

RESISTANCE AND OUTCOME EXPECTATIONS IN COGNITIVE-BEHAVIORAL
THERAPY FOR GENERALIZED ANXIETY DISORDER

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Abstract

Higher levels of resistance have been consistently found to be negatively associated with outcome in psychotherapy. However, the pathways through which resistance impacts therapy outcomes are underexplored. Given that outcome expectations have been identified as an important common factor influencing therapy outcomes, the goals of the present study were to: (1) examine impact of resistance on client and therapist outcome expectations (COE & TOE respectively) (2) explore whether the impact of resistance on these expectations mediates the relationship between resistance and therapy outcome. These relationships were tested among 44 clients with severe generalized anxiety disorder treated with Cognitive Behavioral Therapy for severe generalized anxiety in the context of a randomized controlled trial (Westra, Constantino, & Antony, 2016). Resistance was measured for a midtreatment session and COE and TOE were assessed at baseline and immediately after the session at which resistance was measured. Treatment outcome was measured via client-rated worry severity at posttreatment. As predicted, higher resistance was associated with lower subsequent COE and TOE ($B = -0.73, p < .001$ and $B = -0.46, p < .001$, respectively). COE post resistance in turn predicted higher posttreatment worry ($B = -0.5, p < .001$) indicating mediation; TOE in contrast was not found to mediate the relationship between resistance and outcome ($B = -0.02, p = .876$). These results suggest that resistance is potentially demoralizing to both clients and therapists. But it is the lower morale of clients associated with resistance that is detrimental to therapy outcome. This study makes a contribution to understanding the influences on outcome expectations. The discussion will consider the importance of managing resistance as one strategy for maintaining positive expectations for therapy.

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Resistance and Outcome Expectations in Cognitive-Behavioral Therapy for Generalized Anxiety Disorder

Described as "going against, opposing, diverting, blocking, or impeding the direction set by the therapist" (Westra, Aviram, Kertes, Ahmed, & Connors, 2009), unresolved resistance can lead to poor therapy outcome and premature therapy termination (Westra, Constantino, & Aviram, 2011; Beutler, Moleiro, & Talebi, 2001; 2002). Client resistance, which is essentially disruptions in collaboration, may be especially relevant in therapeutic models where therapist directiveness can trigger resistance in clients, especially among clients who are ambivalent about change (Westra, 2012). For example, in cognitive-behavioral therapy (CBT), a more directive and action-oriented therapeutic approach with a client who is less ready for change may lead to disagreement with the therapist's suggestions for tasks to facilitate change and this may lead to tensions or breakdowns in the alliance.

Although higher levels of resistance have been consistently found to be negatively associated with outcome (Westra & Norouziyan, 2018), little is known about the mechanisms through which this occurs. It is possible that resistance may negatively impact other critical treatment variables and processes in therapy. For example, clients' prognostic expectations about the efficacy of therapy, or outcome expectations, have been empirically supported as an important common factor that is also related to the quality of the therapeutic alliance (Greenberg, Constantino, & Bruce, 2006). And a significant body of research has shown that higher early outcome expectations are consistently related to better treatment outcomes (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011; Constantino, Arnow, Blasley, & Agras, 2005). Most of all, at least one previous study found that the occurrence of an alliance rupture (i.e., tensions in the therapeutic alliance) was associated with significant reductions in client outcome expectations

from pre- to post-rupture (Westra, Constantino, & Aviram, 2011). This suggests the possibility that tensions in the alliance such as those involved in resistance may be associated with a loss of confidence in therapy (i.e., lowered expectations for treatment success). And combating clients' demoralization or inducing a positive expectancy set for change is considered a major factor in the efficacy of all therapeutic models (Frank & Frank, 1991).

Moreover, encountering resistance can also have a powerful impact on the therapist as well. Although an understudied factor in psychotherapy research, research has demonstrated that positive therapist feelings toward a client are associated with better client engagement, lower resistance and completion of treatment (e.g., Hoffart & Friis, 2000; Westra, 2012; Wolf & Hayes, 2009). Higher levels of client resistance might arguably 'contaminate' or negatively influence therapist's belief in the client's ability to benefit from the treatment – after all it would be harder for a therapist to believe in a client if he or she seems to thwart therapist efforts or is noncompliant. In fact, resistance and client anger has been found to significantly 'derail' therapists in CBT from administering the treatment protocol (Boswell et al., 2013; Zickgraf et al., 2015). Very few studies have focused on investigating therapist outcome expectations (or belief in client's ability to benefit from therapy) but of the existing studies therapist outcome expectations have been found to be consistently associated with better client outcomes (Martin, Moore, & Sterne, 1977) even when controlling for client expectations (e.g., Lewin, Peris, Bergman, McCracken, & Piacentini, 2011; Meyer et al., 2002). Given that therapist expectations may also influence the process of therapy, it would be of interest to investigate this link empirically as a possible pathway through which resistance impacts outcomes.

In short, very little is known about how resistance exerts its negative impact on therapy; that is, the mechanisms through which it seems to impede therapy progress. To address this gap,

the present study sought to examine links between resistance and both therapist and client expectations among Generalized Anxiety Disorder (GAD) clients in the context of Cognitive-Behavioral Therapy (CBT). First, the literature on resistance, and a similar construct of alliance ruptures, will be presented to understand their impact on treatment outcome. Next, the client outcome expectation literature will be reviewed and the impact of positive outcome expectations on therapy outcome will be discussed. Our current knowledge of therapist outcome expectations will then be reviewed. Finally, GAD will be briefly described and the aims of the current study will be presented.

Resistance and its Theoretical Underpinnings

Although it is generally well accepted in the practice of therapy that client's resistance to change is an important and a challenging moment that can have important implications for therapy process and outcome, there is little agreement regarding the meaning of resistance and its management (Bischoff & Tracey, 1995). Among the current conceptualizations of resistance there seem to be two schools of thought: one that views resistance as an intrapersonal phenomenon and, thus, the one that reflect a client's intrapsychic processes and another that regards resistance as arising in the context of a therapeutic relationship – an interpersonal phenomenon.

Therapeutic approaches differ in their conceptualization of resistance as either intrapersonal or an interpersonal phenomenon. Major schools of psychotherapy expressed this distinction in various forms, including patient-centered versus therapist-centered phenomenon (Bauer & Mills, 1989), transference versus realistic resistance (Rennie, 1994a), resistance and counter-resistance (Bernstein & Landaiche, 1992) and a most recent distinction between trait versus state resistance (e.g., Beutler, Harwood, Michelson, Song, & Holman, 2011). However, it

is important to note that despite these differences in conceptualization there is a common agreement that resistance is a variable that is strongly linked to therapy outcome (Orlinsky, Grawe, & Parks, 1994). The following section will briefly focus on the theoretical concept of resistance from major schools of psychotherapy before presenting the literature on client resistance in psychotherapy and how resistance is conceptualized in the current study.

Resistance in psychoanalysis. Freud is often regarded as the person who brought the concept of resistance to the forefront within the field of psychology. However, he may not have been the first one to observe resistance as Ellis (1985) reported that early philosophers and practitioners of therapy (e.g., Jean-Martin Charcot, Pierre Janet) noted that clients desiring psychological change will often resist their own and their therapists' best efforts. Nonetheless, Freud remains the first one to define the concept of resistance, to incorporate it in his theory of psychoanalysis and to note that resistance is a prominent phenomenon arising in process of therapy. Freud (e.g., Breuer & Freud, 1895/1955) postulated that resistance is an intrapsychic phenomenon, occurring within a patient and that represents an underlying pathology. Specifically, according to Freud an intrapsychic discomfort experienced by a patient will trigger patient's defensive mechanisms that will prevent painful and disturbing memories stored and activated in unconsciousness to enter consciousness. In his theory resistance was regarded as a persistent phenomenon occurring outside of a patient's awareness and occurring in a variety of ways (Freud, 1916/1963). The most prominent example of Freud's conceptualization of resistance is what is called a "transference resistance" that represents a patient's re-enactment of repressed interpersonal attitudes and processes in therapy (Freud, 1912).

Resistance and the psychodynamic perspective. Transference resistance and patient's defense mechanisms have been regarded by psychodynamic practitioners as central to addressing

patient's psychopathologies and interpersonal difficulties (e.g., Blatt & Erlich, 1982; Strupp, Schacht, & Henry, 1988). In terms of conceptualizing resistance, psychodynamic researchers extended Freud's view of resistance as a phenomenon that is influenced both by intrapsychic processes and threats inherent in the therapeutic interaction (e.g., Basch, 1982; Brehm, 1976; Horney, 1942; Jung, 1954; Strupp, 1973). For example, some believed that resistance represented an opposition to the "liberation of forces and maintenance of the status quo" (Horney, 1942, p. 267) while others proposed that resistance was a reaction of a patient to a perceived loss of control imposed by a therapist (e.g., Jung, 1954; Jahn & Lichstein, 1980; Strong and Matross, 1973). The latter notion was further explained by Strupp (1973) who suggested that a patient's resistance was influenced by his or her perceived fear of the negative consequences that might be associated with relinquishing control to a therapist.

Messer (2002) – a more recent psychodynamic researcher – defined resistance as a client's unconscious, inherent desire to avoid analytical work. Specifically, in *ego* and *object* terms, resistance refers to one's automatic way of avoiding and revealing the hidden drives, desires, and feelings in the context of psychotherapy (Messer, 2002). Resistance can also be viewed as an adaptive way of asserting oneself in psychotherapy and protecting one's sense of *self*. For example, a client who feels threatened by a therapist's inquiry or desire to put the client in touch with disavowed feelings or hidden motives, might withhold or falsify information or dismiss a therapist's request altogether blocking the direction of the therapy set by a therapist – a classic example of resistance.

According to the psychodynamic perspective and Messer (2002) in particular, resistance can be presented in different forms in the therapy process. First, the client might be resistant to recognize impulses and fantasies and conflicting or particularly painful feelings. Messer argues

that empathy should be used to facilitate client's exploration of disturbing or painful experiences. Second, a client may resist expressing his/her feelings towards the therapist – a powerful phenomenon of transference or re-enacting one's interpersonal style with the therapist without being aware of such a process. Other ways of expressing resistance include missing therapy sessions, clients' use of resistance to demonstrate self-efficacy and resistance to change outside the therapy sessions (the least addressed aspect in psychoanalytic therapy). Addressing the phenomenon of resistance in the therapy can help understand client's core defense mechanisms, and discover repressed desires and motives (Messer, 2002). Interpretation of resistance regardless of the form it is expressed is a valuable target of interpretation. The goal of the psychoanalytic therapist according to Messer is to increase a client's awareness of repressed impulses, fantasies or feelings.

The psychodynamic view of resistance changed over time to include the impact of a therapist on occurrence of resistance: that is, client resistance can be evoked by therapist errors, including poorly timed and inappropriate interventions, inflexibility of a therapist and other relationship-related conditions (e.g., Basch, 1982; Blatt & Erlich, 1982; Greenson, 1967). One example of how psychodynamic intervention can give rise to resistance is during interpretation: although this intervention is associated with positive therapy outcome, poorly timed and insensitive use of interpretations can lead to client resistance and, thus, poor therapy outcome (Crits-Christoph & Gibbons, 2002). Gradually, the psychodynamic view of resistance came to encompass both intrapsychic processes (e.g., client unconscious defense mechanisms) as well as relationship related processes within a client's awareness (e.g., Mahalik, 1994; Schuller, Crits-Christoph, & Connolly, 1991). Namely, resistance was conceptualized to reflect both the “work of therapy” (Tracey, 1986) and strains in the therapeutic relationship (Greenson, 1965). As a

result, psychodynamic researchers have since focused their attention on investigating the relationship between alliance ruptures, resolution and their impact on therapy outcome (e.g., Colli & Lingardi, 2009; Safran, Muran, & Samstag, 1994; Stiles et al., 2004).

Resistance and the humanistic perspective. Compared to other schools of psychotherapy resistance has received relatively little attention within the humanistic perspective. Although not addressed directly, the concept of resistance was examined by client-centered researchers; they compared directive and non-directive therapists' styles and observed that the directive style of a therapist was associated with higher reports of resistance (Snyder, 1945; Gillespie, 1953). Snyder (1945) further explained this observation by noting that a directive therapeutic style is associated with the notion that therapist is in the best position to determine what is best for the client. In contrast, therapists who adopt a non-directive style believe that only the client knows what is best for him and her and, thus, is tentative and flexible in reflections and proposed interventions.

This explanation is in line with Carl Rogers's belief that people possess innate tendency towards self-enhancement that can be nurtured and further developed given the appropriate therapeutic conditions (Rogers, 1951). That is, Rogers believed that resistance was not a phenomenon residing within the client but rather a concept that develops within a therapeutic relationship. In fact, Rogers believed that if client-centered therapy was delivered properly no resistance should occur. Specifically, Rogers noted that if the necessary therapeutic conditions to minimize threat are present (namely, therapist's genuineness and congruence, unconditional positive regard and empathic understanding) resistance is not likely and change will inevitably occur (Rogers, 1961).

A more recent therapeutic approach that has a solid base in the client-centered approach

is motivational interviewing (MI; Miller & Rollnick, 2002). According to MI, one of the ways of reducing or preventing resistance and minimizing threat to one's personal goals and values is by instilling sense of autonomy or capacity for self-direction. Much like Rogers, MI also views resistance as an interpersonal concept reflecting a failure in the therapeutic relationship; persistent resistance is associated with a therapist skills deficit rather than client characteristics (Miller & Rollnick, 2002).

Resistance and the cognitive and behavioral perspective. In the original form of behavioral therapy resistance was not considered a significant concept that needed to be addressed. However, high rates of dropouts and homework noncompliance led behavioral and cognitive therapists to consider the phenomenon (Golden, 1989). For example, therapists often observed that clients did not desire to complete the tasks and assignments that might be successful in achieving desired behavioral change. Thus, the concept of resistance was defined as “the failure of the client to comply with therapeutic procedures” (Golden, 1989, p. 4). With the observations derived from studies examining the relationship between client resistance and therapist directive behavior, behavioral researchers came to focus on therapist behavior (e.g., Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Patterson & Forgatch, 1984) that can influence the occurrence of resistance. Thus, resistance can be impacted by qualities of the therapist as well as the style of therapy delivery (Lazarus & Fay, 1990).

Developments in cognitive therapy led therapists to further focus their attention on the intrapsychic processes that might be contributing to resistance, including client's motivation to preserve existing cognitive structures and schemata (e.g., constructivism; Liotti, 1989; Mahoney, 1990, 1988a, 1988b). According to this view resistance serves as a protection against disintegration of the client's existing core cognitive structures such as their reality, identity, and

personal values (Mahoney, 1998b). Thus, resistance was viewed as the essence of core cognitive structures and, as a result, challenging to alter. Currently both behavioral and cognitive therapists focus on resistance as a phenomenon that is influenced both by client (e.g., faulty cognitive schemas) and therapist (skill in development and implementation of interventions, Engle & Arkowitz, 2006). Both schools of thought view resistance as an obstacle to successful therapy outcome that needs to be overcome in order for therapy benefit to occur (Stevens, Muran, & Safran, 2003).

Resistance as a Key Moment in Psychotherapy

In the current study relational context is regarded as essential to understanding resistance (Westra, 2012). That is, resistance can be defined as something that occurs within the context of a relationship – in order for resistance to develop there must be something or someone to oppose (Beutler et al., 2011; Meichenbaum & Turk, 1987; Miller & Rollnick, 2002). Both a client and therapist can equally contribute and influence negative processes occurring in the course of therapy. In fact, a therapist can exert a powerful impact on a client's level of resistance. Thus, resistance is not a static concept, but rather can be defined as a product of both client's ambivalence towards therapy/therapist and a therapist's response to this ambivalence (Moyers & Rollnick, 2002).

Psychotherapy research has consistently shown that resistance to a therapist or a therapy can be toxic to maintaining a strong therapeutic collaboration (one of the major vehicles of change) and therapy outcome (e.g., Beutler, Clarkin, & Bongar, 2000; Beutler, Goodrich, Fisher, & Williams, 1999; Beutler, Harwood, Michelson, Song, & Holman, 2011; Binder & Strupp, 1997). For example, Watson and McMullen (2005) found that clients experiencing resistance to the therapist rate those sessions as being low in therapeutic alliance. Moreover, clients

experiencing higher levels of resistance may not benefit from the therapy and/or can terminate therapy prematurely when compared to the clients who do not exhibit resistance and/or those who are able to manage resistance successfully in therapy (e.g., Beutler, Moleiro, & Talebi, 2001; 2002). In addition, higher levels of early resistance have been found to be predictive of future therapy engagement with respect to the therapy tasks and overall benefits of therapy (Aviram & Westra, 2011).

One aspect that is intriguing is that resistance does not need to be frequent to exert its toxic impact on therapy process. Recent studies suggest that even small doses of resistance are capable of predicting subsequent engagement (homework compliance, and/or overall involvement in the therapy process) and therapy outcome. For example, Aviram and Westra (2011) found that higher levels of early resistance in CBT for clients with generalized anxiety disorder (GAD) were found to significantly predict lower homework compliance and poorer outcomes. Moreover, higher levels of resistance were associated with maintenance of the diagnosis one year post-treatment (Aviram & Westra, 2011). Similarly, Jungbluth and Shirk (2009) found that even though it was an infrequent phenomenon, observing resistance as early as the first session of the therapy for adolescents with depressive disorder was predictive of future therapy involvement and accounted for thirty three percent of variance in subsequent therapy engagement.

These findings suggest that such moments of resistance may represent *key-moments* in the therapy process that must be attended to and managed immediately and effectively in order to prevent their toxic impact on the therapy process. This notion is consistent with the research that demonstrates a strong link between effective therapy and relative absence of resistance (Orlinsky, Grawe, & Parks, 1994; Beutler, Moleiro, & Talebi, 2001; 2002; Beutler, Rocco, Moliero, & Talebi, 2001). It has been argued that presence of critical and clinically significant

moments in therapy should be thoroughly studied in order to understand change processes in therapy (Greenberg, 1986). Resistance may be one of those critical moments. Specifically, although the absence of resistance may not necessarily predict the effectiveness of therapy, the presence of even small doses of resistance can have detrimental effects on the therapy process, including poor outcomes and limited client engagement (e.g., Aviram & Westra, 2011; Binder & Strupp, 1997; Critchfield, Henry, Castonguay, & Borkovec, 2007; Jørgensen, Hougaard, Rosenbaum, Valbak, & Rehfeld, 2000; Jungbluth & Shirk, 2009). Thus, effective management of resistance and thus maintain client engagement are critical components of facilitating effective therapy process.

Resistance and Alliance Ruptures

Moments of resistance may be representative of ruptures in the therapeutic relationship (Safran & Muran, 1996). In fact, Safran and Muran's (1996) work on alliance ruptures details a very similar phenomena to that of resistance. Safran and Muran (2000) differentiate between two types of alliance rupture: confrontational and withdrawal. And each type has a distinct impact on therapy process and therapist and client experiences (Coutinho, Ribeiro, Hill, & Safran, 2011). In a confrontation rupture, the client expresses his or her disagreement, anger or dissatisfaction with therapy or therapist in a direct manner (e.g., criticizing the interpersonal skills of a therapist). In contrast, in a withdrawal rupture a client disengages or withdraws from a therapist or the process of therapy (e.g., by providing minimal responses or not responding at all; Safran & Muran, 1996, 2000). In essence then, alliance rupture represents a macro concept that can be influenced by many factors (both client and therapist alike), whereas resistance is a micro phenomenon that represents an alliance rupture but depending on how it is managed may or may not impact alliance overall. Alliance rupture is resistance that is long enough (and often unmanaged) that

leads to loss of therapeutic relationship.

Given that research consistently demonstrates the importance of the therapeutic alliance as one of the predictors of therapy outcome across different therapeutic modalities (Horvath, Del Re, Flückiger, & Symonds, 2011), unresolved ruptures, like continued resistance, can lead to further deterioration of the therapeutic collaboration and even to premature termination of therapy (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder & Strupp, 1997; Coutinho, Ribeiro, Hill, & Safran, 2011; Safran & Muran, 1996). Thus, given its significance in the therapy process, successful resolution of resistance and alliance ruptures can be regarded as a core clinical skill in the practice of psychotherapy (Moyers & Rollnick, 2002; Safran, Muran, Samstag, & Stevens, 2002). I now turn to the consideration of the issue of development and management of resistance in a CBT context in particular.

Resistance in CBT

Although considered a standard and front-line intervention for clients with anxiety disorders, not all clients benefit equally from CBT. Among the possible factors that might contribute to lack of potency of CBT are ambivalence about change, treatment nonadherence, and resistance (Arkowitz & Westra, 2004; Sanderson & Bruce, 2007; Westra, 2012). In the context of CBT Newman (1994) identified some common expressions of resistance including homework noncompliance, going in a direction opposite to one set in the sessions, negative responses toward a therapist, in-session disengagement (silence, brief answers), and challenging and disagreeing with a therapist. An ambivalent CBT client may not readily “buy” the rationale and, thus, express their concerns and disagreement with the rationale and goals. Other signs of resistance include a client not responding to a therapist’s question, a therapist makes a suggestion and the client disagrees, a therapist reflects a client’s experience and the client interrupts or

sidetracks (Westra, Aviram, Kertes, Ahmed, & Connors, 2009). While resistance in CBT is often centered on homework noncompliance, it can also be conceptualized in much broader terms involving in-session disengagement in the moment-to-moment interpersonal process of therapy (Westra, Aviram, Kertes, Ahmed, & Connors, 2009). All these behaviors reflect instances of resistance that can occur in response to a therapist demanding action from a client or directing the course of therapy for which they are not ready.

Therapist style has also been found to be associated with a client's level of resistance. Specifically, it has been demonstrated that more directive approaches are associated with higher levels of resistance, while supportive, self-directed approaches are associated with lower levels of resistance (Aviram & Westra, 2011; Beutler, Moleiro, & Talebi, 2002). For example, in a study conducted by Patterson and Forgatch (1985) therapists alternated between directive (teach and confront) and supportive styles in a therapy session, and found that while the former increased resistance, the latter more supportive style facilitated cooperation. In a similar fashion, Miller, Benefield, and Tonigan (1993) reported that a directive therapy style was associated with significantly higher levels of resistance and that in turn predicted poorer outcomes up to one year post treatment in clients with drinking problems.

Bischoff and Tracey (1995) also studied the relationship between client resistance and therapists' directiveness in the context of CBT. Client and therapist's speaking patterns were coded. Client resistant responses included challenging the therapist, disagreeing with the therapist, expressing hopelessness, blaming, defending, pushing his or her own agenda, sidetracking, not responding to a question, not answering and disqualifying (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984). Directive therapist behaviors included teaching, structuring, confronting and challenging, interpreting and directive information seeking. The

findings of the study supported that the occurrence of client resistance was predicted by the therapist's antecedent directive behavior (Biscoff & Tracey, 1995).

These studies suggest that the therapists level of directiveness is closely tied to the client's level of resistance and, thus, therapy outcomes. In fact, findings of Beutler et al. (2001) support exactly this notion: the authors identified that those clients with high trait-like resistance benefit more from a nondirective therapeutic approach, whereas those clients who are low on trait-like resistance show greater benefit from more directive therapy (Beutler, Rocco, Moleiro, & Talebi, 2001). Thus, directiveness should not be regarded as something negative; but rather its utility is dependent on the context. Specifically, directiveness can be helpful for those clients who are cooperative and ready to change, while it can be detrimental to those who are resistant and ambivalent (Beutler et al., 2011; Beutler, Rocco, Moleiro, & Talebi, 2001). Therefore, the ability to *hear* client resistance and disengagement and successfully navigate moments of resistance as they occur throughout the session, seems to be a critical component of effective therapeutic process.

Resistance can be regarded as an important communication signal from a client; one that can help a therapist navigate the therapy process. Namely, Miller and Rollnick (2002) postulated that client resistance is a way of letting a therapist know that he or she is not on board and if attended to immediately should signal a therapist to slow down, proceed with caution or abort whatever he or she is doing. On its own the occurrence of such instances is not problematic. In fact, it can be very informative for a therapist as it conveys client's attempt to reaffirm their freedom of choice and protect their autonomy. It is when the therapist fails to attend to such signals and/or ignores them and proceeds with the agenda without acknowledging the client that these instances of resistance become detrimental. Thus, when instances of resistance occur Miller

and Rollnick (2002) recommend *rolling with resistance*, that is, using empathic reflections and explicitly attending to and supporting the client's autonomy and self-determination.

The importance of responding with support in instances of resistance has also been emphasized in the therapeutic alliance literature (e.g., Safran & Muran, 1996; Safran, Muran, Samstag, & Stevens, 2002). Castonguay and colleagues (1996) investigated instances of alliance ruptures in the context of CBT and observed that during such moments CBT therapists responded by fixating on therapeutic techniques (Castonguay, Goldfried, Wisner, Raue, & Hayes, 1996). Similarly, another study investigating alliance ruptures in CBT found that lack of acknowledgment of opposition from a client and persistence with the agenda resulted in alliance rupture (Aspland et al., 2008). These researchers also observed that therapist's willingness to abandon therapeutic techniques and focus on issues pertinent to the client resulted in successful resolution of alliance ruptures. In addition Burns and Auerbach (1996) argued that use of directive therapeutic approaches (such as CBT) in the context of client noncompliance can invalidate client's experiences and perceptions. Similarly, Aspland and colleagues (2008) concluded that in the instances of alliance rupture in CBT, therapists should become more empathic and responsive, and encourage clients to express their concerns rather than continuing with technical interventions.

In fact, recent research in managing resistance in CBT is centered on the introduction of more supportive techniques to manage resistance and noncompliance, such as Motivational Interviewing (MI; Federici, Rowa, & Antony, 2010; Slagle & Gray, 2007; Westra, 2012). In the context of CBT for GAD, randomized clinical trials support the integration of MI into CBT in improving client engagement and outcomes (Westra, Arkowitz, & Dozois, 2009; Westra, Constantino, & Antony, 2016). In the Westra et al. (2016) study for instance, clients receiving

MI integrated with CBT were over 5 times more likely to no longer meet diagnostic criteria for GAD at one-year follow-up, compared to those receiving CBT alone. Moreover, MI-CBT clients were found to show continued improvement over time after treatment ended, while CBT alone clients either maintained their gains or relapse slightly. Interestingly, lowered levels of resistance in MI-CBT compared to CBT alone has been found to fully account for between group differences (Aviram & Westra, 2011; Constantino, Westra, Antony, & Coyne, in press).

Although we know that resistance has a negative impact on therapy outcome and must be resolved to ensure positive therapy outcome, little is known regarding *how* resistance exerts its negative impact on therapy outcomes. One possible mechanism through which resistance can impact therapy outcome is by affecting client outcome expectations, or optimism about benefit of therapy. The literature on client and therapist outcome expectations as well as research linking expectations to the alliance will be reviewed next.

Client Outcome Expectations

Client expectations are considered to be an important “common factor” germane to all treatments (Asay & Lambert, 1999) and have been estimated to account for approximately fifteen percent of the variance in the outcomes of psychotherapy (Lambert, 1992). Research on expectations in psychotherapy differentiates between several types of expectations, including client *outcome* expectations (i.e., the belief that treatment will be helpful; sometimes also referred to as prognostic expectations), *treatment* expectations (i.e., belief about the process of therapy: client’s role, format of therapy, duration of therapy), and *self-efficacy* expectations (i.e., a client’s belief about his or her own ability to perform treatment-related activities) (Greenberg, Constantino, & Bruce, 2006). As with most existing research on expectations, in this study, outcome expectations are considered.

Most studies on client outcome expectations have focused on assessing expectations early in therapy (either before any encounter with a therapist or during the first sessions). Here, higher early outcome expectations have been consistently related to better treatment outcomes (Constantino et al., 2011; Greenberg, Constantino, & Bruce, 2006). The beneficial impact of positive outcome expectations on therapy outcome has been noted as early as 1980s. In their review, Noble, Douglas, and Newman (2001) observed that although early (pre-1980) studies demonstrated a curvilinear relationship between outcome expectations and therapy outcome (i.e., clients with moderate degree of outcome expectations demonstrated better therapy outcome than those with low or high expectations), the majority of studies from 1980 to 1999 demonstrated a significant linear relationship between client outcome expectations and therapy outcome.

Similarly another review study conducted by Arnkoff, Glass, and Shapiro (2002) that examined twenty-four studies until 2000 year found a significant positive relationship between outcome expectations and treatment outcomes across multiple measures. Another study reviewing the link between outcome expectations and therapy outcome between 2000 and 2005 found that most studies indicated a positive correlation between outcome expectations and therapy outcome as well as therapeutic alliance, signaling that outcome expectations is a critical factor in healing process (Greenberg, Constantino, & Bruce, 2006). In the most recent meta-analysis study (that involved $N = 8,016$ clients across 46 independent samples), Constantino and his colleagues (2011) reported a significant positive association of early outcome expectations (measured either before therapy or immediately after the 1st session) and therapy outcome; of the 46 samples, 11 demonstrated an averaged negligible effect, 19 a small effect, 10 a medium effect, and 6 large effect (r range = $-.37$ to $.79$) (Constantino et al., 2011). And in a more recent meta-analysis investigating the association between early treatment outcome expectations and

posttreatment outcome using 81 independent samples with 12,722 patients, there was a small but significant positive effect size ($r = .18$, 95% CI [.14, .22]) (Constantino, Vīslā, Coyne, & Boswell, 2018).

In the context of CBT, research has found that positive expectancy for change can lead to treatment gains even before introducing specific treatment techniques (e.g., Illardi & Craighead, 1994; Fennell & Teasdale, 1987; Penava, Otto, Maki, & Pollack, 1998). In another study conducted by Westra and her colleagues (2007), clients with higher early outcome expectations in CBT had better treatment outcomes, since they were more engaged early in the therapy process (as measured by homework completion) (Westra, Dozois & Marcus, 2007).

Kirsch (1990) proposed a self-confirming phenomenon as a possible mechanism through which outcome expectations impact therapy outcome. Specifically, anticipation about one's own experience tends to be self-confirming. For example, expectations of reduced pain lead to actual reduction of pain (Kirsch, 1990). Kirsch noted that expectancies are thought to exert a direct effect on non-volitional responses. Research in the area of negative mood regulation further corroborates this notion. For example, participants expecting a positive outcome in an experimental activity rated their performance and tasks more positively when compared to those who had negative initial expectations about their enjoyment in an experimental activity (e.g., Catanzaro, 1989). Furthermore, it has been suggested that expectations can lead individuals to re-evaluate their experiences to fit their expectations (Catanzaro & Mearns, 1999). Thus, client's positive expectations about therapy benefit would tend to pull for confirmation and lead to positive therapy outcome, therefore, forming important self-fulfilling prophecies.

Facilitating Positive Expectations: The Importance of the Alliance

Although enhancing outcome expectations is an important clinical goal that will have an

impact on therapy outcome, how does one inspire optimism in therapy? Many studies and theorists in this area seem to point to the importance of therapeutic relationship as a vehicle for fostering positive outcome expectations (e.g., Frank & Frank, 1991; Kirsch, 1990; Tinsley, Bowman, & Ray, 1988; Constantino & DeGeorge, 2008; Wampold, 2007). In their book “Persuasion and Healing” Frank and Frank (1991) contend that efficacy of all therapies lies in combating clients’ *demoralization* or inducing a positive expectancy for change. The authors argue that all psychotherapies have at least four features in common that are capable of inducing positive expectancy for change, namely 1) an emotionally charged, confiding therapeutic relationship, 2) a designated healing setting 3) a treatment rationale (i.e., a schema that reflects a therapist’s conceptualization of the factors contributing to a client’s problems), and 4) a treatment procedure or ritual for ameliorating symptoms (Frank & Frank, 1991).

Thus, echoing alliance researchers, Frank and Frank (1991) also stress the importance of a confiding relationship between a therapist and a client, adding that such relationship can help combat client demoralization. According to Frank and Frank, a genuine and accepting therapist willing to listen to a client’s position and who views a client as capable is able to induce positive expectations. A similar contention has been articulated by Wampold (2007) who argued that a client would be more willing to accept a less demoralizing explanation of his or her problems if the explanation comes from an understanding and trustworthy therapist willing to collaborate with a client. Wampold stresses the importance of collaboratively building a treatment rationale that would fit a client (2007). Kirsch (1990) similarly articulated the importance of establishing a trustworthy therapeutic relationship in order to facilitate acceptance of treatment rationale and enhance client expectations about therapy benefit.

Consistent with the alliance rupture literature Kirsch (1990) also argues that in instances of

alliance rupture that might provoke anger and disappointment, it is important for a therapist to remain empathic and demonstrate acceptance of the client's feelings as opposed to reacting with anger or being critical. In fact, Kirsch argued that those therapists who convey a sense of understanding and empathy to a client are capable of enhancing outcome expectations. Both Kirsch and Frank also stress the importance of other expectancy enhancing strategies, including inquiring about a client's expectations, providing information to modify expectations and ensure that they are realistic, correcting misconceptions or answering questions about treatment, and providing a client with feedback to highlight positive changes and emphasize strengths. However, both agree that a strong and supportive therapeutic relationship is key to enhancing client outcome expectations.

Similarly, Lopez and colleagues (2000) suggested an important link between hope and the working (or therapeutic) alliance. Specifically, the authors argue that instilling hope parallels the development of three key aspects of working alliance. As defined by Bordin (1976), the working alliance consists of agreement between a client and a therapist on *tasks* and *goals* of treatment and establishing a strong *bond*. The authors argue that hope can be instilled via the very actions necessary to establish a working alliance. To nurture hope, Lopez and colleagues recommend a) providing empathy, trust and understanding to clients, b) modeling hope in language and behavior, c) exploring how hope has developed or diminished in a client's life, and d) developing hope in the early phase of treatment (Lopez, Floyd, Ulven, & Snyder, 2000).

Evidence linking alliance and expectations. A number of qualitative and quantitative studies support a significant role of the alliance in facilitating expectations. In a qualitative study examining post-treatment interviews in grief therapy, Cutcliffe (2004) observed that therapists were fostering hope by creating an interpersonal environment where the client would feel cared

for by their therapist. In response to such an environment clients felt safe to explore their feelings towards the deceased one, express negative emotions (if any) in a non-judgmental environment and felt hopeful about the process of grieving. Based on his observations, Cutcliffe suggested that the very essence of hope inspiration lies in a caring therapeutic relationship (Cutcliffe, 2004).

To examine how hope might be induced in practice, Larsen and Stege (2010) examined the practice of five psychologists who received formal hope education training either via graduate course in hope in counseling psychology, workshops on hope in therapy or via supervised practice that focuses on hope. The researchers videotaped the first sessions of therapy (either sessions 1, 2 or 3) of eleven clients and then asked therapists to comment on hope-related moments or interventions using Kagan's (1975) Interpersonal Process Recall measure. All the psychologists in the study reported that a strong therapeutic alliance was the major vehicle of inspiring hope. Specifically, giving the space to the client to express their concerns and actively listening to them, expressing support and understanding and providing the sense of acceptance were the major "strategies" employed by therapists to foster hope. Relatedly, compassionately attending to a client's pain was observed to be vital to facilitating hope. Taken together these qualitative studies demonstrate the importance of the therapeutic alliance in facilitating positive outcome expectations.

There are several quantitative studies that support this qualitative work in demonstrating a link between strong alliance and positive outcome expectations. For example, a study investigating the link between pretreatment expectations as predictors of therapeutic alliance across supportive-expressive therapy and cognitive therapy revealed that patients [Major Depression, GAD, and/or Obsessive-Compulsive Disorder] with greater pretreatment

expectations formed better alliances with their therapists at both early and late treatment (Connolly Gibbons et al., 2003). Similarly Constantino and colleagues investigated outcome expectations as a factor contributing to therapeutic alliance in the treatment of Bulimia Nervosa using CBT or Interpersonal Therapy (Constantino, Arnow, Blasey, & Agras, 2005). They found that patient early expectations of improvement were positively related to both early- and middle-alliance quality in both therapy types. The researchers argued that clients with positive expectations will work harder to engage in the treatment process and form a strong and collaborative relationship with their therapist. And in the recent meta-analysis by Constantino and colleagues (2018), more positive pre- and early outcome expectations were found to be significantly related to more positive experiences of alliance, which in turn related to better outcomes (Constantino, Visla, Coyne, & Boswell, 2018). Similar findings were noted by Meyer and colleagues (2002) who used the data derived from the Treatment of Depression Collaborative Research Project (Elkin, 1994) in finding that early high alliance mediated the relationship between early outcome expectations and treatment outcome across multiple treatment types (CBT, interpersonal therapy, imipramine combined with clinical management, and placebo with clinical management) (Elkin, 1994).

Moreover, Westra, Constantino and Aviram (2011) found alliance ruptures to be strongly associated with *subsequent* outcome expectations. In particular, alliance ruptures in CBT for generalized anxiety disorder were found to be associated with a significant drop in outcome expectations immediately following the rupture (from pre-rupture levels). On average, clients showed a 25% drop in their belief that the therapy would be beneficial (measured on a scale from 0% to 100%). Interestingly, those with higher baseline outcome expectations (greater optimism about therapy prognosis) were inoculated against this effect; while only those with lower

expectations to begin with showed the expected drop in expectations following alliance ruptures. This suggests that not only do early expectations influence alliance formation but that a reciprocal role also exists in that adverse events in the alliance likely also impact later expectations.

Taken together, these findings suggest an important link between therapeutic alliance and client outcome expectations. Specifically, the findings suggest that a strong therapeutic bond is associated with positive early client outcome expectations, while ruptures and/or strains in the relationship may have a negative impact on client's beliefs in the benefit of therapy. While these studies suggest that quality of the alliance is related to client outcome expectations, little research has been done on therapist's outcome expectations and its relationship with alliance quality and/or outcomes. Of course both a client and therapist form the relationship and focusing on one while ignoring the other may not give us a full picture of what is occurring in therapy.

Therapist Outcome Expectations

Frank (1991) suggested that therapist's ability to convey realistic hopefulness is critical to therapy outcome. In their review of expectations, Greenberg, Constantino and Bruce (2006) have noted that all major psychotherapies are united by their aim to reshape patients' expectations. That is, during a clinical encounter a therapist works to understand a client's sense of agency and their goal-directed thinking and foster belief that change is possible through a *shared sense of hope* for positive therapy outcome.

Moreover, the concept of hope in the therapeutic relationship has been viewed as a "contagion", such that hope and hopelessness can be "contagious" within the relationship (Coppock, Owen, Zagarskas, & Schmidt, 2010). For example, a recent study examining therapist hope argued that therapist's hope is at least as important as client's hope for therapeutic change

(Flesaker & Larsen, 2012). In this qualitative study the researchers investigated the importance of hope among reintegration counselors working with women on probation and parole. Analyses indicated that hope played a critical role in these therapists' experiences. Specifically, hope was required for therapists to combat setbacks especially when therapists were faced with clients whose own hope was challenged. Moreover, therapists reported that maintaining hope about positive outcome was helpful to boost their own potential, to make them believe in their ability to help their clients, as well as create more meaningful connections with clients. Therapists in this study noted that finding hope requires skill that takes effort; they noted that it is a skill that can be learned by both therapists and clients. They remarked that integrating hope in thinking and acting (i.e., adopting hope-seeking orientation) is essential in fostering hope in themselves and their clients as it can bolster therapists' abilities to find new possibilities and sustain their ability to work amidst clients' pain. Importantly, therapists noted that hope helped them to protect against burnout suggesting that fostering hope might be important to the well-being of therapists as well as to positive therapy outcome (Flesaker & Larsen, 2012).

In an effort to delineate what constitutes therapist hope Overholser and colleagues (2010) proposed ten essential cognitive beliefs that might be critical to foster positive expectancy in therapists (Overholser, Braden, & Fisher, 2010). Of note, the authors emphasized the importance of communicating these beliefs to clients to promote positive expectations rather than discouragement. Their list of core beliefs that might promote positive therapy outcomes include: (1) "People can change" - therapist's belief in the ability of clients to make adaptive changes and emphasizing free will; (2) "Change is often a gradual process" - refers to the belief that behavior change is a process that occurs over time and involves progression through several stages; (3) "Change typically requires developing new actions and new attitudes" – such a belief

can help therapists in therapeutic dialogues expand the range of options available to clients that often feel ‘stuck’; (4) “Intimate relationships play a central role in all important life events” – this belief also includes therapeutic relationship and the importance of strong alliance as a critical component of successful psychotherapy; (5) “Understanding precedes changing” – this belief would help therapists to fully comprehend the client and their problems by creating a safe environment for a client to share their experiences; (6) “Negative life events often turn out better than had been expected” and (7) “Past events cannot be changed but often can be tamed” – these beliefs can help therapists communicate to clients that losses and pain often promote personal growth and, thus, help clients reframe their thinking around negative events; (8) “Emotions are a natural part of human existence”, (9) “Balance is a central ingredient for adaptation” and (10) “Most labels are not helpful”. Considered together, the authors argued that these beliefs can help therapists highlight client’s strengths, normalize their experiences and they may help clients achieve balance in their lives. Along with these core beliefs the authors also emphasized the importance of training and experience as well as complete confidence of therapists in the process of therapy (Overholser, Braden, & Fisher, 2010).

In the few studies that have considered therapist expectations, these have been consistently related to client outcomes. Specifically, both early (e.g., Goldstein, 1960; 1962; Martin, Guhr, Hunter, & Acree, 1977; Martin, Lindsey, & Sterne, 1977; Martin & Sterne, 1975) as well as more recent studies (Lewin, Peris, Bergman, McCracken, & Piacentini, 2011; Meyer et al., 2002; Connor and Callahan, 2015) support the importance of therapist early prognostic expectations in predicting actual client outcomes. In an early study, Martin, Sterne, Moore, and McNairy, (1977) conducted a study examining the relationship between therapist’s expectancies and therapy outcome among 84 patients hospitalized with schizophrenia. Using the Therapist’s

Prognostic Expectancies Measure (Martin & Sterne, 1975), they found that therapist's expectations predicted patient adjustment immediately after discharge as well as at 9-month follow-up. The author's speculated that therapist's with high expectations may communicate their hope to clients during therapy which might in turn lead to better therapeutic response. Martin and colleagues consistently reported that therapist expectancies were related to client symptom reduction (Martin, Lindsey, & Sterne, 1977; Martin & Sterne, 1975). And more recently, among 54 psychotherapy trainees, Connor and Callahan (2015) found that higher therapist expectations for client improvement were positively correlated with clinically significant change in their clients. Therapists' expectations explained 7.3% of variance in whether or not clients experienced clinically significant change. The authors emphasized the link between high therapist expectations and therapeutic alliance, such that high expectations might foster stronger therapeutic alliance. Moreover, they speculated that therapists with high expectations about their clients might work harder to push their clients in the direction of change (Connor & Callahan, 2015). While these early studies consistently demonstrated that therapist expectations predicted client outcomes, they did not examine whether therapist expectations accounted for client outcome *beyond* client expectations.

In a more recent study in the context of the Depression Collaborative Research Program, Meyer and colleagues (2002) asked therapists, after the first therapy session, to estimate client functioning one year post treatment. Therapist estimates were found to be significantly associated with both alliance and clinical outcome, even when accounting for client outcome expectations. Similarly, in a study of youth receiving CBT for obsessive-compulsive disorder, therapist expectations were again found to be significantly predictive of outcomes even when accounting for client expectations (Lewin, Peris, Bergman, McCracken, & Piacentini, 2011).

Lewin and colleagues interpreted this finding as reflecting therapist' accurate judgments of client prognosis when considering patient severity and impairment. However, since they controlled for baseline client severity in their analyses, this explanation seems limited to explain this effect.

Coppock and colleagues (2010) conducted a naturalistic study of brief therapy with 10 therapists and 43 adult clients; client and therapist hope was measured by State Hope Scale (Coppock, Owen, Zagarskas, & Schmidt, 2010). Clients presented with a variety of problems ranging from mood disorders and relational issues to eating disorders and personality disorders. The study revealed that therapist's hope in their clients measured after the first session of therapy was related to therapy outcome (controlling for client initial hope and severity) but client's hope was not predictive of outcome. The researchers speculated that therapists' initial hope may be a reflection of the potential they observe in their clients' sense of agency and options to solve their problems. Moreover, they suggested that therapists with high hope might work harder with their clients to explore their goal-related thinking and promote other ways of achieving desired change. Similarly, they speculated that therapists with high hope in their clients may indirectly impact their clients by projecting their own hope (Coppock, Owen, Zagarskas, & Schmidt, 2010).

As noted by Constantino and his colleagues most of the research on outcome expectations to date has been from one dyad's member perspective and at single time points despite the fact that OE and alliance is a dyadic and dynamic construct (Constantino et al., in press). Addressing such gap, this team of researchers explored the outcome expectancy-alliance association using an actor-partner interdependence model, where "actor" effects represented the relation between each member's outcome expectancy at one session and their own next session alliance. And "partner" effects represented the relationship between each member's partner's outcome

expectations at one session and their own next session alliance. The results of this study revealed that 1) at the within-dyad level, there were expectancy-alliance actor effects for both patients and therapists; 2) there was a within-dyad partner effect, such that when clients reported higher outcome expectancy at one session their therapists reported better alliance in the next session. Moreover, both of these effects translated into better therapy outcome; supporting not only a dependency between outcome expectancy and alliance between clients and therapists, but finding evidence that this seems to impact outcomes.

In short, the few studies that have measured and examined therapist outcome expectancies have consistently supported these expectations as having significant prognostic value, even very early in treatment, and in some cases beyond clients' own outcome expectations and other prognostic factors, such as symptom severity. However, in these studies examining therapist expectations often seems secondary to the main purpose of the studies, which was to examine the prognostic significance of client expectations. Moreover, investigators have also often either not explained these findings or findings have been interpreted in terms of the prognostic accuracy of therapists (i.e., "therapists' as prophets" or "prognosticators"). And in some cases, researchers acknowledged the possibility that therapists may not be psychics but rather that therapist expectations actually influence the process of therapy (and hence outcome) creating a self- or other-fulfilling prophecy (Kirsch, 2005; Rosenthal, 1994).

Interpersonal expectancy. Given existing research delineating the robust capacity of our expectations to pull for confirmation (Greenberg, Constantino, & Bruce, 2006; Kirsch, 2005; Rosenthal & Jacobsen, 1968), there is reason to suspect that therapist outcome expectations may operate in the same manner. Specifically, research on interpersonal expectancy effects in the social psychology domain (e.g., Goldenberg, 1992; Rosenthal & Jacobsen, 1968; Rosenthal,

1994; Weiner, 1979) seems relevant to psychotherapy process research in suggesting that, similar to client outcome expectations, therapists who have greater expectations for their clients may go on to have clients who experience greater improvements in therapy.

In Rosenthal and Jacobsen's classic study (1968), randomly selected children whose teachers were led to believe that their students would demonstrate surprising intellectual gains did in fact show greater gains than children in the control group. This research was groundbreaking in demonstrating how teachers' expectations might serve as self-fulfilling prophecies, such that children may become "brighter" when expected to by their teachers. Studies evaluating the influential role of teachers' expectations on student performance (e.g., Goldenberg, 1992; Rosenthal & Jacobsen, 1968; Weiner, 1979) may serve as a basis for exploring the potential effects of therapists' expectations on client outcomes in therapy. Moreover, they offer preliminary evidence to support that therapists' own expectations for their clients may matter in determining therapeutic outcome, and potentially beyond clients' own outcome expectations.

The mediation of such Pygmalion, or "Rosenthal," effects has been conceptualized to involve teachers' non-verbal behaviors, including increased warmth, patience and perseverance, and the provision of differentiated feedback to the high-expectancy students (Harris & Rosenthal, 1985; Rosenthal & Jacobsen, 1968; Rosenthal, 1994). It is possible that similar mediation occurs in therapy when therapists have high expectations for their clients. That is, therapists' who expect clients to have the ability to benefit from treatment (or believe in the *efficacy* of the treatment being administered) may elicit a powerful self or even other-fulfilling prophecy (Kirsch, 1990). Such therapists may behave in a more interpersonally facilitative manner that encourages clients to confirm therapist expectations.

Likewise, it is possible that therapists who hold pessimistic outcome expectations for their clients unwittingly contribute to their clients' poor therapeutic outcome, in this case pulling for confirmation in the opposite direction. For example, using a measure that was developed to capture the emotional reactions therapists have toward clients, Wolff and Hayes (2009) found that therapists with stronger negative reactions to their clients were seen as less empathic and less effective by their clients with drug and alcohol problems. Also using this same measure of therapist emotional reactions, Westra, Aviram, Connors, Kertes, and Ahmed (2012) reported that early therapist positive reactions to clients, such as liking, fondness, felt connection with the client, and optimism about client's future were consistently linked to lower midtreatment resistance (as observed by independent raters). Moreover, such positive attitudes towards the client were associated with change in client resistance levels from early to midtreatment. Although this study did not measure therapist expectations per se, it may be that more positive and less negative feelings of therapists towards their clients is associated with better client engagement in therapy.

Moreover, relationship strains such as those encountered in resistance, may themselves adversely affect therapist reactions and attitudes toward clients. For example, Zickgraf et al. (2015) reported that even though resistance was rare in the context of CBT for panic disorder, it had a strong and consistent ability to negatively impact therapists' adherence to CBT model (Zickgraf et al., 2015). In particular, higher client resistance was associated with lower CBT model adherence. Similar findings were reported by Boswell and colleagues (2013) who found that in the context of CBT for panic disorder, higher levels of client hostility were associated with lower therapist adherence (Boswell et al., 2013). The authors concluded that the interpersonal aggression that often accompanies alliance strains could significantly derail

therapists by creating a “therapist drift” in fidelity to treatment. Similarly, Castonguay and colleagues (2010) found that interpersonal hostility may result in therapists being pulled off-track, feeling deskilled, and responding in a hostile and possibly harmful way (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Taken together, the reviewed studies suggest the importance of monitoring therapists’ expectations that might directly or indirectly impact therapy outcome. Therapists’ beliefs in their clients might be an empowering strategy to boost therapy outcome, to bolster clients’ hope in the benefit of therapy and to help form a strong therapeutic alliance. Moreover, negative reactions to clients may be detrimental to therapists’ reactions and possibly their expectations for a positive outcome.

Before considering the aims of the present study, I briefly elaborate the study context of patients with generalized anxiety disorder.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) is a chronic condition that is characterized by excessive and uncontrollable worry and that is associated with significant personal and economic costs (e.g., Mendlowicz & Stein, 2000; Katon et al., 1990). The core processes associated with the condition include intolerance of uncertainty (Ladouceur et al., 2000), positive and negative beliefs about worry (Wells & King, 2006), emotional avoidance and interpersonal problems (Newman et al., 2008). While considered to be the frontline treatment for anxiety disorders, (e.g., Chambless et al., 1996) nonresponse to CBT is a common occurrence (e.g., Westen & Morrison, 2001). In the area of GAD specifically, up to 50% of clients may be considered nonresponders to CBT (e.g., Hunot, Churchill, Teixeira, & Silva de Lima, 2007). Client ambivalence has been proposed as a critical factor limiting the effectiveness of CBT (e.g., Westra, 2004). In addition,

researchers have also found that CBT has the lowest average effect size for GAD when compared to CBT for other anxiety disorders (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008).

Clients with GAD have been found to hold both positive (e., “worry motivates me” or “worry prevents bad things from happening) and negative (e.g., “worry interferes with my life) beliefs about worry (e.g., Borkovec & Roemer, 1995; Westra, 2004). Moreover, worry has been found to have important avoidant and self-reinforcing functions protecting the individual from experiencing feared emotional arousal (Borkovec, 1994). Such ambivalence about worry can be expressed indirectly in CBT especially around the tasks of therapy in the form of homework noncompliance, arguments with the therapist and failure to be an active participant in the therapy process (e.g., Newman 2002; Westra, 2004). Thus, unless ambivalence is addressed it appears less likely that individuals with GAD will respond to standard lines of treatment. In an effort to improve therapy response rates for individuals suffering from GAD, therapeutic approaches designed to increase intrinsic motivation of clients and decrease ambivalence about change (core processes associated with GAD) have been developed and integrated into CBT in recent years (Marker & Norton, 2018; Westra, 2012; Westra, Constantino, & Antony, 2016;).

Overview and Aims of the Present Study

As noted previously, while resistance is negatively associated with outcome, little is known about the mechanisms through which resistance exerts this negative influence. In a parallel fashion, there is widespread agreement on the importance of hope or outcome expectations as a common factor influencing outcomes in therapy. Although little is known about how precisely to foster faith and hope in therapy, a positive therapeutic relationship has been postulated as a key factor. Accordingly, when considering variables which might be impacted by alliance strains,

such as those present in resistance, demoralization or reduced client and therapist outcome expectations seems to be reasonable candidate for further examination.

Thus, the aims of the current study were to investigate: (1) whether greater resistance is associated with a decline in subsequent client outcome expectations, (2) whether greater resistance is associated with a subsequent decrease in subsequent therapist outcome expectations, and (3) whether any reduced outcome expectations immediately following resistance might mediate or explain the impact of resistance on therapy outcomes. These questions were examined in the context of a randomized clinical trial (RCT) of CBT for severe GAD (Westra, Constantino, & Antony, 2016). It was hypothesized that higher levels of mid-treatment resistance would be followed by a reduction in both client and therapist outcome expectations, which in turn would both be associated with poorer therapy outcomes in terms of post-treatment worry. That is, reductions in both client and therapist outcome expectations following resistance were expected to mediate therapy outcomes.

Method

Data for the present study were derived from a RCT comparing CBT alone to CBT integrated with motivational interviewing (MI-CBT) for severe generalized anxiety disorder (GAD; Westra, Constantino, & Antony, 2016). The CBT alone group was used in the study given that MI-CBT therapists were explicitly trained in the management and minimization of resistance, thus restricting the phenomena of interest. A local Institutional Ethics Review Board for research involving human participants approved all measures and procedures in the larger RCT; a separate approval was obtained for the current study that used the data collected during the parent RCT. Informed consent was obtained for all study procedures at the time of initial study intake.

Participants and Selection

Clients were enrolled in the original RCT over an eighteenth-month period, from February 2012 to April 2013. They were recruited from community advertisements in the greater Toronto area directed towards individuals who worry excessively. Forty-four adults were randomized to the CBT-alone group (ten of the included cases were practice cases); all clients completed fifteen sessions of CBT. The first step in the selection process involved a phone screen to ensure that participants would likely meet criteria for GAD based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV-TR; American Psychiatric Association, 2000). Next, participants who had a high probability of meeting diagnostic criteria for GAD and who obtained a score of 68 or higher (out of a possible 80) on the *Penn State Worry Questionnaire* (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990) were invited to complete the *Structured Clinical Interview for Axis-I DSM-IV Disorders* (SCID-I; First, Spitzer, Gibbon, & Williams, 1996).

The diagnostic interviews were conducted by advanced doctoral students in psychology; all students were trained to criterion in the administration of the SCID-I. Inter-rater reliability was obtained by reviewing a random sample of 25 percent of audio-taped interviews for participants who were successfully enrolled in the study. Reliability was found to be good, with an overall kappa for all diagnoses of .75, and 1.0 for GAD in particular. The correlation between reliability raters for GAD severity was $r = .79, p < .001$. All participants met the DSM-IV diagnostic criteria for GAD, which was updated to include DSM-V criteria (American Psychiatric Association, 2013). The PSWQ was re-administered at the time of the in-person interview, and only participants who scored above the cut off for high severity GAD (i.e., above 68) were considered eligible. Given the high rates of comorbidity between anxiety and

depression (Stein, 2001; Wittchen, Zhao, Kessler, & Eaton, 1994), individuals with comorbid depression and/or other anxiety disorder diagnoses were included to enhance external validity.

Additional inclusion criteria included being at least 16 years of age, receiving a GAD severity score on the diagnostic interview (SCID-I) of at least 4, no concurrent substance dependence or substance dependence within 6 months prior to study inclusion, no history of psychotic or bipolar mood disorder, no evidence of neurological problems, major cognitive impairment, or learning disability, and no significant suicidal ideation. Clients were required to not engage in any concurrent psychotherapy and to refrain from taking benzodiazepine medications for at least two months prior to study enrollment. Those clients who were concurrently using an antidepressant were required to be on a stable dose at study entry (i.e., for at least 3 months) and to remain on that dose throughout the study; a washout period of 12 weeks was required for individuals who had recently discontinued antidepressant medication.

Therapists and Therapist Training

There were 13 CBT therapists (all female), including 12 PhD candidates in clinical psychology and one postdoctoral psychologist. Each therapist saw between one and seven clients, with a median of three clients per therapist. To control for allegiance effects that are commonly encountered in RCT's (Luborsky et al., 1999) and to ensure that therapists' orientation aligned with the treatment they were delivering, therapists were nested in each treatment condition. Moreover, therapists also self-selected the treatment they wished to deliver. This ensured that they were all delivering a treatment they believed in and were not required to deliver components of treatment that they did not regard as effective or one that they came to believe over time was less effective.

Training consisted of readings, four day-long workshops, discussions and at least one

practice case with video observation and feedback until competence was reached; therapists in the CBT alone group saw one practice case each and all were deemed competent in the delivery of CBT. Therapists received ongoing supervision for study cases, which consisted of video review and weekly individual meetings with a postdoctoral fellow with expertise in CBT. A recognized expert in CBT supervised the postdoctoral fellow. Case supervisors only oversaw therapists within their treatment group assignment (MI-CBT or CBT alone, respectively).

Treatment

Treatment consisted of fifteen weekly, 1-hour individual sessions of CBT. The treatment manual was derived from several evidence-based protocols of CBT for GAD (e.g., Coté & Barlow, 1992; Craske & Barlow, 2006; Zinbarg, Craske, & Barlow, 2006), and included psychoeducation regarding anxiety and worry, progressive muscle relaxation, training in self-monitoring, cognitive restructuring (i.e., with a focus on probability overestimation and catastrophic thinking), and one or more additional behavioral strategies (e.g., behavioral experiments, reduction of worry behaviors, imaginary exposure to feared outcomes). Homework activities were routinely assigned, including, but not limited to, self-monitoring, relaxation practice, thought records, and eliminating worry behaviors.

Therapists were instructed to implement treatment strategies in a specific order, beginning with progressive muscle relaxation, followed by cognitive restructuring, and specific behavioral strategies. However, the time spent on each treatment component of the treatment protocol was left to the judgment of the therapist as indicated by the needs and responsiveness of clients to each treatment component. In an effort to establish consistency in the management of homework noncompliance or resistance to therapy, procedures for CBT-consistent management were extracted from the literature and therapists were instructed to adhere to them in instances of

non-compliance (e.g., Beck, 2005; Kazantzis & Shinkfield, 2007; Tompkins, 2004; Waters & Craske, 2005). Specifically, the strategies for preventing homework noncompliance, such as working collaboratively to develop homework, anticipating obstacles as well as CBT-consistent manners of responding to noncompliance (e.g., validating the difficulty of completing homework and understanding the reasons for noncompliance, providing psychoeducation on the importance of homework completion, and working with clients to problem-solve obstacles) were emphasized as strategies to manage noncompliance in CBT sessions.

Distal Outcome Measure

Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990). The PSWQ is an extensively used 16-item measure assessing trait worry on a 5-point Likert scale, and was the primary outcome measure in the present study. The PSWQ possesses high internal consistency and temporal stability, as well as good convergent and discriminant validity (Brown, Antony, & Barlow, 1992; Meyer, Miller, Metzger, & Borkovec, 1990). This instrument effectively differentiates individuals with GAD from those with other anxiety disorders and from healthy controls (Brown, Antony, & Barlow, 1992). Total scores range from 16 to 80, with higher scores indicating greater worry. The Cronbach's α for the current study was .62 at baseline (likely secondary to restricted range with only high severity clients included), and .95 at posttreatment assessment.

Proximal Outcome Measure

Credibility and expectancy questionnaire (CEQ; Devilly & Borkovec, 2000). The CEQ is a widely used self-report scale for measuring expectancy for improvement and treatment credibility. The CEQ was used to assess both therapist's and client's belief in the benefit of therapy. Furthermore, in this study an adapted scoring strategy developed by Borkovec,

Newman, Pincus, and Lytle's (2002) was used, in which outcome expectations were assessed based on a participant's response to a single item. To assess *client outcome expectations* clients were asked to respond to the following item, "By the end of therapy how much improvement in your anxiety do you really feel will occur?" clients were asked to rate their responses from 0 to 100 percent. To assess *therapist outcome expectations* therapists were asked to respond to the parallel item, "By the end of therapy, how much improvement in this client's anxiety do you really feel will occur?"

The single-item CEQ expectancy measure has been shown to possess adequate test-retest reliability (Deville & Borkovec, 2000), and to predict adaptive treatment processes and outcomes (e.g., Borkovec et al., 2002; Safren, Heimberg, & Juster, 1997). Previous studies have also used a single item to assess outcome expectations and found that the measure predicts post-treatment outcome (Ametrano & Constantino, 2011; Borkovec et al., 2002; Price, Anderson, Henrich, & Rothbaum, 2008; Vogel, Hansen, Stiles, & Gotestam, 2006).

Process Measures

Adapted client resistance code (Westra, Aviram, Kertes, Ahmed, & Connors, 2009; Appendix A). In the Client Resistance Code (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Patterson & Forgatch, 1985), resistance is defined as any behavior that opposes, blocks, diverts, or impedes the direction set by the therapist. Resistance can be expressed either directly (i.e., verbal statements such as "I do the breathing and it helps but it doesn't fix it", or "I just hate writing things down") or indirectly (i.e., in process, such as disagreeing, ignoring, interrupting). Rather than being considered exclusively a characteristic of clients, resistance is believed to be inextricably embedded in the interpersonal process between client and therapist, and is thus considered, in large part, a measure of interpersonal process. In this sense, this

measure reflects the degree of collaboration in the therapy process. The CRC consists of 11 categories of resistant behavior (e.g., disagreeing, blaming, sidetracking, ignoring) and has been shown to possess good construct and predictive validity (Chamberlain et al., 1984; Patterson & Forgatch, 1984), as well as face and content validity (Bischoff & Tracey, 1995).

The central definition of resistance was retained in the adapted version of the CRC, but the coding was altered in a number of ways to enhance reliability and validity (Westra, Aviram, Kertes, Ahmed, & Connors, 2009). First, the 11 subcategories of resistance in the CRC were collapsed to form a single resistance code. This was done given that the presence or absence of resistance was of primary interest, rather than the particular content forms of resistance, as defined by the CRC. Moreover, using a global definition of resistance aids in achieving reliability among coders in identifying complex processes like resistance given that reliability on a single score (rather than multiple codes) is more readily achievable. Second, rather than using transcripts and segmenting sessions into turns of talk or thought units, videotapes of sessions were segmented into 30-second time bins, and each time bin was coded. Using time bins has a number of advantages in that talk turns do not need to be identified and coding can be done directly from the video. This allows coders to focus on identifying the gestalt construct through the use of both verbal and nonverbal cues. This is particularly important in coding resistance, given that intonations and inflections (rather than particular words) can often denote the presence and intensity of client opposition. The specific length of the time bins was chosen as it was long enough to capture resistance, while still being short enough to ensure valid coding.

Following segmentation, each time bin is rated for the presence of resistance on a 4-point scale ranging from 0 to 3. Zero reflects 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 not sending a unilateral message that he/she is going against the therapist) or in content (e.g., “I do the breathing and it helps, but it doesn’t fix it”). A code of 2 reflects clear and unequivocal resistance in process (e.g., ignoring, not responding, talking over the therapist in order to oppose) or in content (e.g., clearly and unequivocally expressed doubts or disagreements; “Thought records don’t work for me”). Finally, a code of 3 represents hostile or confrontational resistance, that typically occurs in process (e.g., responses that are clearly overly firm and emphatic), but may also occur in content (e.g., “You’ve got your work cut out for you with me!”)

CBT competence. To assess therapists’ competence in delivery of CBT Cognitive Therapy Rating Scale (CTRS; Young & Beck, 1980) was used. The scale includes ratings on eleven dimensions, including General Skills (e.g., collaboration, understanding, interpersonal effectiveness) and Specific Cognitive Therapy Skills (e.g., agenda setting, focus on key cognitions, homework). Scores on the CTRS range from 0 – 66, with higher scores representing higher competence.

Procedure

Resistance coding. The team of resistance coders consisted of three graduate students in clinical psychology (2 PhD and 1 Master’s level) and one licensed psychologist. Two of the coders were involved in adapting the CRC for use with CBT for GAD. The remaining two coders were trained to criterion over a period of 10 months. After reading the *Manual for Rating Interpersonal Resistance* (Westra, Aviram, Kertes, Ahmed, & Connors, 2009), coders participated in a 2-day workshop and coded samples of publicly available therapy sessions, followed by therapy session videotapes from a previous RCT of CBT for GAD (Westra, Arkowitz, & Dozois, 2009). Next, the coders independently rated new practice sessions, meeting

weekly to review discrepancies until they achieved proficiency, as assessed by 85% observed agreement. Coders were unaware of clients' outcome status. Interrater reliability was calculated throughout the coding process to reduce the possibility of coder drift, and was calculated by double-coding 20% of all recordings. Weighted kappa coefficients for each pair of raters ranged from .70 to .98, with a mean of .85, indicating good to excellent agreement (Fleiss, 1981).

For this study, resistance was coded for one session in the middle phase of treatment (sessions 5, 6, or 7). Given previous research indicating that only clear, unequivocal resistance (code of 2) and hostile resistance (code of 3) are predictive of outcomes (Aviram, Westra, & Eastwood, 2011), the present study only considered the frequency of these forms of resistance. That is, each time bin could receive a code of 1, 2, or 3. And only those time bins receiving a code of at least a code of 2 (clear resistance) were considered in the present study. The total level of resistance then was the number of time bins with a code of 2 and/or 3 divided by the total number of time bins.

CBT competence. To rate CBT competence, five undergraduate students were trained over a period of six months in the use of the Cognitive Therapy Rating Scale (CTRS) by the postdoctoral fellow specializing in CBT. Of note, all raters worked independently and met regularly to resolve any questionable codes to achieve consensus. Double coding a subset of 25 percent of independently coded tapes to assess rater reliability yielded an intraclass correlation coefficient (ICC) of .84. The overall rating of the CBT sessions was good, with total scores on the CTRS averaging 45.54 ($SD = 5.28$). CTRS coding was completed on one early session, one middle session, and one late session for 100% of client-therapist dyads.

Clients completed the PSWQ at baseline and posttreatment. Client and therapist outcome expectations (COE & TOE, respectively) were measured after each session. Baseline COE was

measured prior to session 1; that is, before the client encountered the therapist. Baseline TOE was measured after session 1 after the first meeting with the client since a therapist must have some interaction with the client in order to determine their prognostic expectations for that individual.

Results

Client demographics, as well as the means and standard deviations for all study measures are presented in Table 1. The study sample was predominantly female and white, generally well educated, and presented with a high rate of diagnostic comorbidity. The majority of the therapists in the study were in their late 20's ($M = 28.41$, $SD = 3.21$), had on average $M = 213.30$, $SD = 119.76$ therapy hours and identified their primary therapeutic orientation as CBT (86.4%).

CBT competence was good (range of $M = 38.99$, $SD = 7.72$ to $M = 45.98$, $SD = 9.55$). Scores compare favorably, for example, with the average score of 41.28 ($SD = 4.24$) on the CTRS in the CBT group of the Treatment of Depression Collaborative Research Program (TDCRP; Shaw et al., 1999).

Analyses focusing on determining the impact of resistance on COE and TOE as well as the mediation analyses were conducted using Rstudio software. All the relationships (i.e., direct impact of resistance on COE and TOE and mediation) were analyzed in a single model using Structural Equation Modeling (SEM) that is a path analysis using lavaan package (the acronym stands for *latent variable analysis*); the model is depicted in Figure 1. SEM is a powerful multivariate technique that uses path analyses and a system of regression-type equations to capture dynamic and complex relationships in the model of interest (Gunzler, Chen, Wu, & Zhang, 2013). One of the advantages of using SEM as opposed to Barron and Kenny's (1986) method for testing mediation is that the latter is ill-suited to test variables in a causal

relationships, that is, since mediation analysis assumes both causal and temporal ordering among the three variables in the model (intervention, mediator and response) *a priori* assignment of each variable as either a cause or an effect as in Barron and Kenny's model negates the assumption of mediation. Most of all, SEM allows to determine indirect and total effects in a single model as opposed to using ad hoc measures in standard regression models (Gunzler, Chen, Wu, & Zhang, 2013). Finally, SEM provides statistics regarding the model fit of the hypothesized mediation model. Fit indices included: Comparative Fit Index, Tucker-Lewis Index, Standardized Root Mean Square Residual and Root Mean Square Error of Approximation (Hu & Bentler, 1999).

Of note, the unstandardized coefficients were preferred to standardized coefficients as they allow for simple interpretation of an effect of one variable on another. In this study COE and TOE are presented as percentages (clients and therapists rate their beliefs on a scale from 0 to 100% in 10-point increments). To convert resistance scores to percentages in order to match the metric system of COE and TOE, resistance scores (number of time bins with a code of 2 and/or 3 divided by the total number of time bins) were multiplied by 100.

To account for the nested nature of the data, that is, to determine whether there was a therapist effect, the path model was also analyzed using STATA statistical software. To determine if there was a therapist effect the coefficients and probability values were compared to those obtained in SEM model and if the values obtained using STATA were not different from those obtained in SEM no therapist effects were assumed.

The data were investigated for nonlinearity and no concerns were observed. In order to control for the influence of client initial worry severity and initial level of outcome expectations on subsequent expectations, all the analyses were controlled for baseline worry levels (i.e.,

PSWQ) and baseline COE and TOE level. Table 2 contains the summary of individual regression analyses as well as summary of the mediation analysis that tested impact of all variables on the dependent variable of post treatment PSWQ scores.

Resistance and Client Outcome Expectations

Although all paths were analyzed in a single model, for simplicity results for each path will be presented separately. The results indicated that resistance significantly predicted COE, $B = -0.73$, $SE = 0.15$, $p < .001$ (B is the unstandardized slope estimate and SE is the standardized error). That is, an increase in resistance was significantly associated with lower client outcome expectations after the session during which resistance occurred, such that one percent increase in resistance was associated with a 0.73 drop in COE. STATA revealed no significant therapist effects as the obtained values were almost identical to those obtained using SEM in R, $B = -0.74$, $p < .001$.

Resistance and Therapist Outcome Expectations

Similar to COE, the impact of resistance on TOE was estimated. Resistance was found to significantly predict TOE, $B = -0.46$, $SE = 0.12$, $p < .001$. Mirroring the results of COE and resistance, in this analysis an increase of resistance in the midtreatment session was associated with lower post-session TOE, such that a one percent increase in resistance lead to a 0.46 drop in outcome expectancy scores for therapists. Again, STATA revealed no significant therapist effects as the obtained values were almost identical to those obtained using SEM in R, $B = -0.44$, $p < .001$.

Mediation Analyses

Prior to establishing whether COE and/or TOE mediate the relationship between resistance and therapy outcome the effect of resistance on therapy outcome (i.e., PSWQ scores post

treatment) was estimated in a separate model without including COE and TOE. The results indicated that resistance significantly predicted post-treatment PSWQ scores, $B = 0.66, p < .001$; with a one unit of increase in resistance being associated with a 0.66 increase in PSWQ post-treatment. Next, to investigate whether COE and TOE were possible mediators of the relationship between resistance and therapy outcome the full model was estimated. Again, PSWQ scores at baseline, as well as baseline COE and TOE, were used to control for initial worry severity and outcome expectations.

Here, COE post resistance significantly predicted posttreatment worry, $B = - 0.5, SE = 0.11, p < .001$. STATA results, $B = - 0.46, p = .002$, indicated no significant therapist effects. Specifically, a one percent increase in resistance was associated with 0.73 drop in COE, which in turn was associated with a 0.5 increase in PSWQ scores post treatment.

In terms of TOE the results did not support a significant association between resistance, TOE and post-treatment worry, $B = - 0.02, SE = 0.14, p = .876$. That is there was no support for mediation. With COE and TOE taken into account resistance no longer predicted PSWQ posttreatment, $B = 0.25, SE = 0.18, p = .161$, suggesting that COE fully mediated the relationship. That is, reductions in COE is a path through which resistance exerted its negative impact on therapy outcome in this study.

In the current mediation model robust fit indices included: Comparative Fit Index (CFI; generally $CFI > 0.9$ indicates satisfactory fit), Tucker-Lewis Index (TLI; generally $TLI > 0.9$ indicates satisfactory fit), Standardized Root Mean Square Residual (SRMR; generally SRMR close to 0.08 indicates good fit), and Root Mean Square Error of Approximation (RMSEA; generally $RMSE < 0.05$ indicates good fit) (Hu & Bentler, 2009). The model fit indices indicated that the model in the study had a good fit: $CFI = 1.00, TLI = 1.06, SRMR = 0.05, RMSEA =$

0.00.

Discussion

Resistance has been identified as a significant obstacle to effective therapy (Binder & Strupp, 1997). Although resistance is a relatively rare phenomenon, it can be challenging to navigate and poorly managed resistance can lead to poor therapy outcome (Westra & Norouziyan, 2018). Most importantly, in the context of CBT, resistance is considered to be a factor limiting the effectiveness of the treatment (e.g., Antony, Ledley, & Heimberg, 2005; Gilbert & Leahy, 2007). In addition, the psychotherapy literature increasingly highlights the importance of common factors in promoting positive therapy outcome. For example, outcome expectations have been argued to be critical for the therapeutic alliance and positive therapy outcomes.

Despite the recognized importance of resistance to therapy outcomes, it is not clear exactly *how* resistance operates. In the current study I sought to investigate one major mechanism through which resistance may exert its negative impact on therapy outcome: via outcome expectations (client & therapist) or participant optimism about therapy outcome. These questions were investigated in the context of a recent randomized controlled trial of CBT for GAD.

Resistance and Client Outcome Expectations

In the present study, consistent with previous research (Westra, Constantino & Aviram, 2011), higher levels of midtreatment resistance were associated with reductions in subsequent client outcome expectations. Specifically, an increase in the frequency of resistant moments was associated with a significant subsequent drop in client estimates of expected improvement. These findings suggest that presence of resistance is *demoralizing* as it is associated with decreases in client's expectations of therapy benefit. Stated differently, when clients find themselves arguing and disagreeing with therapists, or feel that they are being ignored and dismissed by therapists,

and/or experiencing their therapists as controlling, convincing, and persuading, they experience this as demoralizing (i.e., they lower their expectations of treatment success).

Importantly, the results suggest that this lowered morale goes on to impact the overall outcome of therapy. That is, when the drop in client expectations following resistance was accounted for resistance no longer predicted therapy outcome. This supports the conclusion that the common factor of client outcome expectations might be a mechanism through which resistance exerts its toxic impact on therapy outcome since it was found to fully mediate outcomes.

One possible explanation for these findings involves Kirsch's contention that expectations are self-fulfilling and pull for confirmation (Kirsch, 1990). Thus, it is possible that when clients experience resistance, their associated lowered outcome expectations (i.e., demoralization) may influence subsequent process to confirm these new lowered expectations. For example, clients might not work as hard or invest as much in treatment if they believe that recovery is unlikely.

These findings converge with quantitative and qualitative research on alliance strains. For example, the findings of the present study converge with those of an intensive interpersonal process analysis during resistance episodes, using the Structural Analysis of Social Behavior (SASB, Benjamin, 1974), between clients who went on to have high versus low outcome expectations following the first session of CBT for GAD (Ahmed, Westra, & Constantino, 2012). Rather than complementing therapist affiliative relational bids, clients who went on to have low versus high outcome expectations, separated from the therapist to assert their own positions, disclosed much less, and were significantly more likely to engage in hostility during resistance episodes. These findings further underscore a potentially potent association between in-session interpersonal process and early client outcome expectations.

Moreover, qualitatively, Coutinho, Ribeiro, Hill, and Safran, (2011) reported that those clients who experienced alliance ruptures described feeling demoralized i.e., abandoned or criticized by the therapist. The authors added that during alliance rupture clients also reported feeling sad, helpless, ambivalent, confused and desperate. Importantly, clients reported that these events lead to *a loss of confidence* in the therapist or in the possibility of getting help from therapy. For example, Coutinho et al. cited one client who reported that she had already been losing motivation in therapy and following an alliance rupture she completely lost interest in therapy. Furthermore, following alliance ruptures clients reported feeling vulnerable (e.g., more upset, tired, and that the negative effects lasted all day or week after the session). Clients also reported feeling angry and disappointed with their therapists and some reported feeling so indignant that they wanted to go back and demand their therapists explain why they said what they said (Coutinho, Ribeiro, Hill, & Safran, 2011).

In short, these studies suggest that alliance ruptures can stir up powerful feelings in clients that leave them feeling discouraged and demoralized. Such studies also fill an important gap in our impoverished understanding of the influences on client expectations (Weinberger, & Eig, 1999), and converge in finding that interpersonal processes marked by low levels of affiliation between client and therapist may be a potential influence on such expectations. That is, experiencing miscoordinated collaboration or disrupted attachment with one's clinician may result in clients feeling less optimistic about the treatment's ability to help. Stated differently, during moments of resistance when clients' freedom to express their disagreement or oppose the direction set by the therapist or therapy is limited (i.e., when clients find themselves communicating their disagreement in an assertive, distancing, or even hostile manner) it tends to be associated with a lowered belief in the ultimate effectiveness of treatment.

Resistance and Therapist Outcome Expectations

Similar to the impact on clients, the occurrence of resistance was also found to be *demoralizing* for CBT therapists. In particular, higher levels of resistance were associated with a significant lowering of the therapist's belief in the ability of their client to benefit from treatment. However, unlike client outcome expectations, therapist outcome expectations were not found to play a mediating role vis-à-vis outcome; suggesting that it is the client's and not the therapist's perceptions of resistance that are important to therapy outcome.

As note earlier, there are some studies that *have* found therapist expectations to be significantly associated with outcomes. However, these studies have typically not included client outcome expectations or when they have included both therapist and client outcome expectations, they did not analyze them in a single model (e.g., Lewin, Peris, Bergman, McCracken, & Piacentini, 2011; Connor & Callahan, 2015). That is, they did not examine the impact of therapist outcome expectations, when first accounting for the known impact of client expectations on outcomes.

The notion that it is the clients' perceptions of important therapy processes that is important to outcome has been echoed in other research. For example, Elliot and colleagues found client's perceptions of empathy predicted outcomes better than therapists' perceptions of empathic accuracy measures (Elliott, Bohart, Watson, & Greenberg, 2011). Interestingly, in their meta-analytic review on the impact of alliance on individual therapy outcome Horvath and his colleagues (2011) reported that in the early phases of therapy, therapist and client's perceptions of alliance do not match (Horvath, Del Re, Fluckiger, & Symonds, 2011). Specifically, integrating the findings from over 200 research reports based on 190 independent data sources the researchers found that the relationship between client perceived alliance and

individual therapy outcome was stronger ($r = .28$) compared to the link between therapist perceived alliance and therapy outcome ($r = .20$). The authors emphasized that misjudging the client's perception of alliance, that is assuming that the alliance is good, can render therapy less effective; thus, it is recommended that therapists monitor client's perception of alliance throughout their work with them, instead of assuming.

A number of other studies have reported a similar trend of clients' perceptions influencing therapy outcome more than therapists'. Marmarosh and Kivlighan (2012) compared 36 client-therapist dyads in an effort to identify the relationship among client and counselor agreement about the working alliance, session evaluation and client symptom change. The authors reported that sessions were rated as "smooth" when both therapists and clients agreed on their ratings of the working alliance and when the alliance was rated as high. Echoing findings of Horvath and colleagues (2011) and Elliott and colleagues (2011), Marmarosh and Kivlighan also found that clients perceived sessions as "smooth" when their ratings and not the therapist's ratings of the working alliance were high and less "smooth" when therapists' ratings of alliance were higher than those of their clients; these lend yet more support to the notion that it is the client's perceptions that are the most important to therapy process.

Research by Zilcha-Mano and colleagues (2015) that focused on delineating the unique impact of therapist-reported alliance on therapy outcome has revealed a similar trend. Namely, the authors examined the relationship among 149 patients diagnosed with depression who were randomized to dynamic expressive-supportive therapy, antidepressant medications combined with clinical management, and placebo with clinical management. The results of the study revealed that therapist's average alliance score for an individual patient was not associated with therapy outcome. In addition, the relationship of therapist's alliance scores to outcome was

mainly a within-patient effect rather than between-patient effect (i.e., time-specific improvement in alliance reported by the therapist was due to decrease in reported symptoms). In relation to genuineness, Eugster and Wampold (1996) found that when the client perceived their therapists as being “real” reported session progress was better, compared to when therapists’ rated their own genuineness. In a later study, Zilcha-Mano and colleagues found that therapist-rated alliance had a stronger impact on outcome in alliance-focused therapies compared to cognitive-behavioral therapy (Zilcha-Mano, Muran, Hungr, Eubanks, Safran, & Winston, 2016).

In short, client’s perceptions of important therapeutic processes (e.g., alliance, empathy) seem to be better predictors of therapy outcome than therapists’ ratings of the same processes. Carl Rogers in 1959 suggested that in the outcomes of therapy the client is the one who accurately perceives the other person. If therapists are unaware of these findings, they can make erroneous assumptions about the alliance. For example, it is possible that the therapist can assume that once the therapeutic alliance has been established it would remain intact and thus they may be less inclined to monitor any fluctuations in alliance or to seek feedback from clients. Similarly, therapists might regard themselves as possessing qualities necessary to establish a strong bond (e.g., empathy, unconditional positive regard, genuineness) and once again be less aware or less inclined to check how the client is experiencing them in relation to possessing such qualities.

Resistance and Therapist Morale

Even if it was not associated with client outcomes when accounting for client perceptions, relationship strain (i.e., resistance) *was* found to be demoralizing to therapists. And this finding may be valuable in and of itself in terms of raising therapist awareness. The finding that resistance negatively impacts therapists’ morale is consistent with findings from Coutinho and

colleagues (2011) who observed that following alliance rupture therapists reported feeling ambivalent, confused, guilty, and incompetent. Moreover, they found that therapists reported feeling that clients left sessions feeling invalidated and rejected.

This decrease in therapist morale might have other unintended consequences including the possibility that therapists might not work as hard in subsequent sessions if they perceive that therapy is unlikely to be successful for a given client. That is, resistance may “contaminate” or negatively influence therapist beliefs in their clients and their ability to improve in therapy; after all, it is harder to believe in the client who the therapist may perceive as thwarting their efforts to help or one who is perceived as being ‘difficult’ or noncompliant. This notion is similar to observations in research finding that resistance can cause therapists to “drift” or get ‘derailed’ from CBT protocols (e.g., Boswell et al., 2013). Specifically, in the context of CBT for panic disorders Boswell and colleagues (2013) observed that patient trait interpersonal aggression was related to lower observer competence ratings of CBT therapists. The authors noted that consistent with previous research, interpersonally challenging clients can lead to treatment- and therapist-rejecting behaviors that in turn may lead to therapists feeling deskilled, being pulled off-track and responding in possibly unhelpful ways. Most of all, the authors added that although many CBT protocols include strategies for dealing with resistance such as homework noncompliance, therapists may be less well equipped to manage interpersonal resistance.

In short, therapists inevitably encounter interpersonal situations in therapy that are very difficult to deal with and navigate effectively such as client noncompliance, opposition or resistance to change, failure to make progress, client hostility and/or criticism directed at the therapist or therapy. These can often lead to therapeutic impasses and strong emotional reactions in therapists (anxiety, helplessness, frustration, etc.). And stepping out of the typical and

automatic negative reactions (reduced empathy, control, persuasion, defensiveness, etc.) to these situations has been characterized as quite a difficult problem for therapists (Binder & Strupp, 1996; Westra, 2012). In addition, there is mounting evidence that how therapists navigate these impasses may be critical to client outcomes. For example, in a prospective study, responses to video vignettes of difficult interpersonal scenarios were predictive of actual client outcomes when those trainees later went on to see clients (Anderson et al., 2016).

Fostering Hope in Therapy

The present study makes an important contribution to understanding the influences on outcome expectations. In particular, we know that it is important to foster hope in therapy, yet little empirical guidance is available on how to achieve this. Given the findings of the present study, learning how to recognize and manage resistance might be one such strategy given its link with demoralization, especially client loss of confidence in therapy benefit. Furthermore, this is consistent with Frank and Frank's (1991) contention that a strong therapeutic relationship is a major vehicle for sustaining client morale.

Resistance has been long regarded as a central phenomenon to the course of therapy (e.g., Beutler, Clarkin, & Bongar, 2000; Beutler, Goodrich, Fisher, & Williams, 1999; Beutler, Harwood, Michelson, Song, & Holman, 2011; Binder & Strupp, 1997). Psychotherapy research has consistently shown that resistance to a therapist or a therapy can be detrimental to maintaining a strong therapeutic collaboration and therapy outcome. For example, clients experiencing higher levels of resistance may not benefit from the therapy and/or can terminate therapy prematurely when compared to the clients who do not exhibit resistance and/or those who are able to manage resistance successfully in therapy (e.g., Beutler, Moleiro, & Talebi, 2001; 2002). Most of all, although the absence of resistance may not necessarily predict

effectiveness of therapy, the presence of even small doses of resistance can have detrimental effects on the therapy process, including poor outcomes and limited client engagement (e.g., Aviram & Westra, 2011; Binder & Strupp, 1997).

Given its association with therapy process and outcome, resistance can be considered an important clinical marker that must be attended to and effectively managed. However, navigating and managing resistance is not an easy task (e.g., Binder & Strupp, 1997). Moreover, therapist observation of key process phenomena, such as resistance, cannot be assumed and is often difficult, as process cues indicating alliance tensions can be subtle and relatively invisible (Hara, Westra, Aviram, Button, Constantino, & Antony, 2015).

There is good evidence in psychotherapy literature that suggests that therapists' behaviors during moments of resistance maintain client resistance, such that a more supportive and less directive style can be effective in managing resistant moments (Beutler et al., 2011; Westra & Norouzian, 2018). For example, qualitative and quantitative studies consistently find that shifting to a supportive rather than a directive style of therapy when relationship strains occur is beneficial to therapy outcome (e.g., Aspland et al., 2008; Castonguay et al., 1996). In particular, Castonguay and colleagues (1996) observed that relationship strains can occur when CBT therapists increase their adherence to the model and persistent with the application of certain techniques despite clients' expressed disagreement and lack of engagement in the process. The benefit of responding in a supportive manner in moments of resistance was also echoed by Aspland and colleagues (2008) who reported that successful resolution of alliance ruptures was only achieved when CBT therapists reduced their focus on the treatment rationale and specific techniques, and instead, in collaboration with the client, focused on what was most salient for the client. Similarly, Ribeiro and colleagues (2014) recommended that therapists' adopt an accepting

rather than challenging stance when working with ambivalent clients in order to preserve the therapeutic relationship and promote positive therapy outcome. Specifically, the authors observed that when clients expressed their ambivalence and therapists responded by insisting that the clients adopt an alternative framework, clients in turn responded with reactance/resistance further contributing to the client feeling “stuck”. The authors encouraged therapists to respond with acceptance in such instances and explore clients’ ambivalence before challenging the client’s position.

When take together with the results of the present study, this indicates that successful resolution and/or management of resistance may be critical to sustaining client hope in the benefit of treatment. Frank and Frank (1991) posit that an emotionally charged and confiding relationship with a helping person is an important means of *remoralizing* clients. In particular, Frank and Frank argued that when the client perceives the therapist as competent and having a genuine concern for them it increases the client’s willingness to depend on the therapist for help. Most of all, according to Frank and Frank when therapists are *genuine* in regard to their clients and when they accept their clients for who they are (and accept their positions/perspectives), their motivation to help the client persists regardless of the client’s condition. Thus, a positive relationship may not only be instrumental in maintaining client morale but may be equally beneficial to the therapist and their belief in the client.

Wampold (2007) made a similar proposition regarding the importance of sustaining client morale. Specifically, he argued that when the client feels understood and accepted by the therapist they are more willing to accept an alternative, less demoralizing explanation of their problems. Furthermore, therapy is not regarded as an enterprise in which an alternative explanation is offered by the therapist but rather a special interpersonal process where alternative

explanations emerge as a result of collaborative work based on a strong therapeutic relationship (Wampold, 2007; Baldwin, Wampold, & Imel, 2007). Accordingly, managing deviations from this collaboration such as resistance and alliance tensions/ruptures, takes on particular importance.

A prominent expectancy researcher Irving Kirsch also emphasized the reciprocal nature of the relationship between the therapeutic alliance and expectations (e.g., 1985, 1990, 1997). Kirsch noted that clients' perception of their therapist as trustworthy increases the likelihood that therapists' interpretations will be accepted, which in turn enhances expectations. Kirsch also contended that the client is the expert on their life while the therapist is an expert in intervention methods. He further argued that when ruptures in the therapeutic relationship occur the therapist should respond by empathizing with the client, accepting the client's anger and recognizing their own contribution to the rupture, as opposed to responding with anger and criticism toward the client. In his work on expectancy modification Kirsch (1990) noted that providing empathy and communicating understanding of a client's experiences is critical. Both Frank and Kirsch emphasize the importance of a strong therapeutic relationship to expectancy enhancement. Moreover, each highlights other factors that are critical to improving expectations, such as openly inquiring about client's expectations, providing realistic information that can modify expectations, correcting misconceptions about therapy and providing feedback that highlights strengths and changes.

Ahmed and colleagues (2012) noted that enhancing clients' positive expectations for change can also be achieved by therapists' sensitivity to interpersonal processes. That is, therapists should carefully observe their clients' behaviors especially in key moments of resistance: when clients oppose the direction set by the therapist and/or doubt and challenge

therapy or a therapist. In such moments therapists should observe whether clients are reciprocating their interpersonal bids; for example, if therapists affirm and express understanding clients should accordingly respond by opening up and disclosing more. Stated differently, therapists should carefully observe whether harmony is preserved in moments of resistance; that is, whether clients are engaged and collaborating or disengaged and not collaborating. In particular, Ahmed et al. (2012) contend that when resistance occurs and a client responds by separating from their therapist, asserting their beliefs and not disclosing in a non-friendly and even hostile manner it should signal to the therapist that the client is not on board and is not collaborating. Moreover, it is therapist's responsibility and obligation to get the collaboration back on track. This suggests then that therapists should remain attuned to such signals of relational conflict that are most common in the moments of disagreement, or when a client is challenging the therapy process or the therapist.

Stated differently, clients behaviors during resistance can serve as critical signals and potent sources of feedback to therapists. For example, when disharmony between therapists and clients' behaviors is observed, therapists should perceive this as a signal to shift their behavior (e.g., be more responsive and open to clients' concerns as opposed to pushing their own agenda onto their clients) in order to draw the client back into a harmonious, positive, and collaborative relationship. That is, therapists should remain open and willing to hear and respond to clients' concerns and make efforts to communicate to their clients that their concerns are valid without clients having to fear jeopardizing the therapeutic relationship. The client should feel that they are able to influence the course of therapy, that they can safely express their doubts and that their concerns will be taken seriously and will be attended to. Such interaction is empowering as it may also enhance the client's sense of agency; an effect that can last well after therapy is over

(Westra, Constantino, & Antony, 2016).

It is worth noting that therapists may not be naturally inclined to hear negative feedback about therapy techniques and/or remain open to criticism toward themselves as therapists. Indeed, research suggests that it is difficult and challenging for therapists to hear messages opposing their suggestions or preferred directions (e.g., Binder & Strupp, 1997). 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 provocative behaviors such as disagreement, opposition, challenging of the therapist or therapy, criticism, or even hostility (e.g., Fremont & Anderson, 1988; Henry, Strupp, Schacht, & Gaston, 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). As such, Binder and Strupp (1997) contend that the therapist's ability to establish and maintain a positive therapeutic alliance when they inevitably encounter such behaviors has been vastly overestimated.

Perceptions of Resistance in CBT

In addition to experiencing common and natural difficulties dealing with interpersonal conflict, therapist unproductive directive and controlling responses to resistance may be particularly likely when working within the context of the CBT model. Within the CBT framework, opposition (e.g., homework non-compliance, disagreement with therapist advice, challenging the therapist/therapy) can be 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 behaviors (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 (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 often 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-behavioral 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 their 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 their 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., non-compliance, disengagement, withdrawal etc.), is seen as an impediment to treatment progress, engaging in

behaviors 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.

However, this very ability to ‘roll with resistance’ seems to be critical in fostering good outcomes, perhaps vis-à-vis sustaining clients’ beliefs in the benefit of therapy. In support of this, a recent study found that within CBT, natural variations in therapist use of Motivational Interviewing (MI) spirit – a client-centered approach focused on expressing empathy, validating clients’ concerns and accepting of clients’ doubts – to manage moments of disagreement between client and therapist were strongly associated with better subsequent process and outcomes (Aviram, Westra, Constantino, & Antony, 2016). The findings of the present study suggest that one mechanism through which such an effect might occur is through sustaining client morale. That is, it is possible that when clinicians respond to disagreement with support rather than control or confrontation, this nurtures client confidence in the treatment process. Considering that many instances of resistance in CBT center on the tasks of treatment, if such therapist flexibility does not occur, therapists risk losing the confidence of clients in the treatment process. Thus, increasing therapist awareness of signals of client resistance may improve performance at key moments, and ultimately, enhance therapy outcomes (e.g., Constantino, Boswell, Bernecker, & Castonguay, 2013).

Why would Failure to Roll with Resistance Reduce Client Confidence?

To answer this important question, research on interpersonal problems and GAD in particular will be considered. Interpersonal difficulties marked by submissive and non-assertive

behaviors are prevalent in individuals with GAD (Przeworski et al., 2011). For example, people with GAD worry about interpersonal matters more so than any other topic (Roemer, Molina, & Borkovec, 1997), and are highly sensitive to interpersonal threats, as evidenced by self-reports of sensitivity and hypervigilance (Nisita et al., 1990). Furthermore, researchers have found that unaddressed interpersonal problems may lead to a failure to sustain treatment gains made in CBT for GAD (Borkovec, Newman, Pincus, & Lytle, 2002).

According to Safran and Muran (2000), strains in the therapeutic alliance tap into the tension between human needs for agency and relatedness, and the resolution of alliance ruptures can provide important opportunities for clients to learn to negotiate these dialectical needs in a constructive fashion. Accordingly, viewing breaches in the alliance merely as issues of client noncompliance or obstacles to be ‘smoothed over’ can prevent therapists from recognizing these as critical opportunities to gain access and work with clients’ characteristic interpersonal patterns and ways of navigating needs for agency and connection (Stevens, Muran, & Safran, 2003).

Extending this notion to the current study, when the client explicitly disagrees with or opposes the therapist’s direction (which is exceptionally difficult for clients in general, and especially in the case of anxiety and GAD), the client is deviating from their expected or typical interpersonal pattern of deference. This deviation, then, represents an opportunity for the therapist to either confirm (perpetuate) or disconfirm (provide a corrective relational experience that serves to counter) the client’s relational schema. Conceivably, a therapist who cultivates the MI spirit in response to client opposition - by shifting their focus in order to understand and validate client concerns about treatment, by actively incorporate client input in therapy, and by explicitly supporting the client’s autonomy-taking behavior - is communicating an important interpersonal message to the client. The message is that the client’s thoughts and feelings are

important, understandable, and worthy of exploration. They are also communicating that it is safe for them to articulate disagreement or go against the therapist's (another's) direction.

Furthermore, a therapist who behaves empathically in response to disagreement (as opposed to becoming defensive, controlling, or withdrawn) is challenging the client's relational schema by modeling the ways in which self-assertion can serve to increase intimacy, trust, and closeness in relationships. Occupying this alternative frame of reference to the client's understanding of self and other may serve to increase the client's confidence in the therapeutic relationship, thus leading to a greater ability to work together in therapy. Moreover, this corrective experience may also serve to counter the client's negative expectations that behaving assertively and exerting one's agency is destructive to maintaining relationships.

In contrast, a therapist who remains directive in the presence of resistance (e.g., by explicitly assuming an expert role, insisting on his or her point of view as more relevant than that of the client's, and relying on persuasion at the expense of exploring the client's perspective) risks communicating to the client that his or her reservations about treatment are misguided and irrelevant to the process of therapy, as well as inferior to those of the therapist. This directive response may also communicate that the client should put aside their thoughts and feelings in favor of those of the therapist (i.e., defer). It is easy to envision how the latter interpersonal message may serve to reinforce the client's belief that he or she needs to be accommodating in order to maintain safety in relationships, and that attempts at self-assertion are errant and will be ignored or met with confrontation, rejection, and disapproval. Not only does this message serve to discourage the client from asserting their wants and needs to the therapist (thus diminishing safety and the ability to work together in therapy), but more dangerously, this may reinforce the client's tendency to distrust and disregard their personal sensibilities, thus essentially

compromising the client's sense of agency and trust in self. In other words, in this scenario, the annihilation of agency experienced developmentally in relation to caregivers is echoed in the context of the relationship with the "expert" therapist.

Nevertheless, and as noted by several investigators, the experience of the self is often, if not primarily, shaped and influenced in relation to others (e.g., Muran, 2002; Rogers, 1951; Safran & Muran, 2000). In other words, while therapy interventions can be and often are important tools that help guide clients in accomplishing desired changes such as the enhancement of agency, these cannot be disembedded from the relational context in which they are presented and implemented. And this relational context often takes primary importance. Therefore, a therapist who coerces the client to comply with certain interventions thought to contribute to the facilitation of client agency, although well-intentioned in terms of the desired ultimate outcome, is essentially undermining the client's agency in the immediate sense, stripping the client of the opportunity to exercise their agency in the here-and-now therapy context.

Taken as a whole, both theoretical and empirical evidence suggests that cultivation of the MI spirit is particularly helpful during moments of client opposition and this may be due to its effects on enhancing client agency (which has been suppressed through developmental experiences with powerful and needy caregivers). Furthermore, these rare moments of client autonomy-taking behavior present golden opportunities with unrivaled immediacy for the therapist to create a corrective relational experience, one in which attempts at exerting one's agency are met with validation and support, as opposed to being discouraged through coercion and disapproval.

Indeed, Faris and colleagues (2009) suggest that perhaps one of the primary mechanisms

of change in MI more broadly is its contribution to the enhancement of client agency. In particular, counselors who embody the client-centered relational qualities comprising the MI spirit, thus actively evoking clients' thoughts and resources (rather than disseminating their own expertise about specified behaviors or applying pre-developed problem-solving treatment strategies), may contribute to positive treatment outcomes by providing an empathic workspace that sets the stage for a co-constructive dialogue which facilitates client agency and self-healing (Faris, Cavell, Fishburne, & Britton, 2009). And, as we have seen, this may be particularly relevant during times of alliance tensions.

Training Implications

Recent suggestions by practitioners and researchers to integrate Motivational Interviewing (MI) in action-based treatments such as CBT might be particularly useful in navigating resistance and, as a result, enhancing outcome expectations (e.g., Arkowitz, Westra, Miller, & Rollnick, 2008; Aviram, Westra, Constantino & Antony, 2016; Westra & Arkowitz, 2010). MI is a client-centred model that offers systematic instructions on effective management of resistance (e.g., empathizing with the client, reframing resistance as nonthreatening). As noted, MI is rooted in client-centred methods that involve expressing empathy, providing unconditional positive regard, and fostering a client's sense of agency (Rogers, 1957).

MI is fundamentally a *way of being* with clients that promotes a safe, collaborative atmosphere in which clients can resolve their conflicting feelings about change, moving toward their most valued self. MI therapists operate as evocative consultants in the client's journey, consistently communicating the message, "I don't have what you need, but *you* do. And I will help you find it." In supporting client autonomy, MI helps clients recognize themselves as the authority. Working within the MI spirit, therapists avoid pejorative perceptions of clients as

unmotivated or difficult. Rather, ambivalence and resistance are viewed as a normal part of the vicissitudes of change.

Critically, MI highlights the importance of *how* therapists respond to resistance as the response can either augment or minimize resistance. Specifically, responding to resistance with confrontation, persuasion or arguing with the client is counterproductive according to MI as this communicates disconnection from the client and experience (Miller & Rollnick, 2002; Westra & Constantino, in press). Instead, MI proposes to “roll with resistance”, which is one of the core concepts of MI and what makes the approach especially relevant to implement in moments of resistance.

The concept of “rolling with resistance” entails a therapist adopting an empathic stance, using reflective responses, inviting the client to elaborate on their doubts and thereby normalizing a client’s ambivalence toward change. Such responses communicate to the client that the therapist is on “their side” and collaborating as opposed to coercing or confronting them. Furthermore, a growing research base points to the effectiveness of adding MI to address engagement in CBT (e.g., Federici, Rowa, & Antony, 2010; Flynn, 2011; Westra, Aviram & Doell, 2011). For example, Zickgraf (2015) noted the limitation of CBT in addressing key moments of resistance and proposed to integrate evidence-based models such as MI to navigate resistance since resistance has strong potential to derail CBT therapists.

Moreover, in terms of RCTs on CBT for GAD, Westra, Arkowitz and Dozois (2009) compared four sessions of MI pretreatment to no intervention prior to CBT for GAD. MI-CBT vs CBT alone was associated with greater homework compliance and symptom reduction particularly for those with severe worry at the outset of treatment (Westra, Arkowitz, & Dozois, 2009). Among those with high worry severity, those who received MI, as compared to those who

did not, showed substantially lower levels of resistance (i.e., higher receptivity to change) in CBT, and this accounted for their higher levels of worry reduction in treatment (Aviram & Westra, 2011). However, these results warranted some caution, given several notable confounds: MI+CBT clients had more sessions, had two different therapists (one delivering the MI pretreatment, another the CBT), were inherently aware of being in the experimental condition, and had MI delivered to them sequentially vs. fully responsively.

Addressing these limitations, a second trial compared the efficacy of 15 sessions of CBT alone to 4 sessions of MI followed by 11 sessions of fully integrated MI+CBT for clients with high worry severity GAD (Westra, Constantino, & Antony, 2016). This integration was accomplished in two ways: (1) by continuously using MI spirit in conducting CBT, and (2) by responsively shifting into primary MI strategies in response to markers of client ambivalence or resistance. When MI-CBT therapists judged the resistance to be resolved, they would then shift back into primary CBT, though still with the MI spirit. Although MI-CBT and CBT achieved comparable post-treatment outcomes, MI-CBT patients evidenced greater worry and distress reduction and had a greater likelihood of clinically significant change at 12-month follow up. In fact, MI-CBT clients continued to improve over the follow-up period, while the CBT alone clients showed evidence of some relapse. The authors posited that this delayed or sleeper effect might be due to the long-term benefits of therapists promoting the *client-as-expert* stance, especially when clients assert their own needs in session (i.e., resist therapist direction), which could help clients develop trust in their own directions and resources. In contrast, it is possible that CBT clients attributed their change more to the treatment techniques or the therapist, potentially leaving them more vulnerable to relapse after termination. In support of this, reduced resistance in MI-CBT vs CBT alone fully accounted for the between group differences in long-

term outcome (Constantino et al., 2019).

From the training perspective then it is critical to integrate effective management of resistance in clinical encounters. Successful resolution of resistance not only preserves the therapeutic alliance but also has the potential of remoralizing clients. As Owen and Hilsenroth (2014) argued, the competence of therapists should be reconceptualized as their ability to most effectively and successfully guide “within-case adherence flexibility” (p. 286). For example, within CBT competence of therapists can be reconceptualized as their ability to attune to critical moments – resistance being one of them – and appropriately respond in order to optimize outcomes (e.g., Boswell et al., 2013; Zickgraf et al., 2015). The present study suggests that such collaboration – especially in key moments – can help boost client’s confidence in therapy by enhancing their sense of autonomy and agency.

It might be particularly useful to train developing therapists to become proficient observers of important clinical markers by illustrating such markers in videotaped therapy sessions (e.g., real or simulated; Westra & Constantino, in press; Singer-Nussbaum et al., 2018). Continuous observation of such processes may help trainees to become attuned to subtle nuances of interactive processes. For example, observation of interactions can help trainees to not only listen for the content of the interaction but also help them identify subtle nonverbal cues that might be communicating that the client and therapist are not on the same page. Moreover, observation of such interactions would allow trainees to become more aware of their responses during these moments; allowing them to better monitor themselves during clinical encounters. Thus the combination of training therapists to identifying critical moments, and equipping them with empirically-supported interventions to navigate these moments, may constitute a valuable training direction in order to reduce resistance and enhance sustained client engagement and

morale.

Limitations, Strengths, and Future Directions

The present study adds to a growing body of literature that points to the relevance and importance of resistance. The major strength of the current study is its focus on potential mechanisms through which resistance operates. The results suggest that lowered treatment outcome expectations or confidence in treatment is a potential mechanism through which resistance relates to therapy outcome in CBT for GAD. A further strength of the present study is the inclusion of both client and therapist outcome expectations – the latter being a particularly overlooked variable in psychotherapy research. Moreover, the study used well-validated, reliable and rigorous measures for identifying interpersonal resistance (i.e, Manual for Rating Interpersonal Resistance; Westra et al, 2009). In terms of statistical methods used, the study used multilevel modeling that allows for simultaneous assessment of the relationship between study variables.

This study also had a number of important limitations. First, the results are restricted to a sample of clients with severe GAD receiving CBT. As such it will be important to see if these findings can be replicated in other samples receiving different treatments, including in naturalistic settings. Second, resistance coding was conducted for one session given that such coding is highly labor-intensive and time-consuming. However, it is worth noting however that resistance levels tend to be highly correlated over time in therapy (e.g., Button, Westra, Hara, & Aviram, 2015) and thus coding one treatment session may provide adequate information on which to base predictions (e.g., Westra, Constantino, & Aviram, 2011). Future research could use additional sessions, perhaps at other points in treatment, in order to further examine relationships with resistance. Third, a single-item measure of client and therapist outcome

expectations was used. This strategy has been used previously by researchers who have found it to be predictive of therapy outcomes in CBT (e.g., Price, Anderson, Henrich, & Rothbaum, 2008; Vogel, Hansen, Stiles, & Gotestam, 2006). Finally, the sample size was relatively small, so it will be important to attempt to replicate the results with larger samples. And finally, while structural equation modeling has a number of advantages to traditional correlation methods, causal conclusions cannot be drawn on the basis of this data.

In addition to replication with other populations, future studies should also examine how initial outcome expectations or other client factors might moderate the relationship between resistance and subsequent therapy outcome. For example, given evidence that early outcome expectations are critical to therapy processes (e.g., Ahmed, Westra, & Constantino, 2012; Aviram & Westra, 2011) it is possible that clients who start therapy with initially low outcome expectations might be more vulnerable to any negative impact of resistance as opposed to those who start therapy with initially high outcome expectations. That is high initial optimism might serve a “buffering” effect for any potential future alliance strains. At least one study, again with CBT for GAD, has suggested that this may be the case (Westra, Constantino, & Aviram, 2011).

Despite the limitations, the current study makes an important contribution to understanding the influences on outcome expectations. It identified that resistance is demoralizing to both the therapist and client; and that demoralization on the part of the client goes on to be associated with therapy outcomes. In doing so, it is suggestive of one possible means of fostering hope in clients. And more generally, the present study underscores the importance of training that includes teaching therapists to be observant of resistance and alliance strains and to respond effectively to such moments with supportive, autonomy-granting, agency-enhancing strategies.

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TABLES & FIGURES

Table 1
Sample Characteristics and M and SD for study variables

Variables	CBT (<i>N</i> = 44)		<i>M</i>	<i>SD</i>
	<i>n</i>			
Gender				
Female	41			
Male	3			
Age			34.57	12.09
Ethnicity/race				
Caucasian	35			
Asian	4			
Hispanic	3			
African Canadian	2			
Marital status				
Married/Cohabiting	21			
Never married	20			
Divorced/Widowed/Separated	3			
Employment status				
Unemployed/Not in school	13			
Employed/In school	31			
Highest level of education				
High school	15			
Postsecondary	21			
Graduate school (Masters/PhD)	8			
Worry Chronicity in months			165.84	153.33
Comorbidity				
Anxiety Disorder	33	75%		
Major Depressive Disorder/ Dysthymic Disorder	18	41%		
Penn State Worry Questionnaire (PSWQ)				
Baseline			75.31	3.21
Post-CBT			41.45	17.34
Client Outcome Expectations (COE)				
COE Baseline			60.57	20.27
COE Post-Resistance session			68.86	20.57

Therapist Outcome Expectations
(TOE)

TOE Baseline	57.05	13.22
TOE Post-Resistance session	57.50	15.27

Table 2
Simple Correlations Between the Study Variables

	BslnCOE	COE	BslnTOE	TOE	Resistance	BslnPSWQ	PSWQ
BslnCOE	1						
COE	.57*	1					
BslnTOE	-.02	.15	1				
TOE	.06	.36*	.59*	1			
Resistance	-.1	-.53*	-.19	-.51*	1		
BslnPSWQ	.04	.15	-.11	.02	.02	1	
PSWQ	-.34*	-.69*	-.21	-.33	-.52*	-.39	1

Note. Penn State Worry Questionnaire (PSWQ) measured after last CBT session; baseline PSWQ (BslnPSWQ) measured prior to commencing therapy; Resistance measured early in therapy (session 5, 6 or 7). 2. Client outcome expectations (COE) measured after the session during which resistance occurred. 3. Therapist outcome expectations (TOE) measured after the session during which resistance occurred. 4. Baseline client outcome expectations (BslnCOE) measured prior to commencing therapy; Baseline therapist outcome expectations (BslnTOE) measured after session 1. * represents significant correlation at .05 level

Table 3
Regression Coefficients

Variables	Coefficient (<i>B</i>)	Standard Error (<i>SE</i>)	<i>p</i> – value
1. DV: PostPSWQ			
BslnPSWQ	- 0.26	0.7	.710
Resistance	0.66	0.16	< .001
2. DV: PostPSWQ			
BslnPSWQ	0.34	0.61	.582
COE	- 0.63	0.12	< .001
3. DV: PostPSWQ			
BslnPSWQ	- 0.17	0.8	.832
TOE	- 0.33	0.21	.119
4. DV: PostPSWQ			
BslnPSWQ	0.25	0.6	.657
Resistance	0.25	0.18	.161
COE	- 0.5	0.11	< .001
TOE	- 0.02	0.14	.876
COE			
BslnCOE	0.53	0.1	< .001
Resistance	- 0.73	0.15	< .001
TOE			
BslnTOE	0.56	0.13	< .001
Resistance	- 0.46	0.12	< .001

Note. 1. Penn State Worry Questionnaire (PSWQ) measured after last CBT session; baseline PSWQ (BslnPSWQ) measured prior to commencing therapy; Resistance measured early in therapy (session 5, 6 or 7). 2. Client outcome expectations (COE) measured after the session during which resistance occurred. 3. Therapist outcome expectations (TOE) measured after the session during which resistance occurred. 4. Baseline client outcome expectations (BslnCOE) measured prior to commencing therapy; Baseline therapist outcome expectations (BslnTOE) measured after session 1.

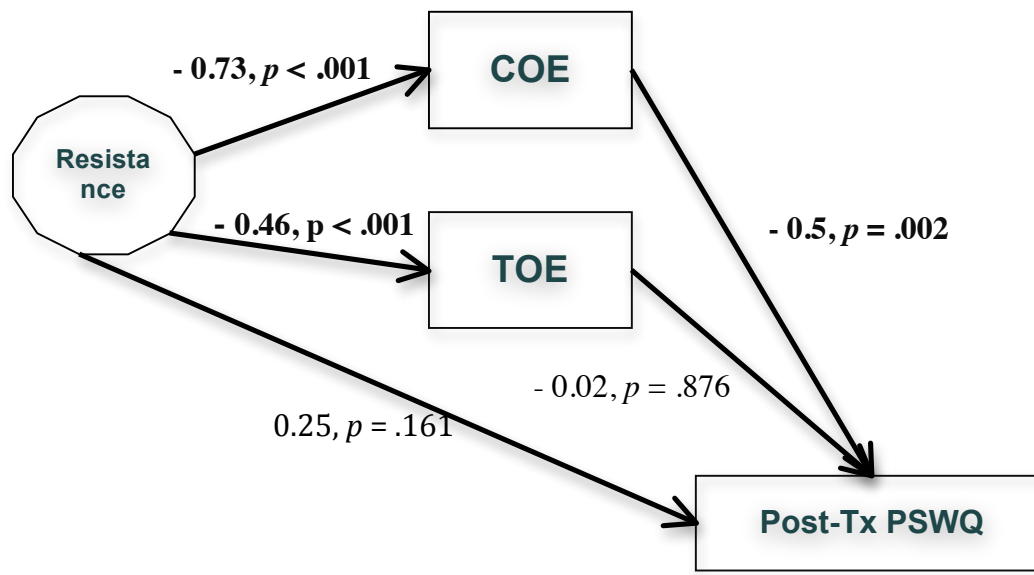


Figure 1. Study model examining the impact of resistance on client and therapist outcome expectations (COE and TOE, respectively) as well as on post treatment worry represented by scores on Penn State Worry Questionnaire (Post-Tx PSWQ).

Appendix A

MANUAL FOR RATING INTERPERSONAL RESISTANCE

Henny A. Westra, Aviram, A., Kertes, A., Ahmed, M., & Connors, L. (2009)

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Key Coding Principles/Concepts

Definition of Resistance is "going against, opposing, diverting, blocking, or impeding the direction set by the therapist." This is the core definition and every code counted as resistance must meet this definition.

This system is meant to capture *both* resistance to the therapist, as well as resistance to treatment/therapy (i.e., resistance to being in this treatment/changing). The gestalt concept that the system is meant to capture is *talk and/or process* that reflects pessimism/contrariness/skepticism (e.g., "I don't buy this," "this won't work," "I can't/won't change," "I won't go along with this," "I don't agree with you.")

In a typical therapy session, the therapist is nearly always setting a direction (e.g., asking a question, making a reflection or suggestion), and inviting or asking the client to comply with this direction (i.e., by answering the question, responding to the reflection or suggestion). Therefore, you can nearly always determine 'where the therapist is going.' Client responses can then be coded as to whether or not they 'go along' with the therapist's invitation or request to follow OR go against/block this direction.

Central to coding using this system is that coders continually ask themselves: "*Is this behavior meant to cooperate with the therapist - to go where the therapist is going - or to go against the therapist?*"

This is a process coding system and thus content is secondary. Coders should rely less on the words used, and centrally decipher and rely on what is being communicated beyond the words. That is, coders need to ask: "What is the intention of this client/therapist behavior?" irrespective of the words used. Often, the very same client words can communicate cooperation or resistance. In coding, one is trying to *capture the underlying interpersonal message*. That is, is the client's communication (in its totality) meant to say: "Go ahead; keep going; I'm with you," or is it meant to say: "Back off; I don't agree; I'm not on board with where you're going." For example, a client statement of "I don't know" may very well be cooperative (non-resistant) if the client has considered the therapist's question and then seems to genuinely be indicating that they don't know (and the overall tone is one of cooperation). However, these same words ("I don't know"), if stated quickly, carelessly, or with an irritated tone would be communicating resistance. It is also possible for the same response, "I don't know," to be coded as both resistance and non-resistance at different time points within the same session. For example, if the therapist repeatedly presses the client for a response, you would want to closely keep an eye on the client's response because that same response, "I don't know" - which earlier could have been cooperative (depending on the context), could shift to communicate resistance (i.e., "stop asking me that!")

Client statements do NOT automatically get coded as resistance. This includes any `counter-change` statement, statement of hopelessness, difficulty completing therapy tasks, or any statement of the problem. These statements can seem to automatically communicate resistance (e.g., “I can’t change,” “The homework didn’t work for me,” “What you are suggesting seems hard,” “I have a lot of problems”), but as mentioned earlier, whether or not these client statements communicate resistance depends on the context. That is, whether or not resistance can be inferred from client responses in such situations *depends on the process with which - and the context in which* - they express their reservations (i.e., how it came about and what it is communicating). Stated differently, a client can articulate all kinds of problems, lack of progress, or even concerns with the therapist or the therapy, but this is not necessarily (and certainly not automatically) coded as resistance - it is not about the content but the interpersonal context - the intent of the client to oppose or block the therapist OR to go along.

To illustrate, if the therapist proposes an experiment and asks the client how they feel about it, to which the client responds that they are afraid and unsure if they can do it – this is NOT coded as resistance because the therapist had asked the client about their feelings, thus giving the client autonomy to express their reservations. Here, the client is actually cooperating with the therapist by responding to their question truthfully. For example, the therapist might say: “I bet this sounds pretty scary. What are your thoughts about this exercise?” to which the client responds with reluctance or reservations. This would NOT be coded as resistance because in process, the client is actually following the therapist’s lead. However, if the therapist either in their initial question or subsequent statements somehow communicates that the client is not free to have reservations, e.g., “Yes, but you’re supposed to feel anxious,” and the client continues to articulate their doubts or concerns e.g., “Well, I don’t know about this. It sounds pretty hard,” this would be coded as resistance because the client is not going along with the therapist’s direction that they should warm up to the proposed task.

Another contextual clue would be *unsolicited* statements of “I can’t,” “This won’t work,” “That is hard,” etc. That is, if such statements come out of nowhere (i.e., are not elicited by the therapist asking or clearly inviting such responses), then they would likely be expressing objection or resistance to where the therapist is going.

Again, rely less on the content than the interpersonal context. Ask yourself: “What is really going on here interpersonally?” “What is the client’s statement/behavior meant to communicate to the therapist - beyond the words they use?”

To take another example, if the therapist is in the middle of proposing a homework assignment, and the client jumps in to indicate that they don’t think they can do it (i.e., the client’s message is not meant to help the therapist adjust the homework to the client’s preferences, but to abandon the homework altogether, thus taking control away from the therapist), this will be coded as resistance.

In other instances, a therapist may be asking the question while preserving the client’s freedom to answer in whatever way they choose. However, the client’s response may still be coded as resistance IF the tone or content makes it clear that they are intending to oppose e.g., “Well, I’m

not feeling any better if that's what you're asking," or "I know you want me to feel better by now, but I really don't." Importantly, although the therapist did not have an agenda when asking this question, the client is responding as if they did, and their intent is clearly meant to oppose the therapist.

Develop an interpersonal paraphrase. This can really help in determining whether a client's response is resistance. Ask yourself: "*What is this client really saying to the therapist on a process or interpersonal level?*" For example, an interpersonal paraphrase for the client statement: "Well, it's not quite so extreme as what you are saying" might be "Wait a minute, slow down, don't jump to the conclusions you are jumping to."

Ask yourself: "What is the therapist's intention?" It is also very useful to constantly ask yourself what the therapist wants the client to do. For example, if a therapist asks the client whether something is helpful or unhelpful, and the client responds honestly that they find a given technique unhelpful - this is NOT resistance. The therapist had invited the client to respond truthfully and with autonomy; therefore, although the client may not be on board with a certain technique the therapist had suggested, at this moment they are cooperating *interpersonally* with the therapist by answering them truthfully. If that same therapist question is leading, however (i.e., it is clear from the context that the therapist wants the client to respond that they are feeling better), then the same response: "No, this is not helpful," would be coded as resistance (i.e., opposing the direction of the therapist). Always ask yourself: "Where is the therapist going? What does the therapist want?" Then the client's response can be assessed for whether or not it complies with this direction.

Trust your gut/Rely on the gestalt. Often, you can 'feel' that resistance is present in the interaction, but have difficulty putting this into words right away. What also often occurs during coding is that you 'think' or reason through a response so much that you lose the 'gestalt' of the response. Always rely on the gestalt. It's important to take a step back and ask yourself: "Is there something wrong/off here?" "*If I were the therapist, would I feel this client is challenging/doubting/questioning/going against/not cooperating with me or the therapy?*" If the answer is "yes, this feels off," then it is likely resistance. Always walk your code through the 'final clinical test' (i.e., does it 'feel' like resistance?) Then, make sure you can explain or justify your code.

Ask yourself: "How could this response be turned into something else?" It is also very helpful to ask yourself (when you cannot decide about the form of resistance): "How could this response be turned into something else?" For example, "I think this response is a 1 but how could this be turned into a 0? What would need to be there for this to be a 0?" or "I think this response is a 2, but how would it have to look like in order for it to be a 1?" In other words, considering how the client's response would have to be different in order for it to be something other than the code you think it is (i.e., playing with different versions of it) is helpful when trying to arrive at more confidence in your final code.

A note on the adaptation of the manual. In this adapted coding system, the focus is on interpersonal process (i.e., as opposed to content or client verbalizations). In the original coding system, the focus was on content and process, thus relying more on verbal content and

statements than the present system does. Stated differently, in this system, client statements can *never* be coded in isolation of the interpersonal context and message (i.e., of opposition or cooperation) that is being communicated. Interpersonal resistance is nearly always captured in the tone, gestures, speed of response, and other nonverbal aspects of or the 'totality' of the response. The specific words are of course relevant, but are always secondary to the interpersonal message being communicated. Thus, as already noted, the exact same words (“I can't do this” or “This is not working”) can be coded as resistance or not resistance, depending on the interpersonal context and the interpersonal message they are communicating (i.e., “I am with you” or “I am going against you”). Therefore, even when considering the examples below of client statements displaying the different types of interpersonal resistance, these must always be considered in terms of the interpersonal context in order to be validly coded (i.e., the message they send to the therapist regarding cooperation or opposition).

Types of Interpersonal Resistance

There are several main types of interpersonal resistance:

- Disagree, Confront, Challenge, Doubt
- Own Agenda / Sidetrack / Interrupting
- Ignoring / Not responding / Not answering
- Questions about treatment

Disagree, Confront, Challenge, Doubt (I won't... I don't agree). Client responses in this category indicate dissatisfaction with the therapy and/or the therapist, disagreements with the therapist, or skepticism about the treatment/therapy/therapist. This category also includes client failure to comply with a session directive or homework, as well as responses indicating that the client does not think the therapist can help the client, complaints about the therapist, disagreements with the therapist's statements or suggestions including “Yes, but...” statements.

Other responses here include any complaints, negativity, skepticism about treatment/change e.g., “You're okay but I don't think this treatment will work for me,” or “I really don't have a lot of hope that this will work.”

This category also includes remarks of an “I can't” nature. Here, the remarks can be in reference to either change or treatment/therapy e.g., “I can't do thought records,” “I can't do that homework,” “I couldn't do the homework,” “I tried to change my thinking but I can't,” “I know it's an unnatural worry but there's nothing I can do that is able to control it.” This can also include hopelessness, defeated, self-blaming statements in relation to the treatment/therapist/therapy; i.e., statements indicating an inability of the client to engage with therapy/treatment or change, as well as statements of prolonged, repetitive, defeatist or negative conditions regarding therapy.

VERY IMPORTANTLY (as noted under Key Principles), such statements do NOT automatically get coded as resistance. They must be resistance in process (i.e., they must communicate opposition interpersonally - not just verbally). Stated differently, *it must be clear*

from the interpersonal context (rather than simply through the words used) that the statement or behavior is meant to oppose, disagree, or challenge the therapist/therapy.

For example, the statement: “I really don't have a lot of hope that this will work” may not be coded as resistance if the therapist had just asked the client about their thoughts about the utility of treatment. It could be coded as resistance, however, if this statement was unsolicited, came out of nowhere (i.e., the message interpersonally is to oppose), or was in response to a therapist discussing the benefits of treatment (e.g., when presenting the treatment rationale), thus opposing the direction of the therapist.

Responses in this category could also include 'polite' agreement, where the tone or the lack of enthusiasm clearly indicates that the client is not totally on board (e.g., polite or dismissive “yes,” “sure,” “okay,” “sounds good/fine”). There may also be an absence of head nods or non-verbal gestures communicating agreement, which may indicate that the client is not in agreement/not buying what the therapist is saying. This may also include highly impoverished responses, with little to no elaboration (i.e., interpersonally, the client is saying I do not agree). A dismissive or sarcastic tone could also indicate resistance (e.g., “well” or “sure” said sarcastically, or client tone that clearly indicates skepticism/disagreement). Non-verbal behaviour indicating the client has doubts (e.g., sighs or dismissive gestures such as looking away/clearly not paying attention) could also indicate resistance.

It is important to pick up on leading questions made by the therapist. Often these will be obvious from the content of the question itself e.g., “Are you feeling *better* this week?” “Is that the *only* way things could turn out?” Always try to gauge what the therapist is really intending (i.e., is there clearly a ‘right’ answer or response to the question or statement?) Then, try to gauge whether the client complies with, or provides the response the therapist is expecting or trying to elicit. There may also be instances when leading questions will not be obvious from the question itself, but may be inferred as leading from the context (e.g., the therapist clearly has an agenda for the client to say or see something). Additionally, you will sometimes see the therapist asking what seems like a neutral, autonomy granting, or open question, which is clearly leading e.g., “Did you get a chance to do that thought record?” “Could it turn out differently than you think?”

Note as well that when the disagreement has to do with the client correcting the therapist on some factual matter, but the client and therapist are generally cooperating (i.e., the client’s correction is meant to help the therapist move in the direction they are heading rather than to oppose the therapist’s direction), this will NOT be coded as resistance. Client corrections that are meant to block the therapist, however, will be coded as resistance, even if these are factual. Importantly, this differentiation should not be inferred from the content of the client’s correction (i.e., what is the disagreement about – whether factual or not), but from the timing and the spirit with which the client corrects the therapist. In general, always try to gauge whether the client’s disagreement/correction was done to help the therapist move things along in the direction set by the therapist, or if the correction was done to halt/block the therapist. Is the client’s intention to help or block the therapist? For example:

T: “So you have panic attacks daily”

C: (friendly tone) “Actually no, not everyday” or “Well, I would not say daily” (NOT resistance)

(the interpersonal message here is - please continue)

T: “So you have panic attacks daily”

C: “No! (stated firmly) Not everyday” or “I didn’t say everyday. (stated firmly) I said every other day” (Resistance)

(the interpersonal message here might be – “you don’t know what you are doing”)

Own Agenda, Sidetrack, Interruptions. (You won’t, because I won’t let you talk about what you want to). This category includes own agenda responses indicating the client wants to discuss an issue different from the current direction set by the therapist, or instances in which the client persists in discussing tangentially related issues, thus not allowing the therapist to talk. While it is valid for a client to bring up other areas of concern, such responses would be coded as resistant if they indicate that the client is *not attending to the therapist* by bringing up a new topic (i.e., the therapist is trying to set a direction and the client is not going along). This often has the quality of the therapist feeling invisible; i.e., the client acts as if the therapist is not there.

Interrupting. There are two steps in coding interruptions:

- 1) First determine whether an interruption is resistance or not. *Interruptions are NOT automatically coded as resistance* (i.e., not every interruption sends a negative interpersonal message about control). There are positive and negative interruptions. The context is key in determining which kind of an interruption it is. If the interruption represents friendly talkover (i.e., the client is engaged/cooperating, and thus talks over the therapist, but the context is one of helping/going along/facilitating the direction of the therapist), this is not resistance. However, if the context and intent of the client is to block the therapist (i.e., talk over in order to oppose), then it is coded as resistance. That is, in order for an interruption to be coded as resistance it must occur in an opposing or negative interpersonal context. Ask yourself: “If I were the therapist, would this come across as friendly/helpful or would it come across as blocking me?”
- 2) Once you have determined that an interruption is resistance, you will need to ensure that it meets the definition of an interruption as follows: If the client begins to talk while the therapist is talking, *but then* quickly relents before saying anything substantive (concedes the floor to the therapist), this would NOT be coded as an interruption because the client considered interrupting, but has chosen to ‘follow’ the direction of the therapist. Additionally, if the therapist has communicated ‘enough’ of their thought and then begins to trail off (either spontaneously or as the client begins to talk; i.e., the therapist’s new direction is “go ahead and talk”) then this would also NOT be coded as an interruption (e.g., “So you’re being somewhat perfectionistic and...” trails off or client starts talking). However, if the therapist raises their voice (i.e., does not trail off but is clearly communicating “I want to continue to have the floor,” “I am not finished yet”), and the client continues to talk, then this is coded as an interruption. As always, in identifying

whether an interruption has occurred, the central concept you should pay attention to is whether the client is following the direction set by the therapist (i.e., if the therapist clearly indicates “I want to say something” and the client does not concede, this will be considered an interruption).

In some instances you may see the therapist interrupting the client. Here, the therapist is taking the floor from the client, thus setting a new direction (i.e., “I want to say something”). The key question for coding is: “Does the client stop what they are doing, and follow the new therapist direction (cooperating), or does the client not respond to/take in the information interjected by the therapist (resistance)?” Sometimes, you may see that the client concedes to the therapist's talkover (makes room for the therapist to take the floor), but then does not respond to what the therapist interjected. This would be considered ignoring (see below).

Ignoring and Not Responding. This category includes client responses indicating that they are ignoring the therapist, either by not responding or by going in a different direction (i.e., Own Agenda/Sidetrack). Client responses in this category often have a feel *as if the therapist has not said anything*. Ignoring is coded as resistance because the client is not following the therapist's direction. This is true even if the therapist's statement is a simple reflection or a 'minimal encourager.' That is, it doesn't matter what the therapist is doing – whether they are asking a question, making a reflection, etc. The therapist is always trying to influence the client to follow, and in these instances the client is choosing not to follow (i.e., to ignore or refuse to be influenced by the therapist). Some acknowledgement of therapist responses (even minimal encouragers) would be expected (head nods, “yes,” “un-huh,” or clear integration or expansion upon what the therapist had said). If the client does not acknowledge or integrate what the therapist has said (i.e., ignoring, going their own way, acting as if the therapist has not said anything), this is resistance.

For example, if the client is telling their story and not responding to the therapist at all although the therapist tries to interject (if only just to track the client's story), or if they don't allow the therapist interject/completely ignore the interjection – this would be considered resistance. Another example of this is if the therapist does manage to interject something, and the client seems to not have heard the therapist at all/acts as if the therapist did not say/ask anything. For example:

T: “What time would be best for you to do this?”

C: “What should we do about my husband?” (ignoring – resistance)

Versus

“I think evening would be best.” (Cooperating – not resistance)

C: “So my daughter was saying that she thought I was too harsh.”

T: “And you're wondering whether she might be right.”

C: “And then she said I didn't listen to her and...” (ignoring - resistance)

Not Responding/Not Answering (You can't... because I won't give you information, or I'll give you inconsistent/wrong information). This category includes client responses indicating that they are withholding information by not responding to a question for two seconds or more.

Note that *the client's intent must be clearly resistant* (i.e., not just taking time to ponder or think about their response). This category includes not answering, or avoiding answering a direct question. That is, all therapist questions must be answered. Always check to make sure the client's answer is relevant to the therapist's question (i.e., is not ignoring). Examples of client responses to a direct question that are considered resistance include instances in which the client is being evasive, non-direct, or leaves the statement open-ended. In addition, short, curt, highly abbreviated responses may fall here (i.e., one-two word answers in response to the therapist, or clearly resistant, non-cooperative, brief, or 'polite' responses such as "sure," "ok," "whatever," where the client's tone is clearly resistant). By providing such abbreviated or clipped responses, the client is sending an interpersonal message that they are not going along.

Note, that often what follows a client pause can signal resistance as well (e.g., (pause)... "well...")

Also, note that "I don't know" can often signal not answering. Sometimes clients genuinely do not know something, but this should be obvious from the context (e.g., the client pauses before saying I don't know in order to genuinely consider the therapist's question). In other instances, "I don't know" is an opposing response (i.e., "I'm not going to follow you by thinking about this," "I'm not going to respond to this").

T: "How often does he do this sort of thing?"

C: "I'm not sure." (said immediately and without further amplification) – Resistance.

T: "If you did nothing, in six months would everything be hunky-dory?"

C: "It could be, it could not." – Resistance, because the client is responding to the therapist's direct question by being evasive (tone must clearly indicate the client is meaning to oppose the therapist by not responding truthfully or taking time to consider the therapist's question).

T: "What are you expecting to happen in these sessions?"

C: (laughs) "I don't know." – Resistance, because client tone is dismissive (i.e., laughter) and client is not going along with therapist direction to discuss their expectations regarding therapy.

A note on coding exposure exercises. In CBT the therapist will at times do exposures in session or assign them for homework between sessions. Clients often experience distress in conducting such exposures (in fact, experiencing distress is a requirement of a 'good' exposure exercise). The client's distress and/or protest at the difficulty of the task is NOT coded as resistance in these situations. For example, one can often see the client 'complaining' that "this is difficult," "I can't stand it," "I don't want to do this," etc. This is not coded as resistance, since it typically does not represent *interpersonal* resistance to the therapist/therapist's direction, but rather represents *intrapersonal* resistance to anxiety/experience, or may represent descriptions of their experience. In other words, such statements typically do not carry the key message of interpersonal protest directed at the therapist (which is the central construct captured in this system).

However, during such exposures, the therapist will typically continue to engage and dialogue with the client (e.g., “Where is your anxiety rating now?” “What are your thoughts now?” “Take a deep breath”). Such interactions CAN be coded for resistance. That is, the client should still be expected to interact with the therapist when the therapist requests this (e.g., by asking a question, making a reflection, giving a direction). If the client ignores the therapist's questions or other attempts to interact (set a direction), this would be coded as resistance. For example, during an exposure:

C: “Oh, I hate this!” (NOT resistance – expressions of distress, resistance to the client’s inner experience/anxiety)

C: “This is too hard” (NOT resistance - because not in response to the therapist)

T: “Where is your anxiety right now on a scale of 1 to 10?”

C: “It's high” (Not resistance – the client is going along with the therapist’s direction by responding to their question)

T: “Give me a number on the scale of 1 to 10.”

C: “I don't know exactly, but it's up there (Resistance – in response to a direct question, the client is giving an open-ended, evasive response)

T: “What are your thoughts?”

C: “I don't like this. I think I'm going to pass out.” (Not resistance – the client is responding to the therapist’s question)

T: “And where is your anxiety right now?”

C: “Oh, My hands are so clammy.” (Resistance – the client is ignoring the therapist’s question)

T: “Stick with it, you're doing well”

C: (looking distressed) “I'm not doing well!” (Resistance – client disagrees with the therapist)

T: “Let's stick with it until the anxiety starts to go down”

C: Nods. (Not resistance – although not responding verbally, client indicates agreement non-verbally)

Questions about the Treatment/Therapist. Sometimes the client doesn't necessarily come out and state their doubts (e.g., “I don't think this will help”), but rather they may ask questions stemming from underlying skepticism/doubt. These questions are often meant to doubt/challenge the therapist/therapy. These are not questions that are asked in order to get more information, but rather have the interpersonal message that ‘I don’t’ know about/don't like this’ (e.g., “How effective is this therapy?” “How many people have you seen?” “Have you read my file?”) Underlying such questions is a skepticism (i.e., “I don't know about this/about you,” “I don't trust this therapy/you”).

Questions in this category can also include doubting/challenging the requirements of the therapy, or questioning treatment procedures (e.g., confidentiality, filling out questionnaires). That is, the client is resisting participating in the treatment process. Again, tone and intent is very important; if it is simply a question for the purpose of clarifying (e.g., “So, I fill out questionnaires after each session?” “No one else will see these tapes?”), then it is NOT resistance. However, if the tone is clearly questioning or resisting the treatment (e.g., in negative tone, “So, are you *sure* everything is confidential?” “Do we *have* to videotape?”), then it would be coded as resistance. It

is important to note where the question is coming from (i.e., is it really a question/attempt to clarify, or is it coming from a place that says “I don't want to do this/not sure about this”).

Importantly, *it is ONLY resistance if the question(s) have not been prompted by the therapist*. For example, if the therapist says: “It sounds like you have some questions about the therapy,” or “Do you have any questions about this?” then the client is cooperating with the direction set by the therapist and it would not be coded as resistance. Questions that 'come out of the blue' (i.e., are not prompted by the therapist) and/or are clearly highly skeptical (even if prompted by the therapist e.g., “So what's the point of doing this then?”) count as resistance.

These *questions can often carry with them a 'role reversal'* - i.e., a sense that the client is 'taking over' control of the session. The underlying message is: “I want you to answer to me now,” “I'm acting on you,” “You answer to me.” This can be coded as resistance because the client is opposing the general rules of therapy, which are that the therapist acts on the client. Ask yourself: “Who is in control now?” In these exchanges, clients often put the therapist in the position of convincing, arguing, reflecting on their own self as a therapist with an accompanying loss of power/control. These questions have a 'taking the bait' quality, where the therapist is 'on their heels,' defending themselves, responding to the client by answering their questions, and 'letting go' of their role of being in control of the session and encouraging the client to self-reflect (e.g., “I did read your file,” “I am qualified,” “CBT does work”).

When coding such interchanges, CONTINUE to code it as resistance while the therapist is in responding or 'taking the bait' mode, and the client is patiently listening/nodding/providing minimal encouragers such as “okay.” Resistance is coded UNTIL the interaction shifts or the roles have flipped back, and the therapist resumes their role, or the client makes a genuinely cooperative response. This can happen if the client switches topics to something else (thus ending the resistant interchange) or if the therapist manages to reassume their role within the interchange, stops being defensive, or resumes their role of encouraging client self-reflection (e.g., “It sounds like you have concerns about the therapy/me,” “People often have a lot of concerns about treatment. Tell me more”). Here, the therapist has stepped out of being in a defensive/self-reflective mode, and resumed their role of exploring/encouraging/leading the client to reflect on their concerns/doubts, etc.

Assigning Resistance Codes (to Time Bins)

Each session is divided into 30 sec time bins. We have found that this is long enough to capture most forms of resistance, while being short enough for valid coding.

Once you have decided that resistance is present, you then rate the quality of resistance using the following scale:

- 0 – Absence of resistance
- 1 – Minimal, qualified resistance
- 2 – Clear, unqualified resistance
- 3 – Hostile, confrontational resistance

*Note that these codes are NOT mutually exclusive. That is, *for each time bin, you may assign more than one code*. For example, a given time bin can contain both a code 1 and a 2, or it may contain a code 2 and a 3, or it may contain a 1, 2, and a 3. However, *each code may only be assigned once within the same time bin*. In other words, the coder should note the *presence* of each quality of resistance within any given time bin (i.e., does the time bin contain qualified, clear, AND/OR hostile resistance?) Once the coder has decided that a given time bin has in it a certain form of resistance (1, 2, or 3), that code is only assigned once within that particular time bin. For example, if a time bin contains a 1, 2, 2, 3, 1, and 3 – it will be coded 1, 2, 3.

* Note that the above coding rule applies for all codes with the exception of code 0. That is, code 0 is mutually exclusive. Once a coder has decided that a given time bin contains an instance of resistance (1, 2, and/or 3), that time bin cannot be coded a 0. Stated differently, code 0 is reserved for time bins in which there is an *absence of resistance*.

0 – Absence of resistance. The client is going along with the therapist.

1 – Toned down, gentle, tentative, or qualified resistance. Client responses in this category reflect nice, polite, or gentle resistance. The client is not 'going along' and/or is being skeptical/expressing concern, BUT the context is generally one of cooperativeness. In other words, the client is simultaneously communicating "I want to try," "Please don't abandon me," "I want to work with you," "I do have some hope/belief in this," BUT or AND "I don't know about this," "I have some reservations/questions/doubts."

Client responses reflecting this code may also be construed as assertiveness. Hostility and firm confrontation are *absent* in these resistant responses. Clear resistance is also absent in these responses (i.e., the client is *not* sending a unilateral or clear interpersonal message that he/she is going against the therapist). Rather, *these responses are sending a mixed interpersonal message of opposition with a simultaneous intent or wish to cooperate with the therapist*.

1 codes are often expressed as qualified, tentative, toned down, apologetic-like statements or behaviours with a softer, gentler tone. The message is: "I want to work with you - want to get along - I don't want to alienate you, BUT I have some concerns - I don't agree - I can't do that - I am not quite on board." Other instances of this code may include a 'non-response' to the therapist (e.g., silence or absence of head nodding that indicate that the client is not on board, but the response is passive or gentle, rather than being clearly or overtly oppositional/confrontative/hostile). That is, the client is preserving the therapeutic relationship by cooperating with the therapist and is not overtly communicating that they are in opposition.

Ambivalent ("yes, but") responses may often reflect qualified resistance, although this is not always the case. To determine whether these responses are qualified resistance, the key is to gage the interpersonal message they communicate. Specifically, the "Yes, but..." part of a statement may be a throw-away response (especially if said quickly), while the overall response is really communicating disagreement (e.g., "Yes, but I can't do it"), and would therefore be considered clear resistance (code 2). A paraphrase here might be: "That is all fine for you, but I'm not on board." You need to consider the gestalt or interpersonal message communicated by the response. In contrast, "Yes, but..." responses that reflect qualified rather than clear resistance are

typically more elaborated e.g., “I want to try this, but I’m not sure,” “I do the breathing and it helps, but it doesn’t fix it.” Again, these responses communicate a *simultaneous* message of cooperation, with some reservations or disagreements. Even a response that sounds overtly resistant e.g., “I’m just not sure,” but is expressed in a soft, humble, non-aggressive tone, would be coded as a 1. The interpersonal message is “I’m conflicted – I want to go along; please stay on my team... BUT I have some concerns.”

When in doubt, refer to the Key Principles and Definitions in making this judgment. 1 codes have a quality of appealing or clearly sending a message to the therapist to “hang in there with me,” while in 2 codes this quality is absent.

Other useful questions to ask yourself when deciding whether an ambivalent response is qualified or clear resistance are: (i) Can you easily replace the “Yes” with a “No” *without altering the response* (e.g., “Yes, but I can’t do it” may easily be translated into “No, I can’t do it,” and still be consistent with the intention/interpersonal message of the response). In this case, it would be considered clear resistance (code 2). If, however, replacing the “Yes” with a “No” changes the message in the response, it is likely qualified resistance. (ii) What happens to the meaning or interpersonal message of the response when you replace the “But” with an “And?” (i.e., “Yes, and I can’t do it”). If the client’s statement retains its original meaning, it is likely qualified resistance. That is, the person meant the “Yes” part of the response.

Questions about therapy are usually considered 1 codes, because they are by definition not clear resistance (i.e., the client is not coming out directly/straightforwardly in stating their skepticism; rather, they are putting it in the safer form of a question). This is generally true unless the question is clearly highly doubtful (e.g., “What is your success rate?” “Does this therapy work?”) That is, client questions that would likely put the therapist on edge or make the therapist uncomfortable, or questions that are stated in an aggressive or clearly highly skeptical tone are NOT coded as qualified resistance.

A 1 code also includes instances in which the client’s intention is not to stop the therapist altogether (i.e., the client is not sending a clear stop message, but sending a “slow down” message). Here, the client is not trying to block the therapist from doing what they are doing, but is asking them interpersonally (or verbally), to put the brakes on a bit.

C: “Well, I wouldn’t quite say that” (palm up to signal the therapist to slow down) – Qualified resistance, because the client is not completely disagreeing with/opposing the therapist

C: “Well, I definitely wouldn’t say that” – Clear resistance, because the client clearly meant to stop the therapist.

2 – Clear, unequivocal resistance - either in process (e.g., sidetrack, talking over, ignoring) and/or in content (i.e., clearly and unequivocally expressed doubts that are intended to block the therapist from the direction they are going in). Code 2 includes instances in which the client does not qualify or soften their response, but clearly, firmly, straight-forwardly and overtly states their disagreement/doubts or challenges/questions the therapist (when not invited to), and/or in process clearly runs over the therapist, clearly and without pretense goes against the therapist.

Examples include: “No. I do not agree,” “I'm not doing that,” “I don't believe this is going to work,” “Does CBT *really* work?”

Clear resistance also includes any non-verbal responses (e.g., vocal tone, behavioural gestures) that clearly indicate or send the message “I don't agree,” “I don't buy this,” such as the client shaking their head, rolling their eyes, or deliberately/obviously looking away from the therapist. The underlying message here would be: “I don't hear you.” Pure, non-verbal responses (i.e., client gestures without a verbal message) are typically considered clear resistance since when these are intended to communicate resistance they send a clear message to the therapist. That is, it is very difficult to imagine a ‘toned down’ or qualified eye roll or head shake.

Additionally, when an interruption is meant to communicate resistance, it is always coded as clear resistance because such interruptions always send a clear blocking interpersonal message to the therapist.

3 – Hostile, confrontational resistance. The client’s tone is critical in these responses, and needs to be clearly hostile, combative, or discrediting the therapist. Responses in this category would often make the therapist feel uncomfortable, since they can have an edge of a personal attack/ critique of the therapist. They can often be responses to the person of the therapist or directly address the therapist (i.e., a shift in focus from what is being discussed/the treatment to the person of the therapist). A good question to ask yourself is: “If I were the therapist, how would this response make me feel?” Hostile, combative responses often feel unsettling to therapists since they seem to be sending a personal, negative message (e.g., questioning the therapist’s competence, criticizing them, putting them down). Note that such responses are usually very rare (so they typically require some significant pondering or strong consideration before assigning the code).

For example, at the end of a long session, the client says: “They didn't tell me about all these questionnaires. If they had, I wouldn't have come.” (i.e., discounting any benefit from their contact with the therapist).

Another example may be: “Well. You've got your work cut out for you with me!”

Hostile resistance in process includes client responses that are clearly overly firm or emphatic. Examples include:

C: “No! I didn't say that! I said...”

C: “*You* didn't hear what I said...” (i.e., overtly stating or clearly implicating a fault of the therapist/therapy; the paraphrase here might be: “You have no idea what you’re doing,” “I already told you that!” “You are not listening”).

C: “Well, Dr. X (said sarcastically), I didn’t mean that, I meant...” (Note here that the use of therapist’s name is also a good clue that a message is being sent directly to the therapist).

T: “What kinds of things help with the worry?”

C: “Nothing, nothing, nothing at all helps!” (Quick, dismissive, not softened)

OR

C: “No one has been able to help me at all because nothing helps!” (global and clearly implying that this therapist will not be able to help either).

Again, tone and non-verbals (e.g., heavy sighs, eye rolling) that clearly indicate that the client is unhappy with the therapist or the therapist's direction are critical. Hostile resistance responses are often sarcastic, caustic, highly clipped, demeaning, or imply disgust or clear unhappiness with the therapist.

In distinguishing between clear and hostile resistance, it can be helpful to 'put yourself' in the therapist's shoes. A code 3 is usually a statement or reaction on the part of the client that would make the therapist very uneasy (e.g., a clear, firm, repeated, emphasized statement that "this won't work," "this is useless," and certainly would include any direct or highly implied challenge to the therapist/therapy, such as 'grilling' about the therapy/therapist). A code 3 response may also be a clearly passive-aggressive non-verbal client behaviour that sends the interpersonal message: "I don't want to be here" or "I don't care about what you have to say." This would include behaviors such as answering/searching through a cell phone during the session *with no justification/apology*, deliberately looking away from/ignoring the therapist when they are talking to the client, etc.

Other Procedural Notes

Required Materials. Transcripts are not used in coding using this system. The coder must have at least an audiotape (but preferably a videotape) to code using this system because the way in which things are expressed (i.e., timing, intonation, tone, volume) is absolutely key for valid coding. We recommend coding directly from the video or audio file. Transcripts are not necessary or even useful, because they can encourage coders to rely too much on the words, thus reducing their attention from the gestalt, and undermining the validity of the coding (given that this is a process coding system).

Whatever mode you chose (video or audio), you should be consistent. For example, when using video, you should be consistent in the video capture of the information (e.g., camera in the same position for each dyad – preferably able to capture the client fully) in order to ensure consistency in the stimulus used for coding. Also, if you use only audio, note that at times, you will miss some codable information. We find that the majority of information relevant to coding using this system can be picked up from audio (e.g., tone, speed of responding), but at times visual observation can provide additional codable information (e.g., eye roll, client looking away, physically withdrawing from the therapist) or be very helpful in the coding of a verbal response.

Note that we do not code explicitly for the type of resistance. Rather, this coding system is designed to capture the quality of resistance (as defined by the 0 to 3 scoring system). In other words, we are not interested in the specific type of resistance (e.g., ignoring versus disagreeing). Rather, we are interested in the presence of resistance and whether it is qualified, clear, or hostile. However, the type of resistance is important when noting the reason for your numeric code assignment (e.g., "I coded this as a 2 because it is an interruption/clear disagreement").

The DEFAULT code is always 0 – absence of resistance. That is, if the response can be interpreted as cooperative (there is a competing argument or interpretation that can be made that the client is actually being cooperative), then you must code it as cooperative. That is, the

response must be unambiguously resistant to get a resistance code. In cases of ambiguity, always default to cooperation.

Unintelligible responses are coded as 0.

Always note in the comments column of the coding template the basis for your response (e.g., ignoring, disagreeing). In other words, it is not only important to get the correct code, BUT it is also important to ensure that you are right for the right reason. Therefore, you should briefly explain your reason for each resistance code that you give.

You must code from the beginning to the end of the session in sequence in order to appreciate the context of the session. For example, sometimes a client will disagree with something either repeatedly (based on something the therapist had said earlier in the session) or a few time bins after the therapist has made their point. In other instances, the previous context clearly makes a subsequent response resistance. For instance, the client has spent 10 minutes outlining the problems worry causes for them at work and then later when the therapist asks: “So is this a problem for you at work?” the client responds with “Yes, it definitely is!” (sounding exasperated). While this response may seem cooperative because the client is answering the question, it is actually resistant because of the previous context (i.e., is intended to criticize the therapist for not listening/understanding the client’s earlier statements).

Carry over. If the client’s resistance continues into the next time bin, then the next time bin would also be coded as resistance. For example, the client continues to elaborate their disagreement or objection (e.g., provides elaboration or examples to further underscore how the therapist is wrong). *Carry overs always continue to be coded at their initial form/quality of resistance* (e.g., a 2 continues to be coded as a 2 carry over and would only come down to a 1 if the client explicitly throws in a partial agreement or somehow softens their resistance). For example,

T: “I know you think you are incompetent, but do other people really notice it all that much?”

C: “Yes, they do.” (2) “The other day my boss sat me down and told me I was delegating too much ...” (continuation 2).

Note that if the client then says (in the next time bin or at the end of this time bin): “I know that I tend to think, *wrongly*, that everyone notices, but...” (i.e., I partially agree with you), then the carry over code would reduce to a 1 – qualified resistance.

Similarly, if the client firmly disagrees with the therapist in a confrontational manner (thus receiving a hostile resistance code), and then goes on to clearly elaborate their disagreement, the carryover code may be reduced to 2 if the tone is no longer hostile, combative, and the message is not personally directed at the therapist.

Do NOT code expressed doubts about PREVIOUS therapy (i.e., a client may have had bad experiences before but still feel hopeful/non-resistant to this therapy/therapist). Thus, you should only be coding client resistance to *the current* therapy/therapist. Previous treatment/therapist is

relevant only in so far as these are linked to the current therapy/therapist or it's clearly implied that the comments are also directed toward/relevant to the current therapy/therapist (e.g., the therapy is clearly CBT and the client says: "I thought doing thought records was a waste of time," "The relaxation exercises don't help me at all").

DO NOT give the client a 'pass' because you like him/her, or otherwise 'excuse' their resistance for another reason (e.g., "they are just anxious/shy," "that's just their personality style"). Code what is there, regardless of the reason for it.

*Adapted from the Client Resistance Code; Kavanagh, K., Gabrielson, P., & Chamberlain, P. (1982). *Manual for coding client resistance*. Unpublished instrument, Eugene, Oregon.