comprised of 64-items rated on a 6-point scale ranging from strong agreement (+1 to +3) to strong disagreement (-1 to -3). The BLRI assesses the conditions necessary for client change as explicated by Rogers (1957):

therapist empathy, unconditionality, positive regard, and congruence; thus consisting of four subscales. A total score for the BLRI is obtained by summing the scores on all four subscales, with each scale score ranging from -3*n* to +3*n*, where *n* is the number of scale items. Given the current study was interested in client-rated therapist empathy, the 16-item empathy subscale was utilized exclusively, and possible scores ranged from -48 to +48. Sample items include: "_____wants to understand how I see things" and "_____ usually senses or realizes what I am feeling" (Barrett-Lennard, 1962).

The BLRI has been shown to have high convergent validity with the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), and excellent split-half and test-retest reliability, with scores ranging from .86 to .92 for the four subscales (Barrett-Lennard, 1962; Hollenbeck, 1965). Moreover, it has been effectively used in the measurement of clinical, educational, and family relationships (Hollenbeck, 1965; Simmons, Roberge, Kendrick, & Richards, 1995). Gurman (1977) found the empathy subscale to have a mean internal consistency coefficient of .84 across 14 studies, and a mean test-retest reliability coefficient of .83 across 10 studies. The average Cronbach's α for the BLRI empathy subscale in this study was .85 at session 1, .90 at session 3, and .91 at session 5.

Adapted Client Resistance Code (Westra et al., 2009). In order to measure the amount of resistance in a given therapy session, observer ratings of resistance were used. Coders used an adapted version (Westra et al., 2009) of the Client Resistance Code (CRC; Chamberlain et al., 1984) to code an early CBT session (i.e., session 3 or 5) for resistance. The CRC is a process-based coding system, applicable to various treatment approaches. According to the CRC, resistance is defined as any behaviour that opposes, blocks, diverts or impedes the direction of the therapist. Client resistance is conceptualized to reflect a client's engagement (on a moment-

to-moment basis) with the process of therapy, rather than a static client characteristic. Resistance may be expressed directly (e.g., "I don't want to do thought records") or more commonly, indirectly (e.g., ignoring, interrupting, or disagreeing). The CRC is comprised of 11 categories of resistant behaviour (e.g., disagreeing, challenging, sidetracking, interrupting, ignoring etc.) and has been demonstrated to have good construct and predictive validity (Chamberlain et al., 1984; Patterson & Forgatch, 1985), as well as face and content validity (Bischoff & Tracey, 1995). Higher levels of resistance have been associated with poorer psychotherapy outcome and client retention (Chamberlain et al., 1984; Jungbluth and Shirk, 2009).

In the adapted version, while the central definition of resistance is the same, the coding was altered to enhance reliability and validity (Westra et al., 2009). First, the 11 subcategories of the CRC were collapsed to form a single resistance code, given the presence or absence of resistance in general was of primary importance (i.e., the total frequency of 1s, 2s, 3s) rather than the particular type of resistance present. In addition, using a global definition of resistance aids in helping to achieve reliability among coders in identifying complex and highly nuanced processes such as resistance. That is, attaining reliability on a single code is more likely than on multiple codes. Second, videotapes of sessions were segmented into 30-second time bins, instead of using transcripts and segmenting sessions into turns-of-talk units. The length of the time bins was selected given 30-seconds is long enough to capture the construct of interest (i.e., resistance), and short enough to ensure valid coding.

Procedure

Resistance Coding. Each 30-second time bin was coded for the presence of resistance on a 4-point scale ranging from 0 to 3. Zero indicates the absence of resistance (i.e., client is cooperative). A code of 1 reflects minimal or qualified resistance, either in process (e.g., "polite"

or gentle responses where the client is being evasive or non-direct, and not sending a clear message that he/she is going along with therapist) or in content (e.g., “I fill out the thought records, and they help, but don’t fix it”). A code of 2 indicates clear and unequivocal resistance in process (e.g., interrupting in order to oppose, ignoring, not responding) or in content (e.g., clearly and unequivocally expressed doubts or disagreements; “Relaxation does not work for me” or “I hate completing thought records”). Finally, a code of 3 represents hostile or confrontational resistance, either in process (e.g., responses that are clearly overly firm), or in content (e.g., “You’ve got your work cut out for you with me!”).

The team of resistance coders was comprised of three graduate students in clinical psychology (two Doctoral, one Master’s level) and one PhD psychologist. Two of the coders were involved in adapting the CRC for use with CBT for GAD, and the remaining two coders were trained to criterion over a period of 10 months. Coders were required to read the *Manual for Rating Interpersonal Resistance* (Westra et al., 2009), and to participate in a two-day workshop where they coded samples of publicly available therapy sessions and session videotapes from a previous RCT of CBT for GAD (Westra, Arkowitz, & Dozois, 2009). Subsequently, the coders were required to independently code new practice sessions, and to meet weekly to review coding discrepancies until they achieved proficiency as assessed by 85% observed agreement. Coders remained blind to the clients’ outcome status throughout the coding process. In order to reduce the possibility of coder drift, inter-rater reliability was calculated throughout the coding process by double coding 20% of all recordings. Weighted kappa coefficients were calculated for each pair of raters and ranged from .70 to .98, with a mean of .85, indicating good to excellent agreement (Fleiss, 1981).

Clients completed empathy ratings immediately following every other therapy session in the larger RCT, beginning with session 1. Trained observers coded resistance in one randomly selected session in the early phase of treatment (session 3 or 5), and the corresponding client ratings of therapist empathy for the coded session were used. Given previous research indicating that clear, unequivocal resistance (a code of 2) and hostile resistance (a code of 3) are significantly associated with treatment outcomes (Aviram, Westra, & Eastwood, 2011; Hara et al., 2015), the present study only considered the frequency of clear and hostile resistance in observer coder ratings. That is, each time bin could receive a code of 0, 1, 2, or 3, and only those time bins receiving a code of 2 (clear resistance) or 3 (hostile resistance) were considered in the present study. The frequency of clear or hostile resistance was calculated by dividing the number of 30-second time bins containing a code of 2 or 3 by the total number of time bins in the session. Clients completed the PSWQ at baseline, posttreatment, and follow-up assessments.

Informed consent was obtained at the time of initial study intake for all measures and procedures. A local institutional ethics review board for research involving human participants approved all study measures and methods.

Results

Multilevel Modeling (MLM) was used to examine the relationship between resistance and client-rated empathy, in addition to the potential mediating effect of client-rated empathy between resistance and treatment outcomes. MLM was selected as the parametric procedure given the hierarchal structure of the data; that is, clients ($N = 44$) were nested within therapists ($n = 13$). Given that several clients received CBT treatment from the same therapist, group mean centering across all therapists was utilized in all MLM analyses to account for both within and between group differences in observed resistance and/or empathy ratings (Enders & Tofighi,

2007). Upon inspection, the residuals for the random-intercepts models used in the MLM analyses (e.g., models for Hypothesis 1 and 2), were found to be approximately normal.

Client demographics, including means and standard deviations for all study measures, are presented in Table 1. The study sample was mainly female and Caucasian, with a mean age of 34 years, a high rate of diagnostic comorbidity, and most with at least some postsecondary education.

Correlations between the various measures used in the present study are presented in Table 2. Of note, higher observed resistance was significantly negatively correlated with subsequent client-rated empathy (BLRI S3 or 5), and positively correlated with PSWQ scores at posttreatment and at one-year posttreatment. That is, greater resistance was found to be significantly associated with lower client-rated empathy and greater posttreatment worry. Baseline ratings of client-rated empathy were very highly positively correlated with client subsequent ratings of empathy (at session 3 or 5), and negatively correlated with posttreatment worry. Finally, client ratings of therapist empathy at session 3 or 5 were also significantly negatively correlated with PSWQ scores at posttreatment.

Hypothesis 1: Higher levels of resistance would be negatively associated with post-session client-rated empathy, even when accounting for baseline levels of client-rated empathy.

A random-intercepts model for the regression of BLRI (S3 or S5) on observed resistance in that session, while accounting for baseline levels of client-rated empathy, is presented in Table 3. Overall, higher resistance was significantly predictive of lower client-rated empathy at the end of the session, even when accounting for baseline client-rated empathy. In particular, the within group resistance variable (RESc; $t = -2.33$, $p = 0.027$) significantly predicted client-rated empathy. This indicates that while accounting for baseline client ratings of therapist empathy, the

amount of observed resistance for a particular client significantly predicted his or her ratings of therapist empathy at the end of the session. More specifically, for every one percent increase in observed resistance, corresponding post-session BLRI ratings are predicted to decrease by 0.19 points, as indicated by an estimated Fixed Level 1 slope value of -0.19. An R^2 measure using within residual variance and intercept between residual variance of the regression of BLRI on resistance variables demonstrated that 10% of the variance in client ratings of therapist empathy ($R^2 = 0.10$) is accounted for by observed resistance.[1]

Notably, the between group resistance variable (mRES; $t = -0.42$, $p = 0.678$) did not significantly predict client post-session ratings of therapist empathy. This indicates that there were no therapist effects of resistance on empathy in this sample. In other words, the therapists in this sample did not differ substantially in the level of empathy they engendered based on the average level of resistance (Enders & Tofighi, 2007).

Hypothesis 2: Client-rated empathy would mediate the relationship between higher levels of resistance and poorer treatment outcomes.

A random-intercepts model was also utilized to calculate the regression of post-resistance client-rated empathy on treatment outcomes, beyond baseline client ratings of therapist empathy. To test the hypothesized mediating effect of client-rated empathy on the relationship between resistance and treatment outcomes, within and between group resistance variables were included in the model, as well as baseline PSWQ ratings. The random-intercepts models used to test the mediating effect of client-rated empathy between resistance and treatment outcomes are presented in Table 4. Overall, client-rated post-resistance empathy did not mediate the

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[1] An R^2 measure using within residual variance and intercept between residual variance of the regression of BLRI on baseline BLRI ratings showed that 66% ($R^2 = 0.66$) of the variance in BLRIS3 or S5 scores may be accounted for by baseline ratings (BLRI S1) of client perceived empathy.

relationship between resistance and posttreatment worry outcomes because the hypothesized mediator (client ratings of empathy post-resistance) did not significantly predict posttreatment (BLRIc $t = 0.11$, $p = 0.917$; mBRLI $t = -1.03$, $p = 0.312$) and one-year posttreatment (BLRIc $t = -0.10$, $p = 0.918$; mBLRI $t = -0.38$, $p = -0.711$) worry outcomes. That is, client ratings of therapist empathy post-resistance did not *uniquely* predict PSWQ outcomes at posttreatment or at one-year follow-up, beyond resistance, baseline empathy and PSWQ ratings.

Discussion

The current study examined the impact of resistance on client perceptions of therapist empathy, and assessed whether client perceived empathy mediated the relationship between observed resistance and posttreatment outcomes. Results provided support for the hypothesized relationship between resistance and empathy, demonstrating that resistance was significantly associated with lower client post-session ratings of therapist empathy, above and beyond clients' baseline empathy ratings. Moreover, observed resistance was found to account for 10% of the variance in client ratings of therapist empathy. This proportion of variance is notable when considering that baseline empathy ratings were a very strong predictor of client empathy ratings, predicting 66% of the variance (i.e., it is very difficult to predict future empathy ratings from anything beyond previous ratings).

Although observed resistance and clients' BLRI ratings were also significantly correlated with posttreatment outcomes, contrary to the hypothesis, this drop in client ratings of therapist empathy following higher levels of resistance did not mediate the relationship between resistance and treatment outcomes. That is, client post-resistance ratings of therapist empathy does not account for the impact of resistance on outcomes.

Resistance is Associated with Lower Perceived Empathy

The results of the present study provide strong support for the hypothesized link between resistance and empathy in psychotherapy, and underscore the adverse impact of resistance on client perceptions of therapist empathy in CBT. This study corroborates existing observational research documenting therapist deleterious behaviour during resistance or breakdowns in the therapeutic alliance (e.g., Aspland et al., 2008; Castonguay et al., 1996; Francis et al., 2005; Ribeiro et al., 2014). The present study extends these findings by demonstrating that observer ratings of decreased therapist empathy following resistance (e.g., Castonguay et al., 1996; Francis et al., 2005; Miller et al., 1993 etc.) effectively translate into *client* perceptions of lack of empathy. That is, while it has been demonstrated in the literature that CBT therapists become increasingly directive (e.g., persuasive, challenging, agenda-driven), and less supportive/empathic during moments of increased resistance, the current study was the first to empirically demonstrate that in fact, client ratings of therapist empathy decrease following moments of observed resistance. This is particularly important given that it is *client* perceptions, as opposed to therapist perceptions of empathy, that have been consistently related to therapeutic outcomes in the literature (e.g., Elliott et al., 2011; Moyers & Miller, 2013).

The present findings also suggest that the processes that occur during moments of resistance in CBT have a robust capacity to impact clients' perceptions of therapist empathy irrespective of their initial perceptions of the therapists' empathic ability (i.e., baseline ratings of the initial empathic climate as rated by the client). In other words, even if a client perceives his or her therapist to be reasonably empathic following session 1, these results suggest that the presence of resistance later in therapy has the capacity to negatively shift this initial perception. Further, it is currently not entirely clear in the literature as to what influences client perceptions

of empathy. The present study partially provides an answer to this important question by demonstrating that disruptions in the therapeutic alliance are a key influence on client feelings of being understood. This is particularly significant given the importance of empathy, especially client perceived empathy, in predicting successful psychotherapy processes and treatment outcomes (Greenberg et al., 1993; Linehan, 1997; Mahoney, 1995; Watson, 2002).

Studies strongly and consistently demonstrate that empathy is among the most potent predictors of successful psychotherapy, found to account for up to 10% of the variance in outcomes irrespective of the theoretical approach used (e.g., Bohart et al., 2002; Duan & Hill, 1996; Greenberg et al., 2001; Horvath & Bedi, 2002; Martin et al., 2000; Orlinsky et al., 1994; Patterson, 1984 etc.). Moreover, empathy in psychotherapy has been widely regarded as key in the development of a strong therapeutic alliance (e.g., Barrett-Lennard, 1997; Horvath & Greenberg, 1989; Rogers, 1980; Watson, 2002), and has been identified as an active ingredient and consistent predictor of client change (Rogers, 1975; Taylor, 1990; Westra, 2012). Regardless of the theoretical orientation used, high empathy counselors have been found to have higher success rates than low empathy counselors, whose work has been linked to higher drop-out, weaker working alliances, and less client change (Moyers & Miller, 2013).

In addition to being associated with more positive psychotherapy outcomes, perceiving one's therapist as highly empathic has been reliably shown to affect other key psychotherapy processes as well, including decreases in negative self-treatment, enhancements in clients' affect regulation, increases in the development of self-empathy, and significant improvements in insecurity, among others (Watson, 2002; Watson et al., 2014). Given its predictive capacity, it is not surprising that client perceived empathy in the current study was related to posttreatment outcomes, including post-session 1, 3, and 5 ratings.

In their work examining empathic relational bonds and personal agency in psychotherapy, Angus and Kagan (2007) outline the importance of empathic attunement in enabling clients to disclose specific, emotionally salient stories to the therapist (Angus & Hardtke, 2006), in sustaining clients' self-reflection and heightened personal agency (Bandura, 2006), and in positively enhancing client expectations for change and motivation for engagement (Westra, 2004). Thus, the negative impact of resistance on empathy may also indirectly adversely impact other important processes in treatment as well. Identifying one context (i.e., resistance) which seems to significantly inform clients' perceptions of empathy may be an important step in ultimately facilitating more positive relational climates in psychotherapy, ones in which resistance is appropriately managed (i.e., using support and empathy) and within which clients' psychotherapeutic gains (e.g., decreases in negative self-treatment, increased personal agency, more positive working alliance) may be preserved.

Revisiting Resistance as a Key Clinical Phenomenon

It is also interesting to note that resistance is typically rare compared to cooperation. For example, in the present study resistance occurred on average in only 14% of all 30-second time bins in a given session. Despite its rarity, however, observed resistance significantly predicted lower client ratings of therapist empathy in the current study. This finding is in line with work by Hara and colleagues (2015) demonstrating that observer ratings of resistance, as opposed to therapist ratings, were highly and consistently related to both proximal (therapeutic alliance and homework compliance) and distal (posttreatment worry severity) treatment outcomes. Thus, albeit rare and infrequent, resistance represents a key and important phenomenon, which holds tremendous capacity to derail important psychotherapeutic processes. These observations have recently been validated by Zickgraf and colleagues (2015) using the Westra and colleagues

(2009) resistance coding system, who also found that even though resistance was rare, it had a strong and consistent capacity to negatively impact CBT therapists' adherence to CBT. In particular, researchers found that the higher the client's resistance, the less adherent the therapist was to the CBT model, and the more the therapist resorted to interventions outside of the model.

In keeping with previous research (e.g., Ahmed et al., 2012; Arkowtiz & Westra, 2004; Aspland et al., 2008; Castonguay et al., 1996; Newman, 1998 etc.), this study also suggests that during moments of resistance, CBT therapists may behave in ways that *pull* for their clients to perceive them as unempathic. And while therapists' direct responses to client resistance were not measured in the current study, clients clearly interpreted therapists' responses to their opposition as unempathic. Based on existing observational research examining CBT therapists' responses to client opposition (e.g., Aspland et al., 2008; Castonguay et al., 1996; Francis et al., 2005; Ribeiro et al., 2014), therapists typically respond to resistance by increasing direction, arguing, withdrawing, or focusing less on exploration or client validation. Given that resistance is reliably associated with increased risk of producing the specific behaviours that clients find unempathic (Henry et al., 1986; Lorr, 1965; Myers, 2000; Watson et al., 1998), it is not surprising that following resistance in the present study, clients felt their therapists were significantly less empathic and rated their level of empathy as such.

Interestingly, work by Viklund, Holmqvist, and Nelson (2010) demonstrates that when asked to identify key moments in therapy, clients are most likely to recall moments in which there was disagreement between the client and therapist (e.g., the therapist failed to understand the client's perspective/objection). This finding suggests that clients may be particularly inclined to remember moments in which the therapist has responded to their objections (resistance) by being increasingly rigid or unempathic. Thus, compared to moments where the client is

cooperative, therapist behaviours during or following resistance appear to be critical in informing clients' perceptions, and represent key process phenomena that have the capacity to largely inform psychotherapy practice and training.

Why Would Post-Resistance Empathy Not Mediate Outcomes?

Surprisingly, even though resistance was significantly negatively associated with client perceived empathy, and empathy was correlated with outcomes at posttreatment, client post-resistance ratings of therapist empathy were *not* found to mediate the relationship between observed resistance and posttreatment outcomes. In other words, the negative impact of resistance on empathy does not seem to be responsible for the deleterious impact of resistance on treatment outcomes.

One possible explanation for the lack of findings regarding mediation might be that foundational empathy that is established in the therapy relationship (i.e., client ratings of therapist empathy post-session 1) is more central to treatment outcomes than the drop in empathy associated with resistance. In other words, client experienced empathy may be shaken significantly by higher levels of disharmony in the relationship (resistance), but perhaps not injured to the point of endangering outcomes. This suggests a certain stability to the empathy that is established early in the relationship in CBT, and this was supported in the present study by a strong predictive capacity of early empathy to predict later empathy ratings. If future research finds a similar pattern, it would suggest that even though resistance seems to be associated with lower client perceived empathy, the harmful potential consequences of this may be obviated somewhat by the level of the empathic foundation that is established early in the relationship.

Although it is possible, it is difficult to imagine that the negative impact of resistance on empathy is unimportant. Alternatively, it is also possible that the impact of *sustained* or *repeated*

resistance on empathy may mediate the relationship between resistance and treatment outcomes more so than one early instance of resistance. This interpretation is consistent with existing research (e.g., Button et al., 2015) demonstrating that resistance tends to be highly correlated over time. Thus, future research could examine whether the negative impact of repeated injuries to empathy might be more impactful to outcome than lowered perceptions of therapist empathy following an early session containing high levels of resistance.

Another explanation for the lack of findings regarding mediation might be that empathy is part of a larger, more complex pathway between resistance and treatment outcomes. In other words, lowered empathy as a result of resistance may be one link in a chain of influences on outcome. For example, observed resistance may negatively impact perceived empathy (demonstrated in the current study), which in turn impacts other variables, such as client outcome expectations, the therapy alliance, or client agency, which *then* impacts treatment outcomes. That is, the effect of resistance on empathy may indirectly impact outcomes vis-à-vis negatively impacting other variables, which *together* are deleterious to treatment outcomes. In order to elaborate what such a chain of events may look like, below I will elaborate on one prime candidate in this regard: the common factor of outcome expectations.

Resistance, Empathy, and Outcome Expectations

A number of studies have demonstrated that addressing clients' outcome expectations is a critical clinical process, with the potential of leading to enhanced therapeutic alliances, better treatment outcomes, and decreased premature termination of psychotherapy (e.g., Constantino, 2012; Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011; Constantino, Castonguay, Zack, & DeGeorge, 2010; Joyce & Piper, 1998). In particular, Swift and Derthick (2013) identify increasing a client's faith in the therapist to be one key way in which client outcome expectations

may be enhanced. Moreover, they indicate that perceiving the therapist as trustworthy (influenced by warmth, genuineness and empathy) is critical in enhancing a client's faith in his or her therapist (Strong, 1968). Similarly, Angus and Kagan (2007) underscore the role of therapist empathy in enhancing a client's belief in the treatment and motivation for engagement, which may largely drive therapy outcomes. And work by Constantino (2012) highlights the importance of an engaged relationship (affiliative, collaborative, purposeful), and by extension inherently empathic, in facilitating a client's belief in achieving positive outcomes, such as psychological improvement.

It is possible then that upon perceiving their therapists as less empathic following moments of resistance in CBT, clients may lower their beliefs in the therapist's ability to help them, or in the treatment more generally. According to Frank and Frank (1991), clients tend to enter psychotherapy in a state of *demoralization*, often feeling powerless and unable to change their problem or situation. Psychotherapy provides a healing context and a confiding relationship that can be used to enhance clients' expectations for treatment and faith in themselves. Frank and Frank (1991) contend that it is these outcome expectations that help restore a client's sense of agency and power in changing his or her own circumstance, and that ultimately drive treatment outcomes.

Thus, it is possible that a client may lose faith in the treatment if his or her therapist fails to listen and/or to integrate the client's feedback/wishes. This may be especially true since in our experience, very often the nature of client opposition centers on desires to make course corrections or to redirect the therapy/therapist (e.g., "I didn't do/like the homework", "Relaxation doesn't work for me", "I don't believe that balanced thought" etc.). In other words, although not exclusively so, resistance often directly or indirectly centers on the tasks of treatment and client

wishes and attempts to influence the direction of the therapist/treatment. If the client is repeatedly dismissed or ignored at these times, with the therapist continually pursuing his or her own path and becoming more rigid and controlling at these junctures (i.e., unempathic), the client would likely perceive a lack of mastery or an inability to shape or influence the treatment process, and accordingly, lose confidence in the treatment. This impact on outcome expectations then might significantly impact treatment outcomes, thereby representing a more complex meditational pathway than a direct impact of post-resistance empathy on outcomes.

In partial support of this line of reasoning, Ahmed, Westra, and Constantino (2012) demonstrated a link between therapists' empathic/supportive management of resistance and client outcome expectations in the context of CBT. Specifically, evidence of greater relational conflict and interpersonal tension during resistance was found more often in therapist-client dyads in which the client went on to have low outcome expectations. In contrast, therapist behaviours in the high expectations group when resistance was present were characterized by a greater focus on understanding and communicating empathy, actively listening and validating the client, and less time teaching, guiding or directing the client. Thus, control and influence (i.e., a lack of empathy and understanding) during resistance may alienate the client and lower his or her belief in the efficacy of the treatment, which in turn, may negatively impact his/her treatment outcomes (Westra, 2012). This possible pathway should be explored in future studies.

Clinical Implications

Overall, the findings of the current study underscore the importance of identifying resistance as a key phenomenon and process marker in psychotherapy capable of influencing client perceptions of therapist empathy. The current study highlights the importance of therapist in-session sensitivity to resistance, and emphasizes the ways in which resistance may pull for

decreased therapist empathy in the context of CBT. Moreover, the present study demonstrates the importance of increased therapist empathy precisely at times when therapists may be least inclined to do so (i.e., during moments of resistance). Given research demonstrating that empathy contributes to the facilitation and establishment of core 'common factors' of change (e.g., stronger working alliance, belief in treatment, sense of mastery or agency, engagement in the treatment etc.; Ahn & Wampold, 2002; Castonguay & Beutler, 2006; Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2007, Westra, 2004), any steps towards enhancing therapist awareness of and responsiveness to resistance may improve clients' perceptions of therapist empathy, and ultimately enhance the psychotherapy process.

Given that therapists have been shown to experience difficulty navigating negative processes in psychotherapy (Binder & Strupp, 1997; Hill et al., 1992; Hunsley et al., 1999; Todd, Deane, & Bragdon, 2003), and clients do not freely or openly express their concerns about therapy (Rennie, 1993; Rhodes et al., 1994), this study encourages therapists to pay increased attention to signals of disharmony or noncollaboration. In line with findings by Hara and colleagues (2015), which demonstrated that when compared to observer ratings of resistance, therapist ratings of resistance failed to relate to key proximal and distal therapy outcomes, this study supports therapists' difficulty in identifying negative interpersonal processes. Interestingly, there is evidence to suggest that enhancing therapist awareness of negative treatment processes can improve treatment outcomes. For example, Lambert and colleagues (2001) and Whipple et al. (2003) demonstrated that making therapists aware of difficulties in treatment by giving therapists feedback when cases are failing improves client outcomes.

In addition to encouraging therapist awareness of resistance and its impact on perceived empathy, this study underscores the importance of *responding* flexibly and empathically to

resistance within the CBT context. As outlined by previous researchers (e.g., Beck, 1995; Garland & Scott, 2007; Goldfried, 1982; Kazantzis & Shinkfield, 2007) resistance in CBT is often conceptualized as an "obstacle" to be overcome rather than a normal part of the process of change (Westra, 2012). As a result, CBT therapists have been found to increase their use of directive and action-oriented techniques when faced with resistance, and this response has been found to exacerbate resistance compared to more supportive approaches (e.g., Aspland et al., 2008; Castonguay et al., 1996; Ribeiro et al., 2014). Hence, the findings of the present study encourage CBT therapists to reframe resistance as arising from inappropriately timed therapists' directive responses, rather than as a barrier or threat to effective intervention (Westra, 2012). Moreover, these findings support the use of therapist empathy/support rather than direction in responding to resistance in CBT, which involves working more intently during *or* following moments of client ambivalence or opposition to demonstrate empathy and understanding.

Indeed, models of effectively responding to resistance are emerging. For example, Motivational Interviewing (MI; Miller & Rollnick, 2002) is centered on the effective management of resistance, and emphasizes the importance of therapist responsivity (Stiles, Honos-Webb, & Surko, 1998) to moment-to-moment motivational markers in treatment (e.g., Constantino, Boswell, Bernecker, & Castonguay, 2013; Miller & Rollnick, 2013; Westra, 2012). Within the MI framework, when a client expresses ambivalence about change or resistance to treatment, therapists are encouraged to 'roll with' the resistance rather than to confront or challenge it (Miller & Rollnick, 2002; Westra, 2012). Moreover, ambivalence or resistance is seen as a normal part of the change process, and is not pathologized (Miller & Rollnick, 2002). Thus, CBT therapists who are able to effectively identify and manage signals of client resistance

may improve their performance at key moments, thereby enhancing client perceptions of empathy and psychotherapy process and treatment outcomes.

Strengths, Limitations, and Future Directions

The present study was the first to explore the impact of resistance on client perceived empathy in CBT for GAD. It is novel in that the study examined perceived empathy via client, rather than therapist or independent observer ratings. Moreover, a rigorous and valid system was used to code resistance. Empirically, this study is consistent with and validates observational research demonstrating that therapist behaviour becomes less supportive/empathic during moments of resistance (e.g., Ahmed et al., 2012; Castonguay et al., 1996; Francis et al., 2005; Ribeiro et al., 2014). Importantly, the present study also addressed an important gap in the literature by examining one pathway through which resistance impacts therapy outcomes (i.e., client perceived empathy). Finally, a major strength of the current study was its use of Multilevel Modeling, which considered and accounted for the nested nature of the data.

In terms of limitations, this study exclusively examined those with GAD in the context of CBT. It would be important to assess whether these findings extend to other clinical populations beyond GAD and to other treatment approaches outside of CBT. In addition, the sample size in the current study was relatively small, and future studies should consider using larger sample sizes to test the phenomena under examination. It may also be that examining resistance and empathy at an early time-point in psychotherapy (i.e., session 3 or 5) may have been a limitation in the current study. That is, the sustained, or *incremental* effect of *repeated* resistance on empathy may play a more significant role in mediating the relationship between resistance and treatment outcomes, compared to empathy ratings following an early session in which resistance

was present. Accordingly, future studies should examine the impact of sustained and repeated resistance on client ratings of therapist empathy.

Furthermore, while both resistance and empathy are conceptually and theoretically closely related constructs, for the purposes of the current study and consistent with previous literature (e.g., Francis et al., 2005; Miller et al., 1993, Patterson & Forgatch, 1985 etc.), resistance and empathy were conceptualized and measured as two distinct concepts. To the extent that resistance and empathy overlap or represent facets of the same construct, measuring the two as separate variables in the present study could be considered a limitation. Moreover, having client ratings of therapist empathy *between* time-points in the current study (i.e., between baseline and session 3 or 5) would have been useful. That is, we have interpreted decreases in client ratings of therapist empathy in the current study to be associated primarily with the presence of resistance. And while 10% of the variance in client post-session ratings of therapist empathy was found to be accounted for by resistance, suggesting a unique impact of resistance on client post-session ratings of therapist empathy, this drop in client ratings may have been due to other factors (i.e., other than resistance) that may have occurred between session 1 and session 3 or 5. Future studies should aim to measure empathy and resistance at closer time points throughout therapy to circumvent this limitation.

Finally, given that resistance was found to be significantly negatively associated with client perceptions of therapist empathy in the current study, and yet empathy was not found to mediate the relationship between resistance and treatment outcomes, future studies should examine other pathways through which resistance may impact outcomes. These pathways may include empathy and client outcome expectations, the therapy alliance, or client agency. Examining such pathways may help to answer the question of *how* resistance negatively impacts

treatment outcomes, and may shed light on how we may rectify the toxic effect of resistance on outcomes.

Conclusions

To our knowledge, this is the first study to examine the relationship between observed resistance and client perceived empathy by using client ratings of empathy. Observed resistance was found to be significantly negatively associated with clients' post-session ratings of therapist empathy, but client perceived empathy was not found to mediate the relationship between resistance and treatment outcomes. This study underscores the link between resistance and empathy in psychotherapy, and suggests that perceived therapist empathy may be a part of a more complex meditational pathway between resistance and treatment outcomes. This study makes a significant contribution to our understanding of resistance in CBT, and validates existing observational research demonstrating that CBT therapists respond to resistance by becoming increasingly directive and less supportive/empathic (e.g., Ahmed et al., 2012; Aspland et al., 2008; Castonguay et al., 1996 etc.). In doing so, the present study suggests that there is a critical need to enhance therapist in-session responsivity to resistance in psychotherapy practice and training, particularly given that this phenomenon tends to be rare and infrequent, but nonetheless disrupts important therapy processes.

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Table 1

Sample Characteristics

Measure	CBT (*N* = 44)
Penn State Worry Questionnaire (PSWQ)	
Baseline	*M* = 75.31, *SD* = 3.21
Post CBT	*M* = 41.45, *SD* = 17.34
One-year posttreatment	*M* = 44.00, *SD* = 18.72
Observed Resistance	*M* = 0.14, *SD* = 0.14
Barrett-Lennard Relationship Inventory (BLRI) – Empathy Subscale	
Baseline	*M* = 27.27, *SD* = 12.12
Post-session 3 or 5	*M* = 30.17, *SD* = 14.61
Gender	41 Female, 3 Male
Age	*M* = 34.57, *SD* = 12.09
Ethnicity	35 Caucasian 4 Asian 3 Hispanic 2 African Canadian
Marital status	21 Married/Cohabitating 20 Never Married 3 Divorced/Widowed/Separated
Employment status	13 Unemployed/Not in school 31 Employed/In school
Highest level of education	15 High school 21 Postsecondary 8 Graduate school
Worry chronicity	*M* = 13.82 years (range 1 – 45)
Comorbidity	33 (75%) Anxiety Disorder 18 (41%) Major Depressive Disorder/Dysthymic Disorder

Table 2

Correlations Among all Measures

Measure	1	2	3	4	5	6
1. Observed Resistance	---	-.27 *p* = .075	-.39** *p* = .010	-.04 *p* = .799	.36* *p* = .015	.44** *p* = .005
2. BLRI Baseline (S1)		---	.82*** *p* = < .001	.23 *p* = .140	-.38** *p* = .010	-.28 *p* = .085
3. BLRI S3 or S5			---	.21 *p* = .177	-.40** *p* = .007	-.30 *p* = .060
4. PSWQ Baseline				---	-.04 *p* = .800	.18 *p* = .274
5. PSWQ Posttreatment					---	.82*** *p* < .001
6. PSWQ One-year						---

Note. *$p < .05$, **$p < .01$, ***$p < .001$; 1: Observed Resistance, 2: Barrett-Lennard Relationship Inventory (BLRI) Empathy subscale score at baseline (session 1), 3: BLRI session 3 or session 5, 4: Penn State Worry Questionnaire (PSWQ) at baseline, 5: PSWQ Posttreatment, 6: PSWQ at one-year follow-up assessment.

Table 3

Random-Intercepts Model: Empathy Regressed on Observed Resistance

	Coefficient	*se*	*t-value*	*p-value*
DV: BLRI S3 or 5				
Baseline BLRI	0.93	0.01	9.29	< 0.001***
Observed Resistance				
RESc	-0.19	0.08	-2.33	0.027*
mRES	-0.11	0.26	-0.42	0.678

Note. *$p < .05$, ***$p < .001$. Barrett-Lennard Relationship Inventory (BLRI) scores include Empathy subscale scores exclusively; RESc represents within therapist effects of resistance on client-rated empathy; mRES represents between therapist effects of resistance on client-rated empathy.

Table 4

Random-Intercepts Models: Mediation

	Coefficient	*se*	*t-value*	*p-value*
DV: PSWQ Posttreatment				
Baseline PSWQ	0.22	0.84	0.27	0.791
BLRI				
Baseline BLRI	-0.27	0.37	-0.75	0.461
BLRIc	-0.04	0.37	-0.11	0.917
mBLRI	-0.38	0.37	-1.03	0.312
Observed Resistance				
RESc	0.31	0.22	1.43	0.164
mRES	0.46	0.46	0.99	0.331
DV: PSWQ One-Year				
Baseline PSWQ	1.80	0.96	1.88	0.073
BLRI				
Baseline BLRI	-0.31	0.43	-0.72	0.478
BLRIc	-0.04	0.42	-0.10	0.918
mBLRI	-0.15	0.39	-0.38	0.711
Observed Resistance				
RESc	0.45	0.24	1.88	0.073
mRES	0.64	0.49	1.31	0.204

Note. $*p < .05$, $***p < .001$. Barrett-Lennard Relationship Inventory (BLRI) scores include Empathy subscale scores exclusively; Penn State Worry Questionnaire (PSWQ); RESc represents within therapist effects of resistance; mRES represents between therapist effects of resistance; BLRIc represents within therapist effects of client-rated empathy; mBLRI represents between therapist effects of client-rated empathy.