TESTING THE CONTEXT RESPONSIVITY HYPOTHESIS: MANAGING RESISTANCE IN

COGNITIVE BEHAVIOURAL THERAPY

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A DISSERTATION SUBMITTED TO

THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN PSYCHOLOGY

YORK UNIVERSITY

TORONTO, ONTARIO

August 2015

Abstract

Despite growing recognition of the importance of context-responsivity in psychotherapy, and recommendations to develop context-responsive models through identification of clinical markers to which therapists need to be responsive, the notion of context-responsivity in relation to key markers such as resistance remains largely understudied. The current study sought to examine therapist responsiveness during identified moments of resistance (i.e., client disagreement with therapist direction) in the context of cognitive-behavioural therapy (CBT) for generalized anxiety disorder (Westra et al., 2015). There were two ways in which context-responsivity was investigated. The first was to examine whether differences in therapist style (i.e., more supportive and less directive behaviour) in the presence of disagreement go on to predict proximal (i.e., level of subsequent resistance in the session following therapist management of resistance) and distal (i.e., pre-to-post worry reduction) therapy outcomes. To this end, the present study utilized the Manual for Rating Interpersonal Resistance (Westra et al., 2009) to identify moments of client disagreement with therapist direction. In turn, the Motivational Interviewing Treatment Integrity (MITI; Moyers et al., 2010) was used to rate therapist use of theoretically indicated motivational interviewing (MI) skills (e.g., level of empathy, collaboration, evocation, and support of client autonomy) during identified moments of disagreement. The second approach to investigating context-responsivity was through comparing variations in therapist MI adherence in the presence of disagreement, with variations in therapist general MI adherence during randomly selected moments in therapy, in order to examine whether the timing of therapist use of MI principles differentially impacts treatment outcomes. Results indicated that clients whose therapists displayed higher levels of MI relational conditions in the context of disagreement had substantially lower levels of subsequent

resistance and post-treatment worry. Furthermore, while variations in therapist MI adherence in the context of disagreement were consistently and substantially related to CBT outcomes, variations in therapist general MI adherence were not. These findings provide support for the context-responsivity hypothesis, and serve to suggest that systematic incorporation of the client-centered relational conditions advanced in MI to the responsive management of resistance in CBT is a valuable clinical endeavor which should become a priority for clinical training.

Dedication

To my sister who always believed in me and challenged me to aim higher than I thought I could

achieve. To my brother, whose kind and unfettered spirit does not cease to amaze me, and has

taught me much about human tenacity. To my father, who taught me independence of thought,

and who, with his humour, has helped me to stay grounded when I was tempted to take life too

seriously. And to my mother, whose finely tuned empathy, perceptive ability, and deep

compassion have shaped my interest in, and understanding of the subtleties of human experience.

Acknowledgements

There are no words profound and gratitude-infused enough to express my deep appreciation to my graduate supervisor, and indeed my mentor, Dr. Henny Westra. Your dedication, guidance, and unwavering support have challenged me to grow as a clinician and academic. Your capacity for critical thought and courage to challenge conventional beliefs has taught me to be creative, and to hold my ideas unapologetically – with passion and conviction. I have deeply enjoyed our long and spirited conversations about therapy process and the human experience. You have provided me a foundation in psychology that will inspire me for a lifetime, and I can only hope our invigorating, co-constructive conversations will continue as I embark on the next steps of my career.

I would like to sincerely thank my committee members, Dr. Lynne Angus and Dr. Karen Fergus, for their guidance and invaluable feedback on my dissertation, which has significantly strengthened this research. My sincere thanks also go to Dr. David Flora for providing such detailed and constructive feedback on the statistical analyses of this project, and to Melissa Button and Kimberley Hara for their assistance in coding the numerous hours of psychotherapy sessions that made this study possible. My heartfelt gratitude also goes to Dr. Bill Stiles for taking the time to be on my committee. I have long admired his body of work and it is truly an honour to have him participate in this process.

I am grateful to the wonderful faculty at York University who have provided me with excellent clinical training and taught me to deeply believe that the client's process must be trusted and respected. I have been particularly moved by Dr. John Eastwood whose ferocious intellect has challenged and motivated me to become a thoughtful researcher and clinician.

To my parents to whom this work is dedicated; your precious qualities have played a crucial role in shaping the person, therapist, and researcher I am today. My accomplishments are a reflection of the values you have instilled in me. This is your success too.

Finally, to Eran, who never ceases to amaze me with his steadiness, humility, and ability to stay positive regardless of life's burdens. You encourage me to do the same. Thank you for accompanying me through it all, and, like my father, for reminding me to laugh.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Testing the Context Responsivity Hypothesis: Managing Resistance in Cognitive

Behavioural Therapy

"The true art of a counselor is tested in the recognition and handling of resistance" (Miller & Rollnick, 2002, p. 110).

In the practice of psychotherapy, a client's resistance to change, which can manifest as opposition to the therapy or the therapist, is one of the most important and challenging realities clinicians face. Evidence for the negative impact of resistance on the process and outcome of therapy is reported throughout the psychotherapy research literature (e.g., Beutler, Clarkin, & Bongar, 2000; Beutler, Goodrich, Fisher, & Williams, 1999; Beutler, Harwood, Michelson, Song, & Holman, 2011; Binder & Strupp, 1997). Those clients who exhibit resistance, or opposition to the direction set by the therapist or therapy, experience less benefit from, and are more likely to prematurely terminate treatment than those who exhibit cooperation (e.g., Beutler, Moleiro, & Talebi, 2001; 2002; Beutler, Rocco, Moliero, & Talebi, 2001; Clarkin & Levy, 2004; Orlinsky, Grawe, & Parks, 1994). Moreover, resistance has been characterized as a major obstacle to effective treatment, whose successful navigation in therapy has been greatly overestimated (Binder & Strupp, 1997).

Research in psychotherapy process suggests that resistance need not be frequent to be detrimental to psychotherapy process. Recent studies demonstrate that, even in small doses, resistance is a critical predictor of reduced subsequent engagement and treatment outcomes. For example, Jungbluth and Shirk (2009) reported that observed resistance in the first session of cognitive behavioural therapy (CBT) for adolescents with depressive disorder was an infrequent,

but nonetheless substantive predictor of task involvement in later sessions, accounting for 33 percent of the variance in subsequent engagement. Relatedly, despite being relatively rare compared to moments characterized by the absence of resistance, Aviram and Westra (2011) found that higher levels of resistance in CBT for clients with generalized anxiety disorder (GAD) significantly predicted lower homework compliance and poorer outcomes, accounting for 36 percent of the variance in treatment outcome. Moreover, higher levels of resistance were also able to differentiate clients who retained the diagnosis one year post-treatment from those who did not (Aviram & Westra, 2011). Collectively, such findings suggest that not all moments in therapy are of equal significance, and that resistance may represent a *key, in-session clinical event*, requiring distinct therapist focus and attention.

Key Moments in Psychotherapy

A number of therapy process researchers have argued for the presence of critical, decisive, or significantly harmful events in psychotherapy (e.g., Elliott, 1983; Rand, 1979; Standal & Corsini, 1959; Stiles, Honos-Webb, & Surko, 1998; Strupp, Hadley, & Gomez-Schwartz, 1977). For example, Elliott pointed to methodological problems characterizing psychotherapy process research, including the tacit acceptance of a uniform process in psychotherapy (i.e., uniformity assumption myths; Kiesler, 1966), which assumes that all therapist responses have equal weight or significance. He further cautioned against the exclusive use of global questionnaire measures to assess client and therapist perceptions of the therapy process, given their tendency to obscure the vast amount of information provided when asked about particular events in psychotherapy. Relatedly, given that the examination of therapist techniques across therapy sessions has failed to establish the effectiveness of specific techniques, researchers have suggested that the examination of brief, salient events occurring within sessions

may reveal important aspects of therapy effectiveness better than previous efforts (Stiles et al., 1998). As noted by Greenberg (1986), in order to better understand change processes in psychotherapy, researchers must investigate clinically meaningful events that take place within therapy sessions.

Conceptually, moments of resistance may be of particular interest when examining questions about psychotherapy process and outcome. Rather than being a stable occurrence throughout the therapy hour, resistance has been shown to fluctuate within therapy sessions in response to contextual cues, such as therapist demand (i.e., direction) and the timing of interventions (Miller & Rollnick, 2002). Furthermore, whereas the absence of negative interpersonal process may not be sufficient for therapeutic change, the presence of even small amounts of resistance may be sufficient to predict poorer outcomes (e.g., Aviram & Westra, 2011; Binder & Strupp, 1997; Coady, 1991a; 1991b; Critchfield, Henry, Castonguay, & Borkovec, 2007; Henry, Schacht, & Strupp, 1986; Jørgensen, Hougaard, Rosenbaum, Valbak, & Rehfeld, 2000; Jungbluth & Shirk, 2009). As Henry and colleagues have argued, even a low frequency of negative process can interfere with a client's improvement (Henry, Schacht, & Strupp, 1990). Consistent with these findings, a recent qualitative analysis which asked clients to identify important events in their recently completed psychotherapy sessions found that, despite representing a relatively infrequent event in the context of therapy, clients predominantly identified disagreements with their therapists (Viklund, Holmqvist, & Nelson, 2010). Collectively, these findings suggest that instances of interpersonal opposition may represent key moments in the therapy process which warrant further investigation.

The notion of resistance as a key moment in therapy has been further echoed in the therapy alliance literature. Researchers have suggested that resistance may represent ruptures in

the therapeutic relationship, signified by "patient behaviours or communications that are interpersonal markers indicating critical points in therapy for exploration" (Safran & Muran, 1996, p. 447). If these ruptures are not successfully managed and resolved, they can lead to further deterioration in the therapeutic relationship and even to the discontinuation of treatment (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Binder & Strupp, 1997; Coutinho, Ribeiro, Hill, & Safran, 2011; Rhodes, Hill, Thompson, & Elliott, 1994; Safran & Muran, 1996). Accordingly, the ability to detect and effectively manage moments of resistance has been postulated as a fundamental clinical skill in the practice of psychotherapy (Burns & Auerbach, 1996; Horvath, 1995; Moyers & Rollnick, 2002; Safran, Muran, Samstag, & Stevens, 2002).

But what does successful navigation of resistant moments in therapy entail? To consider this question, the notion of resistance in psychotherapy is first further elaborated, and a review of the theoretical literature on the concept of resistance is presented. Second, research on the topic of client resistance in response to therapist directive and non-directive behaviour is considered, and therapist qualities thought to be important to successful navigation of resistance are reviewed, with particular focus on therapeutic responsiveness.

Resistance

Despite a strong consensus across differing psychotherapy theories that resistance is a significant clinical phenomenon, carrying important implications for therapy process and outcome, there is little agreement concerning the meaning of resistance, its interactive nature within the therapeutic relationship, or the management of resistance in the therapy session (Bischoff & Tracey, 1995). The majority of conceptualizations view resistance as either an intrapersonal entity, reflecting client intrapsychic processes, or alternatively, as an interpersonal phenomenon – and thus a product of the therapeutic relationship.

The conceptualization of resistance as either an intrapersonal or interpersonal phenomenon is an important distinction which differentiates the major schools of psychotherapy. This distinction has been expressed in various ways, including patient-centered versus therapist-centered resistance (Bauer & Mills, 1989), resistance versus counter-resistance (Bernstein & Landaiche, 1992), transferential versus realistic resistance (Rennie, 1994a), and most recently, trait versus state resistance (e.g., Beutler et al., 2011). Despite these differences however, resistance has remained a pervasive concept within psychotherapy research and practice, and has been described as a process variable that is robustly linked to treatment outcome (Orlinsky et al., 1994). A brief discussion of the theoretical concept of resistance from the perspectives of the major schools of psychotherapy will precede a review of the research on client resistance in psychotherapy.

Psychoanalytic. Although Freud is generally credited for bringing the concept of resistance to the forefront within the field of psychology, he was in fact not the first to acknowledge the phenomenon of resistance. Ellis (1985) observed that ancient philosophers (e.g., Confucius, Seneca, Marcus Aurelius) and early practitioners of psychotherapy (e.g., Jean-Martin Charcot, Pierre Janet) have long recognized that individuals who try to alleviate their psychological problems often resist their own and their teachers' best efforts. Nevertheless, Freud is often perceived as originally defining the concept of resistance, describing it as a central tenet of his theory of psychoanalysis, and more generally, developing it into a prominent aspect of the process of psychotherapy.

Freud (e.g., Breuer & Freud, 1895/1955) first conceived of resistance as evidence of patient pathology. According to Freud, the patient's intrapsychic discomfort triggers defensive mechanisms that prevent painful thoughts and memories activated within the unconscious from

entering consciousness. Resistance was conceptualized as persistent, acting outside of the patient's awareness, and occurring in a variety of different forms (Freud, 1916/1963). For example, one of Freud's prominent formulations of resistance involved the patient's tendency to experience and re-enact repressed interpersonal attitudes and processes within the therapeutic relationship, a process which has been referred to as transference resistance (Freud, 1912).

Resistance became a central tenet of psychoanalysis because it was only in this form of psychotherapy that an explicit attempt was made to overcome patient resistance through analysis and interpretations of its modes, causes, and functions (Greenson, 1967). In turn, Freud's notions about resistance as an intrapersonal phenomenon, symptomatic of unconscious conflicts and psychological defenses, served an important role in shaping psychodynamic thought about the treatment of mental illness. For example, the identification of the client's defense mechanisms and transference resistance has been regarded by prominent psychodynamic researchers as of primary importance in addressing the client's interpersonal experience (Blatt & Erlich, 1982), and in the diagnosis and treatment of psychopathology more generally (Strupp, Schacht, & Henry, 1988).

Psychodynamic. Freud's contemporaries extended his views of resistance, conceptualizing it as influenced by both client intrapsychic processes, as well as threats inherent in the therapeutic interaction (e.g., Basch, 1982; Brehm, 1976; Horney, 1942; Jung, 1954; Strupp, 1973). For example, Horney believed that resistance was a manifestation of "forces that oppose liberation and strive to maintain the status quo" (p. 267). Other theorists proposed that the client may be resisting a loss of control in light of the extra-psychic influence imposed by the therapist (e.g., Jung, 1954; Jahn & Lichstein, 1980; Strong and Matross, 1973). For instance,

Strupp suggested that the most important factor influencing client resistance is his or her anxiety over perceived negative consequences following the relinquishment of control to the therapist.

Gradually, recognition was given to aspects of the 'real relationship' between the client and therapist, as psychodynamic theorists began to examine therapist errors related to client resistance, including poorly timed and inappropriate interventions, therapist inflexibility, and other relationship conditions (e.g., Basch, 1982; Blatt & Erlich, 1982; Greenson, 1967). For example, although generally associated with positive outcomes in psychodynamic treatment, researchers suggested that therapist interpretations need to be used cautiously, concluding that a high rate of transference interpretations used in a clinically inflexible and insensitive manner can lead to poor treatment outcomes (Crits-Christoph & Gibbons, 2002).

Increasingly, psychodynamic conceptualizations of resistance came to encompass both transferential and non-transferential components, reflecting client unconscious defenses, as well as therapist and relationship processes within the client's conscious awareness (e.g., Mahalik, 1994; Schuller, Crits-Christoph, & Connolly, 1991). Put differently, resistance was believed to reflect both 'the work of therapy' (Tracey, 1986), and a breakdown in the therapeutic alliance (Greenson, 1965). Psychodynamic researchers have since then tackled this latter notion, examining the relationship between alliance rupture, rupture resolution, and treatment outcome (e.g., Colli & Lingiardi, 2009; Safran, Muran, & Samstag, 1994; Stiles et al., 2004).

Cognitive and behavioural. Although resistance was not considered a concept in the original version of behaviour therapy, high dropout rates and treatment failures due to client noncompliance eventually led behaviourists and cognitive behaviourists to further consider this phenomenon (Golden, 1989). In particular, behaviour therapists observed that clients do not always comply with homework and other therapy assignments, which in turn prevents the

achievement of behavioural change as the desired treatment outcome. Resistance was therefore operationally defined as "the failure of the client to comply with therapeutic procedures" (Golden, 1989, p. 4).

Other behaviourists brought attention to studies demonstrating the relationship between client resistance and therapist directive behaviour (e.g., Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Patterson & Forgatch, 1984). These researchers emphasized the influence of the person of the therapist, leading to the notion that resistance is not at all the result of client processes, but rather an outcome of the skill and personal qualities of the therapist, as well as of how therapy was conducted (Lazarus & Fay, 1990).

Subsequent developments in cognitive behavioural theory (e.g., constructivism; Liotti, 1989; Mahoney, 1990, 1988a, 1988b) led to a renewed interest in intrapsychic events that may contribute to resistance, including client motivations to preserve existing cognitive structures and organizing schemata. According to this view, the cognitive processes that constrain an individual's sense of self and the world are the essence of resistance, and are the most difficult to alter. Emphasis was also given to the self-protective nature of resistance, which was seen as serving a natural and often healthy function in protecting core organizing cognitive processes involving an individual's sense of reality, identity, power, and personal values from rapid or sweeping disintegration (Mahoney, 1998b).

Currently, cognitive behavioural theories of resistance typically center on client factors (e.g., faulty schemas, treatment interfering behaviours) and therapist skill factors in the development and utilization of homework and other treatment strategies (Engle & Arkowitz, 2006). Behaviourists and cognitive behaviourists generally consider resistance an obstacle to therapeutic progress, and as such, a problem to be overcome so that treatment can continue

(Stevens, Muran, & Safran, 2003). Given that this study will undertake an investigation of therapists' management of resistance in the context of cognitive behavioural therapy (CBT), the literature on resistance in CBT, including management strategies of treatment noncompliance will be subsequently reviewed in more detail.

Humanistic. The notion of resistance has received comparatively little attention within the humanistic literature. While not directly addressing this concept, the first research on client resistance within the humanistic school represented the efforts of client-centered therapists who examined the relationship between directive and non-directive therapist behaviour and client response, finding higher rates of resistance with higher rates of therapist directiveness (Snyder, 1945; Gillespie, 1953). Resistance was regarded as a negative therapeutic outcome, as opposed to an ever-present entity residing within the client. Snyder delineated major differences in the underlying assumptions of directive and non-directive models. In particular, he noted that while directive therapists operate on the assumption that the therapist is in the best position to know what is in the client's best interest, non-directive therapists believe that the client has the right and responsibility to decide on his or her goals for therapy, and is uniquely capable of determining his or her best interest. Rogers (1951) similarly believed that people possess a basic tendency toward the enhancement of the self, which can be nurtured and expanded given the appropriate therapeutic conditions.

According to Rogers (1951), resistance was not an inevitable part of psychotherapy, but occurred primarily as a response to "…poor techniques of handling the client's expression of his problems and feelings… out of unwise attempts on the part of the counselor to short-cut the therapeutic process by bringing into discussion emotionalized attitudes which the client is not yet ready to face" (p. 151). In fact, no resistance was considered possible, if the client-centered

model was offered in its ideal form. Rogers (1961) identified three basic conditions, including therapist congruence, empathic understanding, and unconditional positive regard, and noted that when these conditions were present and experienced by the client, threat would be minimized and change would invariably occur.

Similarly, a more recent therapeutic approach in which resistance is minimized by way of minimizing threat to the client's personal goals and values, sense of autonomy, or capacity for self-direction is motivational interviewing (MI; Miller & Rollnick, 2002). MI is built on the foundation of the principles and methods of client-centered therapy (Rogers, 1961). Much like Rogers (1942) who conceptualized resistance as a response to a failure in the therapeutic relationship, MI considers persistent resistance as reflecting a therapist skill issue, as opposed to a client problem.

Summary. Clearly, resistance is an important concept which has long fascinated psychotherapy researchers and clinicians, and been discussed within every major framework of psychotherapy. Although the psychodynamic, cognitive-behavioural, and humanistic approaches differ in regard to the significance and meaning that is attributed to this phenomenon, a convergence of historically disparate viewpoints has been adopted by psychotherapy process researchers of various orientations (e.g., Bischoff & Tracey, 1995; Greenberg, Elliott, & Lietaer 1994; Henry, Strupp, Schacht, & Gaston, 1994; Meichenbaum & Turk, 1987; Rennie, 1994a) who consider resistance as emanating from both unconscious and conscious processes that are best interpreted as embedded in an interactional context.

Implicit in this premise is the recognition that, rather than being a fixed quality that is primarily attributed to the client, resistance is a fluctuating state that may wax and wane over the course of therapy and in response to emerging therapy context characteristics. Accordingly, it

has been suggested that both the client and therapist contribute to negative process and outcome through manifestations of discordant behaviour (e.g., criticism, withdrawal, disengagement), and that this relationship is not necessarily linear or causal (Binder & Strupp, 1997). In other words, clients who display high levels of resistant behaviour do not necessarily produce negative process and poorer outcomes. Rather, it is likely that negative psychotherapy process unfolds over time in the therapeutic relationship in a pattern of mutual responsiveness (i.e., behaviour that is affected by the emerging context). Indeed, responsiveness has been described as a pivotal concept contributing to therapeutic outcomes, denoting the mutual influence of client, therapist, and emerging context characteristics (Stiles et al., 1998). This concept is reviewed next.

Responsiveness in Psychotherapy

Stiles and colleagues (1998) propose that human interaction is systematically responsive. That is, people use an elaborate system of interpersonal signals to perform social tasks such as responding to each other's questions, staying on related topics, and taking turns when speaking. In the context of psychotherapy, examples of responsiveness include a therapist who designs homework assignments based on client preferences, or adjusts their vocal tone mid-sentence because of a change in the client's posture or facial expression (Stiles, 2009). Microanalysis of human interaction indicates that participants frequently adjust their communication in light of ongoing feedback from others with whom they are interacting. For example, in the context of interpersonal-psychodynamic treatment for clients with depressive and anxiety disorders, Elliott et al. (1994) found that therapists made ongoing adjustments in the wording of interpretations in response to clients' reactions. For instance, therapists were at times noted to pause before proceeding to provide an interpretation in order to support the client, when the client appeared to have experienced difficulty tolerating emotional pain associated with hearing the interpretation.

In a recent study on therapist responsiveness in the context of CBT and interpersonal psychotherapy (IPT) for depression, Elkin and colleagues (2014) sought to test the hypothesis that therapist behaviours indicating appropriate responsivity during the first two sessions of therapy were related to measures of early client engagement in treatment, including clients' positive perceptions of the therapeutic relationship, contribution to the therapeutic alliance, and probability of remaining in treatment for more than four sessions. The authors defined therapist responsivity as "the degree to which the therapist is attentive to the patient; is acknowledging and attempting to understand the patient's current concerns; is clearly interested in and responding to the patient's communication, both in terms of content and feelings; and is caring, affirming, and respectful towards the patient" (p. 53). To measure therapist responsivity, the authors developed the Therapist Responsiveness Scale using therapy videotapes collected in the Treatment of Depression Collaborative Research Program (TDCRP; Elkin, 1994), a multi-site collaborative study of CBT and IPT, as well as pharmacotherapy reference and control conditions, in the treatment of patients with major depressive disorder.

Elkin and colleagues (2014) identified four factors thought to reflect therapist responsiveness, including: 1) Attentiveness (e.g., making eye contact, staying on topic, demonstrating interest); 2) Early empathic responding (e.g., understanding client's perspective, responding to expressed feelings, making inferences regarding unexpressed feelings); 3) Negative therapist behaviour (e.g., disrupting flow, lecturing, expressing judgement/criticism); and 4) Positive therapeutic atmosphere (i.e., caring/ compassionate, respectful, compatible level of discourse, and appropriate emotional quality/intensity). Results of this study indicated that positive therapeutic atmosphere was a significant predictor of client engagement, as reflected in clients' positive assessments of the therapeutic relationship, as well as retention in treatment. The

authors concluded that this factor drew together, in a comprehensive manner, aspects of therapist

behaviour reflecting care, compassion, respect, and attunement to client affect, which serve to

create a positive atmosphere in which therapeutic work could ensue. While this study tested the

relationship between therapist responsivity and client engagement during the first two sessions of

therapy, it is important to note that, although not tested, therapist responsiveness is likely

conducive to client progress throughout the course of therapy.

Indeed, appropriate therapeutic responsiveness is implicit in many important clinical

skills, such as timing of therapeutic interventions and empathic attunement. In particular,

empathic attunement is a therapist perceptual skill (Bennett-Levy, 2006), which has been

referred to as "an active ongoing effort to stay attuned on a moment-to-moment basis with the

client's communications and unfolding process" (Bohart, Elliott, Greenberg, & Watson, 2002, p.

90). This form of empathy is most likely to be emphasized in client-centered and experiential

therapies, which require a high level of empathic attunement to client experiencing at multiple

levels, including the nuances of feelings and implicit meanings in clients' narratives, as well as

the overall essence of the client's immediate experience. Much like empathic attunement, the

term responsiveness refers to a process as opposed to a stable state or trait of an individual.

According to Elliott et al. (2004), to be fully responsive, therapists need to listen and

observe attentively, as well as resonate with, clients' stories, current difficulties, and styles of

processing (i.e., immediate reactions to novel information, insights, or affective processes)

within the session. Indeed, a responsive therapist needs to be able to stay empathically attuned on

a moment-to-moment basis to the client's communications, in order to determine the appropriate

manner of responding. It is, in fact, questionable whether appropriate responsiveness can take

place without the involvement of empathic attunement. Accordingly, it may be argued that

empathic attunement is an important prerequisite step to appropriate therapeutic responsivity. Notably however, whereas empathic attunement typically refers to a fine-grained process that occurs on a moment-to-moment basis within the session, responsiveness may occur on broader time scales, including therapist choice of an overall treatment approach, formulation of treatment strategies, or selection and timing of treatment techniques (Stiles et al., 1998). Therefore, appropriate responsiveness may be conceptualized as a higher-order term which encompasses empathic attunement.

Generally speaking, a therapist's competence is largely determined by his or her ability to systematically respond to emerging information about client progress in order to promote positive outcomes. That is, in order to be responsive, a therapist must recognize the client's needs, problems, and resources as they emerge in treatment, and intervene in ways that take these variables into account. Indeed, despite attempts to control for therapist adherence to a manual which may or may not relate to treatment outcome (Webb, DeRubeis, & Barber, 2010), it is unavoidable that therapists will make decisions and take actions that are based on emerging client and interaction characteristics related to the idiosyncrasy of the respective clinical situation. Accordingly, an important distinction where responsiveness is concerned is that between adherence and competence. Namely, whereas adherence refers to therapist use of prescribed techniques and avoidance of proscribed techniques, competence refers to therapist skilful use of techniques (Waltz, Addis, Koemer, & Jacobson, 1993). Stiles and colleagues (1998) note that competence is not always associated with adherence; that is, a rigid, unresponsive implementation of a treatment may be technically adherent, but real competence demands that therapist behaviour be based on sensitivity to relevant aspects of the therapeutic relationship and emerging client requirements.

Indeed, therapy process researchers are increasingly highlighting the importance of context-responsivity in psychotherapy. For example, context-responsivity figures prominently in marker-guided therapeutic approaches such as emotion-focused therapy (EFT), which highlights emerging, in-session client markers as opportunities for differential therapy interventions thought to be best suited to facilitating productive work (e.g., Greenberg, 2015; Greenberg, Rice, & Elliott, 1993). Greenberg and colleagues draw on research findings demonstrating that clients in therapy enter specific problematic emotional processing states that are identifiable through statements and behaviours marking underlying affective problems. To help clients process their feelings, process-experiential therapists attend to a variety of different markers, and intervene in specific ways that have been studied extensively and identified as particularly effective (see Greenberg et al., 1993, for a review of EFT empathy-based task markers and interventions).

In addition to clinical markers specific to EFT, a number of additional markers and interventions have been described in the literature. For example, Angus and Greenberg (2011) have recently specified a set of problem and meaning markers and interventions which combine working with client narrative and emotion in therapy. To illustrate, the marker of a 'same old story,' which reflects a repetitive description of difficulties in which the client is stuck, is best dealt with by promoting client re-experiencing of specific event memories. Similarly, the marker of an 'empty story,' one that is devoid of emotion, is best enriched by means of therapist empathic conjectures about client implicit feelings (Angus & Greenberg, 2011). Other clinical markers and interventions that have been identified in the literature include alliance rupture and repair (Safran & Muran, 1996; 2000), trauma narrative retelling, and confusion and clearing a space (e.g., Elliott, Watson, Goldman, & Greenberg, 2003; Greenberg & Watson, 2006).

Notably, while each of the marker-guided therapeutic approaches may describe different clinical markers and interventions, they all share in common an emphasis on context-responsivity, in that therapists are required to continuously observe and recognize, on a moment-by-moment basis, various client states, and decide how best to proceed. Relatedly, in a recent paper on context-responsive psychotherapy integration, Constantino and colleagues proposed an *if-then* psychotherapy framework, consisting of developing and testing therapist responsiveness modules that can be applied transdiagnostically and across theoretical orientations in response to common markers in the therapy process (Constantino, Boswell, Bernecker, & Castonguay, 2013). These researchers suggest that the field of psychotherapy will advance substantially when it has derived empirical markers of frequently occurring themes in the psychotherapy process, and developed evidence-based strategies for responsively addressing these emergent themes.

Constantino and colleagues (2013) drew on recent trends in the psychotherapy research literature, suggesting that common, transtheoretical treatment factors are instrumental in promoting clinical improvement, perhaps even to a greater extent than theory-specific treatment packages (Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011). Based on this research literature, Constantino et al. proposed several client characteristics and treatment processes that frequently occur across various forms of psychotherapy and to which it is important to be responsive. It is interesting to note that many of these proposed context-responsive markers are closely related to the concept of resistance, in the sense that they reflect cues of client lack of engagement in the therapy process, or otherwise denote a breakdown in the relationship between client and therapist, which, if left unattended, may lead to resistance and further negative process.

In particular, among the proposed context-responsive markers is *change ambivalence*, reflecting client low motivation, uncertainty about change, therapist, and/or treatment, or a conflict between a desire to change and a desire to maintain familiar patterns. Relatedly, another proposed clinical marker is low client *outcome expectations*, reflecting pessimism and limited prognostic belief in the treatment's efficacy. Finally, another important marker is that of *alliance ruptures*, which reflect negative shifts in the client-therapist bond or sense of coordinated collaboration. According to Constantino et al. (2013), these clinical markers have been consistently related to negative psychotherapy process and outcomes, and as such, necessitate therapist preparedness to respond flexibly, skilfully, and responsively. Accordingly, a context-responsive integration model centering on systemized, flexibly manualized, and empirically tested modules for addressing specific psychotherapy process themes is proposed (Boswell & Castonguay, 2007; Constantino et al., 2013; Constantino, Overtree, & Bernecker, 2012).

In summary, the importance of context-sensitivity and therapist flexibility has long been recognized in the psychotherapy process literature. Stiles (2009) indicates that the proper application of many treatment manuals explicitly demands appropriate responsiveness, emphasizing the need for clinical judgment and interpersonal sensitivity in the use of large repertoires of strategies and techniques (e.g., Beck, Rush, Shaw, & Emery, 1979; Greenberg et al., 1993; Kendall & Beidas, 2007; Klerman, Weissman, Rounsaville, & Chevron, 1984). For example, the construct of responsiveness is arguably highly related to the concept of rapport as described by Beck and colleagues, who recommend that therapists engage in behaviours thought to facilitate rapport in CBT, including maintaining eye contact, following the content of client speech, trying to infer and reflect client feelings, and carefully timing when to talk and when to listen.

Finally, in their review of negative process in psychotherapy, Binder and Strupp (1997) identified a generic skill they believe to be crucial to the management of negative psychotherapy process, involving what Schön (1987) defined as "reflection-in-action," or the ability to observe process as one is participating in it, and improvise effective strategies while in the midst of acting. Notably, the value of reflective action may be traced to the seminal work of Harry Stack Sullivan (1954), who first introduced the concept of 'participant observation' to emphasize the importance of therapist attentiveness, not only to the overt and covert behaviour of the client, but also to his or her own personal reactions as they occur throughout the therapeutic encounter. Arguably, the ability to observe interpersonal process as one is participating in it (i.e., reflection-in-action) is a necessary prerequisite for appropriate responsiveness, and indeed, for the effective management of resistance; a topic which I turn to next.

Therapist Responsivity in the Context of Resistance

The importance of appropriate responsiveness in the presence of resistance is perhaps best discussed by Miller and Rollnick (2002), who pioneered the approach known as motivational interviewing as an alternative to the traditional, directive therapeutic approaches that existed at the time for the treatment of addictive behaviours. MI is based on the client-centered therapy of Carl Rogers (1956), with a particular emphasis on enhancing intrinsic motivation to change by exploring and resolving ambivalence. MI departs from many directive, action-oriented approaches to psychotherapy with respect to its conceptualization and management of resistance. Namely, rather than an obstacle to be overcome, MI considers resistance as a normal, expected, and understandable response to change, containing important information to be understood. Moreover, within the framework of MI, resistance is not considered a static quality of clients, but rather the product of a client`s ambivalence about

change, and how a therapist responds to this ambivalence (Moyers & Rollnick, 2002). That is,

persistent client resistance is considered a clinical skill error.

   According to Miller and Rollnick (2002), resistance is the client's way of letting the

therapist know they are not on board, akin to an alternating traffic signal that tells the therapist to

"proceed with caution, slow down, or stop what you're doing" (p. 99). On its own, the

occurrence of the red light is normal, and may in fact provide helpful information to the

therapist. The red light is only problematic insofar as it stays on; that is, if resistant responses

persist or escalate throughout the course of the session or treatment. Therefore, the therapist must

immediately and continuously attend to and successfully navigate moments of resistance as they

occur throughout the session in order to reduce their negative impact (Miller & Rollnick, 2002).

Given the adverse effects of responding with direction in the presence of resistance, MI

therapists faced with resistance are encouraged to shift into a supportive style by 'rolling with

resistance,' which includes the use of empathic reflections, as well as supporting client autonomy

to hold beliefs and make decisions that may run counter to the goals of the therapist or therapy.

   Notably, responsivity takes on particular importance with respect to resistance. Research

demonstrates that client resistance is highly responsive to clinician style. In particular, cultivation

of a more supportive and less directive stance in the presence of resistance has been identified

and supported as particularly effective, and these findings are reviewed below.

   Therapist behaviours influencing client resistance. Generally speaking, therapist

demand or directiveness has been found to reliably increase resistance, whereas supportive

approaches have been associated with its reduction (Beutler, Engle, et al., 1991; Beutler, Mohr,

Grawe, Engle & McDonald, 1991). For example, Miller, Benefield, and Tonigan (1993)

randomly assigned clients with problem drinking to therapists using either a client-centered or

directive counselling style. The authors reported that the directive counselling style was associated with significantly higher levels of resistance, which in turn predicted poorer outcomes up to one year post-treatment. In another recent study of a poor outcome case in the context of narrative therapy, Ribeiro and colleagues (2014) examined the impact of therapist responses on client and therapist collaboration, in situations where the client presented evidence of ambivalence. These researchers found that client responses indicating ambivalence tended to emerge in response to therapist challenging interventions (e.g., confronting, debating client's beliefs, tracking and highlighting change evidence for the client). In turn, the therapist most often responded to statements of ambivalence with further challenging behaviours, which contributed to the deterioration in the quality of the therapeutic collaboration (Robeiro et al., 2014).

Further evidence for the negative impact of directiveness on resistance was provided by Patterson and Forgatch (1985), who observed a significant increase in client noncompliant reactions following therapist 'teach' and 'confront' (i.e., directive) behaviours. In contrast, therapist 'support' and 'facilitate' (i.e., supportive) behaviours were found to elicit greater client cooperation. In another interesting study, Bischoff and Tracey (1995) considered the sequential dependence of therapist directive behaviour and client resistance in a set of ten analogue sessions. Results indicated that, although a therapist's directive behaviour reliably increased the probability of a subsequent resistant behaviour on the part of the client, there was no similar relationship between client behaviour and subsequent therapist behaviour. The authors suggested that the joint finding of relative independence for the therapist and dependence for the client supports the notion that the therapist is dominant and the client's consequent resistant response is predicated upon therapist behaviour.

The importance of therapist responsiveness to client resistance has also been highlighted by Elkin and colleagues (2014) who, in the aforementioned study on therapist responsiveness and client engagement in therapy, also carried out exploratory analyses to examine whether therapist in-session behaviours indicating responsivity differ based on clients' level of resistance. Results indicated that positive therapeutic atmosphere (i.e., one of the factors that was used to measure therapist appropriate responsiveness) significantly predicted client positive contribution to the therapeutic alliance, only for those clients who were rated as resistant to treatment. The authors concluded that the provision of a positive therapeutic atmosphere characterized by therapist responsiveness may help to mitigate clients' negative attitudes regarding the therapist or the treatment. Accordingly, therapists need to be particularly alert to resistant behaviour, even as early as the first two sessions of therapy, and to try to be responsive to client concerns (Elkin et al., 2014).

Indeed, in their reviews of the differential effects of therapist directiveness in psychotherapy, Beutler and colleagues consistently identify client resistance to change and treatment as an important process marker indicating the use of supportive rather than directive methods (see Beutler et al., 2011; Beutler, Rocco, et al., 2001, for reviews). Consistent with these findings, Aviram and Westra (2011) found that receiving MI prior to CBT for generalized anxiety, as opposed to receiving no MI pretreatment, was associated with substantially lower levels of resistance in the first session of CBT, which is turn was predictive of more positive treatment outcomes as well as greater client engagement in therapy.

Therapists' ability to shift into a more supportive rather than directive counselling style in the presence of resistance has also been emphasized in the therapy alliance literature, with respect to the effective management of alliance ruptures (e.g., Safran & Muran, 1996; Safran et

al., 2002). For example, Aspland and colleagues (2008) observed that alliance ruptures in CBT resulted from therapists who persisted in following their clinical agenda irrespective of client opposition, and noted that progress toward successful resolution was facilitated by therapists' willingness to discontinue persevering with technical interventions, and turning their attention to issues that were salient to the client. Consistent with these findings, in a study of alliance ruptures in CBT, ruptures have been found to occur when therapists responded to strains in the therapy relationship by persisting dogmatically with the application of therapeutic techniques (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Interestingly, further quantitative and content analyses in this study suggested that it was not the prescribed techniques per se that were detrimental; rather, it was their rigid implementation in particular contexts of strains in the therapy alliance that interfered with change. That is, the relationship between the therapist's focus on prescribed cognitive therapy techniques and treatment outcome was no longer significant once the influence of the quality of the therapy relationship was statistically controlled.

Accordingly, Castonguay and colleagues note that research findings on the relationship between therapist directive behaviour and negative therapy process do not necessarily imply that the techniques or processes of change prescribed in various treatments are harmful in and of themselves (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). In fact, the use of cognitive and behavioural interventions in CBT has been repeatedly associated with positive treatment outcomes (Burns & Nolen-Hoeksema, 1991; DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999). What such findings do suggest, however, is that therapists need to be trained to identify instances in which clients do not react favourably to a certain therapy direction or intervention, and respond to such markers in a clinically flexible and sensible way,

with good timing and appropriate responsiveness (Castonguay et al., 2010). These authors draw our attention to an important statement made by Goldfried and Davison (1994); namely, that rather than blaming the client for not responding to psychotherapy interventions, therapists need to remember that when it comes to responsiveness to change, "the client is never wrong" (p. 17).

Relatedly, Constantino and colleagues (2013) propose that while treatment could originate from any distinct therapeutic approach or orientation, it is crucial for the therapist to be prepared to shift into (and out of) specific modules/strategies based on empirically-derived clinical markers that necessitate such shifts. Implied in this notion is that therapists would need to (at least temporarily) revise the focus and theoretical goals of the treatment which they are applying. For example, in the case of client noncompliance or resistance in the context of CBT, shifting into interpersonal, metacommunicative strategies to address these strains may necessitate temporarily suspending one's cognitive and behavioural techniques in favour of alliance-preserving and supportive approaches such as MI. Indeed, some researchers have called for shifting into MI to address emergent ambivalence and resistance during the treatment course, even when working primarily from a different theoretical approach (Arkowitz & Westra, 2004; Westra, 2012).

The detrimental effects that are likely to ensue as a result of therapist failure to respond flexibly in the presence of resistance have been emphasized by Burns and Auerbach (1996), who argue that continuing to use a directive approach such as cognitive therapy in the context of client noncompliance, runs the risk of conveying the message that the client's perceptions are irrational or invalid. Instead, these authors suggest that, "When patients are stuck or angry or expressing strong negative affect, therapists need to set their cognitive and behavioural techniques temporarily on the shelf and respond in an empathic manner" (p. 150). Similarly,

Westra (2012) notes that failure to hear and respond to client opposition in a manner that communicates acknowledgement and appreciation of the client's message may lead to important interpersonal consequences that may ultimately disrupt positive treatment outcomes, including undermining client safety in self-assertion and disclosure in therapy, as well as communicating judgement or lack of acceptance of the client.

       The need for moment-to-moment studies on therapist responsiveness in the context of resistance. Despite the recognized importance of therapist flexibility and appropriate responsiveness in the presence of resistance, less research has been done to examine therapist responsivity to client resistant responses and behaviours on a *moment-to-moment basis*, as they occur during therapy sessions in the context of directive therapeutic approaches. In particular, previous studies on the management of resistance in therapy have typically investigated the differential effects of general counselling style, regardless of fluctuating client in-session behaviour, to demonstrate that more supportive and less directive approaches are associated with reduced resistance and increased cooperation in therapy (e.g., Aviram & Westra, 2011; Miller et al., 1993). For example, in a study comparing the effects of directive versus client-centered feedback interventions on drinking outcomes among problem drinkers, the degree of therapist confrontation during the session was positively correlated with client resistance, which in turn predicted poorer subsequent drinking outcomes one year post-treatment (Miller et al., 1993). Similarly, in two randomized controlled trials (RCTs) of CBT for generalized anxiety, clients who received MI either added or integrated into CBT, compared to clients who did not receive MI, showed substantially lower levels of resistance in CBT, which accounted for higher levels of worry reduction in treatment (Aviram & Westra, 2011; Constantino, Westra, & Antony, 2015).

Also of note, Beutler and colleagues (Beutler, Forrester, Gallagher-Thompson, Thompson, & Tomlins, 2012; Beutler et al., 2011; Beutler, Rocco, et al., 2001; Groth-Marnat, Roberts, & Beutler, 2001) have investigated therapist responsivity to client reactance, rather than measuring therapist responses on a moment-to-moment basis. That is, differences in supportive versus directive counselling styles were examined at the level of client global characteristics. In particular, Beutler addresses psychological reactance, a "state of mind aroused by a threat to one's perceived legitimate freedom, motivating the individual to restore the thwarted freedom" (Brehm & Brehm, 1981, p. 4). This social psychology variable addresses important client processes (i.e., motivation to protect freedoms, control expectancies) that relate to how a particular client might experience a therapist's directive behaviour. Indeed, reactance has been found to predict differential response to directive versus non-directive therapies, with low reactance levels serving as indicators for clients who respond effectively to directive interventions, and high reactance levels serving as indicators necessitating the use of supportive approaches (Beutler, Engle, et al., 1991; Beutler et al., 2011; Courchaine, Loucka, & Dowd, 1995; Horvath & Goheen, 1990; Tracey, Ellickson, & Sherry, 1989).

Nevertheless, although reactance may occur on a general level as a client characteristic (and people likely enter therapy with varied initial levels of reactance, ambivalence about, or resistance to change), rather than a fixed personality trait, resistance is conceptualized as a fluctuating phenomenon that varies over the course of therapy and arises in response to contextual demands, including therapist behaviour, the timing of interventions, and the target behaviour under consideration (Miller & Rollnick, 2002). Accordingly, it is possible for resistance to arise in clients who are not high in reactance, such as in the case of opposing a particular direction, task, or homework assignment suggested by the therapist. Consistent with

this notion, in a recent study describing the pattern of client resistance (i.e., client responses that go against the direction set by the therapist) over the course of the first session of CBT for generalized anxiety, findings demonstrated that resistance appeared in prolonged clusters (i.e., sustained episodes) for clients who did not respond to treatment, and had a more scattered pattern for clients with positive treatment outcomes (Aviram, Westra, & Eastwood, 2011). Such findings suggest that resistance is in fact a fluctuating phenomenon that is likely to shift on a moment-to-moment basis within therapy sessions and in response to the emerging therapy context.

Although a number of studies have identified moments of alliance ruptures in order to investigate CBT therapists' in-session management of negative therapy process, this research has typically been confined to the use of qualitative and/or descriptive research methods (e.g., Aspland et al., 2008; Castonguay et al., 1996). More recently, using quantitative methods, Ahmed, Westra, and Constantino (2012) sought to compare therapist behaviours during identified moments of client resistance and cooperation, using an intensive interpersonal process coding system to quantify therapist in-session behaviours in the context of CBT for GAD. These researchers found that clients who went on to be optimistic about their ability to benefit from treatment after the first session of therapy (as assessed by changes from baseline expectancy on the Credibility and Expectancy Questionnaire; Devilly & Borkovec, 2000), had therapists who managed to remain understanding, affirming, and supportive during moments of expressed resistance. In contrast, clients who went on to be pessimistic about the prospect of benefiting from treatment had therapists who attempted to control them or were otherwise dismissive of their concerns. While this is an example of a quantitative study that examined therapist responses to client resistance on a moment-to-moment basis, the focus of this study was on client outcome expectations, rather than therapists' management of resistance. Furthermore, Ahmed and

colleagues used a circumplex model of interpersonal behaviour known as the Structural Analysis of Social Behavior (SASB; Benjamin, 1974), which classifies therapist responses along two dimensions of affiliation and control, but does not provide a more fine-grained differentiation of therapist responses along the directive and autonomy-supportive distinction. Therefore, this study does not permit a clear or direct test of specific therapist responses that are supportive (e.g., preservation and support of client autonomy) and directive (e.g., controlling). Such studies are needed in order to adequately test therapists' moment-to-moment responsivity during moments of resistance.

The Motivational Interviewing Treatment Integrity (MITI) coding system. To better capture therapist responsiveness to client responses that go against the direction of the therapist or therapy, an arguably more suitable measure is the Motivational Interviewing Treatment Integrity (MITI; Moyers, Martin, Manuel, Miller, & Ernst, 2010) coding system, a commonly used instrument for coding therapist competence and adherence to MI. Given that the MITI originated from the theoretical framework of MI, where desirable and undesirable responses to resistance are explicitly defined, this measure is likely to enable a more direct test of therapist responsivity to client resistance on a moment-to-moment basis within therapy sessions. In particular, the MITI assesses the frequency of specific supportive and directive clinician behaviours germane to MI, including MI adherent (e.g., affirm, support, reinforce client autonomy) and non-adherent behaviours (e.g., confront, argue with client, direct or advise without client permission). Additionally, the MITI includes global ratings of therapist style that are designed to capture the client-centered relational stance of MI (i.e., MI "spirit"), including level of therapist empathy, collaboration, respect for client autonomy, and reliance on evoking the client's perspectives and ideas about change.

The MITI and its extended version, the Motivational Interviewing Skills Code (MISC 2.0; Miller, Moyers, Ernst, & Amrhein, 2003) have been used in various studies that have examined the association between therapist adherence to MI and treatment outcomes (e.g., Bertholet, Palfai, Gaume, Daeppen, & Saitz, 2014; Boardman, Catley, Grobe, Little, & Ahluwalia, 2006; Borsari et al., 2015; Catley et al., 2006; Feldstein & Forcehimes, 2007; Gaume, Gmel, Faouzi, & Daeppen 2008, 2009; McCambridge, Day, Thomas, & Strang, 2011; Moyers, Martin, Houck, Christopher, & Tonigan, 2009). Briefly, the MISC is an MI assessment coding system that measures therapist behaviours, client behaviours, and the interaction between the two. Coding with the MISC is done for the entire MI session. In contrast, the MITI only codes therapist (and not client) behaviours, and requires a 20-minute segment randomly selected from a longer therapy session to evaluate the quality of MI being delivered in the session as a whole (Moyers et al., 2005).

By and large, investigations of MI adherence (using the MITI and the MISC) and their relation to symptom change have been equivocal, with some studies finding significant relationships between MI adherence and treatment outcomes while others do not. For example, Gaume and colleagues (2009) used the MISC to examine the effects of MI relational variables on drinking outcomes in a one-session brief motivational intervention (BMI) for problem drinkers. Findings demonstrated that MI spirit and MI consistent behaviours were associated with positive drinking outcomes at one year post-treatment, whereas MI inconsistent behaviours were correlated with poorer drinking outcomes at 12 months follow-up. However, in another study conducted by Gaume and colleagues (2008), MI Spirit, MI consistent, and MI inconsistent behaviours during a one-session alcohol intervention failed to predict a change in drinking behaviours from baseline to 12 months. Similarly, in another study examining the role of

empathy in an MI intervention for underage college drinkers, empathy (as rated by the MITI) failed to predict drinking outcomes (Feldstein & Forcehimes, 2007).

More recently, increased MI spirit and MI consistent behaviour as measured by the MITI have been shown to predict reduced marijuana use among college students (McCambridge et al., 2011). Notably however, therapist behaviour in this study was rated over the entire MI session as opposed to the usual, randomly selected 20-minute segment as recommended by the MITI. Another recent study by Borsari and colleagues (2015) used the MISC to code BMI sessions from two RCTs that facilitated significant reductions in alcohol use and alcohol-related consequences in mandated students. Findings revealed significant relationships among relational aspects of MI and post-session alcohol use, yet there were no links between MI consistent behaviour and subsequent changes in alcohol use or problems. Finally, in another recent study, Bertholet et al. (2014) used the MISC to code 314 BMI sessions taken from three RCTs of MI for problem drinking. Findings demonstrated that, contrary to the authors' expectations, therapist MI spirit was not significantly related to changes in drinking outcomes across studies.

Studies utilizing the MITI and MISC observational coding systems have also examined the association between therapist adherence to MI principles and in-session client behaviours and processes. For example, higher ratings of MI spirit have been positively associated with client engagement in session as assessed using the patient involvement dimension of the Vanderbilt Psychotherapy Process Scale (VPPS; O'Malley, Suh, & Strupp, 1983), and with scores on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) among individuals undergoing an MI intervention for smoking cessation (Boardman et al., 2006). Nevertheless, a number of limitations characterized this study, including an inability to relate MI adherence to actual behavioural outcomes given extremely low smoking cessation rates. In another smoking

cessation study, Catley and colleagues (2006) used the MISC to examine whether counsellor MI adherence was associated with more productive in-session client behaviours. Results revealed that the MI relational stance and the frequency of MI consistent behaviour predicted better client in-session functioning (i.e., expression of affect, cooperation, disclosure, and engagement). Nevertheless, the authors noted that their findings should be interpreted cautiously due to a number of limitations, including low reliability for counsellor behaviours, as well as non-independent ratings for therapist MI adherence and client behaviour variables (thus making it possible that raters were more inclined to see positive client behaviours in sessions in which they noted greater MI adherence). Finally, another limitation of the study was the lack of ability to effectively examine the association between MI adherence and change in the targeted behavior of smoking cessation.

In summary, while studies that have used the MISC and MITI coding systems provide some support for the efficacy of supportive and empathic relational skills emphasized in MI in facilitating more positive treatment outcomes, findings are inconclusive. This is in fact fitting with the larger literature on therapist adherence and treatment outcome. Namely, in a recent meta-analysis, Webb et al. (2010) found no significant relationship between adherence (i.e., the degree to which therapists deliver theory-specific interventions that are consistent with a given therapy protocol) and symptomatic improvement across 32 studies of psychotherapy outcome, regardless of the therapeutic approach under study. Furthermore, studies on MI adherence have traditionally rated therapist MI consistent behaviour over the entire session or during randomly selected 20-minute segments (in accordance with MISC and MITI guidelines, respectively), as opposed to during theoretically indicated key moments (such as moments of in-session client opposition to therapist direction).

In fact, to the author's knowledge, no previous study has tested the responsivity hypothesis (defined in the present study as the level of therapist support) on a moment-to-moment basis during identified key moments of resistance in a directive therapeutic approach. Given that resistance is both a critical clinical phenomenon with powerful implications for the process and outcome of therapy, as well as highly responsive to varying contextual cues such as therapist behaviour, it becomes imperative to further examine therapists' moment-to-moment management of resistance in order to better understand, quantify, and evaluate the significance of this important phenomenon.

Arguably, the examination of therapist appropriate responsiveness in the presence of resistance may be especially indicated in the context of CBT. Researchers suggest that action-oriented approaches such as CBT may be particularly vulnerable to engendering resistance given the relatively high levels of therapist directiveness when compared to other therapeutic approaches such as client-centered and emotion-focused therapies, which adopt a more empathic and evocative (as opposed to prescriptive) approach (Blagys & Hilsenroth, 2002; Watson & McCullen, 2005). Accordingly, in the following section, the literature on resistance and noncompliance in CBT is reviewed, and typical management strategies of resistance within CBT are subsequently outlined.

Resistance and Noncompliance in CBT

Although considered a front-line intervention and becoming more widely available for many mental health disorders (Butler, Chapman, Forman, & Beck, 2006; National Institute of Clinical Excellence, 2004, 2009, 2011), research demonstrates that a substantial portion of clients do not adequately respond to CBT, drop out prematurely, or relapse at follow-up. In a multidimensional meta-analysis of CBT for depression, GAD, and panic disorder, Westen and

Morrisson (2001) reported that only approximately half of the individuals who complete treatment experience significant improvement, that the average client remains symptomatic post-treatment, and that up to 50 percent of clients seek further treatment. Thus, a substantial number of people fail to benefit significantly from CBT for these disorders.

Investigators in recent years have suggested that treatment non-adherence, ambivalence about, and resistance to change may play a significant role in limiting response to CBT (e.g., Antony, Roth Ledley, & Heimberg, 2005; Arkowitz & Westra, 2004; Sanderson & Bruce, 2007). For example, while homework assignments are widely hypothesized as essential to the efficacy of CBT (Kazantzis, Deane, Ronan, & L'Abate, 2005), client resistance and noncompliance with in-session treatment activities and between-session homework is a commonly acknowledged problem among CBT practitioners (Helbig & Fehm, 2004; Huppert & Baker-Morissette, 2003; Kazantzis, Lampropoulos, & Deane, 2005; McAleavey, Castonguay, & Goldfried, 2014; Schmidt & Wollaway-Bickel, 2000; Szkodny, Newman, & Goldfried, 2014). In recent surveys of expert CBT clinicians, the most frequently cited reasons for insufficient response to treatment were 'lack of engagement in behavioural experiments' and 'noncompliance' (Bruce & Sanderson, 2010; Sanderson & Bruce, 2007). Moreover, in a recent survey of psychotherapists on their clinical experiences conducting CBT for GAD, the majority of respondents identified client resistance to the directiveness of treatment, and an inability to work independently between sessions as barriers to treatment efficacy (Szkodny et al., 2014).

Beyond homework noncompliance, Newman (2002) outlined various behaviours that may constitute resistance in CBT, including taking actions that run counter to what was agreed upon in the session, high levels of expressed negative emotion toward the therapist, in-session avoidance such as frequent use of "I don't know" or prolonged silence, debates with the

therapist, as well as challenging and disagreeing with therapist comments. Other manifestations of resistance in CBT that have been identified include lack of collaboration on tasks and goals, and client disagreement with the therapist's formulation of their problems (Watson & McMullen, 2005).

Although relatively silent on the management of resistance until recently, ways of understanding and working with client noncompliance are beginning to appear in the CBT literature (e.g., Beck, 2005; Leahy, 2001, 2003; Sookman & Pinard, 2007). Nevertheless, CBT theories of resistance typically center on client factors, such as counterproductive therapy beliefs (Leahy, 2001, 2003; Sookman & Pinard, 2007) and treatment-interfering behaviours (Pollard, 2007; Van Dyke & Pollard, 2005), as well as on therapist skill factors pertaining to the development and utilization of homework assignments (Engle & Arkowitz, 2006). Theories and recommendations regarding the management of resistance in CBT are reviewed in the following section.

Management of resistance in CBT. Resistant behaviours and noncompliance with CBT are often conceptualized as forms of client dysfunctional beliefs or assumptions, and are therefore managed using cognitive interventions and techniques (Leahy, 2008; Sookman & Pinard, 1999; Van Dyke & Pollard, 2005). For example, in a recent survey of cognitive behavioural therapists regarding problems related to homework compliance, a majority of participants (64.6%) reported responding to these problems by using psychoeducation to explain the goals of the prescribed assignment (Helbig & Fehm, 2004). Similarly, in a survey of CBT experts regarding the management of resistance in panic disorder and agoraphobia, most of the recommendations for dealing with noncompliance were aimed at preventing it through reviewing and expanding on psychoeducation (Sanderson & Bruce, 2007).

In cases in which clients' counter-therapeutic behaviours do not respond to an educative approach, it is suggested that more therapist creativity may be needed, but the basic technique still revolves around identifying, testing, and modifying the dysfunctional beliefs that are assumed to drive the client's maladaptive behaviour (e.g., Ledley, Marx, & Heimberg, 2005). As summarized by Newman (2007), "The client's feelings are valid as feelings (and therefore warrant attention and empathy), but the cognitive underpinnings of these feelings may be deeply flawed, much to the client's disadvantage, and it is the therapist's responsibility to help clients assess and modify such cognitive flaws" (p. 173). Relatedly, in a recent paper concerning client noncompliance with behaviourally based assignments, Clark (2013) outlines a number of maladaptive client beliefs that might engender reluctance to engage in these activities, noting that "The identification and modification of these treatment-resistant schemas should be incorporated into the case formulation and become a central goal in the CBT treatment plan if the clinician notices the emergence of treatment-interfering behavior" (p. 448).

Cognitive behavioural models have also highlighted therapist factors that may contribute to limited treatment response. For example, although not a highly cited obstacle to positive outcomes in CBT, poor delivery of treatment, defined as therapists who do not "push themselves or clients to get the most out of each phase of treatment," was noted by several respondents in the survey conducted by Sanderson and Bruce (2007, p. 33). Accordingly, the suggested recommendation involves ensuring that therapists conduct 'high-fidelity treatment' (i.e., attend to delivering each of the primary emphases of CBT, including psychoeducation, cognitive restructuring, and exposure, in a way that maximizes the gains clients can receive from each of the treatment components). In addition, given evidence linking competence in reviewing and designing homework with positive outcomes in CBT (Bryant, Simons, & Thase, 1999;

Detweiler-Bedell & Whisman, 2005; Startup & Edmonds, 1994), much emphasis has been placed on therapists' skill in constructing and using homework assignments (Kazantzis & Dattilio, 2007; Kazantzis & Shinkfield, 2007; Tompkins, 2004). Recommendations for addressing noncompliance with homework assignments include reviewing the therapeutic rationale and key concepts, as well as stressing the importance of active participation and the role of the task in improving treatment outcomes (Beck, 2005; Kazantzis et al., 2005; Sanderson & Bruce, 2007; Tompkins, 2004; Antony et al., 2005; McKay, Abramowitz, & Taylor, 2010).

In summary, given that CBT models typically regard resistance and noncompliance with treatment as arising from faulty beliefs and attitudes held by clients about making changes, emphasis has been placed on the application of standard cognitive behavioural techniques in order to remediate the difficulties, thus allowing the primary therapeutic work to continue (e.g., Beck et al., 1979). That is, unlike other approaches that view working with resistance as a pivotal part of the change process (e.g., Miller & Rollnick, 2002; Stevens et al., 2003), cognitive behavioural theorists have traditionally viewed resistance and noncompliance as an obstacle to be overcome, so that CBT techniques can be used to address the client's presenting problems (Beck, 1995; Raue & Goldfried, 1994). Stevens and colleagues argue that when the negotiation process between the client and therapist breaks down, the faith that cognitive behavioural therapists have in techniques, and their belief that resistance is simply a roadblock to vanquish, can prove detrimental to the work of therapy. Indeed, given that therapist directiveness has been found to reliably increase resistance, current recommended directive strategies for dealing with resistance in CBT would arguably serve to increase rather than diminish this phenomenon. Consistent with this notion, research indicates that CBT therapists tend to respond to client resistance and noncompliance by increasing their adherence to treatment rationale and

techniques, which in turn has been shown to result in further negative process and poorer treatment outcomes (e.g., Aspland et al., 2008; Castonguay et al., 1996; Leahy, 2001; Viklund et al., 2010).

Aims of the Present Study

In short, resistance has been characterized as a major obstacle to effective psychotherapy, which can be clinically challenging to navigate successfully (Binder & Strupp, 1997). Observational methods of assessing resistance in-session indicate that resistance is a fluctuating phenomenon (e.g., Aviram & Westra, 2011; Aviram et al., 2011, Jungbluth & Shirk, 2009; Keijsers, Schaap, Hoogduin, & Lammers, 1995). And even though it can be relatively rare, resistance has been consistently linked to negative therapy process and treatment outcomes (Beutler et al., 2011). In the case of CBT, client resistance and noncompliance have been frequently cited as among the most important factors limiting treatment efficacy (Antony et al., 2005; Bennett-Levy & Thwaites, 2007; Gilbert & Leahy, 2007; Leahy, 2001; Safran, 1998). The ability to effectively navigate key moments of resistance is therefore particularly important to effective therapy process and outcome.

As previously discussed, cultivation of a more supportive and less directive stance in the presence of resistance has been demonstrated as particularly effective in reducing resistance and increasing cooperation in therapy (e.g., Beutler, Engle, et al., 1991; Beutler, Mohr, et al., 1991; Miller et al., 1993; Patterson & Forgatch, 1985). Nevertheless, research demonstrates that CBT therapists faced with resistance tend to respond rigidly as opposed to flexibly, persisting with their own agenda (i.e., increasing adherence to techniques and treatment rationale), which in turn has been shown to result in further negative process and reduced clinical improvement (e.g., Aspland et al., 2008; Castonguay et al., 1996). With the forgoing in mind, researchers have

suggested that the adoption of a more supportive as opposed to directive relational style may enable more flexible responding in the presence of client opposition, thus ultimately leading to reduced resistance and improved CBT outcomes (Westra & Arkowitz, 2010). Accordingly, cognitive behavioural therapists are increasingly recommending the inclusion and integration of supportive approaches such as MI (Arkowitz & Westra, 2004; Federici, Rowa, & Antony, 2010; Slagle & Gray, 2007; Westra, 2012). Nevertheless, to a large extent, not much attention has been paid within the CBT literature to strategies for effectively managing resistance. In fact, studies have not compared the more directive, traditional approach to managing resistance in CBT to more supportive approaches as informed by other treatment models such as MI. The investigation of therapist responsivity to client resistance on a moment-to-moment basis in the context of CBT is therefore especially indicated.

Furthermore, increasing trends in the psychotherapy research literature highlight the importance of common treatment factors in promoting clinical improvement, thus giving rise to recommendations for the need to train clinicians in responding to and negotiating empirically indicated common factors such as resistance (e.g., Constantino et al., 2013). Nevertheless, despite the growing recognition of the importance of context-responsivity in psychotherapy, and recommendations to develop a context-responsive model through identification and substantiation of common treatment processes to which therapists need to be responsive, the notion of context-responsivity in relation to specific key markers such as resistance remains largely understudied in CBT. Here, a key question involves not just the type of intervention used, but the context in which it is offered. That is, given the lack of significant relationships found between general therapist adherence ratings and treatment outcome (e.g., Webb et al., 2010), it is important to examine whether the *timing* of specific interventions (i.e., more supportive therapist

behaviour specifically in the presence of resistance, versus generally as traditionally rated using randomly selected points across therapy) differentially impacts treatment outcome in CBT.

To address these gaps in the literature, the current study sought to examine therapist responsiveness during identified key moments of interpersonal resistance (client disagreement with therapist rationale, input, or direction) in the context of a recent RCT examining the efficacy of an integrated MI and CBT treatment (MI-CBT), compared to CBT alone, in the treatment of high severity GAD (Westra et al., 2015). Given that it was of interest to examine variability in therapist management of resistance in the context of CBT, only participants from the CBT alone group were included in the current study. Furthermore, given that therapists in the MI-CBT group of the larger clinical trial were trained to be responsive (i.e., offer supportive interventions) in the presence of resistance, less variability in therapist behaviour in response to resistance was expected to occur in this treatment condition[1].

In particular, it was of interest to examine whether differences in CBT therapists' style (i.e., more supportive and less directive behaviour) in the presence of resistance go on to predict proximal (i.e., level of observed resistance following therapist management of resistance) and distal (i.e., pre-to-post worry reduction) therapy outcomes. To this end, the present study utilized the abovementioned MITI (3.1.1; Moyers et al., 2010) observational coding system in order to rate therapist behaviour and overall therapeutic style (e.g., level of empathy, collaboration, evocation, and respect for client autonomy) during moments of resistance in early sessions of

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[1] Notably, the MI-CBT condition was characterized by substantially lower levels of resistance than the CBT alone group of the larger clinical trial (Constantino et al., 2015), and as expected, the MI-CBT had a very low overall level of resistance (M =.06, SD = .07, vs. CBT alone: M =.16, SD =.14; Westra et al., 2015). Nevertheless, it is noteworthy that therapists in the MI-CBT condition of the larger clinical trial were rated as adherent to *both* MI (M = 4.48, SD = .12 for observer-rated therapist empathy, and M = 4.42, SD = .04 for observer-rated therapist MI spirit on a 5 point MI adherence scale) and CBT (e.g., at session 6, M = 3.69, SD =.65 on a 6 point CBT adherence scale; Westra et al., 2015), thus implying that they were behaving responsively (i.e., shifting therapeutic style based on client and context characteristics).

CBT for GAD. This system was also used to measure general MI adherence (i.e., at randomly selected times across therapy) for therapists in the CBT alone group, in order to rule out CBT therapist use of MI and ensure treatment fidelity and valid differentiation of treatments.

In addition, an observational coding system of interpersonal resistance was utilized to identify moments containing client responses and behaviours that indicate resistance to the direction set by the therapist (Manual for Rating Interpersonal Resistance; Westra, Aviram, Kertes, Ahmed, & Connors, 2009). Namely, in this coding system, resistance is defined as any client behaviour that goes against, opposes, diverts, blocks, or impedes the direction set by the therapist. That is, in a typical therapy session the therapist is nearly always attempting to set, or proceed in, a particular direction (e.g., by asking a question, making a reflection, or offering a suggestion), and inviting the client to comply with this direction (i.e., by answering the question, responding to the reflection or suggestion). Client responses are then coded as to whether they go along with, or go against, the therapist's direction.

Studies that have utilized the Manual for Rating Interpersonal Resistance have provided evidence for the association between the occurrence of this form of oppositional resistance in therapy and treatment outcome. For example, in a study of CBT for high severity GAD, the level of interpersonal resistance coded in the first session of therapy was found to strongly predict worry outcomes even up to one year post-treatment (Aviram & Westra, 2011). Furthermore, results of this study indicated that the level of resistance in the first session of CBT predicted subsequent engagement in therapy sessions as well as homework completion. More recently, a study comparing therapists' post-session ratings of client resistance with those of trained observers (utilizing the Manual for Rating Interpersonal Resistance) in the context of CBT for GAD found that, while therapists' ratings were not related to client post-session alliance scores

or post-treatment worry, the ratings of trained observers were in fact highly predictive of these outcome measures (Hara et al., 2015).

In another recent study, Sijercic and colleagues utilized the Manual for Rating Interpersonal Resistance and the MISC to code the first session of CBT for GAD. Client statements made in order to oppose the therapist (i.e., in the context of interpersonal resistance) were then separated from those made when no evidence of opposition or disharmony was present. Findings indicated that a higher number of statements against change representing opposition (i.e., interpersonal resistance) were highly toxic to subsequent homework compliance and post-treatment worry outcomes even up to one-year post-treatment, whereas arguments against change that occurred when interpersonal resistance was not present (i.e., mere disclosures of ambivalence as captured by the MISC) bore no significant relationship to outcomes (Sijercic, Button, Westra, & Hara, in press). Most recently, the Manual for Rating Interpersonal Resistance was utilized by another research group examining the relationship between interpersonal factors and therapist adherence in the context of CBT for panic disorder (Zickgraf, Chambless, et al., 2015). Consistent with these researchers' hypotheses, findings indicated that when observed levels of resistance were higher, this significantly interfered with treatment integrity. In particular, higher levels of resistance in CBT were related to lower levels of therapist treatment adherence, as well as higher use of off-protocol interventions (Zickgraf et al., 2015).

Collectively, the aforementioned studies provide support for the use of the Manual for Rating Interpersonal Resistance in identifying this important clinical phenomenon (i.e., client opposition to the direction set by the therapist) that goes on to have important implications for therapy process and outcomes.

In designing the current study, I chose to focus on interpersonal resistance that involves client disagreements with therapist direction, suggestion, and/or input. The selection of instances representing client disagreements was guided by both practical and empirical reasons. Practically, while many forms of resistance are not episodic in nature and occur only momentarily (e.g., ignoring, interrupting, sidetracking), disagreements are often episodic in nature (i.e., having the form of a narrative, or thematically related sequence of exchanges which often contain a beginning and end), and can even involve protracted episodes. Moreover, disagreements often represent instances of clear, *explicit* client opposition to therapist direction, and such episodes can therefore be easily and reliably identified. As such, these disagreement episodes can also be somewhat distinguished from the concept of alliance ruptures, which are defined as consisting of both withdrawal and confrontation markers (e.g., Safran & Muran, 1996, 2000).

It is also noteworthy that, whereas Safran and Muran (2006) define ruptures in the therapeutic alliance as moments of tension, conflict, or misunderstanding in the collaborative relationship between client and therapist, disagreement episodes as conceptualized in this study are more closely related to Bordin's (1979) transtheoretical model of the therapy alliance, in which rupture events are defined as disagreements between client and therapist concerning therapy goals and tasks (see Coutinho, Ribeiro, Sousa, & Safran, 2014, for a review of methods of defining and identifying alliance rupture events). Indeed, in the context of CBT, which typically consists of a clearly defined set of therapy goals and tasks, client resistance often occurs in the form of disagreements concerning those aspects of the alliance. Nevertheless, it is also the case that, especially when ineffectively managed by the therapist, those moments of client

disagreement can often result in tension, conflict, and strains in the collaborative bond between client and therapist.

Finally with respect to the decision to focus in the present study on interpersonal resistance that involves client disagreement with therapist direction, episodes of client disagreement were deemed especially relevant to examining CBT therapist management of resistance (as opposed to ignoring or interrupting for example), given that in these instances, therapist responses of coercion or argument versus support and preservation of client autonomy are thought to be especially apparent. That is, CBT therapists' ability to roll with resistance seems especially transparent when clients explicitly voice disagreement with the therapist.

The present study examined the context-responsivity hypothesis in two major ways. First, variations between CBT therapists in terms of the level of support provided to the client during disagreement were identified and assessed using the MITI for their predictive capacity. Second, the MITI was also utilized to examine CBT therapists' level of support at randomly selected 20-minute segments from sessions representing early, middle, and late phases of therapy (i.e., sessions 1, 6, and 11, respectively). This more general level of support (exemplifying the method traditionally used in standard adherence coding to assess therapist treatment fidelity) was then compared to context-specific levels of MI adherence during moments of disagreement to determine any differential impact of the *timing* of therapist support.

Based on previous research concerning the detrimental effects of therapist directiveness in the presence of resistance, the following hypotheses were advanced:

Hypothesis 1: Higher ratings of CBT therapist MI adherence in the context of client disagreement will be associated with better therapy outcomes, as reflected by significantly lower

ratings of post-treatment worry, as assessed by the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990).

Hypothesis 2: Higher ratings of CBT therapist MI adherence in the context of client disagreement will be associated with better proximal therapy outcomes, as reflected by significantly lower levels of subsequent resistance coded in the session immediately following the session identified for disagreement.

Hypothesis 3: CBT therapist context-specific MI adherence (i.e., during disagreement episodes) is expected to exert more pronounced effects on measures of therapy outcomes (i.e., result in significantly lower ratings of post-treatment worry and subsequent resistance) when compared to CBT therapist general MI adherence (i.e., during randomly selected moments in therapy).

Method

A local Institutional Ethics Review Board for research involving human participants approved all measures and procedures in the larger RCT. Informed consent was obtained for all study procedures at the time of initial study intake.

Participants and Selection

Clients were enrolled over an 18 month period from February 2012 to April 2013. Participants were recruited from community advertisements in the Greater Toronto Area targeting individuals who worry excessively. As a first step in the selection process, potential participants had to pass an initial phone screen based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev; DSM-IV-TR; American Psychiatric Association, 2000) criteria for GAD. Only those individuals who had a high probability of meeting criteria for GAD diagnosis and who scored above the cut off for high worry severity, as defined by a baseline

PSWQ score equal to or greater than 68 out of 80 points (Meyer et al., 1990) were invited to complete the Structured Clinical Interview for Axis-I DSM-IV Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1996).

Diagnostic interviews were conducted by advanced clinical psychology graduate students who were trained to criterion in the administration of the SCID-I. Interrater reliability based on a random sample of 25 percent audiotaped interviews for participants who were successfully enrolled in the study was good, with an overall kappa for all diagnoses of .75, and 1.0 for GAD. The correlation between raters for GAD severity was $r = .794$, $p < .001$. All participants met the DSM-IV diagnostic criteria for GAD, which was updated to include proposed DSM-V criteria which were under development at the time of the study (American Psychiatric Association, 2013)[2]. Furthermore, 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 were considered eligible. Interviewers also completed severity ratings of GAD and of comorbid diagnoses. Given the high rates of comorbidity between anxiety and depression (Stein, 2001; Wittchen, Zhao, Kessler, & Eaton, 1994), a decision was made to include individuals with comorbid depression and/or other anxiety disorder diagnoses in order to enhance external validity.

Additional selection criteria included being at least 16 years of age, receiving a GAD severity score on the SCID-I of at least 4, absence of concurrent psychotherapy, no concurrent

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[2] The key goals of the proposed DSM-V criteria were to improve recognition of GAD and avoid the high number of 'false negative' cases (Wittchen et al., 2002). This was to be accomplished by a) making it easier to meet the GAD criterion pertaining to pathological worry so that it would not need to be uncontrollable as stipulated in the DSM-IV, b) decreasing the minimum number of required symptoms associated with the DSM-IV (i.e., restlessness or feeling keyed up or on edge, muscle tension, irritability, being easily fatigued, difficulty concentrating or mind going blank, and sleep disturbance) from three to one, and c) reducing the minimum duration of GAD from six to three months. Furthermore, behavioural criteria were introduced (i.e., avoidance of situations in which a negative outcomes could occur, marked time and effort in preparing for situations in which a negative outcome could occur, procrastination due to worries, and excessive reassurance seeking due to worries) of which the presence of at least one was postulated as required for the diagnosis.

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, no significant suicidal ideation, and no use of benzodiazepines for at least 2 months prior to study enrollment. Participants who were not taking psychotropic medications were required to abstain from taking medications for the duration of their treatment in the study. Consistent with other clinical trials of CBT for GAD, and in the service of external validity (i.e., given that individuals with high severity anxiety disorders are commonly taking antidepressant medications), concurrent antidepressant medication was permitted, provided that participants remained on a stable dose for at least 12 weeks prior to study inclusion, and agreed to remain on that dose for the duration of their participation in the study. A washout period of 12 weeks was required for individuals who had recently discontinued antidepressant medication.

Therapists and Therapist Training

CBT therapists ($N = 13$, all females) included 12 doctoral graduate students in clinical psychology and one post-doctoral fellow. Each therapist saw between 1 and 6 cases ($M = 2.31$, $SD = 1.49$). To control for the treatment allegiance effects that are commonly encountered in RCTs (Luborsky et al., 1999), therapists were nested within treatment group. That is, each therapist delivered either MI-CBT or CBT alone, and no therapist delivered treatment for both treatment groups. Moreover, potential therapists were informed about both treatment conditions and self-selected which treatment group they preferred to receive training in and deliver. This process ensured that therapists were not in the position of being required to deliver components of treatment that they did not themselves regard as highly effective.

Therapist training consisted of readings, attending a 4 day workshop including discussion and role-play, followed by at least one practice case with intensive feedback and video review of therapy sessions. The workshops were led by a licensed clinical psychologist with extensive experience in CBT, and by a post-doctoral fellow specializing in CBT. Case supervision (including both practice and study cases) for the CBT alone group was overseen primarily by the post-doctoral fellow specializing in CBT. Case supervisors only oversaw therapists within their treatment group assignment (MI-CBT or CBT alone, respectively). Once supervisors determined that a therapist was competent in their delivery of the treatment, the therapist proceeded to see study cases. Therapists in the CBT alone group saw one practice case each, and all were deemed competent in the delivery of CBT. Supervision consisted of videotape review and weekly meetings for individual supervision.

Treatment integrity for the CBT was assessed using the Cognitive Therapy Rating Scale (CTRS: Young & Beck, 1980). Ratings are made on 11 different dimensions including interpersonal skills (e.g., collaboration, understanding), specific CT skills (e.g., focus on key cognitions, application of CBT techniques), and overall session quality. Five undergraduate psychology students were trained to criterion over a period of 6 months by the post-doctoral fellow specializing in CBT. The raters worked independently, met regularly to reduce rater drift, and resolved any disagreements through discussion 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 ($SD = 5.28$). This compares favourably with the average score of 41.28 ($SD = 4.24$) on the CTRS in the CBT group of the Depression Collaborative Research Program (Shaw et al., 1999).

Treatment

Participants in the CBT alone group received 15 weekly, 1 hour sessions of individual CBT, as well as two, 1 hour follow-up sessions at one and three months post-treatment, which were designed to reinforce skills learned during the active phase of treatment. Treatment was adapted from a number of evidence-based protocols (e.g., Craske & Barlow, 2006; Zinbarg, Craske, & Barlow, 2006), and included progressive muscle relaxation, cognitive restructuring (with an emphasis on probability overestimation and catastrophic thinking), and one or more behavioural strategies (i.e., behavioural experiments, reduction of worry behaviours, imaginal exposure to feared outcomes). A session-by-session manual was developed for the RCT (Westra et al., 2015). Therapists were instructed to implement treatment in a specific order, commencing with progressive muscle relaxation, followed by cognitive restructuring, and behavioural strategies. The length of time spent on each treatment component however, was left to the judgment of the therapist as indicated by the needs and responsiveness of clients to each treatment element.

Furthermore, in order to establish consistency in the management of homework noncompliance, procedures for CBT-consistent management practices were extracted from the literature (e.g., Beck, 2005; Kazantzis & Shinkfield, 2007; Tompkins, 2004; Waters & Craske, 2005) and made explicit. Namely, these included the integration of strategies for preventing homework noncompliance (e.g., working collaboratively to develop homework assignments, anticipating obstacles), as well as CBT-consistent manners of responding to noncompliance (e.g., validating the difficulty of completing homework assignments and understanding the reasons for noncompliance, providing psychoeducation on the importance of homework completion, as well as working with clients to problem-solve identified obstacles).

Self- and Clinician-Report Measures

      Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990). The PSWQ is a widely used 16-item instrument assessing trait worry. The PSWQ possesses high temporal stability and internal consistency, as reflected by a Cronbach's α of .93 for all anxiety disorders, and .86 for GAD, as well as good convergent and discriminant validity (Brown, Antony, & Barlow, 1992; Meyer et al., 1990). It also differentiates individuals with GAD from those with other anxiety disorders (Brown et al., 1992). PSWQ scores range from 16 to 80, with higher scores indicating greater worry. The PSWQ was administered at baseline, immediately following every CBT session, post-treatment, and at all follow-up assessments.

      Therapist Ratings of Resistance. Given that there is no published measure of therapist-rated resistance, Westra and colleagues (2015) constructed one for their clinical trial. Namely, therapists completed three visual analogue scales (VASs) where they rated clients on the dimensions of Passive-Active, Defensive-Receptive, and Rigid-Flexible. The average Cronbach's α for these items over the first 7 sessions was .79, indicating good internal consistency. A higher score on each dimension indicated more positive therapist ratings (i.e., less resistance).

      In the current study, therapists' ratings of client defensiveness were examined for the purposes of sample selection. In particular, at the end of each session, therapists were asked to draw a mark on a ruler ranging from 1 to 100 that best reflected the level of client defensiveness during the session, where 1 indicated client defensiveness and 100 indicated client receptiveness. Therapist ratings were then converted into numerical scores, and the sessions that were rated as highest on client defensiveness were selected for resistance coding.

Credibility and Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000). The CEQ is a widely used self-report scale for measuring client expectancy for improvement and treatment credibility. Following Borkovec and colleagues' (2002) adapted scoring strategy, outcome expectations were assessed based on participant response to an item asking how much they expected to improve by the end of treatment on an 11-point scale (from 0 to 100 percent in 10-point increments). The CEQ expectancy item has been shown to possess adequate test-retest reliability and high internal consistency (Devilly & 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 one item to assess outcome expectations and found the single expectations item to predict post-treatment outcome (Borkovec et al., 2002; Price, Anderson, Henrich, & Rothbaum, 2008; Vogel, Hansen, Stiles, & Gotestam, 2006). Clients completed the CEQ at the beginning of treatment and immediately following each therapy session. Therapists in the larger RCT were also required to rate their outcome expectations. Namely, Westra et al. (2015) adapted the CEQ expectancy item for use of therapists, who were asked to rate how much improvement they believe their clients would experience by the end of treatment.

Process Measures and Method

See Figure 1 for a flow chart of the procedures in the present study. Each of the steps in the procedure is further elaborated below. After this, detailed descriptions of the two process measures used in this study (i.e., to code resistance and MI adherence, respectively) are provided, followed by information on coder training and reliability for each of these process coding systems.

Sample Selection. Given that it was of interest to examine therapist responsiveness during moments of disagreement, CBT sessions in which the phenomenon of interest (i.e., resistant disagreements) was present were identified using a two stage process. First, therapist VAS ratings of client defensiveness for early CBT sessions (i.e., sessions two through six) were reviewed in order to identify sessions in which therapists rated clients as highly defensive[3]. In this process, it was decided to include sessions that were rated as 60 (out of 100) or lower on client defensiveness, given that this ranking was deemed low enough to indicate that a sufficient level of resistance (i.e., client defensiveness or lack of receptiveness) was likely to be present. A total of 17 sessions were selected using this identification method.

Next, given recent findings that ratings of trained observers of resistance were highly predictive of client outcomes while therapists' ratings of resistance were not (e.g., Hara et al., 2015), in cases where therapists did not rate their clients as defensive for any of the sessions under review, a second step was taken to identify sessions in which resistance may be present despite the therapist not reporting this phenomenon. Namely, four advanced undergraduate coders who were trained in the identification of resistance reviewed sessions two through six of the remaining dyads, and selected the session which they deemed as containing the highest level of observed resistance. A total of 13 additional potential sessions were selected using this identification method. When a dyad contained no instances of disagreements for any of the sessions being reviewed, these clients were not included in the final sample for the current study ($n = 13$). In summary, out of the 43 participants in the CBT alone group who had completed treatment, only those who were identified as having a sufficient level of resistance were included in the final sample for the current study ($N = 30$).

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[3] Session 1 was not included in this sample selection given that it was of interest to preserve an early therapy session (i.e., a session prior to the identification of resistant disagreements) to include as a baseline measure for client resistance.

Resistance Coding. Following session selection, the videotapes for the identified

sessions were coded in their entirety for resistance using the Manual for Rating Interpersonal

Resistance (Westra, Aviram, et al., 2009; see Appendix A). Briefly, this observational coding

system defines resistance as *any behaviour which opposes, blocks, diverts, or impedes the*

direction set by the therapist. Rather than being considered a characteristic of clients (typically

pejoratively), resistance is viewed as inextricably embedded in the interpersonal process between

client and therapist and is thus considered a measure of interpersonal process. There are several

main types of interpersonal resistance, including 1) disagreeing, confronting, or challenging the

therapist's direction, suggestion, or input; 2) sidetracking or interrupting in order to

impede/block the therapist's direction; 3) not responding (e.g., ignoring therapist input, not

answering therapist questions); and 4) questioning the therapist's direction (please refer to later

section on Process Coding Measures, for a detailed description of this coding system).

Disagreement Episode Identification. During the resistance coding process, coders

identified one specific form of resistance that often occurs episodically; namely, client

disagreement. Disagreement episodes consisted of a sequence of time bins that began with an

instance of clear client disagreement with the therapist's direction, input, or suggestions; i.e.,

client statements that can be paraphrased as "I don't agree with you" (see Appendix B for

illustrations of disagreements signifying the beginning of a disagreement episode). With respect

to the length of the extracted disagreement episode, this was defined as beginning in the first

instance of client disagreement, and as ending once the client and therapist had shifted into

discussing another topic. Importantly, the conclusion of a disagreement episode was not

dependent on whether the disagreement between the client and therapist was successfully

resolved, and typically would end when the therapist changed the topic.

It was important to ensure that the length of disagreement episodes was sufficient to allow for valid coding using the MITI. With this in mind, disagreement episodes that were less than approximately one minute were not included in the final sample for MITI coding. A total of 67 disagreement episodes were identified for subsequent MITI coding. Disagreement episodes varied in length, ranging from 1.14 to 34.23 minutes ($M = 9.34$, $SD = 7.64$). In addition, the number of disagreement episodes per session varied, ranging from one to five episodes ($M = 2.23$, $SD = 1.04$)[4].

MITI Coding for Disagreement Episodes. Therapists' supportive and directive behaviours during moments of disagreement were rated using the MITI behavioural coding system (Moyers et al., 2010), a common measure of MI adherence in the psychotherapy literature. In particular, the MITI was developed to assess overall treatment integrity to MI by producing five global or gestalt scores of therapist behaviours (Evocation, Collaboration, Autonomy/Support, Empathy, and Direction) and frequency counts of specific therapist behaviours (MI adherence, MI non-adherence, closed-ended questions, open-ended questions, giving information, simple reflections, and complex reflections).

Subsequent Resistance Coding. Given that it was of interest to examine whether differences in therapist style in the presence of client disagreement go on to predict subsequent levels of resistance, resistance coding was also conducted for the session immediately following the target session containing disagreement. These subsequent sessions were coded in their entirety for resistance.

General MI Adherence Coding. As part of the overall adherence procedures in the larger clinical trial (Westra et al., 2015), and in accordance with MITI guidelines, therapists'

[4] In instances when more than one disagreement episode was present in a given session, the MITI ratings for each episode were averaged across the episodes to yield overall scores for therapist behaviours in response to resistance.

general MI adherence ratings were derived for randomly selected 20-minute segments from

sessions representing early, middle, and late phases of therapy (i.e., sessions 1, 6, and 11,

respectively). These segments were then transcribed and coded using videos and transcripts

utilizing the MITI. Following this procedure, average MITI ratings across early, middle, and late

therapy sessions were calculated for each therapist to reflect their general level of MI adherence.

Process Coding Measures

Manual for Rating Interpersonal Resistance (Westra, Aviram, Kertes, Ahmed, &

Connors, 2009). An adapted version of the Client Resistance Code (CRC; Chamberlain,

Patterson, Reid, Kavanagh, & Forgatch, 1984) was used to code resistance in the current study

(see Appendix A for a description of the adapted manual). The original CRC is a pan-theoretical

measure that is not tied to any particular psychotherapy approach. Resistance in the CRC is

defined as any behaviour which opposes, blocks, diverts, or impedes the direction set by the

therapist. Opposition can be expressed either directly (i.e., verbal statements such as "I just hate

writing things down") or indirectly (i.e., in process, such as disagreeing, ignoring, or interrupting

the therapist). Importantly, this is a process coding system and thus content is secondary. That is,

it must be clear from the interpersonal context (rather than simply through the content of client

statements) that the intention of the client's response or behaviour is meant to go against the

therapist's direction. The CRC has been shown to possess good construct and predictive validity

(Chamberlain et al., 1984; Patterson & Forgatch, 1985; Tracey & Ray, 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. First, the 11

subcategories of resistance in the CRC (i.e., challenging, disagreeing, expressing hopelessness,

blaming, defending others or self, pushing client's own agenda, sidetracking, not responding, not

answering, and disqualifying) 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 greatly aids in achieving reliability among coders in identifying complex processes

such as resistance, since 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. 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 videotape (rather than using transcripts). This allows coders to focus on

identifying the gestalt construct through the use of both verbal and nonverbal cues[5]. In our

experience, 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 given that it was deemed long

enough to capture the construct of interest (i.e., resistance), while still being short enough to

ensure valid coding.

Within each time bin, coders first decided whether resistance was present or absent. In

turn, each time bin was rated for the presence of resistance on a four-point rating scale ranging

from 0 to 3, reflecting the quality of expressed resistance. That is, rather than relying on the

content of the client's response to differentiate types of resistance (e.g., disagreeing versus

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[5] Notably, client nonverbal cues as coded by the Manual for Rating Interpersonal Resistance (Westra, Aviram, et al., 2009) include both nonverbal (e.g., posture, physical gestures, eye movements, facial expressions) and paralinguistic (i.e., non-semantic characteristics of the voice, including tone, laughter, pauses, and rhythm of speech) behaviours.

ignoring) as in the original CRC, different qualities of expression were coded. In particular, 0 reflects the absence of resistance (i.e., client is being 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 or clear 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"). In these responses, while the client is opposing the therapist or expressing concern, the context is generally one of cooperation. Such responses have a quality of the client having some recognition of, acknowledgement, or even agreement with the therapist's input and direction, while politely and gently disagreeing, opposing, or redirecting. That is, responses in this category have a mixed underlying interpersonal message of opposition, along with a simultaneous wish to collaborate and maintain connection with the therapist.

In contrast, 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"). These codes are differentiated from qualified resistance in that the client clearly communicates opposition to the therapist, with no softening of the opposition, and no preservation or acknowledgement of the therapist's input.

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!") These codes are distinguished from clear resistance in that there is an added display of deliberate disregard for the therapist, which is often captured in tone (e.g., sarcastic, dismissive) or other nonverbal behaviours (e.g., eye rolling, dismissive gestures). These responses may also seek to disparage or undermine the

therapist, and often have a feel of involving the therapist on a personal level (e.g., nonverbally or verbally criticizing, mocking, belittling or questioning the therapist's competence, approach, or input).

Given previous research indicating that clear, unequivocal resistance (a code of 2) and hostile resistance (a code of 3) were the codes accounting for the highest variance in the prediction of treatment outcomes (Aviram et al., 2011), the present study only considered the frequency of clear and hostile resistance in observer coder ratings. That is, each time bin could receive a code of 1, 2, or 3, and only those time bins receiving a code of 2 and/or 3 (i.e., clear or hostile resistance) were considered in the present study. The frequency of clear and hostile resistance was calculated by dividing the number of 30-second time bins containing a code of 2 or 3 by the total number of time bins in the session. This was done to control for session length.

Motivational Interviewing Treatment Integrity (MITI 3.1.1; Moyers, Martin, Manuel, Miller, & Ernst, 2010). The MITI scale is considered the most widely utilized MI fidelity instrument. It has been used in numerous studies to assess clinician competence and fidelity to the principles of MI (e.g., Jensen et al., 2011; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005; Tollison et al., 2008; Turrisi et al., 2009), has demonstrated sound reliability and sensitivity (Madson & Campbell, 2006; Moyers et al., 2005), and has been found to predict treatment outcome across a wide range of behavioural domains (Moyers et al., 2009).

As previously mentioned, the MITI is divided into two components known as global scores and behavioural counts. A *global score* requires coders to assign a single number from a 5-point Likert scale to characterize the entire interaction, thus capturing the rater's global impression or overall judgment about the dimension. Five global dimensions are rated, including therapist empathy, evocation, collaboration with the client, respect for the client's autonomy, and

direction of the session (i.e., focus) toward the target behaviour[6] (see Appendix C for a summary

of the global scores).

In line with the MITI manual guidelines (and because scores are generally highly

correlated), the global scores for therapist Evocation, Collaboration, and Autonomy/Support

were averaged together to yield the MI Spirit global score (Moyers et al., 2010). In the present

study, the MI spirit and Empathy global scores during disagreement episodes were also highly

positively correlated ($r = .91$, $p < .001$) and thus nearly redundant, suggesting one overarching

global dimension of "MI adherence." Therefore, an aggregate variable was created by averaging

together therapist ratings of Empathy and MI Spirit during disagreement episodes. It will be

referred to as *Disagreement MI Adherence*.

Similarly, and as was previously mentioned, average MITI adherence ratings for

randomly selected 20-minute segments in early, middle, and late therapy sessions were

calculated for each therapist in the study to reflect their overall or general levels of Empathy and

MI spirit throughout treatment. Given that the MI Spirit and Empathy global scores that were

rated for general adherence were also strongly positively correlated ($r = .89$, $p < .001$), an

aggregate variable was created by averaging these two global scores. This variable will be

referred to as *General MI Adherence*, to reflect the nature of these ratings for randomly selected

segments of therapy.

The second component of the MITI consists of *behavioural counts*, which require coders

to tally instances of particular therapist behaviours that occur from the beginning of the segment

being reviewed until the end. Behaviour counts are intended to capture specific therapist

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[6] In the present study, the global score Direction was not included as part of the MITI codes differentiating therapist directive versus supportive behaviour, given that the degree of therapist focus on the target behaviour during moments of resistance was not deemed as necessarily reflecting therapists' coercion versus preservation of client autonomy.

behaviours without regard to how they fit into the overall impression of the clinician's use of MI.

Therefore, the coder is not required to judge the quality or overall adequacy of the event as with

global scores, but simply to count it. Therapist utterances may be assigned one of five primary

behaviour codes, including MI Adherent, MI Nonadherent, Giving Information, Questions, and

Reflections. Within the latter two categories, sub-classification is required, as coders differentiate

between Open and Closed Questions, and Simple or Complex Reflections, respectively. In

particular, Open Questions as compared to Closed Questions are queries that allow room for

various possibilities in response, rather than having a closed (i.e., yes, no, or one word) response.

Similarly, whereas Simple Reflections reflect restatements of what the client said which add little

to no meaning to the client's words, Complex Reflections serve to add meaning to what the

client said, steering the conversation in a new direction, or incorporating an implied, but unstated

feeling (Moyers et al., 2007).

In the present study, the MITI behavioural counts were adapted in order to better reflect

the nature of the CBT sessions being reviewed (and considering that these were not MI sessions

for which the MITI was originally intended). In particular, in the MITI, instances where the

therapist directs the client (e.g., makes demands, gives advice) are normally coded as MI-

Nonadherent; that is, they are considered negative or undesirable therapist behaviours given that

in the context of MI, these behaviours are often intended to coerce the client or go against the

client's will. In the context of CBT however, there are many instances where direction takes

place but does not occur in a coercive context, thus not necessarily being considered negative. To

differentiate therapist direction that is considered coercive (i.e., the traditional MI Nonadherent

code) from instances of therapist direction that do not occur in a coercive context, the Direct

Neutral code was created. Namely, this category was designed to capture utterances in which the

therapist provides direction, advice, instructions, or other input that is intended to guide the client, *but does not go against the client's will*, thus not impeding the client's autonomy (or warranting an MI Nonadherent code).

In addition, the MI Adherent category of the MITI manual was adapted to better capture therapists' behaviours that preserve client autonomy during moments of resistance. To this end, three of the original MI Adherent codes were preserved (i.e., *affirming* the client by saying something complimentary, *supporting* the client with statements of compassion or sympathy, and *emphasizing the client's control*, freedom of choice, autonomy, and ability to decide), but the latter MI adherent category was further divided into three subcategories defined as 'autonomy codes.' Specifically, the MI Adherent autonomy codes in the present study included: 1) giving direction or information in the context of asking permission (e.g., "Is it okay if I share with you some information about..."); 2) explicit statements that emphasize the client's autonomy or ability to decide (e.g., "It's up to you whether you want to do this or not"); and 3) therapists' 'checking' behaviours (i.e., when the therapist adds a statement to check whether their input/suggestion makes sense to the client, or whether their reflection fits with the client's experience). Please refer to Appendix D for a detailed summary of the behavioural counts adapted for use in the CBT sessions of the current study.

Because critical indices of MI functioning are imperfectly captured by frequency counts, MITI guidelines recommend the use of summary scores computed from the behavioural counts, rather than the individual codes themselves (Moyers et al., 2010). These summary scores include: 1) Percent MIA Adherent (computed by dividing the number of MI Adherent codes by the total number of MI Adherent and MI Nonadherent codes); 2) Percent Complex Reflections (computed by dividing the number of Complex Reflections by the total number of Simple and

Complex Reflections); and 3) Percent Open Questions (computed by dividing the number of Open Questions by the total number of Closed and Open Questions). For the purposes of the present study, an additional MITI summary score was created to reflect the added Direct Neutral code. In particular, Percent Direct Neutral was created by dividing the number of Direct Neutral codes by the total number of behavioural counts in the coded segment.

Training and Reliability

      Resistance coding. The team of resistance coders consisted of three graduate students in clinical psychology (two doctoral, one Master's level), and one Ph.D. psychologist. Two of the coders were involved in adapting the CRC for use with CBT for GAD, and were trained to criterion over a period of one year. The remaining two coders were trained to criterion over a period of 10 months. Namely, after reading the Manual for Rating Interpersonal Resistance (Westra, Aviram, et al., 2009), coders attended a 2 day workshop on interpersonal resistance coding. Samples of publicly available therapy sessions, followed by therapy session videotapes from a previous RCT of CBT for GAD (Westra, Arkowitz, & Dozois, 2009) were reviewed and discussed by the group extensively at weekly meetings. Following this, the coders independently coded new practice sessions, meeting regularly to review discrepancies in coding, until adequate interrater reliability as assessed by observer agreement was achieved at 85 percent. Practice videotapes, which were different than the ones used to code resistance in the current study, were specifically chosen to reflect more difficult coding situations in which resistance was repeatedly present.

      Coders were kept blind to clients' outcome status throughout the coding process. To reduce the possibility of coder drift, reliability was examined continuously throughout the coding process. Interrater reliability was calculated by double-coding 25 percent of all tapes. Weighted

kappa coefficients were calculated for each pair of raters and ranged from .70 to .98, with a mean of .85, indicating good to excellent agreement (Fleiss, 1981).

MITI coding. The team of MITI coders consisted of six advanced undergraduate students in psychology who were trained to criterion over a period of 4 months. Namely, after reading the MITI manual (3.1.1; Moyers et al., 2010), coders participated in an intensive 2 day workshop which included didactic presentations, as well as coding and discussion of publicly available videotapes of MI and CBT. During the training process, approximately 30 practice sessions were coded. Of the initial group of coders, only those who had achieved 85 percent observed agreement against test materials advanced to the second stage of training, which consisted of coding additional practice sessions from a previous RCT of CBT for GAD (Westra, Arkowitz, et al., 2009). In turn, only those students who had maintained 85 percent observed agreement against criterion scores were included in the final group of coders who moved on to coding the therapy sessions in the present study. During this process, weekly 5 hour meetings were held to discuss any unresolved coding issues for a period of 2 months, followed by tri-weekly 5 hour meetings. In addition, coders continued to independently code test materials against criterion scores, and discrepancies were reviewed in group meetings.

Coders were kept blind to clients' outcome status and study hypotheses throughout the coding process. Interrater reliability as assessed by ICCs was calculated by double-coding 25 percent of all tapes. The ICC statistic was chosen because it is a more conservative estimate of interrater reliability than Pearson's r in that it adjusts for chance agreement as well as systematic differences between raters (McGraw & Wong, 1996). ICCs for global scores and behavioural counts ranged from .71 to 1.0 with a mean of .89, and from .85 to .99 with a mean of .93, respectively, indicating good to excellent agreement.

Results

Sample Characteristics

Table 1 presents the characteristics of therapists in this study. The majority of the

therapists ($n = 11$) identified their primary orientation as cognitive-behavioural. The overall

rating of the CBT sessions was good as assessed by the CTRS (Young & Beck, 1980), which

rates therapists on different dimensions including interpersonal skills (e.g., collaboration,

understanding), specific cognitive therapy skills (e.g., focus on key cognitions, application of

CBT techniques), and overall session quality. Specifically, total scores on the CTRS for

therapists in this study averaged 45.54 ($SD = 5.28$), which compares favourably with the average

score of 41.28 ($SD = 4.24$) on the CTRS in the CBT group of the Depression Collaborative

Research Program (Shaw et al., 1999). Therapists' age ranged from 26 to 41 years old.

Table 2 presents the characteristics of clients in this study. The sample was

predominantly female and Caucasian, generally well-educated, and presented with a high rate of

diagnostic comorbidity, including other anxiety (e.g., social anxiety, panic) and depressive (e.g.,

major depression, dysthymia) disorders. Age ranged from 21 to 63 years old.

Preliminary Analyses

The means and standard deviations for all study variables are presented in Table 3. The

skewness and kurtosis of each of the predictor and outcome measures was evaluated to determine

the extent of their deviation from normality via normal quantile-quantile plots. No substantial

violation of normality was uncovered that would jeopardize the assumptions of the analyses

(Meyers, Gamst, & Guarino, 2006), and data transformations were not deemed necessary. No

outliers were identified within the dataset. Thus, all 30 cases were included in the following

analyses.

Range of MI Adherence. It should also be noted that observed ratings of both Disagreement MI Adherence and General MI Adherence demonstrated a relatively limited range on the MITI 5-point Likert scale (i.e., Disagreement MI Adherence ratings ranged from 1 to 3.84, with an average of 2.37, and General MI Adherence ratings ranged from 1.06 to 3.34, with an average of 1.99). That is, although these variables were not significantly skewed, it is worth nothing that the therapists in the present study rarely achieved scores on the higher end of the MITI scale, and the average tended to fall in the low to moderate range of the global scores.

Consistency of disagreement management. Even though average scores were calculated across disagreement episodes for each therapist, it was also of interest to examine the level of consistency in therapists' management of disagreement in cases where more than one disagreement episode was identified within the session. Here, standard deviations for Disagreement MI Adherence ratings were calculated for each session with two or more disagreement episodes ($n = 21$). These standard deviations ranged from 0 to 1.44 ($M = .55$), indicating that therapists were at times inconsistent in their management of resistance within a given session. Namely, whereas some sessions were characterized by virtually no variation in ratings of therapist MI Spirit in response to resistance ($SD = 0$), other sessions were characterized by relatively high variability in therapist behaviour ($SD = 1.44$) for different disagreement episodes that occurred within the same session.

Intercorrelations of Measures

Behavioural count summary scores during disagreement and study outcome measures. Table 4 presents the intercorrelations among the behavioural count summary scores averaged across the disagreement episodes and the study outcome measures. As expected, the Percent MI Adherent summary score was significantly and positively correlated with both

Percent Complex Reflections ($r = .47$, $p = .010$) and Percent Open Questions ($r = .37$, $p = .043$), as well as significantly negatively correlated with Percent Direct Neutral ($r = -.49$, $p = .007$). That is, higher levels of therapist MI adherent behaviours (i.e., affirming, supporting, and emphasizing client autonomy) during disagreement were associated with higher levels of reflections that convey a deeper/more complex picture of what the client has said and questions that allow for a wide range of possible answers, as well as lower levels of therapist directive behaviour. Similarly, Percent Open Questions was also significantly negatively correlated with Percent Direct Neutral ($r = -.37$, $p = .046$), indicating that higher levels of open-ended, evocative questions in the presence of disagreement were associated with lower levels of therapist direction, advice, and instruction.

Notably, with the exception of a significant negative correlation between Percent Complex Reflections and early levels of observed client resistance (i.e., resistance that took place in a session prior to the disagreement episode session; $r = -.56$, $p = .032$), no significant correlations were observed between the MITI behavioural count summary scores in the context of disagreement and the study outcome measures. That is, levels of MI adherent behaviours, complex reflections, open questions, and directive behaviours during disagreement were not correlated with observed levels of subsequent resistance or with client worry scores post-treatment.

Behavioural count summary scores during randomly selected 20-minute therapy segments and study outcome measures. Table 5 presents the intercorrelations among MITI behavioural count summary scores averaged across the randomly selected 20-minute segments in early, middle, and late phases of therapy, and the study outcome measures. Notably, no significant correlations were observed between the Percent MI Adherent, Percent Complex

Reflections, Percent Open Questions, and Percent Direct Neutral summary scores.

With respect to the study outcome measures, Percent Complex Reflections was significantly positively related to post-treatment PSWQ scores ($r = .38$, $p = .039$), indicating that a higher level of therapist reflections that add meaning or incorporate an implied but unstated feeling to what the client had said, as measured during randomly selected therapy segments, were related to higher levels of client worry at the end of treatment. No other significant correlations were observed between the general MITI behavioural count summary scores and the study outcome measures.

Given that, for the most part, no significant relationships were found among the context-specific (during disagreement) and general (during randomly selected 20-minute therapy segments) MITI behavioural count summary scores and the study outcome measures, these summary scores were not included in the subsequent main analyses.

Global measures of MI adherence and study outcome measures. Table 6 presents the intercorrelations among the MI Adherence global scores and the study outcome measures. Notably, ratings of General MI Adherence and Disagreement MI Adherence were moderately correlated in an absolute sense but not significantly related ($r = .30$, $p = .113$). With respect to the study outcome measures, ratings of General MI Adherence were not significantly related to post-CBT PSWQ scores or to levels of resistance in the session following the identified disagreement session.

In contrast, ratings of Disagreement MI Adherence were significantly negatively correlated with clients' post-treatment worry scores ($r = -.42$, $p = .023$), as well as with observed levels of client opposition to therapist direction following the disagreement session ($r = -.52$, $p = .003$). In other words, higher levels of therapist empathy, evocation, collaboration, and

autonomy-support in the presence of disagreement (but not during randomly-selected moments in therapy) were associated with significantly lower levels of resistance in the subsequent session, as well as with reduced client worry at the end of treatment.

Early levels of resistance (i.e., observed resistance in a session prior to the disagreement episode session) were moderately correlated in an absolute sense but not significantly related to higher levels of resistance immediately following the disagreement session ($r = .51$, $p = .053$). In addition, early levels of observed resistance were not significantly related to post-CBT PSWQ ($r = -.06$, $p = .760$)[7]. Finally, subsequent resistance (i.e., resistance measured immediately after the disagreement episode session) was significantly positively correlated with post-treatment worry ($r = .61$, $p < .001$). In other words, higher levels of client opposition following the session identified for resistant disagreements were associated with higher levels of worry at the end of treatment.

Regression Analyses

Hypothesis 1: Higher ratings of CBT therapist MI adherence in the context of client disagreement will be associated with significantly lower ratings of post-treatment worry.
The data analytic strategy for examining the relationship between therapist supportive behaviour during moments of disagreement and subsequent symptom change was multilevel modeling (MLM). MLM was the selected parametric procedure due to its advantage over more traditional statistical approaches, including its ability to model nested data (i.e., data that is hierarchically organized). As an initial step, an unconditional model was fitted to the data using restricted

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[7] Notably, it is possible that early levels of resistance were not significantly related to post-treatment PSWQ given the sampling method used in this study to identify resistant disagreements. That is, given that disagreement episode sessions were chosen to reflect the first instance in each dyad where there was evidence for clear disagreement, this may have inadvertently led to a restricted range for estimates of early resistance. Nevertheless, given that higher levels of resistance that took place before the disagreement episode session were in fact substantially associated with higher levels of resistance immediately following the disagreement episode session, early resistance was arguably a solid index of resistance that can be used to provide a baseline measure of client opposition to therapist direction.

maximum likelihood (REML). In this dataset, the intraclass correlation was .171, suggesting that 17.1% of the total variance in post-treatment PSWQ scores may be accounted for by differences between therapists. MLM was thus used to account for this influence of the clustering of clients ($N = 30$) within therapists ($N = 13$).

A random-intercepts model was examined for the regression of post-CBT PSWQ on the Level 1 variable Disagreement MI Adherence, while also accounting for clients' baseline PSWQ scores. Regression diagnostics were assessed for the random-intercepts model, and there was no evidence to suggest significant departures from model assumptions. When the random-intercepts model was fitted to the data using REML, $\hat{\gamma}_{10} = -10.27$ was the estimated fixed Level 1 slope, indicating that, while accounting for client baseline symptom severity, for each one-point increase in MI adherence during disagreement, post-CBT PSWQ scores were predicted to decrease by 10.27[8]. This effect was significant, $t(22.02) = -2.57$, $p = .018$, with Disagreement MI Adherence accounting for 12.6% of the total variance in post-CBT PSWQ scores.

Hypothesis 2: Higher ratings of CBT therapist MI adherence in the context of client disagreement will be associated with significantly lower levels of subsequent resistance. When the random-intercepts model was estimated to account for the non-independent observations in this data set, a statistically inadmissible solution was obtained. That is, the variability in observed levels of resistance in the session immediately following the disagreement episode session that was due to nesting of clients within therapists was found to be negligible, thus leading to an improper solution. This implies that the ICC is very close to zero.

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[8] Notably, considering that the standard deviation on the PSWQ is approximately 8 points, this decrease in 10.27 points on the PSWQ represents more than a full standard deviation reduction on this measure of client worry (Brown et al., 1992).

A simplified, ordinary fixed effects regression model was thus estimated, using Disagreement MI Adherence in the prediction of subsequent resistance. Regression analyses indicated that Disagreement MI Adherence was a significant predictor of subsequent resistance, ($t = -3.23$, $p = .003$). Specifically, higher levels of observed MI adherence during disagreement were significantly and substantively related to lower levels of observed resistance in the following session, accounting for 27.2% of the variance in subsequent resistance.

A second hierarchical linear regression was conducted in which observed levels of resistance measured in a session prior to the disagreement session were first entered into the equation, in order to control for the impact of clients' baseline tendency to oppose the therapist on the observed findings[9]. Regression analyses indicated that, even while accounting for early levels of resistance, Disagreement MI Adherence was a significant predictor of subsequent resistance, ($t = -3.09$, $p = .009$). Namely, higher levels of therapist MI adherence at the time of disagreement were significantly and substantively related to lower levels of observed resistance in the following session, accounting for 32.8% of the variance in subsequent resistance.

Hypothesis 3: Higher levels of CBT therapist context-specific MI adherence (i.e., during disagreement episodes) will result in significantly lower ratings of post-treatment worry and subsequent resistance, when compared to CBT therapist general MI adherence (i.e., during randomly selected moments in therapy). To examine this hypothesis, the abovementioned set of regression analyses were repeated using therapists' General MI Adherence scores.

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[9] Notably, due to limited coding capacity, only $n = 15$ early sessions (i.e., sessions that took place prior to the target session identified for the presence of disagreement) were coded to provide a baseline measure of client opposition to therapist direction.

General MI Adherence in the prediction of post-treatment worry. A random-intercepts

model was examined for the regression of post-CBT PSWQ on the Level 1 variable General MI

Adherence, while accounting for clients' baseline PSWQ scores. Regression diagnostics were

assessed for the random-intercept model, and there was no evidence to suggest significant

departures from model assumptions. When the random-intercepts model was fitted to the data

using REML, $\hat{\gamma}_{10}$ = -.81 was the estimated fixed Level 1 slope, indicating that, while accounting

for client baseline symptom severity, for each one-point increase in General MI Adherence, post-

CBT PSWQ scores were predicted to decrease by .81. This effect was not significant, $t(16.70) =$

-.14, $p = .892$. That is, higher levels of General MI Adherence were not significantly related to

client post-treatment worry. For ease of comparison, Table 7 presents the random-intercepts

models examining Disagreement MI Adherence and General MI Adherence in the prediction of

post-treatment PSWQ.

General MI Adherence in the prediction of subsequent resistance. An ordinary fixed

effects regression model was estimated using General MI Adherence in the prediction of

subsequent resistance. Given that subsequent resistance was usually measured at an earlier time

point than were therapist MI adherence estimates taken in the middle (i.e., session 6) and late

(i.e., session 11) phases of therapy, only early therapist MI adherence ratings (i.e., session 1)

were used for the purposes of the regression analyses examining General MI Adherence in the

prediction of subsequent resistance. General MI Adherence was not found to be a significant

predictor of subsequent resistance, ($t = -.95$, $p = .351$). That is, higher levels of General MI

Adherence were not significantly predictive of resistance in the session immediately following

the disagreement episode session.

A second hierarchical linear regression was also conducted, in which observed levels of resistance measured in a session prior to the disagreement episode session were first entered into the equation in order to control for the impact of clients' tendency to oppose the therapist on the level of resistance following the disagreement session. Regression analyses again indicated that, while accounting for early levels of resistance, General MI Adherence was not a significant predictor of subsequent resistance, ($t = -1.14$, $p = .278$). Table 8 presents the regression analyses examining Disagreement MI Adherence and General MI Adherence in the prediction of observed levels of resistance following the disagreement episode session.

Discussion

Despite growing recognition of the importance of context-responsivity in evidence-based treatment approaches such as EFT (Greenberg et al., 1993), narrative-informed EFT (Angus & Greenberg, 2011), and short-term dynamic psychotherapy (see Binder & Strupp, 1997, for a review), as well as recommendations to develop context-responsive models through identification of common clinical markers to which therapists need to be responsive, little research has been conducted on this important hypothesis in the context of CBT. There were two ways in which context-responsivity was investigated in the present study. The first was to examine whether variability between CBT therapists in the level of MI adherence in the presence of one particular form of resistance (i.e., disagreement with therapist direction, suggestion, or input) were associated with proximal and distal therapy outcomes. Results indicated that clients whose CBT therapists displayed higher levels of empathy, evocation, collaboration, and autonomy-preservation in the context of disagreement had substantially lower levels of subsequent resistance in the session following the disagreement. In addition,

higher levels of MI spirit and empathy during disagreement episodes were significantly related to lower levels of worry at the end of therapy, with a large effect.

The second approach to investigating responsivity to contextual markers of resistance in CBT was through comparing variations in therapist MI adherence in the presence of disagreement, with variations in therapist general MI adherence during randomly selected moments in therapy. Here, the question centered on whether the *timing* of CBT therapist use of MI principles (e.g., using empathy when empathy is specifically indicated and essential) differentially impacted treatment process and outcomes. Results revealed that, while variations in ratings of therapists' MI adherence in the context of disagreement were consistently and substantially related to CBT outcomes, variations in ratings of therapists' general MI adherence were not. In other words, doing the 'right' thing (e.g., empathy, support of client autonomy), at the right time, seems to be significantly more potent than doing that same thing at any given time.

Both of these findings provide strong support for the context-responsivity hypothesis, and each of these findings is further discussed below. First, I focus on the finding that CBT therapists who were more 'MI-like' at times of disagreement produced better overall treatment outcomes. In other words, ***what*** you do in the context of disagreement matters. In turn, I discuss the *timing* of therapist cultivation of the MI relational stance. That is, I further elaborate the interpretation and implications of the finding that, comparatively speaking, an increase in MI adherence in the context of disagreement was much more powerful than that same increase in MI adherence generally (i.e., non-context-specific) within CBT sessions. In other words, ***when*** you become more 'MI-like' matters. I then speculate on why cultivating the MI relational stance in that particular context (i.e., at the time of client disagreement with therapist direction)

might carry so much 'therapeutic weight.' This is followed by a discussion of the implications for measuring CBT treatment adherence in relation to the 'responsiveness critique' (Stiles et al., 1998), and speculation that the effects found in this study might constitute a key CBT 'therapist effect.' Finally, the implications of the need for appropriate responsivity to resistance markers for clinical practice and training are outlined.

Context Responsivity in CBT: *What* you do in the Presence of Resistance Matters

Resistance is a concept that has long been regarded as central to the course of psychotherapy. Therapists of many orientations report phenomena that can be understood as resistance (Wachtel, 1999), leading some researchers to consider this concept a common clinical marker in the therapy process (e.g., Constantino et al., 2013; Westra, 2012). Nevertheless, although empirical findings indicate that resistance is consistently linked to negative therapy process and outcomes (e.g., Beutler, Rocco, et al., 2001), and can be exceedingly challenging to navigate effectively (Binder & Strupp, 1997), client resistance has been the focus of relatively little empirical psychotherapy process research. It is perhaps surprising that such a prevalent and important phenomenon, described by some as "…perhaps the single most important factor… in determining the success or failure of the therapeutic enterprise" (Wachtel, 1999, p.103), has received such little empirical attention. This is especially unfortunate, given that there is good evidence to suggest that client resistance can be highly responsive to therapist behaviour, with the cultivation of a more supportive and less directive relational style identified as particularly effective for successfully managing this phenomenon (see Beutler et al., 2011, for a review).

The results of the present study provide further evidence in support of the relationship between cultivating a client-centered, MI relational stance in the presence of resistance and

improved therapy process and outcomes in CBT. In particular, the presence of higher levels of core MI skills thought to facilitate the effective management of resistance (i.e., empathy, evocation, collaboration, and support of client autonomy) were related to significantly lower levels of subsequent resistance and post-treatment worry, accounting for a substantial amount of variance (32.8% and 12.6%, respectively) in CBT treatment.

While previous studies on the management of resistance have typically investigated the differential effects of the general MI counselling style on the process and outcome of therapy (e.g., Aviram & Westra, 2011; Miller et al., 1993), the current findings extend this work by measuring therapist responsivity to client opposition on a *moment-to-moment basis*, thus enabling specific, quantitative investigation of the effects of therapists' management of resistance on treatment outcomes in CBT for GAD. Moreover, although studies that have examined client and therapist behaviour sequentially during therapy sessions have noted a reliable increase in client resistance following therapist directive behaviour (e.g., Bischoff & Tracey, 1995; Patterson & Forgatch, 1985), to the author's knowledge, this is one of the first studies to selectively measure therapists' behaviour on a moment-to-moment basis *during precisely specified and identified key moments of disagreement* in CBT. This enabled the investigation and quantification of the impact of different CBT therapist behaviours during these key moments on subsequent therapy process and outcome.

Notably, findings of the present study converge with those of qualitative and quantitative investigations that have emphasized the importance of shifting into a more supportive rather than directive counselling style in the context of relational dissonance in the therapeutic alliance in CBT (e.g., Aspland et al., 2008; Castonguay et al., 1996). For example, the current findings provide some support for Castonguay et al.'s observation that strains in the therapy alliance

resulted when CBT therapists increased their adherence to the therapy model and persisted with the application of techniques in the presence of client disagreement and reluctance to engage with suggested interventions. Specifically, Castonguay and colleagues described a consistent pattern whereby a client would present a distressing life event and express a wish to discuss the emotional pain associated with it, and the therapist would respond by attempting to fit the client's experience to aspects of the cognitive therapy rationale. This exchange was typically followed with the client's assertion that his or her thoughts and feelings were in fact justified, and refusal to engage in cognitive therapy tasks suggested by the therapist, to which the therapist responded by persisting in re-emphasizing the cognitive behavioural therapy model. An analogous pattern was observed in the current study, whereby CBT therapists were at times noted to perseverate on their own agenda in the presence of client disagreement, as well as ignore and dismiss affect-laden client disclosures for the sake of continuing to impart expertise, even when clients repeatedly expressed their will to discuss these experiences. This in turn led to increased client opposition to the therapist's direction, which was met with further therapist attempts to persuade the client of the benefits of complying with the tasks prescribed by the treatment model (see Appendix F for an example of therapist unresponsive management of resistance).

Similarly, in their task analysis on the resolution of alliance ruptures in CBT, Aspland and colleagues (2008) noted that progress toward successful resolution was facilitated only when CBT therapists reduced their focus on treatment rationale and techniques, and instead became more collaborative and attentive to issues that were salient to the client. The authors concluded that, upon noticing a rupture, therapists should become more empathic and responsive, by encouraging clients to express their concerns rather than persisting with

technical interventions, in order to restore the collaborative therapeutic relationship. Similar

recommendations were made by Ribeiro and colleagues (2014) who, in a recent process

analysis of a poor outcome case in the context of narrative therapy for depression, found that

therapist directive interventions tended to lead to, as well as to follow, client statements of

ambivalence, a process which led to deterioration in the quality of the therapeutic collaboration.

Ribeiro et al. (2014) noted that, when therapists respond to client ambivalence by insisting that

the client adopts an alternative framework, this may invoke a strong reactance on the part of the

client, possibly contributing to increased resistance and a "hardening of the client's stuck

position" (p. 356). Instead, these authors suggested that client statements of ambivalence may

be interpreted as a marker of needing more support before being able to accept further

challenges. These recommendations are in line with findings of the present study, indicating

that when CBT therapists responded to disagreement by becoming more 'MI-like' (i.e.,

displaying empathy, reflecting the client's experience, preserving client autonomy to disagree

with the therapist's suggestions, and actively collaborating with the client in a manner that

enables him or her to influence the trajectory of treatment), this was associated with reduced

subsequent resistance and improved treatment outcome.

  Given that the present study examined the extent to which using an MI relational stance

during moments of client opposition was associated with better outcomes *in the context of CBT*,

this also lends support to the notion that action-oriented treatments such as CBT can integrate

more of an MI stance (Westra, 2012). Furthermore, the current findings that CBT therapists

who "naturally" exhibited higher levels of MI spirit in the context of disagreement had clients

who went on to have lower levels of resistance in the following session, suggest that the

relational context in which change strategies of CBT are suggested and implemented plays a

decisive role in determining clients' receptivity to them. Moreover, given that higher levels of MI adherence in the presence of disagreement were related to lower post-treatment worry outcomes in this study, this suggests that responding to resistance in an empathic, evocative, and autonomy-supportive manner may not only contribute to fostering client engagement in therapy, but may also play a pivotal role in facilitating change more broadly.

These findings are consistent with Bordin's (1979) transtheoretical conceptualization of the working alliance as central to the change process in psychotherapy. That is, in contrast to assumptions in CBT concerning the centrality of techniques in contributing to treatment outcomes (whereas the alliance is thought to form a static, stable base), Bordin notes that the process of negotiation that occurs between the client and therapist concerning the tasks and goals of therapy both provides the underlying conditions that are necessary for change to take place, and forms an essential part of the change process in itself. Other researchers have also emphasized the importance of the therapeutic alliance as a mechanism of change, suggesting that the therapist's embodiment of elements comprising the MI spirit, including empathic responding, evocative reflections, and adopting a client-as-expert stance in the presence of resistance, may be vitally important in contributing to improved clinical outcomes in a range of treatment approaches (e.g., Angus & Kagan, 2009; Faris, Cavell, Fishburne, & Britton, 2009; Westra, 2012).

Deviation of effective resistance management from existing CBT recommendations. It is clear that navigating resistance is a challenge for many CBT therapists. For example, in a recent study on factors associated with therapist adherence in the context of CBT for panic disorder, Zickgraf et al. (2015) noted that client opposition to therapist direction substantially derailed CBT therapists, decreasing their adherence to the therapy model and increasing the

likelihood of using interventions from outside the CBT protocol. The authors concluded that the

CBT manual provides little to no guidance concerning how to cope with markers of resistance

while maintaining adherence to the CBT model. Furthermore, these authors noted that while the

manual's authors may have assumed that skilled therapists can effectively negotiate and manage

opposition in therapy, even the most experienced therapists in their study displayed variability in

their ability to manage client opposition while staying on protocol (Zickgraf et al., 2015).

Similarly, in another recent investigation of client characteristics influencing therapist adherence

and competence in CBT for panic disorder, Boswell and colleagues (2013) observed that higher

levels of interpersonal aggression were associated with lower adherence and competence ratings

among highly trained and supervised therapists who were using a manualized CBT protocol.

These researchers concluded that, although CBT manuals include strategies to address

manifestations of resistance such as homework noncompliance (based on the conceptualization

that resistance reflects client maladaptive beliefs or assumptions, and should therefore be

managed using cognitive interventions and techniques), therapists may be less equipped to

effectively respond to markers of interpersonal aggression or anger in the therapeutic

relationship.

Further compounding this difficulty, current recommendations for managing resistance

and noncompliance in CBT diverge considerably from those supported by a growing body of

psychotherapy process research (and again found to be effective in the current study). In

particular, the fundamental response to resistance and noncompliance in CBT is to apply the

same basic methods used to address any other problem which the client presents. That is, given

that the primary source of noncompliance in CBT is thought to lie in faulty beliefs and attitudes

held by clients about making changes, therapists are encouraged to increase compliance by

modifying these client beliefs, a process which is typically accomplished by cognitive and behavioural interventions (e.g., Leahy, 2008; Sookman & Pinard, 1999; Van Dyke & Pollard, 2005). For example, Raue and Goldfried (1994) suggest that, when clients express reluctance to participate in therapy, the CBT therapist's role is to convince them that complying is in their best interests, fostering an attitude of friendly submission. That is, unlike other approaches which consider working with resistance an important mechanism contributing to the change process, cognitive-behavioural therapists have traditionally viewed resistance as a hindrance, as illustrated by labels such as therapy-interfering behaviour (Leahy, 2001). For example, client noncompliance has been defined by CBT experts as an "unwillingness to engage in the activities that clinicians know to be integral to good treatment outcome" (Ledley et al., 2005, p. 170). With this definition in mind, and given the general therapist-as-expert nature of CBT, it is easy to see why therapists have been encouraged to increase (rather than decrease) their adherence to the therapy model in the presence of resistance, persisting in the application of standard treatment interventions.

Nevertheless, findings of the present study suggest that continuing to be directive and to insist on cognitive and behavioural techniques in the presence of client opposition is in fact counterproductive, serving to engender further negative process and resulting in poorer treatment outcomes. These findings also converge with those of other recent studies that have utilized the SASB to examine interpersonal process in CBT for generalized anxiety. For example, Ahmed and colleagues (2012) found that during moments of client opposition to therapist direction, therapists were often observed to respond with attempts to influence clients (i.e., watching and controlling behaviours), which in turn was associated with reduced client expectations concerning their prospect of benefiting from therapy. Similar findings were observed by Kertes,

Aviram, and Westra (2015), who found evidence that the therapy process immediately following

CBT therapists' presentation of the treatment rationale could be 'derailed' among some clients

who did not receive MI prior to CBT. In particular, this derailment of interpersonal process was

characterized by a relational pattern consisting of therapist attempts to control and influence the

client, and client behaviours indicating lack of engagement (e.g., separation, deference, and

passive submission).

Considering the magnitude of the impact of responsive navigation of resistance on

critical therapy processes and outcomes, and to the extent that the current findings can be

replicated in future CBT studies, these results suggest that therapists may need to reevaluate or

even abandon current directive strategies for negotiating resistance and client noncompliance in

CBT, by adopting supportive strategies that have been developed by other client-centered

models such as MI. These recommendations are consistent with previous studies in which

fundamental MI skills such as empathy have been linked to improved CBT outcomes (e.g.,

Burns & Nolen-Hoeksema, 1992; Miller, Taylor, & West, 1980), and further buttress

recommendations made by a growing number of CBT therapists regarding the integration of MI

to increase engagement in CBT (e.g., Federici et al., 2010; Flynn, 2011; Slagle & Gray, 2007).

Moreover, given increasing recognition of resistance as a significant clinical marker limiting

treatment response, coupled with the lack of empirically supported strategies for effectively

navigating resistance and noncompliance in CBT, the current findings address a significant gap

in the CBT literature. As noted by Zickgraf et al. (2015), investigators need to consider building

into CBT treatment manuals evidence-based modules such as MI for addressing therapy

processes like resistance that might derail CBT therapists, causing them to deviate from highly

structured protocols. According to these researchers, such deviations from CBT protocols are not only clinically appropriate, but also warranted to maintaining client engagement in therapy.

A little good process goes a long way? In their examination of the relationship between client and therapist interpersonal processes and treatment outcomes, Henry et al. (1990) concluded that, "Whereas the absence of a negative interpersonal process may not be sufficient for therapeutic change, the presence of even relatively low levels of negative therapist behavior may be sufficient to prevent change" (p. 773). Since then, this observation has been repeatedly corroborated by psychotherapy process studies indicating that even minimal levels of negative interpersonal processes are highly predictive of poor therapy process and outcome (e.g., Anderson, Knobloch-Fedders, Stiles, Ordoñez, & Heckman, 2012; Aviram et al., 2011; Hara et al., 2015; Jungbluth & Shirk, 2009; Kertes et al., 2015; Macdonald, Cartwright, & Brown, 2007; Zickgraf et al., 2015). For example, using the Manual for Rating Interpersonal Resistance (Westra, Aviram, et al., 2009), Hara and colleagues found that, while client resistance occurred in only 20% of all 30-second time bins coded in therapy sessions, it was still a substantial predictor of client engagement and outcome in CBT for GAD. Similarly, using the same resistance identification system, Zickgraf et al. (2015) noted that it was in fact "striking" that a variable such as client resistance which occurred on average in only approximately 13% of all 30-second time bins was still able to significantly impact therapy process by substantially derailing therapist adherence to the CBT protocol. Collectively, the aforementioned findings concur with Henry and colleagues' observation that a little bad process can go a long way.

Interestingly, findings of the present study suggest that a little dose of good process – *when implemented at the right time* – might also have far-reaching implications. In particular, it is noteworthy that the bandwidth of MI-like behaviour (i.e., responses and interventions) among

CBT therapists during moments of disagreement in the present study was actually quite narrow, and reflective of poor to slightly less than average MI-consistent behaviour in the group of therapists as a whole[10]. Nevertheless, it is quite striking that within this relatively limited range, even a modest increase of 1 point on the 1 to 5 point MI adherence Likert scale was associated with a large effect of approximately a full standard deviation reduction in post-treatment worry (Brown et al., 1992). In other words, one might not need to be an extremely proficient MI therapist in order to effectively respond to resistance in therapy. Indeed, learning to cultivate even modestly more empathic, evocative, and autonomy-supportive responses at particular moments of disagreement can potentially yield large dividends.

This finding should be encouraging to CBT practitioners who are contemplating integrating the humanistic MI skills for more effectively managing resistance and noncompliance in therapy. Nevertheless, it is very important to note that true embodiment of the MI relational style (and indeed the effective use of MI) requires a fundamental shift in frame of reference that may not always be easily accomplished. According to Rollnick and Miller (1995), using MI skills as a clever technology to facilitate change (i.e., in a more calculated or manipulative fashion) is in fact antithetical to the very foundations of what is meant by the MI spirit. That is, the incongruent use of MI, commonly referred to as "words without music" (Rollnick & Miller, 1995), runs contrary to the theoretical underpinnings of MI, given that it derives from a therapist-as-expert model, thus essentially undermining the client-centered conditions comprising the MI spirit which have been shown to play a decisive role in re-

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[10] In fact, as the coding unfolded and the (seemingly uniform) relatively poor management of resistance as it generally occurred within CBT sessions became apparent, it was the author's impression that there may not be enough variability in therapists' MITI ratings to demonstrate any meaningful changes due to limited range.

engaging the client during moments of dissonance in the therapeutic relationship and improving treatment outcomes.

Consistent with this notion, the current study found that MI adherence, as rated by the global scores of the MITI (i.e., coders' overall impressions of therapists' embodiment of core MI principles comprising the MI spirit), was significantly related to treatment outcomes, whereas MI adherence as rated by behavioural counts (i.e., frequencies of specific MI-consistent and inconsistent therapist behaviours without regard to how well they fit into the overall impression of therapist use of MI) was not. This latter finding suggests that the practice of specific MI-consistent behaviours (in contrast to global MI spirit/empathy) may not in itself be important to the effective management of resistance in CBT. Rather, it is the CBT therapist's ability to create an overall, gestalt interpersonal climate and attitude consisting of empathy, acceptance, and egalitarianism which is the determining factor in the successful navigation of opposition in therapy.

This finding is also consistent with those reported by Moyers et al. (2005), who found that therapist MI-inconsistent behaviours (e.g., directing, giving advice, pointing out drawbacks to a client's plan) showed an unexpected positive relationship with client engagement in MI for substance use. Importantly however, this unexpected relationship occurred when, and only when, MI-inconsistent behaviours were observed in the larger context of therapist overall interpersonal skills (i.e., embodiment of MI spirit). The authors concluded that when MI-inconsistent behaviours occur within an empathic, accepting, and autonomy-preserving interpersonal context, these may in fact convey a sense of genuineness and transparency on the part of the therapist that may serve to facilitate (rather than suppress) the therapeutic alliance. Collectively, these findings combined with those of the current study, as well as extensively

discussed by prominent psychotherapy process researchers (e.g., Angus, Watson, Elliott, Schneider, & Timulak, 2014; Norcross, 2011), serve as a reminder that the quality of the therapeutic interaction and the manner in which things are expressed are more important than their manifest content.

Accordingly, rather than a set of techniques that can be easily learned and acquired, MI is better understood as a clinical style informed by the client-centered foundations set forth by Carl Rogers (1956). Given that the conceptual framework of MI and its underlying spirit are fundamentally humanistic rather than behaviourist (Miller & Rollnick, 2009), this implies that the incorporation of humanistic principles to the training and practice of CBT therapists may be required for the optimal integration of these two methods. Notably however, a recent review on humanistic psychotherapy research concluded that, despite both a renewed interest in and proliferation of research in support of humanistic methods and core principles, there has been a paradoxical parallel decline in humanistic training programs over the past 25 years (Angus et al., 2014). Given the current findings concerning the relationship between cultivating the client-centered MI relational stance in the presence of resistance and improved CBT outcomes, combined with those of other studies demonstrating the relationship between therapeutic processes promoted in humanistic psychotherapies and positive CBT outcomes (e.g., Burns & Nolen-Hoeksema, 1992; Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007; Leahy, 2002; Miller et al., 1980; Watson & Bedard, 2006), this suggests that the integration of humanistic principles into CBT practice is not only possible, but indeed necessary.

Context Responsivity in CBT: *When you become More MI-Like Matters*

The second approach to examining context-responsivity in the present study was to compare variations in therapists' MI adherence ratings during moments of expressed client

opposition (i.e., Disagreement MI Adherence) with variations in MI adherence as rated during

randomly selected moments in therapy (i.e., General MI Adherence), in order to determine

whether the *timing* of therapist use of core MI principles differentially impacts CBT outcomes.

As hypothesized based on the theory of context-responsivity, findings indicated that variations

in MI adherence during disagreement were consistently and significantly related to proximal

and distal therapy outcomes, in sharp contrast to general (i.e., at randomly selected time points)

variations in MI adherence which were unrelated to outcomes. In particular, higher levels of MI

spirit (i.e., empathy, evocation, collaboration, and support of client autonomy) in the context of

disagreement, *but not* during randomly selected moments in therapy, were significantly

associated with lower levels of subsequent resistance and post-treatment worry[11].

Furthermore in terms of magnitude of effects, results indicated that for each one-point

increase in Disagreement MI Adherence and General MI Adherence, post-CBT worry scores

were predicted to decrease by 10.27 and .81, respectively, thus indicating that context-specific

adherence ratings had approximately ten times the impact on post-treatment worry outcomes

compared to general MI adherence. A similar pattern was observed with respect to proximal

therapy outcomes, with Disagreement MI Adherence accounting for a substantial amount of

variance (32.8.%) in subsequent resistance, whereas General MI Adherence was not a

significant predictor of subsequent negative process (in the form of resistance) in CBT.

Collectively, these findings suggest that there are significant events or key moments in

therapy, such that how the therapist responds in those key moments matters to treatment

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[11] These findings echo previous investigations concerning the inconsistent relationship found between general MITI adherence ratings (i.e., using randomly selected segments of therapy) and treatment outcomes. Namely, while studies that have utilized the MITI coding system provide some support for the efficacy of MI relational skills in facilitating more positive treatment outcomes, findings are generally inconclusive. This is in fact fitting with the broader literature on therapist adherence and treatment outcome, suggesting that adherence does not provide a consistent linear association with therapy outcomes (e.g., Wampold & Imel, 2015; Webb et al., 2010).

outcome to a much greater extent than the therapist's general implementation of those same skills. These findings lend support to the notion long held by prominent psychotherapy researchers, who argue that process varies over time, and that examining process without attention to the context in which it occurs perpetuates a uniformity myth from which psychotherapy process research should escape (e.g., Elliott, 1983, 1984; Greenberg, 1986; Rice & Greenberg, 1984; Stiles et al., 1998; Stiles, Shapiro, & Elliott, 1986). In particular, these researchers caution that, implicit within psychotherapy process studies that aggregate process or randomly select therapy segments, is the assumption that all therapist behaviours are equivalent, regardless of their timing, appropriateness, and the context in which they occur. And in fact, as the present findings demonstrate, different processes have different meanings and significance in different contexts.

For example, in their review of the literature on therapist interpretations in psychodynamic treatment, Spiegel and Hill (1989) concluded that the contribution of these studies has been limited, and that this is partly due to lack of attention to considerations of appropriateness, context, and timing in which interpretations occur. The authors cited evidence from various studies in support of this conclusion, such as those reported by Hill and colleagues (1988) who found that, while interpretations were one of the most helpful interventions when clients were low on experiencing levels (i.e., form of cognitive-affective processing in which clients use internal felt experience as the basis for self-examination and the resolution of personally significant issues; Bohart, 1993; Klein, Mathieu-Coughlan, & Kiesler, 1986; Pascual-Leone & Greenberg, 2007), they were in fact no more helpful than other interventions when clients were high on levels of experiencing. In a similar vein, it may be that communicating in an empathic, evocative, and autonomy-supportive manner carries more

'therapeutic weight' during moments when the client is explicitly opposing the therapist's direction, than at other times such as when the client is on board with the therapist's agenda.

This is not to say that conditions such as empathic understanding, collaboration, evocation, and support of client autonomy should not inform and underlie every clinical encounter. Indeed, research evidence suggests that these client-centered conditions, when genuinely held by the therapist and effectively communicated to the client, are the building blocks of the therapeutic alliance, and indispensible to the change process more broadly (Angus et al., 2014). What these findings do suggest, however, is that there may be certain moments in therapy in which cultivating the MI-like relational conditions is relatively more important. And in fact, responding in an MI-like manner may be absolutely vital and irreplaceable to facilitating positive treatment outcomes at times of client opposition. As noted by Hill (1990), "Context appears to be particularly important in determining the effects of therapist interventions" (p. 289). Indeed, eminent psychotherapy process researchers have tackled this problem (i.e., addressing contextuality in their work) by developing and testing both intensively and extensively marker-guided interventions thought to be best suited to addressing particular client problem states (e.g., Angus & Greenberg, 2011; Greenberg et al., 1993; Safran & Muran, 2000).

Resistance is an important clinical marker in psychotherapy. Given that therapists' cultivation of MI relational skills in the presence of disagreement was more strongly associated with improved subsequent process and outcome compared to randomly selected moments, this suggests that resistance in particular may represent a key clinical event in the CBT psychotherapy process (e.g., Aviram & Westra, 2011; Beutler et al., 2011; Constantino et al., 2013; Viklund et al., 2010; Zickgraf et al., 2015). Nevertheless, and as noted by Apocada and Longabaugh (2009) in their review of mechanisms of change in MI, it is perhaps striking that,

albeit representing an integral concept within MI, resistance has remained a highly under-investigated topic even within the MI literature.

The current findings concerning the major impact of therapists' ability (or lack thereof) to effectively respond to this crucial clinical marker highlight the need to investigate specific, context-responsive, and evidence-based principles for the skilful negotiation of client opposition to therapist direction. Similar recommendations concerning the need to identify markers of interpersonal resistance and effective strategies for coping with these key in-session events have also been made in the therapy alliance literature with respect to alliance ruptures. For example, Safran and colleagues (e.g., Eubanks-Carter, Muran, & Safran, 2010; Safran & Muran, 1996, 2000) delineated conceptual markers of ruptures (e.g., confrontation and withdrawal), noting that these represent critical clinical events requiring differential and responsive intervention on the part of the therapist. According to Muran (2002), the ultimate goal of this research program is to provide clinicians with context-sensitive, 'when-then' information to help facilitate the intervention process at times of therapeutic impasse[12].

Other important contextual markers beyond resistance and alliance ruptures can of course also be identified (see Constantino et al., 2013, for a review of some proposed clinical markers necessitating context-responsive intervention). For example, some key process markers that have been described in the literature include client outcome expectations (e.g., Frank, 1961; Greenberg, Constantino, & Bruce, 2006), change ambivalence (e.g., Westra, 2012), in-session client experiencing (e.g., Greenberg & Pascual-Leone, 2006), and client narrative-emotion

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[12] It should be noted that, while the concepts of alliance ruptures and resistance are often used interchangeably, client resistance as measured in this study (i.e., client disagreement with therapist direction, suggestion, or input), may not necessarily lead to a rupture event. Whether or not these moments of disagreement result in what can be thought of as a rupture in the collaborative bond between client and therapist also depends on the therapist's ability (or lack thereof) to address the client's concerns and navigate these moments effectively.

process markers (e.g., Angus & Greenberg, 2011; Boritz, Bryntwick, Angus, Greenberg, & Constantino, 2014). It is also noteworthy that some of these core processes and markers may be related. For example, Ahmed et al. (2012) used the SASB to compare early interpersonal process during moments of resistance between clients who went on to have high versus low outcome expectations in CBT for GAD. Findings indicated that therapy dyads in which clients went on to have low outcome expectations were characterized by markedly less affiliative interpersonal process during moments of resistance, compared to dyads in which clients went on to have high prognostic expectations. In particular, therapists in the low, compared to the high, expectations group demonstrated substantially more difficulty remaining sensitive, attuned, and responsive to client needs during moments of disagreement and opposition (Ahmed et al., 2012). Accordingly, these findings suggest a potentially strong association between therapist responsivity during moments of resistance and client expectations concerning their ability to benefit from treatment. Given that higher outcome expectations have been consistently related to adaptive treatment processes and outcomes (see Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011, for a meta-analytic review), this suggests one potentially important consequence of the effective management of resistance in therapy.

To summarize, findings of the present study combined with those of previous research suggest that resistance represents a key clinical marker carrying important implications for therapy process and outcomes, which are, at least in part, strongly determined by therapists' ability (or lack thereof) to responsively navigate this phenomenon. With the foregoing in mind, one might ask why does being more 'MI-like' (i.e., displaying empathy, evocation, collaboration, and support of client autonomy) during moments of client opposition, and especially during these particular moments, matter so much to therapy process and outcome? In

other words, given the current findings concerning the substantial and differential importance of cultivating the MI relational style particularly during moments of in-session opposition, this raises the question: What is so unique or important about this particular contextual marker of client resistance that makes CBT therapists' embodiment of MI principles especially relevant and influential in those particular moments? In the following section, I offer one possible answer to this question.

Why might it be important to be more 'MI-like' especially at moments of client opposition? A complete discussion of all the reasons why embodying the MI relational stance is both clinically appropriate and especially indicated during moments of resistance is beyond the scope of this paper. Nevertheless, in this section, I propose one potential underlying mechanism which might account for the substantial impact of therapists' appropriate responsivity in the context of resistance on therapy process and outcome; namely, the enhancement of client agency, and more broadly, the provision of a corrective relational experience (Alexander & French, 1946).

The idea of enhancing client agency, broadly defined as the capacity to exercise control over one's life (Bandura, 2001), or in the context of therapy – the client's capacity to actively influence the course of his or her psychotherapy (Bohart, 2006; Bohart &Tallman, 1999) is a key concept across therapeutic orientations. Not only is agency considered a positive indicator of psychological functioning, but improvement in psychotherapy is often thought to result from clients' mobilization of agency and use of interventions to heal themselves (Rogers, 1951; Williams & Levitt, 2007). Indeed, an emerging body of literature suggests that clients engage in self-guided activities both inside and outside of therapy, and that these activities account for more outcome variance than the techniques associated with specific psychotherapy models (e.g.,

Lambert, 1992; Ogles, Anderson, & Lunnen, 1999). This research implies that, in many clinical instances, effective therapeutic approaches emphasize evoking therapeutic elements from clients rather than imparting expert information. Accordingly, prominent psychotherapy researchers have suggested that therapists' ability to engage clients may be more important than their interventional expertise (e.g., Bohart, 2000; Orlinsky et al., 1994). This latter notion is highly consistent with therapists' embodiment of MI spirit, which has been described as akin to "…learning to take the passenger seat and trusting the client to take control of the steering wheel" (Bell & Rollnick, 1996, p. 284).

Notably, research by Rennie (1994b) on client deference in psychotherapy indicates that clients are often reluctant to exert their agency, thus maintaining an outwardly cooperative and agreeable stance, while defiantly maintaining their own internal position. Rennie describes a number of reasons that help explain client deference, including fear that opposition might be resented by the therapist, leading him or her to become less invested in the client or hold it against the client in some way. Moreover, deference may occur as a result of client attempts to meet therapist expectations in the interest of being a 'good client,' or otherwise feeling reluctant to exert agency due to a belief that to do so would mean to reverse expected roles in therapy (i.e., to usurp the therapist's expertise). Similar observations were made by Frankel and Levitt (2009), who conducted a qualitative investigation of client experiences of disengaged moments in therapy, noting that, among other reasons, clients may withdraw or lessen their intensity of involvement in therapy in an attempt to safeguard the alliance, as well as forestall discussions that could result in being criticized, confronted, or invalidated by the therapist.

As Rennie put it, "the power differential in the counseling relationship makes it difficult for clients to challenge the counselor" (1994a, p. 55). Extending this notion to the current study,

and given the constraints that clients often experience against challenging the perceived

authority of the therapist, it is during these rare moments of overt expressed opposition that

clients are in fact taking a *considerable interpersonal risk* by going against the therapist and

asserting their needs in the therapeutic relationship. Indeed, in a recent study examining

interpersonal process using the SASB to code segments identified for the presence of resistance,

Ahmed et al. (2012) found that client behaviours during these moments often reflected the

autonomy-taking behaviour defined as "Asserting and Separating." This is a deviation from the

far more typical client behaviours of either disclosing information or following the therapist that

characterize the vast majority of the therapeutic encounter.

Importantly, not only is such autonomy-taking behaviour on the part of the client made

difficult due to constraints introduced by the power differential inherent in all therapeutic

relationships, but difficulties involving self-assertion can also represent broader interpersonal

problems. That is, the ability to express and look after one's views, needs, and desires

(especially when these are in conflict with those of the other), often lie at the heart of the

problems that bring clients to therapy, stemming from their early attachment histories (Stevens

et al., 2003). From this perspective, moments of client opposition may represent opportunities

for a corrective relational experience.

To elaborate, children develop mental models about close relationships during the course

of repeated interactions with attachment figures, and these models include information about

whether others will be available and responsive (Bowlby,1969, 1973). If the child experiences

distress and engages in attachment behaviours that are responded to quickly and reliably by the

primary caregiver, then the child develops an internal working model that fosters security in

relationships and the ability to flexibly and comfortably interact with others. However, if the

child experiences distress and engages in attachment behaviours that go unanswered and/or rejected, the child will develop an internal working model in which others cannot be relied on, and where certain aspects of the self that are experienced as threatening to relationships must be concealed (Bowlby, 1973; Stevens et al., 2003).

Notably, although these relational schemas develop in the context of early attachments as a way of predicting and maintaining interactions with important figures, they continue to influence interpersonal behaviour throughout the lifespan (e.g., Hazan & Shaver, 1987; Simpson & Rholes, 1998). Researchers have argued that the degree to which adults perceive conflict in relationships as threatening will depend on the content of their early attachment working models (Pietromonaco, Greenwood, & Feldman Barrett, 2004), and several investigators who have tested the association between adult attachment styles and conflict resolution strategies have confirmed this notion. For example, Corcoran and Mallinckrodt (2000) found that insecure individuals are more likely to engage in destructive conflict resolution strategies, including avoiding (i.e., disengagement from discussions that may lead to conflict), and obliging (i.e., giving in to the demands of the other person). Similarly, Shi (2003) found that high levels of anxiety were positively associated with forfeiting one's own concerns in order to please others.

It is, of course, understandable that individuals with high levels of attachment anxiety, who are preoccupied with fears of rejection and abandonment, would readily defer to others in order to maintain safety in relationships. This latter observation has been echoed by clinicians who describe a long-standing interpersonal style in individuals with generalized anxiety, consisting of anticipating the needs of others and being excessively giving and accommodating, while simultaneously diminishing the importance of personal needs (e.g., Newman, Jacobson, &

Castonguay, 2014; Newman, Llera, Erickson, Przeworski, & Castonguay, 2013; Przeworski et

al., 2011; Westra & Arkowitz, 2010).

In fact, researchers have argued that insecure attachment may be a potential risk factor in

the development of GAD (Newman et al., 2013, 2014). Studies that have examined the

relationship between subtypes of attachment and GAD symptoms have found that the presence

of these symptoms is positively associated with insecure attachment (e.g., Brown & Whiteside,

2008; Mickelson, Kessler, & Shaver, 1997; Muris, Mayer, & Meesters, 2000; Muris, Meesters,

Merckelbach, & Paulette, 2000). Furthermore, individuals with GAD often report attachment

histories in which their feelings and needs were neglected and disregarded by caregivers. For

example, perceived parental alienation and rejection have been associated with worry in children

(Brown & Whiteside, 2008; Muris, Meesters, et al., 2000) as well as with GAD symptoms in

adolescents and adults (Cassidy, Lichtenstein-Phelps, Sibrava, Thomas, & Borkovec, 2009;

Hale, Engels, & Meeus, 2006). According to Westra and Arkowitz (2010), under such early

relational conditions, one can become highly adept at vigilantly anticipating the needs of others

and attempting to fulfill them (even when at the expense of one's own needs), in order to

safeguard connections with important others. Moreover, these individuals may fear that if they

begin to assert themselves by setting interpersonal boundaries or becoming more focused on

managing personal needs, significant others will withdraw or reject them.

In addition, other detrimental parenting behaviours that have been associated with the

development of GAD symptoms include parental overprotection (Beesdo, Pine, & Wittchen,

2010; Nordahl, Wells, Olsson, & Bjerkeset, 2010), and harsh discipline characterized by high

expectations and strict rules (Shanahan, Copeland, Costello, & Angold, 2008). According to

Newman and colleagues (2013), the combination of parental overprotection and harsh discipline

may convey to the child that he or she is incapable of functioning independently and without parental intervention, thus serving to impede the child's development of a sense of autonomy. Under such conditions of perceived inability to handle life events autonomously, coupled with fears concerning the destructive nature of exerting agency in interpersonal relationships, it is understandable that individuals with GAD may avoid self-assertion and instead use accommodating and compliant interpersonal behaviours as a means to prevent personal failure and limit anticipated hostile responses from others.

With respect to the latter, research has demonstrated that interpersonal difficulties marked by submissive and non-assertive behaviours are in fact highly prevalent in individuals with GAD (Przeworski et al., 2011). More broadly, findings suggest that difficulties with interpersonal dynamics may play a key role in the exacerbation and/or perpetuation of GAD symptoms (Durham, Allan, & Hackett, 1997). 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 deficits may lead to a failure to sustain advances made in CBT for GAD (Borkovec, Newman, Pincus, & Lytle, 2002). The aforementioned findings, coupled with the notion that standard CBT does not sufficiently or adequately address long-standing interpersonal issues stemming from early relationships (Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997), have led clinicians to argue for the need to develop new treatments that incorporate interventions aimed at fostering and correcting maladaptive interpersonal problems in GAD (Newman et al., 2013). In particular, Newman and colleagues argue for the need to provide

corrective experiences both inside and outside of the session to help clients change their views

of self and others, as well as develop more adaptive ways to have their interpersonal needs met.

The idea of addressing long-standing interpersonal dynamics through the therapeutic

relationship is not new. Researchers have long argued that the experience of a corrective

relational experience with the therapist is a critical component of the change process (e.g.,

Alexander & French, 1946; Rogers, 1951). Indeed, fundamental interpersonal dilemmas such as

the tension between the need for agency and self-assertion and the need for connection and

relatedness are likely to pervade the therapeutic relationship, which contains many of the

features that characterize early attachment relationships (e.g., the therapist's comforting

presence, the potential for emotion regulation, provision of a 'secure base' that enables safe

exploration of difficult psychological terrain; Meyer & Pilkonis, 2001). 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 et al., 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 opposition, by shifting their focus in order to understand and validate client concerns about treatment, actively incorporating client input in therapy, and explicitly supporting the client's autonomy-taking behaviour, is communicating an important interpersonal message to the client; namely, that his or her thoughts and feelings are important, understandable, and worthy of exploration, and that it is safe to articulate disagreement or go against the therapist'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. Posing this alternative frame of reference to the client's understanding of self and other may not only serve to increase the client's confidence in the therapeutic relationship, thus leading to a greater ability to work together in therapy, but this corrective experience also serves to counter the client's 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 focusing on persuasion and imparting expertise 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, the annihilation of agency experienced developmentally in relation to caregivers is echoed in the context of the relationship with the "expert" therapist.

To further contextualize and illustrate this argument concerning the possible detrimental impact of therapist directive behaviour during moments of disagreement on client agency, let us reconsider therapist responses to the examples of client assertion (disagreement) presented in Appendix F:

Client: [*discussing her experience of the relaxation exercise which she did not find helpful*]…I have not been able to be a hundred percent focused at all, even listening to it when we're here, my mind is still going somewhere else. (Therapist: Mhmm) So it's really hard to just keep those thoughts away. I don't get any, like I don't get the immediate response so, I don't know if that makes sense at all?

Therapist: Yeah, it does make sense. (Client: So- [*attempts to continue to describe her experience of the relaxation exercise but is interrupted by the therapist*]) So it is very important that you do fill in the form (Client: Mhmm). And there's a reason for that. (Client: Mhmm) Because like I talked about in our first session, it's very important to monitor. Rather than come to the session and think on top of your head what really happened during the past week. So many things have happened and it's hard to remember all the details (Client: Mhmm). And often times when

we make generalizations it doesn't really reflect the true reality. So it is very

important that you do complete the log so that you know what was your anxiety

level before and you know whether it's effective afterwards because you reassess

your anxiety.

Later in the session, after the client repeatedly expresses her reluctance to engage in the

relaxation exercise, noting that, among other things, she has no time to practice relaxation, the

therapist continues to insist on the completion of this exercise, suggesting different times in the

day when this can be accomplished:

Therapist: Is there a different time during the day you can do this?

Client: When? That's, that's the thing, when? When would I do this? I don't have, there

                     is no time (Therapist: Mhmm) when I'm alone, cause when I'm home my

                     husband's there the whole entire time. When do I get time to, or I'm driving or

                     I'm at work (Therapist: Mhmm), so. There's really kind of no other quiet time.

                     [*client is clearly upset; exasperated, trembling voice*]

Therapist: Okay. Any time, there might be a possibility during lunch? [*therapist ignores

                     client affect; persists to problem-solve ways to ascertain client complies with

                     homework*]

Client: Yeah, but that would mean I lose twenty minutes of my lunch. [*client asserts

                     herself, continuing to oppose therapist's direction*]

Therapist: Okay.

Client: So yeah.

Therapist: Okay. So how, how important is treatment then for you, in terms of, I know life is

very busy, but how important is it in terms of the other things going on in your

life right now? [*highly coercive, accusatory, blaming tone*]

In the first example, the client describes her reaction to the relaxation exercise, noting various reasons why she did not find it helpful in reducing her anxiety. The client attempts to continue to elaborate her experience, but is quickly interrupted by the therapist who responds by providing psychoeducation concerning the benefits of engaging in relaxation, demonstrating no interest or curiosity in the client's perspective. A few moments later (as illustrated by the second example), the therapist attempts to problem-solve ways in which to get the client to comply with the homework, albeit against the client's will. The client repeatedly responds by opposing the therapist's suggestions, and becomes overtly emotional in the process. The therapist ignores the client's affect, and instead responds by accusing the client that her lack of compliance is indicative of her lack of investment in therapy.

One can easily see the underlying message communicated by this therapist's dismissive and coercive behaviour; namely, that the client's experience is irrelevant to the therapy, that she must comply with the therapist's direction in order for treatment to be effective (i.e., *she cannot trust her own experience as a guide* for what is helpful or unhelpful in accomplishing change), and that asserting her perspective, when this is divergent from that of the therapist, will result in confrontation and rejection. In other words, not only does this therapist's behaviour serve to suggest that the client should refrain from exerting agency given that her thoughts and feelings are irrelevant or inferior to that of the therapist, but another embedded message is that behaving assertively is dangerous, and can lead to deterioration in relationships. Stated more generally, important messages are being communicated about the self, others, and relationships. And given

that these interpersonal dynamics may be at the heart of generalized anxiety (Angus & Kagan, 2009; Borkovec et al., 2002; Newman et al., 2013, 2014), it may not be surprising that responsive navigation of these precise (and rare) moments seems to have wider reaching implications for worry and anxiety, and perhaps even interpersonal functioning.

Now, consider the following example of client assertion in response to a suggestion made by the therapist with respect to behavioural experiments, which was met with therapist 'MI-like' behaviour (see Appendix E for the entire transcript):

Therapist: …with leaving so early, you never prove to yourself that even if you leave fifteen minutes later, you're not going to be late anyway. So you're not learning that the worst case scenario isn't going to happen. So the idea is we want to change those worry behaviours, being over-prepared, because then you start to prove to yourself that you don't have to be so strict and you don't have to be so over-prepared for everything. Cause the worst case scenario isn't gonna happen. Okay? So we can do that through thought records, and you can say 'oh okay, you know, I probably won't be late,' but let's test it out. And that's kind of a scary step. Right? Because it's actually doing it. [*client smiles silently; fidgeting; therapist appears to notice the client's discomfort, pauses, and then smiles, asks client*] Do you-

Client: [*interrupts*] No. [*laughing, fidgeting; i.e., I don't want to do this***]**

Therapist: So is there some hesitancy there? (Client: Yeah) Okay. [*therapist pauses, giving space for the client to elaborate her reluctance to engage in the suggested task*]

Client: Like my job is in Mississauga, and I feel like I have to leave an hour and a half early, even if it takes me half an hour to get there, because there could be traffic.

Therapist: Mhmm.

Client: There's unexpected delays, like I would rather be there, like I don't know, I don't

know if I could actually make myself sleep in for extra fifteen minutes, or wait for

extra fifteen minutes [*starts laughing uncomfortably*; *continued opposition to*

therapist suggestion]

Therapist: Yeah, I know, it's going to be – it's hard, and you know what? I won't ask you to

do it all at once, okay, and that's why I like your idea of gradual baby steps, okay?

And what we're going to do today is brainstorm, not just the leaving early piece,

but other things. And then we'll pick and choose where to start. We're going to

start easy, or medium maybe, and then work up to hard once we're – you're –

feeling more comfortable.

In this example, the therapist's suggestion that the client tests out her anxious prediction

is met with hesitancy, as illustrated by the client's non-verbal behaviour such as looking away

silently, smiling, and fidgeting. The therapist demonstrates attunement to the client, picking up

on and reflecting her discomfort, as well as inviting her to elaborate on her experience. The

client then expresses opposition to the therapist's suggestion, indicating that she feels unable to

engage in the proposed task. The therapist responds empathically, validating the client's

concerns and affirming the client by explicitly incorporating her preferences for how to go about

accomplishing desired behavioural changes. The therapist also emphasizes the client's

autonomy, indicating that she is the one who is in charge of determining the pace and order in

which to go about the tasks of treatment.

In this case, the therapist's empathic attunement to the client's opposition, and her

evocative, as opposed to dismissive, reaction as illustrated by reflecting the client's discomfort

and providing space for the client to elaborate her experience, sends the message that the client's

thoughts and feelings are essential to informing the treatment. The emphasis on the client's autonomy to determine the manner in which they go about accomplishing the tasks of therapy serves to strengthen the client's sense of mastery and agency since she has the power to influence the trajectory of therapy. Furthermore, the therapist's affirmation and responsiveness to client input makes it clear that this is a collaborative relationship in which the therapist trusts the client's inner wisdom in directing the therapy. In turn, the therapist's trust may be internalized by the client as self-trust (Rogers, 1951). Finally, the therapist's supportive and empathic (as opposed to controlling or rejecting) behaviour in response to the client's opposition sends the message that it is safe for the client to assert herself and her needs, and that disagreement is not destructive to maintaining relationships.

It is also worth noting that, although the therapist in this example responded to disagreement in an empathic and autonomy-supportive manner, she did not abandon or discard the treatment agenda. That is, the therapist demonstrated interest in the client's experience, actively reflecting and mining for the client's input concerning her level of comfort engaging in the suggested task, while maintaining the overall intent to include this task as part of the treatment plan. Accordingly, this example serves to illustrate that transitory moments of resistance are not a cause for concern (i.e., a sign that the therapist is unhelpful or misguided); rather, resistance often merely serves to indicate that what the therapist is offering may be too far ahead of the client, and that further exploration and validation of client concerns are necessary (Westra, 2012).

Indeed, with respect to the latter, there are arguably moments in therapy in which therapists' directive behaviour (e.g., providing psychoeducation, making suggestions, constructing homework) is in fact highly appropriate and responsive to facilitating client agency.

Researchers have long considered cognitive and behavioural interventions such as cognitive restructuring and behavioural experiments as useful tools designed to promote client agency by way of altering problematic thought patterns thought to contribute to client passivity, or increasing client behavioural skills so that they have more options of responding (Corey, 2001; Hollon & Beck, 1979). In other words, the enhancement of client agency in CBT is thought to occur, at least in part, through the implementation of cognitive and behavioural interventions designed to change problematic thoughts and debilitating behaviours that may restrict client choices or lead to passivity.

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 cognitive or behavioural 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 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

behaviour 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 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 behaviours 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 et al.,

2009). More specifically in the case of generalized anxiety, the client-as-expert relational stance

in MI is thought to be fundamental to enabling clients to regain a sense of mastery over worry

and the sense of powerlessness to affect self and others that is core to this disorder (Angus &

Kagan, 2009).

Support for the 'responsiveness critique.' Findings of the present study concerning the

differential effects of context-specific variations in therapists' MI adherence also contribute to

the literature on the measurement of treatment adherence, and to the 'responsiveness critique' of

psychotherapy process research more broadly (Stiles et al., 1998). Namely, researchers

examining the relationship between treatment adherence and outcome have generally employed

observational measures whereby trained coders have coded one or more therapy sessions, or

randomly selected segments of sessions, using measures of therapist adherence. Scores on these

measures have then been correlated with scores on client outcome measures. For example, in the

case of the MITI, ratings of therapist adherence using randomly selected 20-minute segments of

therapy sessions are thought to be representative of the session as a whole. Underlying this approach to measuring treatment adherence (whether aggregating process across the entire therapy session or randomly selecting therapy segments) is an assumption that the therapy process does not vary significantly over time, and that different moments within the therapy session are basically interchangeable in terms of their clinical significance. Researchers have called this assumption into question however, noting that aggregating process as though all process during the session is the same, or otherwise randomly sampling moments in therapy without attention to the context in which they occur, may lead to omissions of significant in-session events which are differentially important to treatment process and outcome (e.g., Greenberg, 1986; Macdonald et al., 2007).

This overgeneralized and indiscriminate approach to measuring treatment adherence may be one reason that adherence ratings have been generally unrelated to therapy outcomes, accounting for less than 1% of the variance in outcomes (Webb et al., 2010). Alternatively, researchers have also suggested the possibility that therapist adherence plays a relatively small role in contributing to treatment outcomes (Wampold & Imel, 2015). Nevertheless, another possible factor that is likely to attenuate any underlying process-outcome association is therapist responsivity (Stiles et al., 1998). According to this latter notion, therapist interventions do not operate in vacuum and are in fact contextually-driven, in that therapists adapt their behaviour to the unfolding context of treatment, including emerging client behaviours and needs. As such, rather than concluding that variations in therapists' behaviour are unrelated to outcome, it is arguably likely that these relationships are obscured by different levels of therapist techniques or behaviours based on these emerging client and interaction characteristics. And, according to Stiles and colleagues (Stiles, 2009, 2013; Stiles et al., 1998), if one fails to specify the particular

context (e.g., by aggregating process or utilizing random sampling methods), important relationships between process and outcome may be obscured.

Other psychotherapy process researchers who have investigated the treatment adherence-outcome relationship have come to similar conclusions. For example, Owen and Hilsenroth (2014) examined the contributions of within- and between-case variability in the adherence-outcome association in the context of psychodynamic treatment for patients with depressive disorders. Results indicated that within-case variability in adherence ratings was significantly associated with positive treatment outcomes, even after controlling for alliance scores, general levels of techniques used across treatment, and the proportion of variance in outcomes attributed by therapists. To explain the relationship between within-case variability in adherence and positive treatment outcomes, the authors proposed the notion of *adherence flexibility*; that is, within-case variations in treatment adherence may reflect therapists' efforts to be responsive to emerging client needs and the context of the therapy session by increasing or decreasing their use of interventions. These findings are also consistent with those of Boswell et al. (2013) who found that the majority of the variance in therapist adherence in CBT was at the session level, suggesting that treatment fidelity is contextually driven.

Relatedly and with respect to the current study, it is arguably the case that context-specific variations in therapists' MI adherence were significantly predictive of treatment outcome (while general adherence ratings were not) because these variations represent therapists' 'appropriate responsiveness' (Stiles et al., 1998). Stated differently, therapists who displayed higher levels of empathy, evocation, collaboration, and autonomy-preservation during moments of disagreement were in fact demonstrating higher levels of adherence flexibility, adapting their focus on treatment-specific techniques based on emerging client needs. Given

that resistance has been shown to relate to maladaptive treatment processes and outcomes (Beutler et al., 2011), and that supportive interventions relate to the diminishment of resistance (e.g., Aviram & Westra, 2011; Miller et al., 1993), it follows that therapists who are able to respond to disagreement skillfully, by flexibly modifying their directive approach in order to attend to emerging client needs and reservations about treatment are being appropriately responsive.

In contrast, when general (i.e., non-context-specific) adherence ratings for the same client-therapist dyads in the present study were examined in relation to their predictive capacity, they were consistently found to be unrelated to treatment outcomes. These findings highlight the need to carefully consider context in psychotherapy research, for example by designing more fine-grained studies that allow for smaller, strategically selected, and better specified units of analysis when investigating therapy process-outcome relationships (Stiles et al., 1986). Accordingly, rather than assuming that any given process has equal significance or meaning at any point in therapy, it is important to identify and investigate key markers or moments in therapy (e.g., in the present study, disagreement or opposition to therapist direction) in order to capture meaningful therapy processes that contribute to treatment outcomes. These findings are consistent with recent recommendations made by prominent psychotherapy process researchers to identify salient therapy markers that are common to all therapy models, and which require responsive intervention on the part of the therapist (Constantino et al., 2013).

Could management of disagreement be a key CBT therapist effect? Wampold and Imel (2015) argue that, while adherence to a particular theoretical model plays little to no role in contributing to outcomes, important differences between therapists nevertheless exist and the precise nature of these effects should be further delineated in order to improve clinical

outcomes. The current findings regarding variations in CBT therapists' ratings of MI adherence during disagreement and their relation to treatment outcome may very well point to a key factor differentiating CBT therapists; namely, therapist variability in the management of resistance. Notably, therapists in the current study who displayed higher levels of MI relational conditions in the presence of disagreement were in fact not trained in MI. In other words, this is not a source of variance that is controlled in CBT. In fact, CBT investigators have recently noted that the cognitive-behavioural model provides little to no guidance in dealing with patient hostility, anger, or resistance (Boswell et al., 2013; Zickgraf et al., 2015). Nevertheless, these researchers found that resistance has the capacity to substantially derail CBT therapists.

Furthermore, and as was discussed earlier, current recommendations which do exist for managing resistance and noncompliance in CBT (which were also the guidelines provided for CBT therapists in the current study), are in fact quite the opposite from those proposed in MI. Nonetheless, some therapists in the current study were clearly not rigidly following these guidelines and by doing so, were introducing a source of variability between CBT therapists. Taken together, these findings suggest that *naturally occurring* (i.e., untrained) variations in CBT therapists' relational skills (i.e., level of empathy, collaboration, evocation, and preservation of client autonomy) during moments of resistance matter to treatment outcome.

These specific findings are also broadly consistent with what we know about particular therapist effects in psychotherapy. In particular, in his review of the literature on therapist effects, Wampold (2001) concluded that the preponderance of evidence indicates that these effects are in fact quite large, accounting for up to 9% of the variance in treatment outcomes, and greatly exceeding the effects of specific treatment interventions. But what are the individual differences that characterize effective therapists? William and Chambless (1990) addressed this

question in a study examining the relationship between CBT therapist characteristics and client outcome in exposure therapy for agoraphobia. Results indicated that clients who rated their therapists as more empathic, caring, and involved were significantly more likely to improve. Similarly, Burns and Nolen-Hoeksema (1992) examined the direct and indirect influence of therapist empathy on outcome in a large sample of clients undergoing CBT for depressive disorders. Results indicated that clients of therapists who were rated as the most empathic improved significantly more than clients whose therapists received the lowest empathy ratings. This finding held even when controlling for baseline depression severity and homework compliance, suggesting that empathy may have a unique and direct effect on CBT outcomes (as opposed to working specifically or solely through its influence on client compliance with homework assignments in CBT).

Aside from empathy, therapeutic flexibility has recently emerged as another possible factor differentiating more and less effective CBT therapists. For example, in a study on therapist responsiveness to client engagement in the context of manual-based CBT for anxious youth, Chu and Kendall (2009) found that therapist flexibility was significantly related to increases in later client engagement, which subsequently predicted improvement in post-treatment diagnostic status as well as reduced functional impairment. Relatedly, a more recent study on therapist factors and client outcomes in CBT for anxious youth found that, when compared with a didactic 'teacher style,' a more flexible style (defined as a collaborative coach who does not tell the child what to do, but helps him or her discover the skills that accomplish a collaborative goal) was a significant predictor of fewer child-reported anxiety symptoms (Podell et al., 2013). Finally, and as was discussed earlier, variability in therapists' adherence scores from one session to another has been found to predict better outcomes, leading

researchers to suggest that therapists who demonstrate adherence flexibility may contribute to improved treatment outcomes (Owen & Hilsenroth, 2014).

Taken together, the results of the present study combined with those of previous research, suggest that variations in therapists' relational skills such as empathy, collaboration, and flexibility are important predictors of outcome in CBT. Notably, while relational savvy appears to be a generally important source of therapist variability contributing to treatment outcomes, the current findings add to the literature by suggesting that it is *relational sensitivity at particular moments* when especially indicated (e.g., responsivity at times of client self-assertion and opposition to therapist direction) which may differentiate more and less effective CBT therapists.

To the extent that future research replicates these findings, the current study suggests that it may be important to systematically train CBT therapists in appropriate responsivity during moments of resistance, rather than allowing these relational skills to freely vary among therapists. Notably, delineation and incorporation of systematic guidelines to inform therapists on how to behave responsively during moments of resistance appears especially important given findings of the current study that therapists were at times inconsistent in their response to disagreement within a given session. That is, while some of the sessions were characterized by virtually no variations in ratings of therapist MI adherence in response to disagreement, other sessions were characterized by relatively high variability in therapist behaviour during different disagreement episodes that occurred within the same session. These findings suggest that, while therapists were at times demonstrating appropriate responsivity in the presence of resistance (without knowing it perhaps, or worse yet, doing so yet possibly simultaneously feeling "guilty" for deviating from the protocol), this was likely based on natural therapist inclinations

concerning what behaviour may be clinically appropriate at any given moment in therapy, as opposed to a clear and consistent set of guidelines concerning strategies for effectively negotiating opposition in therapy.

Another possibility for the current findings concerning therapists' inconsistent behaviour during moments of disagreement is that therapists may not always recognize markers of resistance in therapy, and are thus unable to responsively adjust their behaviour when it occurs. Finally, and as will be discussed shortly, another possibility for the lack of consistency in responding to opposition in therapy is the great difficulty therapists experience in maintaining a supportive and facilitative stance in the face of negative interpersonal process (e.g., Binder & Strupp, 1997). Regardless of the cause of this inconsistency however, and given current findings that cultivation of the MI relational stance during disagreement is substantially related to reductions in negative process and improved treatment outcomes, it is clear that training in the responsive management of resistance in CBT is highly indicated. I turn to this topic next.

Clinical and Training Implications

The psychotherapy field is converging; accumulating evidence from psychotherapy process research indicates that variability in approach is important to treatment outcomes, and that a contextual approach (i.e., guided by transtheoretical key clinical markers as opposed to divergent monolithic treatment models) is indicated in improving the practice of psychotherapy (Angus et al., 2014; Constantino et al., 2013; Norcross, 2011; Stiles et al., 1998; Wampold & Imel, 2015). For example, Owen and Hilsenroth (2014) argue that "… even within the same therapist-client dyad, all psychotherapy sessions are not created equal, nor should they be expected to be… The concept of therapist competence would be best reconceptualised, operationally defined, and subsequently coded as the ability of the therapist to most

appropriately and effectively guide [the] within-case adherence flexibly (i.e., tact and timing) and [we] look forward to future research that might examine this issue further" (p. 286). More specifically, within the context of CBT, variations in therapist response to an increasingly identified key clinical marker – client opposition to therapist direction – have been identified as important predictors of treatment outcomes, leading investigators to conclude that therapist flexibility in responding to emergent client needs is important to the optimization of CBT outcomes (e.g., Boswell et al., 2013; Podell et al., 2013, Zickgraf et al., 2015). Moreover, given the precision of the current study (i.e., the examination of therapist behaviour during particular in-session events identified for the presence of disagreement), the current findings contribute to the literature by specifying particular therapist skills that are indicated in the effective management of this crucial clinical marker. To the extent that results of the present study are replicated and causal directions are more firmly established in future studies, more precise clinical recommendations concerning the responsive management of resistance can be derived.

In general, rather than assuming all moments in therapy are of equal significance, it is important for therapists to recognize that there are key moments in therapy which are differentially related to treatment outcome and which require responsive intervention. Resistance represents one such key moment (or clinical marker), carrying important implications for the process and outcome of therapy. Accordingly, these findings suggest that it is important for CBT therapists to respond flexibly in the presence of resistance, by shifting from a directive focus on change-based strategies and technical interventions, to a supportive focus marked by empathic attunement to client concerns and reservations.

To elaborate, during moments of client expressed opposition to therapist direction, suggestion, or input, it is important for CBT therapists to be prepared to pause momentarily, and

dial back from the theoretical focus and goals of the treatment which they are applying, in order to responsively address emergent resistance or ambivalence by embodying the MI spirit. This includes 1) being more evocative and curious about the client's expressed reservations, and prioritizing exploration of the client's personal reasons for change and ideas regarding how to go about it, rather than continuing to provide education or persuade the client to accept the therapist's ideas and methods for accomplishing change in therapy; 2) actively collaborating with the client by incorporating client suggestions and input into the treatment plan, and tempering advice giving and personal expertise based on the client's input; 3) preserving the client's autonomy to disagree with the therapist's direction (e.g., by repeatedly checking in with the client whether the therapist's suggestions are fitting and/or acceptable, using tentative language when offering expertise, and explicitly acknowledging the client's freedom to choose); and 4) attempting to deeply understand and empathically explore the client's internal experience during moments of resistance (i.e., demonstrating an effort to gain a deeper understanding of, and add meaning to, the client's words and nonverbal behaviours), rather than ignoring and disregarding the client's perspective in favour of continuing to focus on the agenda or impart expertise.

Notably, effectively infusing MI spirit into CBT practice during moments of disagreement can be a challenging clinical endeavour, given that this involves reframing traditional views of resistance and noncompliance in CBT. That is, from a cognitive-behavioural perspective, resistance is generally avoided given than it is thought to reflect problematic, anti-therapeutic behaviour (Stevens et al., 2003). However, rather than viewing resistance or opposition in therapy as an obstacle to be avoided or defeated so that treatment can continue in accordance to a predetermined agenda, working effectively with resistance in therapy involves

reframing it as important information to be understood and integrated into the course of treatment. As noted by Westra (2012), "The MI therapist recognizes the futility of defeating resistance by controlling it, persuading, or counterarguing. Rather, he or she seeks to actively cultivate a positive perception of resistance to change, actively reframing it to extract the positive value in it – to see the wisdom in it" (p. 79). And such a perspective and attitude allows one to approach and embrace resistance rather than attempt to shut it down. Indeed, researchers from various therapeutic orientations have long recognized that resistance and opposition in therapy can reflect important clinical information, including client anxiety and ambivalence about change, attempts to support important needs or learned survival strategies, or expressions of agency and self-assertion made in an attempt to exert influence over the course of one's therapy (e.g., Mahoney, 1998b; Rennie, 1998; Wachtel, 2011; Westra, 2012).

Moreover, it may be especially important for therapists to recognize these relatively rare moments of client expressed disagreements as instances of self-assertion (rather than opposition) and therefore, as opportunities to respond in a manner that supports this adaptive autonomy-taking behaviour. It is the experience of having the therapist react in a different way than perhaps had been expected (or react differently than other people in the client's life), while simultaneously recognizing and validating the client's experience, which can lead to important learning and growth (Stevens et al., 2003). Said differently, rather than an obstacle to change, resistance may afford an opportunity for a corrective relational experience which, if recognized and handled responsively by the therapist, can lead to enduring shifts in the client's way of being in the world and relating to others. In the words of Miller and Rollnick:

Resistance is a key to successful treatment if you can recognize it for what it is: an opportunity. In expressing resistance, the client is probably rehearsing a script that has

been played out many times before. There is an expected role for you to play – one that

has been acted out by others in the past. Your lines are predictable. If you speak these

same lines, as others have done, the script will come to the same conclusion as before.

But you can [and as the current findings suggest, *should*] rewrite your own role (2002, p.

109).

Notably, although one cannot prevent resistance from occurring in therapy, and transient

disagreements in the therapeutic relationship, as in all other interpersonal relationships, will

inevitably occur over the course of treatment, it is the presence of sustained resistance which the

therapist needs to be mindful of. Indeed, according to Miller and Rollnick (2002), resistance is

only problematic insofar as it persists or escalates throughout the course of the session.

Therefore, and given that resistance is highly influenced by therapist behaviour, this suggests

that persistent resistance is not a client problem, but a therapist skill error. In other words, if

resistance is increasing or persisting during the session, the onus is on the therapist to be

attentive to and recognize this important marker for what it is; a type of stop signal, a red light

indicating that the client is not on board, and that it is important to double back, hear the client's

message, and work to re-establish engagement and collaboration in the working relationship.

Accordingly, and what may be the greatest contribution of the current study in terms of

training implications, these findings suggest therapists need to *learn to become good observers*

of important clinical markers such as client opposition to therapist direction. That is, therapists

should be trained in moment-to-moment attunement to process, thus allowing for identification

of emerging common clinical markers such as resistance. In turn, training should incorporate

evidence-based strategies for flexibly and responsively managing these therapy process markers.

These recommendations for a process-oriented and context-responsive approach to clinical

training echo those of Constantino and colleagues (2013) who propose that, "Trainees may be better served, compared to traditional methods, by learning to (a) be mindful of process and person markers, and (b) implement empirically supported responsiveness modules when faced with empirically substantiated markers" (p. 13).

Training in the observation and identification of moment-to-moment cues indicating opposition and disharmony in the therapy process is especially indicated, given findings that therapists often experience difficulty identifying negative process (e.g., Castonguay et al., 2010; Henry et al., 1990; Hill, Thompson, & Corbett, 1992; Thompson & Hill, 1991), thus leading clients' negative perceptions of therapy to go unnoticed or unacknowledged (e.g., Pekarik & Finney-Owen, 1987; Todd, Deane, & Bragdon, 2003). Nevertheless, recent findings suggest that such training in process-guided, moment-to-moment observation and identification of in-session cues of opposition is not only vitally important, but also possible. Namely, a recent study by Hara et al. (2015) compared therapists' post-session ratings of resistance with those of trained observers using a process coding system for the identification of resistance in therapy (Westra, Aviram, et al., 2009). Therapist and observer ratings were then examined as correlates of proximal (i.e., homework compliance, quality of therapy alliance) and distal (i.e., post-treatment worry) treatment outcomes. Findings indicated that, while observer ratings were highly and consistently related to proximal and distal therapy outcomes, therapists' ratings were not. Accordingly, not only do these findings highlight the need to enhance therapists' proficiency in attending to and identifying important clinical cues reflecting resistance and opposition in therapy, but they also support the notion that such training in moment-to-moment observation and recognition of key clinical markers is indeed possible.

In the author's personal experience, training in psychotherapy process coding systems designed to capture important clinical markers such as resistance is invaluable to sharpening one's ability to *observe process while in the therapist's chair*, and to decoding what are often highly subtle cues which call for responsive intervention. As previously argued, the ability to observe process as one is participating in it (i.e., 'reflection-in-action'; Schön, 1987) is a necessary prerequisite for appropriate responsiveness, and indeed, for the effective management of resistance in therapy.

It should also be noted that observation and identification of cues indicating client opposition to therapist direction is a clinical skill that is not always readily or easily attained. And this likely involves a number of factors. First, such cues reflecting opposition are often far from obvious, consisting of highly subtle, and often nonverbal and paralinguistic behaviours including variations in tone, volume, and speech patterns, timing of pauses and silences, as well as posture and bodily gestures (Watson & Greenberg, 2000; Westra, 2012). Perhaps relatedly, difficulties identifying opposition in therapy are further magnified given that clients are often reluctant to openly oppose or question the therapy and the therapist, and therefore tend to minimize their reactions or resort to subtle defensive manoeuvres, while maintaining an outwardly cooperative and complaisant demeanour (e.g., Rennie, 1994a; Rhodes et al., 1994). Finally, learning to become proficient observers of signals of disharmony and dissonance in the therapeutic relationship is also challenging given the enormous difficulty that therapists, and indeed human beings, have in identifying negative processes in which they are recipients or participants (see Binder & Strupp, 1997, for a review).

Accordingly, systematic training is required in the observation and recognition of these crucial clinical markers. In this regard, Binder and Strupp (1997) have suggested that training in

observation and systematic analysis of interpersonal processes illustrated in videotaped therapy sessions can lead to important gains in clinicians' ability to detect subtle nuances of negative process. It is also the author's opinion that such observational training is imperative, as this provides a wealth of information concerning the moment-to-moment interactive processes that occur between the client and the therapist. Such observational data is particularly crucial, given that often times, words can convey different meanings depending on the context and the way in which they are communicated. For example, the client and the therapist may be talking about one thing but nonverbally communicating entirely different meanings. Another advantage of observational training is the ability to examine client responses that immediately follow therapist interventions, thus helping to demonstrate the manner in which different therapist behaviours are heard and experienced by the client. Relatedly, an important advantage of observational learning is the ability to examine how the therapist responds to various client behaviours; notably, the observer may also use this as an opportunity for self-monitoring and reflection on their internal reactions to various client behaviours, thus leading to greater self-awareness regarding one's characteristic ways of construing and navigating the therapeutic relationship. This latter observation is particularly important given findings that therapists, even those who are highly experienced, are vulnerable to engaging in destructive interpersonal process (Binder & Strupp, 1997).

Relatedly, and in addition to training in the observation and identification of key process markers requiring responsive intervention, the current findings highlight the need to incorporate training in client-centered relational conditions underlying MI spirit to the skilful negotiation of disagreement and noncompliance in therapy. This notion is consistent with recent recommendations made by prominent psychotherapy researchers concerning the need to

incorporate humanistic psychotherapy principles and interventions (e.g., endorsement of the centrality of a genuinely empathic and prizing therapeutic relationship, focus on the promotion of genuine respect for each client's agentic role in contributing to the success of therapy) to psychotherapy training programs (Angus et al., 2014). As these researchers have noted, and as illustrated by the current findings with respect to CBT, each of the major therapeutic orientations can be optimized when they draw on core humanistic psychotherapy principles.

Strengths, Limitations, and Future Directions

A major strength of the present study is its rigorous methodology, including strategic and intensive process coding and methods to identify and isolate specific episodes within therapy sessions that contained the clinical marker of interest (i.e., client disagreement with therapist direction, suggestion, or input). A major advantage of precisely specifying key moments of disagreement and examining therapist adherence to theoretically indicated strategies at these specific times, is the quantification of the size of the effect of therapist behaviours during resistance on important therapy processes (i.e., future resistance) and outcomes. Moreover, by also including randomly selected segments of therapy for comparison, the study was also able to convey an appreciation of the relative magnitude of the responsive versus general use of core clinical strategies such as empathy.

The present study also used well-validated, reliable, and rigorous measures for coding interpersonal resistance (i.e., Manual for Rating Interpersonal Resistance; Westra, Aviram, et al., 2009) and therapist MI adherence (i.e., MITI; Moyers et al., 2010). Furthermore, the study was careful to adapt the MITI coding system for use in the context of CBT, by anticipating and accounting for differences in typical MI and cognitive-behavioural therapy processes.

Moreover, an additional strength of the current study is the use of separate individuals to code for MITI and interpersonal resistance, a process which was undertaken in order to prevent the MITI coders from becoming overly sensitized to moments of resistance in therapy. Likewise, for this same reason, the MITI coders used to code Disagreement MI Adherence were pulled out of the larger group of coders and asked to complete this task after coding for General MI Adherence was nearly complete. This was done again because if one first codes disagreement episodes, this might arguably bias ratings of General MI Adherence to preference those episodes in the ratings. Finally with respect to study strengths, the relationships between variations in therapists' MI adherence during moments of disagreement and treatment outcomes were examined in the context of a well-controlled RCT of CBT for clients with high severity GAD (Westra et al., 2015), thus allowing for some relative homogeneity in various elements of the treatment process through minimization of external variance.

Several significant limitations of the present study should also be acknowledged. First, the sample size of the present study was small, and there was not enough variability to enable MLM analyses in the measurement of subsequent resistance. Here, it is important to note that the variability in observed levels of subsequent resistance due to nesting of clients within therapists was found to be negligible (thus leading to an improper solution). This implied that very little of the variance in subsequent resistance could be accounted for by the clustering of clients within therapists. Nevertheless, future studies using larger samples of both clients and therapists are needed to increase confidence in the generalizability of the current findings.

An additional limitation of the current study involves the collapsing of context-specific MI adherence ratings (i.e., during disagreement) for therapists who had more than one disagreement episode per session. That is, given the small sample size of the current study, there

was not enough power to account for the nesting of disagreement episodes within therapists. It is therefore possible that, in the case of therapists with more than one disagreement episode per session, the relationship between therapists' MI adherence during disagreement and treatment outcomes was also influenced by the level of consistency (or lack thereof) in therapists' behaviour during different disagreement episodes within the session. For example, one might ask whether inconsistency in therapist behaviour is differentially related to treatment outcomes, irrespective of the average level of therapists' adherence to MI spirit during moments of opposition. With respect to the latter, it is worth noting that, while the current findings revealed that there were some instances of inconsistency in MI adherence ratings for therapists with more than one disagreement episode, by and large, therapists in the present study displayed limited range on the MITI measure (tending to fall in the low to moderate range of the MITI global scores). Nevertheless, it will be important for future studies with larger samples to account for the influence of the clustering of disagreement episodes within therapists.

In addition with respect to study limitations, findings are correlational rather than causal; future studies should experimentally manipulate therapist management of disagreement in order to examine causal connections. Finally, the present study only included individuals with high severity GAD who underwent CBT. It would be important to examine whether the present findings would extend to other contexts such as directive treatment models beyond CBT or different clinical populations.

In terms of future directions, findings of the present study concerning the relationship between therapist cultivation of the MI spirit during disagreement and improved CBT outcomes suggest one focal potential mechanism through which MI exerts its effects more broadly; namely, therapists' management of interpersonal resistance. And this more specific proposal

could be tested in future studies where MI is added or integrated into treatment. That is, previous research has identified reductions in resistance upon receiving MI, and found this to be a crucial mediator leading to increased client engagement and enhanced CBT outcomes (Aviram & Westra, 2011; Constantino et al., 2015). While such findings can *imply* that therapists' management of resistance might be the actual mediator (since sustained resistance is considered a therapist skill error), findings of the present study suggest that it is possible to enhance specificity by directly examining therapists' management of resistance as the *actual* mediator of outcomes when MI is added/integrated into existing treatments. Such studies would have important implications for understanding how and why adding and/or integrating MI with existing treatments may be effective in enhancing client outcomes. Namely, while empirical studies strongly support the value of adding MI to existing therapies in increasing engagement with treatment and improving clinical outcomes (see Westra, Aviram, & Doell, 2011, for a review), the underlying mechanisms through which MI achieves its benefits are currently not well understood. It would be interesting to examine whether adding and/or integrating MI with existing treatments leads to improved treatment outcomes due to therapists' effective management of resistance.

Furthermore, given that therapists' cultivation of the MI relational stance was specifically indicated in the context of client opposition to therapist direction, this suggests that there is something particularly important about therapists' management of those particular moments in therapy. By specifically examining therapists' behaviour during key moments of in-session disagreement, future studies can begin to investigate what occurs during these moments that makes this contextual marker of resistance so influential to therapy process and outcome. For example, I speculated about one potential mechanism that may help explain why therapist

cultivation of the MI spirit particularly during moments of client opposition to therapist direction was substantially related to improved therapy process and outcome. In particular, it was proposed that provision of the client-centered relational conditions highlighted in MI in the presence of resistance may lead to improved clinical outcomes due to their effects on enhancing client agency and providing a corrective relational experience. Future studies could more directly investigate the impact of resistance and its management on client agency.

To this end, recent inventive research suggests one way in which such investigations may be attempted. In particular, Watson, Steckley, and McMullen (2013) found that clients' self-reported experience of therapists' empathy contributed to significant changes in their attachment styles and treatment of self, as evidenced by changes on the introject surface of the SASB circumplex model which pertains to client behaviours that are directed toward the self. Notably, future studies can identify certain key moments in which therapist 'MI-like' behaviour is thought to be especially indicated in relation to facilitating important internal changes, and therapist behaviour during these key moments can be examined in relation to changes in clients' treatment of self that are thought to be related to an enhanced sense of agency. Such studies will prove especially important given that, albeit representing a key concept across psychotherapy models, little empirical research currently exists on the mechanisms responsible for the facilitation and enhancement of client agency in psychotherapy.

Future studies may also investigate other possible sequela of the effective (and ineffective) management of resistance in therapy, such as improved client outcome expectations, higher levels of in-session experiencing, or stronger alliance ratings, and examine whether these latter processes mediate treatment outcomes. For example, recent studies have found that the relational quality between the client and the therapist was strongly associated with subsequent

client outcome expectations (Ahmed et al., 2012), and that the negative impact of alliance ruptures on treatment outcome was mediated by its influence on reducing outcome expectations (Westra, Constantino, & Aviram, 2011). Given that higher outcome expectations have been consistently related to adaptive treatment processes and outcomes (Constantino et al., 2011), these findings suggest one potentially important consequence of therapists' management of resistance. Examining important processes that are set in motion by therapists' effective and/or ineffective management of resistance will contribute to our understanding of the ways in which key transtheoretical therapy markers and treatment processes are related to and shape one another. Relatedly, given the current findings which strongly support the context-responsivity hypothesis, it will be important for research to identify additional important markers beyond resistance that necessitate context-responsive intervention on the part of the therapist.

In conclusion, this study began with a fundamental notion of MI: namely, that "The true art of a counselor is tested in the recognition and handling of resistance" (Miller & Rollnick, 2002, p. 110). Findings of the present study serve to support this central tenet of MI, extending it further to the context of CBT for the treatment of anxiety. It is the author's hope that these findings, in convergence with other emerging research concerning the importance of therapist flexibility in approach and responsivity to key clinical markers, will contribute to the movement toward context-responsive psychotherapy integration, guided by important process markers that cut across psychotherapy models. As noted by Constantino and colleagues (2013), a modular approach to psychotherapy training, one that is based on guidelines for therapist responsive interventions to frequently occurring therapy contexts and key clinical markers, may enable clinicians to more readily and freely make moment-to-moment decisions that are informed by emergent client needs and context characteristics. In the case of the present study, although

future research is necessary to generalize and replicate the findings, these results suggest that systematically incorporating and integrating training in humanistic core principles, particularly in the embodiment of the client-centered relational conditions advanced in MI to the responsive management of resistance in CBT, is not only possible, but an extremely valuable clinical endeavour which should become a priority for clinical training.

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Appendix A

MANUAL FOR RATING INTERPERSONAL RESISTANCE
Westra, H. A., Aviram, A., Kertes, A., Ahmed, M., & Connors, L. (2009)
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<u>Key Coding Principles/Concepts</u>

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 (about tricky segments), "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?" etc. In other words, contemplating 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, try playing with various versions of it in order 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).

<u>**Types of Interpersonal Resistance**</u>

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 gage what the therapist is really intending (i.e., is there clearly a `right` answer or response to the question or statement?) Then, try to gage 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 gage 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.

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

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. 1codes have a quality of appeasing 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, disagreeing, interrupting). 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," etc.)

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.

Each time bin is coded for <u>peak</u> resistance (i.e., the highest code in the bin). So for example, if there is a `1` in the bin but also a `2`, the bin would be coded as `2` (regardless of when the 1 occurred).

If the response is softened after it has been made, in keeping with coding peak resistance you would *not* drop the score. For example, the response: "I doubt that I can stop worrying... but I'll give it a try" is coded 2 and not 1, even though it is softened at the end. In contrast, the response: "I'll give it a try... but I doubt that I can stop worrying" is coded a 1 and not 2 because it is softened up front.

When unclear about the intensity of a resistance response, always code the less intense score on the rating scale (i.e., if the client's response could be interpreted as either 1 or 2, code 1 by default).

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 intensity level* (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. (1982a). *Manual for coding client resistance*. Unpublished instrument, Eugene, Oregon.

Appendix B

Examples illustrating the beginning of disagreement episodes

Discussing catastrophic thinking:

Therapist: …Let's talk more about catastrophizing. Is there a thought, something that happened in the last week that exemplifies catastrophizing, when we blow things out of proportion?

Client: Not in the last week.

Therapist: Okay, anything that happened in the previous weeks?

Client: I can't think of anything because that's not something that bothers me, I don't think I catastrophize. And to me catastrophe is a word that is used for earthquakes and floods, that's a catastrophe. [*Disagreement*]

Discussing probability overestimation:

Therapist: (*referring to client's anxiety about daughter's upcoming surgery*)…And I'm sure the doctors have given you information about the risks too.

Client: Yeah, I mean, it's a six minute surgery. It's just that she's still going under, and she's so little, you know… it's my child.

Therapist: Right, so you're understandably worried and thinking about the one thing that could happen and that's definitely a probability overestimation because you start thinking about that happening, and it stirs up all the anxiety and makes you feel super confident that something horrible is going to happen. So it's really important to keep in mind those actual base rates of how likely things are to go wrong, just based on probability.

Client: But now I'm thinking well, if it's a one in a million chance that something will go

                 wrong, someone's gotta be the one. [*Disagreement*]

Discussing behavioural experiments to test out anxious beliefs:

Therapist: (*therapist introduces rationale for behavioural experiments*)…So it's really

                 different ways to use our environment to test out our thoughts. So just from the

                 brief summary that I've given, any thoughts about where to start?

Client: It's just, it makes me almost a little worried though… I think sometimes being

                 anxious is a good thing, or like having anxiety about something is a good thing.

                 And it kind of scares me that maybe I won't be cautious in situations anymore and

                 things can happen. [*Disagreement*]

Appendix C

Summary of MITI Global Scores on a Dimension from High (5) to Low (1)

Evocation: Curiosity, Exploring/Drawing Out vs. Telling/Ignoring/Fact-Gathering.

High: Curious about client reasons and ideas regarding change; follow up and elaborate client ideas; actively seek to explore client ideas when client does not; can provide info, but does not rely on it as means of helping clients change; prioritize exploration of client personal reasons for change and the means to go about it; actively create opportunities for client 'change talk' to occur.

Low: Provide reasons and education regarding change in absence of drawing out/exploring client knowledge/inputs; superficial interest in client ambivalence or reasons for change; miss opportunities to explore client reasons/feelings regarding change in detail; ignore client ideas when offered; rely on fact/info-gathering; does not respond to 'change talk'; provide clients with reasons vs. eliciting reasons from client; talk client into changing.

Collaboration: Working Together vs. Dominating/Playing the Expert.

High: Query client ideas; incorporate client suggestions; actively mine for client input; can either implicitly or explicitly identify/regard the client as the expert; tempers advice giving and expertise depending on client input (education/advice responsive to client); does not rely on authority or dominance; is willing to be influenced by client; can use own expertise but does so in a collaborative/co-thinking manner.

Low: Explicitly assumes expert role; minimizes client ideas; dominates conversation; there is no feeling of working together; argues with client; is passive, disconnected, or dismissive; does not try to reach mutual understanding; one-way communication; rely on personal knowledge vs. client's knowledge; often ahead of the client.

Autonomy/Support: Non-Coercive (i.e., you Get to Decide/Have Choices and Control) vs. Coercive (i.e., I Know what is Best for you/Do Things My Way).

High: e.g., "You get to choose," "What would you like to do?" "What do you think of that?" "You know what is best," "Only you can know," etc. Explicitly or implicitly conveys that the client is free to choose; allows client to choose topic of discussion; may also explicitly indicate that the client is free to choose not to change or to maintain the status quo; may also express optimism regarding the client's ability to change.

Low: e.g., "You have no choice," "There is a right way to see things – my way," "You need to do what I think is best," "There is only one way to approach this/to change," etc. Is rigid; Conveys pessimism in the client's ability to change (do NOT lower score if the clinician is empathizing with client's perceived lack of choices).

Empathy: I'm Deeply Interested in What You Think vs. I'm Not Trying to Get What You Think (Absence of Effort) or I Don't Care What You Think.

High: Attempt to deeply understand and explore the internal experience of the client; view session as opportunity to learn about the client; active interest in deeply understanding; accurately perceiving complex story and probing to gain clarity; often encouraging client to elaborate; strong effort to understand beyond what the client has said (to add meaning); attempting to `put oneself in client shoes` (to think as if they are the client); uses many complex reflections.

Low: No interest in client`s perspective or worldview; no active attempt to understand the client; ignoring client's perspective; not concerned with the client; in their own world; little effort to gain a deeper understanding of the client; shallow; hostility toward client or dislike of the client; asking a lot of questions or providing a lot of factual information would by definition mean low empathy.

Direction: We're Going Somewhere vs. Aimless/Unfocused/I Have No Clue Where we're Going.

High: Exert influence; structures; can clearly see `where they are going` or that they are going somewhere – has direction; consistent efforts to return to, or stay on topic or task. Note: Direction can be EITHER dominating or autonomy-supportive and collaborative. This distinction will influence the other global codes.

Low: Exert little influence over discussion or course of session; no focus; lack structure; passive and aimless; non-directive listening, or listening without sense of movement or going anywhere; focus on tangential topics OR focus has been diverted from client self-reflection; a lot of time spent on intellectual or abstract discussion; unproductive client reiterations of the problem with no sense of movement; does not attempt to move things; allows client to wander; does not feel like it is going anywhere.

Appendix D

Summary of MITI Behavioural Counts and Coding Considerations

Closed Question (CQ). Answered with a "Yes" or "No" response OR Restricted Range (e.g., "How old are you?" "How often does this happen?"). Closed questions that are intended to be open but begin with a stem word (e.g., can, could, did, would, should, are, will, have) should be coded as closed (e.g., "Can you tell me more," "Could you explain").

Open Question (OQ). Allows a wide range of possible answers. Question may seek information, invite client's perspective, or encourage self-exploration. "Tell me more" statements are also coded as open questions.
- Only one question per volley is coded (either CQ or OQ, *but not both*); *OQ trumps CQ* if both occur
- Reflections turned into questions (with inflection at end) are coded as questions (either open or closed)
- Always ask if the context is positive, negative, or neutral to determine whether it is a question or a higher code (see following page)

Simple Reflection (SR). Conveys understanding but adds *little or no meaning*; doesn't go beyond client's original intent in the statement; summaries may be coded as simple reflections if therapist does not use the summary to add an additional point or direction.

Complex Reflection (CR). Adds *substantial meaning or emphasis*; conveys deeper/more complex picture; may add subtle or very obvious content or combine statements from clients to form summaries that are complex.
- Only one reflection per volley is coded (either SR or CR, *but not both*)
- When can't distinguish between a simple and complex reflection, simple should be used
- CR trumps SR; When a series of SR & CR are used, only CR is coded
- Reflections that are checked with a question (e.g., "Is that right?" "Does that fit?") get an additional MIA – Checking code (both elements are coded)

Direct-Neutral (DN). Provides direction, guidance, advice, instructions that are *attempts to influence the client,* but NOT to coerce / go against client's will (i.e., context is neutral). Paraphrase: "I would like you to do... think about... consider..."
E.g., "Let's do a thought record / make a list," "Write that down," "I wonder if not everyone thinks that way," etc.
Also includes: education / information *intended to influence* & structure statements *intended to direct therapy*.
- If context is negative (i.e., coercive/confrontational), utterance will receive a MINA code
- Therapists are *expected to direct in CBT* and *do not need permission to do so*. However, if therapist explicitly asks for permission, they will get an additional MIA code (i.e., Asking Permission)

Giving Information (GI). Gives information, educates, explains concepts, provides feedback that is *NOT intended to influence the client* (e.g., responds to client questions; merely giving information with no effort to direct).

- Always check if information is intended to influence client. *If yes, give Direct-Neutral code. If no, default to GI.*
- GI can also be MIA (If something is *added* like asking for permission or inviting client to disregard info) OR MINA (if *spirit or tone* is coercive, confrontational; i.e., "Do what I want!")

MI Adherent (MIA). (Indicate type: Affirm, Support, Autonomy Codes).

- *Affirm (prizing)*: saying something positive or complimentary (e.g., client's strengths, abilities, or efforts).
- *Support*: statements of compassion or sympathy (e.g., "This hasn`t been easy," "That sounds hard," "You`re in a tough spot right now"); going out of the way to resonate with suffering / difficulty.

- *Autonomy Codes*: statements that support and demand autonomy (e.g., "You decide," "Only you can know").
    Asking Permission: giving direction/information *in context of permission* (e.g., "Is it okay if I tell you about...").
    Emphasizing client control: explicit statements that indicate freedom of choice, autonomy, or ability to decide (e.g., "It`s up to you whether you want to do this or not," "This is totally your choice," "We'll try things and see what works for you").
    Checking: when therapist adds in a *check* on *their* statement (a Reflection, Direct-Neutral, GI, etc.) at the beginning or the end of the statement (e.g., "Is that right?" "Does that fit for you?" "Am I hearing that correctly?" "I could be wrong about this, but..." "I'm not sure if this is right," "You are free to take or leave this," "You don't have to agree"). Has a *tentative* quality*; statements *invite the client to correct / veto the therapist.*

- MIA code takes precedence over other codes.
- When in doubt, give alternate or 'lower' code (i.e., Question, Reflection, Direct-Neutral, and GI).
- Opening and closing statements that serve as formalities are structuring statements and are not coded.
- Therapists may say "good" as a way of facilitating conversation. Unless explicitly tied to a client utterance and affirming the client in some way, they should *not* receive MIA code.

MI Non-Adherent (MINA).

- *MINA-Coercive*: Confronting disagreeing, arguing, correcting, judging, shaming, blaming, criticizing, moralizing.
- *MINA-Direct*: Directing the client by giving orders, commands or imperatives in a *negative context*; i.e., *therapist persists to follow their agenda* ("You should..." "Try doing..."), *despite client objection/resistance.* Giving information, advice, direction, suggesting, offering solutions *without first obtaining permission and in a negative context*

*(designed to coerce / persuade client).*E.g., "For this week, I want you to do..." "For homework you will...“). However, could be *Direct-Neutral if the context is neutral.*

- MINA code takes precedence over other codes
- When in doubt, give alternate or 'lower' code (i.e., Question, Reflection, Direct-Neutral, and GI).

Other key points

Context is Crucial: With DN, GI, CQ, OQ, SR, and CR, always ask: "Is the context <u>positive</u>, <u>negative</u>, or <u>neutral</u>?"

3 ways to ask a Question:
  (1) <u>OQ or CQ</u>: Context is neutral (most questions will occur here).
  (2) <u>MINA</u>: Leading questions, statements in disguise, or questions with a "right answer" (e.g., "So, is your worry productive?" "Has your anxiety come down after doing the exposure?" "Sure, a plane crash is always possible; but is it probable?")
  (3) <u>MIA</u>: Checking questions (e.g., "Does that make sense?" "Am I hearing you correctly?" "Does this fit?")

3 ways to make a Reflection:
  (1) <u>SR or CR</u>: Context is neutral.
  (2) <u>MINA</u>: Reflections made in the context of coercion or confrontation (e.g., "Sounds like you might not want to get better" in response to client saying they did not complete their homework).
  (3) <u>MIA</u>: When the therapist begins with a reflection, but adds a question to *check* the reflection's validity (e.g., "Sounds like that made you feel quite inferior. Does that fit?") In such cases, both elements are coded (i.e., CR/SR + MIA).

3 ways to give Direction:
  (1) <u>MINA</u>: If direction is given in the spirit of coercion/command (i.e., therapist persists to follow their agenda despite client objection/disagreement/resistance; e.g., "Do as I say") or the context is confrontational.
  (2) <u>MIA</u>: If direction is given in the context of emphasizing client autonomy (e.g., asking permission, checking, suggesting client is free to disregard/veto direction).
  (3) <u>DN</u>: Context is neutral (i.e., client and therapist are collaborating/on the same page; sense of working together toward the same goal/s; therapist's direction is responsive to client's needs).

4 ways to give Information:
  (1) <u>MINA</u>: *Context is clearly negative*; i.e., If GI is given in the spirit of coercion, correction, command (e.g., "do what I say," "I am right") or confrontation, judgement, ignoring, or dominating the client.
  (2) <u>MIA</u>: If GI is given in the context of emphasizing client's autonomy (e.g., Asking Permission, Checking, or Emphasizing client control; i.e., suggesting client is free to disregard/veto information).

(3) <u>DN</u>: If GI is intended to guide/influence the client, BUT is *not coercive/against the client's will.*

(4) <u>GI</u>: If GI is given at any other time (i.e., straightforward education, feedback), but *not for the purpose of influencing* (e.g., responds to client questions; giving information with no effort to direct).

Do not be a 'literal' coder. Do not rely on the words (e.g., every time I hear the therapist say: "I think..." that is automatically a MINA); Rather, it is the overall spirit and context you are primarily considering; any therapist statement can be a MIA, MINA, or another code depending on the context; *always rely on the spirit/context of the statement.*

Do not "gestalt code." Do not form an overall impression of the therapist and then interpret everything within that impression (e.g., "This therapist has lots of MINAs, so he/she is unlikely to have any MIAs or positive bumps on the global scores," or "This therapist isn't very empathic so they won't have any complex reflections.") It is very common for therapists to have both good and not so good moments; avoid Gestalt coding or coding from an overall impression.

Do not "backwards code." Don't go back and reinterpret a previous code based on what comes next (e.g., when a MIA occurs at the end of the volley, such as DN and then Checking, this is coded as DN + MIA. Do not go back and recode the DN as MIA). Similarly, do not go back and recode a previous question as MINA if a MINA follows it.

Each code can be assigned only once within a volley. Cannot have an OQ and CQ or a SR and CR in the same volley; only one question code and one reflection code per volley.

Client facilitative statements. Minimal encouragers (e.g., "yeah," "right") do not break a therapist volley, *unless* they break the therapist's utterance (e.g., response to therapist utterance, something that conveys an idea).

Uncodable statements.
- Irrelevant banter (chatter related to other people that is clearly not focused on or has no relevance to the problem or the client; e.g., "I take that bus too," "it's cold in here").
- Incomplete/unfinished thoughts (e.g., "you mentioned..." client interrupts).
- Facilitative statements (e.g., "ok," "right," "good").
- Self-disclosure statements that are not therapy-related (e.g., "excuse me," "I also like that show").
- Structuring statements that are not therapy-related (e.g., "we will meet for 50 minutes each week," "let's take a break").
- Greetings (e.g., "thanks for coming in today," "it was very nice to meet you").

MIA and MINA should always affect global scores ratings. e.g., therapist Checking or Emphasizing client control would be a bump up in Autonomy/Support, and therapist Confronting would get a bump down on Collaboration/Empathy, etc.

Target Behaviors in MI for anxiety are diffuse. Anxiety and related behaviors and problems may include perfectionism, assertiveness, worry, procrastination, rumination, self-esteem, interpersonal problems, sleep, depression, avoidance, unfinished business, among other things.

Great Questions to ask when deciding on codes (especially higher order codes such as MIA, MINA, or CR):
- What is the therapist's underlying message? What is the therapist really trying to say?
- What is the paraphrase? Create a paraphrase
- Can I turn this into something else? E.g., if this were really meant as an autonomy-granting (as opposed to coercive) question, what would it have to sound like? What would need to be there?

Appendix E[13]

Example illustrating high MI Adherence during disagreement

<u>Therapist suggests behavioural experiment to test out the client's anxious predictions:</u>

Therapist: …with leaving so early, you never prove to yourself that even if you leave fifteen minutes later, you're not going to be late anyway. So you're not learning that the worst case scenario isn't going to happen. So the idea is we want to change those worry behaviours, being over-prepared, because then you start to prove to yourself that you don't have to be so strict and you don't have to be so over-prepared for everything. Cause the worst case scenario isn't gonna happen. Okay? So we can do that through thought records, and you can say 'oh okay, you know, I probably won't be late,' but let's test it out. And that's kind of a scary step. Right? Because it's actually doing it. [*client smiles silently; fidgeting; therapist appears to notice client's discomfort, pauses and then smiles, asks client*] Do you-

Client: [*interrupts*] No. [*laughing, fidgeting; i.e., I don't want to do this – beginning of disagreement*]

Therapist: So is there some hesitancy there? (Client: Yeah) Okay. **(Bumps up on MI Spirit and Empathy - attunement to opposition, reflection, asking for elaboration)**

Client: Like my job is in Mississauga, and I feel like I have to leave an hour and a half early, even if it takes me half an hour to get there, because there could be traffic.

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[13] Of note, in accordance with the MITI manual, global scores are given on a 5-point Likert scale, with the coder assuming a beginning score of three and moving up or down from there. Unlike the behavioural counts in which coders code all that transpires between the client and the therapist in the segment under consideration (i.e., the entire dialogue is taken into consideration), global scores require the coder to look specifically for moments that would increase or decrease the global scores. In the examples below, I have indicated the specific places in the therapy segments that would count toward the evaluation of the global scores.

Therapist: Mhmm.

Client: There's unexpected delays, like I would rather be there, like I don't know, … I

don't know if I could actually make myself sleep in for extra fifteen minutes, or

wait for extra fifteen minutes [*starts laughing*; *continued opposition to therapist*

suggestion to do behavioural experiment]

Therapist: Yeah, I know, it's going to be – it's hard, and you know what? I won't ask you to

do it all at once, okay, and that's why I like your idea of gradual baby steps, okay?

And what we're going to do today is brainstorm, not just the leaving early piece,

but other things. And then we'll pick and choose where to start. We're going to

start easy, or medium maybe, and then work up to hard once we're – you're

feeling more comfortable. **(Bumps up on MI Spirit – expressing support;**

affirming client; emphasizing client autonomy/control and choice with

respect to behavioural experiment)

Client: Okay. [*fidgeting*]

Therapist: Okay? But do you, um, see the idea of why this might be (Client: Yeah)

important? **(Bumps up on MI spirit – evocative; ensuring client is on the same**

page as opposed to passively complying with task)

Client: And, I mean, even if I have been late. On my schedule, late (Therapist: Mhmm) is

still early. (*client begins to cooperate*)

Therapist: Right. Okay. And we talked about that last week, we went through a thought

record on that, right? (Client: Yeah) Okay. So let's talk, so leaving early is one

that you mentioned, okay, so maybe I'll get you to brainstorm as well. What are

some other things that you feel like, in our day to day life, you are doing?

Client: Well, whenever I go to my boyfriend's house, I always pack early, I don't

               (Therapist: Okay) know why I do that.

Therapist: Okay, packing…

Client: And a lot of stuff. Like everybody else always packs the night before. I can't do

               that.

Therapist: Okay. So I'm wondering if that's wanting to make sure you have everything so

               something… **(Bumps up on MI spirit and Empathy; evocative, reflecting;**

               communicating interest in client's experience contributing to worry

               behaviours)

Client: Yeah and I'll check like three or four times to make sure I have everything

               (Therapist: Okay) that I want and…

Therapist: So you mentioned three things. Packing a lot of things, like over-packing. Packing

               beforehand. (Client: Yeah.) And then checking your stuff.

Client: Yeah (Therapist: Okay). And also money, like if I'm going to the store, I'd rather

               take a hundred dollars, even if I'm going to get milk, so that I have more.

Therapist: Okay. So, taking out more money than you need?

Client: Yeah.

Therapist: Okay. I'm making a list too so I can keep track. [*collaborative; communicating to*

               client that they are working on this together]

Client: … [*therapist pauses, granting client space to think*] Oh, if I'm home alone… I'll

               check a few times to make sure the lights are off, and the stove is off and the

               doors are locked and… [*chuckles*] I don't know if that really applies [*said*

               embarrassingly].

Therapist: Yeah! I think it does, because it sounds like you're worried that something bad might happen if you're home alone. **(Bumps up on Empathy; affirming client's idea; tone indicates tentatively guessing at underlying thought contributing to client's anxiety)**

Client: Well like, not so much that – like, I'm not scared to be home alone. [*therapist's tentativeness allows client to disagree with her earlier reflection*]

Therapist: Okay.

Client: I actually prefer it.

Therapist: Okay.

Client: But, I don't know… I just know that's what my parents would want. (Therapist: Mhmm) And I know that's what I should do.

Therapist: Okay.

Client: I'll get into bed, and I'll be like, 'did I lock the front door? I can't remember I locked the front door,' and I'll go up and go and check.

Therapist: Okay. Would that make you anxious if you couldn't do it?

Client: Yeah, like I wouldn't be able to sleep until I checked (Therapist: Okay).

Therapist: So let's write that on the list. And so what do you check, the locks?

Client: Yeah.

Therapist: What else?

Client: Lights.

Therapist: Okay.

Client: Oven (Therapist: Stove?) and stove, just in case. [*nervous laughter*]

Therapist: Okay. So you're checking those things. Other things that you're doing? So sometimes it's hard to just brainstorm off the top of your head, but when you think about some of your more common worries, you can think about worry behaviours, things you do or don't do.

Client: Uh, whenever I've got money to go shopping… Before, when I was working, I didn't care. I would go into BCBG and buy whatever I wanted. (Therapist: Mhmm) But now I'm so conscious of the price and the sale, and I really take a long time to make a decision. [*laughing nervously*]

Therapist: Okay. So it's a hard time… and I know money is a little bit harder, because you don't have an income and… so that may be something that we would target later on if you felt like you were taking way longer than you thought you should be taking, **(Bumps up on MI Spirit – emphasizing client autonomy/control with respect to choosing behavioural experiments; demonstrating flexibility in taking client's personal considerations into account when designing task)** but what about other decisions? Are you afraid of making a wrong choice on some other things and it takes you a long time to decide?

Client: No, no I'm usually pretty good about decisions; it's just recently that I have been… (Therapist: Okay) And I think that's mainly because I don't have a lot of money.

Therapist: Right. What about reassurance seeking? So sometimes people will feel like they're asking people if things are going to be okay…?

Client: Yeah, I do that with my boyfriend sometimes.

Therapist: Okay. So, what sort of things do you ask him?

Client: It's sort of like, 'do you still love me?' Kind of, needing reassurance. Yeah, I have noticed myself doing that.

Therapist: Okay, so can we put that on the list? (Client: Yeah) **(Bumps up on MI Spirit; collaborative, supporting client autonomy)**

Client: I guess with so many relationships now that don't last longer than two weeks, it seems a little unbelievable to me that I could have a relationship that lasts so long.

Therapist: Okay… So with a friend or…

Client: With my boyfriend, I think (Therapist: Oh, okay). Because most of my friends I've known since I was young. And our moms are friends and it's like kind of we're a family more than (Therapist: Mhmm.) friends. And I make friends pretty easily. But relationship-wise, sometimes I worry, 'how long is this gonna last?' Like… Too perfect is … do you know what I mean?

Therapist: Right, Right, like when's the other shoe gonna drop. **(Bumps up on Empathy; reflecting; guessing at client's experience)**

Client: Yeah, I'm waiting for him almost to do something that's like 'Oh you're nuts,' or something.

Therapist: Right. Okay.

Client: Which I know is…not, that's not… This isn't coming out right [*laughing; said embarrassingly*]

Therapist: No, I can, [*therapist notices client's embarrassment and offers support*] I'm getting the sense that it's a nagging worry. Even though (Client: 'What if,' yeah) you might to be able to… okay. **(Bumps up on Empathy – attunement to client experience; supports client; reflecting/communicating interest)**

Client: It's the 'what if' again, like what if… something happened.

Therapist: Right, and so do you find yourself, when you're having those worries, asking for reassurance? (Client: Yeah) Okay, so that'll be something to think about for sure. And the idea is we're making this list, and we can target any of these things through a thought record too, but it's almost like we're taking an extra step and doing something about it, right? (Client: Yeah) Um, and like I said, we're going to start small and work up. We're not going to make you do anything too stressful or anxiety-provoking right now. **(Bumps up on MI spirit – sensing client's reservation and emphasizing client control/autonomy)**

Client: Thanks.

Therapist: Other things that you notice yourself doing?

Client: … [long *pause*] No… [*smiling*]

Therapist: Is there something…? [*smiling*] **(Bumps up on Empathy – attunement to client's discomfort and tentatively attempting to explore her experience)**

Client: I'm not telling [*laughs nervously*]

Therapist: Ah. [*therapist smiles, pauses, giving client space*]

Client: Um… [*laughs nervously; covers face with hands*]

Therapist: Is it, do you think it's embarrassing, or? **(Bumps up on Empathy – attunement to client affect and tentatively reflecting client's experience)**

Client: No it's just silly (Therapist: Oh okay).

Therapist: What is it?

Client: If somebody uses my car, I'm like neurotic about gas, like, they have to fill it back up or else (Therapist: Okay) I get like really anxious about not having

enough gas (Therapist: Okay), I do not know [*starts laughing nervously; i.e., 'what's wrong with me?'*]

Therapist: No, I think that's a good one **[***notices client's discomfort and provides support, affirming client***]**. Because… is it a worry that you might run out (Client: Yeah) if you…? (Client: Yeah! [*said in relief*]) Okay. **(Bumps up on Empathy – attunement to client affect and providing support)**

Client: Me and my friends were in the Ottawa valley one time, and I don't know if you've been there but it's like country, like boondocks.

Therapist: Yeah, not a lot of gas stations.

Client: No. And it was so much time, and we got stuck with no gas. And it wasn't my car or else that would never have happened.

Therapist: Mhmm. But there's something that happened that (Client: Yeah) now you're worrying about (Client: Now I'm worried about). So how often does it like, what happens?

Client: My mom will take the car to get groceries or whatever and I'll be like, 'don't forget, if it's below a quarter of a tank, you have to fill it.'

Therapist: Okay. So can we put that down… asking people to fill up the gas? Or… **(Bumps up on MI spirit – collaborative; checking with client)**

Client: Yeah sure (Therapist: Okay).

Therapist: I guess there's two things. Asking people to fill up, and actually not requiring them to, so just letting them not fill it up, right? That sounds like it would be an even harder step, so (Client: Yeah) there's two different things. Let's put both down. Okay. So what I'd like you to do for homework, along with the thought

records, and I'm just taking a look at the time, I don't think we'll get to relaxation

practice today… [*topic shifts - disagreement episode ends*]

Appendix F

Example illustrating low MI Adherence during disagreement

Therapist reviews homework assignment on progressive muscle relaxation:

Therapist: Okay. So let's go over the progressive muscle relaxation exercise. Did you log

                down your experience on that form there?

Client: I thought about it, but it kind of ended up slipping my mind. Just the whole form

                thing. (Therapist: Okay) I like the idea of condensing it, because the [relaxation

                exercises] are just so long. (Therapist: Mhmm) It's really long and using it with

                people who are anxious… I just want to get it over with. [*Opposing therapist*

                direction – therapist wants to review homework and client goes against this

                direction; i.e., I don't want to do the homework you suggested – disagreement

                episode begins]

Therapist: Did you have that experience yourself?

Client: Yeah, absolutely. I just want to, you know, I just want to get it over with.

Therapist: Well, what do you think are the benefits of spending that actual twenty minutes to

                do the tension and relaxation? **(Bumps down on MI Spirit and Empathy– no**

                interest in client's experience or in what causes difficulty with relaxation

                exercise; persists in providing psychoeducation concerning benefits of

                relaxation)

Client: Umm… I feel like when we do it here, it's calm and then my mind will be more

                focused and centered. Because I already set time for this. But if I'm at home, I

                feel at home I have two hundred other things to do (Therapist: Mhmm) and then

                I'm tired, I have to wake up early or… (Therapist: Mhmm) I think making the

time is challenge number one, and kind of setting that time aside (Therapist: Mhmm). And it doesn't work the same when trying to do it yourself. [*client ignores therapist's question regarding the benefits of relaxation, and instead continues to provide reasons against completing the task; i.e., therapist's directive stance fails to gain client's cooperation*]

Therapist: Okay. So did you find that you found you were distracted again? **(Bumps down on Empathy – no interest in, or attempt to reflect, client's experience)**

Client: Yeah. Cause throughout this I have not been able to be a hundred percent focused at all, even listening to it when we're here my mind is still going somewhere else. (Therapist: Mhmm) So it's really hard to just keep those thoughts away. I don't get any, like I don't get the immediate response so, I don't know if that makes sense at all? [*Client continues to express opposition to relaxation exercise*]

Therapist: Yeah, it does make sense. (Client: So-) So it is very important that you do fill in the form (Client: Mhmm). And there's a reason for that. (Client: Mhmm) Because like I talked about in our first session, it's very important to monitor. Rather than come to the session and think on top of your head what really happened during the past week. So many things have happened and it's hard to remember all the details (Client: Mhmm). And often times when we make generalizations it doesn't really reflect the true reality. So it is very important that you do complete the log so that you know what was your anxiety level before and you know whether it's effective afterwards because you reassess your anxiety. **(Bumps down on MI Spirit – no interest in client's perspective; persists in discussing the benefits of monitoring)**

Client: This week was totally non-routine, first on Thursday and Friday I had that

training. (Therapist: Okay) And we had the closing of our house and we've been

moving our stuff every single day of the week. (Therapist: Mhmm) So on top of

everything else it's just kind of not... Other than that I'm exhausted because I've

been, like today at seven o'clock I was already at the paint store. Getting paint

and moving boxes so the whole thing like, it just kind of gets… and I'm thinking

tomorrow we have the movers coming in so there's a lot kind of going. [*Client*

continues to give reasons to justify noncompliance with relaxation exercise]

Therapist: Yeah, definitely. A lot going on in your mind and, and I can imagine moving is

very hectic, lots of things to do on the list. [*inauthentic feel/tone to therapists*

words; i.e., words without music therefore would not contribute to an increase in

MI Spirit]

Client: [*interrupts*] Yeah. And then that training for work I did last Thursday on how to

communicate with diplomacy, tact, and credibility. That was how it's called but

it's really about people like me who just need to say things that people at work

don't really appreciate. So the first day was extremely painful because not only I

had to re-live a lot of experiences, I had to hear, I heard a lot of people doing that,

so. [*client's voice trembles, on the verge of tears; clearly discussing something of*

great importance to her]

Therapist: Okay.

Client: Yeah.

Therapist: [*interrupts*] Sorry, I don't mean to interrupt; I would love to hear more of that, but

I do want to talk more about the relaxation piece [*client takes deep sigh*] and look

at maybe how we can problem solve together to see how we can include it.

(Bumps down on MI Spirit and Empathy – complete misattunement to client affect, and effectively disregarding client's affect-laden disclosure and continuing to perseverate on own agenda by insisting that they problem solve ways to include the relaxation exercise) This is a very important part of treatment. [*client sighs in exasperation*] Without this part then, you know, the skills that we're learning later on won't quite make sense, and so the practices that you do on a weekly basis, it builds up to, (Client: Yeah) ultimately we're learning-

Client: [*interrupts and continues to disagree with therapist direction*] I just still, I don't think what we're doing is effective.

Therapist: Okay.

Client: Especially, if we're doing it here it's fine, but taking it home it's just, I just don't see the benefit. [*continued disagreement*]

Therapist: Do you feel you've given it a fair shot though? **(Bumps down on MI Spirit and Empathy – argumentative/coercive; no interest in client's perspective)**

Client: Yeah! I'm trying to get my mind away from everything else and I can't. I have two hundred other things to do and I just don't feel, it just doesn't feel like it works. The first week I tried with the recording. (Therapist: Mhmm) It was really bad because I was paying attention and all the background sounds of what was going on. And then trying to do without it, it's hard to keep track of the time so-

Therapist: [*interrupts*] I just wonder-

Client: [*client raises voice to interrupt*] The thing is, I want to get to the point and this is

               kind of like forcing me to go through things that I don't see… you know what I

               mean?

Therapist: I'm not sure what you mean by 'get to the point?'

Client: For instance, our new house is on Queen Street East, I don't want to drive on

               Queen Street because the stupid street car is there and I get annoyed. My husband

               wants to go on Queen Street because he likes to look around. But I want to get to

               the objective, to the result. I don't necessarily want to enjoy the ride. So with this

               it's really hard because it's hard to see the benefit (Therapist: Yeah), if I'm not

               feeling the benefit immediately or what I am doing is just so little, it's just the

               effort versus benefit's really hard to see. [*continued disagreement*]

Therapist: Yeah. So therapy is a slow process. It's not a one shot deal so it's not like taking a

               pill and you get better. [*client sighs, laughs in exasperation*] It's a lot of hard

               work. It's a lot of working through issues that we don't want to work through

               because they're very distressing and uncomfortable for us. But this is an aspect of

               treatment that I feel will benefit you because you did mention that you experience

               a lot of tension in your shoulder and also in your jaw. And so the purpose of the

               relaxation exercise [*client sighs in exasperation*] is to teach you what is the

               difference between tension and relaxation so that whenever you feel tension you

               can tell yourself, 'okay relax those muscles.' (Client: Okay) That's essentially the,

               the point- **(Bumps down on MI Spirit and Empathy – disregarding client's**

               expressed needs and continuing to perseverate on treatment rationale;

stifling client's autonomy by insisting that she completes relaxation exercise against client's expressed will)

Client: [*interrupts*] Yeah well, we haven't-

Therapist: of this exercise.

Client: [*interrupts*] we haven't talked about this so... [*blaming tone*]

Therapist: Okay so maybe-

Client: [*client raises voice to interrupt*] Yeah so that's good, so I understand what is the objective.

Therapist: Okay (Client: Because-) Let me review very quickly with you. I did mention this to you, but because- **(Bumps down on MI Spirit and Empathy – argumentative; rather than attuning to client's expressed need to understand the rationale for relaxation exercise, therapist responds defensively, indicating to client that she did in fact explain the rationale for relaxation)**

Client: [*interrupts*] Because on the recording it says, 'Oh pay attention between the difference between tension and relaxation' [*ridiculing tone*] like, yeah okay, of course there's a difference but I'm not getting where do we want to get to with that.

Therapist: Yeah. We want to be able to identify when we feel tense, yeah? So that during the day if you are tense all day, you may not notice because this is the norm. But now that you've done this for so long, if you've been practicing the PMR, then you will know that this is not the relaxed state. (Client: Okay) And you will tell yourself 'okay I need to (Client: Okay) relax.' Some people, when they feel tension in their body then their mind gets going and they go, 'okay something

must be wrong,' and that might get them to think about worries or negative thoughts, okay? When you're feeling more relaxed and more comfortable, different thoughts might come to you, (Client: Oh, okay) right? When you are feeling relaxed, what do you think would you be thinking? **(Bumps down on MI Spirit and Empathy – shallow recapitulation of psychoeducation and treatment rationale with not apparent regard to client affect or experience)**

Client: I think it's the other way around. You're relaxed because you're already having those thoughts. I don't think you're tense and then because you're tense you get into thoughts, I think it's the other way around. [*client disagrees with therapist's rationale, irritated tone*]

Therapist: Okay.

Client: Your mind is driving the tension in the muscles.

Therapist: So that'd be interesting to find out if that's true or not, right? So I'm not sure what's the experience for you, but I'd be very interested knowing when you're feeling relaxed, ask yourself, 'what's going on in my mind versus when I'm feeling tense? What am I thinking to myself?' So this is a very important component of treatment and I strongly encourage you to fill in that form.

Client: Okay. [*irritated tone, passive compliance*]

Therapist: The form only takes about, maybe a couple minutes of your time, okay. You mentioned that you normally do this right before bed. Is there a couple minutes right after the exercise do you think you can fill in the form?

Client: I already turn the lights off so that's kind of… [*client disagrees with therapist's suggestion as to when to complete relaxation exercise*]

Therapist: You turn the lights off. Okay. Is there a different time during the day you can do this? [*therapist rigidly persisting with own agenda*]

Client: When? That's, that's the thing, when? When would I do this? I don't have, there is no time (Therapist: Mhmm) when I'm alone, cause when I'm home my husband's there the whole entire time. When do I get time to, or I'm driving or I'm at work (Therapist: Mhmm), so. There's really kind of no other quiet time. [*continued disagreement; client clearly upset, trembling voice*]

Therapist: Okay. Any time, there might be a possibility during lunch?

Client: Yeah, but that would mean I lose twenty minutes of my lunch. [*continued opposition*]

Therapist: Okay.

Client: So yeah.

Therapist: Okay. So how, how important is treatment then for you [*client laughs, sighs in exasperation*] in terms of, I know life is very busy, but how important is it in terms of the other things going on in your life right now? **(Bumps down on MI Spirit and Empathy – highly coercive statement; blaming, i.e., "your lack of compliance suggests that therapy isn't truly important to you")**

Client: Umm… It's just that I can't not go to work. I can't not [*trembling voice, on the verge of tears*] (Therapist: For sure) drive. I cannot choose not to do things that I have to do at home. So those, those have to be done.

Therapist: Okay. You're getting teary-eyed, what's going on for you right now? **(Bump up on Empathy – demonstrates attunement to client's expressed affect; switches into supportive/exploratory mode)**

Client: Yeah it's, umm.

Therapist: Is this hard for you or…?

Client: Yeah [*client reaches to take a Kleenex, wipes her tears*], well… It's just that I

               don't have… I would love to have a long time. I don't. I don't have time to

               myself or just to do-

Therapist: [*interrupts*] And is that upsetting for you?

Client: Yeah, cus I like having.

Therapist: You would like some alone time? **(Bump up on Empathy – demonstrates

               interest in the client's experience; nevertheless, only a slight bump up as

               therapist uses questions as opposed to attempting to reflect the client's

               experience)**

Client: I enjoy alone time. So I actually usually wait till my husband goes to bed. I would

               rather that he goes to bed before I do, so I can actually just do nothing. Because,

               sometimes I think I have to talk, there's a tension, there's something that I have to

               do, and I have to do like, I have to do everything else so I have to you know…

               And the insurance for the new house, who has to look for it? Who has to do

               everything? So I have to do everything.

Therapist: Mhmm. What if you don't do it? What would happen? **(Bumps down on MI

               Spirit and Empathy – switches back into directive mode as opposed to

               continuing to support/explore client's experience)**

Client: Then things don't get done, so. [*sarcastic tone; client senses therapist's direction

               and responds with opposition*]

Therapist: Is there evidence to show that that's true, that-

Client: [*interrupts*] Yeah! Yeah. They don't get done or they don't get done properly.

And my husband, some things can be delegated to him, but others, it's just not

gonna get done, so. [*continued disagreement*]

Therapist: Okay. So you're telling me, during your *whole* day [*client sighs in exasperation*],

you're not going to be able to find twenty minutes to do this? Do you think twenty

minutes is possible? [*client laughs nervously*] Out of twenty-four hours of the

day, if you slept maybe twenty minutes less [*client laughs nervously*]. Do you

think that's possible? **(Bumps down on MI Spirit and Empathy – coercive;

argumentative; implies judgment that client is not assigning enough

importance to treatment, i.e., "Are you really telling me that you can't find

20 minutes in your *whole* day to do this?")**

Client: Not during the day. Like during the day when I leave (Therapist: Mhmm) my

house and I come back and things aren't happening, no, there is nowhere that I

can go. [*continued disagreement*]

Therapist: Okay. So I understand that there is a list of things that you need to do. And I'm

sure there's a priority as well. Is that true, there's a priority of things?

Client: Yeah, there has to be a priority.

Therapist: Is there something that's lower down on the priority that could be dropped. It

might be uncomfortable to drop it, but you can survive. Is there that one thing on

your list there?

Client: [*client pauses, fidgeting with hands*] I don't think I do things that are not a priority

or [*sighs in exasperation*]. Sometimes I prioritize actually sitting down and

watching TV because that's my down time. I make sure I have some down time because otherwise I'm doing things-

Therapist: [*interrupts*] Can this be swapped then? The relaxation exercise. I'm sure the TV is a way for you to not think about anything (Client: Yes), just to relax- **(Bumps down on Empathy – disregards client disclosure concerning importance of downtime and suggests she replaces this with relaxation homework)**

Client: [*interrupts*] It's the moment that I can actually not think about anything else (Therapist: Mhmm) and just focus on that (Therapist: Mhmm) story. So that is why I actually really enjoy going to the movies, cause that's the only time I can not think of myself and things (Therapist: Mhmm) seem to go away and that's the time when I can actually get my head to stop thinking about what I'm thinking. [*client disagrees with therapist's suggestion*]

Therapist: Okay, okay. So how can I help you [*client sighs in exasperation*], what can I do for you? Or what can we do together to problem solve this issue of, of doing this exercise? What do you think? [*although therapist's language appears collaborative, there are no bumps up on MI Spirit because the overall direction is still very coercive, going against client's expressed wish not to engage in relaxation*]

Client: [*client pauses, laughs nervously*] Well I don't think-

Therapist: [*interrupts*] I'm very concerned for your well-being. I would like treatment to be effective for you and for you to have some relief in regards to the tension you're feeling in your body. And I really strongly think that this is something that might

be helpful [*client sighs in exasperation*] and so, I'd be more than willing to discuss with you what are some possibilities.

Client: I don't know, maybe now that we're moving I actually have more than one room in the house, so I could be able to maybe go into another room (Therapist: Okay). Cause now I can't (Therapist: Okay). I can't even go to another room because there is not even room. So… [*irritated tone; passive compliance*]

Therapist: Okay. So, have you moved into your new house already?

Client: Tomorrow.

Therapist: Tomorrow, okay. So is that something that you could do? Try out in a different room? I mean, you don't need much, just a chair (Client: I know, yeah, yeah) in a room, and try this this exercise-

Client: [*interrupts*] Yeah, at least I can close the door because, like I said, what happens is that my husband's home all the time, all the time. He doesn't go anywhere.

Therapist: Okay, so do you think you can make that commitment starting tomorrow [*client laughs nervously*], to try this exercise? If you can, twice a day, if not, then at least once a day and fill in that form. Yeah. Do you understand how to fill in the form? Do you have any questions on that?

Client: Oh I have it here. Yeah, it's fine.

Therapist: It should only take about a couple minutes max. Okay. Now, if you have any questions about the procedure, ask me, okay. Umm, we're going to be doing it again later on (Client: Okay) in today's session, so we'll go over it as well. Okay? Alright, and are you feeling okay?

Client: [*pauses, laughs nervously*] Yeah. It actually, if you think about it, it actually adds

                   something else for me to worry about. [*client again attempts to oppose therapist's*

                   assigned homework exercise]

Therapist: Mhmm.

Client: And it sounds weird, but it's-

Therapist: [*interrupts*] Is it a worry or is it something that's on your list to do?

Client: It's something that on my list to do that (Therapist: Mhmm) takes space or in my,

                   that's there, so.

Therapist: Mhmm. I don't want this to be stressful for-

Client: [*interrupts*] It becomes a chore. That's what it is. It becomes a chore oh, I have to

                   do it. [*client reaches to get Kleenex, wipes tears, appears exasperated*]

Therapist: Yeah, it is hard work and it is something that you have to incorporate into your

                   free time. Just like learning how to play the piano. **(Bumps down on MI Spirit**

                   and Empathy – coercive; no preservation of client autonomy; disregards

                   client's opposition)

Client: I'd never learn how to play the piano [*sarcastic tone, laughs*].

Therapist: Okay, or any instrument.

Client: I don't play anything [*laughing sarcastically*].

Therapist: Okay. Or learning any new skill.

Client: Yeah [*defeated tone*].

Therapist: Okay? I'm just using it as an example, it may not relate to you, but learning any

                   new skill we need to actually put it into our schedule and to practice for it to

                   become effective, okay. This is the same thing. It's hard at the beginning because

this is a new skill that you're learning. It becomes easier over time. **(Bumps down on MI Spirit and Empathy – continues to persist in arguing for benefit of homework; disregards client's opposition)** Okay. Okay so let's move on to our next section; I want to talk about catastrophic thinking and probability overestimation [*topic shifts - disagreement episode ends*].

Tables and Figures

Table 1. *Therapist Characteristics*

Measure	Therapists ($N = 13$)
Gender	13 Female
Age	M = 29, SD = 5.06
Identified primary orientation	11 Cognitive-behavioural
	1 Client-centered
	1 Integrative
Baseline outcome expectations for CBT as rated by the CEQ	M = 51, SD = 9.98
Average CTRS ratings	M = 45.54, SD = 5.28

Note. CBT, Cognitive Behavioural Therapy; CEQ, Credibility and Expectancy Questionnaire; CTRS, Cognitive Therapy Rating Scale

Table 2. *Sample Characteristics*

Measure	Participants ($N = 30$)
Gender	28 Female
	2 Male
Age	M = 35.61, SD = 12.75
Ethnicity	23 White/European
	3 Asian (e.g., South Asian, East Asian, Southeast Asian)
	2 Hispanic/Latin American
	1 Biracial/Multiracial
	1 Other
Marital status	15 Single
	12 Married/Cohabitating
	1 Divorced/Separated
	2 No data
Highest level of education	1 Some high school
	1 Completed high school
	7 Some post-secondary education
	21 Completed post-secondary degree or diploma
Average family income	13 less than $50,000
	12 $50,001-$100,000
	4 $100,001-$150,000
	1 $150,001-$175,000
Employment/education status	11 Unemployed/Temporarily unable to go work/school
	15 Employed currently
	4 In school currently
Concurrent antidepressant medication use	11 Yes
	19 No
Comorbidity	26 (87%) Other anxiety disorder
	22 (73%) Major depressive disorder/Dysthymic disorder

Table 3. *Means and Standard Deviations for Study Variables*

Measure	M (SD)
Pre-CBT PSWQ	75.62 (3.27)
Post-CBT PSWQ	44.43 (17.30)
Resistance Pre Target Disagreement Session	.09 (.09)
Resistance Post Target Disagreement Session	.18 (.13)
Disagreement MI Adherence	2.37 (.80)
General MI Adherence	1.99 (.64)

Note. CBT, Cognitive Behavioural Therapy; PSWQ, Penn State Worry Questionnaire

Table 4. *Intercorrelations among Behavioural Count Summary Scores during Disagreement Episodes*

Variable	Percent Complex Reflections	Percent Open Questions	Percent Direct Neutral	Pre-CBT PSWQ	Post-CBT PSWQ	Resistance Pre Target Disagreement Session	Resistance Post Target Disagreement Session
Percent MI Adherent	.47** (*p* = .010)	.37* (*p* = .043)	-.49** (*p* = .007)	.07 (*p* = .709)	-.26 (*p* = .162)	-.31 (*p* = .254)	-.22 (*p* = .235)
Percent Complex Reflections		.10 (*p* = .594)	-.25 (*p* = .190)	-.19 (*p* = .313)	-.32 (*p* = .089)	-.56* (*p* = .032)	-.32 (*p* = .086)
Percent Open Questions			-.37* (*p* = .046)	.21 (*p* = 265)	.22 (*p* = .247)	.20 (*p* = .468)	-.03 (*p* = .869)
Percent Direct Neutral				.21 (*p* = .267)	.13 (*p* = .492)	-.17 (*p* = .553)	-.03 (*p* = .887)
Pre-CBT PSWQ					-.06 (*p* = .760)	-.01 (*p* = .971)	-.14 (*p* = .462)
Post-CBT PSWQ						.34 (*p* = .218)	.61** (*p* < .001)
Resistance Pre Target Disagreement Session							.51 (*p* = .053)

Note. CBT, Cognitive Behavioural Therapy; PSWQ, Penn State Worry Questionnaire; *p* < .05, two-tailed; **p* < .01, two-tailed

Table 5. *Intercorrelations among Behavioural Count Summary Scores during Randomly Selected Therapy Segments*

Variable	Percent Complex Reflections	Percent Open Questions	Percent Direct Neutral	Pre-CBT PSWQ	Post-CBT PSWQ	Resistance Pre Target Disagreement Session	Resistance Post Target Disagreement Session
Percent MI Adherent	.30 ($p = .108$)	-.12 ($p = .545$)	-.36 ($p = .051$)	-.26 ($p = .174$)	-.19 ($p = .318$)	-.42 ($p = .124$)	-.07 ($p = .704$)
Percent Complex Reflections		-.06 ($p = .772$)	-.05 ($p = .794$)	-.17 ($p = .358$)	.38* ($p = .039$)	.42 ($p = .116$)	.14 ($p = .477$)
Percent Open Questions			.13 ($p = .504$)	.20 ($p = 292$)	-.15 ($p = .429$)	-.09 ($p = .762$)	-.31 ($p = .094$)
Percent Direct Neutral				-.41* ($p = .026$)	.17 ($p = .383$)	.25 ($p = .378$)	-.11 ($p = .581$)
Pre-CBT PSWQ					-.06 ($p = .760$)	-.01 ($p = .971$)	-.14 ($p = .462$)
Post-CBT PSWQ						.34 ($p = .218$)	.61** ($p < .001$)
Resistance Pre Target Disagreement Session							.51 ($p = .053$)

Note. CBT, Cognitive Behavioural Therapy; PSWQ, Penn State Worry Questionnaire; *$p < .05$, two-tailed; **$p < .01$, two-tailed

Table 6. *Intercorrelations among Primary Study Variables*

Variable	Disagreement MI Adherence	Pre-CBT PSWQ	Post-CBT PSWQ	Resistance Pre Target Disagreement Session	Resistance Post Target Disagreement Session
General MI Adherence	.30 ($p = .113$)	-.13 ($p = .500$)	-.02 ($p = .921$)	-.33 ($p = .226$)	-.18 ($p = .351$)
Disagreement MI Adherence		-.09 ($p = .639$)	-.42* ($p = .023$)	-.46 ($p = .083$)	-.52** ($p = .003$)
Pre-CBT PSWQ			-.06 ($p = .760$)	-.01 ($p = .971$)	-.14 ($p = 462$)
Post-CBT PSWQ				.34 ($p = .218$)	.61** ($p < .001$)
Resistance Pre Target Disagreement Session					.51 ($p = .053$)

Note. CBT, Cognitive Behavioural Therapy; PSWQ, Penn State Worry Questionnaire; *$p < .05$, two-tailed; **$p < .01$, two-tailed

Table 7. *Random-Intercepts Models Examining Disagreement MI Adherence and General MI Adherence in the Prediction of Worry Reduction*

	Disagreement MI Adherence	General MI Adherence
Post-CBT PSWQ	*Coefficient* = -10.27	*Coefficient* = -.81
	p = .018	*p* = .892
	se = 4.00	*se* = 5.91
	t Ratio = -2.57	*t Ratio* = -.14

Note. CBT, Cognitive Behavioural Therapy; PSWQ, Penn State Worry Questionnaire

Table 8. *Regression Analyses Examining Disagreement MI Adherence and General MI Adherence in the Prediction of Subsequent Resistance*

Resistance Post Target Disagreement Session	Disagreement MI Adherence		General MI Adherence	
	Accounting for early resistance	Not accounting for early resistance	Accounting for early resistance	Not accounting for early resistance
	$R^2 = .328$	$R^2 = .272$	$R^2 = .072$	$R^2 = .031$
	$t = -3.09$	$t = -3.23$	$t = -1.14$	$t = -.95$
	$p = .009$	$p = .003$	$p = .278$	$p = .351$
	Beta = -.65	Beta = -.52	Beta = -.29	Beta = -.18

Figure 1. *Flow Diagram of Coding Procedures*