

PREDICTORS OF SKILL IN RESISTANCE MANAGEMENT IN PSYCHOTHERAPY

ALYSSA A. DI BARTOLOMEO

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Abstract

Appropriately responsive management of resistance in psychotherapy remains a foundational skill that is associated with positive client outcomes (Westra & Norouzian, 2018). Despite this, little is known about which individual differences contribute to successful management of resistance. Findings suggest that psychotherapy performance does not improve with experience (Goldberg et al., 2016), that psychotherapists lack humility due to positively biased self-assessment (Walfish et al., 2012), and that difficult moments in psychotherapy may dysregulate therapist emotions (Grecucci & Sanfey, 2014). This thesis therefore had two primary aims: 1) to identify whether psychotherapy training experience ($n = 98$ untrained participants and $n = 76$ trained participants) was associated with resistance management, and 2) to identify whether humility and difficulties regulating emotions in trained individuals ($n = 76$) were associated with resistance management (i.e., as operationalized using the Resistance Vignette Task – RVT; Westra et al., 2021). Results indicated that trained individuals performed significantly better on the RVT than untrained individuals, however, years of experience within the trained sample were not associated with RVT scores. Furthermore, humility and difficulties regulating emotions were each independently associated with resistance management in the trained group. These findings suggest the possibility of improving training to focus on key skills, such as resistance management, through supporting humility and emotion regulation in training. By identifying ways to improve therapist skill in resistance management (i.e., by introducing skill training and promoting humility and emotion regulation in therapists), client outcomes may subsequently improve.

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Correspondence regarding this thesis should be addressed to A. Di Bartolomeo, 407 Behavioural Sciences Building, Department of Psychology, York University, 4700 Keele Street, Toronto, Ontario, Canada, M3J 1P3, email: alyssaad@yorku.ca.

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Predictors of Skill in Resistance Management in Psychotherapy

Higher levels of resistance (client opposition towards change or the therapist) have deleterious effects on client outcome in psychotherapy (Beutler et al., 2011; Constantino et al., 2019; Olson et al., 2022; Westra et al., 2009). Therefore, appropriately managing resistance is an important therapist skill (Miller & Rollnick, 2002; Westra & Norouzian, 2018). However, identifying resistance is particularly challenging given its subtlety (Westra & Di Bartolomeo, in press), and responding appropriately also proves to be difficult given that correct responses of support and empathy tend to be less likely given interpersonal pulls toward control at these times (Aviram et al., 2016; Henry, 1986; Olson et al., 2022). That is, according to extant research, responding appropriately to resistance requires therapists to provide support and validation in moments that often pull for directiveness or confrontation (i.e., where clients may convey disagreement and conflict to the therapist; Aviram et al., 2016).

Despite resistance being a ubiquitous experience and the management of resistance being an important skill, little is known about what contributes to psychotherapist ability to manage resistance effectively. This thesis therefore aims to identify which individual differences may contribute to one's ability to appropriately manage resistance. I will first begin by reviewing resistance and resistance management, which will be followed by an overview of potential individual differences that may contribute to appropriately responding to resistance (i.e., years of psychotherapy experience, intellectual humility, and emotion regulation).

Resistance

Resistance is an interpersonal process in which the client opposes the therapist's direction (e.g., making a demanding statement, encouraging change). Such opposition may present in different ways. For example, resistance may involve disagreement expressed by the client to the

therapist, it may involve the client withdrawing from the conversation (e.g., sidetracking), or it may involve clients interrupting the therapist (Westra et al., 2009). Moreover, another way that resistance has been conceptualized is as alliance ruptures (Safran & Muran, 2000). Alliance ruptures are moments in therapy in which there is tension or a breakdown in the collaboration between the client and the therapist (Safran et al., 2011). Muran and Eubanks (2020) also underscore that alliance ruptures may present as subtle misattunements between both parties. Safran and Muran (2000) describe two types of alliance ruptures: confrontation and withdrawal. Confrontation ruptures consist of moments when the client explicitly expresses their discontent with the therapist or proposed direction. In this way, the client is moving toward aggression or control and against the therapist. Conversely, withdrawal ruptures are more subtle and consist of moments when the client is moving away from the therapist or the therapeutic process. For example, withdrawal ruptures include episodes in which clients are disengaging with their emotional experience, being passive, avoiding the therapist's questions, or being overly appeasing (Eubanks et al., 2019).

Ultimately, sustained resistance is the result of two forces (i.e., the direction of the therapist and the direction of the client) at odds with one another. In this way, it "takes two to tango". In other words, while the presence of resistance is important to recognize in psychotherapy, it is important that psychotherapists respond appropriately in these moments to prevent the exacerbation of resistance or a possible rupture. It is also important to note, that resistance (i.e., *opposing* the therapist or the process) emerges as a response to something proposed by the therapist. As a result, resistance is a co-regulatory process in which both the client and therapist are partaking in (Westra & Norouziyan, 2018).

Research strongly and consistently supports that higher levels of resistance are associated with poorer therapy outcomes, including long-term outcomes (Aviram et al., 2016). There is robust evidence that resistance is a key moment in psychotherapy given that it can have deleterious effects on client outcomes (e.g., Beutler et al., 2011; Constantino et al., 2019; Olson et al., 2022; Westra et al., 2009). For example, studies have found that increased levels of resistance are associated with poorer proximal and distal outcome measures, poorer homework compliance, and a higher likelihood of early termination (e.g., Aviram & Westra, 2011; Beutler et al., 2001; Henry, 1990; Jungbluth & Shirk, 2009; Piper et al., 1999; Westra et al., 2012). Furthermore, resistance has also been associated with poorer client outcome expectations. In other words, resistance has been found to lower client beliefs about their prognosis in therapy (Constantino et al., 2018) and, given that client expectations account for a large proportion of therapy outcomes (Westra & Constantino, 2012; Frank, 1961; Greenberg & Watson, 2006), it is important to recognize and manage resistance effectively (Westra & Di Bartolomeo, in press; Westra & Norouzian, 2018). To do so, it is necessary to understand how resistance emerges.

Recognizing and Managing Resistance

Resistance can arise from mismanaged client ambivalence (i.e., conflicting feelings about change; Feldstein Ewing et al., 2016). Ambivalence is very common in psychotherapy given that clients often come to therapy during the contemplation stage of change (Prochaska & DiClemente, 1983). In other words, conflict is inherent in the change process (Mahoney, 2003) and clients often seek out therapy to overcome their ambivalence. Client's inner beliefs about change are often articulated in therapy through client motivational language (Gylmn & Moyers, 2009). The part of the self that wants to change is observed through change-talk, while the part of the self that resists change is observed through counter change-talk. For example, a client

ambivalent about quitting smoking might begin by stating, “*smoking is bad for my health, I must quit*” – change talk – followed by, “*but nothing else relaxes me other than cigarettes*” – counter change-talk. It is also important to note that counter change-talk may be innocuous or harmful (Sijercic et al., 2016). While ambivalence is normal, when counter change-talk is used to oppose a therapist direction, the interpersonal message present is that the client is interpersonally (rather than intrapsychically) resisting, and therefore often engenders interpersonal conflict (Sijercic et al., 2016; Westra & Norouzian, 2018). In fact, Sijercic et al. (2016) found that counter-change talk that opposed the therapist or the therapeutic direction was associated with poorer client outcomes whereas counter-change talk used to express client ambivalence was not. It is in these moments of client motivational language – particularly in moments of resistant/opposition-counter change-talk - that the therapist response (i.e., therapist responsivity) is indicative of what occurs next (Olson et al., 2022).

Research shows that supportive responses (e.g., empathy, validation) as opposed to directive statements (e.g., control, demand, lecturing, cheerleading) are more effective in reducing resistance (Miller & Rollnick, 2002; Moyers & Martin, 2006; Patterson & Chamberlain, 1994; Westra & Norouzian, 2018). This can be seen across treatment modalities where more directive treatments (e.g., cognitive behavioural therapy - CBT) often elicit more resistance than non-directive treatments (e.g., motivational interviewing - MI) (Aviram et al., 2016; Leahy, 2001; Westra, 2012). For example, a study by Constantino and colleagues (2019) examined the effects of CBT compared to MI integrated into CBT for severe generalized anxiety disorder on client resistance. Findings revealed that therapists who administered CBT alone were met with significantly higher levels of resistance from their clients compared to their MI-CBT counterparts. Likewise, Aviram et al. (2016) found that CBT therapists who were more

supportive during moments of disagreement had substantially better client outcomes compared to therapists who were more directive. Furthermore, a study by Miller et al. (1993) examined the difference between two different therapist styles (i.e., directive-confrontational counseling and client-centred counselling) on client resistance for clients with alcohol abuse. Miller et al. (1993) found that the directive-confrontational counselling style resulted in significantly more client resistance, which in turn predicted poorer outcomes, compared to the client-centred approach. Additionally, a study by Olson and colleagues (2022) found that inappropriately responding to client resistance (i.e., using directive responses) was associated with poorer outcomes up to 1-year post-treatment for clients with severe generalized anxiety disorder compared to appropriate responsiveness at these times (i.e., responses that were supportive in nature).

Thus, research findings underscore the importance of responding to resistance with supportive statements. For example, Miller and Rollnick (2002) – developers of MI – introduced the skill of “rolling with resistance”. This technique discourages therapists from advocating for change when client ambivalence or resistant counter-change talk is present. Instead, in MI, resistance is viewed as feedback that suggests the therapist may be working toward a level of change that the client is not ready for. In this way, MI therapists will therefore explore the client’s counter change-talk or reasons against change while providing empathy and validation. Using the previous smoking example, “*nothing else relaxes me other than cigarettes*”, an appropriate and reflective response here could be, “*Smoking is the only thing keeping me calm during such a stressful time.*” Note the contrast between an appropriate response (i.e., one that empathizes with the client’s position) and an unhelpful directive response, “*I am sure we can brainstorm other activities to relax you. Why don’t we try some meditation.*” In this example, the client would likely feel unheard by the therapist and may exhibit more resistance further

exacerbating the rupture. Thus, therapist erroneous responsivity (i.e., directiveness) to client resistance is often the culprit for sustained resistance (Olson et al., 2022).

Identifying resistance is a difficult task since it can present in different ways. Likewise, resistance is often subtle and at times overtly friendly in nature making it easily overlooked. Given this, therapists may often struggle to respond appropriately to these moments simply due to a lack of awareness of their presence; that is, they lack perceptual acuity for detecting such empirically supported signals predictive of outcome (Westra & Di Bartolomeo, in press). In other words, it is a prerequisite for therapists to recognize client ambivalence and to discern different types of motivational language (e.g., client change-talk versus counter change-talk) prior to being able to respond appropriately. The subtleties in the expression of ambivalence and resistance make identifying the presence of these episodes and discerning the types of motivational language extremely difficult (Westra & Di Bartolomeo, in press). As a result, therapists may therefore miss these signals (i.e., resistance) from clients which in turn may exacerbate client resistance over time.

Another reason that therapists may struggle to respond appropriately to resistance may be because it has negative effects for therapists as well. These include impairing therapist performance via increasing emotional arousal. For instance, two studies found that higher levels of resistance were associated with therapists experiencing high levels of negative emotions (Boswell et al., 2013; Zickgraf et al., 2016). Likewise, Westra et al. (2012) found that when faced with clients who exhibited high levels of resistance, therapists experienced an increase in negative emotions such as anger. Therefore, understanding what differentiates an appropriate from an erroneous response, in addition to being able to recognize resistance, is crucial to effective responding in these difficult moments. Despite knowing how to overcome inappropriate

responsivity, there is little research investigating which individual differences contribute to the ability to manage resistance. Being able to identify these individual differences will in turn enhance resistance management skill, and consequently, improve client outcomes.

Possible Predictors of Resistance Management Skill

There may be many individual differences that contribute to performance in managing resistance. First, many studies have investigated whether level of psychotherapy experience is associated with therapist performance and, contrary to popular belief, experience has not been associated with therapist performance or client outcomes (Anderson et al., 2016; Berman & Norton, 1985; Montgomery et al., 2010). However, no research has examined whether experience matters when it comes to resistance management. Two other individual differences that have not received empirical attention but may contribute to skill in resistance management are intellectual humility (i.e., the ability to recognize one's epistemic shortcomings and ignorance) and emotion regulation (i.e., an individual's ability to recognize, manage, and respond to an emotional experience).

Experience

A consistent finding in psychotherapy research supports that trained therapists do not typically perform better (i.e., obtain better clinical outcomes or have higher levels of skill development and maintenance) compared to either non-therapists or paraprofessionals. While surprising, meta-analyses have found that years of experience or training have little effect on client outcomes compared to no training (Christensen & Jacobsen, 1994; Boer et al., 2005). In fact, a review by Montgomery et al. (2010) concluded that paraprofessionals (i.e., individuals from helping professions outside of psychology including nurses or clergy members) can be as effective at delivering cognitive behavioural therapy as trained therapists. One of the first studies

to test the association between experience and therapist performance was conducted by Strupp and colleagues (1979) who randomly assigned college students suffering from depression to a trained psychotherapist or to a college professor who had a reputation for helping students. Results from this study revealed that there were no significant differences in client treatment outcomes between groups. More recently, Anderson and colleagues (2016) assessed whether clinical psychology doctoral students performed better than doctoral students from other disciplines (i.e., biology, chemistry, experimental psychology, history, comparative arts, communication, and human sciences) on client outcomes and the therapy alliance and found negligible effects. Instead, Anderson et al. (2016) found that therapist baseline interpersonal skills (e.g., empathy, warmth, alliance bond capacity) were responsible for producing better client outcomes and a stronger alliance across groups. Counterintuitively, Goldberg et al. (2016) also found that client outcomes *declined* slightly with more years of experience (i.e., when psychotherapists had either more years of experience or more client cases). In other words, research points to other factors outside of experience that contribute to positive client outcomes and therapist performance. However, this has yet to be tested in relation to resistance management in particular.

Humility

Humility – having a modest view of one’s abilities – is necessary for a growth mindset and is associated with openness during disagreements (Porter & Schumann, 2018). Intellectual humility, in particular, refers to awareness of one’s professional epistemic shortcomings and training limitations and thus was selected as the focus for the present thesis (over other types of humility such as, relational humility). While limited research has investigated the role of humility in psychotherapists, higher intellectual humility has been associated with higher

academic performance among post-secondary students (Wong & Wong, 2021), a more accurate assessment of one's knowledge (Krumrei-Mancuso et al., 2020; Lehmann et al., 2021), and a higher likelihood of seeking out challenges and persisting after setbacks (Porter et al., 2020). Additionally, research finds that higher levels of intellectual humility are associated with other common factors in psychotherapy such as empathy (Krumrei-Mancuso, 2017), which contributes to successful psychotherapeutic outcomes (Elliot et al., 2018). A study by Leman et al. (2021) also found that intellectual humility buffered the association between one's actual intelligence and their perceived intelligence. In other words, while intellectual humility was not associated with intelligence itself, those who had higher levels of intellectual humility were more accurate in guessing their own level of intelligence compared to those with less intellectual humility.

It is important to highlight that therapists are subject to self-assessment bias (i.e., therapists often overinflate their assessment of skills; Macdonald & Mellor-Clark, 2015) and that therapists are poor predictors of their actual performance (e.g., Nissen-Lie et al., 2013; Westra et al., 2021). For example, a study by Walfish and colleagues (2012) investigated self-assessment bias in mental health professionals and found that 25% of participants viewed their skill to be at the 90th percentile compared to others in their profession, and no participants rated their skills below average. Furthermore, participants from this study overestimated their rates of client improvement and underestimated client deterioration. Additionally, Mathieson et al. (2009) tested the association between therapist self-assessment and supervisor-rated competence and found these to be unrelated. Westra et al. (2021) also found that, despite actual participant skill declining following a continuing education workshop, participants' self-assessment of their skills increased over the same time period. Thus, these findings underscore that self-perception is not

associated with performance and is not a reliable index for gauging one's own level of skill as a psychotherapist.

This self-assessment bias and overconfidence may be detrimental to client outcomes given that the requisite of humility to adapt and change in response to client needs may be lacking and that accurate self-assessment is obviously central to skill development (Tracey et al., 2014). It is therefore probable that greater intellectual humility may be an important attribute of those who are able to manage difficult psychotherapeutic moments (i.e., including resistance). Navigating resistance in psychotherapy is fraught with errors due to these moments being difficult to detect and respond to productively (Westra & Di Bartolomeo, in press). Ongoing errors on the part of the therapist may therefore result in negative feedback from clients (e.g., complaints about lack of progress or therapist deficiencies). This in turn may threaten the therapist's ego given that most therapists believe themselves to be more effective than they are (Mathieson et al., 2009; Westra et al., 2021). In this way, therapists with a predisposition for openness to, and accepting and learning from, their errors (i.e., have higher levels of humility), may therefore be better able to accept negative client feedback more readily and readjust more quickly after an error has occurred. This important possibility, however, has yet to be tested.

Difficulties in Regulating Emotions

In addition to being humble and open to learning, it seems important that therapists remain emotionally regulated (i.e., being able to recognize and manage their emotions following an emotionally evocative stimuli or experience) when managing challenging situations involving client criticism and reluctance. While research has investigated the effects of emotion regulation within client populations (e.g., borderline personality disorder, social anxiety disorder; Daros & Williams, 2019; Jazaieri et al., 2015), research on the effects of emotion regulation within

psychotherapists is limited. Despite this, changes in one's emotions in-session is ubiquitous, even for the therapist. Being able to regulate one's emotions, however, is particularly important given that research suggests that certain emotions impact an individual's goals, attitudes, and social decision making. For example, unpleasant emotions have been found to be associated with overall lower confidence and more risk-averse behaviour (Isen & Daubman, 1984). Conversely, positive emotions have been associated with more confidence and greater cooperation (Forgas, 1990). Furthermore, additional research supports that high levels of emotional arousal indicated by physiological indices (e.g., skin conductance) occur during negative interpersonal interactions (Van't Wout et al., 2006). These findings highlight that one's ability to be responsive in social interactions may be dependent on their current emotions, however the findings are not specific to psychotherapy.

It can be speculated that, if a therapist is more likely to be emotionally dysregulated (i.e., experiences heightened emotion that negatively interferes with goal-directed behaviour; Thompson, 1994) they may experience more anxiety or frustration in-session in general and therefore lack the ability to respond appropriately to challenging process markers, like resistance. Moreover, those who are better able to regulate their emotions in general may be able to decrease the intensity of negative emotions during interpersonal conflict in therapy (i.e., resistance) and therefore experience higher levels of confidence and cooperation, in turn mitigating sustained resistance and alliance ruptures. However, empirical support for emotion regulation in psychotherapists is needed to confirm these hypotheses.

Much of the extant literature on emotion regulation in psychotherapists emphasize emotional reactivity (i.e., an emotion process which refers to the intensity, speed and duration of emotion following a trigger; Streleau & Zawadski, 1995; Zelkowitz & Cole, 2016) in response to

countertransference in psychotherapy (i.e., internal therapist reactions in session as a result of unresolved conflicts within the therapist; Gelso & Hayes, 1998). In fact, some even argue that countertransference sometimes manifests in the form of alliance ruptures between therapists and their clients (Safran & Muran, 2000; Safran & Muran, 2006) and that countertransference occurs in most psychotherapy sessions (Hayes et al., 1998). Additionally, Coutinho et al. (2011) conducted a qualitative study on the impact of alliance ruptures and concluded that confrontation events resulted in an increase of intense and negative emotions in the therapist.

Muran and Eubanks (2020) attempt to tackle the phenomena of therapist emotion regulation in their book *Therapist Performance Under Pressure: Negotiating Emotion, Difference, and Rupture*. Of note, they argue that performing “under pressure” is a difficult skill which requires therapists to regulate their emotions effectively and momentarily. Performance in any domain (i.e., including in psychotherapy) can cause higher levels of physiological (i.e., cortisol levels; Chatard et al., 2002; Lautenbach et al., 2014) and self-reported stress (e.g., LeBlanc, 2009). As a result of these stress levels, performing well becomes more difficult (Jones & Hardy, 1990). Additionally, Muran and Eubanks (2020) underscore the findings from a study by Andrade and colleagues (2009) which found that decisions that are made which are dependent on emotion may become the precedent for future decisions. In other words, therapists who experience emotional dysregulation may allow emotion to cloud their judgement on how to respond to key therapeutic moments (e.g., resistance) and this may become a repetitive and ongoing pattern, in turn harming their performance and client outcomes. Furthermore, Kaplowitz et al. (2011) tested whether emotional intelligence (i.e., perceiving emotions, integrating emotions in thought, understanding emotions, and managing emotions) was predictive of client outcomes. Findings revealed that managing emotions in particular was associated with better

client-rated improvement. However, this study did not examine whether managing emotions during difficult moments (i.e., during moments of resistance) was indicative of better management of such moments. Thus, testing this association remains an important next step.

Aims of the Present Study

The current study had two primary aims. Given that previous studies have found experience within therapist samples to be negatively associated with psychotherapy performance (Goldberg et al., 2016) and that some research has found no association between trained and untrained individuals on psychotherapy performance (Anderson et al., 2016), this study aimed to assess (a) whether level of experience providing psychotherapy among community therapists (i.e., trained) and non-therapists (i.e., untrained) and (b) whether level of experience within the trained group, are each associated with resistance management skill. The second aim of the present study was to explore, with trained therapists, whether intellectual humility and difficulty regulating emotions were significantly associated with resistance management skill.

To gauge skill in managing resistance, the Resistance Vignette Task was used (RVT; Westra et al., 2021), given its predictive capacity of in-vivo interview performance among therapists (Di Bartolomeo et al., 2022). Participants from varying levels of experience (i.e., untrained undergraduate students or trained therapists – either from graduate programs or practicing therapists – completed self-report measures assessing overall difficulties regulating emotions and intellectual humility, followed by completing the RVT (Westra et al., 2021). Consistent with the previous literature, it was hypothesized that training status would not be associated with RVT performance, and that years of experience in the therapist group would also not be predictive of RVT scores. Conversely, it was hypothesized that intellectual humility and difficulties regulating emotions would each be significantly associated with RVT performance in

the trained group. Stated differently, it was anticipated that participants who perform well on the RVT would have fewer difficulties regulating their emotions and higher levels of intellectual humility. For exploratory purposes, humility and difficulties with emotion regulation were also examined concurrently among trained therapists.

Method

Participants

One-hundred-and-seventy-eight participants with varying levels of experience and training were recruited to take part in the current study. Participants were either untrained and had no psychotherapy experience, or they were trained in psychotherapy (i.e., they were either a graduate student in a therapy program such as, a clinical psychology graduate program, social work program, or counselling program, or they had graduated from a therapy program and were a practicing therapist). Participants with no experience (i.e., untrained participants) were recruited from York University's Undergraduate Research Participant Pool, were enrolled in a first-year psychology course, and were screened to ensure that they did not have any experience conducting psychotherapy. Of the untrained participants, 27.5% were enrolled in a psychology degree, 16% were enrolled in a health science degree, 11% were enrolled in a biology degree, 3% were enrolled in a medical science degree, 1% were enrolled in a social work degree, 1% were enrolled in a chemistry degree, and 40.5% indicated "other". The trained participants (students in training and practicing therapists) were recruited through email advertisements distributed to various professional associations and graduate schools. Of the trained participants, 74% endorsed being in the psychology discipline, 8% endorsed being in the social work discipline, 5% endorsed being in the counselling discipline, 1% endorsed being in the psychiatry discipline, 1% endorsed being in the health science discipline, 1% endorsed being in the medical

field, and 15% indicated “other” as their discipline. An overview of additional participant demographics is delineated in Table 1.

Measures

Comprehensive Intellectual Humility Scale

The Comprehensive Intellectual Humility Scale (CIHS) is a 22-item self-report measure ($\alpha = .85$) that assesses intellectual humility (Krumrei-Mancuso & Rouse, 2016; Appendix A). The CIHS is comprised of four subscales: independence of intellect and ego, openness to revising one’s viewpoint, respect for others’ viewpoints, and lack of intellectual overconfidence. Items are rated on a 5-point Likert scale from strongly disagree to strongly agree. Sample items include, “My ideas are usually better than other people’s ideas,” (negatively keyed), “I am willing to change my mind once it’s made up about an important topic,” and “I am willing to hear others out, even if I disagree with them.” The CIHS has strong internal consistency, and convergent and divergent validity (Krumrei-Mancuso & Rouse, 2016).

Difficulties in Emotion Regulation Scale (DERS)

The DERS is a 36-item ($\alpha = .91$) self-report measure that assesses emotion regulation problems (Gratz & Roemer, 2004; Appendix B). The DERS contains six subscales: lack of emotional clarity, lack of emotional awareness, difficulty regulating behaviour when distressed, difficulty engaging in goal-directed cognitions and behaviours when distressed, unwillingness to accept emotional responses, and lack of access to strategies to feel better when distressed. Items in the DERS are rated on a 5-point scale from Almost Never (0-10%) to Almost Always (91-100%). Sample items include, “I experience my emotions as overwhelming and out of control,” “I know exactly how I am feeling” (negatively keyed), and “When I’m upset, I have difficulty

thinking about anything else.” The DERS has good test-retest reliability and adequate construct and predictive validity (Gratz & Roemer, 2004).

Resistance Vignette Task (RVT)

The RVT was adapted from the Video Assessment of Simulated Encounters-Revised (VASE-R; Rosengren et al., 2008) which presents vignettes of clients with substance use concerns. The RVT, however, presents participants with clinical examples of client opposition to the therapist or the direction of therapy in the form of brief video-taped vignettes. Participants are shown one practice vignette, followed by 10 test vignettes,¹ that depict common resistance scenarios such as concerns about change, problems with therapy, lack of problem recognition, and noncompliance. Participants are instructed to write a response within 45 seconds after watching each vignette. Most of the RVT vignettes were recreations of common resistance issues seen in a variety of clinical problems (e.g., anxiety, depression, eating disorders). Two of the RVT vignettes were drawn from the Facilitative Interpersonal Skills task (FIS; Anderson et al., 2009; www.fisresearch.com), and the another two vignettes were brief recreated fragments from the Centre for Alliance Focused Training’s video on alliance ruptures (www.therapeutic-alliance.org). The RVT has shown to have strong predictive validity of in-session resistance (Di Bartolomeo et al., 2022).

Participants are scored on their ability to “roll with resistance” on each vignette. The scoring manual for the RVT was adapted from the VASE-R “rolling with resistance” subcomponent. Participants are given a score of -1 if their response would likely increase resistance, a score of 0 if the response would not increase or decrease resistance, a score of +1 if their response would likely reduce resistance, and a score of +2 if they provided a “rich

¹ Only 8 ($\alpha = .87$) of the 10 RVT vignettes were used in the present study given that two clients from the RVT are shown in the FIS which was also used as part of the broader study.

response” (i.e., used multiple elements of high levels of appropriate responsivity that would decrease resistance). Total scores on the RVT for the present study range from -8 to +16. Average scores on the RVT for the present study range from -1 – +2. For more detailed information on the scoring of the RVT and for examples of poor and good responses please see Appendix C.

Procedure

Participants were sent an online questionnaire in which they completed all self-report measures and the RVT. Following data collection, the research team coded the RVT using the RVT manual (see Appendix C for more information).

RVT Coding

The eight test items for the RVT were coded by two clinical psychology graduate students and a PhD level psychologist. Coders reviewed the scoring manual and completed approximately 5 hours of practice coding until adequate reliability was met. Coding was then completed independently by each coder. Twenty percent of all data was double coded to assess interrater reliability. Interclass-correlations (ICCs) were used to determine interrater reliability. The ICCs for the RVT ranged from .86 to .98, indicating good to excellent reliability.

Data Analytic Approach

Four participants were excluded in data analysis because of failing more than half (i.e., more than two) of the attention checks in the self-report component. Thus, data analyses were conducted on 174 participants (i.e., 98 untrained participants and 76 therapists and graduate students in training). The RVT average score was used in the analyses given that only eight out of the 10 RVT items were used in the present study. Thus, the results from the current study can be compared to previous studies that used the RVT.

Simple linear models were conducted to assess the hypotheses. First, a linear model was estimated to assess whether RVT average scores differed by training status (i.e., untrained and trained). Age was entered as a covariate into this model given that age was not normally distributed within the untrained sample. A second linear model was then estimated to examine whether psychotherapy experience in the trained sample (i.e., as defined by years of experience since starting a psychotherapy program) was associated with RVT average scores. Next, a series of linear models were conducted to assess the associations between intellectual humility and difficulties regulating emotions on RVT average score in the trained sample. Only the trained sample was used to assess the association between intellectual humility and difficulty regulating emotions on RVT average score given that the predominant interest was to examine individual differences in *therapists*. Similarly, as seen in Table 2, the untrained sample was starkly different from the trained sample in the present study (i.e., had extremely different scores on all measures) and thus combining samples would not provide accurate results.

Results

Table 1 presents demographic information for participants and the mean, standard deviations, minimum, and maximum for all study variables by group.² All variables had near normal distributions (i.e., normal skewness and kurtosis) with the exception of humility in the trained group (kurtosis = 3.40). A sandwich estimator was used in models where assumption violations were present and is further delineated below.

There was a very strong correlation between group (i.e., trained versus untrained) and RVT average score ($r = .74$). Given the very large difference in this and the DERS and humility scores, the trained group alone was considered for predictors of RVT performance. Thus, Table 2

² The difference in RVT scores was tested between students in training ($M = 3.58$, $SD = 4.89$) and practicing therapists ($M = 3.10$, $SD = 6.06$) and was found to be not significant, $t(57) = .44$, $p = .66$, CI [-.25, .39].

presents the intercorrelations for difficulties regulating emotions, intellectual humility, and RVT average scores for the trained group only. From Table 2, it is apparent that there was a moderate negative correlation between intellectual humility and difficulties regulating emotions. There was also a significant positive correlation between intellectual humility and RVT average score, and a significant negative correlation between difficulties regulating emotions and RVT average score.

Do RVT scores differ between Trained Versus Untrained Groups?

A linear regression was used to examine first whether training level (i.e., untrained versus trained) had an effect on RVT average scores. Once again, age was controlled for in this model given that it was not normally distributed across training levels. A sandwich estimator was used to correct for the violation of heterogeneity of variance. All other assumptions were met.

Findings revealed that being trained was significantly associated with better RVT performance, $t(167) = 6.76, p < .01, 95\% \text{ CI } [.72, 1.18]$ compared to being untrained, while controlling for age. More specifically, those in the trained group had a .95 unit increase in RVT score on average compared to the untrained group. Given the range of RVT average scores in the present study (i.e., -.75 to 2.00), a difference between groups on average of .95 is substantial (i.e., it is greater than one-standard deviation, $SD = .77$). Age, on the other hand, was not significantly associated with RVT performance when controlling for training level, $t(167) = 1.87, p = .06$. The R^2 for this model was .57, suggesting that the set of training level and age account for 57% of the variance in RVT scores, $F(2, 167) = 110.50, p < .01$.

Do RVT scores Differ Among Therapists as a Function of Experience?

Next, to identify whether RVT scores differed within the trained sample, years of experience was regressed onto RVT scores. The simple regression analysis did not yield

statistically significant results, thus bringing into question the strength of association between years of experience and RVT, $b = .02$, 95% CI $[-.01, .04]$, $t(73) = 1.51$, $p = .13$. To assess whether this effect is negligible (i.e., statistically, and practically insignificant), we used a regression-based equivalence testing approach described in Alter and Counsell (2023). Prior to testing whether this association was negligible, we needed to define what the smallest (practically) meaningful effect is in this context (i.e., the smallest effect size of interest; SESOI). Since the RVT is a relatively new instrument (Westra et al., 2021), it was difficult to identify the SESOI. However, given that the RVT is scored in increments of one point (i.e., scores increase and decrease by one point and range from -8 to +16), we decided to take a conservative approach and used a one-point difference in scores as the SESOI. Therefore, the SESOI was set at $b = .12$ (measured in unstandardized units of the outcome variable) such that our equivalence interval is $(-0.12, 0.12)$. Thus, if the observed effect for years of experience (and its associated uncertainty; i.e., confidence interval) falls entirely within the SESOI bounds, from $-.12$ to $.12$, we can conclude a negligible association between years of experience and RVT average score.

Testing for a negligible effect between years of experience and RVT was carried out using the ‘negligible’ package in R (Cribbie et al., 2023). Equivalence testing results were statistically significant, $b = 0.2$, 95% CI $[-.004, 0.04]$, $t(73) = -9.11$, $p < .001$, providing evidence for a negligible effect of experience on RVT performance. Figure 1 illustrates the magnitude of the effect graphically and provides a visual depiction of the regression coefficient’s point estimate and its associated 90% confidence interval in relation to the SESOI band (i.e., the area within the vertical red dashed lines) and its centre (i.e., the vertical grey dashed line). We can observe in Figure 1 that the effect size estimate ($b = .02$) is closely centred around 0 and the CI band spans a small proportion of the entire SESOI region. This further suggests that we have

strong inferential evidence in support of a statistical and practical negligible association between years of experience and RVT average score. These findings are congruent with extant research findings that support no association or a negative association between years of psychotherapy experience and psychotherapy performance (e.g., Anderson et al., 2016; Goldberg et al., 2016).

Intellectual Humility, Difficulties Regulating Emotions and RVT Average

Three linear models were used to assess the association between intellectual humility and RVT average, difficulties regulating emotions and RVT average, and the set of intellectual humility and difficulties regulating emotions on RVT average in the trained sample only³ ($n = 76$). Findings from these models are delineated below and are presented in Table 3.

Intellectual Humility and RVT Average

A linear model was estimated to test the association between intellectual humility and RVT average score in the trained sample. Due to issues with normality and homogeneity of variance, a sandwich estimator was used to obtain more accurate standard errors (Table 3). Findings revealed that every one-unit increase in intellectual humility was associated with a 0.02 increase in RVT average score, which was statistically significant, $t(74) = 2.28, p = .03, 95\% \text{ CI } [.003, .042]$. Thus, higher levels of intellectual humility were associated with better RVT performance supporting our hypothesis. The R^2 for this model was .07 suggesting that intellectual humility accounted for approximately 7% of the variance in RVT performance.

Difficulties Regulating Emotions and RVT Average

³ In addition to conceptual reasoning for assessing the trained group only, it was clear in the present study that the two samples differed in their levels of humility and difficulties regulating emotions. A t-test was conducted on intellectual humility between the trained and untrained group and there was a significant difference, $t(162) = 5.08, p < .001, 95\% \text{ CI } [3.98, 9.05]$. Likewise, there was a significant difference between the trained and untrained group for difficulties regulating emotions, $t(160) = -10.42, p < .001, 95\% \text{ CI } [-34.46, -23.48]$.

Next, a linear model was estimated to assess the relationship between difficulties regulating emotions and RVT average score in the trained sample. Findings revealed that every one-unit increase in difficulties regulating emotions was associated with a .01 decrease in RVT average score, which was statistically significant, $t(74) = -2.12$, $p = .03$, 95% CI = [-.025, -.001]. Thus, lower levels of difficulties regulating emotions were associated with better RVT average scores supporting our hypothesis. The R^2 for this model was .06 suggesting that difficulties regulating emotions accounted for approximately 6% of the variance in RVT performance.

Intellectual Humility, Emotion Regulation and RVT Average

To explore the effect of intellectual humility and emotion regulation as a set on RVT average in the trained sample a third linear model was estimated. Once again, a sandwich estimator was used to correct for issues with normality and homogeneity of variance. Findings revealed that every one-unit increase in intellectual humility was associated with a .015 increase in RVT average score when controlling for difficulties regulating emotions, which was no longer significant $t(74) = -1.24$, $p = .22$, 95% CI [-.006, .037]. Likewise, every one-unit increase in difficulties regulating emotions while keeping intellectual humility constant, was associated with a .009 decrease in RVT average score which was also no longer significant, $t(74) = 1.49$, $p = .14$, 95% CI [-.022, .004]. The R^2 for this model was .09, suggesting that the set of intellectual humility and emotion regulation account for approximately 9% of the variance in RVT performance. When considering intellectual humility and difficulties regulating emotions together, their coefficients become smaller in absolute value compared to their coefficients when entered into a model independently which is likely due to shared variance (i.e., $r = -.45$, Table 2). It is therefore likely, that this shared variance shrunk the effects.

Discussion

The present study had two primary aims: 1) to assess whether level of psychotherapy experience was associated with resistance management skills as assessed by the Resistance Vignette Task (RVT) and 2) to assess whether therapist intellectual humility and difficulties regulating emotions were associated with RVT performance. The hypothesis that level of experience would not be associated with RVT performance was partially supported. Although there was a significant difference in RVT performance between those who were trained (i.e., practicing therapists and psychotherapy students in training) versus untrained (i.e., non-therapist undergraduate students), there was no additional benefit of increased years of experience among psychotherapists. It is important to note as well that, although the trained sample outperformed the untrained sample, their scores were still moderate at best (i.e., their average total RVT score was 3.16 out of a possible 16). Conversely, more years of experience within the trained group was not associated with higher RVT scores.

Training and RVT Performance

The findings that the trained group significantly outperformed the untrained group contradict the hypothesis and the extant literature (e.g., Anderson et al., 2016). This may reflect the constitution of our untrained sample given that we recruited a sample of undergraduate students. In contrast, other studies to date that have compared level of psychotherapy training to outcome have examined these effects in paraprofessionals or people from other helping professions (e.g., Boer et al., 2005; Montgomery et al., 2010). Furthermore, these findings may indicate that people who enter psychotherapy programs have higher levels of baseline characteristics that contribute to resistance management compared to individuals who do not seek out, or have no interest in practicing, psychotherapy. In fact, extant findings do suggest that individuals who self-select toward interpersonal helping roles (e.g., nurses, therapists) have

higher levels of empathy than individuals who do not (Hassenstab et al., 2007; O'Brien & Haaga, 2015); and empathy is a foundational skill for resistance management (Muran & Eubanks, 2020; Westra & Norouzian, 2018). Thus, it is plausible that higher levels of common factors such as empathy, contributed to the observed differences between training level and resistance management in the present study.

Why does experience not predict RVT performance?

The present study found no association between years of experience and RVT performance within the trained group, and this is consistent with extant research suggesting that more experience is not indicative of better performance (e.g., Anderson et al., 2016; Goldberg et al., 2016). It is possible that existing training practices in psychotherapy have prevented improvements in skill development and maintenance (e.g., Rousmaniere et al., 2017). The current state of psychotherapy training emphasizes the use of didactic and lecture-based continuing education workshops (Davis et al., 1999; Forsetlund et al., 2012) and highlight knowledge rather than skill development. Although such an approach is convenient as it requires fewer resources, it does not aid in skill acquisition and maintenance (e.g., Westra et al., 2021). For example, a systematic review by Pearse and colleagues (2021) concluded that, although continuing education programs for health professionals (e.g., medical, nursing, social work staff) led to improvement in participant self-perceived confidence and knowledge overall, improvements in objective skill-based measures were insignificant. Instead, the review highlighted that multimodal programs which combined didactic teaching *and* more practice-focused activities (e.g., role-play simulating tasks) were more effective in producing larger improvements in skill development. Recent studies have also begun to test the effects of deliberate practice (i.e., systematic, and continuous practice with expert feedback) for

psychotherapy training. Westra and colleagues (2021) tested the effect of a deliberate practice motivational interviewing psychotherapy workshop compared to a traditional didactic and lecture-based workshop. Findings from this study found that the deliberate practice group significantly outperformed the traditional group on all measures (e.g., resistance management, empathy). The difference between groups was even maintained at follow-up. That is, the deliberate practice group maintained their scores four months later, whereas the traditional group began trending toward their baseline.

Interestingly, RVT scores in the Westra et al. (2021) study also differed significantly pre-to-post training. That is, individuals in the deliberate practice group had an average baseline total RVT score of 4.15 and an average follow-up (i.e., four months later) total RVT score of 14.50 out of a total possible 20 (i.e., the original measure has 10 items). Given that scores on the RVT for the present study did not differ significantly between practicing therapists and students in psychotherapy programs ($M = 3.10$ and 3.58 respectively), and that overall scores were low compared to total possible scores (i.e., the present study had a total possible score of 16), it is clear that individuals would likely benefit from more systematic deliberate practice resistance management training.

Therefore, while there is empirical support for resistance as a key moment in therapy, few therapists are being taught the skills necessary to address such a common concern (Muran & Eubanks 2020; Westra & Di Bartolomeo, in press; Westra & Norouzian, 2018). One exception to this is the work of Eubanks-Carter et al. (2015) who created the Alliance Focused Training (AFT) program which aims to assist therapists in developing and maintaining a strong therapeutic alliance with their clients. This program underscores that alliance ruptures are a common experience (i.e., they are reported by approximately 20-45% of clients and 40-55% of

therapists; Muran et al., 2009) and uses the repair strategies as outlined by the Rupture Resolution Rating system (Eubanks-Carter et al., 2015) to teach therapists how to recognize, tolerate, and repair alliance ruptures when they occur. Research testing AFT has found that it has been associated with improved interpersonal processes, therapist capacity for experiential reflection, and improved therapist awareness, acceptance, and comfort navigating ruptures (Eubanks et al., 2019; Muran et al., 2018; Safran et al., 2014). Relatedly, Westra and Di Bartolomeo (in press) proposed psychotherapy process coding as a way to improve psychotherapist outcomes by utilizing recognition of, and responsivity to, markers uncovered in psychotherapy process research as empirically associated with eventual therapy outcomes. In their paper, Westra and Di Bartolomeo (in press) argue that being attuned to key process markers such as resistance on a moment-to-moment basis in session is key in being able to respond effectively. Furthermore, they encourage psychotherapy training and continuing education programs to use process coding to teach future and practicing clinicians with hopes of redressing the null relationship between experience in psychotherapy and outcome. Future research is needed to test the potential efficacy of such process-oriented training.

Humility and Difficulties Regulating Emotions

The hypothesis that intellectual humility and difficulties regulating emotions within the trained group would be independently associated with RVT performance was supported. Findings revealed that individuals who had more intellectual humility had better RVT scores, and those who had fewer difficulties regulating emotions also had better RVT scores. When assessing the effect of intellectual humility and difficulties regulating emotions as a set on RVT performance there was no association. In other words, intellectual humility and difficulties regulating emotions seem to contribute similarly in terms of their effect on resistance

management. It is likely that this finding is reflective of a high level of shared variance between intellectual humility and difficulties regulating emotions ($r = -.45$, Table 2).

Intellectual Humility & the Enhanced Ability to Manage Resistance

Extant research underscores that therapists actually overestimate their abilities and do not recognize how difficult it is to “get it right” (Macdonald & Mellor-Clark, 2015; Mathieson et al., 2009; Walfish et al., 2012). In fact, this self-assessment bias is consistent across treatment modalities and many helping professionals (Eva et al., 2005; Probst et al., 2022; Walfish et al., 2012). Thus, having high levels of humility may be necessary to combat self-assessment bias therapists face. As stated previously, intellectual humility has been associated with mastery behaviours (i.e., seeking challenges and persisting after setbacks; Porter et al., 2020). For example, Porter and colleagues (2020) found that high school students with more intellectual humility had higher mastery behaviours than those with less intellectual humility. Likewise, intellectual humility has also been associated with self-rated and peer-rated openness and high levels of interpersonal engagement (Meagher et al., 2020). It therefore follows that therapists with higher levels of intellectual humility may be more likely to seek out challenges, (i.e., which are plentiful in-session), persist after setbacks (i.e., following resistance), be more open, and engage with others more compared to therapists with lower levels of intellectual humility.

Furthermore, having a growth mindset (i.e., being able to recognize errors as an opportunity to grow; Dweck & Leggett, 1988) may go hand in hand with humility and be useful in identifying a path forward following a mistake. Miller and Srougi (2021) found that having a growth mindset was associated with better academic performance, and Brady and Alleyne (2017) also highlight the importance of a growth mindset for sport performance. It is likely then that having a growth mindset along with humility is necessary to correct mistakes and accurately

assess one's own performance (Miller & Srougi, 2021). Although intellectual humility may be difficult to train, future work may examine growth mindset training as a way to target a very similar skillset (Lewis et al., 2020; Zeeb et al., 2020). For instance, Lewis et al. (2020) conducted a pilot study to test growth mindset training for nursing students and found participants had increased growth mindset attributes following the study.

Emotion Dysregulation and its Effect on Resistance Management

Psychotherapy naturally elicits stress in therapists given the demand there is to “perform” under pressure (Muran & Eubanks, 2020). That is, therapists are required to process and respond to information quickly, and this may be especially difficult in the context of challenging interpersonal encounters where clients oppose, withdraw from, or criticize the therapist. The rapid pace of therapy itself may make it difficult to respond appropriately during such difficult moments and such impasses may challenge the therapists' self-perception. Difficult moments in psychotherapy and the idea of responding “under pressure” can elicit emotional reactivity in therapists (Muran & Eubanks, 2020). For instance, therapists who are feeling particularly frustrated or anxious may experience more difficulty responding appropriately in a challenging clinical situation (Ariely, 2011; Muran & Eubanks, 2020). In this way, therapists may be more inclined to respond impulsively and reactively to difficult moments (e.g., resistance) – instead of thoughtfully and systematically – which may exacerbate disagreement. For example, Westra and colleagues (2012) found that therapists who experienced negative emotional reactions (i.e., felt drained, helpless, guilty, or frustrated) toward their clients early on in treatment elicited more resistance from their clients.

Extant research also supports that emotion regulation is relational (i.e., coregulation; Butler & Randall, 2013; Gulsrud et al., 2009; Hilpert et al., 2020). Coregulation is the

phenomena in which two close others form a dyadic emotional system (Feldman, 2003; Tronick, 1989). More specifically, Butler and Randall (2013) define coregulation as a “bidirectional linkage of oscillating emotional channels (subjective experience, expressive behaviour, and autonomic physiology) between partners, which contributes to emotional and physiological stability for both partners in a close relationship” (p. 203). Coregulation has predominantly been examined between parent-child dyads and intimate partners (e.g., Gulsrud et al., 2009; Hilpert et al., 2020). In fact, Butner and colleagues (2007) found that couples tend to experience similar levels of positive and negative affect on a day-to-day basis and Loo and Lunkenheimer (2020) found that greater levels of parent-child coregulation was associated with greater levels of each dyad member’s own emotion regulation. These findings have been replicated on a moment-to-moment basis in intimate partners. Rohrbaugh et al. (2009) brought 25 couples into the laboratory and recorded them having a disagreement. Following this, each partner was instructed to rewatch the recording and identify their emotional experience throughout the discussion. Findings from this study revealed high levels of coregulation between partners on a moment-to-moment basis. Given that coregulation occurs between different types of dyads (e.g., parent-child, romantic partners) it is plausible that therapist-client dyads also experience coregulation in session. As a result, therapists may become emotionally dysregulated in response to their clients’ emotional state, and thus it may become more difficult for therapists to respond appropriately during key moments.

While coregulation in therapist-client dyads have yet to be tested, research does support that therapists and their clients often engage in similar interpersonal behaviour. A core principle in the Structural Analysis of Social Behaviour (SASB) is that “hostility pulls for hostility” and “friendliness pulls for friendliness” (Benjamin, 1974). In one of the first studies to test the SASB,

Henry et al. (1986) compared the interpersonal process between four psychotherapists and different clients (i.e., each therapist saw a client with good and poor outcomes). Results from this study revealed that, in cases where therapists used more affiliative behaviours and fewer hostile behaviours, clients also exhibited more friendliness and less hostile behaviours. Conversely, in cases where therapists displayed more hostility, clients also displayed higher levels of hostility. These findings have been replicated in several studies (e.g., Coady, 1991; Henry et al., 1990; Jorgensen et al., 2000). Therefore, it is likely that therapist emotional reactions play an important role in the escalation or de-escalation of interpersonal outcomes with their clients. Given that the presence of resistance may engender hostility from the client toward the therapist, it is likely for therapists to become emotional reactive and dysregulated in response and fail to respond appropriately during these challenging moments. Thus, therapist emotion regulation is imperative to overcome this interpersonal vortex of “hostility pulling for hostility”.

It is also important to recognize the interplay between intellectual humility and emotion regulation. It is likely that being receptive to criticism and feedback, and being open to learning from one’s mistakes, would also potentially mitigate emotional reactivity levels (i.e., an emotion process which refers to the intensity, speed and duration of emotion following a trigger; Streleau & Zawadski, 1995; Zelkowitz & Cole, 2016) and subsequent emotion dysregulation due to a more accurate self-perception of one’s skills. For instance, if therapists are able to recognize their own limits and are open to making errors in session, they may therefore feel lower levels of negative emotions when with their clients. The overlap between intellectual humility and emotion regulation may therefore explain the lack of significance when looking at these variables as a set on RVT performance.

Clinical Implications

The present study has important clinical implications. As stated previously, resistance is a ubiquitous experience for all therapists (Westra & Norouzian, 2018). Therefore, being able to appropriately manage such resistance is necessary to prevent the exacerbation of resistance and alliance ruptures which are known to damage clinical outcomes (Aviram et al., 2016; Olson et al., 2022). By identifying that a) stagnant training practices may be contributing to poor resistance management and b) individual differences like intellectual humility and emotion regulation play key roles in resistance management, researchers and training developers can pivot to new training practices. For instance, psychotherapy programs may introduce process-oriented training as a way of teaching core foundational skills such as resistance management and they may adopt systematic and continuous practice training methods (i.e., deliberate practice). By doing so, psychotherapists will likely improve their skills (Westra et al., 2021) and in turn, client outcomes may improve.

Furthermore, introducing emotion regulation training may also be effective in improving client outcomes long terms. There is a large body of research that has tested various emotion regulation strategies for different populations (e.g., Brockman et al., 2016; Cheng et al., 2009; Dryman & Heimberg, 2018; Varma et al., 2022; Wolgast et al., 2011). Cognitive reappraisal (i.e., the attempt to reinterpret an emotional-eliciting situation by altering its meaning; Gross & John, 2003), acceptance of emotions, affect labeling (i.e., putting words to feelings; Muran & Eubanks, 2020) and suppressing emotions are four common strategies implemented when trying to regulate emotions (Ford et al., 2017; Shallcross et al., 2013), with cognitive reappraisal and acceptance having the most empirical support (Cheng et al., 2009; Mohammed et al., 2021; Wojnarowska et al., 2020), and suppressing emotions being known to predict poorer psychological health (Aldao et al., 2010). Most recently, affect labeling has also been receiving

much empirical attention and promising evidence for emotion regulation (Torre & Lieberman, 2018). Although these strategies have been tested in various clinical and non-clinical populations (e.g., Brockman et al., 2016; Cheng et al., 2009; Mohammed et al., 2021), it is unclear whether they would be effective for therapists. For example, perhaps reinterpreting client resistance in a way that does not threaten the therapist's self-perception (i.e., using cognitive reappraisal) may enable therapists to respond more appropriately. Future research should assess whether these common emotion regulation strategies may assist therapists with their in-session performance and responsiveness.

Nonetheless, it is clear that therapists experience a protective self-assessment bias, often overestimating their abilities (e.g., MacDonald & Mellor-Clark, 2015), and it is likely necessary to have a high level of intellectual humility to combat the deleterious effects of this bias. In a similar way, interactions with difficult clients in therapy and difficult moments evoke emotional dysregulation in therapists that may interfere with effective performance (Gregucci & Sanfey, 2014; Westra et al., 2012). Thus, individuals who experience more intellectual humility and fewer emotion dysregulation difficulties may be able to learn from previous mistakes and implement emotion dysregulation strategies to perform better in-session compared to those with less humility and more emotion dysregulation. Thus, future work should investigate intellectual humility or growth mindset training and emotion regulation training for resistance management.

Limitations and Future Directions

It is important to note the limitations of the present study. First, the current study was cross-sectional and therefore the directionality of some of our observed relationships remain unclear. For example, it is unclear whether fewer difficulties in regulating emotions and higher humility predicts higher RVT scores or vice versa. Additional research is needed to investigate

the longitudinal relationship between these variables. Second, our trained sample size was rather small ($n = 76$) and additional work should test whether our findings replicate in a larger, more diverse sample. Third, while the RVT has been found to be predictive of in-session performance, this study did not test whether these therapist factors (i.e., therapist experience, intellectual humility and emotion regulation difficulties) were indicative of in vivo performance. Additional research should examine whether therapist experience, intellectual humility, and emotion regulation are predictive of resistance management in-session with clients.

Fourth, future work is urged to examine which other emotion processes are particularly crucial for resistance management. While our findings suggest emotion dysregulation as a whole is harmful for performance, it is important to identify which other processes such as baseline emotional intensity, emotional reactivity, or time it takes to return to baseline emotions (i.e., emotional recovery) are predictive of resistance management (Linehan et al., 1993). Some research has investigated the role of therapist emotional reactivity and its impact on resistance (Poulin et al., in preparation) and found that emotional reactivity was negatively associated with resistance. In other words, more emotional reactivity was associated with less resistance. It is plausible that perhaps this may be due to one's inability of regulating their emotional reactions and thus avoiding exploring resistance or providing any direction to the client. Nonetheless, additional research is needed to explicitly test whether additional emotion processes are predictive of one's ability to manage resistance. Determining which factors are most indicative of skill could further promote training practices.

Conclusion

Overall, this study aimed to extend the literature on the effects of psychotherapy experience on psychotherapist performance by assessing its effect on resistance management. To

my knowledge, it was also the first to test whether intellectual humility and emotion regulation difficulties among therapists are associated with resistance management in psychotherapy. It is evident from this work that additional resistance management training should be implemented to further enhance skill development in psychotherapists. Furthermore, the findings highlight the importance of the therapist, particularly their ability to be humble and regulate emotions as key factors contributing to therapist performance under pressure. Additional work is needed to test whether these factors are indicative of actual in-session resistance management.

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Table 1*Participant Demographics and Descriptive Statistics by Training Status*

Variables	Untrained (<i>N</i> = 98)				Trained (<i>N</i> = 76)				
	<i>M</i>	<i>SD</i>			<i>M</i>	<i>SD</i>			
Age	20.72	6.26			35.39	10.03			
Gender	<i>N</i>	%			<i>N</i>	%			
	Male	27	27.84%			16	21.05%		
	Female	69	71.13%			60	78.95%		
	Non-binary	1	1.03%			0	0%		
Race/Ethnicity	Black/Afro-Caribbean/African	10	10.87%			0	0%		
	White/European	18	19.57%			55	72.37%		
	Hispanic/Latin American	3	3.26%			1	1.32%		
	Middle Eastern	3	3.26%			0	0%		
	Asian (e.g., South Asian, East Asian, Southeast Asian)	44	47.83%			13	17.11%		
	Biracial/Multiracial	14	15.22%			7	9.21%		
	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>	
RVT Total Score	-6.02	2.18	-8.00	1.00	3.16	5.71	-6.00	16.00	
RVT Average Score	-.75	.27	-1.00	.12	.4	.72	-.75	2.00	
DERS	94.58	23.04	46.00	169.00	65.75	13.48	39.00	105.00	
Intellectual Humility	80.74	8.46	64.00	101.00	87.12	8.30	56.00	106.00	

Note: DERS = difficulties regulating emotions scale; RVT = Resistance Vignette Task. The total possible scores for the RVT range from -8 to +16.

Table 2*Correlations Between all Study Variables in the Trained Group Only*

Variables	1	2	3
1. Intellectual Humility	–	-.45***	.26***
2. DERS		–	-.25***
3. RVT Average Score			–

Note: DERS = Difficulties in Emotion Regulation Scale, higher scores reflect greater emotion regulation difficulties; Higher scores on Intellectual Humility reflect higher levels of intellectual humility; RVT = Resistance Vignette Task. *** indicates p -values less than .001.

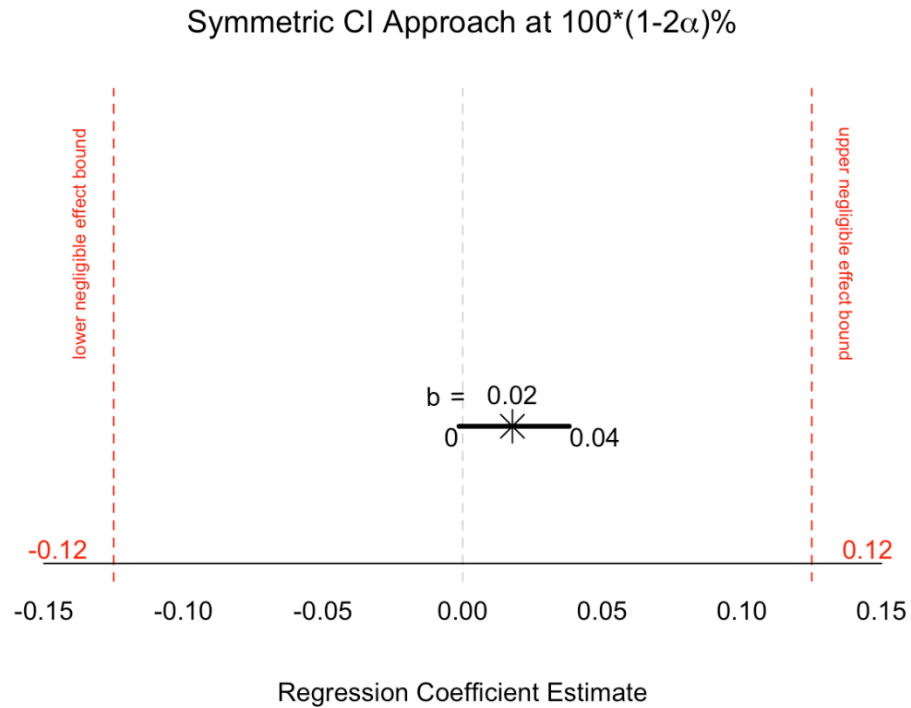
Table 3*Regression results of intellectual humility and DERS on RVT average*

Predictor	<i>B</i>	<i>SE</i>	<i>t</i>	<i>p</i>	<i>R</i> ²	95% CI for <i>B</i>
<u>Model 1</u>						
Intellectual Humility	0.02	0.01	2.28	.03	.07	[.003, .042]
<u>Model 2</u>						
DERS	-0.01	0.006	-2.12	.03	.06	[-.025, -.001]
<u>Model 3</u>						
					.09	
Intellectual Humility	0.015	0.01	1.49	.14		[-.006, .037]
DERS	-0.009	0.007	-1.24	.22		[-.022, .004]

Note. $N = 76$. DERS = difficulties regulating emotions; RVT = Resistance Vignette Task. Model 1, $F(1, 73) = 5.13, p = .03$; Model 2, $F(1, 73) = 4.89, p < .03$; Model 3, $F(2, 72) = 3.5, p = .04$.

Figure 1

Negligible Association between Experience and RVT Average Score Results



Note: A graphical illustration of the Symmetric Confidence Interval (CI) Approach is presented. Here, we can reject the null hypothesis that the effect size falls outside of the SESOI bounds and find inferential evidence in support of a statistical and practical negligible association between years of experience and RVT average score.

Appendix A – Comprehensive Intellectual Humility Scale (CIH)

The items are rated on a 5-point Likert scale with 1 = strongly disagree, 2= disagree, 3 = neither agree nor disagree, 4 = agree, and 5 = strongly agree.

Instructions: Carefully read each statement and indicate the degree to which you agree each statement is true for you.

1. My ideas are usually better than other people's ideas.*
2. For the most part, others have more to learn from me than I have to learn from them.*
3. When I am really confident in a belief, there is very little chance that belief is wrong.*
4. I'd rather rely on my own knowledge about most topics than turn to others for expertise.*
5. On important topics, I am not likely to be swayed by the viewpoints of others.*
6. I have at times changed opinions that were important to me, when someone showed me I was wrong.
7. I am willing to change my position on an important issue in the face of good reasons.
8. I am open to revising my important beliefs in the face of new information.
9. I am willing to change my opinions on the basis of compelling reason.
10. I'm willing to change my mind once it's made up about an important topic.
11. I respect that there are ways of making important decisions that are different from the way I make decisions.
12. Listening to perspectives of others seldom changes my important opinions.*
13. I welcome different ways of thinking about important topics.
14. I can have great respect for someone, even when we don't see eye-to-eye on important topics.
15. Even when I disagree with others, I can recognize that they have sound points.
16. When someone disagrees with ideas that are important to me, it feels as though I'm being attacked.*
17. When someone contradicts my most important beliefs, it feels like a personal attack.*
18. I tend to feel threatened when others disagree with me on topics that are close to my heart.*
19. I can respect others, even if I disagree with them in important ways.
20. I am willing to hear others out, even if I disagree with them.
21. When someone disagrees with ideas that are important to me, it makes me feel insignificant.*
22. I feel small when others disagree with me on topics that are close to my heart.*

Reverse scored items are indicated using *

Appendix B – Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by selecting the appropriate number from the scale below.

1-----2-----3-----4-----5
 Almost never sometimes about half the time most of the time almost always
 (0-10%) (11-35%) (36-65%) (66-90%) (91-100%)

- 1) I am clear about my feelings.
- 2) I pay attention to how I feel.
- 3) I experience my emotions as overwhelming and out of control.
- 4) I have no idea how I am feeling.
- 5) I have difficulty making sense out of my feelings.
- 6) I am attentive to my feelings.
- 7) I know exactly how I am feeling.
- 8) I care about what I am feeling.
- 9) I am confused about how I feel.
- 10) When I'm upset, I acknowledge my emotions.
- 11) When I'm upset, I become angry with myself for feeling that way.
- 12) When I'm upset, I become embarrassed for feeling that way.
- 13) When I'm upset, I have difficulty getting work done.
- 14) When I'm upset, I become out of control.
- 15) When I'm upset, I believe that I will remain that way for a long time.
- 16) When I'm upset, I believe that I will end up feeling very depressed.
- 17) When I'm upset, I believe that my feelings are valid and important.
- 18) When I'm upset, I have difficulty focusing on other things.
- 19) When I'm upset, I feel out of control.
- 20) When I'm upset, I can still get things done.
- 21) When I'm upset, I feel ashamed at myself for feeling that way.
- 22) When I'm upset, I know that I can find a way to eventually feel better.
- 23) When I'm upset, I feel like I am weak.
- 24) When I'm upset, I feel like I can remain in control of my behaviors.
- 25) When I'm upset, I feel guilty for feeling that way.
- 26) When I'm upset, I have difficulty concentrating.
- 27) When I'm upset, I have difficulty controlling my behaviors.
- 28) When I'm upset, I believe there is nothing I can do to make myself feel better.
- 29) When I'm upset, I become irritated at myself for feeling that way.
- 30) When I'm upset, I start to feel very bad about myself.
- 31) When I'm upset, I believe that wallowing in it is all I can do.
- 32) When I'm upset, I lose control over my behavior.
- 33) When I'm upset, I have difficulty thinking about anything else.
- 34) When I'm upset, I take time to figure out what I'm really feeling.
- 35) When I'm upset, it takes me a long time to feel better.
- 36) When I'm upset, my emotions feel overwhelming.

Reverse-scored items (place a subtraction sign in front of them) are numbered 1, 2, 6, 7, 8, 10, 17, 20, 22, 24 and 34.

Calculate total score by adding everything up. Higher scores suggest greater problems with emotion regulation.

SUBSCALE SCORING:** The measure yields a total score (SUM) as well as scores on six sub-scales:

- 1) Nonacceptance of emotional responses (NONACCEPT): 11, 12, 21, 23, 25, 29
- 2) Difficulty engaging in Goal-directed behavior (GOALS): 13, 18, 20R, 26, 33
- 3) Impulse control difficulties (IMPULSE): 3, 14, 19, 24R, 27, 32
- 4) Lack of emotional awareness (AWARENESS): 2R, 6R, 8R, 10R, 17R, 34R
- 5) Limited access to emotion regulation strategies (STRATEGIES): 15, 16, 22R, 28, 30, 31, 35, 36
- 6) Lack of emotional clarity (CLARITY): 1R, 4, 5, 7R, 9

Total score: sum of all subscales

**"R" indicates reverse scored item

REFERENCE:

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41-54.

Appendix C – Resistance Vignette Task (RVT) Scoring

- 1 Likely to make resistance worse (often some type of Demand for Change)
 - Problem solving, directive, advice, challenging, cheer-leading, leading question(s), coercive, pushy judgemental, fix-it
 - Note: If any -1 element is present, the whole response is -1 (questions are often 0 or -1)

- 0 Neutral - Doesn't make Resistance worse but doesn't make it better either
 - Low effort (“flat”) response
 - Inaccurate reflections or reflections that are “off”
 - Reflections turned into questions (i.e., spoiled reflections)

- +1 Likely decreases resistance (usually ‘Supportive’ responses)
 - A single reflection (simple or complex)
 - A paraphrase
 - One ‘extra’ quality reflecting high levels of support

- +2 Rich / High Quality Response
 - Multiple Reflections. Two or more reflections (here both elements should be able to ‘stand on their own’; NOTE - two reflections that say essentially the exact same thing would count as a 1, not a 2)

 - Response Contains Qualities Reflecting High Levels of Support
 - Affirmation or a Reframe
 - Validating &/or Normalizing
 - Autonomy Support
 - Explicitly Stated Support
 - Overtly Collaborating re relational climate
 - Response reflects high attunement to the way something is said
 - Use of joined language
 - Enthusiastic, Emphatic, or Resonant quality

RVT response examples

Prompt:

This vignette depicts a woman who engages in drug use and reports that she is not concerned about the effects of the use on her children.

Response that would likely make resistance worse:

“Ok, so there are some aspects of drug use that your kids aren't exposed to. What are some other areas where they might be more exposed?”

Response that would likely decrease resistance:

“So, you have this sense that it does not impact them. Like, ‘I've deliberately made sure not to have my drug use impact them.’ Does that sound right?”