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Therapist Relational Skills and Client Resistance in a Short Motivational Programme for Offenders

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ABSTRACT

Developing a better understanding of client resistance, and better evidence-based practise principles for dealing with resistance, have the potential to increase the efficacy of psychotherapy. There has been very limited research into client resistance, and even less which has investigated the link between therapist behaviours and resistance. The limited research to date has been conflicting and has primarily focused on narrowly operationalised definitions of resistance, as well as limiting measurement of therapist behaviours to therapist technical skills rather than interpersonal skills. There is little research investigating specific therapist relational skills that contribute to or reduce the likelihood of client resistance, and how this in-session interpersonal dynamic takes place.

This study utilised a multi-method design to investigate the relationship between a number of therapist relational skills (therapist empathy-perspective taking, therapist empathy-attunement, and therapist resistance) and client resistance. Resistance was defined as oppositional behaviour within the session, or lack of engagement with the other member of the dyad, and perceived as the outcome of an interpersonal process. DVDs of therapy sessions were accessed from a Short Motivational Programme run by the Department of Corrections in New Zealand. Each of the DVDs was coded on a minute by minute basis, using measures of therapist interpersonal skills and client resistance. The study also measured the working alliance. The analysis combined: a group analysis of broad patterns across the dyads; a single case analysis involving a visual analysis of graphed data, supplemented with descriptive statistics; and a narrative analysis of client-therapist dialog.

The results showed that therapist resistance and client resistance were strongly and positively related. The relationship between the two variables was also found to be temporally proximal at the level of a one minute segment. There was also a strong, but inverse relationship, between therapist empathy and client resistance, and again, the relationship was temporally proximal at the level of the one minute segment. Therapist resistance, especially, was closely synchronised to client resistance in terms of the timing of onset and cessation, and was also synchronised in terms of the level (intensity) of the two measures. The findings provide evidence for the idea that client resistance is often the result of an interpersonal dynamic, rather than simply an intrapersonal characteristic, and can be contributed to by poor therapist relational skills. The results showed that either therapist or client resistance can appear first, and tend to elicit resistance from the other member of the dyad (and lack of perspective taking by the therapist), which in turn elicits further resistance from the other dyad member. This appears to set in place a conflictual interpersonal dynamic that tends not to cease until the therapist stops resisting the client's message, and takes a more empathic-perspective taking stance. The results also suggested that therapist perspective taking and therapist resistance may be specific interpersonal dynamics contributing to successful/unsuccessful therapist confrontations.

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INTRODUCTION AND OVERVIEW

More than 50 years of research into psychotherapy has firmly established a number of therapeutic models as efficacious, and attention has increasingly turned to understanding the specific processes through which psychotherapy exerts its effects (Lambert, 2013). Lambert outlines extant research which suggests there are both common and specific factors that account for treatment efficacy within different models, and emphasises the need to understand the specific mechanisms of change attributable to these factors, rather than comparing one broad theoretical mode to another. This approach is recognised as critical to improving treatment outcomes. Recent reviews by a task force commissioned by the American Psychological Association drew attention to a number of important common therapist and therapeutic relational factors, and specifically recognised the importance of therapist empathy and the therapeutic alliance (Norcross, 2011). They highlighted the importance of adapting the therapeutic relationship to meet the specific needs of a client and specifically recommended adjusting a therapist's style to address resistant and reactant processes in clients.

Client resistance and client motivation are considered to be closely related concepts, and are often conceptualised as being at the opposite ends of the same scale (Engle & Arkowitz, 2006; Mann, Ginsburg, & Weekes, 2002). This makes understanding the concept of client resistance difficult to do without considering of the idea of motivation, and this is further contributed to by the fact that much of the extant literature and research into resistance has been undertaken from within the theoretical model known as motivational interviewing (MI; Miller & Rollnick, 1992, 2002b, 2012). Understanding and addressing a client's motivation to change, and to engage in treatment, has gained increasing recognition as an important factor in improving treatment outcomes (Hal Arkowitz, Westra, Miller, & Rollnick, 2008), as has understanding and addressing client resistance (Aviram & Westra, 2011; Leahy, 2001; Westra, 2011). It has been recognised that this may be particularly important with some client populations. Within offending populations it has been proposed that a client's motivation may be the critical factor to address (Mann et al., 2002), raising the possibility that re-offending rates can be further reduced by addressing these issues. However, there has been considerable difficulty gaining accurate and valid measurements of clients' motivation levels, and recent research suggests that investigating client resistance may be a more fruitful endeavour (Westra, 2011).

Resistance has a long history within psychotherapy, but despite the importance of the concept, there is a considerable lack of research into the area, and considerable variability with regards to definitions and practise principles within the various models of psychotherapy (Aviram & Westra, 2011; Engle & Arkowitz, 2006). MI is one model that features client motivation and resistance as foundational principles, and this model has received by far the greatest amount of

research. Several meta-analyses have now established MI as efficacious (Hettema, Steele, & Miller, 2005), but the mechanisms through which it achieves positive treatment outcomes are still not clear (Miller & Rollnick, 2012; Miller & Rose, 2009). MI places great emphasis on the therapist's relational skills, and the authors have theorised that two core active ingredients contributing to the efficacy of MI may be: therapist empathy; and the avoidance of non-prescribed MI behaviours which could cause client resistance (Miller & Rollnick, 2012). However, there is a lack of research investigating the specific therapist relational skills that contribute to or reduce the likelihood of client resistance, and even less understanding of how this interpersonal dynamic takes place (Gaume, Gmel, Faouzi, & Daeppen, 2009). There has also been little research regarding resistance in offending populations, although there is some evidence that programmes addressing an offender's motivation may be superior to traditional treatment programmes (Anstiss, Polaschek, & Wilson, 2011).

The review of the literature in this study will be undertaken in a number of chapters. Chapter 1 briefly explores the efficacy of psychotherapy, and how there is the potential to enhance treatment efficacy by deepening the field's understandings of the specific mechanisms through which common factors exert their positive treatment effects. The importance of therapists' relational skills is highlighted, with a specific focus on the therapeutic relationship and therapist empathy. The important and related concepts of client motivation and resistance are then introduced, and the relevance of these for psychotherapy outcomes is stressed. The connection between therapist relational skills and client resistance is then briefly introduced, and the fact that there has been little research into the relationship between these constructs is discussed. The chapter also highlights specific populations where client resistance is a central issue, and introduces therapeutic models shown to be effective with these clients. In Chapter 2, motivation and resistance are defined and explored in more depth. The problems faced when researching motivation are outlined, and the potential benefits of investigating client resistance are detailed. Following this, the various ways that resistance (and motivation) have been theorised within different psychological models are described, including psychodynamic theory, self-determination theory, and reactance theory. The discussion of resistance within these models also focuses on the therapeutic variables and processes considered to be important when working with resistance. Chapter 3 continues the theoretical discussion of client resistance, but focuses on the psychotherapeutic model known as motivational interviewing (MI), which is the most highly researched treatment model that clearly conceptualises its approach to dealing with resistance and motivation. The key research and practised based insights from which MI evolved are first introduced, followed by an explanation of the various components of MI. The focus then turns to client resistance, and the way this is conceptualised within MI. The approaches suggested as critical to effectively working with resistance in order to maximise treatment outcomes are delineated, along with practises known to negatively affect outcomes.

The discussion then turns to the efficacy and effectiveness of MI, and the specific mechanisms that have been linked to positive treatment outcomes. In Chapter 4 the focus turns to a review of the research into client resistance with regards to both process and outcome, and highlights the specific therapist relational skills that have been demonstrated as most closely linked to resistance. Initially the research into resistance in general is discussed, before focusing on resistance research from within an MI framework. The chapter highlights the gaps and weaknesses in the extant research, specifically focusing on areas that have not been studied, as well as methodological weaknesses within existing research. The discussion outlines a number of unanswered and important questions that these gaps and weaknesses expose, with regards to the link between therapist relational skills and client resistance. Chapter 5 then focuses on the therapist relational skills highlighted from the previous chapters as having an important relationship to client resistance. These therapist relational variables are defined and described. The research with regards to these relational skills is then outlined, as are the links between these skills and outcome. The connection between the relational skills and client resistance is also delineated. This chapter concludes the literature review component of the study.

Chapter 6 outlines the aim of the current study: to investigate the relationship between therapist relational skills and client resistance within an offending population. This chapter also includes a diagram which gives a broad overview of the steps taken in this research. The research was somewhat complex in that it involved a pilot study and a main study, as well as the use of a multi-method design, and the diagram of tasks will hopefully provide greater clarity for the reader regarding the logistical steps undertaken. The chapter therefore also functions as an introduction to the methodological components of the research.

Chapter 7 outlines the methodology of the two phases of the study. The pilot study is first described and covers: the study's design, the details of the short motivational programme which provided the data for the study, the participants and the cultural and ethical considerations with regards to these people, and the measures selected and the rationale for their choice. The pilot study also details the procedures undertaken and includes participant selection and training of researchers. Importantly, this section also details insights which were gained in sessions training the researchers, and which were used to guide changes to the measures used in the study. Finally, the details and results of the inter-rater reliability analysis are detailed. The second part of the methodology section details the main study, and includes: details of participants, a description of the procedures used, and an overview of the final measures selected for use. The chapter finishes with an explanation of the various analysis methods used to answer the various research questions, and functions as an introduction to the results section of the research.

Chapter 8 outlines the results. The chapter is titled results and interpretation because the qualitative (narrative analysis) component of the analysis required an intermediate level of

interpretation, before making a final interpretation in the discussion section. The results section begins with an analysis of the aggregated data across an entire therapy session for each measure, for each dyad. The relationships between the measures are analysed for each dyad, and common patterns across dyads are also investigated. This group analysis is then conducted again, and in the same manner, but this time on the replication sample. The results section then moves to a close up analysis of each individual dyad. This is initially undertaken via a visual analysis of the graphed data from each measure, supplemented with descriptive statistics, and investigates the relationships between a therapist's relational skills and client resistance on a minute by minute basis. The close up investigation then turns to an analysis of the actual narrative between the client and therapist, and examines the moment to moment narrative viewed through the lens of the measures used and the variables they represent. This close up analysis (both a visual analysis and a narrative analysis) is completed for each dyad in the main sample, but not the replication sample. The results section concludes by considering whether there was any relationship between the variables measured and the particular session number which was used for each dyad, and also with consideration of whether cultural issues may have been related to the results seen.

Chapter 9 presents the discussion, and is divided into three sections due to the complexity of integrating and interpreting the results from various components of the mixed method design. At each stage of the discussion, the findings are presented in light of the extant research. In the first two sections of the discussion the drawing of broader conclusions is kept quite minimal, and the focus is on interpreting the findings from each specific area of the analysis and results. The first section considers the results from the group and visual analysis, and discusses the extent of the scores on the various measures, along with the relationships between the variables measured. The second section discusses the findings from the narrative analysis, and considers the patterns noticed within dyads featuring both high and low levels of client and therapist resistance. The third section of the discussion then integrates the conclusions and interpretations from within the first two sections, and considers the findings more broadly. This section then discusses the limitations and strengths of the study, offers ideas for further research, and finishes with a summary of the conclusions of this research.

CHAPTER 1: PSYCHOTHERAPY EFFICACY, MOTIVATION, AND RESISTANCE

Over the past fifty or so years, a range of psychotherapeutic models have been rigorously tested and firmly established as effective across various populations, and across a range of problem types (Lambert, 2013). However, although these modes of therapy have been shown to be superior to no treatment or a placebo treatment, numerous results from comparative research as well as dismantling studies and components analysis research have generally found that that no particular mode of therapy is consistently superior to another (Lambert, 2013). One possible interpretation of this finding is that different therapies contain *common factors* (as opposed to *specific factors*) that are curative, but that do not differentiate one therapy mode from another. Specific factors—often referred to as techniques—are seen as pertaining to a particular treatment, and include therapeutic prescriptions such as exposure therapy and systematic desensitisation. In contrast, common factors represent elements of treatment that are not specific to any particular treatment modality, and include a variety of characteristics of the therapist, client, and therapy procedures. Lambert suggests these common factors can also be grouped according to three categories (support, learning, and action) representing the sequential processes that generally exist across most therapies. Examples of common factors include catharsis, providing corrective emotional experiences, encouragement of facing fears, and modelling. Two common factors that have attracted a lot of interest are therapist empathy and the therapeutic relationship. This interest has been driven by decades of research consistently finding that these factors are related to outcome.

At the same time that interest has grown in the exploration of common factors, the past two decades have also seen a growing focus on process research that aims to identify the actual mechanisms through which psychotherapy exerts change, rather than a broad and limited focus on research comparing one mode of therapy against another (Lambert, 2013). Developing the fields understanding of the mechanisms of change in psychotherapy is critical to improving treatment outcomes, and the need for this research has been widely recognised (Kazdin, 2007; Lambert, 2013). A number of researchers have specifically emphasised the requirement for research which investigates the precise role of common factors in therapeutic change, the mechanism through which they play this role, and the ways in which common factors can be utilised to enhance treatment outcomes (Goldfried & Davila, 2005; Kazdin, 2007; Norcross & Lambert, 2011). This line of research is embodied in the research undertaken by the task force commissioned by the American Psychological Association (APA) Division of Psychotherapy (Norcross & Lambert, 2011). Norcross and Lambert suggest that of the total treatment outcome variance attributable to psychotherapy, the percentages attributable to various psychotherapy

components were: unexplained, 40%; patient contribution, 30%; therapy relationship, 12%; treatment method, 8%; individual therapist, 7%; and other factors, 3%. Although these percentages are tentative, they are supported by thousands of outcome analyses, hundreds of meta-analyses, and the authors note that there are some clear take home messages, which include: the contribution of the therapeutic relationship, and the importance of adapting therapy to specific clients rather than taking a one size fit all approach. A further take home message emphasised by the authors is the well-established importance of the person of the therapist. With these concepts in mind, the task force undertook a set of detailed meta-analyses investigating the effectiveness of a range of specific elements of the therapeutic relationship, and also of a number of methods of treatment adaptation for clients. The results of this review revealed a number of demonstrably effective relationship elements, including: the working alliance; empathy; and key methods of adapting therapy to individual clients, including adapting to a client's resistance/reactance level. These findings are foundational principles for the current research, and it is to a discussion of client resistance, empathy, and the therapeutic alliance that this discussion now turns.

The research findings and recommendations by the task force outlined above in regards to resistance are by no means isolated (Norcross & Lambert, 2011). A number of researchers have highlighted the fact that many individuals fail to respond, drop out, or are unable to maintain their gains in treatment, and that there is considerable room to improve therapy outcomes by addressing these factors (Muran et al., 2009; Westra & Arkowitz, 2011). Studies suggest that motivational issues with clients are common realities for clinicians, and a growing number of researchers have advocated for more research into the concept of motivation (Arkowitz & Burke, 2008; Moses & Barlow, 2006). Furthermore, although motivational issues are seen across many different client populations and problem areas (Arkowitz, Miller, Westra, & Rollnick, 2008), there is reason to believe that some populations are less motivated to change (more resistant to change) than others (Miller & Rollnick, 2012) and may specifically benefit from interventions based on a solid psychology of motivation and resistance. These ideas reflect the well know concept of specificity in psychotherapy, as stated by Paul (1967) "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" (p. 44).

A common theme in both the literature and research with regards to resistance is the coinciding discussion and investigation of motivation (Aviram & Westra, 2011; Leahy, 2001; Miller & Rollnick, 2012). Resistance and motivation are often conceptualised as being at the opposite ends of a scale, or resistance as being "counter-motivational" (Engle & Arkowitz, 2006; Miller & Rollnick, 2002b; Westra et al., 2011; Westra, 2011). Furthermore, there is very little research that has been undertaken into resistance, but that which has been done has often been from

within the theoretical framework of MI (Miller & Rollnick, 2012), although this has until recently been dominated by outcome research. For these reasons, this review starts by considering the related concepts of motivation and resistance concurrently.

One population where motivational issues have been recognised as challenging are individuals who come to treatment with regard to offending issues. Therapeutic programmes for offending populations have been shown to be effective (reduce recidivism), but there is significant room for improvement (McMurrin, 2002). The motivational challenges associated with this specific population have been widely recognised as problematic, and have been directly related to outcome (McMurrin, 2009). Some authors have even suggested that motivating offenders to change, engage in treatment, and maintain their changes are one of the most important, if not the most important, issues for rehabilitation programmes in offending populations (Garland & Dougher, 1992; McMurrin, 2002). In line with this, it has been suggested that motivational programmes may initiate change via different mechanisms than traditional cognitive behavioural programmes (Anstiss et al., 2011). This is perhaps in line with Moyers and Rollnick's (2002) suggestion that, from within an MI perspective, clients should generally be able to implement changes in behaviour in a straightforward manner once their ambivalence to change has been resolved. The research on this is limited, but the recent study by Anstiss et al. supports this potential, with the study showing effects on offending recidivism were significantly greater in a motivational programme than in a traditional cognitive behavioural therapy approach. The programme used by Anstiss et al. was an adaption of MI, a treatment intervention with a large focus on therapist relational skills (Miller & Rollnick, 2012). However, as will be explained further on, the specific aspects of the therapist relational skills, and the precise ways in which they interact with client resistance and motivation to create positive change, are still largely unidentified. But before moving into a review of the complex relationships between therapist relational skills and resistance/motivation, it is important to define motivation and resistance.

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CHAPTER 2: MOTIVATION AND RESISTANCE ACROSS DIFFERENT PSYCHOLOGICAL MODELS

Research into the concept of motivation has until recently had very little impact in the field of psychotherapy (Arkowitz & Miller, 2008). The construct of motivation has been suggested as being under-theorised and under-articulated across the many therapeutic schools of thought, and evidence based practices regarding motivation are not well established (Polaschek & Ross, 2010). This is important, because the way one conceptualises motivation determines therapeutic activities, which are in turn involved in determining outcome.

Motivation is a complex concept, and has been interpreted and defined in a variety of ways (Karoly, 2006). Cox and Klinger (2011) point to an earlier definition which recognised motivation as a goal directed behaviour, defining it as a concept "to account for factors within the organism which arouse, maintain, and channel behaviour toward a goal" (p. 4). The close relationship between motivation and resistance has led some researchers to suggest that investigating motivation indirectly through the study of resistance may potentially overcome some of the limitations of motivational research (Westra, 2011). Several limitations have been noted, including the poor predictive validity of measures of motivation, definitional problems, challenges with ceiling effects, and social desirability bias. Westra points out that although clients are often understandably reluctant to report their true levels of motivation for therapy and change, resistance is often still expressed interpersonally within therapy sessions.

The concept of resistance has a long history within psychotherapy. Despite this fact, it has been suggested that different psychotherapeutic models have differing views on what resistance actually is, which has contributed to resistance being one of the most important but least understood concepts in psychotherapy (Aviram & Westra, 2011; Engle & Arkowitz, 2006). Engle and Arkowitz further note the extremely limited body of research in this area. With regards to a definition, there appears to be some general consensus that resistance refers to a barrier to change within therapy (Beutler, Harwood, Michelson, Song, & Holman, 2011; Engle & Arkowitz, 2006). Leahy (2001) suggests a definition of resistance as "anything in the patient's behaviour, thinking, affective response, and interpersonal style that interferes with the ability of that patient to utilize the treatment and to acquire the ability to handle problems outside of therapy and after therapy has been terminated" (p. 11). The author notes that resistance is used to refer to the way in which a client does not comply with a specific role defined by the therapist, and that this could differ in different settings. Leahy points out that when resistance occurs in therapy, it is important to understand what is being expected of the client so that the resistance can be understood. Noticeably, these descriptions clearly highlight the role of the

therapist in the resistance. There is also general agreement that resistance exists both as a trait within a person, and as a state that can be evoked by the environment, with the latter sometimes being labelled reactance (Beutler et al., 2011; Engle & Arkowitz, 2006). The concepts of resistance and reactance are often used interchangeably by leading researchers in the area (Beutler et al., 2011), and they will not be differentiated for the purposes of this review. However, the term reactance is generally used to recognise that the therapeutic environment can contribute to non-compliance in therapy, and the resistance does not lie solely with the client.

However, the term resistance is so laden with different meanings that an exploration of the nature of resistance is difficult to undertake outside of the specific theoretical frameworks in which it is conceptualised (Engle and Arkowitz, 2006). This is reflected in the wide range of terminology used to discuss resistance, e.g., ambivalence, low motivation, and reactance. In the following discussion, a range of theoretical conceptualisations of resistance are reviewed. In the first instance, resistance is considered from the viewpoint of: psychodynamic theory; cognitive behavioural theory; self-determination theory; integrated approaches; and reactance theory. The discussion then focuses on MI, which is where the main body of the research into resistance and motivation have been undertaken. MI is discussed in a separate chapter, due to the centrality of this model to the current research.

A Psychodynamic View of Resistance

The psychodynamic model has long emphasised the importance of resistance in therapy (Leahy, 2001). Rather than seeing resistance as a problem which needs to be overcome so that the real business of psychotherapy can be engaged in, the psychodynamic therapist views resistance as an essential component of treatment that needs to be understood and attended to. The psychodynamic model has developed and changed over the years, but earlier models placed a lot of emphasis on intra-psychoic and drive models (Levenson, 2010). In these models, the *ego* is said to moderate conflicts between the unbounded expression of basic sexual and aggressive drives of the *id*, on the one hand, and the internalised societal constraints of the *superego* on the other. This redirection of *id* impulses is seen as a defence in service of the *ego*, which may happen unconsciously (or out of awareness), and which is important to understand in order to remove impediments (resistance) to therapy (Leahy, 2001). Leahy delineates that client's defences—such as denial, repression, isolation, and intellectualisation—are unlikely to represent the actual problem, but is enacted to prevent the client from the emergence of inner conflicts, which could be overwhelming.

More recently, psychodynamic models have become less intra-psychoic and more interpersonal/relational in both their theorising and practise (Levenson, 2010). Strupp (1980)

noted the poor treatment outcomes achieved with many resistant clients, and the difficulties of developing a working relationship with these people. Strupp outlined that the difficult styles that some resistant clients brought to therapy often provoked therapists into reacting in a negative manner (e.g., with hostility, disrespect, confusion), and this negatively affected the therapy dynamic and outcome. Levenson (2010) describes the efforts made by Strupp and others to develop strategies which enable therapists to develop empathy and maintain a personal equilibrium when working with challenging clients. Wachtel (1993) suggests that therapist communications generally involve both an overt focal message, as well as a meta-message, which represents an attitude about what is being conveyed in the focal message. The author suggests this attitude can often be responsible for client resistance, and notes the importance of recognising that a client is often in conflict. He suggests therapists need to see the world through the client's eyes, to gain an understanding of the adaptive aspects of the clients troubling actions, and to walk a fine line between communicating acceptance and promoting change. He emphasises that by understanding that the client is in conflict, the therapist can respond more effectively to the client's dilemma regarding change and maintaining status quo. This view is supported by Bromberg (1998, p. 206) who suggests "resistance can be usefully reframed as part of an enacted dialectical process of meaning construction, rather than an archaeological barrier preventing the surfacing of disavowed reality" (p. 206). He puts forward the idea that change is resisted to protect a stable and unitary self. Leahy notes the commonalities between the psychodynamic conceptualisation of resistance and the schema-focused cognitive therapy model (Beck et al., 1990; Young, 1990).

The psychodynamic approaches used to deal with resistance vary, and some have been outlined above, but they generally include: interpreting defences, focusing on how the patient's transference interferes with treatment, engaging in corrective "re-parenting", and providing a corrective emotional experience through empathic reflection and relating (Leahy, 2001). Therapist empathy and the therapeutic alliance are seen as critical to therapeutic intervention (Levenson, 2010).

Psychodynamic Approaches in Offending Populations

Cordess (2002) outlines a psychodynamic view of motivation and resistance within offending populations, and notes that most offenders will have some leaning towards preserving the status quo, which also preserves a person's current identity. The author questions the increasing tendency of rehabilitation to be crime centred rather than client centred, with an offence not being seen so much as a manifestation of underlying issues, but rather as the central issue itself. The author notes that therapy which does not have the client's interests at its heart risks sabotaging the therapeutic relationship, having the offender be mistrustful and continually on

guard (resistant), thus limiting efficacy of treatments. Cordess outlines the fragility of the therapeutic alliance when working with this population and the importance of establishing and maintaining the alliance. He points out a number of factors which can enhance or endanger the formation of a therapeutic alliance. These include the willingness of the therapist to spend time getting to know the offender, and to enable the offender to be truly heard and listened to. Cordess also notes that offenders can produce unconscious reactions in a therapist (countertransference), and the importance of therapists recognising these states, and dealing with them appropriately.

A Cognitive Behavioural View of Motivation and Resistance

Engle and Arkowitz (2006) note the difficulty finding research literature in CBT which refers to resistance or non-compliance. Leahy (2001) outlines that, within a CBT framework, resistant behaviours have generally been viewed as based on maladaptive beliefs, assumptions, and schemas. Leahy suggests that the sometimes negative view by CBT of the psychoanalytic approach to resistance is only partially justified, and that many experienced therapists regularly utilise psychoanalytic/psychodynamic concepts such as resistance in practise, even if they may use different jargon - such as “non-compliance” or “motivation”. Leahy suggested there is a growing awareness that CBT needs to adapt to address clients’ impediments to change.

The underlying concept of CBT is that our thoughts and interpretations of events primarily determine our emotional reactions and behaviours. Engle and Arkowitz (2006) point out that more recent formulations of CBT have extended thinking beyond thoughts, beliefs and attitudes to include cognitive structures labelled “schemas” (A. T. Beck, Freeman, & Davis, 2003; Young, Klosko, & Weishaar, 2006). Schemas are said to reside in long-term memory, to code and evaluate external stimuli, and to be used to categorise and interpret experiences in a meaningful way. They are also believed to involve emotional components and action tendencies (Barlow, 2002). Beck, Freeman, et al. suggest that when a therapist tries to attend to these schemas the client can react by using coping styles of avoidance or compensation, which can lead to resistance in therapy. Recent descriptions of CBT place an increasing and more explicit focus on the concept of the therapeutic relationship, and highlight the need to address ruptures in the therapeutic alliance (Westbrook, Kennerley, & Kirk, 2011). Cognitive behavioural therapists are also increasingly drawing on ideas from motivational interviewing to conceptualise and address issues of client resistance and motivation (Hal Arkowitz, Miller, et al., 2008; Westbrook et al., 2011).

Self Determination Theory

Ryan and Deci (2000) have delineated a theory of motivation, called self-determination theory (SDT), which recognises the multiplicity of the construct, and the fact that people can be motivated toward behaviours by a wide range of different factors. Ryan, Lynch, Vansteenkiste, and Deci (2011) point out that many clients have mixed motivation, and that a key skill in psychotherapy is attending to a client's motivation and resistance over the short and long term. SDT recognises that humans have a natural propensity toward self-organisation, growth, integration of the self, and resolution of psychological inconsistency (Ryan & Deci, 2000). The two core principles of SDT, *psychological needs* and the *continuum of relative autonomy*, will now be briefly detailed.

Innate Psychological Needs

Ryan and Deci (2000) emphasise that psychological needs and the psychological value of goals have been largely ignored. SDT posits the existence of three innate psychological needs—*competence, relatedness, and autonomy*—and suggests these are critical for understanding the content (what is being pursued) and process (why it is being pursued) of goals that are pursued. The authors propose that an individual's motives or goals need to be directly linked to these three core innate needs in order for there to be an enhancement of growth and well-being.

A Continuum of Relative-Autonomy

Another important concept within SDT is that of the self-determination continuum (Deci & Ryan, 2000; Ryan, Lynch, Vansteenkiste, & Deci, 2011). This classification scheme provides a framework for conceptualising both the type of motivation (extrinsic motivation and intrinsic motivation), as well as whether the behaviour is externally regulated or internally regulated (self-determined). Intrinsic motivation is said to exist when individuals undertake an activity because the activity is intrinsically rewarding and has inherent value for them. These activities are also intrinsically regulated, and have an internal locus of causality. Extrinsically motivated behaviours, in contrast, vary to the degree in which their regulation is autonomous (self-regulated). In line with this, extrinsic motivation features four sub-categories of regulation, each with their respective perceived locus of causality (marked in brackets): external regulation (external), introjected regulation (somewhat external), identified regulation (somewhat internal), and integrated regulation (internal regulation). SDT therefore takes the view that non-intrinsically motivated behaviours vary in the degree that they are autonomous. For example, a student may not find homework activity inherently enjoyable, and this behaviour would therefore not be intrinsically motivated behaviour. However, they could vary in the degree that the behaviour is autonomously regulated. If they were undertaking the activity simply because

their parents insisted, then this would be considered extrinsic motivation which is externally regulated. If they were undertaking their homework because they felt it was important in order to reach a desired career, then this would still be extrinsically motivated behaviour, but with a personal endorsement. In other words, extrinsically motivated behaviours can differ with regards to their relative autonomy.

There is now considerable research supporting the view that activities that are intrinsically motivated, or more autonomously regulated, are more stable. Ryan et al. delineate the importance of motivation to initially engage in therapy, to maintain that engagement, and to ensure motivation continues once therapy has finished. With regards to psychotherapy, evidence suggests that motivation for change nearer the autonomous end of the continuum resulted in greater levels of treatment adherence and long term enduring change (Markland, Ryan, Tobin, & Rollnick, 2005).

Self-Determination Theory and Client Resistance

Ryan and Deci (2011) point out that many clients display some amount of resistance to change, and that being able to deal with low motivation or resistance by clients is an important skill for therapists to have. The authors also note that most environments where therapists work, as well as the therapists themselves, will have quite strong expectations for client's to change, and these parties may have considerable investment in client outcomes. The authors note the tension between these therapist and environmental expectations and the idea of supporting a client's autonomy, and highlight that therapists need to be aware of their own motives within therapy. The authors of SDT outline three core features of autonomy support as being: the person in the one-up position (therapist) taking and acknowledging the perspective of the client; the providing of as much choice as possible for a client; and the provision of a meaningful rationale for situations where it is not possible to provide choices to a client.

Self-Determination Theory and Motivational Interviewing

A number of authors (Markland et al., 2005; Vansteenkiste & Sheldon, 2006) have suggested that there would be benefit in integrating SDT and motivational interviewing. Vansteenkiste and Sheldon suggest that MI—which will be discussed on more detail in the coming sections—utilises many techniques which are consistent with SDT's concepts of autonomy support. The authors suggest that SDT may provide a stronger conceptual framework to help understand some of the mechanisms through which MI enhances positive motivation. Specifically, the researchers suggest it is unlikely that MI works by enhancing intrinsic motivation to change, because there is little inherent enjoyment in changing problematic behaviours. Rather, they suggest that MI may work by promoting integrated or identified motivation for change. In other

words, MI may promote relatively greater internal regulation of extrinsically motivated behaviour. The authors also suggest that supporting a client's autonomy may reduce the chance of resistance by reducing the client's perception of a difference in power in the therapeutic relationship, and lessen the feel that the therapist is the expert who is there to control the proceedings.

The importance of considering concepts outlined by SDT when working with offenders has also been noted (McMurrin, Sellen, Campbell, Cox, & Klinger, 2011), with emphasis given to supporting autonomy and encouraging the internalisation of extrinsic motivation in order to achieve better and longer lasting therapeutic outcomes.

Integrated and Synthesised Models of Resistance

Two contemporary and integrated understandings of resistance have been put forward by Leahy (2001) and Engle and Arkowitz (2006).

Leahy outlined an integrative model of resistance, and suggests a view of resistance as "a contextual construct in that it refers to how a patient does not comply with a specific role defined by the therapist" (p. 21). The author outlines the importance of understanding the client's resistance, and what is being required of the client in this context that is contributing to the resistance. The integrated approach is firmly founded in cognitive behavioural theory, but also draws components from psychoanalytic and other frameworks. The author outlines a number of dimensions of resistance (validation resistance, self-consistency, moral resistance, victim resistance, risk aversion, and self-handicapping), which cross various theoretical stances. A final dimension is resistance arising due to the reaction of a therapist to the client (countertransference). Leahy suggests each of these dimensions of resistance is a fairly self-contained style of thinking, with its own rules and logic that a therapist needs to understand and attend to. He emphasises understanding the client's resistance to therapy, and what a client believes they may be giving up if they abandon their "resistant" position.

Engle and Arkowitz (2006) reviewed a range of approaches to resistance and have offered a synthesis of key points. They suggest that resistance is related to change, and outline a range of reasons resistance can occur including: therapist deficiencies; problems in the therapeutic relationship; ambivalence or internal conflict between aspects of the self; to reduce the motivational state of reactance; anxiety reduction through avoidance of painful thoughts or feelings; and because the status quo provides security and consistency of the self. The authors take the view that resistance is generally better framed as resistant ambivalence, where change is both desired and undesired, and with both stances having understandable reasons. They describe their model as primarily reflecting that "resistant ambivalence derives from

discrepancies among self-schemas relevant to change” (2006, p. 52). The authors emphasise that ambivalence provides important information and needs to be explored and understood from the client’s perspective, in an empathic and supportive environment, and that a client may well be unaware of their schemas and the discrepancy between them. The authors delineate that resistance should be seen as a state, rather than a trait, and is often associated with an attempt to maintain the status quo and reduce uncontrollability.

Engle and Arkowitz (2008) also note that therapists can be tempted to persuade or even force clients to change when a desired therapeutic outcome is not being achieved. They point out that this approach by therapists can evoke strong reactance by a client and further reduce the likelihood of achieving the change desired by the therapist. The authors suggest therapists need to be wary of pushing for change, and focus on understanding and resolving factors contributing to the resistance seen in the client. The authors therefore take the stance that resistance is both an intrapersonal and interpersonal phenomena. Intrapersonal resistance is seen as reflecting discrepancies amongst self-schemas relevant to change. Interpersonal resistance is seen as reflecting the fact that resistance occurs in the interpersonal interactions between a therapist and client, where both transference and countertransference play pivotal roles.

The authors draw on knowledge from within gestalt therapy’s two-chair work and MI to suggest that an empathic and supportive approach by a therapist is likely to be more effective in dealing with resistance than an overtly directive style.

Reactance

Reactance (Brehm & Brehm, 1981) is a social psychological theory with a solid body of research associated with it. Although it is not specifically a theory of resistance and is not aligned with a therapeutic approach, it has been noted that the theory has a great deal to offer in understanding and dealing with resistance (Engle & Arkowitz, 2006). Brehm (1966) introduced the concept of “free behaviours”: activities a person can undertake now or in the future.

Psychological reactance is said to be experienced when either another person, or the person themselves, limits or eliminates these free behaviours. Reactance arousal is thought to be a motivational state where a person is driven to restore access to a free behaviour that has in some way had restrictions imposed on it. This can manifest in a range of behaviours, and commonly includes non-compliance or oppositional behaviour. Brehm and Brehm point out that there is a complex relationship between the strength and importance of a freedom, and the level of threat to that freedom, involved in determining the final level of reactance elicited to the restricted freedom.

Engle and Arkowitz (2006) note there is high quality research suggesting compliance is less likely to occur when people are given strong directives than when requests are communicated in a non-authoritarian manner. Thus reactance may be a specific form of resistance which is important to consider, especially in relation to therapist activities which may act to limit or control the behaviour of clients.

Summary of Differing Psychological Models of Resistance

In summary, there appears to be a need for more clearly articulated conceptualisation of resistance within CBT, as well as clearly established practise principles for dealing with resistance. Across the various models discussed above, there were a number of common themes which came through. There is a general consensus that resistance is not just to be considered as an intrapersonal issue existing within a client, but that resistance takes place within the context of a therapy session, and needs also to be recognised as the product of an interpersonal dynamic between a therapist and client. It is emphasised that resistance needs to be recognised, understood, and dealt with in order to maximise treatment outcomes. Therapists also need to be aware that intrapersonal resistance also occurs for a reason——such as protecting ones identity or maintaining stability——and need to be wary of a forcing or pushing a client towards change. The therapist also needs to be able to see the possible role they may play when resistance arises, recognise and deal with any countertransference, maintain a personal equilibrium, use an empathic and supportive style, understand the world through the client's eyes, support the client's autonomy, help develop intrinsic motivation rather than imposing external motivators, and be sure to maintain a good therapeutic alliance.

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CHAPTER 3: MOTIVATIONAL INTERVIEWING

Motivational interviewing (MI; Miller & Rollnick, 1992, 2002, 2012) was initially developed as a treatment for problem drinking. The MI approach is somewhat unique amongst the spectrum of psychological theoretical models and interventions, in that it is not focused so much on implementing change, as it is on resolving ambivalence about change in order to facilitate positive behaviour change. Miller and Rollnick (2012) delineate that the intervention style emerged from a number of key insights Miller gained during his research and practise from 1978 to 1985. His research in populations of problem drinkers showed that the counsellor to whom a client was assigned was by far the largest predictor of the client's outcome. Client drinking behaviour at a 12 month follow-up could be predicted by in session client resistance. Furthermore, empathic listening by a counsellor predicted 67% of the drinking outcomes for these clients at 6 months, and accurate empathy was still predictive of client outcome at a 1 and 2 year follow-up. Further research validated these findings, and showed that the clients of therapists with low client-centred skills had up to four times the relapse rates of clients assigned to highly skilled counsellors. Miller (Miller & Rollnick, 2012) describes that over the following years, whilst lecturing on cognitive behavioural methods for dealing with addiction, his students encouraged him to more explicitly delineate what it was about his own therapeutic style that enabled client change. Miller suggests that his reflections produced two insights: the first was the way he responded to client resistance, which he notes was generally through the use of reflective listening; the second insight was that he tended to arrange his conversations with clients so that they, rather than he, argued for change. These two concepts remain core to the most recent conceptualisations of MI today. The centrality of client resistance in the approach is also evidenced in the latest definition of MI (although resistance is referred to as ambivalence), "a person-centred counselling style for addressing the common problem of ambivalence about change" (p. 21).

In the time since Miller's initial insights, there have been over 1,200 publications from within an MI framework, which include over 200 randomised clinical trials (Miller & Rollnick, 2012), across a wide range of client populations and problem types, and there has been significant uptake of the therapeutic style by practitioners (Hal Arkowitz, 2009).

What is Motivational Interviewing?

MI has developed and changed over the past three decades, as is reflected in the three quite different books the authors have released (Miller & Rollnick, 1992, 2002, 2012). In the most recent edition the authors offer both a practitioner's definition of MI—"Motivational

interviewing is a person-centred counselling style for addressing the common problem of ambivalence about change”, as well as a technical definition— “*Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal, by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion*” (p. 29). These definitions reflect the idea that therapists in MI focus on facilitating the client’s self-generated talk about change, rather than trying to directly persuade a person to change (Moyers & Rollnick, 2002). Within MI, ambivalence about change is seen as the “symptom” suggesting the use of MI is indicated, rather than the use of a more action oriented therapeutic model. The therapeutic style of MI is firmly based in the principles of Rogers (1957), but is also somewhat directional in the sense that therapists have goals for client of achieving positive behaviour change in a particular direction. In the coming sections, some of the key broad concepts underpinning MI will be discussed including: the two key components of MI (the Spirit of MI, and the Methods of MI); how resistance is conceptualised in MI, and how resistance is dealt with.

Motivational Interviewing Spirit

The Spirit of MI reflects its basic relational stance, and has changed considerably over the three releases of the author’s books. In the most recent conceptualisation of MI (Miller & Rollnick, 2012), there are four components of MI Spirit: *partnership, acceptance, compassion, and evocation*. Acceptance is further broken down into four elements: *absolute worth, affirmation, autonomy support, and accurate empathy*. As can be seen, many of these concepts are not unique to MI: Collaboration (partnership) has been widely researched within the therapeutic relationship/alliance (Norcross, 2011); autonomy is a central concept within self-determination theory (SDT; Ryan, Lynch, Vansteenkiste, & Deci, 2011); and acceptance and accurate empathy are well-known concepts within client-centred therapeutic models. Each element of MI's spirit will now be briefly described.

The concept of partnership reflects the idea that MI is not something that is done to a person, but is rather an act of collaboration between two people, both of them bringing significant expertise to the table. The authors note that this precludes a therapist from taking an expert and authoritarian stance (getting stuck in the “expert trap”), where the therapist's own agenda is imposed, and where the righting reflex is a regular feature.

The acceptance component of MI spirit contains four parts (absolute worth, accurate empathy, autonomy support, and affirmation), all of which aim to manifest an attitude of deep acceptance for the client as a person, although this is highlighted as not requiring acceptance of the status

quo with regards to the client's behaviours. Accurate empathy is another well-known Rogerian concept (Rogers, 1965; Truax & Carkhuff, 1967), and represents an active interest and effort to understand the client's perspective, and to sense their personal meanings. It is noted that the opposite of this stance would be for the therapist to impose their own perspective. Autonomy support is at least partially derived from Ryan and Deci's (2000) self-determination theory (previously outlined above, under the various conceptual models of motivation and resistance), and involves honouring and acknowledging that clients have both the capacity and right to determine the direction of their lives. The authors note the link between self-determination theory and reactance theory, in that a therapist's move to restrict this freedom is likely to result in defensiveness and reactance by the client. The third component of MI Spirit is compassion: the active concern for the welfare and best interest of others. The fourth and final component of MI Spirit is evocation, where the client is understood to have the wisdom and coping skills needed to make changes, and the role of the therapist is to draw these out and understand the client's perspective. Evocation also aligns with the idea of ambivalence, in that clients are seen as already having arguments both for and against change within themselves, and the role of the therapist therefore becomes the eliciting and strengthening of the client's pre-existing internal motivation for change.

Motivational Interviewing Methods

Miller and Rollnick (2012) delineate that the MI Methods consist of four core processes (*engaging, focusing, evoking, and planning*) which are delivered using four core communication skills (*asking open questions, affirming, reflective listening, and summarising*). The four processes embody the actual progression that clinicians encounter, and recognise the overlapping nature of these. It is important to note that many of the MI Methods are not specific to MI, and the use of these techniques is not in itself MI (Hal Arkowitz, Miller, et al., 2008). Miller and Rollnick (1992, 2002, 2012) explain that the use of MI Methods without the incorporating the Spirit of MI is not truly MI, but instead becomes more of a cynical trick used to try and manipulate someone.

Client Resistance and Dysfunctional Conversations about Change

Miller and Rollnick (2012) point out that many of the conversations which helping professionals have with clients are about change, whether it be changes in lifestyle, behaviour, thinking or other. They highlight that when helping professionals venture into the world of a client's motivation for change, these conversations can often end up being quite dysfunctional, even though therapist's actions are sincerely motivated, and that MI is in part targeted at rectifying

this. Within MI, resistance has been conceptualised not so much as an intrapersonal trait within a client, but rather as the outcome of an interpersonal interaction between a client and therapist (Moyers & Rollnick, 2002). Moyers and Rollnick suggest that a client's resistance in therapy is the outcome of a process that can be likened to a multiplication equation (client resistance x therapist response), where the client comes to a therapeutic session with an initial level of resistance, but it is the therapist's response to the client's initial resistance that determines the final level of client resistance. Responses to client resistance such as confronting a client, arguing, or persuading are labelled therapist counter-resistance. Moyers and Rollnick draw on the theory of reactance (Brehm & Brehm, 1981) to help explain the client's reaction to the therapist, suggesting the client's response is a reaction to a perceived loss of choice or freedom, which has been imposed by the therapist.

More recent conceptualisations of MI have slightly refined the concept of resistance (Miller & Rollnick, 2012), and suggest that it is a broader concept consisting of two sub-categories: *sustain talk* (based upon *ambivalence*), and *discord* in the relationship. Ambivalence is said to exist when a person has competing motivations both for and against change, which are voiced through change talk or sustain talk respectively. Sustain talk represents talk by the client in favour of maintaining the status quo (i.e., resistance to change), and is the opposite of change talk, which is a client's self-expressed argument for change. Miller and Rollnick emphasise that within psychology much of what is referred to as resistance is actually just one side of a person's ambivalence about change (sustain talk), and that this ambivalence is a very normal part of most people's lives, rather than being a pathological phenomenon within a person. The researchers highlight the fact that when the concept of sustain talk is removed from the broader concept of resistance, what one is left with is *discord*. Discord is described as a disharmony in the therapeutic relationship, or a breakdown in the working alliance, as indicated by resistance or lack of engagement within a session. This may be manifested by the therapist and client not being on the same page, arguing, talking at cross-purposes etc. It is highlighted that this has parallels to the idea of ruptures in the working alliance (Safran, Crocker, McMain, & Murray, 1990). There is no clear dividing line between sustain talk and discord, but sustain talk is not seen as necessarily signalling that discord exists. Rather, the authors point out that whether discord develops can often depend on how a therapist responds to sustain talk. The authors suggest that well-intentioned therapists can sometimes unwittingly engage in a directive therapeutic style, motivated by a strong desire to set right that which is supposedly "wrong with a person". They refer to this tendency as the *righting reflex*, and emphasise that this reflex is particularly detrimental when it comes into contact with ambivalence. The authors suggest that clients generally have an understanding of the arguments both for and against change, and metaphorically describe this as having two committees in one's head, one that argues for change and one that argues against it (reflecting ambivalence). When an ambivalent client encounters a

therapist with the righting reflex, who takes the position of the committee for change, the natural response for the client is to offer the counter argument (sustain talk), often in the form of “yes...but”. This can further trigger the righting reflex of the therapist, in the form of trying to persuade or convince the client of the need for change, and the beginning of an argument is created.

A related concept underlying MI’s conceptualisation of functional conversations about change is how directive a therapist is. The authors suggest that therapist interactional styles could be seen as existing on a continuum, with *directing* at one end, *following* at the other, and a *guiding* style positioned in the middle. A directive style is seen as implicitly communicating that the therapist knows what is best, and the process often includes the providing of advice and instructions. At the extreme of this directive style is the therapist style of confronting a person with the therapist’s view of reality, and when this is met with resistance from a client, amplifying the forcing and persuading approach. Related to this is the importance of differentiating confrontation as a therapeutic goal (helping clients come face to face with their present situation, reflect on it, and decide what to do about it) as opposed to an aggressive counselling method/style (White & Miller, 2007). White and Miller note that confrontation, as a goal, is best achieved within an empathic, supportive and non-judgemental therapeutic relationship. In contrast to a directive style, a following style involves greater amounts of listening and understanding, implicitly communicating that the client has the wisdom to make the best decisions, with the therapist taking the role of supporting them while they find their own way. Miller and Rollnick suggest MI sits in between these two styles of directing and following, and could be considered a guiding style, which involves both listening and supporting, and the providing of information where necessary. The authors note a number of verbs which they associate with a directing style: authorise, command, determine, lead, manage, and tell. They contrast these to a range of verbs they associate with a guiding style: assist, awaken, collaborate, elicit, inspire, motivate, support.

Moyers and Rollnick (2002) have suggested there are two categories of responses that have been useful in responding to client resistance: reflective and strategic. Reflective responses include a number of variations on reflective listening, with the goal of decreasing the power struggle. Strategic responses suggested by the authors include: supporting a client's autonomy; and ensuring the existence of an egalitarian client therapist relationship. The authors emphasise the problems that can occur when the therapist has an investment in a specific therapeutic outcome, and the inevitability of client resistance when this agenda is pursued. They also draw attention to the critical fact that the above categories of response to client resistance cannot be competently undertaken without the egalitarian Spirit of MI.

Listening, Not Listening, and Client Resistance

It is clear that a therapist's listening skills are seen as central to MI, as illustrated by their inclusion in both the MI Spirit (e.g., accurate-empathy) and MI Methods (e.g., reflective listening). This is in line with Miller's original insights (Miller & Rollnick, 2012), where he hypothesised reflective listening as being a key skill in dealing with client resistance. The contribution of these skills to the efficacy of MI has also been established and will be outlined in the coming sections. It is to a discussion of these listening skills that this review now turns, with a particular focus on how poor listening skills may be related to client resistance.

Miller and Rollnick (2012) strongly emphasise the importance of listening in order to competently practise MI, and explain that the particular listening skill most emphasised in MI is that of reflective listening (also called "accurate empathy" (Gordon, 1970) or "active listening" (Rogers, 1965)). Miller and Rollnick describe reflective listening as including both hearing and responding to a client's message and note that it is just as important to consider what good reflective listening is, as what it is not. There are a number of qualities that represent skills congruent with good reflective listening. Firstly, reflective listening requires the therapist's conviction in the importance of a client's exploration of their own perspectives and experiences. Good listening skills enable this exploration by clients, especially in the face of emotionally challenging discussions. Secondly, good reflective listening skills include the giving of undivided attention (which is also a sign of respect). The therapist's attention is communicated both through appropriate eye contact, and through facial expressions which may mirror the client's emotional expression, and through silent listening. Thirdly, there is the importance of the reflective listening response, which is essentially a guess by the therapist as to the true meaning behind the clients talk. Miller and Rollnick suggest that human beings have a tendency to include the meaning of what they are trying to communicate through words that do not always accurately reflect that meaning. An accurate reflection, rather than a question, is thought to make it less likely that resistance is elicited from the client, and more likely that the client will continue with self-exploration.

The authors also outline a number of therapist responses which do not represent good reflective listening skills. These responses were first described by Gordon (1970) and are referred to as the "12 roadblocks" (Miller & Rollnick, 2012). Miller and Rollnick describe these roadblocks as being *self-centred* (*therapist-centred*) rather than client-centred, and as implicitly intimating that there is a one-up relationship where the therapist is the expert. These responses are called the *roadblocks*, because they divert clients away from their own self-exploration as they have to deal with the therapist's distracting response.

Table 1
Gordon's 12 Roadblocks to Good Listening

No.	Description
1	Ordering, directing, or commanding
2	Warning, cautioning, or threatening
3	Giving advice, making suggestions, or providing solutions
4	Persuading with logic, arguing, or lecturing
5	Telling people what they should do; moralizing
6	Disagreeing, judging, criticizing, or blaming
7	Agreeing, approving, or praising
8	Shaming, ridiculing, or labelling
9	Interpreting or analysing
10	Reassuring, sympathizing, or consoling
11	Questioning or probing
12	Withdrawing, distracting, humouring, or changing the subject

Note. Examples of Gordon's 12 roadblocks. Adapted from "*Motivational interviewing: Helping people change*", by W. R. Miller and S. Rollnick, (2012), New York, USA: Guilford Press.

In summary, reflective listening is suggested as a skill that can be used to encourage self-exploration and minimise resistance. It requires the use a response style that is congruent with reflective listening, as well as the avoidance of responses (roadblocks) that are incongruent with reflective listening.

Efficacy and Proposed Mechanisms of Motivational Interviewing

MI has received considerable research focus over the past 30 years, including over 200 randomised trials and a considerable number of meta-analyses and reviews. The most recent broad meta-analysis included 119 studies which were rated for study rigour (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). The researchers found MI to produce statistically significant and durable results in the small effect range when judged against weak comparison groups, and to be generally equivalent in effect size when judged against specific treatments.

Miller and Rollnick (2012) point out that there is clearly something happening in MI treatment that is frequently related to advantageous outcomes in comparison to no intervention or brief advice, or when used in addition to another therapeutic style. The authors offer some key insights into the research to date. Firstly, there is a great deal of variability in study outcomes

across different sites, studies, and clinicians. Even within well-controlled trials which adhere closely to a therapy manual, there are considerable differences in the efficacy of different therapists, and they suggest MI cannot be expected to be effective when delivered by clinicians with limited skills or training in the therapy style. They also propose that MI may be more effective in the context of systems that tend to use an authoritarian or confrontational style with clients, as has often been the case within addiction treatment contexts. The authors relate this concept to the finding of a considerably larger outcome with minority groups, and suggest that a compassionate and empathic approach by staff may not have been commonly experienced by this group of people. It is emphasised that the present state of the research provides solid evidence as to the efficacy of MI, but that there is still much to be learnt about the specific mechanisms through which MI works, and that very little research has investigated these mechanisms (Apodaca & Longabaugh, 2009; Aviram & Westra, 2011; Hettema, Steele, & Miller, 2005; Lundahl et al., 2010; Miller & Rose, 2009). However, Miller and Rollnick (2012) conclude that the current research points to at least three hypotheses. Firstly, they emphasise the importance of the clinician's empathy—part of the MI Spirit—as a likely mediator of the change process. Secondly, they suggest that the efficacy of MI may have a lot to do with what therapists do not do, and emphasise the importance of avoiding responses and behaviours inconsistent with MI which may create client defensiveness and sustain talk (resistance) (Miller & Rollnick, 2012; Moyers & Martin, 2006). Relatedly, Miller and Rollnick propose that training in MI may improve client treatment effects by suppressing counter-therapeutic responses by therapists. Thirdly, it is proposed that MI may work through strengthening client change talk.

Summary

MI as a therapeutic style which emerged from practice based insights and research suggesting that the therapists interpersonal style and in session client resistance were related, and that these factors were in turn related to therapeutic outcome. MI is focused on strengthening a person's internal motivation and commitment to specific goals, and aims to achieve this through therapeutic style which is both client centred and guiding (directional, rather than directive). MI promotes an atmosphere of acceptance and compassion, in which a person's own reasons for change can be elicited and explored. MI consists of two core components: MI spirit and MI methods. The spirit component recognises that MI is done for or with someone, not on or to them, and encourages an understanding of MI as evoking that which is already present, not installing what is missing. The four key components of MI spirit include: partnership, acceptance, compassion, and evocation. The method of MI features both the four underlying processes of MI (engaging, focusing, evoking, and planning), as well as the five core skills of MI (asking open questions, affirming, reflections, summarising, and where appropriate,

informing and advising). Although these five skills are fundamental to MI, it is the particular way in which they are used (the spirit of MI) that determines whether MI is actually being practised or not, and the use of the methods alone does not constitute proficient MI practice.

From an MI perspective, resistance is viewed as the outcome of an interpersonal dynamic between both the client and therapist. Client ambivalence towards change is viewed as a normal process, and their resistance is seen as often being a reaction towards a therapist's negative biased response to their ambivalence. Counter-resistant responses towards clients are seen as escalating the client's resistance. More recent formulations of client resistance have more clearly differentiated two aspects of resistance: sustain talk and discord in the relationship between clients and therapists. Sustain talk is suggested as an argument by a client for one side of their ambivalence (resistance to change), whereas discord is said to reflect disharmony in the therapeutic relationship or breakdown in the working alliance. A distinction is drawn between confronting a client as a goal and as a therapeutic style, and it is emphasised that an MI style falls between being a directive following style, and can be seen more as guiding and directional. This style is seen as supporting a client's autonomy, and refraining from persuading a client or chasing and pushing an agenda.

MI places great emphasis on listening to a client, on active listening skills, and on being clear about what behaviours both do, and do not, reflect the use of these skills. Roadblocks to good listening are highlighted as behaviours to avoid, many of which a more therapist-centred approach with the therapist as the expert, rather than an approach which has the client's worldview at centre stage.

MI has considerable research supporting the efficacy of the approach, and appears to be particularly effective in populations of minority groups, or within a system where clients are usually exposed to a confrontational and authoritative style. Although there are still questions as to the specific through which MI works, it appears that clinician empathy is critical to the process, as are approaches which reduce client defensiveness and sustain talk, and which strengthen client change talk.

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CHAPTER 4: RESEARCH INTO RESISTANCE

A range of authors have noted that despite the fact resistance has a long history in psychological literature, there has been a limited amount of research undertaken into this important concept (Aviram & Westra, 2011; Engle & Arkowitz, 2006; Apodaca & Longabaugh, 2009). In the following discussion the research undertaken from within a non-MI framework is investigated, followed by a discussion of the research into resistance from within an MI framework. The review highlights the role of client resistance in treatment outcome, and the therapist variables that have been investigated for their relationship to client resistance. Consideration is also given to the way these variables have been operationalised and studied.

Research from Non-motivational Interviewing Studies

The existing research supports a direct association between client resistance and poor therapeutic outcome (Beutler et al., 2011; Beutler, 2001). Beutler et al. undertook a meta-analytic review and found that therapy outcomes can be improved if a patient's pre-existing (trait-like) resistance levels are inversely matched to levels of therapist *directiveness*. The authors defined directiveness as: the extent to which the therapist takes the role of the primary agent of change—whether through their particular style or the specific techniques they use—and how dominant the therapist is in this stance. The authors offer a number of specific interventions which can be considered as high in therapist directiveness, including: instruction, interpretation, guidance, experiential procedures, as well as more confrontational therapeutic styles. The research undertaken by Karno, Beutler, and Harwood (2002) offers a good example of the type of study cited in this meta-analysis. Karno et al. investigated the interaction of therapist directiveness and client resistance on the outcome of therapy. Client reactance (also referred to in this study as anxious resistance) was measured in a pre-treatment assessment session. Therapist directiveness was measured using observer based measures to assign global ratings to 20 minute duration segments of video-recorded therapy sessions. Directiveness was operationalized as: confrontation of patients; therapist initiation of topics; and the extent to which therapists assumed a teacher-stance toward patients. Karno et al. found that clients who scored highly on reactance achieved better drinking outcomes with nondirective therapy, and patients scoring low on reactance showed greater improvement with directive therapy. Studies such as these provide evidence for relationships between broadly defined variables, such as therapist directiveness and client resistance. However, as the researchers point out, these types of studies do not unpack the specific processes that are occurring, and more research is needed which undertakes a fine-grained analysis of the moment to moment interactions between a client and therapist, in order to understand the influence therapists and clients have on each other. For

example, experiential procedures (Beutler et al., 2011) have sometimes been broadly labelled as directive, but these procedures can also be undertaken in a very client-centred non authoritarian manner. The need to consider these more specific questions is further highlighted by studies which show conflicting results to the meta-analysis by Beutler et al., as will now be outlined.

A number of studies have thrown into question the idea of there being a simple relationship between the broad idea of therapist directiveness, client resistance, and poor outcome. A large study undertaken by Arnow et al. (2003) found—contrary to the authors hypothesis—that matching client reactance to a directive therapeutic style positively predicted outcome. The study investigated cognitive behavioural analysis system of psychotherapy (CBASP; McCullough, 2000), which the authors note meets the criteria outlined by Beutler, Engle, et al. (1991) as a directive treatment, and includes a high degree of therapist direction, assigned homework, and use of behavioural strategies. The authors make a number of important observations from their findings. Firstly, the participants were suffering from chronic depression—a diagnosis often associated with a submissive interpersonal style—and the client’s reactance may have been a positive sign that clients’ interpersonal skills were increasing. Secondly, it may be that directive treatments can avoid problematic disturbances in the therapeutic relationship if therapists are aware of these when they arise, and deal with them in an appropriate manner. This calls into question what exactly is meant by “directive”, what specific aspects of therapist directiveness are related to both client resistance and poor outcome, and how generalisable particular findings are to different client populations.

A limited number of non-MI studies have investigated specific in-session therapist and client behaviours with regards to resistance. An early study into client resistance investigated a family intervention for socially aggressive children (Patterson & Forgatch, 1985). It was found that when therapists intervened by confronting and teaching during the training sessions, there was an increased chance of an immediately non-compliant (resistant) response by the client. In contrast, there was a reduced likelihood of non-compliance when therapists used supportive and facilitating approaches. This early research established a preliminary evidence base for the link between in-session therapist behaviours and client resistance, although the study has not yet been replicated in an adult population within the context of individual therapy sessions, nor within an offending population. Furthermore, within contemporary therapeutic practice there is a considerable emphasis on the therapeutic relationship, and intervention styles of confronting and teaching a client are seldom recommended (Westbrook et al., 2011). There would therefore be value in knowing what other specific therapeutic practices are likely to trigger client resistance, and would be contraindicated. Another outcome of the study by Patterson and Forgatch was the establishment of the usefulness of micro-coding therapy sessions.

A study by Bischoff and Tracey (1995), which also used micro-coding, found that there was sequential dependence of a client's response (resistant vs. cooperative) on prior therapist behaviour (directive vs. non directive). The authors also found that the inverse relationship did not exist, in other words, the therapist's response was not sequentially dependent on a client's prior behaviour. The authors note that these results may vary in different populations, and that certain client variables may influence a client's response to directive therapist processes. Furthermore, this study was somewhat unusual in that it investigated well known and researched videotaped therapy sessions that included only four clients (the well-known cases of "Gloria", "Kathy", "Richard", and "Kelly") who were each seen once by three different, and well known therapists (Pearls, Rogers, Ellis, Shostrom, Lazarus and Strupp). The study defined directive therapist behaviours as: teaching, structuring, confronting or challenging, questioning or information seeking, and interpreting or reframing. Although these studies provide evidence for the relationship between in-session directive therapist interventions and client resistance, the particular therapist interventions measured include a very wide range of responses, and the study cannot tell us which of these are more important than another. Nor do these studies tell us how these particular therapist variables interact with client resistance in any moment to cause problems within the therapy sessions. This more specific information is important because there have also been in-session process studies where a sequential analysis has shown that client resistance is not a function of therapist directiveness, providing considerable conflicting evidence regarding the specific nature and relationship of these variables (Watson & McMullen, 2005).

Watson and McMullen (2005) examined two therapeutic styles—cognitive behavioural therapy and process experiential therapy—and measured therapist directiveness, client resistance, therapist alliance, and treatment outcome. The Client Resistance Code (CRC; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984) was used to code client resistance, and the Therapist Behaviour Code—Revised (TBC-R; Bischoff & Tracey, 1995) was used to measure therapist directiveness. Therapist directive behaviour was defined as: a) any statement that leads, directs, or controls the verbal activity of therapy or b) any statement that challenges or confronts the client. The TBC-R consists of five mutually exclusive directive categories including teach, structure, directive questions, confront, and directive interpretation. The results did not support the idea that client resistance is sequentially dependent on preceding directive therapist behaviours. Furthermore, resistance was found to be distinctly lower in sessions where the therapeutic alliance was high, but there was no difference in directiveness between high and low alliance sessions. Watson and McMullen suggest there may be other mediating variables which determine a client's response to directive or non-directive interventions. The researchers propose that directive therapist interventions may not in themselves be the factors damaging a therapeutic alliance, but rather the manner in which the interventions are undertaken, a proposal

supported by other researchers (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Moyers, Miller, & Hendrickson, 2005). Watson and McMullen suggest that a fruitful area for research may be the differentiation of resistance as an expression of a client's autonomy as opposed to an attempt to obstruct the therapy process. They further recommend the use of qualitative research methodologies to specifically investigate the interpersonal dynamics between a client and therapist when resistance occurs.

Other studies, although not directly measuring resistance, have found poor treatment outcomes to be associated with negative interpersonal processes (Henry, Schacht, & Strupp, 1986, 1990). The study by Henry et al. (1986) showed that in good outcome cases, therapists exhibited significantly more affiliated autonomy granting (affirming and understanding), and less blaming and belittling, and clients exhibited significantly less hostile separation behaviour.

Research from within a Motivational Interviewing Framework

Studies Investigating Client Resistance

A number of authors have pointed out that although resistance is a central concept in MI, there has been very little research into the phenomenon from within this framework (Apodaca & Longabaugh, 2009; Aviram & Westra, 2011; Westra, 2011). Apodaca and Longabaugh recently reviewed and evaluated the evidence for various hypothesised mechanisms of change in MI. The authors noted the centrality of resistance to this model, but found only one MI study (Miller, Benefield, & Tonigan, 1993) which had included client resistance. However, as will be discussed further on, a number of MI studies have investigated more narrowly defined aspects of resistance (sustain talk). The early study by Miller et al. found that a more directive therapist style was correlated with greater levels of resistant type behaviour, and that confrontational therapist behaviours predicted client drinking outcomes in a 12 month follow-up. They also found client resistance to be a potent predictor of long term drinking changes. However, the directive therapist styles in this study (e.g., confronting client resistance by emphasizing the evidence of alcohol problems, and disputing client problem minimization) have been noted as comparatively extreme (Catley et al., 2006). When these therapist behaviours are compared to other “directive” therapist behaviours—e.g., teaching, structuring, and directive questions—the diversity of therapist interventions studied under the rubric of “therapist directiveness” is highlighted. This calls attention to the importance of specificity when investigating therapist activities related to client resistance.

There appears to be only two studies (Aviram & Westra, 2011; Westra, 2011) investigating resistance within an MI context since the early research by Miller et al. (1993). Both of these

studies accessed data from a larger randomized controlled trial investigating the efficacy of a pre-treatment MI intervention—in comparison to no pre-treatment—prior to CBT, for a population with generalised anxiety disorder (Westra, Arkowitz, & Dozois, 2009). Westra (2011) found that client resistance differentiated those who had received MI as a pre-treatment, and suggest that the lower rates of observed resistance may have resulted from the skilled use of MI within the preliminary MI intervention. However, the authors note that the study does not provide data regarding the specific therapist behaviours which influenced client resistance. Aviram and Westra (2011) showed that receiving MI prior to CBT improved treatment outcomes for clients with generalized anxiety by reducing client resistance and increasing client engagement with treatment. The authors suggest that MI may increase treatment engagement and enhance outcome through the reduction of a client's resistance to change and to engage with treatment. They recommended further research should be undertaken to understand the specific MI mechanisms leading to decreased resistance, highlighting the principle of rolling with resistance as an important target, and the need for researchers to use in-session process measures. The Aviram and Westra study measured in-session client resistance using the Client Resistance Code (CRC; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984), and the researchers suggest that measuring observer-based resistance may be a more fruitful task than measuring self-reported client motivation.

Studies Investigating Sustain Talk

Although only three MI studies (outlined above) could be found which specifically examined client resistance, there are a number of MI studies which have investigated the concept of *counter change talk* (herein referred to as *sustain talk*), which has been recognised as a subset of resistance (Miller & Rollnick, 2012). MI places great importance on the concept of client language, which has consistently been shown to predict outcomes in MI (Gaume, Gmel, & Daeppen, 2007; Martin, Christopher, Houck, & Moyers, 2011; Moyers & Martin, 2006). As previously alluded to in the review of MI, the language of client change talk can be either towards or away from change, and is respectively labelled change talk and sustain talk. Sustain talk is defined as a client's own arguments against changing. A number of studies have undertaken detailed analyses of in-session client and therapist behaviours with regards to sustain talk. Some studies have found that therapist behaviours which are inconsistent with the methods of MI—i.e., those that: advise without permission, confront, direct, raise concern without permission, and warn—were significantly more likely to precede client sustain talk than therapist behaviours which are consistent with the methods of MI (Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2010; Moyers et al., 2007). Furthermore, sustain talk has been found to be self-reinforcing, and statistically more likely to be followed by further sustain talk (Gaume et al., 2010). Some MI studies have also looked at the relationship between in session therapist

behaviours and client engagement (which could be seen as an opposing concept to resistance). For example, Boardman, Catley, Grobe, Little, and Ahluwalia (2006) found that negative therapist behaviours such as confrontation produced very negative effects on client engagement and the therapeutic alliance, even in a context where there were high levels of MI-consistent behaviours.

However, other MI studies have not found this link between MI-inconsistent behaviours and sustain talk by clients (Catley et al., 2006; Gaume, Gmel, Faouzi, & Daeppen, 2008; Moyers, Martin, Houck, & Tonigan, 2009; Moyers et al., 2005), and these researchers have highlighted a number of areas that remain to be investigated in order to better understand these discrepancies. Firstly, Gaume, Bertholet, Faouzi, Gmel, and Daeppen (2010) point out that little is known about the specific MI-inconsistent behaviours that lead to less change talk and more sustain talk. Related to this is the fact that MI-inconsistent behaviours are not always followed by sustain talk. For example, Moyers et al. (2007) found that MI-inconsistent behaviours were followed by sustain talk 9% of the time, which raises the question of what exactly happened on these particular occasions that did not happen on the other 81% of occasions. Gaume, Gmel, Faouzi, and Daeppen (2008) suggest it may be the combination of specific MI-inconsistent therapist behaviours (e.g., confrontation) along with the overall gestalt and MI attitude of the session that contributes to the final outcome of treatment. Related to these findings, is a study which found that when MI training leads to modest increases in MI-consistent therapist responses but no decrease in MI-inconsistent behaviours, there is no additional benefit for client outcomes. In interpreting these findings Miller and Rollnick (2012) suggest even a minimal amount of MI-inconsistent behaviour by a therapist can evoke resistance in clients and thereby limit positive behaviour change.

Secondly, a number of studies suggest that the manner in which therapists implement the MI methods (both MI-consistent and MI-inconsistent) may be more important than the specific behaviours themselves (Moyers et al., 2007, 2009, 2005), and that a therapist's interpersonal skills and empathy may be more important than the specific methods utilised. Supporting this suggestion is the finding that MI-inconsistent behaviours are not always negative, and may actually enhance client engagement if they are utilised within a context of appropriate interpersonal skills (Moyers et al., 2005). Moyers et al. emphasise that the use of MI skills must be delivered with a deep understanding of, and in congruence with MI Spirit (i.e. therapist interpersonal skills). However, studies have not yet investigated the specific details of how these interactions unfold within therapy sessions. In line with this, the authors suggest research is needed to clarify the interaction between directive therapist techniques—such as confronting and advising—and the interpersonal context where these techniques influence therapy in a positive or negative manner.

Thirdly, Gaume et al. (2008) note there have been very few studies that have investigated the possibility of the inverse relationship between a client and therapist, where sustain talk by a client elicits MI-inconsistent behaviours from therapists. The authors suggest this may set up a negative feedback loop where sustain talk elicits MI-inconsistent behaviours, and MI-inconsistent behaviours elicit sustain talk.

Finally, Catley et al. (2006) have suggested that the variance in findings with regards to MI-inconsistent therapist responses and client behaviours may be related to a number of factors. They point out that the study by Miller et al. (1993) featured a confrontational approach that the antithesis of MI, and that their own study relied on natural variation of therapists to an MI adherent approach. A further limitation to the current research base is that relational skills such as empathy are generally investigated for their relationship to change talk, as opposed to sustain talk. Miller and Rose (2009) have suggested that one pathway to the efficacy of MI may be that relational skills, such as therapist empathy, reduce sustain talk. However, most studies have investigated the relationship between therapist empathy and change talk, rather than sustain talk.

Measurement and Operationalisation of Resistance and Sustain Talk

It is also important to recognise the specific variables measured in the existing studies into resistance and sustain talk, and the way they have been operationalised. The instruments generally used to investigate sustain talk within MI are the Motivational Interviewing Skill Code (MISC; Miller, Moyers, Ernst & Amrhein, 2003) or the Sequential Code for Observing Process Exchanges (SCOPE) which is derived from the MISC. Both of these measures operationalise client resistance considerably more narrowly than measures such as the Client Resistance Code (CRC; Chamberlain et al., 1984). For example, the MISC and SCOPE measures both target the component of resistance referred to as ambivalence, rather than more general discord in the relationship. This means that client statements are only considered to be sustain talk when they are regarded to very specific target behaviours (e.g. talk about smoking or drinking), and negative behaviours towards a therapist/therapy are not included if they do not also make some reference towards the area of change being targeted by the intervention. These studies also raise the question of operationalisation and measurement of therapist interpersonal behaviours. Studies using the MISC or its derivative scales dominate MI process research, and these measures—like all scales—have their restrictions. Firstly, applying global ratings (as is done for therapist empathy in the MISC) to large segments of a therapy session runs the risk of missing important fluctuations in behaviour (Fiske, 1977; Gurman, 1973). Therapist variables such as empathy and autonomy support could potentially fluctuate throughout sessions in ways that are related to in-session client behaviours such as resistance, and global codes would miss these interactions. A second limitation with the MISC is that the three somewhat distinct

components of *MI Spirit*—*collaboration*, *evocation*, and *autonomy* (as at the second edition of MI; Miller & Rollnick, 2002)—are consolidated under the one variable called MI Spirit. Multi-item versions of MI Spirit have been better at predicting important outcome variables (Boardman et al., 2006). Thirdly, codes assigned to therapist behaviours at an utterance level (as opposed to global codes) are based on MI Methods previously described. A possible limitation here is that although the MI methods are meant to be used in the Spirit of MI, the use of these methods does not in any way mean a therapist is actually adhering to MI Spirit (Moyers et al., 2005). For example, although reflections are a core part of practising accurate empathy, a reflection does not mean accurate empathy can be assumed to actually be being practised competently. The coding of these utterances does not necessarily capture the true meaning of the utterance. In some ways this reflects the doubts Carl Rogers himself had about focusing on therapeutic technique (Rogers, 1980). Rogers noted his concern that non-directive therapy had somehow become strongly associated with the technique of simply reflecting a client's feelings back to them, rather than concentrating on listening to and understanding the client, and having an empathic attitude. There appears to be a gap of sorts in these measures, where the constructs so central to MI (e.g., MI Spirit) are not measured on a moment to moment basis. Only the techniques used as a way to achieve this MI Spirit are measured at this level, and the sacrifice that is made is the potential loss of meaning behind the utterance. Stiles, Honos-Webb, and Surko (1998) have detailed the importance of including researchers' evaluative judgements in order to capture the meaning and appropriateness of therapist responses.

Chamberlain, Patterson, Reid, Kavanagh, and Forgatch's (1984) study showed the importance of repeated measurement of in-session client resistance, and the authors suggest that future research should investigate therapist behaviours in a similar manner, alongside client resistance, in order to clarify possible therapist variables related to client resistance. A search of the literature revealed only one study which had gone down this track (Watson & McMullen, 2005), where the authors had investigated therapist directiveness, along with client resistance. This leaves a large number of therapist variables not investigated for their relationship to client resistance, within studies that take repeated measures of both therapist and client variables.

Motivational Interviewing in Offending Populations

With regards to offending populations, there appears to have been only one study investigating the process of MI (Austin, 2012). This study found that where therapists showed greater levels of MI inconsistent behaviours and lower levels of MI consistent behaviours, clients showed greater levels of ambivalence, and were more likely to drop out of the therapy process. Anstiss et al. (2011) evaluated the effects of a brief MI intervention with offenders and found that participants who undertook the programme were significantly less likely to re-offend than those

who did not. Current evidence suggests that an empathic approach contributes to a more positive approach to treatment by offenders (Marshall & Serran, 2004; Ross, Polaschek, & Ward, 2008), and that therapist behaviours are generally associated with changes in offenders (Marshall et al., 2002). Ginsburg (Ginsburg, Mann, Rotgers, & Weekes, 2002) describes the solid theoretical rationale for using MI in an offending population, and points out that although there is some evidence for positive behaviour change using this approach, there is a considerable need for more research.

Summary of Research into Client Resistance

In summary, there is considerable evidence of a relationship between client resistance and a poor outcome in therapy, and the evidence suggests that more resistant clients tend to benefit from non-directive interventions, whereas less resistant clients tend to benefit more from more directive interventions. However, much of this evidence comes from high level meta-analyses and researchers have noted the relationship between these variables is likely to be more complex. This stance is supported by studies which have failed to find the link between therapist directiveness and client resistance, and authors have suggested a number of reasons for this complexity: Firstly there may be differences within different client populations and problems styles; secondly, directiveness includes a wide range of therapist behaviours, and more research is needed to detail the specific behaviours contributing to resistance; thirdly, it may not be so much a directive intervention that causes resistance, but the manner in which an intervention is delivered as well and the therapists interpersonal skills (e.g., empathy). Investigations of therapist's interpersonal skills (as opposed to specific techniques therapists use) and their relationship to client resistance have also been restricted by a number of limitations in the measures used. These limitations include narrowly defining client resistance so that relationship discord is excluded, and only measuring interpersonal skills at a global level so that the moment to moment in-session dynamic between therapist interpersonal skills and client resistance is missed. Furthermore, there is little research investigating the bi-directional interaction between client resistance and therapist interpersonal skills. In combination, the literature review and the review of the research into client resistance suggest a close association between client resistance and important psychological variables such as therapist empathy, the therapeutic alliance, and autonomy support. It is to a discussion of these three variables that this review now turns, in order to explicate their nature and their relationship to resistance.

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CHAPTER 5: THERAPIST RELATIONAL SKILLS ASSOCIATED WITH CLIENT RESISTANCE

Empathy

Empathy has long been recognised as an important component of the change process in psychotherapy, especially from within the experiential-humanistic treatment models. Early scepticism of the role empathy played in creating positive change in psychotherapy has diminished in the face of a substantial body of evidence (Elliott, Bohart, Watson, & Greenberg, 2011). Empathy is increasingly considered a core principle of therapeutic change, based on findings from the task force of APA's Division of Psychotherapy (Division 29). Elliott et al. recently undertook a review into the concept of empathy, which included a meta-analysis of the research to date. The meta-analysis of the relationship between empathy and therapy outcome found a medium effect size (weighted, corrected r) of 0.31, suggesting empathy accounts for approximately 9% of the outcome in therapy.

The definitions and understandings of exactly what empathy is have developed considerably over the past decades. Elliott et al. note that Rogers (1980) placed a great focus on the role of empathy, and it was in the 1940s and 1950s that the concept was put forward and operationalized within psychology. Empathy's central role in psychology then dimmed considerably up until about 1995, but in the last two decades there has been resurgence into research on this construct, and greater consideration given to its role as an important change process in psychotherapy. This has been largely driven by advances in developmental and social psychology, as well as from social neuroscience, which have provided greater understandings of the neurological basis for empathy. Elliott et al. describe how recent research has further developed our understanding of the role of mirror neurons, and it is now suggested there are three neuro-anatomically based processes which together makeup human empathy. These processes are: (a) a process of emotional simulation where a second party's emotional bodily experiences are mirrored, (b) a process of conceptual perspective taking with regard to a second party, and (c) a process of emotion-regulation enacted to soothe the personal distress being experienced by the first party due to the second party's pain. This process then enables the first party to engage in a compassionate response to the second party. The authors note that Roger's original definition of empathy—“the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the client's point of view. It is this ability to see completely through the client's eyes, to adopt his frame of reference . . .” (p. 85)—can easily be seen within this framework. Rogers (1980) further outlined that the “. . .state of empathy, or

being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings.... as if one were the person, but without ever losing the as if condition” (p. 140). Rogers also emphasised the importance of entering the other person’s experience, checking that you have the experience correct and laying aside judgements based on your own values and perspectives. Rogers was extremely wary of focusing on the content of the therapist’s responses and the techniques that were being used, and instead emphasised the general empathic quality of the listening. He also highlights the importance of interacting with people in a way that locates the power in the person, not the expert.

Elliott, Watson, Goldman, and Greenberg (2004) outline their view that empathy is a fundamental component of change in psychotherapy, and performs this role in a number of ways. Firstly, and perhaps most commonly well-known, is empathy’s role in creating a safe environment and in helping clients to feel heard, understood, and supported. Further to this is the role of collaborating to establish the goals and tasks of therapy, core aspects of the therapeutic alliance. The authors also describe the importance of being alert for ruptures in the alliance, and moment to moment shifts in the therapeutic relationship. The second role that empathy plays is in enabling the exploration and deconstruction of client’s perspectives and beliefs about themselves, the world, and others. Empathic reflections can guide and extend the client to gain a deeper understanding of their meanings and intentions. The third role empathy provides is in promoting the enhancement of emotional regulation. An additional point the authors draw attention to is the role that empathic reflections can play in supporting client autonomy and maintaining an egalitarian relationship between a client and therapist.

Although there has been a reasonably large amount of research undertaken into therapist empathy, researchers have pointed out some of the limitations in the studies to date. The correlational nature of the majority of the studies means it is difficult to infer any causal role of empathy (Elliott et al., 2011). A further challenge is the restricted range of therapist empathy and criterion variables, and the unethical nature of purposefully designing a study which place limitations on levels of empathy therapists deliver (Elliott et al., 2011; Elliott, 2010). A search of the literature also showed no existing process research investigating the moment to moment in session relationship between therapist empathy and client resistance. This may be contributed to by the current availability of empathy measures. For example, MI research has investigated the relationship between empathy and sustain-talk. However, although sustain talk is measured on a moment to moment basis, empathy is measured at the global level of the session, making it difficult to see in the session, moment to moment connection between the two variables. This is partially remediated by the moment to moment measurement of therapist reflections, an empathic technique, but this coding system cannot tell us if these techniques are truly empathic reflections, and whether they truly reflect empathic listening skills.

The importance of therapist characteristics in working with offenders has received very limited research attention, especially in regard to the understanding the process of treatment (Polaschek & Ross, 2010). Farbring (2008) discuss the difficulties that counsellors face to maintain empathy and sincere hope for clients in offending populations. The authors outline the need to put one's ego aside in the face of resistance and hostility, and to focus on finding values and goals which clients express amongst their angry negative talk with regards to broader systems. Evidence suggests that an empathic therapeutic style contributes to a more positive approach to treatment by offenders (Marshall & Serran, 2004; Ross et al., 2008).

Autonomy Support

Autonomy support is a central construct within both self-determination theory (SDT) and motivational interviewing (MI; Miller & Rollnick, 2012), as previously outlined, and is thought to be integral to developing a person's internal motivation for change (Ryan et al., 2011). Deci and Ryan (2000) point out that psychotherapy is generally about creating conditions for positive change and that a client's motivation or resistance (also referred to as "amotivation") is integral to this process. It is suggested that more autonomously regulated behaviours are more stable, and that clients are more likely to engage in therapy, as well is to maintain any changes made, when changes are autonomously developed and intrinsically motivated (Overholser, 2005; Ryan & Deci, 2008; Ryan et al., 2011). Some authors have suggested that autonomous motivation should be recognised as a new common factor (Deci & Ryan, 2000; Zuroff et al., 2007), and studies have supported autonomous motivation as a predictor of outcome, which has sometimes surpassed the prediction strength of the therapeutic alliance (Zuroff et al.). A range of authors (Deci & Ryan, 2000; Zuroff et al., 2007) have proposed that autonomy support refers to the attitudes and practices of an individual (e.g., therapist) or the wider social context that enable a client's self-organization and self-regulation of behaviours and experiences.

Deci and Ryan (2000) demarcate research-based components of autonomy support as being: acknowledging and understanding client's perspectives, providing unconditional positive regard, supporting choice, providing a meaningful rationale for interventions, and minimising pressure or control. The authors specifically highlight the importance of understanding and validating a client's internal frame of reference within the therapeutic context, but point out this does not require the endorsement of the person's actions. Deci and Ryan emphasise that the provision of autonomy support requires the therapist to be truly free of an agenda, to not have a personal investment in a specific outcome for the therapy process, and to not impose their own values and perspectives on a client. These ideas are also supported from within an MI framework, where Miller and Rollnick (2012) highlight the importance of honouring and respecting the client's autonomy, and recognising their fundamental right to determine their

future. The authors emphasise that authoritatively trying to coerce or control clients is the opposite of autonomy support, and underscore the likelihood that clients will react to this approach in accordance with reactance theory (Brehm & Brehm, 1981): with oppositional resistance to the imposed restriction to their freedom. Miller and Rollnick suggest that therapists relinquish the idea that they can impose change on a client, and that this will free them of a burden which was an impossible task anyway.

A search of the literature found no specific research into autonomy support and client resistance. From within an MI framework, there have been studies investigating autonomy support and its relation to sustain talk, but as noted, sustain talk represents only a restricted version of resistance. Furthermore, the scale used in these studies (MISC) actually measures MI Spirit, of which autonomy support is only one aspect, with the other two components being collaboration and evocation. In other words autonomy support is not actually separated out and specifically measured for its relationship to client resistance. Furthermore, the moment to moment relationship between therapist autonomy support and client resistance is not captured through the use of these measures, as MI Spirit is measured as a global variable at the level of a session, rather than at the micro level of a therapy segment. A separate line of research has investigated therapist-client interpersonal processes within sessions using the Structural Analysis of Social Behaviour (SASB; Benjamin, Rothweiler, & Critchfield, 2006; Benjamin, 1974). The researchers found that the therapists of clients with poorer outcomes utilised more hostile control and were less likely to exhibit friendly autonomy towards clients (Henry et al., 1986).

Although the importance of considering autonomy within offending populations has been highlighted (Viets, Walker, & Miller, 2002), there does not appear to have been any research into autonomy support within offending populations. Viets et al. point out that simply coercing offenders to change has limited effect, and that it is important to recognise and acknowledge an offenders right to autonomy. Anstiss et al. (2011) found an MI based programme with offenders to be considerably more effective in reducing offending, and raised the question of whether this may reflect the greater sense of agency the MI instils in offenders.

The Therapeutic Alliance

The therapeutic alliance is one of the most researched concepts in psychotherapy, and has received a growing focus in the past decade (Horvath, Del Re, Flückiger, & Symonds, 2011). The roots of the alliance stem back to the time of Freud, who noted the dilemma that clients face where the very process of therapy activates their defences and resistance to therapy, but that for successful treatment clients must somehow collaborate with therapists to work through the uncomfortable material. One of the most recognised conceptualisations of the alliance is that

proposed by Bordin (1979), who coined the term *working alliance*. Bordin suggested that the alliance was primarily about achieving a collaborative relationship, fostered by three processes: establishment of a bond between the client and therapist, agreement on the goals for therapy, and agreement on treatment tasks.

A recent meta-analysis showed the alliance has an effect size of $r = 0.275$, suggesting it accounts for approximately 7.5% of the variance in treatment outcomes (Horvath et al., 2011). Although this is a relatively modest proportion of the total variance in treatment outcome, it remains one of the strongest and most robust predictors of treatment success documented. The research is considerably more limited in offending populations, although the therapeutic alliance has also been recognised as an important correlate of outcome (Polaschek & Ross, 2010). However, the effect of the alliance on an offender's motivation still remains to be investigated. Some studies have also found that adherence to the Spirit of MI is important for enhancing the alliance (Boardman et al., 2006).

Despite the fact that some studies have found little evidence of the alliance being a predictor of therapy outcome (Strunk, Brotman, & DeRubeis, 2010), the authors note that the therapists were all very skilled, well trained, and made good efforts to establish relationships with their patients. It remains to be seen whether these studies can be generalised to forensic settings, where staff training and supervision can be limited (Polaschek, 2010), and where the development of both client motivation and the therapeutic relationship can be challenging factors given the nature of the population (Ross et al., 2008).

A literature search uncovered only one study investigating client resistance and the working alliance (Watson & McMullen, 2005), and this study has been previously discussed above in the review of the research into client resistance. A key finding of Watson and McMullen was the significant relationship between in-session resistance and the working alliance, in contrast to the lack of a relationship between therapist directiveness and client resistance. The authors indicated the need for research which investigates breakdowns in the alliance, and exactly what processes are occurring between the client and the therapist when resistance is observed. They suggest qualitative research is needed to gain a deeper understanding of these processes.

It should be noted that there is a considerable literature, and a number of research studies, investigating the concept of rupture and repair of the therapeutic alliance (Safran, Muran, & Eubanks-Carter, 2011). This idea has some similarities with regards to client resistance and the working alliance, and most of the studies have used working alliance derived measures to investigate alliance rupture and repair. A review of these studies suggests that when a rupture occurs in the alliance between a therapist and a client it can have a positive effect on outcome, as long as that rupture is repaired (Safran et al., 2011). Another related line of research is that

into the relationship between in session interpersonal dynamics of a client and therapist and the working alliance (Samstag, 2008). This research suggests that hostile interpersonal behaviour was correlated with both a poor outcome and a low working alliance. Clarkin and Levey (2004) delineate the similarity between the concept of therapeutic impasses/alliance ruptures (Safran & Muran, 2003) and reactance, and thus the importance of attending to the therapeutic alliance to reduce reactance.

Summary

This review highlighted the importance of investigating the specific mechanisms of change attributable to psychotherapy, rather than comparing one broad theoretical mode to another (Crits-Christoph, Gibbons, & Mukherjee, 2013; Lambert, 2013). Recent reviews by a task force commissioned by the American Psychological Association recognise the importance of understanding the mechanisms of change attributable to common factors across the various therapeutic models, and highlighted therapist empathy and the therapeutic alliance as an important focus (Norcross, 2011). They also drew attention to the importance of adapting the therapeutic relationship to meet the specific needs of resistant/reactant clients.

Motivation and resistance are often conceptualised as being at the opposite ends of the same scale (Engle & Arkowitz, 2006; Mann, Ginsburg, & Weekes, 2002). Understanding and addressing a client's motivation to change, and to engage in treatment, has gained increasing recognition as an important factor in improving treatment outcomes (Hal Arkowitz, Westra, et al., 2008), as has understanding and addressing client resistance (Aviram & Westra, 2011; Leahy, 2001; Westra, 2011). This provides opportunities for improvement in treatment outcomes, especially in client populations where difficulties with motivational and resistance processes are well recognised, such as in offending populations. However, client motivation has proven difficult to study and client resistance is showing promise as a variable with stronger relationships to outcome. Resistance is an important concept within psychotherapy but has received very little research and there is still much to clarify regarding its nature and role in creating positive change (Apodaca & Longabaugh, 2009; Aviram & Westra, 2011; Engle & Arkowitz, 2008). Various models of psychotherapy conceptualise resistance in different ways. Motivational Interviewing (MI) is one model that considers client resistance within its fundamental principles, and MI has received a considerable research supporting the efficacy of the model (Lundahl et al., 2010; Miller & Rollnick, 2012). MI has also shown early positive results, including within offending populations, as well as considerably greater efficacy relative to other models when used with ethnic minority groups and clients with anger problems.

However, research has been dominated by outcome studies, and although considerable progress has been made in delineating the mechanisms through which MI achieves positive outcomes, significant questions still remain (Miller & Rose, 2009). MI places great emphasis on the therapist's relational skills, and Miller and Rollnick (2012) have theorised that two core ingredients contributing to the efficacy of MI may be: therapist empathy, and the avoidance of non-prescribed MI behaviours which could cause client resistance. Other authors have also emphasised that a therapist's interpersonal skills, rather than their technical skills, are likely to be critical in their contribution to a positive outcome for clients (Moyers et al., 2005; Watson & McMullen, 2005). However, there is a lack of research investigating the specific therapist relational skills and aspects of empathy that contribute to or reduce the likelihood of client resistance. There is even less understanding of how this interpersonal dynamic takes place, although the research suggests the interpersonal dynamic between the client and therapist can be bi-directional, meaning both members of the dyad have effects on each other. Within existing MI research, the scales measuring client-therapist dynamics on a moment to moment basis have been largely restricted to a therapist's technical skills (as opposed to interpersonal skills). They have also utilised a narrowly operationalised version of client resistance that largely excludes resistance due to discord in the therapeutic relationship, and focuses on sustain talk. The scales used in these studies have predominantly restricted their measurement of the therapist's interpersonal skills to a global level, meaning that the interaction between therapist interpersonal skills and client resistance have not been captured at the micro-level. Furthermore, there has been little qualitative analysis of client-therapist narrative to attempt to more deeply understand the interpersonal dynamics contributing to client resistance. Within the limited research that has been undertaken into client-therapist interpersonal dynamics, the primary focus has been "directive" therapist behaviours. However, studies of these directive therapist behaviours have generally been in terms of outcome, and when they have been examined for their relationship to client resistance they have shown considerable variability. Many studies have also included very overt therapist behaviours, such as authoritatively and explicitly confronting a client, behaviours which are not considered to reflect competence in contemporary therapy (Westbrook et al., 2011). It would therefore be useful to understand the subtleties of interactions between a client and therapist that contribute to client resistance, and how exactly these dynamics unfold. There does not appear to have been any research regarding client resistance in offending populations, although one recent study has suggested that using MI, which explicitly addresses client resistance, may be of considerable benefit in reducing recidivism (Anstiss et al., 2011).

This study aimed to undertake a close up investigation of particular therapist relational skills (empathy and autonomy support) which have been proposed as relevant to the management of client resistance, and to investigate how the interaction between these client and therapist

behaviours unfold over time. The relationship between the therapeutic alliance and client resistance was also investigated. The aspect of resistance targeted was that reflecting a breakdown in the therapeutic relationship, as demonstrated by negative/oppositional behaviours towards the other member of the dyad and poor engagement in the session. This research can be seen as extending previous studies which have undertaken detailed in-session analyses of a broad range of therapist responses and client resistance, but have generally not investigated the interpersonal skills of therapists and client resistance on a moment to moment basis, and how these variables interact and unfold over time.

CHAPTER 6: AIM OF THE PRESENT STUDY

As noted in Figure 1, this research consisted of two stages: a Pilot Study and a Main Study. The Pilot Study involved a number of processes including: identifying (and sometimes adapting) a set of measures which could be used to answer the research questions; accessing DVDs of therapy sessions to provide the data for the study; and conducting an inter-rater reliability analysis to ensure consistency in the use of the measures selected.

The Main Study aimed to investigate the possible relationship between a number of therapist relational skills (therapist empathic perspective taking, therapist empathic attunement and therapist resistance) and client resistance. The questions were investigated by analysing a Short Motivational Programme with medium risk offenders.

The research questions fell into two broad categories, and multiple methods were used to answer some of the questions.

1. Across all the dyads

- a) What is the extent of client resistance and therapist resistance?
- b) What is the relationship between therapist resistance and client resistance?
- c) What is the extent of therapist empathy?
- d) What is the relationship between therapist empathy and client resistance?
- e) What is the extent of the working alliance?
- f) What is the relationship between the working alliance and client resistance across the dyads?

2. Within each dyad

- a) What is the relationship between therapist resistance and client resistance?
- b) What is the relationship between therapist empathy and client resistance?
- c) What does the narrative between the client and therapist suggest about the relationship between therapist relational skills and client resistance, and how the interpersonal dynamic unfolds?

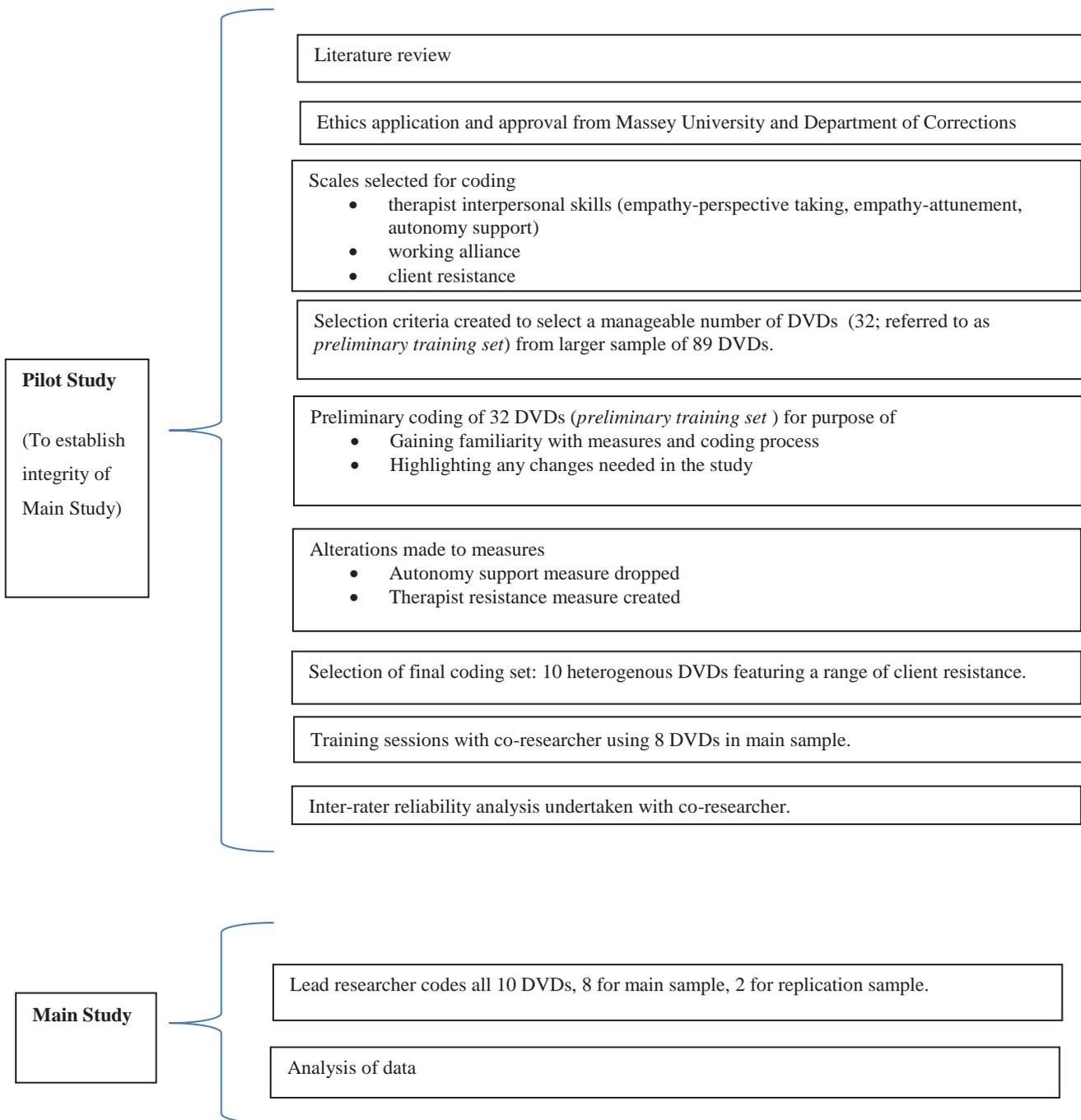


Figure 1. Overview of tasks undertaken in various phases of the research.

CHAPTER 7: METHODOLOGY

Introduction

The present study took place within the wider context of an on-going research project at Massey University, in collaboration with the Department of Corrections, to investigate the effectiveness of a Short Motivational Programme for offenders. The lead researcher in the current study had previously been involved as a co-researcher in this prior research (Austin, 2012), which involved coding the same set of DVD therapy sessions used in the present study. It was partially due to this prior research that possibilities for the current study were established. For the sake of clarity, Table 2 describes some of the terminology used throughout this document.

Table 2
Descriptions of Terminology Used in this Study

Label	Description
Short Motivational Programme (SMP)	A five session programme delivered to offenders. The term “SMP” is used to refer to the broader programme itself within Corrections, as well as a specific SMP instance featuring a specific offender and therapist. SMP’s generally consist of five sessions featuring a therapist (facilitator) and medium risk offender.
Dyad	Client therapist pair
Facilitator	Therapist (these terms are used interchangeably)
Session	The SMPs generally consist of five one hour <i>sessions</i> , each featuring the same therapist and offender. These sessions were recorded on DVD.
Segment	A one minute long area of an SMP session selected for coding.
Section	A group of concurrent <i>segments</i> in a single SMP <i>session</i> . This terminology is often used in this research to refer to groups of segments in a session where there was a specific pattern such as: an absence of client resistance, brief client resistance, or prolonged client resistance.
Utterance	A selection of client or therapist talk, unbroken by the other party.
TR	Therapist resistance
CR	Client resistance
TRC	Therapist Resistance Code (a measure used in the study)
CRC	Client resistance Code (a measure used in the study)
WAI-SR-O	Working Alliance Inventory-Short Form-Revised (a measure used in the

	study)
E-p	Empathy-perspective taking (refers to both the measure and the variable)
E-a	Empathy-attunement (refers to both the measure and the variable)
Section with an <i>absence of client resistance</i>	2 or more concurrent segments where client resistance (CR) =0.
Section with <i>brief client resistance</i>	1-2 concurrent segments where CR>0.
Section with <i>prolonged client resistance</i>	3 or more concurrent segments where CR>0.
“...”	Within the results section analysing the interpersonal narrative, three ellipses (...) are used to show there is a gap in the narrative that has not been recorded. This permitted the restriction of recorded data to only those client and therapist utterances deemed most relevant.
Empathy measure scores.	The anchors on the empathy measures were quite detailed and long (see Appendix B), and the descriptors (outlined below) functioned as a way to quickly summarise the anchors, and represent the scores in a meaningful narrative form.
	1 = very low 2 = low 3 = medium (midpoint) 4= high 5 = very high
Mid-point	This term is used with regards to the empathy scales and WAI-SR-O. For example the empathy scales both had a range from 1-5, with the mid-point being 3. When scores on a measure were aggregated across a session, and their average was calculated, the aggregated average score was often compared to the mid-point on the measure.

This study consisted of two inter-related stages (referred to as the *pilot study* and the *main study*). The pilot study involved a number of processes which ultimately served to ensure the quality of the main study. Firstly, based upon the literature review a number of scales were selected in order to measure client resistance and a range of therapist relational skills (Empathy-perspective taking (E-p), Empathy-attunement (E-a), and Autonomy Support (AS)). Secondly, a selection criterion was developed to reduce the 88 DVDs available to a more manageable number of 32, referred to as the preliminary training set. Thirdly, preliminary training sessions were undertaken and involved the coding of a number of the DVDs in the preliminary training set in order to gain familiarity with use of the measures and the coding process, and to highlight any changes needed to improve the study. Fourthly, based on the preliminary training, it was

realised that a number of changes needed to be made with regards to the measures including: the dropping of one measure, and the creation of an additional measure. Fifthly, a preliminary coding of the 32 DVDs was undertaken by the lead researcher with the new measures (Client Resistance Code (CRC), Empathy-perspective taking (E-p), Empathy-attunement (E-a), Working Alliance Inventory (WAI-SR-O), Therapist Resistance Code (TRC)). This allowed the lead researcher to gain familiarity with the new measures, and also provided data to enable the selection of a small and heterogeneous number of 10 DVDs featuring a range of client resistance, and a variety of therapists and clients, for use in the main study. Sixthly, the data from the coding of these 32 DVDs was utilised to guide selection of specific areas of the 10 DVDs that could be used to undertake training with the co-researcher. Following this, the co-researcher and lead researcher worked together to code 10 minute segments of each selected DVD. This was a learning process for both coders. Finally, the two researchers coded a small section from 9 of the 10 DVDs and undertook an inter-rater reliability analysis to ensure the integrity of the measures.

This marked the end of the pilot study, and the beginning of the main study. In the main study the lead researcher coded all 10 of DVDs in the final coding set, thus providing the final data for analysing the research questions.

Pilot Study

Overview

This research involved the coding and analysis of therapist-client dyadic interactions from therapy sessions which were recorded (on DVD) two to three years prior to this study. The methodology section outlines a range of factors with regards to this process. Firstly, the mixed method design of this study is explained, along with its quantitative and qualitative components, and the reasons for the choice of these methods. Secondly, the Short Motivational Programme (SMP) is introduced, and the basic components of each of the five sessions in the programme are described. Thirdly, the participants in this study—i.e. the facilitators and offenders—are introduced and their demographics are outlined, including the offenders' risk status. A number of ethical considerations with regards to facilitators, offenders, and Maori cultural sensitivities are also discussed. Fourthly, the measures used in the study are described along with the rationale for the selection of both global and molecular scales, and how this choice coincided with both the design of the study and the fact that this was process research. The difficulty finding widely used, reliable, and valid measures for this type of research will also be addressed. It is important to note that the measures section is intimately linked with the following procedure section, due to the fact that decisions were made to change the measures

used during the training stages of the research, with a new measure being added (Therapist Resistance Code), and one measure being dropped (Autonomy Support). Fifthly, the procedure section outlines some of the key tasks undertaken and details their chronological order. This section also describes the processes taken to specifically select DVD sessions that included a range of therapist-client interactional styles (e.g. where there was and was not client resistance), a range of therapists, and a range of offenders.

Design

This study made use of a mixed methods design, which was viewed as the best methodology to answer the research questions.

Mixed methods research.

Mixed methods research is increasingly being seen as an important and stand-alone research methodology for evaluating programmes (Creswell & Clark, 2010; Dattilio, Edwards, & Fishman, 2010; Tashakkori & Teddlie, 2010), and an important addition to research methodologies within the field of psychology (Creswell & Clark, 2010; Dattilio et al., 2010; Hanson, Creswell, Clark, Petska, & Creswell, 2005). Dattilio et al. note that —outside the field of psychology—evaluation research is becoming dominated by a mixed method paradigm that embraces both pragmatism and multiplicity. The researchers have gone as far as to suggest that mixed methods research is critical to improving the understanding of psychological interventions, and gold standard research studies should entail the use of a mixed methods designs. They also put forward a new standard for research when evaluating psychotherapeutic treatments that includes qualitative investigations of treatment programme implementation and systematic case studies.

Mixed methods research has been defined by Creswell and Clark (2010) as incorporating a number of features: (a) it connects and rigorously analyses quantitative and qualitative data based on the research questions; (b) it integrates the two forms of data; (c) it prioritises one or other form of the data depending on the emphasis of the research; (d) it uses these procedures within a single study; and (e) it combines the procedures into specific research designs that target the study's goals. Dattilio et al. (2010) emphasise that this approach provides an innovative way forward to gain a better understanding of the mechanisms of change in psychotherapy, and to inform psychotherapeutic practice. The researchers emphasise that in combining quantitative and qualitative methods, the strengths of each approach are targeted at the specific research questions they can best answer. This ideally eliminates the limitations that come with using any single approach, and allows the information from one method to deepen

the understanding of findings from the other method. Dattilio et al. provide specific examples where studies using quantitative data from group analyses are enhanced by process oriented qualitative and case based studies that can shed light on the quantitative findings. Furthermore, specific and important areas of change highlighted in quantitative studies can be targeted for closer investigation of the client's narrative at these treatment stages, in order to more deeply understand specific treatment components.

Within the current study, the use of quantitative group based research methods allowed the answering of questions such as “across all of the dyads, were there any general patterns between therapist empathic perspective taking and client resistance?” In contrast, the use of a single case design allowed the answering of questions such as “within a given therapy session, what is the relationship between therapist empathic perspective taking and client resistance from minute to minute?”, and “how did the interpersonal dynamic between the client and therapist unfold over time, with regards to specific relational variables?”. As noted by Punch (1998), this approach allowed the study to understand converging numeric trends and relationships shown by the quantitative data, and the specific details of these relationships shown by the qualitative data.

Group Analysis Component of the Design, Using Quantitative Data.

The group research aspect of the study aimed to understand whether there were broad relationships between the variables, across all of the dyads. The use of quantitative group data was considered important in order to enhance the ability of the results to be generalised from the sample to the population (Hanson et al., 2005). This part of the study utilised a naturalistic observational design, where pre-existing recordings of therapy sessions were observed, and the participants in the therapy sessions (therapists and clients) were rated on a number of measures, thus allowing the investigation of broad correlations between therapist and client variables across the dyads. The quantitative group analysis was undertaken before the single case analysis, and therefore laid a foundation for the single case design component of the research. This meant that any patterns found in the group analysis could be more fully explored using the close-up, single case analysis.

As will be discussed further on, it was decided that a replication sample would also be utilised, to see if the results from the quantitative group analysis could be replicated.

Single Case Component of the Design, Using Quantitative and Qualitative Data.

The largest component of the study was a single case design, or more specifically, a naturalistic observational, exploratory, single case, visual analysis, supplemented with quantitative statistics and a qualitative analysis (Hilliard, 1993). In other words: the research used a single case design to investigate intra-subject variables within individual dyads, and used direct replication on a case-by-case basis to explore the generalizability of the findings; the study was naturalistic, in that it made use of pre-existing data from video recorded therapy session and there was no experimental intervention/manipulation, so the aim of this study was to extract the independent and assumed dependent variables; the study was exploratory in that it aimed to generate hypotheses rather than confirm existing hypotheses; the research utilised a visual analysis, in that it used the visual examination of graphically presented data to analyse the temporal unfolding of variables and their relationships within the therapy sessions, and this was supplemented with descriptive statistics; The study was supplemented with a quantitative analysis, in that it used quantitative techniques to analyse the relationships (correlations) between the variables; and finally, the study was qualitatively informed, in that some aspects of the data were expressed in prose (dialog between participants), and this narrative was used to supplement the data analysis, and investigate the temporal unfolding of variables and their relationships.

Single case research designs have a long history in the study of psychological phenomena and have made important contributions to the field. Indeed, a range of well-known historical figures used single case research designs, and were ardent proponents of this methodology. This included: Ebbinghaus (1913) and the seminal studies he undertook into the fundamental principles of memory which still remain intact today; Pavlov (1984) and his well-known intra-subject research into conditioned reflexes; and Skinner (1969) with his studies of operant behaviour. Hilliard (1993) suggests that single case research is best understood as a subset of intra-subject research, in which the generalizability of the findings is investigated through a case-by-case replication, and where aggregation across cases is avoided.

Although the more traditional approach of group analyses have dominated psychological research, the underlying aim of any study is to evaluate phenomena and establish valid inferences, a goal towards which single case designs have much to offer (Kazdin, 2009). Hilliard (1993) points out that single case design research has moved beyond the stigma it once had due to a number of poorly executed early case studies. Kazdin (2003) notes that *case studies*, which are a particular type of single case design, have often relied on anecdotal evidence and had poor internal validity, which limits the inferences that can be drawn.

Unfortunately, the limitations of these types of single case design have often then been associated with all single case design research. Kazdin emphasises that the problems with these studies were not that they were single case designs, but rather that the specific methodology used did not allow them to rule out rival hypotheses that could account for the results seen: in other words they had poor internal validity. Kazdin emphasises the need to recognise the specific challenges associated with single case designs, and to include features in the research that increase the confidence that the data patterns seen cannot be explained by rival hypotheses. In other words, threats to the internal validity of the study are common factors in single case designs but there are steps which can be taken to eliminate or reduce these threats, and it is this that dictates the quality of a study rather than the label 'single case design'. Hilliard notes the resurgence in the use of single case designs, and the unique contribution they can make towards understanding specific change processes within psychotherapy, something which is difficult to achieve through the use of traditional nomothetic designs. Hilliard defines intra-subject research as the investigation of variation of a given variable, within subjects, over time, as a function of other variables that vary within subjects over time. The author clearly delineates the benefits and limitations of both group research and single case research, and points out that although group research has been able to uncover insights with regards to the therapeutic process and therapeutic outcome, it has not been able to provide deep understandings with regards to the process of change or the process of outcome, where the term "process" refers to the changes in variables over time within the therapeutic dyad. He outlined the need for researchers to: deconstruct global outcome results into their various components of interrelated changes, to investigate the impact of the therapist's actions on the client and vice versa, and to investigate how the client-therapist interaction contributes to these changes. In other words, in order to understand these processes of change and processes of outcome, one needs to understand the variability of behaviour within therapeutic dyads across time—i.e., the intra-subject variability of relevant variables over time—the very domain of single subject research.

A relevant example of the difference between nomothetic group research and single case research can be illustrated as follows. The study by Aviram and Westra (2011) investigated 35 individuals for the impact of MI (Miller & Rollnick, 2012) on resistance in cognitive behavioural therapy (CBT) for generalised anxiety disorder. The results of this study showed that receiving MI prior to CBT was associated with considerably reduced observer rated resistance, and that reduced early resistance was associated with considerably greater proximal and distal therapeutic outcomes. What the study did not reveal (and of course, was not designed to reveal) was the specific moment to moment dyadic interaction between the client and therapist that led to the reduction in resistance. This is the domain of single case design studies, as intra-subject research, and is the reason this methodology was chosen as a component of this mixed method research study.

Kazdin (2010) points out that the single case design does not come without its challenges. There are a wide range of types of single case designs, with two methodological extremes being the uncontrolled anecdotal case study at one end of the spectrum, and experimental designs at the other. All of these share a number of common elements including the intensive examination of the individual. The author notes that although true single case *experiments* are able to rule out many of the threats to internal validity and provide an excellent basis for drawing inferences, the majority of studies in the human sciences are not true experiments due to practical and ethical difficulties with manipulating many of the conditions of interest. Despite this challenge, Kazdin delineates a number of steps that can be taken to improve the quality of inferences that can be drawn from non-experimental single case designs. Firstly, data can be objectively and systematically collected using scales, to provide information as to whether change in behaviour has or has not occurred. This is an important precondition to a study, without which there will be little ability to draw inferences from the results seen. Secondly, data can be systematically collected on a number of occasions, or continuously over time, which significantly decreases the threat to internal validity associated with assessment. This process will be even more rigorous if continuous assessment can begin before treatment.

Kazdin (2003) points out that the measurement strategy generally used in group designs involves only one or two observations of the dependent variable. In contrast to this, a single case design aligns with the idea of repeated measures involves continuous measurement of the dependent variable, thus increasing the confidence one can have that the sample behaviour being measured is representative of that particular participant's behaviour in the given condition. This approach is also in line with the epistemological view that behaviour is a continuously unfolding phenomena, that behaviour entails considerable serial dependence, and that measurement strategies need to make sufficient contact with the aspects of the behaviour being studied. Somewhat related to this is the fact that participants in single case designs operate as their own controls, with their behaviour in one part of the experiment being compared to their behaviour in other parts of the experiment. Thirdly, the consideration of past and future projections of performance can be used to understand if extraneous events other than the treatment may have accounted for the changes seen. Fourthly, one can consider the type of effect associated with treatment, including the immediacy and magnitude of the changes seen, in relation to the intervention. Where changes are more immediate in relation to the intervention, there can be more confidence that the intervention was responsible for the change. Similarly, when changes seen are of a larger magnitude, there can be more confidence that the intervention played a part in the changes seen. And when there are both immediate and larger magnitude changes, additional confidence can be had in the role of the intervention in the changes seen. Fifthly and finally, each extra case studied can be viewed as a replication of the original case, and the use of multiple and heterogeneous subjects can enhance the confidence one can have in

any inferences drawn regarding the changes seen. Furthermore, if patterns of change can be demonstrated amongst a number of clients, who vary across subject and demographic variables, then the likelihood that the patterns seen can be explained by the threats to internal validity is less likely.

Design methodology for this study.

It was the rationale outlined above that guided the choice of a mixed methods design for this study. The use of a group analysis allowed the investigation of the broad relationships between therapist relational skills and client resistance. The use of this approach in the first instance enabled the highlighting of broad patterns which could then be more closely investigated in the single case analysis.

The core phenomenon being investigated—the relationship between therapist relational skills and client resistance—is the study of process change, or in other words, the study of the change in variables over time within the therapeutic dyad. This study of intra-subject variability of variables over time lent itself well to the use of a single case research design.

This study used existing DVDs of previously recorded therapy sessions, and therefore was not experimental, which meant many of the threats to internal validity often associated with single case designs needed to be carefully considered. The benefits associated with single case experiments, such as the manipulation of therapy conditions of interest, were obviously not available in this research. However, the investigator was able to take a number of steps to improve the quality of inferences. Firstly, data were collected in a systematic manner, generally using existing scales, and intensive training was undertaken in using these measures. In addition, inter-rater reliability checks were performed. Secondly, data were collected continuously—on a minute by minute basis—from the one-hour long recorded therapy sessions, and in some cases more than one therapy session of a therapist-client dyad was coded. Continuous assessment allowed greater contact with the variables being measured, and examination of the data patterns over time of both client and therapist variables, and the relationships between them. It also allowed participants to act as their own controls, as outlined previously. Thirdly, the collection of interval level data on a continuous basis meant that the immediacy and magnitude of the patterns of change amongst the variables could be taken into account when drawing inferences about the changes seen in the therapy sessions. Finally, a range of both clients and therapists were selected for the study, providing a range of demographic variables (e.g. gender, age, and ethnicity), as well as a range of facilitating experience and levels of training with regards to the therapists. DVDs were selected to provide a fairly heterogeneous sample, including a range of client resistance levels (gauged from the

preliminary coding), as well as a range of therapist relational skills (based on results from the study by Austin (2012)). Baseline measures were not available for this study, primarily due to the fact that initial meetings between clients and therapists were either not recorded, or involved the client filling out a form, which was difficult to code. This was somewhat offset by the fact that there was continuous measurement throughout a session.

The Short Motivational Programme

The short motivational programme (SMP; Anstiss, 2003; Steyn & Devereux, 2006) is a low intensity programme generally targeted at medium risk offenders, and consists of five sessions which are delivered by programme facilitators. In this study, the term therapist and facilitator were used interchangeably. The SMP incorporates the therapeutic styles of both MI and CBT, but is also strongly driven by understandings from within the psychology of criminal conduct, such as the principles of risk, need and responsibility (Austin, 2012). The SMP manual emphasises that facilitators should always seek to use the principles and techniques of MI. The SMP is delivered in accordance with a detailed manual (Anstiss, 2003; Steyn & Devereux, 2006). It begins with a pre-session, which outlines the nature and goals of the programme to the offender. Consent to participate in the programme is gained in this session via the Department of Corrections SMP agreement form (Appendix C), and includes consent to record the SMP sessions and to use the DVD recordings for research purposes. Offenders who consent to the programme are then requested to fill out the University of Road Island Change Assessment Questionnaire (URICA; DiClemente & Hughes, 1990). Common components of subsequent sessions include a bridge from the previous session, introducing an agenda for the current session, a review of homework, the use of an MI approach to facilitate the agenda, a summary of the session, and the setting of homework (Austin, 2012).

The first session consisted of using the principles of MI to elicit the rehabilitative needs (Appendix D) of an offender, through the discussion of the background events that led up to the offending behaviour. Examples of rehabilitative needs include alcohol and drugs, violence propensity, and problematic lifestyle choices. In the later part of Session One, lifestyle factors, social influences, and thinking patterns that may have contributed to offending are discussed, along with the various social relationships the offender has identified as being a positive or negative influence with regards to their offending. In the final stages of the session there is a discussion of the offenders offending supportive attitudes, after which homework is set in the form of considering the rehabilitative needs that were outlined previously.

The second session of the SMP consists of the collaborative construction of an offence chain (the build-up of events leading to an offence), based on the information elicited in the first session. This is initially undertaken with the use of a hypothetical example, after which the

offender is encouraged to map out their own offence chain. The cognitive model (J. S. Beck, 2011) is incorporated at this stage, and at various important stages of the offence chain the offender is asked to record their thoughts and emotions, to rate their thoughts in terms of how strongly they believed them, and to rate the intensity of their emotions. For homework, the offender is asked to review the offence chain. It has been suggested that this session aims to deliver cognitive behavioural content in an MI style (Austin, 2012).

The third session encourages the development of discrepancy between an offender's offending behaviour and their goals and values. Offenders undertake a time prediction exercise where they are asked to consider how their ideal life would look 5 to 10 years into the future, and to be specific with regards to relationships, employment, home life etc. They then undertake a similar exercise, but this time consider where they would be if they continued offending. A decision grid is used to help clarify the discrepancy between the two scenarios, and offenders are then encouraged to explore their behaviours with regards to their rehabilitative needs. Austin (2012) points out that the third session does not include cognitive content, but uses methods often seen within MI approaches. However, as the author also points out, the use of methods such as a cost/benefit analysis does not necessarily mean MI is being practised, a fact which is also emphasised by Miller and Rollnick (2012). At the end of the session offenders are asked to review their decision grids for homework, and to complete further grids with regards to other identified rehabilitative needs.

In the fourth session, the treatment focus is on identifying and amending cognitive distortions that support offending behaviour. Austin (2012) points out that this session uses a cognitive behavioural approach to examine the links between thoughts, feelings, and offending behaviour. Initially facilitators discuss a range of cognitive distortions (e.g. justification and minimisation), and how their use can affect behaviour, before re-emphasising this content through the use of a hypothetical example. Offenders are then asked to apply these concepts to their own situation and offending behaviour. For homework offenders are asked to develop a list of goals that may reduce the chances of them reoffending, and to use the time prediction exercise from session three to do this. Austin suggests that this session aims to deliver overwhelmingly cognitive behavioural content in an MI style.

In the fifth and final session the focus turns to strengthening an offender's commitment to change, through the development of a change plan, based upon goals elicited in earlier sessions. Offenders who are considered to be uncommitted to addressing their rehabilitative needs are not requested to complete this entire session, but rather are asked to complete the motivational assessment questionnaire (URICA) for the second time, and the SMP is terminated at this point. Those offenders who do engage with the material in Session Five then work through their specific goals in more detail and discuss particular problems that might arise for them, as well

options that would support them reaching their goals. These offenders also complete the post-intervention URICA.

Participants

Participants in this study included facilitators (therapists) who delivered the SMP, and offenders who participated in the programme. Each facilitator-offender dyad was assigned a code which ensured the confidentiality of participant details (Table 3). Table 3 shows the total number of dyads available for this study, which were drawn from the participants in the previous study by Austin (2012). The table also shows the specific sessions of the SMP available for each dyad, and the dyads selected for the current study from the larger sample. The table highlights how the DVDs were split into groups to provide the main data for the study, as well as the data for the replication sample. All information which could possibly identify participants was excluded, and data such as ethnicity was only presented as aggregated data so that it could not be linked to particular therapist or offender, or to the results of a particular dyad.

Table 3

SMP Sessions Completed, SMP Sessions Successfully Video-Recorded for the Austin (2012) Study, and SMP Sessions Coded and Analysed in this Study for both the Main Data Set and the Replication Data Set (N=10 Facilitator-Offender Dyads)

Facilitator-Offender Dyad Code ¹	Sessions available from Austin (2012) study (N=89)	Sessions undertaken by dyad	Sessions used as training in <i>pilot study</i> (N=32)	Sessions used in <i>main sample</i> in the <i>main study</i> (n=8)	Sessions used in <i>replication sample</i> in <i>main study</i> (n=2)
A1	Pre-session to 4	Pre-session to 4 (exited)			
A22	Sessions 1 to 5	Pre-session to 5	Session 2,3		
B2	Sessions 1 to 5	Pre-session to 5	Session 2,3,4	Session 3	
B3	Pre-session to 5	Pre-session to 5			
C4	Sessions 1 and 2	Pre-session to 2 (exited)	Session 1 to 4	Session 2	
D5	Sessions 2 to 5	Pre-session to 5			
D23	Sessions 2 to 5	Pre-session to 5			
E6	Sessions 1 to 5	Pre-session to 5	Session 3	Session 3	
F7	Sessions 1 to 3	Pre-session to 5	Session 3		Session 3

F8	Sessions 1 to 4	Pre-session to 5		
G9	Sessions 1 to 5	Pre-session to 5		
G10	Sessions 2 and 3	Pre-session to 3 (exited)		
G11	Sessions 1 to 5	Pre-session to 5		
G12	Sessions 1 to 5	Pre-session to 5	Session 2,3	
G13	Sessions 1 to 3	Pre-session to 3 (exited)	Session 1,2,3	
G19	Session 1	Pre-session and 1 (exited)	Session 2,3	
G25	Session 1	Pre-session and 1 (exited)	Session 1	Session 1
H14	Sessions 2 to 5	Pre-session to 5	Session 3	Session 3
H15	Sessions 1 to 5	Pre-session to 5	Session 2,3,5	Session 5
H26	Session 1	Pre-session and 1 (exited)	Session 1	
I16	Sessions 1 to 4	Pre-session to 5	Session 1,2,3	Session 3
I17	Sessions 1 to 5	Pre-session to 5	Session 1,2,3	Session 3
I18	Sessions 1 to 5	Pre-session to 5		
J20	Sessions 1 to 5	Pre-session to 5	Session 2,3	Session 2
K21	Sessions 1, 3 and 5	Pre-session to 5		
L24	Sessions 3, 4 and 5	Pre-session to 5		

¹Alphabetic letter refers to a specific facilitator, number refers to an offender.

Facilitator demographics.

At the time of the study the Department of Corrections employed approximately 125 facilitators, and the only requirement for inclusion in this study was that a facilitator had been approved by the Department of Corrections to deliver the SMP to medium risk offenders. All Department of Correction's facilitators undertake an eight-week training programme in the foundational skills of facilitating programmes. In addition to this, SMP facilitators undertake five days of seminar based training in the content of the SMP programme, and the practice of motivational interviewing as it relates to the SMP (Austin, 2012). Table 4 outlines facilitators' demographic data, years of experience as a facilitator, the number of SMPs delivered, and

training received in addition to standard Department of Corrections SMP training. Facilitators also had to meet professional practice standards before they began delivering the SMP, which required the submission of a portfolio, a supervisor's report, a manager's report, and reports from co-facilitators. This information went before a panel of experts for review before a facilitator could be approved to deliver the SMP (Austin, 2012). Four of the facilitators reported receiving additional training in MI. The facilitators had a range of training backgrounds, including psychology, law, counselling, nursing, social sciences and arts, and Maori cultural sensitivities.

Table 4

Facilitator Demographic Data¹ for both Main Sample and Replication Sample

Gender	Male	6
	Female	2
Age	Mean (SD)	33 (7.57)
	Range	26-48
Ethnicity ²	NZ European	2
	Maori	3
	Other	3
Highest Qualification	Bachelor's Degree	4
	Postgraduate Diploma	2
	Diploma or Certificate	2
Years of Facilitating Experience	Mean (SD)	3.36 (1.50)
	Range	1.75-6 years
Previous SMPs Conducted	Mean (SD)	8.90 (7.05)
	Range	2-20
Days of MI Training in addition to standard Department of Corrections Training	Mean (SD)	2.55 (2.38)
	Range	0-8

Note. Table adapted with permission from Austin (2012).

¹ Two facilitators had two of their DVDs utilised in the final study, so although there were 10 DVDs used, there were only 8 unique facilitators.

² Ethnicity data has been collapsed into broader categories so as to preserve the identities of the small number of individuals in this study. Facilitators are identified by the ethnicity they selected in first order of rank.

Offender demographics.

The demographic information of offender participants can be seen in Table 5, including age, ethnicity, gender, and risk of recidivism.

Table 5

Offender Demographic Data (N = 10)

Age	Mean (SD)	37.57 (9.99)
	Range	21-56
Ethnicity	New Zealand Māori	40%
	New Zealand European	30%
	Pacific Island / Maori	10%
	Unknown	20%
Gender	Male	9
	Female	1
Risk of Recidivism	Mean (SD)	.41 (.15)
	Range	.12-.61

Risk of recidivism.

Upon commencing their sentences, all offenders underwent assessment to evaluate their risk for being re-imprisoned in the five years following their release. This information was used to guide decision-making regarding rehabilitative interventions, in line with the risk principle of effective correctional rehabilitation (Andrews & Bonta, 2010). This assessment was undertaken using the Risk of Reconviction x Risk of Imprisonment scale (RoC*RoI; Bakker, O'Malley, & Riley, 1999), a second generation actuarial risk assessment tool based on the case histories of 133,000 New Zealand offenders. The SMP is a low intensity programme, generally targeting offenders with a medium risk of recidivism, as reflected by a risk score ranging from 0.30 to 0.70. The offenders individual RoC*RoI scores can be seen in Table 5.

Ethical considerations with regards to participants.

There were three main groups to consider with regards to ethics: facilitators, offenders, and Maori. This research developed out of a study by Austin (2012), which this researcher had also been involved in. Both studies used the same sample of DVDs of recorded therapy sessions between facilitators and offenders, and therefore had the same ethical issues to consider.

Information was reported in such a way that no individual facilitator or offender could be identified, and all identifying information was deleted upon completion of coding.

Facilitators.

The key ethical issues with regards to facilitators were ensuring that they were fully informed, that consent was gained, and that they did not feel coerced into participating. When the DVDs were first accessed in the study by Austin (2012), it was made clear to individual facilitators that their identities, and also their choice regarding involvement in the research (or not), would remain confidential, and that other Department of Corrections staff would also be unaware of their choice regarding involvement. They were also informed that they could withdraw from the study at any time. In the early stages of the current study, approval was gained from management at the Department of Correction to approach the facilitators and request their continued involvement in the research. Facilitators were then approached and a request was made to extend the time period for the use of their DVDs. They were informed of the nature of the new study, and the continued commitment of the researchers to maintain confidentiality. Department of Corrections management were at all times unaware of the specific facilitators involved in the study. Facilitators who requested a summary of the findings were sent a copy to the email address provided on their consent forms.

Offenders.

Consideration was given to whether offenders voluntarily participated in the research, and whether informed consent was given by offenders. The majority of the DVDs used were accessed for this study 2 to 3 years after the offenders had been involved in the Short Motivational Programme (SMP). There was no interaction between the researchers and the offenders. The SMP begins with a pre-session in which the programme is explained to the offender, and their consent to partake in the programme is requested (Austin, 2012). As part of this consent process, the facilitator points out that the data collected may be used for research purposes. Austin noted the potential conflict that exists here, with offenders potentially perceiving that participation may have been of benefit to them, or that non-participation may have in some way been detrimental. The chances of this happening may have been furthered due to the fact that offenders were informed that progress reports will be placed on their file, and could potentially be viewed by a parole board. These issues have been raised by other researchers, and Johnston (Johnston, Love, & Whittaker, 2000) suggested that inducements are ethical when consistent with treatment goals, and when treatment goals may lead to reduced recidivism and increased community safety.

Consideration of Maori interests.

It was important to ensure that the research would be of no harm to Maori, and that it could be of potential benefit to this group of individuals, especially given the disproportionate representation of Maori within the prison system. Cultural consultation was undertaken with a cultural advisor at the outset of the research, and this was maintained through until the completion of the study. It was determined that there was no potential harm to Maori. It was further determined that the study could be of potential benefit to Maori, given that MI has been found to have differentially positive effects with ethnic minority groups (Hetteema et al., 2005).

Measures

Measure selection.

There were a number of variables highlighted as being important to measure from within the literature review—therapist empathy (both perspective taking and affective attunement), therapist autonomy support, and client resistance. This process highlighted what needed to be measured, and the next step involved understanding how to best measure these variables in order to best answer the research questions. It is important to clarify that the concepts of resistance and reactance are often used interchangeably by leading researchers (Beutler et al., 2011), and they will not be differentiated for the purposes of this research. However, the term reactance is generally used to recognise that the therapeutic environment can contribute to non-compliance in therapy, and the resistance does not lie solely with the client. The selection of appropriate measures and the manner in which these measures were used were critical factors in this study. The research was fundamentally process research involving the investigation of the moment to moment interaction between a therapist and a client, and whether (and how) therapist and client variables would be related at this molecular level. Two key considerations for the measures and their use were the timeframe within which behaviours were measured, and the specific operationalisation of the therapist and client behaviours to be measured.

With regards to the measurement timeframe, many studies investigating therapist or client variables have taken measurements at a global level, generally at the level of a one-hour session. As has been pointed out, relying on global ratings means that within session fluctuations in behaviour are concealed (Fiske, 1977; Gurman, 1973). Individual therapist's interpersonal skills are suggested as varying widely across an entire session, highlighting the importance of repeated, within session measurements (Gurman, 1973). Although repeated measurements at regular intervals were necessary, a detailed sequential analysis was not the focus of this study, so it was not necessary to utilise a measure that coded each individual utterance by a therapist or

client. Rather, the method of data collection was driven by the study's goals of investigating the nature of the relationships between these variables. The time interval needed to be small enough to capture the moment to moment interaction of a client and therapist, but did not need to capture every utterance within the dyad. The timeframe also needed to be large enough to allow the meaning of an interaction to come through, but not so large that there would be too many behaviours and interaction styles occurring within the specified timeframe. Previous studies using the Client Resistance Code (CRC)—which was also used in this research— provided some guidance as to the coding timeframes (Aviram & Westra, 2011; Westra, 2011). Aviram and Westra used 30 second duration time segments; however their study only coded for client resistance, and did not investigate any therapist behaviours at the molecular level. It was decided that a one minute timeframe would allow a reasonable amount of time for both therapist and client interaction to take place, and be meaningfully coded.

A related consideration was the *level* of behaviour to code. Many studies coding molecular in-session behaviours take the path of first transcribing the therapeutic discourse, and then coding every utterance made by both the therapist and the client. For example, many motivational interviewing studies use the Motivational Interviewing Skills Code (MISC; Miller, Moyers, Ernst & Amrhein, 2003) which codes each therapist and client utterance according to behaviour categories established from within an MI framework. However, as has been pointed out by Stiles, Honos-Webb, and Surko, (1998), events in therapy sessions that are descriptively equivalent—for example a range of events that would be coded as a reflection—are not necessarily equivalent in value. The mere fact that these therapeutic techniques have been used does not mean they were used appropriately, consistently with recognised treatment principles, and in a manner responsive to the context. In other words, the meaning of the event can be lost in the coding of a technique. Stiles et al. suggest that when evaluative judgements of therapeutic processes are being made they should incorporate an element of judgement regarding appropriate responsiveness of the intervention. The current authors involvement in a previous study (Austin, 2012) using the MISC had highlighted the fact that important and meaningful aspects of a behaviour can be lost when they are simply assigned to a code such as “reflection “, or “open question”. This thinking is also in line with recent alternative conceptualisations of Psychology, where considerable emphasis is placed on the study of meaning, and the management of these meanings (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). It was therefore decided that less technique focused measures of behaviour would be utilised, in order to capture the meaning of client and therapist behaviours.

The knowledge outlined in the above discussion brought the research to a point where it was known what variables would to be measured, and how they could best be measured. The next step was to search existing research literature for the scales that best fitted these requirements.

There were five observer-rated scales highlighted as best fitting the requirements of the research. The majority of the scales—Empathy-perspective taking (E-p), Empathy-attunement (E-a), Autonomy Support, and Client Resistance Code (CRC)—were selected for use in coding each one minute segment of the SMP sessions. The final measure—the Working Alliance Inventory (WAI-SR-O)—was selected as the sole scale to be used to code at the global level of the entire session.

Working alliance.

An adapted version of the Working Alliance Inventory – Observer Version (WAI-O; Horvath & Tichener, 1981; Horvath, 1990) was used in this study, and was the only scale utilised in a global manner, with scoring being conducted on a single occasion after viewing an entire one hour SMP session. The WAI is a coding system grounded in Bordin’s (1979) theoretical model of the therapeutic alliance, and is designed to measure agreement between a client and therapist on the goals of treatment, agreement on how to reach these goals (tasks), and the interpersonal bond between the client and therapist. Bordin’s conceptualization of the therapeutic alliance has been adopted by many psychotherapy researchers, including Horvath and Greenberg (1989) who developed the WAI. The original WAI is a 36-item measure, but there are many iterations of the measure including: client, therapist, and observer versions.

There has been a consistent finding of a moderate but robust relationship between the therapeutic working alliance and treatment outcome, across a broad spectrum of treatments, in a variety of problem contexts (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Ganske, & Davis, 2000). The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and the Working Alliance Inventory/Short Form (WAI-S; Tracey & Kokotovic, 1989) are widely used measures of the working alliance in research, and have been extensively validated. The WAI is a well triangulated measure with good validity data, and the observer versions of the WAI have high inter-rater reliability (Elvins & Green, 2008). An alternative 12-item measure, the Working Alliance Inventory/Short Form Revised (WAI-SR; Hatcher & Gillaspay, 2006) was recently developed and has received good support and validation (Gelso, 2009; Tryon, Blackwell, & Hammel, 2007). The WAI-SR better differentiated goal, task, and bond alliance dimensions and correlated well with other alliance measures. In the present study the WAI-SR measure was adapted slightly to be an observer-rated instrument, as it previously existed only as a client based measure. Observer based versions of longer forms of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) were used to guide these alterations, and the process was undertaken with guidance from the lead supervisor. From herein, the adapted measure will be referred to as the Working Alliance Inventory/Short Form Revised/Observer version (WAI-SR-O).

The WAI-SR-O was selected for use for a number of reasons. The WAI has previously been found to be related to resistance levels, even where the levels of resistance were limited (Watson & McMullen, 2005). The other measures used in this study were not as well established or researched, and it was thought that the use of the WAI-SR-O provided a good frame of reference from which to compare this study with previous research. Furthermore, there is still much to be learnt about specific behaviours that enhance or restrict the development of the therapeutic alliance (Ross, Polaschek, & Ward, 2008), and although this was not the focus of the study, the inclusion of this measure allowed consideration of whether specific therapist behaviours enhance the alliance, and whether client resistance would be related to the development of an alliance.

Empathy.

Empathy is thought to be a higher order category within which various subtypes, aspects, and modes can be identified (Elliott et al., 2011). Elliott et al. highlight three main modes of expressing empathy: empathic rapport, communicative attunement, and person empathy. The authors note this is somewhat in line with current neuropsychological understandings of empathy which suggest that it is composed of an emotional simulation process, a conceptual perspective taking process, and an emotion regulation process. There are very few observational measures of empathy available (Elliott et al.), and of these, only the Truax and Carkhuff (1967) Accurate Empathy measure and its alternate form—Carkhuff's (1969) Empathic Understanding scale—have been widely used in research studies. Watson, Prosser, Goldman and Warner's (2002) measure of expressed empathy has been suggested as an alternative which may have greater the psychometric properties, however an attempt to access this measure was not successful. For this study, two observer based empathy scales were selected, each of which measured slightly different aspects of empathy. The first was the popular Carkhuff (1969) Empathic Understanding scale. The second was an empathy scale which was part of a broader measure of treatment integrity from within an MI perspective (MITI; Moyers, Martin, Manuel, et al., 2007). The anchors on these two scales are quite different, reflecting the fact that they focus on slightly different aspects of empathy. The MITI scale refers to a therapists understanding of a client's perspective, worldview, and point of view, and there is no reference in the anchors to understanding of a client's feelings. In contrast, Carkhuff's scale places considerable focus on understanding and attuning to a client's feelings, as well as on perspective taking.

Empathy-perspective taking (MITI; Moyers, Martin, Manual, Miller, 2003) .

The Empathy-perspective taking scale (E-p) is a component of the MITI and was designed to measure the therapist's level of understanding of a client's perspective and worldview. The

MITI was specifically developed to measure treatment integrity from within an MI framework, and in this context it is an empirically validated measure. However, only one of the five global scales from the MITI (empathy) was used in the current study, and the scale was used to measure behaviour in one minute segments, compared to the 20 minute segments normally used. Care was therefore needed when interpreting data resulting from use of this measure. However, given the lack of alternatives with regards to empathy measures, and the theoretical relevance of this aspect of empathy, it was judged that this scale was the best choice for inclusion in this study. It also offered both the potential to develop a better understanding of how this construct could be measured, as well as its relationship to client resistance.

Empathic understanding.

The Carkhuff (1969) measure of empathic understanding and attunement (herein referred to as Empathy-attunement, or E-a) is a five point Likert scale that was developed from the original Truax and Carkhuff (1967) Accurate Empathy scale, a longer nine point version. Engram and Vandergoot (1978) pointed out that there is extensive information regarding the psychometric properties of the original Truax and Carkhuff scale. The authors also undertook a study which showed strong concurrent validity for the newer measure, which also received excellent inter-rater reliability. Although some authors have raised questions regarding the validity of existing empathy scales (Norcross & Lambert, 2011), including Carkhuff's empathy scale, Hill & Lambert (2004) point out that it remains one of the most frequently used process measures in psychological research.

The potential relationship of empathy to client resistance was a central aspect in this research, and the lack of available options to measure empathy meant that this extensively utilised measure was the best choice for the present study.

Autonomy support.

The 5 point Autonomy Support scale was extracted for use from the Motivational Interviewing Treatment Integrity Scale (MITI; Moyers, Martin, Manual, Miller, 2003). The Autonomy Support scale in the MITI is used to measure the extent to which a clinician supports and actively promotes a client's perception of choice, rather than trying to control the behaviour or choices of a client. Anchors on the scale are designed to measure both supportive and non-supportive therapist behaviours, in other words, to measure behaviours of therapists with regards to behaviour that both supports and limits a client's autonomy. The MITI was specifically developed to measure treatment integrity from within an MI framework, and in this context it is an empirically validated measure. However, in this study the scale was used to measure behaviour at the molecular level of one minute segments, compared to the 20 minute

segments normally used. The above limitations of this measure mean care will need to be taken in the interpretation of data resulting from use of this measure. However, given the lack of availability of other autonomy support measures, and the theoretical relevance of autonomy support, it was judged that this scale was a good choice to include in the study. It also offered both the potential to develop a better understanding of how this construct could be measured, as well as its relationship to client resistance.

Client resistance.

The Client Resistance Code (CRC; Chamberlain et al., 1985) defines resistance as any behaviour which opposes, blocks, diverts, or impedes the direction set by the therapist. Westra, Aviram, Connors, Kertes, and Ahmed (2012) have recently used this measure in a number of studies. They emphasise that resistance is a function of the interpersonal dynamics between a client and therapist, and that the CRC could be viewed as a reflecting the degree of client engagement in a session. Notably, this opposition or lack of engagement does not have to be with regard to any particular behaviour change, as is the case in motivational interviewing studies. The CRC codes resistance based on seven broad categories of resistant behaviour, including interrupting and talking over the therapist, a negative attitude towards the therapist (e.g. disagreement or blaming others), challenging or confronting the therapist, own agenda, and not tracking. Resistance is seen as manifesting both directly (e.g., explicit verbal statements) and indirectly (e.g., disagreeing, ignoring, interrupting, etc.). The CRC has demonstrated face and content validity (Bischoff & Tracey, 1995), as well as good construct and predictive validity (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984; Patterson & Forgatch, 1985). In a study by Westra (2011) inter-rater reliability scores of between 0.73 and 0.87 were achieved (as assessed by ICC), indicating good to excellent agreement amongst coders.

In the present study, the seven categories of resistant behaviour outlined in the CRC were collapsed into a single measure, in the same manner as a number of other studies (Westra, Aviram, Kertes, Ahmed, & Connors, 2009; Westra 2011). Collapsing these seven categories of resistant behaviours into a single measure of client resistance enabled the research to capture the presence or absence of a range of resistant behaviours, which was of more interest than understanding the specific forms of resistant behaviour that might be occurring. This resulted in a client resistance scale with the following four anchor points: 0 = no resistance/co-operation, 1 = minimal, qualified resistance, 2 = clear, unqualified resistance, 3 = hostility/confrontation. In order to make interpretation of the Likert scale more intuitive, the scale was converted from having levels range from 1 to 4 to instead having levels range from 0 to 3, with a zero representing “no resistance”. As with the other molecular scales used in this study, each one minute segment was coded using the CRC. It is important to note that the discussion of the

different levels of resistance in the results and discussion sections of this study often use slightly different descriptors of the different anchors on the scale (see Table 2).

In previous studies (Aviram & Westra, 2011) video sessions have been divided into time-bins as opposed to using talk turns. This has a number of advantages, including the fact that coding can be done directly from therapy sessions recorded on DVDs (rather than using transcripts), thus allowing coders to concentrate on identifying the *gestalt of the timeframe* – including the *verbal and nonverbal cues*. Aviram and Westra emphasise the importance of this when coding resistance, because *voice intonations and inflections*—as opposed to particular words—can often signal the presence and level of client resistance. The Aviram and Westra study made use of 30 second time-bins but did not code therapist responses, instead focusing only on client behaviours in these timeframes. For the purposes of the present study, a slightly larger time-frame of a 1 minute was utilised so that interpersonal interactions could be captured.

Procedure

Approval for this study was granted by Massey University Human Ethics Committee Northern (MUHECN), and the Department of Corrections (see Appendix A).

Initial participant selection.

The DVD recordings of SMP sessions used in this study were initially accessed in a prior study undertaken by Austin (2012), which this researcher had also been involved with and which overlapped with the current study. As part of the on-going collaboration between Massey University and the Department of Corrections (DoC), regular meetings were held between doctoral research students, Massey University research staff, and staff from the DoC, to ensure the quality and integrity of the research being undertaken. In the prior study by Austin, facilitators were recruited through a convenience sample of facilitators currently delivering the SMP to medium risk offenders. At the termination of that study, the DVDs were returned to the Department of Corrections, and a letter was sent to all facilitators informing them of the termination of the study. In that letter, a second document was included (Appendix E) from the current researcher, requesting consent for their involvement in the present study. This document also outlined the current researcher's prior involvement in the research by Austin, the theoretical and practical basis for the planned research, and a commitment to respect the privacy of facilitators. The process of obtaining facilitator approval was undertaken separately and anonymously from the DoC head office, in order to minimise any pressure facilitators might feel to be involved in the research. Of the 12 facilitators approached, 11 consented to the use of their DVDs in this study. The DVDs provided by facilitators consisted of SMP sessions undertaken in 2009/2010. There was a range of differences in sessions provided, such as some

SMP's having missing sessions, or sessions which had not recorded properly. Facilitators were encouraged to submit DVDs without regard for whether offenders had completed all five sessions, or whether all sessions were successfully recorded.

Training in motivational interviewing and use of measures.

Training in the coding of SMP sessions consisted of a number of factors. The lead researcher and co-researcher had considerable familiarity with MI theory, practice principles, and methods. The lead researcher was a Doctoral Psychology student, and the co-researcher was a Clinical Psychologist with 15 years' experience. The co-researcher had 6 months experience delivering the SMP, which included supervision and feedback, and had attended a one day and two day workshop on MI. Both researchers had previously been involved with research into MI, which had involved intensive training in the coding of MI DVD based sessions, although this had involved the use of different measures. During this prior study, both researchers attended a two day training programme on how to code MI sessions using the MISC measure, and the lead researcher had undertaken a further 3 full days of training in preparation for coding in the Austin (2012) study. An important aspect of coding in the current study was that non verbal cues were also coded, which was a change from previous coding the raters had been involved in, where the language coded was based on the literal meaning of the words. Coding practise therefore also involved becoming familiar with considering the perceived meaning behind an utterance. For the present study, the lead researcher undertook seven days of practice coding in order to become familiar with the measures (including two days with the co-researcher), and discover any issues arising in their use (see measure refinement below). During this period, a record was kept of difficulties arising with the use of measures, and discussions were had with research supervisors. Finally, the lead researcher and co-researcher together undertook four days of further coding practice, in order to get inter-rater reliability, as well as having regular discussions with the lead supervisor.

Selection of preliminary training set of DVDs.

For the sake of clarity, it may be useful to reiterate some of the terminology to be used in this section (also see Table 2). An SMP refers to a five session programme involving the same facilitator and offender. The facilitators are referred to interchangeably as both facilitators and therapists. Individual SMP sessions are generally referred to as 'SMP sessions', or 'DVD sessions'. Some facilitators provided DVDs of two multiple SMP's, which meant there were two offenders associated with some facilitators. It is worth reiterating that the pilot study was essentially a process of preparation for the main study. This involved the selection of a manageable number of relevant DVDs (referred to as the preliminary training set) from the

sample of 89 available, gaining familiarity with how the measures and coding process worked, as well as investigating whether there were any ways to make improvements to the study. The selection of a smaller and more manageable number of DVDs for the pilot study was required because the study involved an intensive, close-up focus on the minute by minute interaction between therapists and clients, and each dyad would provide up to 65 data points. Because of the large number of data points per dyad, fewer dyads were required for the study. (Note that a more detailed rationale for the selection of the 10 DVDs in the main study is provided further on). In order to select the DVDs to be used in the pilot study, it was necessary to create a set of DVD selection criteria for use in this process. These selection criteria were based upon information gained from the prior study by Austin (2012), and were created according to a number of factors relevant to the present study. Firstly, the primary purpose of this study was to investigate client resistance, and it was important that DVD sessions were included which actually featured a range of client resistance across the different dyads. Secondly, it was important to have a heterogeneous sample of facilitators, and a cross section of therapist relational skills (i.e. empathy and autonomy support). Thirdly, it was important to include SMPs where there were Maori offenders, as this had been stipulated by the DoC as an important part of the research. All of the DVDs had previously been coded in Austin's research (using the MISC), and there was knowledge as to which SMP sessions contained examples of high and low therapist relational skills and which were likely to include client resistance. Specifically, there was some objective information available from this study with regards to client resistance from the coding of sustain talk by offenders (sustain talk is considered a form of client resistance (Miller & Rollnick, 2012)). There was also objective information available with regard to therapists' relational skills from the coding of therapist acceptance, empathy, and adherence to the Spirit of MI (consisting of collaboration, evocation, and autonomy support) at a global (session) level. This information had been verified as objective through an inter-rater reliability analysis. There was also some subjective knowledge used in guiding the selection of the preliminary training set. This was based on recollections by the coders of client resistance observed whilst coding in the Austin study. Using the total of this knowledge, the current researcher, guided by the lead researcher in Austin's study, split all of the SMPs into three groups based on the dyadic interaction style (poor dyadic relationship, medium dyadic relationship, good dyadic relationship). Based on the above DVD selection guidelines, between three to five SMPs were then selected from within each dyadic interaction style in order to provide heterogeneity of session style, therapist, offender, and to ensure that Maori offenders were included. The outcome of this process was that from the initial 89 DVDs available, the preliminary training set of 32 SMP sessions was selected, involving 9 therapists, 15 offenders, and 32 DVDs (Table 3).

Coding practise and measure refinement.

As noted previously (see pp.71-72), coding was based not only on the literal meaning of the language used (verbal utterances), but also on non verbal cues and the meaning that coders perceived was behind the language being used (see pp. 35-36 and p. 66 for the rationale behind this approach). With the 32 SMP sessions selected as a preliminary training set, a process was then initiated of coding the DVD sessions using the measures selected. This was undertaken in part with the co-researcher. However, during this period it became clear that there were a number of changes that could be made with regards to the measures which would improve this study. Firstly, the Autonomy Support scale was not functioning in the desired manner. This was partially because there was very little explicit autonomy support language being used by the therapists. A number of researchers (Deci & Ryan, 2000; Zuroff et al., 2007) have pointed out that autonomy support is broader than simply explicitly affirming a client's autonomy, and includes activities such as acknowledging and understanding client's perspectives. However, this and other important aspects of autonomy support were not being captured by this measure, although less explicitly obvious autonomy supporting behaviours (e.g., those supportive or non-supportive of the direction of a client's conversation) were sometimes being captured by the empathic perspective taking measure. This insight led to the Autonomy Support scale being dropped. Secondly, during training coding by the lead researcher, and then in training sessions with the co-researcher, it became clear that there was often as much resistance from the therapist as there was from the client, and that this behaviour was not being captured. This was important, because existing measures were capturing the lack of a positive intervention (e.g. low empathy), but were not capturing important negative interventions by therapists which appeared to be related to client resistance. This insight led to the creation and addition of a measure of therapist resistance (Therapist Resistance Code) derived from the Client Resistance Code.

Therapist resistance.

This study was initially only going to investigate three therapist variables for their involvement with client resistance on a moment by moment basis: empathic perspective taking, empathic attunement, and autonomy support. However, on viewing the DVDs in early training sessions, it soon became obvious that it was the therapist who was often resisting the client, and that this appeared to coincide with client resistance. It was therefore decided that a measure for therapist resistance would be created, by altering the Client Resistance Code so that it measured therapist's resistance towards the client (Therapist Resistance Code). A further reason for investigating therapist resistance was that this variable was theoretically relevant, in that it indirectly reflected the 12 Road Blocks to listening (Gordon, 1970) outlined by Miller and Rollnick (2012) as inconsistent with MI practise, and also aligned with the idea of therapist

counter-resistance put forward by Moyers and Rollnick (2002). This was an important addition to the study, and offered the chance to understand not only whether the absence of positive therapist behaviours was related to client resistance, but also whether and how specific negative therapist behaviours were related to client resistance.

Selection of final coding set of DVDs.

At this stage in the research process, the preliminary training set of 32 SMP sessions had been used to gain familiarity with the initial measures selected, to make alterations to the measures, and to provide initial training for the researchers on the final measures. The remaining tasks to be completed in the pilot study were as follows: to select the final coding set of 10 DVDs for use in the main study; to select specific areas in the 10 DVDs that could be used to train the researchers in the final measures selected; and to select specific areas in the 10 DVDs that could be used in the inter-rater reliability coding.

Choosing an appropriate number of DVDs for use in the final study was a balance between getting enough data from a variety of dyads to provide valid answers to the research questions, but not having so much data that there would not be time to undertake an in depth study of the client-therapist narrative. Kazdin (2003) outlines some of the differences between group research and single case design, and the fact that single case designs undertake a considerable number of measurements of a small number of individuals, as opposed to a large number of individuals being measured on only a small number of occasions (group research). For the purposes of this study, 10 individuals were to be measured approximately 50 times each, and in discussions with research supervisors and a behavioural research specialist, this was judged to provide sufficient data to see any relationships that may exist between the variables measured, and to answer the research questions. The decision to use 8 DVDs in the main sample of the study, and two as a replication sample, was also taken in consultation with this team of people. This decision resulted in there being 424 data points for the main sample of 8 dyads, averaging 53 data points per dyad. For the replication sample there were 22 data points across the 2 dyads, an average of 11 data points per dyad, consisting of the first 11 minutes of each DVD.

The next step involved the preliminary coding of all 32 DVDs in the preliminary training set using the final measures selected for the study (E-p, E-a, TR, CR, and WAI-SR-O) created the data necessary for the selection of DVDs for the inter-rater reliability coding and the final coding set in the main study. The selection of the 10 DVDs utilised similar selection guidelines as used in the preliminary training set of 32 DVDs, although there was now a lot more information to inform this process, based on the preliminary coding with the new measures. Firstly, DVD sessions were selected which were believed to contain low, medium, and high

levels of client resistance. Secondly, consideration was given to creating a heterogeneous sample of participants—both facilitators and clients—and therapist interpersonal styles. Finally a check was made to ensure Maori offenders were included in the selection. The outcome of this process was the final coding set of 10 DVDs, with four that were considered to contain higher levels of client resistance, four that contained low levels of client resistance, and two that contained medium levels of client resistance. This final coding set included 8 facilitators and 10 offenders, with 6 facilitators providing 1 SMP session each, and 2 facilitators providing 2 separate DVDs each from different SMPs (see Table 3). There were 8 DVDs selected as the main sample (three with higher levels of client resistance, three with lower levels of client resistance, and two that contained medium levels of client resistance), and the remaining 2 DVDs (one with high resistance and one with low resistance) were set aside for use as the small replication sample.

DVD selection for further training with co-researcher, and inter-rater reliability analysis.

It was important for the inter-rater reliability analysis that the tapes selected covered the full range of therapists, offenders, and a range of dyadic interactions styles. It was therefore decided that the majority of the DVDs included in the research would be used in the reliability analysis. In other words, instead of the co-researcher rating a certain percentage of the DVDs, she rated a small percentage of the majority of DVDs in the final coding set. For each of the 10 DVDs, two sections of approximately 10 minutes each were specifically selected. One 10 minute section was selected to undertake training with the co-researcher, and the other 10 minute section was selected for use in the inter-rater reliability coding. It is important to note that although these DVDs had already been coded by the lead researcher as part of the preliminary training process, the co-researcher brought significant clinical skill to the project, and this part of the process involved training the lead researcher as much as the co-researcher. This resulted in both researchers gaining greater clarity as to the variables being measured in the study, and the calibrating of the researchers' use of the measures across DVDs with a wide range of clients and therapists.

Inter-rater reliability.

Kazdin (2003) emphasises that the validity of any single case design begins with systematically collecting high-quality data. Verifying the reliability of systematic assessment measures used in this study was an integral part of this process, especially because of the somewhat idiosyncratic use, and adaptation, of existing measures. The coding required raters to make judgements regarding the behaviour of participants in video recorded sessions, and to rate the level of these

behaviours on a variety of scales, which were defined in terms of these behaviours. The psychometric integrity of observational data was critical to establish, to ensure that the sources of variability in the data stemmed from the subjects being observed, and not from the idiosyncratic use of measures by the raters (Gwet, 2012). In other words it was important to establish the extent to which the two coders were in relative agreement on their ratings of DVD sessions, across the five measures used in this research.

There are a number of considerations to take into account when calculating inter-rater reliability (Tinsley & Weiss, 1975). A first consideration is the statistic that should be used. Tinsley and Weiss recommend the intra-class correlation (ICC) to measure inter-rater reliability where there is ordinal or interval level measurement. The authors explain that although most research instruments used in psychology do not meet the formal criteria of interval level measurement, ordinal data can be assumed to be at the interval level of measurement without distorting the sampling distribution, as long as this assumption is not grossly inappropriate. It was considered appropriate to treat the scales used in this study as being interval level measures, and the ICC was selected for use.

There are a number of ways that the ICC can be calculated, and the appropriate calculation depends on the experimental designs and conceptual intent of the study (Shrout & Fleiss, 1979). Selecting the appropriate calculation required a number of questions to be answered. Firstly, a decision needed to be made as to whether the calculations required a one way or two way analysis of variance. For this study, each target was rated by each of the same two judges, and the study was only interested in a fixed set of raters, therefore a Target x Judges two-way ANOVA was the appropriate analysis mode. The second question was whether the intent was to measure the degree of relationship between the measurements with regards to consistency, or absolute agreement (McGraw & Wong, 1996). McGraw and Wong suggest a two way ANOVA specifying absolute agreement is the best choice for calculating inter-observer reliability. This mode of analysis was also used in previous studies utilising the same version of the client resistance scale, a further reason for its selection (Westra, 2011). Positive ICC values that approach 1.0 suggest that there is little or no variance between data and no residual variance. ICC values that approach 0 indicate that within group variance is equal to the variance between groups (Haggard, 1958).

The co-researcher utilised 10-20 minute sections of 9 DVDs from the final data set for the reliability coding. This resulted in 26% of the final data set being utilised for the inter-rater reliability analysis. The lead researcher coded these sections of the DVDs separately, during the same day that the co-researcher coded these sections of the DVDs, so that current levels of inter-rater reliability could be quickly calculated, and any need for further training established. Inter-rater agreements were calculated for each measure coded by the researchers. Cichetti's

(1994) categorisation system was used to evaluate the ICCs. A correlation coefficient of below .40 is considered poor, 0.40 to 0.59 is fair, 0.59 to 0.74 is good and 0.75 to 1.0 is excellent. The results from the analysis showed inter-rater reliability for each of the measures as follows: E-p = 0.908; E-a = 0.877; TR = 0.931; CR = 0.944. The inter-rater reliability analysis for the WAI-SR-O measure included only 3 dyads, and the analysis showed a value of 0.742. These results showed that there were excellent reliability on each of the molecular measures, good reliability on the global measure, and indicated that the lead researcher could continue coding the remainder of the final coding set.

Outcomes from the Pilot Study

The outcomes of the pilot study provided: A final set of measures, which had been verified as reliable through the inter-rater reliability analysis; and a final coding set of DVDs to be used for the main study.

Main Study

The outcomes of the pilot study provided both a final set of measures, and a final coding set of DVDs to be used for the main study (Table 3, Table 6). The main tasks in this part of the study were the coding of the final data set to provide the data for the main analysis. Each of these tasks is outlined in detail below.

Participants

The DVD selection process from the pilot study had resulted in the selection in a *final coding set* of 10 DVDs, 8 to be used in the main sample, and 2 for use in the replication sample (Table 3, Table 6). It was extremely important that the identity of the facilitators and clients remained confidential, and therefore there was no identifying demographic information made available for this small sample of participants.

Table 6

Details of Dyads Selected for the Final Coding Set

Dyad identifier	Client resistance	SMP session coded	Main Sample or Replication Sample
	level identified from preliminary coding		
Dyad 1	High	Session 3	Main Sample
Dyad 2	Medium	Session 3	Main Sample
Dyad 3	High	Session 2	Main Sample
Dyad 4	Low	Session 3	Main Sample
Dyad 5	Low	Session 3	Main Sample
Dyad 6	Medium	Session 2	Main Sample
Dyad 7	High	Session 5	Main Sample
Dyad 8	Low	Session 3	Main Sample
Dyad 9	High	Session 1	Replication Sample
Dyad 10	Low	Session 3	Replication Sample

Procedure

A structured system was created for the researchers to undertake coding of the DVDs. An excel template was created into which the scores on the measures could be directly entered. The template included a section for each minute coded, and each of these sections had an area in which the scales for each measure being used could be filled out. A Microsoft Word file was

also created which contained the individual scales to be used, along with guidelines for using the scales (Appendix B). The general procedure undertaken was that a one minute segment of DVD would be watched, after which the Microsoft Word document containing the measures and guidelines was referred to and reflected upon. Generally, the one minute segments would then be watched a second time, whilst referring to the scales/guidelines, and at the end of this second viewing the scales would be coded. In some cases, the segments could easily be coded after watching the segment for the first time. However, in many instances, especially where client and therapist resistance were present to some extent, it was necessary to view the one minute segments between 2 to 4 times.

As was described in the method section (see pp. 71-72), the coders paid attention to both the verbal and non verbal behaviour in DVDs. This could be quite important at times, such as when clients would make an utterance (e.g., "Mmmm") that appeared on paper to be an agreement with a therapist, but when taken in the context non verbal behaviour (e.g., a sarcastic tone) may have been clearly oppositional. This required that coders make evaluative judgements regarding the meaning of a client's behaviour, as has been previously highlighted as an important aspect of research (see pp. 35-36, 66), and in contrast to much of the current research into resistance, which has primarily focused on coding client language. As noted (see p. 70), client resistance did not have to be with regard to any particular behaviour change.

It was notable that there was a considerable difference in the way segments were coded from the preliminary coding in the pilot study to the final coding in the main study. Specifically, it became clear that in the preliminary coding a considerable quantity of the client resistant behaviour had not been captured. There were a number of contributing reasons for this, including the fact that there was perhaps more emphasis placed on the gestalt of the entire encounter at the level of the session rather than the segment, and lack of coder attunement to the resistant language clients were using. In addition, the coders became better at recognising small quantities of resistant behaviour within a segment where the remainder of the segment may not have featured client resistance. The need to code for peak client resistance in a session was outlined in previous studies (Aviram & Westra, 2011; Westra et al., 2011).

Measures

In the pilot study, the five measures selected for use were: An adapted version of the Working Alliance Inventory – Observer Version (Horvath & Tichener, 1981, Horvath, 1990); Empathy-perspective taking (E-p) from the Motivational Interviewing Treatment Integrity Scale (MITI; Moyers, Martin, Manual, Miller, 2003); Empathy-attunement (Carkhuff, 1969), the Autonomy Support scale extracted from the Motivational Interviewing Treatment Integrity measure (MITI; Moyers, Martin, Manual, Miller, 2003); and the Client Resistance Code (CRC: Chamberlain et

al., 1985). For the main study, the Autonomy Support scale was dropped, and an additional scale was added: the Therapist Resistance Code (TRC; Provan, Clarke & Williams, 2012). There were also some specific guidelines put in place to make the use of some of the measures easier to use for both of the coders. The final measures, and the additional guidelines put in place for their use, are reproduced in Appendix B.

Data Analysis

The selection of data analysis techniques for this study required aligning the research questions with best practice principles with regards to single case design research. This was not particularly straightforward; due to the fact that the design of the study was somewhat different from existing single case research studies, as well as there being considerable debate regarding analysis of single case design research. Single case research designs within psychology are predominantly utilised to investigate whether a specific intervention by a therapist creates a change in behaviour by a client (Gast, 2010). Generally, measurements of client behaviour (dependent variable) will be made on a number of occasions prior to the intervention to establish a baseline of client behaviour, after which the intervention is introduced (independent variable manipulation). Post intervention measurements are then made to establish if there were any changes in the client behaviour (dependent variable). In contrast to this, the current study *continuously* measured both therapist and client variables over an entire session, with no predetermined hypothesis regarding the causal role of any given variable. In other words, the research question was not investigating the outcome of a specific intervention, but was rather exploring the relationship between different types of therapist relational skills and client resistance. This provided a challenge with regards to the analysis, because the techniques generally used to analyse the data in single case design studies are generally based on the existence of a specific therapeutic intervention, which was not a feature of this study.

Despite these challenges, there are some underlying principles with regards to the analysis of single case designs which were available to guide decision-making in the present study. The study required guiding principles for two key questions. Firstly, what were the key properties of the data that were of interest to help answer the research questions? Secondly, what were the best analysis techniques to use in order to analyse these data properties? Gast (2010) suggests key properties of a data set to analyse are the *level* and *trend* of the data. Kazdin (2010) emphasises that the degree to which inferences can be drawn depends on the kinds of change that are seen, and suggests it is the *immediacy* and *magnitude* of changes seen that provide the most information with regards to the relationship between variables. These factors fitted well with the research questions, which sought to investigate any relationship between *levels* of client resistance and therapist relational variables over time, including the magnitude and

immediacy of changes in these levels. The next question was which data analysis techniques to use in order to analyse these data properties and the relationships between the therapist and client variables. The question of how to analyse single participant data has been a contentious one (Morgan & Morgan, 2001). The majority of the debate has centred on whether the graphical display and visual analysis of data are sufficient, or whether a more Fisherian approach and inferential statistics should be used. Gast (2010) points out that there is currently no statistical procedure which effectively handles all types of single case data, as was discovered in this research.

The argument for and against visual analysis.

There are a variety of arguments put forward both for and against visual analysis of data. Historically visual analysis techniques have been dominant within the behaviour analysis literature with many authors citing Skinner's (1963) considerable support for this analysis technique. Skinner noted:

The simpler [direct observation] procedure is possible because rate of responding and changes in rate can be directly observed . . . The effect is similar to increasing the resolving power of a microscope: A new subject matter is suddenly open to direct inspection. Statistical methods are unnecessary. When a variable is changed and the effect on performance observed, it is for most purposes idle to prove statistically that a change has indeed occurred (p. 508).

Some have suggested that statistical techniques, such as time series analysis, are less conservative than visual analysis (Parsonson & Baer, 1986). Edwards, Lindman, and Savage (1963, p. 217) argued that an *inter-ocular traumatic test of significance* should be performed, where patterns of graphical representation of data should be of a large enough magnitude to be extremely obvious to viewers, before they are considered significant. However, Gast (2010) also notes that some authors contend the opposite, arguing that type I error has been shown to be more likely, especially where there is autocorrelation within the data. Parsonson and Baer (1986) also argued that visual analysis of graphed data provides access to the primary data, thus allowing multiple judges to inspect and cross verify their conclusions. The data is also made available for independent analysis and interpretation, rather than being hidden behind statistics, allowing interested parties outside of the research to come to their own conclusions. The authors note that this also prevents the manipulation of statistics in order to find a significant result.

A number of issues have also been raised with regards to using visual analysis as the sole method of analysis (Gast, 2010). Judgements made by different raters have been shown not always to be reliable, and there is a lack of universal decision rules to guide visual analysis.

Gast emphasises the long history, dominance, and significant benefits of a visual analysis. However, the author concludes by suggesting that utilising both a visual and statistical analysis may provide the most conservative means to reach a conclusion about the presence or absence of a functional relationship between variables. Gast provides a number of statistical analyses which could be used, but notes that there is no agreement on the correct method to use with single participant data, although a strong recommendation is given to investigate the degree of autocorrelation in the data set. However, the author's recommendations for analyses are restricted to single case designs investigating client behaviour pre-and post a therapeutic intervention, and analyses of continuous dyadic interactions over time are not addressed.

The analysis plan for this study.

With the above discussion in mind, it was decided that in order to best answer the research questions there would be a number of levels to the analysis. Firstly, a *group-level analysis* was undertaken to investigate general patterns of the scores on the measures, for each dyad. This involved an exploration of the relationships between the variables measured at the broad level of the session, for each dyad, and then the comparison of any patterns found amongst the dyads. These relationships were analysed using statistical correlations, descriptive statistics, and a visual analysis of graphs. Secondly, a *single case* close up analysis was undertaken in two phases. It is important to note that client resistance was the central component of the research, and that the primary interest was investigating the relationship between the therapeutic variables and client resistance at each 1 minute segment. In the first phase of the single case analysis, the scores on the measures and relationships between the variables were more closely analysed at the level of a one minute segment, using descriptive statistics and visual analysis of graphed data. In the second phase of the single case analysis, interesting segments of DVDs—generally those with an onset, escalation or cessation of client resistance—were selected for an analysis of the client-therapist narrative at that point in time. This allowed the investigation of the unfolding of client-therapist dynamics within a segment. A more detailed description of the group-level analysis and single case analysis will now be outlined.

Group level analysis.

The group level analysis techniques were driven by the research questions. These could essentially be split into two types of question. Firstly, what was the extent of the resulting scores for each specific variable measured, across all of the dyads? To answer this question, the data for each dyad was aggregated so that scores could be easily compared against other dyads. The second type of question investigated the relationships between each of the measures. This involved entering the raw data into SPSS and calculating the correlation coefficients, as well as

the visual analysis of graphs and use of descriptive statistics. These two types of analyses will now be outlined in more detail.

Analysing the extent of the scores on the measures.

Analysing the *extent of client and therapist resistance* for each dyad was done by calculating the average resistance score across all segments of a session, as was done in the study by Westra (2011). Specifically, for client resistance, this involved adding up the scores on the CRC measure for each one minute segment coded, and dividing by the total number of segments coded, thus providing a single figure which was used to describe the extent of client resistance for that particular dyad. The same process was undertaken to analyse results on the TRC. These scores were then presented numerically and graphically, so that comparisons could be made between the client resistance and therapist resistance scores within a dyad, as well as allowing comparisons of the scores across the dyads. Consideration was also given to the range and variability of the scores. An additional analysis was undertaken for client and therapist resistance, which involved investigating—within each dyad—how often the variables occurred together under two different scenarios. In the first scenario, the segments in a dyad where therapist resistance was present were counted, and then within these segments, the percentage which also featured client resistance was calculated. In the second scenario the segments in a dyad where therapist resistance was absent were counted, and then within these segments, the percentage which featured client resistance was calculated. This analysis provided information regarding the relationship between CR and TR within the dyads that could be analysed across all the dyads to reveal any broad patterns.

Analysing the extent of therapist empathy for a dyad used a similar process as the analysis of resistance. The average empathy scores for a session were calculated for each of the empathy measures, for each dyad. This resulted in two aggregated empathy scores for each dyad, one representing an average empathy score for perspective taking and another representing the average score for attunement. These scores were then presented numerically and graphically, so that comparisons could be made between the two empathy scores within a dyad, as well as comparisons of the empathy scores across the dyads. Consideration was also given to the range and variability of the scores. It is important to note that these average scores were often discussed with reference to the “mid-point on the measure”. For example, if the average score across a session on the E-p measure was 2.9, this would be below the mid-point on the E-p measure (3), which has a range from 1-5.

Analysing the working alliance for a dyad was a slightly different process than for resistance and empathy, due to the fact that the WAI-SR-O was a global measure, and was not coded continuously. This analysis was undertaken by totalling the raw scores on the different

questions of the measure, so that there was an aggregated raw score for each of the subscales (Goals, Tasks, and Bond), as well as a total raw score for the entire measure. This resulted in four raw scores for each dyad with regards to the WAI-SR-O. These scores were presented numerically and graphically, so that comparisons could be made across the dyads.

Consideration was also given to the range and variability of the scores. Scores on the WAI-SR-O were also discussed with reference to the mid-point on the measure (3), which has a range from 1-5.

Analysing the relationships between the variables measured.

The relationships between the five variables measured (E-p, E-a, CR, TR, and WAI-SR-O) were calculated using a Pearson product moment correlation coefficient. Pallant (2007) outlines that this is the coefficient of choice for interval level data when there are two continuous variables. It was important to ensure a set of assumptions were met before performing the correlation analysis. This involved generating a scatterplot and checking the results for outliers and non-linearity of the relationships between the CRC and scores on the measures of therapist variables, as well as between the CRC and the WAI-SR-O. These assumptions needed to be met before the calculation of the Pearson's correlation coefficient could proceed.

Single case close-up analysis.

It is important to re-emphasise that client resistance was the central component around which the research questions, and therefore the analysis, was framed. The single case close up analysis was undertaken in two phases. In Phase 1, the data was graphed, with the scores for each one minute segment being plotted for each measure, and this was repeated for each dyad. A visual analysis was then undertaken to investigate the relationships between the molecular measures (E-a, E-p, TRC, and CRC) across each 1 minute segment, within a given dyad. This analysis was supported with the use of descriptive statistics. Secondly, in Phase 2, segments of interest were highlighted from the previous analysis, and a qualitative analysis of the narrative from these segments was undertaken. These two phases are now elaborated on in more detail.

The quantitative and visual analysis undertaken in Phase 1 investigated each dyad individually for the level of synchrony between the four measures (E-p, E-a, TRC, and CRC), within each segment, whilst also looking for patterns of interest across an entire session. The investigation of synchrony amongst the measures, across the segments, was with regards to the level and intensity of the scores on the measures. The primary focus was the *onset, maintenance, escalation* and *cessation of client resistance*, the relationship of these events to changes in scores on measures of the therapist variables in the same segment, and the timing of these events. For example, where there was an onset of client resistance (CRC score moved from 0 to

more than 0), it was of interest to know the changes in therapist variables in that same segment (e.g., did therapist resistance or therapist empathy scores also change?). This analysis was undertaken using both a *visual analysis* of the graphed data, and through the use of descriptive statistics. For the visual analysis, scores on the individual measures were plotted for each segment, for all measures, and the resulting graphs of the scores on the four measures (E-p, E-a, TRC, and CRC) were stacked on top of each other. This created a simple way for the segment by segment fluctuations on the various measures to be easily analysed (e.g., Figure 13). The use of descriptive statistics provided a mechanism whereby patterns which appeared to exist within the graphed data could be further confirmed using quantitative techniques. There were four key statistics calculated as part of this analysis. Firstly, the number of segments where therapist resistance was present was counted, and within these segments, the number of segments which also contained client resistance was counted and calculated as a percentage of the therapist resistant segments. Secondly, the number of segments where therapist resistance was absent was counted, and within these segments, the number of segments which contained client resistance was counted and calculated as a percentage of the non-therapist resistant segments. Thirdly, the number of segments where client resistance was absent was counted, and within these segments, the number of segments where both therapist empathy scores were above zero was counted, and calculated as a percentage of the non-client resistant segments. Fourthly, the number of segments where client resistance was present was counted, and within these segments, the number of segments where one or more therapist empathy scores were below zero was counted and calculated as a percentage of the client resistant segments.

In the early stages of analysing the data, it became obvious that segments could be grouped together into three types of sections (a section being a group of segments), which had a number of common features. These three section types were: *absence of client resistance* (2 or more concurrent segments where CR=0); *brief client resistance* (1-2 concurrent segments where CR>0); and *prolonged client resistance* (3 or more concurrent segments where CR>0). Because these three sections types potentially added meaningful information it was decided that they would be included in the analysis. The first way in which this was done was by colouring each of these sections types within the graphs: blue represented the absence of client resistance; yellow represented brief client resistance; and pink represented prolonged client resistance. This also enhanced the ease in which the visual analysis could be undertaken. For example, where there was an absence of client resistance (coloured in blue), one could then easily identify patterns therapist measures presented in the stacked graphs above the client resistance graph, within the same coloured section.

The second stage of the analysis, in Phase 2, involved selecting a number of segments from each of the dyads, and undertaking a close up analysis of the narrative between the client and

the therapist. There was no use of made of any particular methodology for the narrative analysis. Rather, the focus was on relating the narrative of the client and therapist to the narrative of the anchors in the measures. In this way, the consumers of the research would be provided with examples of the actual data used in the coding, and could make their own interpretations of the results. The narrative analysis also allowed the investigation and discussion of how interpersonal dynamics unfolded within a segment. In order to restrict the size of the results section, only those utterances deemed most relevant to the measures were recorded, and in many cases excerpts of narrative were left out (this was signalled by the use of three ellipses "...").

The narrative analysis was undertaken in a structured and systematic manner, in order to create consistency across the dyads. The various section types previously highlighted—absence of client resistance, brief client resistance, and prolonged client resistance—were used to isolate segments of interest within a dyad. Particular features of interest within these segments were the absence, onset, escalation, and cessation of client resistance, although only some of these elements were analysed for each dyad. For each of the one minute segments selected for analysis, the scores on each of the measures were first introduced, followed by a table which included the narrative extract from all or part of that segment. The table was structured to present the therapist's and client's utterances in separate rows, and where appropriate, each of their narratives was accompanied by a comment/analysis of the narrative by the lead researcher. The comment/analysis focused on highlighting utterances that represented aspects of the different client and therapist measures. For example, if there was low therapist empathy and an onset of client resistance in the selected segment, then the utterances from the client and therapist which best represented these variables were highlighted. Then, in the comments section beside each of the utterances, a description of what variable this represented was made (E-a, E-p, client resistance, therapist resistance), as well as a comment on the intrapersonal and interpersonal processes that the coder perceived were occurring. Some of the sections of interest had multiple one minute segments analysed, in order to show any important developments over time. At the end of the analysis of each section for a dyad, a brief summary was made of the analysis of that section.

CHAPTER 8: RESULTS AND INTERPRETATION

Introduction

A detailed discussion of the analysis methodology for the results section can be found in the method section. However, a number of key points will be re-visited here to ensure clarity for the reader. Firstly, the research questions were generally framed up with client resistance as the central variable of interest. The other variables (therapist resistance (TR), therapist Empathy-perspective taking (E-p) and Empathy-attunement (E-a), and the working alliance) were mainly of interest in terms of their relationship to this central variable. Secondly, the meaning of specific terminology used can be found in Table 2 in the methodology section. This table also contains details of the qualitative descriptors of the different score levels on the measures. For instance, on the Empathy-perspective taking measure a score of 3 represents the mid-point on the measure and is referred to as medium, a slightly different descriptor than in the measure itself. Thirdly, although there were 10 DVDs in total, 8 were used as a main sample, and the remaining two were used as a replication sample. In the main sample there were two therapists who each contributed two DVDs. Only one session of an SMP was ever analysed for each of the 10 dyads.

The results are divided up into two broad sections. The first section involved a quantitative group-level analysis of aggregated session level scores. In this section, each of the 8 dyads from the main sample was investigated for general patterns across the measures, including the frequency of client and therapist resistance, average session level empathy and resistance scores, and scores on the Working Alliance Inventory. The broad relationships between the variables were then analysed across the dyads. This allowed the answering of general questions such as “what is the frequency of client resistance across these dyads?”, and “is there a common relationship between the scores on the therapist resistance and client resistance measures across the dyads?” There was also a small amount of within dyad analysis undertaken in this section, allowing the answering of such questions as “within the sessions of individual dyads, was client resistance more likely to occur in segments where there was therapist resistance?” At the end of the group level analysis, the two dyads in the replication sample were investigated in a similar manner as the eight dyads in the main sample, to see if the patterns found in the main sample were replicated.

The second section involved a single case close-up analysis of the individual dyads, at the level of the segment, utilising quantitative and qualitative analysis techniques. This analysis of the specific dyads investigated the relationships between the variables at the segment level, and

changes in the variables across segments. The analysis in this section focused on two broad areas. Firstly, descriptive statistics and a visual analysis of graphed data were used to investigate the relationships between the following measures: Empathy-perspective taking (E-p), Empathy-attunement (E-a), Client Resistance Code (CRC), and Therapist Resistance Code (TRC) at the segment level. This allowed the answering of more specific questions than the group analysis, such as “within each dyad, is there a relationship between when client resistance and therapist resistance occur?” Secondly, areas of interest on the DVDs were highlighted from the previous analysis, and a qualitative analysis of the narrative from these segments was undertaken. This allowed the answering of questions such as “What does client resistance actually look like in narrative form?”, and “how does client resistance evolve within a segment?”

Group Level Analysis

The group level analysis was structured in terms of the research questions, with each question being addressed in chronological order. Each research question was answered through a visual analysis of the graphed data from the measures, and supported with descriptive statistics to clarify and support the visual analysis. Table 7 provides an overview of data from all of the measures.

Table 7

Scores on Client Resistance Code (CRC), Therapist Resistance Code (TRC), Empathy-perspective taking (E-p), Empathy-attunement (E-a), and the Working Alliance Inventory total scales and subscales.

Dyad #	SMP					WAI-	WAI-	WAI-	WAI-
	Session #	CR	TR	E-p	E-a	SR-O Goal	SR-O Task	SR-O Bond	SR-O Total
Dyad 1 ^a	3	0.88	0.54	2.52	2.56	8	8	11	27
Dyad 2 ^b	3	0.65	0.75	2.51	2.48	16	12	19	47
Dyad 3	2	0.60	0.71	2.31	2.42	14	8	15	37
Dyad 4	3	0.15	0.06	3.40	3.15	17	16	24	57
Dyad 5 ^b	3	0.23	0.20	3.43	3.17	11	16	24	51
Dyad 6	2	0.53	0.19	2.84	2.69	4	4	12	20
Dyad 7 ^a	5	1.50	1.18	2.26	2.26	6	6	14	26
Dyad 8	3	0.00	0.00	3.64	3.30	18	19	24	61
Dyad 9*	3	0.00	0.00	3.5	3.3				
Dyad 10*	1	0.74	1.04	2.26	2.26				

Note. Dyads with the same superscript involved the same therapist. Score ranges possible on the various measures were as follows: TR=0 to 3, CR=0 to 3, E-p=0 to 5, E-a=0 to 5, WAI-SR-O Goal=4 to 28, WAI-SR-O Task=4 to 28, WAI-SR-O Bond=4 to 28, WAI-SR-O Total=12 to 84.

* Dyad from replication sample

What Was The Extent Of Client And Therapist Resistance Across The Dyads?

The average resistance score across a session for each dyad ranged from 0 to 1.18 for therapist resistance, and from 0 to 1.50 for client resistance, indicating considerable variability between the eight dyads (Table 7 and Figure 2). The mean scores across all dyads were TR = 0.45 (SD= 0.41), CR = 0.57 (SD = 0.48). For four of the dyads the average scores were relatively high, with both client and therapist resistance scoring above 0.50. Only one dyad featured a complete absence of resistance for both the client and therapist. Dyads 1 and 7 contained the same therapist, and both dyads featured client and therapist resistance scores of greater than 0.50. Dyads 2 and 5 contained the same therapist, and were varied in their resistance scores.

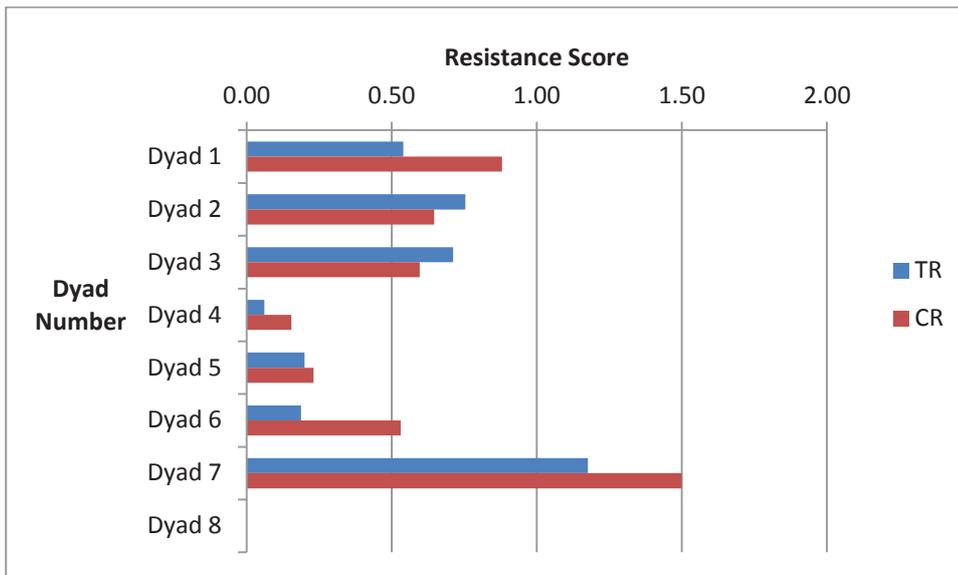


Figure 2. Client resistance and therapist resistance scores for each dyad.

The frequency of client resistance and therapist resistance provides another way of looking at this data (Figure 3). For a number of dyads, both client and therapist resistance were a regular event, with 4 of 8 dyads featuring both client and therapist resistance in greater than 30% of the segments in a session.

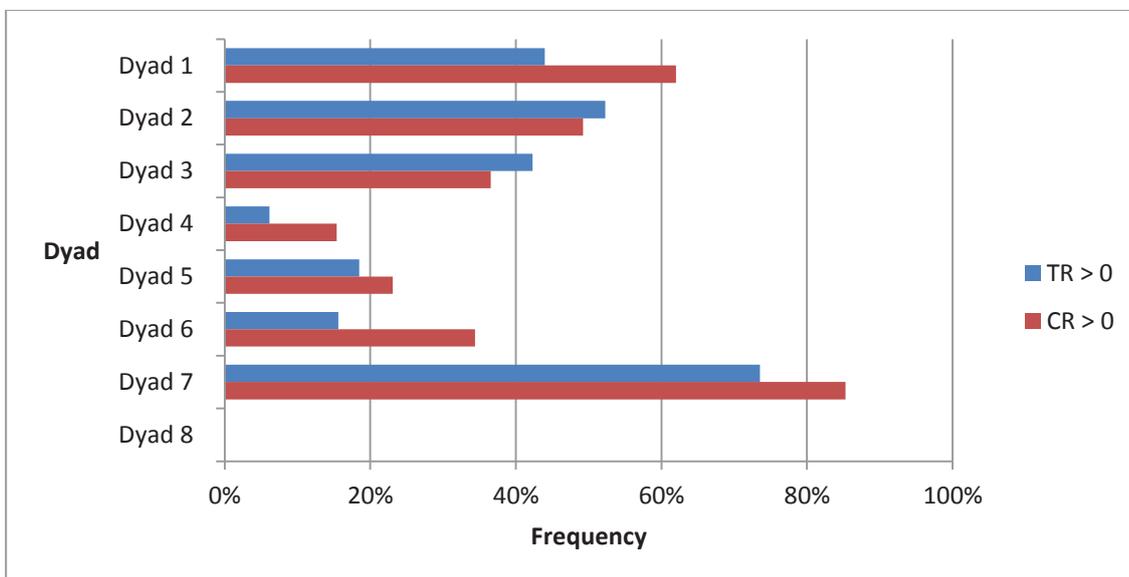


Figure 3. Percentage of segments featuring TR and CR for each dyad.

What Was the Relationship between TR and CR *across* Dyads

Across all dyads, therapist resistance scores and client resistance scores were clearly associated, such that higher and more frequent levels of therapist resistance were related to higher and more frequent levels of client resistance and vice-versa (Figure 2 and Figure 3). This was also evidenced by the significant and strong positive correlation between TR and CR, $r = 0.92$, $p < .01$ (Table 8).

What Was the Relationship Between TR and CR *Within* Dyads

Whereas the previous section showed a relationship between CR and TR at the global level of the session, this section investigated the relationship between CR and TR at the level of the segment. The single case analysis section also examines this, but in more depth.

Across all the dyads, when segments where therapist resistance was present were isolated, it was found that these segments also had a high likelihood of containing client resistance. In contrast, when segments where therapist resistance was absent were isolated, they were found to have a considerably lesser likelihood of client resistance being present (Figure 4 and Table 7). In other words, when therapist resistance occurred in a segment there was almost always client resistance.

This analysis was also undertaken in reverse, with client resistance as the focus (Figure 5, and Table 7). Across all the dyads, when segments where client resistance was present were isolated, it was found that they had a high likelihood of also containing therapist resistance. In contrast, when segments where client resistance was absent were isolated, they were found to have a considerably lesser likelihood of therapist resistance being present.

The above findings showed the close relationship between client and therapist resistance was not only strong, but also temporally proximal. In other words, the relationship existed at the level of a one minute segment. These graphs also showed that although the main pattern was for client and therapist resistance to occur together within the same segments, when this varied it was client resistance that was more likely to occur on its own.

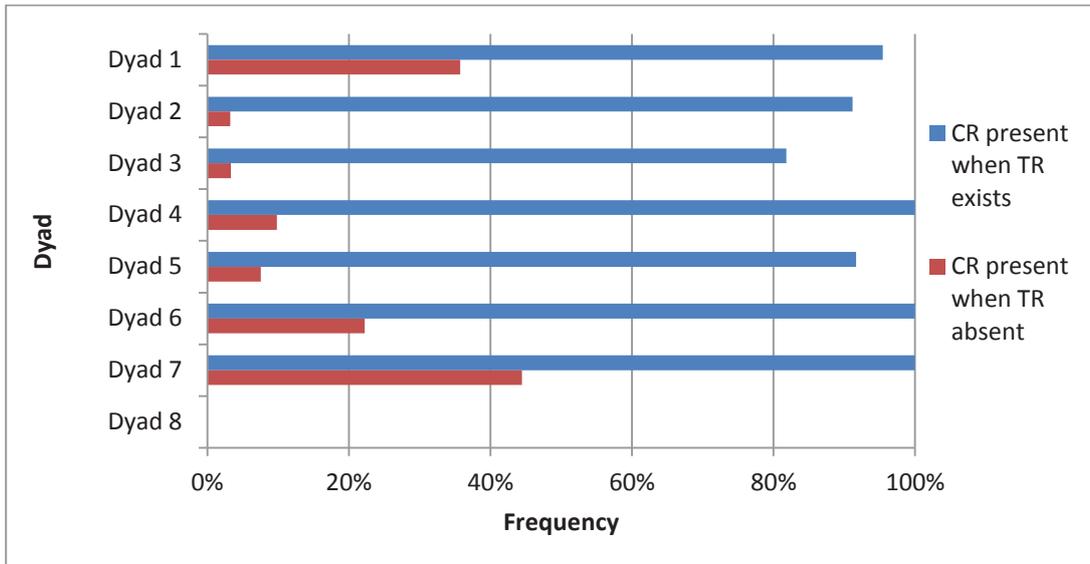


Figure 4. Comparison of frequency of CR, both where TR is present and where TR is absent.

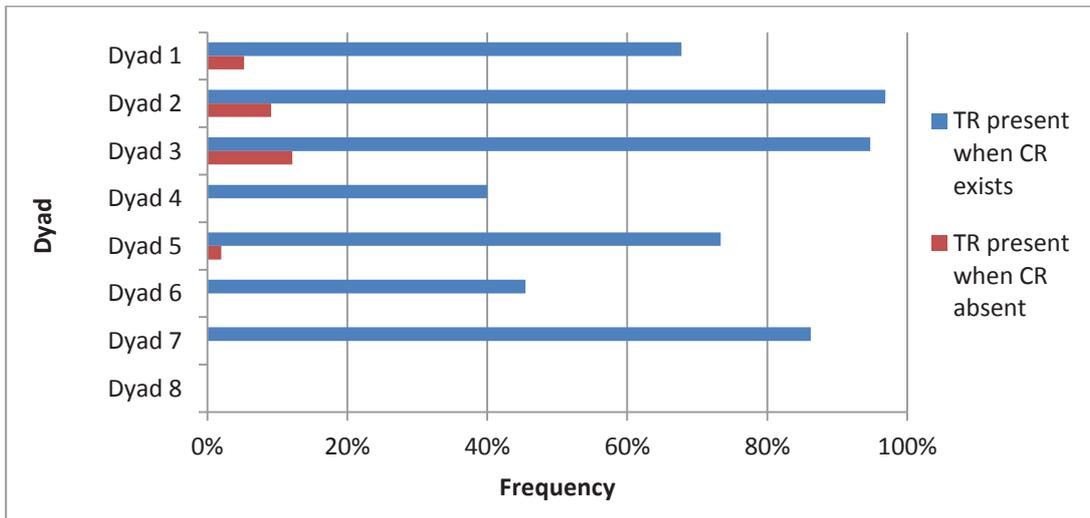


Figure 5. Comparison of frequency of TR, both where CR is present and where CR is absent.

What Was The Extent Of Therapist Empathy?

Results on Empathy-perspective taking (E-p) and Empathy-attunement (E-a) measures are presented in Table 7 and again in graphical format in Figure 6, along with scores on the Client Resistance Code (CRC). The possible score range was from 1-5 on both empathy measures. The scores on the empathy measures were variable amongst the dyads, ranging from 2.3 - 3.6 on E-p, and 2.3 - 3.3 on E-a. The scores on both empathy measures were generally below the mid-point level (3), with only three of the dyads scoring above this level Figure 6, as was reflected by the mean score on the measures: E-p = 2.86 (0.55), E-a = 2.75 (0.40). The scores for E-p and E-a were closely associated across the dyads, with therapists who scored high on E-a also scoring high on E-p, and vice-versa (Figure 6). A Pearson's correlation coefficient

confirmed there was a very strong and significant positive correlation between these empathy measures (Table 8).

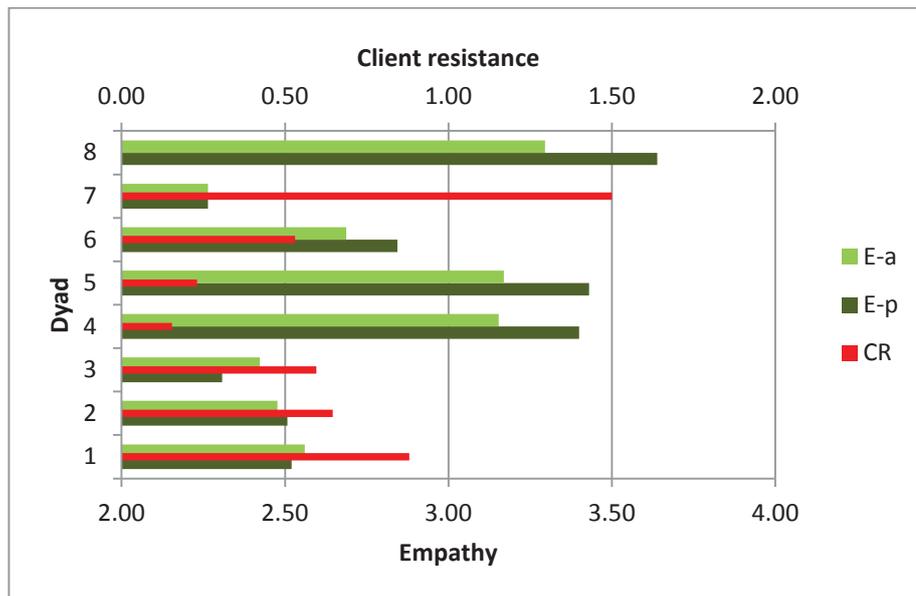


Figure 6. Scores for each dyad on the Empathy-perspective taking (E-p) and Empathy-attunement (E-a) measures.

Note. Graphed scores represent the average of scores for each segment across an entire DVD session. Possible score range was from 1 to 5 for both empathy measures, and mid-point score for the empathy measures = 3.0.

What Was The Relationship Between Measures Of Therapist Empathy And Client Resistance?

Figure 6 showed higher scores on the empathy measures were related to lower levels of client resistance, and vice-versa. This was further established by the strong and significant negative correlation between both empathy measures and CR (Table 8).

What Was The Extent Of The Working Alliance Inventory Scores?

There was considerable variability in the scores on the WAI-SR-O -Total scale, which ranged from 20 to 61 (Figure 7). The average WAI-SR-O -Total score across the dyads was 40.75, which is just below the mid-point score on the measure of 42. The dyads that scored above the mid-point on the WAI-SR-O -Total scale were the same dyads that scored above mid-point on the empathy measures.

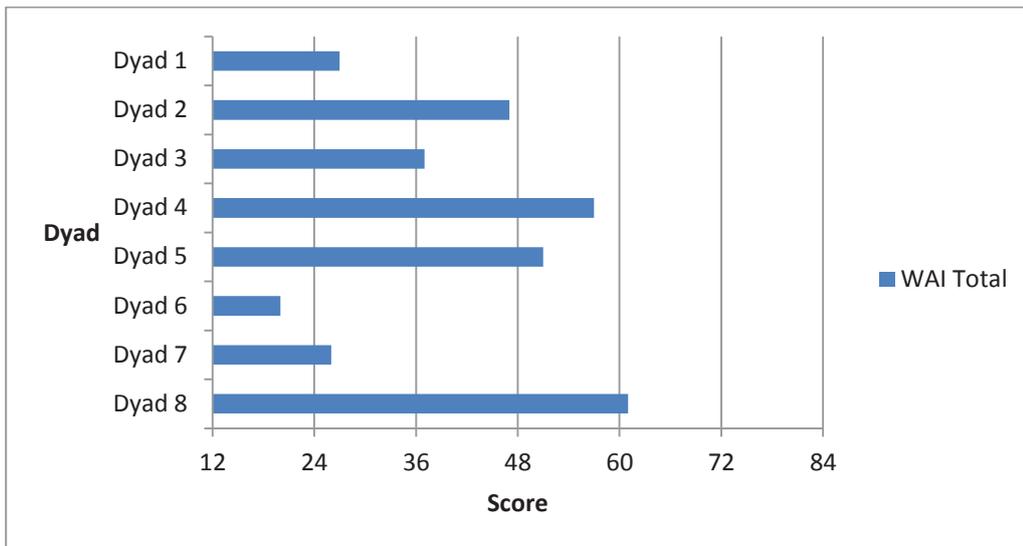


Figure 7. Total scores for Working Alliance Inventory. Possible score range = 12 to 84, and mid-point score for the measure = 42.

There was considerable variability on the WAI-SR-O subscale scores within the dyads (Figure 8). It was noticeable that across all the dyads, scores were considerably lower on the Goal and Task subscales, in comparison to the Bond subscale.

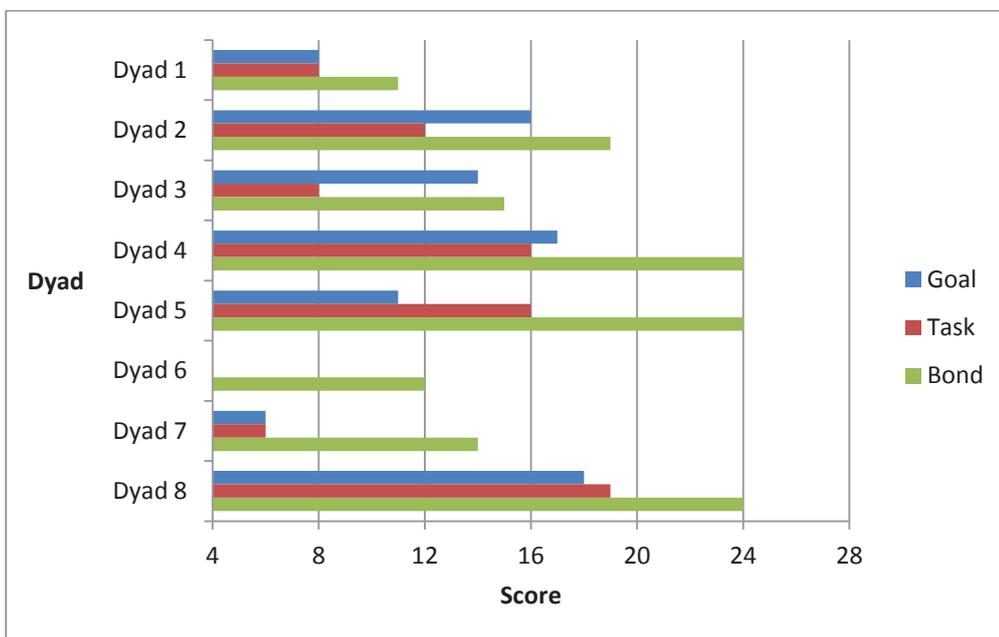


Figure 8. Scores for Working Alliance Inventory subscales.

What was the Relationship Between Scores on the Working Alliance Inventory and Client Resistance Measures?

The WAI-SR-O scores were closely associated with client resistance as shown by the significant and strong negative correlation between the WAI-SR-O total score and CR, as well as the WAI-SR-O -Task and WAI-SR-O -Bond subscales with CR (Table 8).

Table 8
Pearson Product-Moment Correlation Coefficients (r) Between the Measures Across All Dyads (N = 8).

	TR	CR	E-p	E-a	WAI-SR-O Goal	WAI-SR-O Task	WAI-SR-O Bond
TR							
CR	.92**						
E-p	-.89**	-.86**					
E-a	-.91**	-.88**	.99**				
WAI-SR-O - Goal	-.35	-.64	.46	.50			
WAI-SR-O - Task	-.60	-.75*	.82*	.84**	.81*		
WAI-SR-O - Bond	-.56	-.73*	.81*	.81*	.76*	.95**	
WAI-SR-O - Total	-.53	-.75*	.74*	.76*	.90**	.97**	.96**

Note. *p<.05, ** p< .01

Group Analysis of Replication Sample

The replication sample consisted of two dyads. In a similar manner to the main sample, the dyads had been selected to provide a range of client resistance. Dyad 9 was selected to represent a dyad where there was thought to be low client resistance, and Dyad 10 to represent a dyad where there was thought to be higher client resistance.

What was the Relationship between Therapist Resistance and Client Resistance Across Dyads in the Replication Sample?

The relationship between therapist resistance and client resistance scores across dyads in the replication sample supported findings from the main sample of a close positive relationship

between therapist and client resistance (Figure 9). Dyad 10 had relatively high scores on both therapist and client resistance measures, whereas Dyad 9 scored 0 on both measures.

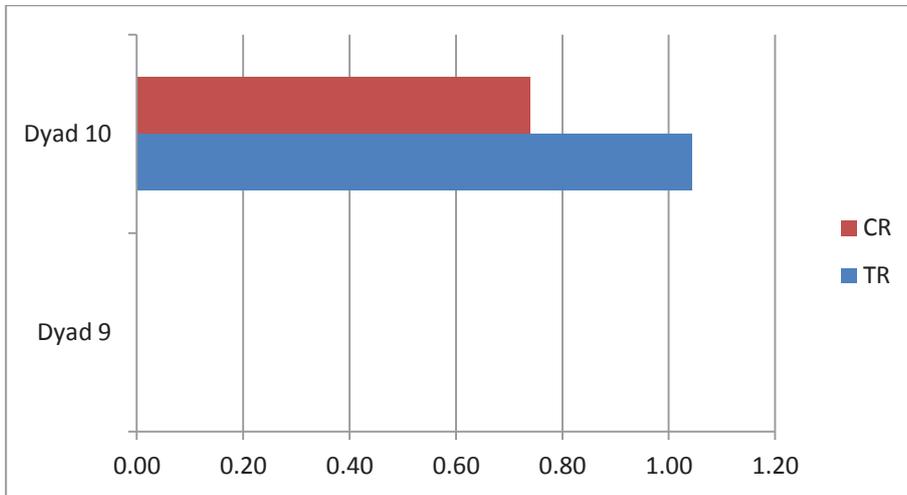


Figure 9. Client resistance and therapist resistance scores in the two dyads from the replication sample.

What was the Relationship between Therapist Resistance and Client Resistance Within Dyads in the Replication Sample?

The relationship between therapist resistance and client resistance scores within dyads in the replication sample supported findings from the main sample, although there was no resistance from either the therapist or client in Dyad 9 to undertake this analysis. In Dyad 10, when segments where therapist resistance was present were isolated, it was found that these segments also had a high likelihood of containing client resistance (Figure 10). In contrast, when segments where therapist resistance was absent were isolated, they were found to have a considerably lesser likelihood of client resistance being present.

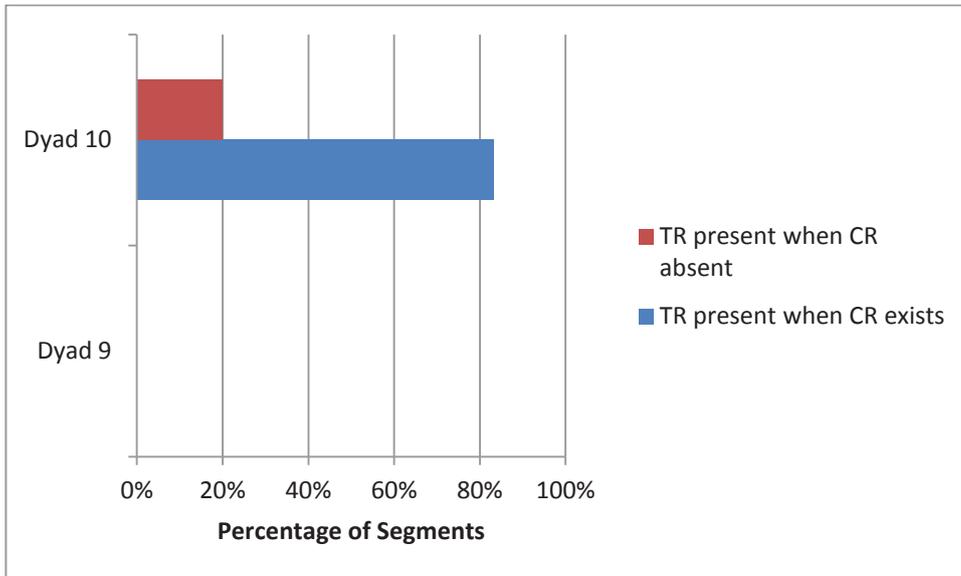


Figure 10. Comparison of frequency of CR, both where TR is present and where TR is absent.

This analysis was also undertaken with client resistance as the focus (Figure 11). Across all the dyads, when segments featuring client resistance were isolated, there was a high likelihood of therapist resistance also being present. In contrast, when segments where client resistance was absent were isolated, they were found to have a much reduced likelihood of therapist resistance being present. These results supported findings from the main sample that the relationship between the two variables was not only strong, but also temporally proximal at the level of a one minute segment.

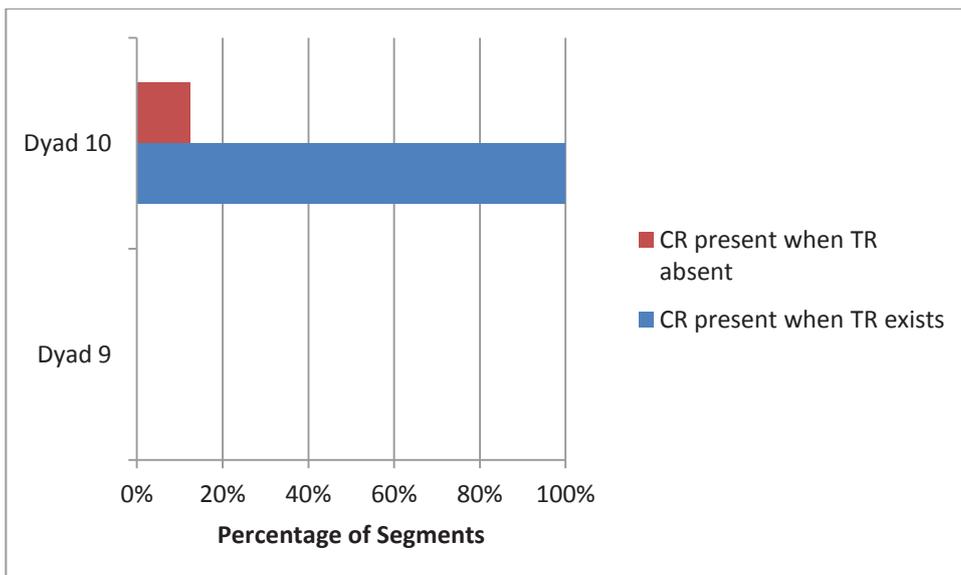


Figure 11. Comparison of frequency of TR, both where CR is present and where CR is absent.

What was the Relationship between Therapist Empathy and Client Resistance in the Replication Sample?

The relationship between the two therapist empathy measures and client resistance, as well as between the two therapist empathy measures themselves, supported the findings from the main sample (Figure 12). Dyad 10 featured therapist empathy scores below 3 (mid-point) on both measures and a relatively high client resistance score. Dyad 9 featured therapist empathy scores above 3 (mid-point) on both measures, and a complete absence of client resistance score. The scores on the therapist empathy measures also coincided.

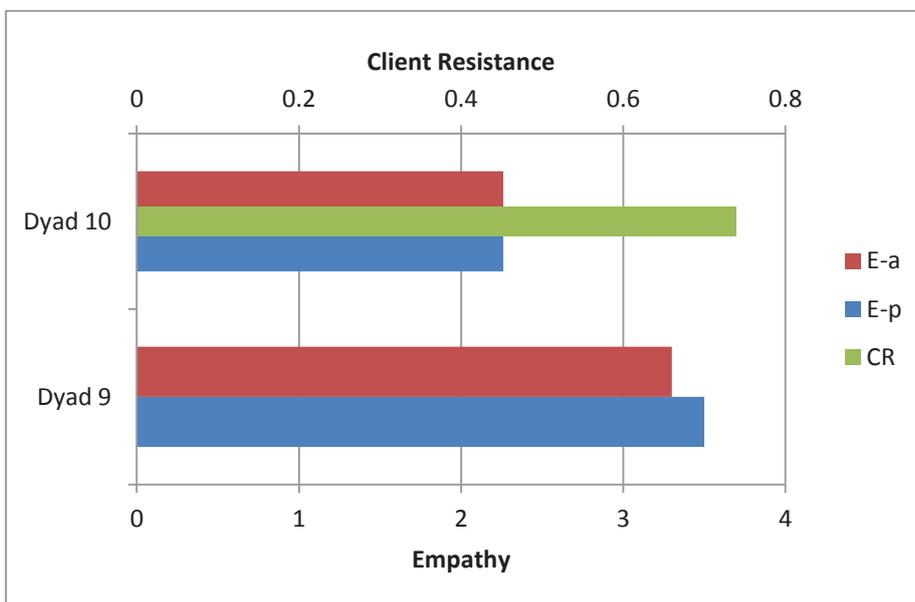


Figure 12. Scores for each dyad on the Empathy-perspective taking (E-p) and Empathy-attunement (E-a) measures. Graphed scores represent the average of all scores across a DVD session. Possible score range was from 1 to 5 for both measures (mid-point score = 3.0)

Single Case Close-Up Analysis of Individual Dyads

The single case close up analysis involved a detailed analysis of each of the dyads one case at a time. For each of the dyads there were two broad types of analysis undertaken. Firstly, a *visual analysis* of the graphed data from the measures (E-p, E-a, TRC, and CRC)—supplemented with descriptive statistics—was used to investigate the relationships between the four variables at the level of a segment (i.e. for each minute coded). Secondly, areas of interest with relation to client resistance were highlighted from this analysis, and a *qualitative analysis of the narrative* from these segments was undertaken.

The visual analysis of the graphs investigated each dyad individually for the level of synchrony between the four measures, within each segment, whilst also looking for patterns of synchrony across an entire session. The investigation of synchrony within the segments focused on a number of properties of client resistance: presence, absence, onset, cessation and level (intensity) of client resistance. These features of client resistance were analysed for their synchrony with the three therapist variables: E-p, E-a, and TR. Scores on all four measures were plotted for each one minute segment, and the four resulting graphs were stacked on top of each other. This created a simple way for the segment by segment fluctuations on the varying measures to be easily analysed. For example, when examining the graphed data it was reasonably easy to see where client resistance was absent or present, and to then explore whether therapist resistance was absent or present in this same segment.

In the early stages of analysing the data, it became obvious that segments could be grouped together into sections which had common features. These three section types were: *absence of client resistance* (2 or more concurrent segments where $CR=0$); *brief client resistance* (1-2 concurrent segments where $CR>0$); and *prolonged client resistance* (3 or more concurrent segments where $CR>0$). Because these three section types potentially added meaningful information, it was decided that they would be included in the analysis. To enable this, each of these section types was colour coded within the graphs: blue denoted sections with an absence of client resistance; yellow denoted sections with brief client resistance; and pink denoted sections of prolonged client resistance.

The second type of analysis involved selecting a number of segments from each of the dyads, and undertaking a close up analysis of the narrative between the therapist and the client. The narrative analysis was undertaken in a structured manner. The various section types previously highlighted (absence of client resistance, brief client resistance, prolonged client resistance), were used to isolate segments of interest. Particular features of interest within these sections were the absence, onset, escalation, cessation and level of client resistance. The pattern of

analysis for these segments involved the following: firstly, the scores on each of the measures were first introduced; secondly a table which presented the narrative extract. The table was structured to present the therapist's and client's utterances in separate rows, and where appropriate, each of their narratives was accompanied by a comment/analysis of the narrative by the lead researcher. The comments/analysis focused on highlighting features of the utterances that represented aspects of the different measures. For example, if there was low therapist empathy and an onset of client resistance in the selected segment, then the utterances from the client and therapist which represented these variables were recorded, and in the comments beside each of the utterances, a description of what variable this represented was made, (E-a, E-p, CR, TR) as well as a comment on the processes which the coder perceived were occurring. At the end of each section, a brief summary was made of the analysis.

Dyad 1

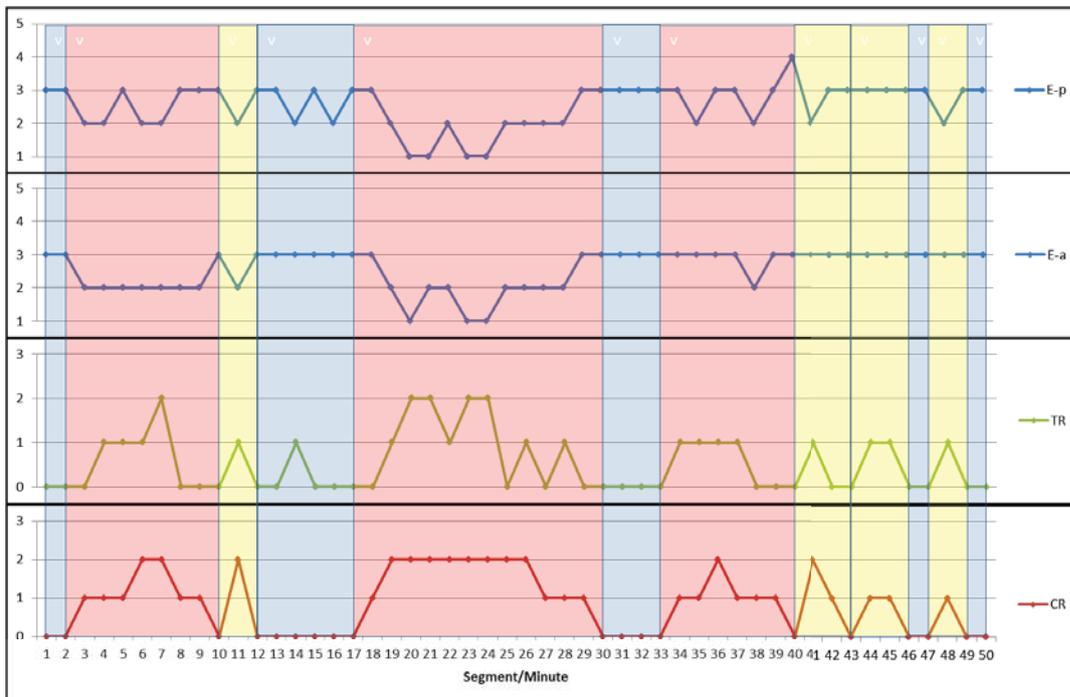


Figure 13. Scores for Dyad 1 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink).

The analysis for Dyad 1 was undertaken on the third session of the SMP, and the therapist was the same therapist who featured in Dyad 7. Session 3 of the SMP is generally thought to focus on the use of MI methods, and not to contain cognitive behavioural content (Anstiss, 2003; Steyn & Devereux, 2006). This is partly reflected in the methods employed during session three which include: a time projection exercise, and a cost/benefit analysis (decisional balance).

Dyad 1 scored 0.54 for therapist resistance (range = 0 to 1.18) and 0.88 for client resistance (range = 0 to 1.50) (Table 7). These scores ranked the dyad fourth highest in terms of therapist resistance and second highest out of the eight dyads in terms of client resistance. The scores indicated there was more therapist resistance than client resistance in the session. Average therapist empathy scores for the session were below the mid-point on both empathy scales (Table 7).

Figure 13 plots the scores on each measure, for each segment, for Dyad 1. There are some clearly synchronous patterns between the measures, and these will now be discussed. Table 9 substantiates these patterns with descriptive statistics.

Visual analysis of graph for Dyad 1.

Table 9

Descriptive Statistics Describing Relationships Between the Variables Within the Session

Scenario	Frequency ¹
CR present when TR exists	95%
CR present when TR absent	36%
E-p and E-a at or above medium (3) when CR absent	89%
E-p and/or E-a below medium (3) when CR exists	71%

¹ See page 86 for details of how these results were calculated.

What was the relationship between client and therapist resistance?

Figure 13 clearly showed that both client resistance and therapist resistance were a regular occurrence in this dyad, and that there was synchrony between measures therapist of therapist relational skill and client resistance. When therapist resistance increased, so did client resistance, and vice versa. In the 22 segments featuring therapist resistance, the majority (21) also featured client resistance (Table 9). There was also clear synchrony between the *timing of change* on the client and therapist resistance measures (Figure 13), particularly with regard to their *onset* and *cessation*. The onset of client resistance occurred on 7 occasions (segments 3, 11, 18, 34, 41, 44, 48) and on 5 of these occasions (segments 11, 34, 41, 44, 48) the onset of therapist resistance also occurred in the same period, with the remaining occasions showing the onset of client resistance preceded therapist resistance by one segment (segments 3 and 18). The

cessation of client resistance occurred on 7 occasions, and on 3 of those occasions therapist resistance ceased in the same period, and in the remaining cases therapist resistance reduced one to two segments before client resistance. There was also a clear relationship between the levels of the measures. High levels of therapist resistance (>1) coincided with high levels of client resistance (>1) as can be seen in the first two sections of prolonged client resistance (highlighted pink).

What was the relationship between therapist empathy and client resistance?

Figure 13 also showed therapist empathy scores being inversely synchronised with client resistance. As can be seen in Table 9, when both empathy scores were at or above a medium score of 3, client resistance was usually absent, and when client resistance was absent E-p and/or E-a were generally below medium. There was also a clear relationship between the *levels* of these measures. High levels of therapist resistance (>1) and low levels of therapist empathy (<3) coincided with high levels of client resistance (>1) as can be seen in the first two sections of prolonged client resistance (highlighted pink). There was also synchrony between the timing of change on the therapist empathy and client resistance measures. A reduction in therapist empathy scores often coincided with an increase in client resistance in the same segment (Segments 3, 11, 41, 48), although this was variable and sometimes empathy reduced after the onset of client resistance (segments 19, 35). Therapist empathy scores often increased from low to medium in the same segment that client resistance ceased (Segments 10, 12, and 49) or the segment prior (Segment 30 and 40).

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

Sections with an absence of client resistance (shaded in blue) featured the least therapist resistance, and consistently featured the highest therapist empathy scores (Figure 13). Sections of brief client resistance were closely synchronised with therapist resistance, and more variably, with therapist empathy (shaded in yellow). Sections of prolonged client resistance (shaded in pink) were closely synchronised with therapist resistance. They also featured the highest levels of both client and therapist resistance for the session, and the lowest levels of therapist empathy. A maintained high level of client resistance was only ever seen in the presence of therapist resistance.

Narrative analysis of Dyad 1

Brief client resistance.

In the following sections, excerpts of narrative from Segments 10-12 (shaded yellow in Figure 13) show an example of client-therapist dialog in segments where there was brief client resistance.

Segment 11 (onset of client resistance).

Therapist empathy scores both decreased to low (2) in this section, and at the same time there was an onset of low-level therapist resistance (1) and high-level client resistance (2). In the previous segment, the therapist had been writing down the chain of events surrounding the client's offending, but did not record a piece of information that was important to the client (that they were acting in "self-defence").

Table 10

Narrative and Analysis of Narrative for Segment 11

Narrative	Analysis of Narrative
Client: "[continued]...through self-defence" [Client prompts the therapist to write down the fact it was self-defence]	Client shows unhappiness at therapist not writing down his suggestion, suggesting possible client resistance.
Therapist: "Yeah, well you got that, prevent yourself from being injured."	Therapist disagrees that he needs to write this down. Therapist is out of tune with the client's emotional tone and is not picking up on the importance of this specific aspect of the client's perspective, suggesting low E-p and low-E-a , and therapist resistance (TR) .
Client: "Due to self-defending myself, you gotta put that down because [interrupted]."	Client shows clear disagreement with therapist not writing down his suggestion, indicating high-level client resistance (CR) .
Therapist: "OK."	Therapist backs down and agrees that he needs to write this down. Therapist moves to re-align himself with the client.

Note. Three ellipses (...) are used to show there is a gap in the narrative that has not been recorded, in order to limit the narrative to the most pertinent utterances.

Segment 12 (cessation of client resistance).

Therapist empathy returned to medium (3) on both measures, and there was a cessation of both client and therapist resistance (0).

Table 11
Narrative and Analysis of Narrative for Segment 12

Narrative	Analysis of Narrative
T: "So if we put 'to prevent a serious injury to yourself', would you agree with that?"	Therapist checks with client as to what he should write down, suggesting E-p and collaboration.
C: "Yeah, to prevent a serious injury to yourself."	Client answers therapist's question, indicating no CR.
T: "Any other benefits, either short or long term that you recognise."	Therapist asks the client's perspective, suggesting E-p.
C: "That's about it, that's all that I was doing."	Client answers therapist's question, indicating no CR.
T: "OK, mmm."	Therapist listens to client with facilitating encouragement, suggesting E-p.
C: "Preventing further injuries to myself"	Client re-emphasises their view, indicating no CR.
T: "Yeah, see any costs, what has it cost you?"	Therapist asks client about costs, suggesting E-p.
C: "Three years jail."	Client answers therapist's question, indicating no CR.
T: "What has three years jail meant for you?"	Therapist explores client's perspective more

deeply, suggesting E-p.

Summary of brief client resistance.

The therapist's lack of collaboration with the client, manifested in an unwillingness to see the importance of the perspective of the client, appeared to elicit strong disagreement from the client towards the therapist (CR), and created discord in the relationship. However, the therapist appeared to recognise the growing discord, and changed his approach. When the therapist began collaborating with the client and actively trying to understand their perspective, client resistance ceased.

Prolonged client resistance.

In the following sections, excerpts of narrative from Segments 3-10 (shaded in red in Figure 13) showed examples of client-therapist dialog in segments where there was prolonged client resistance.

Segment 3 (onset of client resistance).

In Segment 2 there was an absence of client and therapist resistance and therapist empathy was medium (3) on both measures. In Segment 3 there was a marked change. Therapist empathy declined to low (2) on both measures, and there was an increase in client resistance to low level (1), while therapist resistance remained absent (0).

Table 12

Narrative and Analysis of Narrative for Segment 3

Narrative	Analysis of Narrative
T: "What about when you...found yourself stuck in the middle of it [the situation]."	Therapist brings in a new idea to the conversation, and suggests the client found himself "stuck in the middle of it".
C: "I didn't get stuck in the middle of it."	Client disagrees with therapist's view, indicating possible low-level client resistance.
T: "Well, I mean..... you found yourself in the middle of some conflict, even though you hadn't anticipated it or planned it...you were kind of there."	Therapist attempts to clarify what they are meaning, but does so by disputing the client's perspective, indicating possible therapist resistance, although this was not coded. Therapist communicated an inaccurate understanding of the client's perspective, indicating low E-p. The therapist is not attuned to the client's resistance, suggesting low E-a.
C: "Oh, just 10 seconds."	Client again disagrees with therapist's view, indicating client resistance.
...	...
T: Yeah well you said last week, you used the term "you're a [swearing]...there was some intent to get him upset."	Therapist uses client's statements from previous sessions in order to impose their own perspective, which has a different meaning than intended by the client, suggesting low E-p. This could also be seen as a confrontation undertaken by imposing the therapist's

perspective rather than by exploring the client's perspective.

C: "Naaah, I wasn't thinking that at all actually..."

Client disputes therapist's interpretation of the discussion, indicating client resistance.

Segment 4 (continued client resistance, and onset of therapist resistance).

In this segment, therapist empathy was low (2) on both measures, and there was an onset of low level therapist resistance (1), and sustained low-level client resistance (1).

Table 13

Narrative and Analysis of Narrative for Segment 4

Narrative	Analysis of Narrative
<p>...continued from previous segment</p> <p>T: "There was some intent behind it to get him upset, you wanted to get back at him ...it highlighted some of that "thinking", that you highlighted yourself, that you wanted to upset him, and calling him names."</p>	<p>Therapist disputes the client's perspective once more, and confronts the client with their own perspective, indicating therapist resistance. Therapist imposes his own view again, rather than exploring the client's perspective, suggesting low E-p. Therapist does not alter his approach to be congruent with the clients affect, indicating low E-a.</p>
<p>C: [Interrupts] "Naaaah, I didn't wanna...I was just saying that because I had more drugs..."</p>	<p>Client interrupts and denies he was trying to aggravate the victim, indicating client resistance.</p>

Segment 6 (escalation of client resistance).

Therapist empathy was low on both measures in this segment, and there was an increase in client resistance to high (2) while therapist resistance remained elevated at a low level (1).

Table 14
Narrative and Analysis of Narrative for Segment 6

Narrative	Analysis of Narrative
<p>T: “So that kind of highlighted some of that thinking around your emotions, you were feeling upset...”</p>	<p>Therapist authoritatively imposes his own perspective, but insinuates that they are the client’s views or the “actual” reality.</p>
<p>C: [interrupts] “No, not really, I don’t know how to put it actually.”</p>	<p>Client interrupts and disputes the therapist’s understanding of the situation, indicating client resistance.</p>
<p>T: “Mmm, you kind of said upset.”</p>	<p>Therapist disputes client’s perspective, and again imposes their own viewpoint, and communicates an inaccurate understanding of the client’s perspective, indicating therapist resistance and low E-p.</p>
<p>C: “It just drives you crazy.”</p>	<p>Client offers own interpretation of how he felt, and that he was being driven “crazy”.</p>
<p>T: “Yeah, you kind of said upset last week, I recognise you weren’t screaming or crying about it, but it upset you enough that you responded in that way...”</p>	<p>Therapist again disputes client’s explanation with subtle put-down, and argues for own perspective again, indicating TR. Does not explore client’s argument that it “drives you crazy”, showing low E-p. Therapist lacks awareness that they are out of attunement (low E-a). The therapist utilises client’s statements from previous weeks to explore their own agenda and perspectives, under the guise of acknowledging the client’s perspective.</p>
<p>...</p>	<p>...</p>
<p>T: “Mmm, so again, it’s just trying to make</p>	<p>Therapist attempts to incorporate client</p>

sense of that whole crazy situation”

terminology into his own understanding (**moderate E-p**), but misinterprets client’s statement of being driven “crazy” to the situation being crazy (**low E-p**).

C: [Interrupts] “There was no crazy situation, the crazy situation was he attacked me.”

Client interrupts and disputes the therapist’s interpretation of what he said about being driven crazy, indicating high-level **client resistance**.

Segment 8 (reduction in client resistance).

There was a change in events in this segment. Therapist E-p increased and therapist resistance ceased (0). Client resistance reduced to a low level (1).

Table 15

Narrative and Analysis of Narrative for Segment 8

Narrative	Analysis of Narrative
Cont’d from previous...	
C: “He felt like he had to beat me up I suppose...”	The client continues to emphasise the negative behaviour of the victim.
T: “Mmmmm”	Therapist listens facilitatively.
C: “Drunken alcohol man ... drinking for14 hours”	
T: “Mmm.”	The therapist listens and lets the client talk without interruption, suggesting medium E-p.
C: “9 to 9 what’s that.”	The client’s tone is less resistant.
T: “Mmm”	The therapist listens intently to the client, with encouraging facilitating prompts, suggesting Medium E-p.

C: "Yeah, okay 12 hours."

T: "Mmm."

C: "Not very clever..."

Segment 9-10 (cessation of client resistance).

In Segment 9 therapist E-p remained medium (3), therapist resistance remained absent (0) and client resistance remained at a low level (1). In Segment 10 client resistance ceased.

Table 16
Narrative and Analysis of Narrative for Segment 9-10

Narrative	Analysis of Narrative
C: "I already know what to do."	The client somewhat defensively communicates they already know what to do
T: "Yeah"	
C: "Don't put myself in that situation"	Client explains that they will avoid these troublesome situations in the future.
T: "Avoid that totally, and it's a great plan really, it's probably the best, the best idea, and get the best outcome, to avoid those situations entirely, yeah... Well what we are going to look at today is what we call a cost benefit analysis..."	The therapist validates client's perspective, suggesting moderate E-p. Although the therapist's remarks are supportive of the client's comments, they still feel as if they come from an expert/power position, where the therapist is the arbiter of truth.

Summary of prolonged client resistance.

Initially, in Segment 3, the therapist made a comment about the client's offending situation which the client disagreed with, and this appears to have initiated an interpersonal dynamic out of which client resistance developed and escalated. This interpersonal dynamic involved the therapist consistently disputing the client's perspective, communicating an inaccurate understanding of the client's view point (low E-p), and imposing their own perspective. The client consistently reacted to this by disputing the therapist's perspective and re-emphasising

their own viewpoint (low-level CR). From Segment 4 onwards, therapist resistance became even more evident, with the therapist disputing the client's perspective and authoritatively imposing their own viewpoint (low E-p, TR). The combination of low therapist empathy and therapist resistance (towards the client's perspective) appeared to contribute to the escalation of client resistance. The client's resistance to the therapist's perspective also appeared to contribute to the escalating therapist resistance and low-level therapist empathy. The therapist also confronted the client about their offending behaviour in a number of segments where E-p was low and TR was present, and these behaviours were followed by resistance from the client. In Segment 8 the therapist appeared to recognise the elevated discord in the relationship, and decided to simply listen to the client without interrupting or arguing (medium E-p, no TR). This was followed by a reduction in the intensity of client resistance. In segments 9-10 the therapist continued to more accurately reflect the client's perspective (medium E-p, no TR), and then changed the focus of the conversation to their next task, after which client resistance ceased.

Dyad 2

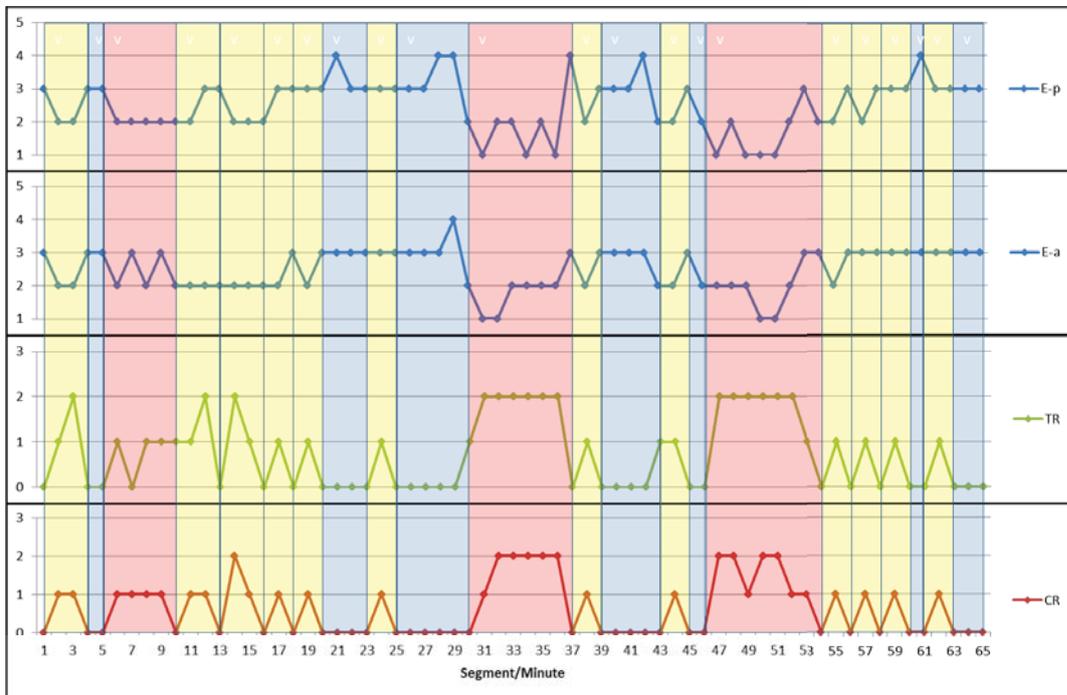


Figure 14. Scores for Dyad 2 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink).

The analysis for Dyad 2 was undertaken on the third session of the SMP, and the therapist was the same therapist who featured in Dyad 5. Session 3 of the SMP is generally thought to focus on the use of MI methods, and not to contain cognitive behavioural content (Anstiss, 2003; Steyn & Devereux, 2006). This is partly reflected in the methods employed during session three: a time projection exercise and a costs and benefits analysis (decisional balance). Dyad 2 scored 0.75 for therapist resistance (range = 0 to 1.18) and 0.65 for client resistance (range = 0 to 1.50) (Table 7). These scores ranked the dyad second highest in terms of therapist resistance and third highest out of the eight dyads in terms of client resistance. Average therapist empathy scores for the session were below medium (<3) for both empathy scales (Table 7), and the scores indicated there was more therapist resistance than client resistance in the session.

Figure 14 plots the scores on each measure, for each segment, for Dyad 1. There are some clear synchronous patterns between the measures, and these will now be discussed. Visual analysis of graph for Dyad 2.

Table 17 substantiates these patterns with descriptive statistics.

Visual analysis of graph for Dyad 2.

Table 17
Synchrony of Client and Therapist Measures across the Segments

Scenario	Frequency
CR present when TR exists	91%
CR present when TR absent	3%
E-p and E-a at or above medium (3) when CR absent	79%
E-p and/or E-a below medium (3) when CR exists	88%

What was the relationship between client and therapist resistance?

Figure 14 clearly showed that both client and therapist resistance were a regular occurrence in this dyad, and that there was synchrony between therapist measures and client resistance. When therapist resistance increased, so did client resistance, and vice versa. In the 34 segments featuring therapist resistance 31 also featured client resistance (Visual analysis of graph for Dyad 2.

Table 17). There was also clear synchrony between *timing of change* on the measures, particularly with regard to the *onset* and *cessation* of client resistance. The *onset* of client resistance occurred on 15 occasions and on 12 of these occasions the onset of therapist resistance also occurred in the same period, and on another 2 occasions client resistance preceded therapist resistance by one segment. The *cessation* of client resistance occurred on 15 occasions, and on 14 of those occasions therapist resistance ceased in the same period. There was also a clear relationship between the *levels* of the measures. Higher levels of therapist resistance (>1) coincided with higher levels of client resistance (>1), as can be especially seen in the last two sections of *prolonged client resistance* (highlighted pink). Lower levels, or an absence, of therapist resistance (0-1) coincided with low levels and an absence of client resistance (0-1), as can especially be seen in the sections with an *absence of client resistance* (highlighted blue).

What was the relationship between therapist empathy and client resistance?

The graph showed therapist empathy scores were inversely synchronised with client resistance. When both therapist empathy measures scored medium (3) or above, client resistance was generally absent. Furthermore, empathy scores were generally below medium (<3) where CR was present (Visual analysis of graph for Dyad 2.

Table 17). There was also some synchrony between *timing of change* on the measures. A reduction in therapist empathy scores generally coincided with an increase in client resistance in the same or following segment. Therapist empathy scores often increased from low to medium

in the same segment, or the segment prior to client resistance cessation, although this relationship was more variable than the relationship between therapist resistance and client resistance.

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

Sections with an *absence of client resistance* (shaded in blue) featured the least therapist resistance, and tended to have higher therapist empathy scores. Sections of *brief client resistance* (shaded in yellow) were fairly closely synchronised with therapist resistance, but not with therapist empathy. Sections of *prolonged client resistance* (shaded in pink) were closely synchronised with both therapist resistance and with therapist empathy scores. They also featured the highest levels of both client and therapist resistance for the session, and the lowest levels of therapist empathy. A maintained high level of client resistance was only ever seen in the presence of sustained high level therapist resistance and low therapist empathy.

Narrative analysis.

Prolonged client resistance.

In the following sections, excerpts of narrative from segments 30-37 (shaded in red in Figure 14) showed examples of client-therapist dialog in segments where there was prolonged client resistance.

Segment 30 (absence of client resistance).

In this segment, therapist empathy moved to low (2) on both measures, and there was an onset of low-level therapist resistance (1), but there was an absence of client resistance.

Table 18
Narrative Excerpts from Segment 30

Narrative	Analysis of Narrative
C: "... he was like, I don't want to fight, I don't want to fight...."	Client communicates that his adversary didn't want to fight.
T: "So the only reason you didn't have a fight with him was because... He wasn't going to go there."	Therapist reflects client's words with slight interpretation/reframe.
C: "Yeah, naah, he didn't want to. "	Client reflects therapist's interpretation.

T: [Interrupts] “So if he'd wanted to, you could have easily...”

C: “Yeah, I would have easily. ”

T: [Interrupts] “You could have easily got another assault charge.”

Therapist reflection contains extra information and a different meaning than the client's utterance.

C: “Yeah.”

...

T: “What do you think about that?”

C: “Oh, I handled it well ... I walked away.”

Client suggests they handled the situation well.

T: “It sounds like”

Therapist ignores client's interpretation of the events, instead moving to present their own conceptualisation of the problem event indicating **low E-p**, and possible **TR**.

C:[Interrupts] “But when it is”

Client interrupts therapist, although it is not clear if this is resistance.

T: [Interrupts] “the only thing that stops you getting into further trouble is other people.”

The therapist interrupts the client, and suggests their own perspective of the client's troubles, which is counter to meaning in the client's narrative, indicating **low E-p** and, low-level **therapist resistance**.

Segment 31 (onset of client resistance).

Therapist empathy declined to very low (1) on both measures in this segment, and there was an increase in therapist resistance to high (2) and an onset of low-level client resistance (1).

Table 19

Narrative Excerpts from Segment 31

Narrative	Analysis of Narrative
... continued	
C: “If he had hit me I would have thrown everything at him”.	The client appears to be “turning up the volume” to emphasise their meaning in

response to the therapist's unwillingness to acknowledge their perspective.

T: [Interrupts] "But it's".

Therapist interrupts trying to give their perspective, indicating probable **therapist resistance**.

C: [Interrupts] "And that's"

Client interrupts trying to give their perspective.

T: [Interrupts] "And it's really hard."

Therapist interrupts with a reframe that does not accurately reflect the client's meaning, indicating possible **therapist resistance**, and **low E-p**.

C: [Interrupts] "That's my rule."

Client interrupts, and affirms his perspective, contrasting the therapists meaning, indicating **client resistance**.

T: [Interrupts] "It's really hard for you when people are"

Therapist interrupts again, and again inaccurately tries to reframe the client's statement by arguing their own perspective, indicating high-level **therapist resistance**.

C: [Interrupts] "That's my right, that's my right."

Client interrupts again, and further asserts his actual meaning, contrasting the therapist's position, indicating (at least) low level **client resistance**.

T: "Trying to goad"

C: "That's what I was saying to you before, this is what I wait for, when I fight, I make sure they hit me first, and I've got every right to beat the shit of them."

Client emphasises he has not been heard, and delivers his message clearly.

Segment 32 (escalation of client resistance).

Therapist empathy remained low to very low (1-2) on both measures in this segment, and there was an increase in client resistance to high (2) while therapist resistance remained high (2).

Table 20

Narrative Excerpts from Segment 32

Narrative	Analysis of Narrative
T: "What's your idea of what self-defence is?"	The therapist brings up a new agenda, questioning the client's decision to use violence.
C: "Someone hits me, I'm going to hit them back, and I'm going to keep going, that's my self-defence."	The client appears to be still reacting to the therapist's unwillingness to acknowledge their perspective, and re-emphasises what he has been repeating for the past minute about his right to use violence for self-defence, indicating client resistance .
T: [Interrupts] "You think that's"	The therapist interrupts and starts to question the client's perspective, indicating high-level therapist resistance , and low E-p .
C: [Interrupts] "I'm not getting hurt"	Client interrupts and argues against therapist's argument, indicating high-level client resistance .
T: "You think that's in the law?"	Therapist challenges the client's perspective, indicating therapist resistance . Therapist is out of tune with the clients irritation indicating very low E-a . Therapist is also confronting the client regarding their rationale and reasoning.
C: "Yeah."	
T: "Yeah."	
C: "It is, because the policeman told me."	
...	

T: “The legal definition of self-defence is actually...”	Therapist confronts the client with information.
C: “Yeah, but he could be beating the shit out of me...”	Client argues against the therapist, indicating client resistance .
T: “So, so,that's not self-defence if he had the opportunity to get away”	
C: [Interrupts] “I am going to make sure he ain’t going to get up.”	

Segment 37 (cessation of client resistance).

In this segment therapist empathy increased markedly, to high on E-p (4) and medium on E-a (3). Both client and therapist resistance ceased (0), having been high in the previous segments.

Table 21

Narrative Excerpts from Segment 37

Narrative	Analysis of Narrative
C: “I wanted to beat the shit out of him for what he did to missus.”	Client explains reason for desire to use violence.
T: [More attuned tone] “So if you did, what then?”	Therapist queries the results of this, but doesn’t challenge perspective, indicating E-p and no therapist resistance . Therapist is more attuned to the clients

	emotional tone, indicating medium E-a .
--	--

C: “The brother went around and beat the shit out of him. Because I wasn't around then.”	
--	--

T: “So what’s stopping you, actually, what’s stopping you, something’s obviously holding you back,....you’ve had the opportunity.”	Therapist explores reasons why the client hasn’t used violence (without challenging or imposing own perspective), indicating medium E-p .
--	--

C: “Her, this, court, I don't want to go to jail ...”	Client gives reasons for not using violence, indicating absence of client resistance .
---	---

T: “Mmm”	Therapist listens, suggesting medium E-p .
----------	---

C: “I’m on my last legs now, I don't want to go to jail for beating that prick up....”	Client gives reasons for not using violence, indicating absence of client resistance .
--	---

T: “So you have had more... opportunity to do that... But what's been holding you back is the fact that you're on your last legs, you don't want to go to prison, you've been making some really good decisions lately ...”	Therapist accurately summarises the client’s perspective, and affirms their positive actions, indicating high E-p .
---	--

Summary of prolonged client resistance.

Throughout Segment 30 the therapist ignored the actual meaning of the client’s replies (low E-p), suggested their own interpretation of the events, and interrupted the client in order to do this (low-level TR). In Segment 31 the therapist continued to interrupt and emphasise an inaccurate understanding of the clients perspective (high TR, low E-p), which was negated by the client (TR), and the therapist did not attune to the client’s growing frustration (low E-a). The client reacted to this by trying to communicate their meaning even more strongly (CR). There was a back and forth volley of interrupting each other and arguing their perspectives, indicating growing discord in the relationship. This argumentative interaction continued into Segment 32

where the client began to more strongly defend their viewpoint that the therapist was misunderstanding and challenging (high level CR). In Segment 37 the therapist's approach changed, and she evoked and explored the client's perspective and more accurately reflected their meaning (high E-p), and became more attuned to the client's emotional state (medium E-a). The therapist did not interrupt or resist the client's perspective by pushing their own agenda (no TR), and client resistance ceased.

Summary of brief client resistance.

A narrative analysis of brief client resistance in segments 2-4 (not included here) showed similar patterns to sections of brief client resistance in Dyad 1. The therapist's unwillingness to hear the client's meaning (low E-p) and directive focusing of the conversation to their own agenda, appeared to frustrate the client and elicit mild CR, which in turn further elicited TR. This in turn triggered CR, and a cycle of argumentative interaction developed. When the therapist stopped interrupting, listened, and created space for the client to talk, client resistance ceased.

Dyad 3

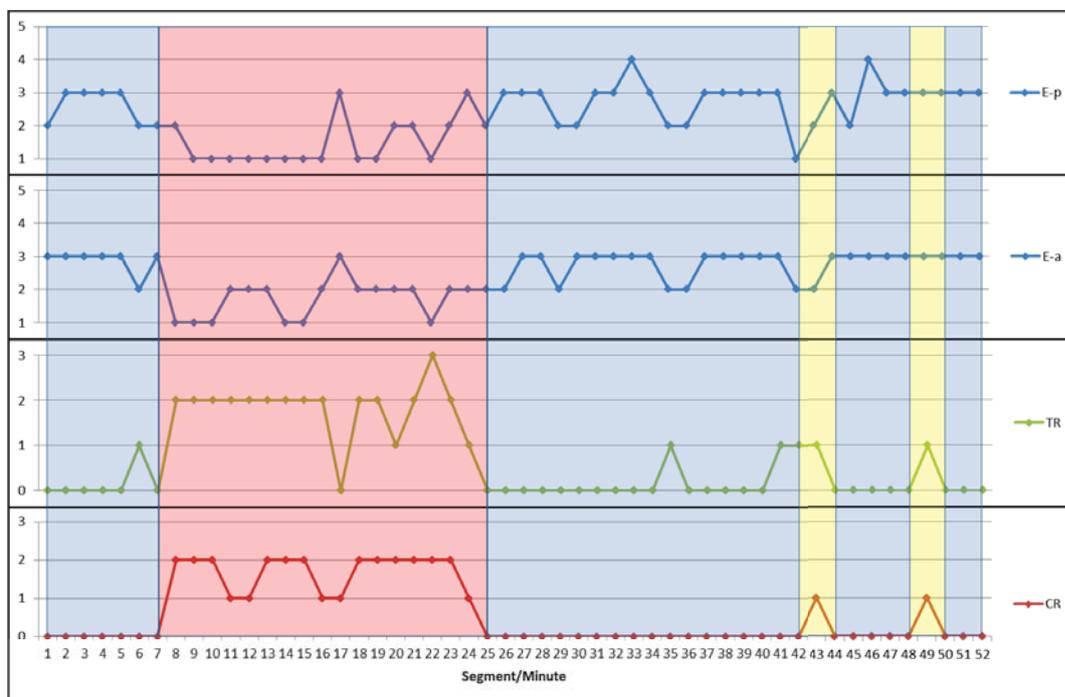


Figure 15. Scores for Dyad 3 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink).

The analysis for Dyad 3 was undertaken on the second session of the SMP. Session 2 has been described as delivering cognitive behavioural content in a motivational interviewing style (Austin, 2012). The session involves the discussion of the chain of events leading up to the offending, and is analogous to educating the client on the cognitive model, but is undertaken in adherence with the spirit and principles of MI (Anstiss, 2003; Steyn & Devereux, 2006). As was seen in Table 7, the average scores for Dyad 3 across the session were 0.71 for therapist resistance (range = 0 to 1.18) and 0.60 for client resistance (range = 0 to 1.50) These scores ranked the dyad third highest in terms of therapist resistance and fourth highest out of the eight dyads in terms of client resistance. Average therapist empathy scores for the entire session were below medium (<3) for both empathy scales. The scores also indicated there was more therapist resistance than client resistance. Figure 15 plots the scores on each measure, for each segment, for Dyad 3. There are some clearly synchronous patterns between the measures, and these will now be discussed. Table 22 substantiates these patterns with descriptive statistics.

Visual analysis of graph for Dyad 3.

Table 22

Descriptive Statistics for Dyad 3

Scenario	Frequency
CR present when TR exists	82%
CR present when TR absent	3%
E-p and E-a at or above medium (3) when CR absent	67%
E-p and/or E-a below medium (3) when CR exists	89%

What was the relationship between client and therapist resistance?

Figure 15 clearly showed that both client and therapist resistance were a regular occurrence in this dyad, and that there was synchrony between therapist measures and client resistance. When therapist resistance increased, so did client resistance, and vice versa. In the 22 segments featuring therapist resistance, 18 segments also featured client resistance (Table 22). There was also a clear relationship between the *levels* of the measures. High levels of therapist resistance (>1) coincided with high levels of client resistance (>1) as can be especially seen in the section of *prolonged client resistance* (highlighted pink). There was also synchrony in the *timing of change* on the measures, particularly with regard to the *onset* and *cessation* of client resistance. The *onset* of client resistance occurred on 3 occasions and on 2 of these occasions the onset of

therapist resistance also occurred in the same period, and the other occasion client resistance preceded therapist resistance by two segments. The *cessation* of client resistance occurred on 3 occasions, and on all 3 occasions therapist resistance ceased in the same period.

What was the relationship between therapist empathy and client resistance?

The graph also showed therapist empathy scores being inversely synchronised with client resistance, although somewhat variably. When both empathy scores were medium or above, client resistance was generally absent (67% of cases), and E-p and/or E-a were predominantly below medium where CR existed (89% of segments). There was a clearer relationship between the *levels* of the measures with more extreme scores, with very low empathy scores more closely coinciding with high levels of client resistance, as can be seen in the section of *prolonged client resistance* (highlighted pink). The timing of change on empathy scores was not clearly related to the timing of change in client resistance scores.

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

Sections with an *absence of client resistance* (shaded in blue) featured the least therapist resistance, and the consistently highest therapist empathy scores. Sections of *brief client resistance* were closely synchronised with therapist resistance, but not with therapist empathy (shaded in yellow). Sections of *prolonged client resistance* (shaded in pink) were closely synchronised with therapist resistance, and also coincided with therapist empathy scores. They also featured the highest levels of both client and therapist resistance for the session, and the lowest levels of therapist empathy. A maintained high level of client resistance was only ever seen in the presence of sustained high level therapist resistance and low therapist empathy.

Narrative analysis of Dyad 3.

Prolonged client resistance.

In the following sections, excerpts of narrative from segments 8-25 (shaded in pink in Figure 15) show examples of client-therapist dialog in segments where there was *prolonged client resistance*.

Segment 8 (onset of client resistance).

There was a notable change this segment, where E-p remained to low (2) and E-a decreased to very low (1), while there was an onset of both therapist and client resistance to a high level (2).

Table 23

Narrative Excerpts from Segment 8

Narrative	Analysis of Narrative
<p>T: "So what are your thoughts? Who will benefit from it?"</p>	
<p>C: "Well, myself especially."</p>	<p>Client gives their perspective in reply to therapist's question</p>
<p>T: "Yeah, you will benefit, who else will benefit, the other people, nobody else will benefit from that?"</p>	<p>Therapist appears uninterested in the client's perspective, and appears to have an agenda they are trying to extract from the client, indicating low E-p.</p>
<p>C: "Yeah, naturally, someone, there will be other people they will benefit all right, but myself especially."</p>	<p>Client grudgingly agrees with therapist, but re-emphasises the point he made.</p>
<p>T: "The biggest benefit is you, what about your children?"</p>	<p>Therapist briefly acknowledges the client's stance, but it does not feel like the therapist is listening to the client, and it appears they move back to their own agenda regarding the client's children, indicating low E-p. The client is beginning to appear unhappy, and client and therapist are out of tune, indicating low E-a.</p>
<p>C: [Tone is unhappy] "Ummm, yeah.."</p>	<p>Client unhappily agrees with therapist.</p>
<p>T: [Interrupts] "One way or the other they will benefit."</p>	<p>Therapist interrupts the unhappy client and authoritatively imposes his own perspective by providing an answer to his own question, indicating low E-p, low E-a and TR.</p>
<p>C: [Interrupts] "They are all right at the moment"</p>	<p>The unhappy client interrupts the therapist and disagrees with him, indicating high-level client resistance.</p>
<p>T: [Interrupts] "Yeah, but, they are all right at</p>	<p>The therapist interrupts the client and</p>

the moment, but if you were out there they would have been better.”	undermines the client’s statement, instead confronting the client and imposing their own perspective, which is somewhat judgemental and blaming, indicating high-level therapist resistance
C: [Nods, doesn't seem happy.]	
T: "So one way or the other they will benefit, all right.”	Therapist authoritatively re-emphasises their own perspective, in opposition to the client’s perspective, indicating low E-p, very low E-a, and high-level therapist resistance .
C: [Undertone of resentment] "Aaahhh, just sort of like, like I said aye, if you fellas are so worried about them being benefited, like I said send me back to them."	The unhappy client confronts the therapist, indicating, and high-level client resistance .

Segment 24 (reduction of client resistance).

In this segment, therapist empathic perspective taking increased to medium (3), empathic attunement remained low (2), and there was a reduction of both client resistance (1) and therapist resistance (1).

Table 24
Narrative Excerpts from Segment 24

Narrative	Analysis of Narrative
T: [Interrupts] "So, yes, you are the only person who can change you. You are the only person who can change you, nobody else can make you.”	Therapist interrupts client, but supports client autonomy, although this is done in a very authoritative manner.
C: "Yep, yep."	Client agrees
...	
T: [Interrupts] "You want to change?"	Therapist interrupts again, perhaps subtly pushing own agenda, suggesting low-level TR .
C: [Interrupts] "That's the thing, like I had to prove to people that I have changed, and that's	Client had to interrupt therapist to perspective across, but is not arguing against therapist,

what I don't like aye."

indicating **no CR**.

T: "Okay, I see what you're saying, you are thinking that you really need to show people that you have changed."

Therapist listens and accurately reflects the client's meaning, indicating **medium E-p, no TR**.

C: "Well, if I don't do that"

T: "Mmhmm"

Therapist listens.

C: "Then where I am now is where I will stay."

Segment 25 (cessation of client resistance).

Therapist empathy was low on both measures (2), therapist resistance ceased, and client resistance also ceased.

Table 25

Narrative Excerpts from Segment 25

Narrative	Analysis of Narrative
C: "Yes."	
T: "And nobody can change that and nobody can take that from you, that's your essence, that's what you have learned, nobody can do anything about it, and that is what I was saying, if we want to change I can change myself only, and you will change yourself. I can give you all those good things right, but it's like taking a horse to a stream, if you swim him in the water it will be looking here and there, but if it doesn't want to drink it is not going to drink. Even if I put his mouth in the water, is not going to drink, you see what I'm saying?"	Therapist first affirms the client's perspective and supports the client's autonomy, but then returns to offering their own perspective on the client's situation in a somewhat demeaning way.

C: "Mmm."

T: "So the programme and everything that we are doing, we talk about things, and at the end of the day if you think this is good this is going to work I will take it, and if you think, ..."

Summary of narrative analysis for prolonged client resistance.

Throughout Segment 8 the therapist appeared to communicate a superficial interest in the client's perspective (low E-p) and to try and evoke an answer they desired from the client, as well as imposing their own perspective. The client responded negatively to this (CR), and the therapist responded to the client's defensiveness by interrupting the client and further imposing their perspective (low E-p, TR). This communication pattern continued and escalated throughout the segment, and the interpersonal dynamic remained very similar throughout Segments 9-23 (narrative not shown). In Segment 24 the therapist's approach changed, with a greater focus on evoking, accurately reflecting, and listening to the client's perspective and meaning (medium E-p). The therapist stopped resisting the client's perspective, and client resistance reduced in intensity. In Segment 25 the therapist dominated the conversation and was, somewhat incongruently, supporting the client's autonomy in an authoritative/expert manner. The therapist then moved the conversation to another topic. Therapist and client resistance both ceased.

Dyad 4

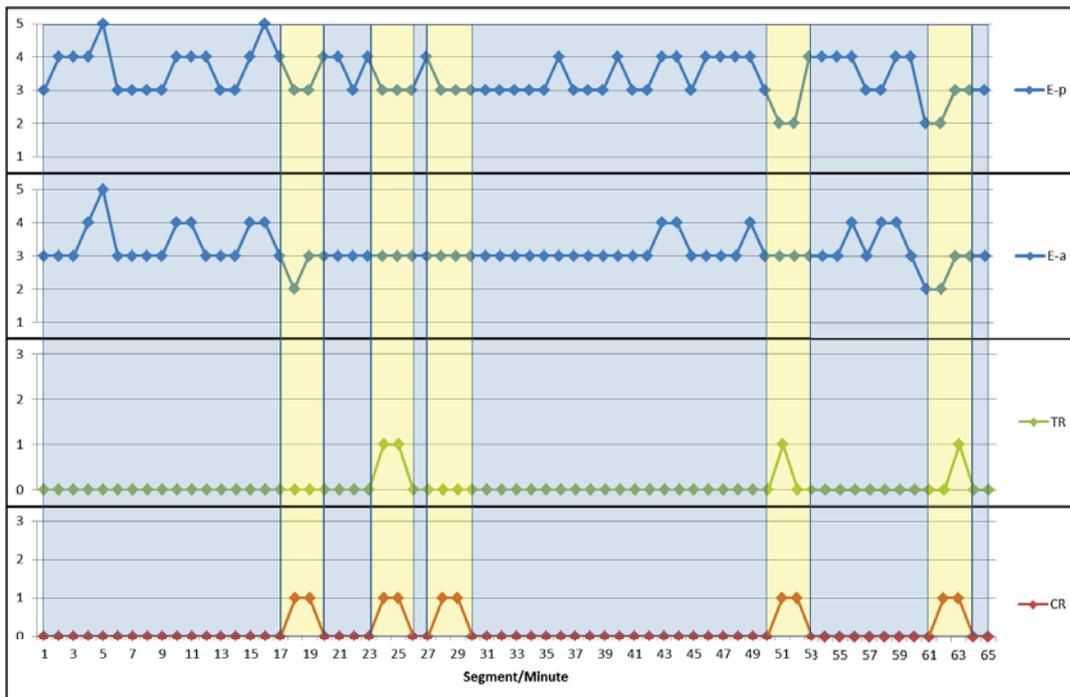


Figure 16. Scores for Dyad 4 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink).

The analysis for Dyad 4 was undertaken on the third session of the SMP. Session 3 of the SMP is generally thought to focus on the use of MI methods, and not to contain cognitive behavioural content (Anstiss, 2003; Steyn & Devereux, 2006). This is partly reflected in the methods employed during session three: a time projection exercise and a costs and benefits analysis (decisional balance). As was seen in Table 7, the dyad scored 0.06 for therapist resistance (range = 0 to 1.18) and 0.15 for client resistance (range = 0 to 1.50) (Table 7). These scores ranked the dyad seventh highest out of the eight dyads in terms of client resistance and therapist resistance. Average therapist empathy scores for the session were above medium (>3) for both empathy scales, and average working alliance inventory scores were also above medium (>4). The scores indicated there was more client resistance than therapist resistance in the session. Figure 16 plots the scores on each measure, for each segment, for Dyad 4. There were some clear synchronous patterns between the measures, and these will now be discussed.

Visual analysis of graph for Dyad 4.

Table 26

Descriptive Statistics for Dyad 4

Scenario	Frequency
CR present when TR exists	100%
CR present when TR absent	10%
E-p and E-a at or above medium (3) when CR absent	98%
E-p and/or E-a below medium (3) when CR exists	40%

What was the relationship between client and therapist resistance?

Figure 16 clearly showed that neither client nor therapist resistance were a regular occurrence in this dyad. However, where they did occur, there was clear synchrony between measures of therapist relational skills and client resistance. When therapist resistance increased, so did client resistance, and vice versa. In the 4 segments featuring therapist resistance, all segments also featured client resistance (Table 26), but client resistance also occurred in isolation to therapist resistance. There was a clear relationship between the *level* of the measures, with therapist and client resistance always being at the same level when they occurred together. There was also synchrony in *timing of change* on the measures with regard to the *onset* and *cessation* of client resistance. The onset of client resistance occurred on 5 occasions and on 2 of these occasions the onset of therapist resistance also occurred in the same period, and the other occasion client resistance preceded therapist resistance by one segment or there was an absence of therapist resistance. The cessation of client resistance occurred on 5 occasions, and on 2 occasions

therapist resistance ceased in the same period, and on one occasion therapist resistance ceased in the segment prior.

What was the relationship between therapist empathy and client resistance?

The graph showed therapist empathy scores being inversely synchronised with client resistance, although somewhat variably. When both empathy scores were medium or above, client resistance was predominantly absent. However E-p and/or E-a were sometimes medium or above where CR existed (Table 26). There was not a clear relationship between the *level* or *timing* of change amongst the empathy and client resistance measures.

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

Sections with an *absence of client resistance* never featured therapist resistance, and contained the highest therapist empathy scores (shaded in blue in Figure 16). Sections of *brief client resistance* featured the highest therapist resistance and lowest empathy scores (shaded in yellow in Figure 16). There were no sections of *prolonged client resistance*.

Narrative analysis of Dyad 4.

Absence of client resistance.

In the following sections, excerpts of narrative from segments 17, 26, and 27 (shaded in blue in Figure 16) were used to provide an example of client-therapist dialog in segments where there was an absence of client resistance.

Segment 17.

In this segment, therapist empathy was high on E-p (4), medium on E-a (3), and there was an absence of both therapist and client resistance (0).

Table 27

Narrative Excerpts from Segment 17

Narrative	Analysis of Narrative
[Therapist is directing client to look at a new topic – offending attitudes]	
T: "...so this one is about... 'Even if I know it is wrong, I still don't do it, but I can do what I want, and it's my choice.'"	Therapist explains what offending attitudes are.

C: "Yeah, more or less, I suppose. I definitely didn't know what he was up to, you know what I mean? "	Client comments on their relevance to his offending, emphasising they didn't know there was a drug deal until the last moment, indicating no CR.
T: "Yep."	Client indicates he understands the client's perspective.
C: "It wasn't until after I already dropped off that I knew."	Client re-emphasises his limited knowledge in the offending, up until the last moment.
T: "Yep."	Client indicates he understands the client's perspective, indicating E-p.
C: "So...yeah."	
T: "So when you're talking here, would it be fair to say you could have said 'nah bro, don't even worry about it.'"	The therapist mildly confronts the client regarding alternative behaviours they could have taken to the offending. However this is done very collaboratively by asking the client's perspective on whether this was a stage in the offence chain where the client could have prevented the offending indicating E-p.
C: "Yeah, whatever."	
T: "I'm just dropping you off, I don't want anything to do with it, is that what you're saying?"	Therapist clarifies whether his understanding of the client's words are accurate, indicating high E-p.
C: "I just didn't care, whatever."	Client clarifies their meaning, indicating no CR.
T: "Does 'whatever' mean, yep, well if you bring it you bring it, if you don't you don't."	Therapist is unsure and again clarifies whether his understanding of the client's words are accurate, indicating high E-p.
C: [Interrupts] "It's like you say something to me and I look at you, and that thought in my	Client expands on his meaning, indicating no CR.

head is going 'bullshit'."

T: "Yeah."

C: "Yeah whatever."

T: "Mmm."

Therapist listens, facilitates and creates space for the client to talk.

C: "Yeah, so I wasn't really worried about what he said, I just wanted to get out of there."

T: "Mmm."

Therapist listens and facilitates client's narrative.

Summary sections with an absence of client resistance.

The therapist was querying the client about their offending attitudes with regards to a critical time point in the offence. The therapist confronted the client with a suggestion they could have prevented the offending by removing themselves from the situation at a certain point, but did this in a non-authoritative manner and sought clarification from the client as to whether they saw the situation in this way, (high E-p). The client expanded on this situation, without resistance, and at each step of the way the therapist continued to ensure that his understanding of the situation was the same as the client's. The therapist did not impose his perspective or assume he had the right understanding of the situation. The therapist gave full attention to the client, and created space for the client to talk. It was obvious the therapist was truly listening to the client. There was no client or therapist resistance.

Brief client resistance.

In the following sections, excerpts of narrative from segments 24-26 (shaded in yellow in Figure 16) showed examples of client-therapist dialog in segments where there was *brief client resistance*.

Segment 24 (onset of client resistance).

There was a notable change this segment. Therapist empathy was medium on both measures, but there was an onset of both client and therapist resistance.

Table 28

Narrative Excerpts from Segment 24

Narrative	Analysis of Narrative
T: "So I was thinking, over here, your mates are manufacturing drugs aye?"	Therapist clarifies a point about offending associates.
C: "Yeah, they were making drugs, yeah."	Client agrees.
T: "OK, so this type of mate, is the type of person that sells drugs to your son."	Therapist appears to have an agenda to confront and present the client with a consequence of his behaviour.
C: "Type of person..., yeah, probably yeah."	Client considers therapist's suggestion
T: "So your son,...last week you were talking about how you don't want to go down your same path"	Therapist further develops his idea.
C: [Interrupts] "Yet, it's funny you should say that though aye... Because, yeah, even though this person is the type of person that would sell my son some drugs, anyone that knows me,, knows not to sell drugs to my kids ..."	Client interrupts and mildly disagrees with the therapist's statement, indicating low-level CR
T: "Mmm, but somehow your sons got drugs."	Therapist mildly challenges the client's stance, indicating low-level TR. The tone of the therapist is egalitarian and genuinely curious.

Segment 25 (maintained client resistance).

Therapist empathy remained medium (3) on both measures, and there was a continuation of both client and therapist resistance at a low level (1).

Table 29

Narrative Excerpts from Segment 25

Narrative	Analysis of Narrative
T: "So thinking about"	
C: [Interrupts] "Being a drug dealer, I won't sell	Client interrupts, in mild disagreement with the

to kids either."	direction of the therapist's conversation, and low-level CR.
T: "But someone does aye?"	Therapist does not acknowledge the client's perspective, and continues with their own agenda, indicating low-level TR and possible low E-p , although this was not coded, perhaps because of the mild tone of the conversation.
C: "Someone does, yeah, and am I worried about that, to tell you the truth not really, I don't really think about it when I do it."	Client agrees with therapist, indicating no CR.
T: "Mmm"	Therapist listens.
C: "I might sell crack to somebody else, and he might sell it to somebody else and then T: "Mmm."	Client openly considers the therapists idea. Therapist listens and facilitates.
C: "I don't think about that, aye."	Client appears engaged in thinking the issues through.
...	
T: "Mmm."	Therapist listens and facilitates.
C: "I'd rather sell drugs to someone then go out and put a gun to their head."	Client points out pros and cons of drug dealing.
T: "Mmm."	Therapist listens
C: "And get their money."	

Segment 26 (cessation of client resistance).

Therapist empathy was medium on both measures (2), therapist resistance ceased, and client resistance ceased.

Table 30

Narrative Excerpts from Segment 26

Narrative	Analysis of Narrative
C: "But in that same case, yeah it does make one ummm, I do a lot of things that doesn't make me feel happy."	Client suggests some of his behaviours don't make him happy.
T: "Mmmm."	Therapist listens and facilitates.
C: "That I dislike, but I do them anyway."	Client continues to explore his offending behaviours.
T: "Mmmm."	Therapist listens and facilitates, indicating medium E-p.
C: "And sometimes, it's not a thing of liking it, but aaaah, having to do it."	Client suggests they may have no choice regarding illegal behaviour.
T: "Mmmm, is it about having to do it, or choosing to do it?"	Therapist listens, and then questions the client about whether they actually have no choice. This is a confront by the therapist, but is done in a way that has the genuine feel of searching for the client's perspective, rather than imposing their own agenda.
C: "Well, choosing, yeah I dunno."	Client thinks hard about the therapist's confront.
T: [Nods] "Mmmm."	Therapist listens and leaves space for the client to think, without imposing their idea any further, indicating medium E-p.
C: "Sometime you're put in a position where you have to do it, even though you don't like it...yeah, I suppose I could always chose not to do it, but then the consequences of that could be actually worse than the consequences of actually doing it."	Client voices their ambivalence about this situation.
T: [Nods during pause while client thinks.]	Therapist acknowledges the client's struggle with ambivalence.

Summary sections with brief client resistance.

In both Segment 24 and 25 the therapist directly focused the conversation in order to explore an agenda he appeared to have, and also confronted the client with regards to negative outcomes of their offending behaviour, sometimes in opposition to the client's perspective (low-level TR). The confront appeared to trigger the client to mildly defend himself both occasions (low-level CR). However, in contrast to previous dyads, the therapist did not react to the client's resistance with their own resistance, but instead allowed the client space and encouraged them to voice their perspective over the remainder of segment 25 and onto segment 26 (medium E-p). This empathic approach, and lack of therapist resistance, appeared to limit the amount of client resistance, and instead elicited thoughtful consideration of the therapist's ideas by the client, indicating no further client resistance. This pattern was also seen in the narrative in segments 18-20 (which were not included here). In comparison to the previous three dyads, it was notable that the therapist also "left space" for the client to talk, which was illustrated by the therapists use of silence while listening, and their facilitative "mmm".

Dyad 5

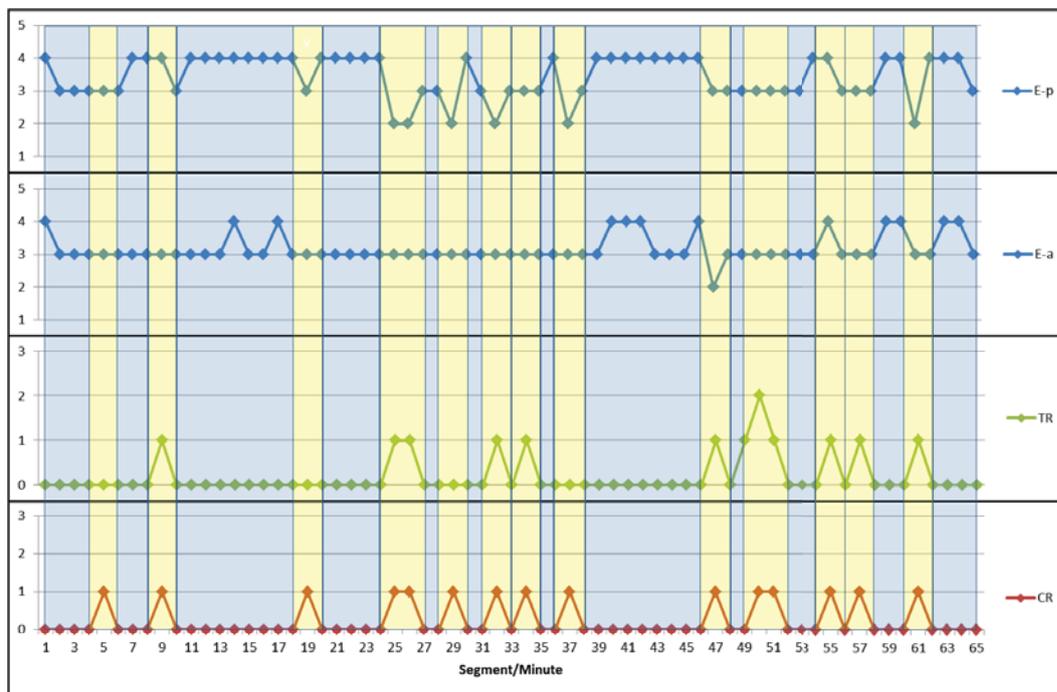


Figure 17. Scores for Dyad 5 for each segment in the session, for all measures. Coloured sections represent 'Absence of Client Resistance' (blue), 'Brief Client Resistance' (yellow).

The analysis for Dyad 5 was undertaken on the third session of the SMP, and the therapist was the same therapist who featured in Dyad 2. Session 3 of the SMP is generally thought to focus on the use of MI methods, and not to contain cognitive behavioural content (Anstiss, 2003; Steyn & Devereux, 2006). This is partly reflected in the methods employed during session three: a time projection exercise and a costs and benefits analysis (decisional balance). As was seen in Table 7, the average scores for Dyad 5 across the session were 0.20 for therapist resistance (range = 0 to 1.18) and 0.23 for client resistance (range = 0 to 1.50). These scores ranked the dyad sixth highest out of the eight dyads in terms of client resistance and fifth out of the eight dyads in terms of therapist resistance. Average therapist empathy scores for the session were above mid-point (>3) on both empathy scales, and average working alliance inventory scores were also above mid-point (>4). These scores indicated there was slightly more client resistance than therapist resistance in the session. Figure 17 plots the scores on each measure, for each segment, for Dyad 5. There were some clear synchronous patterns between the measures, and these will now be discussed.

Visual analysis of graph for Dyad 5.

Table 31

Descriptive statistics for Dyad 5

Scenario	Frequency
CR present when TR exists	92%
CR present when TR absent	8%
E-p and E-a at or above medium (3) when CR absent	100%
E-p and/or E-a below medium (3) when CR exists	47%

What was the relationship between client and therapist resistance?

Figure 17 clearly showed that both client and therapist resistance were a regular occurrence in this dyad, although the level of resistance intensity was consistently low. There was clear synchrony between therapist resistance and client resistance. In the 12 segments where there was therapist resistance, 11 segments featured therapist resistance as well, although there were 4 segments where client resistance occurred without therapist resistance. There was also synchrony in regards to *timing of change* on the measures with regards to *onset* and *cessation* of resistance. The onset of client resistance occurred on 13 occasions and on 8 of these occasions the onset of therapist resistance also occurred in the same period, on one occasion therapist

resistance occurred in the segment before client resistance, and on the remaining occasions there was an absence of therapist resistance. The cessation of client resistance occurred on 13 occasions, and on 9 occasions therapist resistance ceased in the same period. There was also a clear relationship between the *level* of the measures, with both client and therapist resistance generally being either absent, or low level.

What was the relationship between therapist empathy and client resistance?

The graph also showed therapist empathy scores being inversely synchronised with client resistance. When client resistance was absent, both empathy scores were always medium or above (Table 31). However there was not always a low score on an empathy measure when client resistance was present. In total, there were 7 segments containing low therapist empathy on at least one measure, and in all cases there was also client resistance.

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

Sections with an *absence of client resistance* featured the least therapist resistance, and contained the highest therapist empathy scores (shaded in blue in Figure 17). Sections of *brief client resistance* featured the highest therapist resistance and lowest empathy scores (shaded in yellow in Figure 17). There were no sections of *prolonged client resistance*.

Narrative analysis of Dyad 5.

Absence of client resistance.

Segment 10.

The pattern here was similar to that previously seen, so the narrative was not included and the analysis was brief. The therapist was querying the client about the cons of drinking, and listening to and reflecting the client's thoughts, indicating E-p. The client freely offered their perspective. There was no client or therapist resistance.

Brief client resistance.

In the following sections, excerpts of narrative from segments 25-26 (shaded in yellow in Figure 17) showed examples of client-therapist narrative in segments where there was *brief client resistance*.

Segment 5 (onset of client resistance).

Therapist empathy was medium on both E-p and E-a (3). There was an onset of low-level client resistance (1), but therapist resistance was absent.

Table 32

Narrative Excerpts from Segment 5

Narrative	Analysis of Narrative
T: "Umm, drinking heavily, you said that you were vomiting and then, you know back to it again."	Therapist talks through the time of the offence.
C: "Yeah."	
T: "Umm, your partner prompted you to leave, but you made the decision 'no, I'm not going to go with her'."	
C: "Yeah."	
T: "Ummm, and you argued about it for a bit, but you'd already made up your mind."	
C: [Interrupts] "We didn't really argue but yeah."	Client interrupts and mildly disagrees with therapist, indicating low level CR .
T: "Oh, you didn't really argue?"	Therapist checks client's perspective.
C: [not captured]	
T: "Oh, well what would you call it?"	Therapist asks for client's perspective.
C: "Oh, I've said no I'm not going I'm staying here, and she hopped on the car and did a skid and took off."	
T: "Ok, so, so didn't argue about it [write this down] okay, so cool, so then the victim turned up, and you were thinking ..."	Therapist accurately reflects, and continues to explore, the client's perspective.

The client interrupted and disagreed with the therapist (CR), who then requested clarification of the client's actual meaning, and later accurately reflected this to the client. The low-level client resistance ceased towards the end of the segment.

Segment 25 (onset of client resistance).

Therapist empathy remained medium on both measures, and there was an onset of both client and therapist resistance.

Table 33

Narrative Excerpts from Segment 25

Narrative	Analysis of Narrative
T: "So what was it that tripped you up? This time?"	Therapist begins to explore the offending situation from within client's perspective.
C: "Well making that mistake of thinking that it was Shannon that rang me and turning up and it was Chris, and then they are all standing there and drinking and they said, mate have a beer."	Client begins his story.
T: "Mmm."	Therapist facilitates client's story telling.
C: "So I said, I won't be rude; I'll have a couple of beers."	Client suggests they had to have a drink, because it would have been rude to do otherwise.
T: "Yeah, cos at that point when you found out, you could have left."	Therapist ignores the clients meaning (low E-p), and mildly confronts the client by offering advice as to how they could have acted (low level TR). Therapist appears to have switched to a therapist-centred exploration of the situation, rather than a client-centred exploration.
C: "Yeah, it would have been a bit rude."	Client mildly disagrees with the therapist, and re-emphasises their previous statement, (low level CR).

T: "You kind of felt, it make you look"	Therapist appears to be trying to reflect the client's perspective.
C: "It would have been rude, yeah."	Client re-emphasises for the third time that it would have been rude to leave.
T: "It would have been rude, yeah. So there's a chance that could happen again aye?"	Although the therapist recently reflects the clients perspective, they then subtly confront the client by suggesting that the problem situation could arise again, which is not what the client saying (low E-p). Therapist-centred exploration continues.
C: "Naah."	Client disagrees with the therapist (CR).
T: "No, why not?"	

Summary of brief client resistance.

In Segment 25 the therapist ignored reasons the client offered for their actions, and instead offered advice on another course of action they could have taken (low E-p, low-level TR). The client re-emphasised their own perspective twice more, but the therapist was not accurately tracking the client's conversation, and warned that this problematic situation could arise again. This was not what the client was meaning, and the client voiced disagreement with the therapist (CR), which the therapist responded to by questioning the client's perspective. There was a sense in the DVD that the therapist was working very hard, and making interpretations to help achieve an agenda. It seemed that the therapist was very active, but not actively listening.

Dyad 6

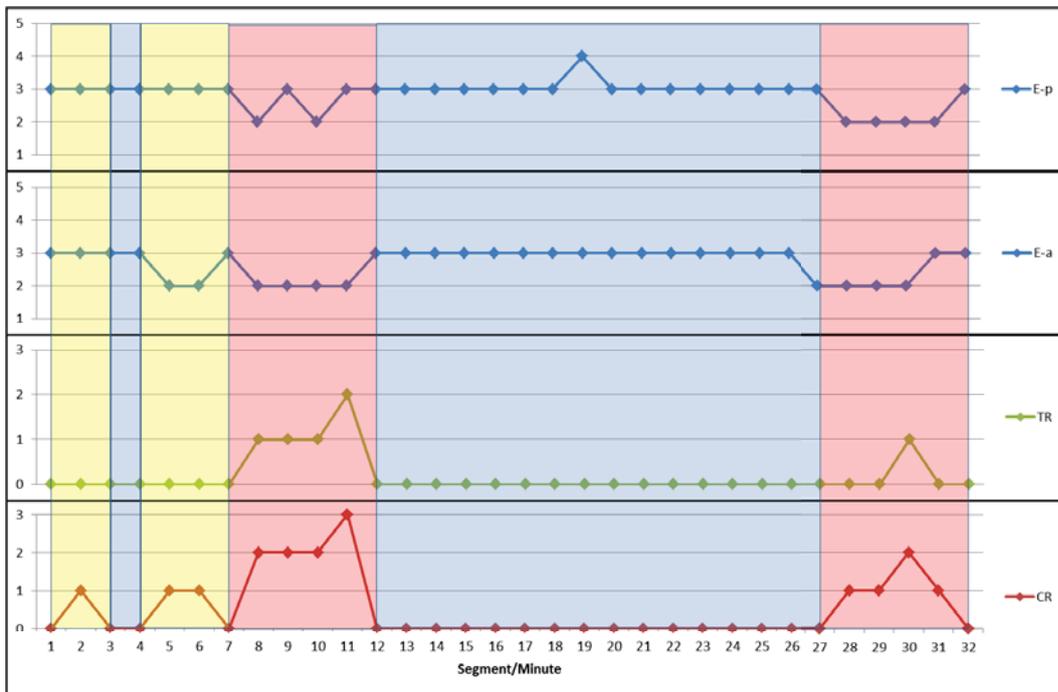


Figure 18. Scores for Dyad 6 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink).

The analysis for Dyad 6 was undertaken on the second session of the SMP. Session 2 has been described as delivering cognitive behavioural content in a motivational interviewing style (Austin, 2012). The session involves the discussion of the chain of events leading up to the offending, and is analogous to educating the client on the cognitive model, but is undertaken in adherence with the spirit and principles of MI (Anstiss, 2003; Steyn & Devereux, 2006). As was seen in Table 7, the average scores for Dyad 6 across the session were 0.19 for therapist resistance (range = 0 to 1.18) and 0.53 for client resistance (range = 0 to 1.50). These scores ranked the dyad fifth highest out of the eight dyads in terms of client resistance and sixth highest for therapist resistance. Average therapist empathy scores for the session were below medium (<3) for both empathy scales, and average working alliance inventory scores were well below medium (<4). The scores indicated there was considerably more client resistance than therapist resistance in the session.

Figure 18 plots the scores on each measure, for each segment, for Dyad 4. There were some clearly synchronous patterns between the measures, and these will now be discussed.

Visual analysis of graph for Dyad 6.

Table 34

Descriptive Statistics for Dyad 6

Scenario	Frequency
CR present when TR exists	100%
CR present when TR absent	22%
E-p and E-a at or above medium (3) when CR absent	95%
E-p and/or E-a below medium (3) when CR exists	91%

What was the relationship between client and therapist resistance?

Figure 18 showed there was clear synchrony between therapist resistance and client resistance. In the 5 segments where there was therapist resistance, client resistance was always present, although client resistance also occurred in isolation to therapist resistance (Table 33). There was also synchrony in regards to *timing of change* on the measures. In the two sections where TR occurred, TR *onset* was synchronised with TR in one section, and followed CR by one segment in the other. In these same sections, the *cessation* of TR was synchronised with CR in one section, and was one segment prior to CR in the other. The relationship between the *levels* of the

measures was not as clear, although high therapist resistance only ever occurred when there was high level client resistance. Therapist resistance tended to be lower than client resistance.

What was the relationship between therapist empathy and client resistance?

The graph also clearly showed therapist empathy scores being inversely synchronised with client resistance. When client resistance was absent, both empathy scores were always medium or above (Table 31), and in 10 of the 11 segments where client resistance was present, therapist empathy was low on at least one measure.

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

Sections with an *absence of client resistance* featured no therapist resistance, and contained the highest therapist empathy scores (shaded in blue in

Figure 18). Sections of *brief client resistance* featured no therapist resistance, but were synchronised with low therapist empathy scores (shaded in yellow). Sections of *prolonged client resistance* featured the highest therapist resistance and lowest empathy scores (shaded in pink). A maintained high level of client resistance was only ever seen in the presence of sustained high level therapist resistance and low therapist empathy.

Narrative analysis of Dyad 6.

Brief client resistance.

In the following sections, excerpts of narrative from Segment 2 (shaded in yellow in Figure 18) show an example of client-therapist narrative in a segment where there was *brief client resistance*.

Segment 5 (onset of brief client resistance).

In Segment 5, therapist empathy was medium on E-p (3) and low on E-a (2), there was an absence of therapist resistance (0), and there was an onset of low level client resistance (1).

Table 35

Narrative Excerpts from Segment 5

Narrative	Analysis of Narrative
T: "Yes, tell me a bit about that, which bits are kind of really familiar for you."	Therapist enquires as to the relevance of the hypothetical example of an offence chain for the client, with regards to their offending.
C: "The whole lot, that is through the past."	Client suggests it is relevant to their past behaviour.
T: "In the past, so not so much now."	Therapist reflects client's thoughts, indicating medium E-p.
C: "Well, because I make sure it doesn't happen."	
T: "Okay."	Therapist suggests they understand client.
C: "Mmm."	
T: "So in terms of kind of, because there are a lot of different things in here and various kind of some negative feelings around relationships."	Therapist has acknowledged that the hypothetical scenario they are exploring is not relevant to the client's situation, but now continues to explore its relevance. There is a feeling that the client and therapist are out of attunement, that the therapist is continuing in spite of the client's negative feelings (low E-a).
C: "Well like I said, that's an everyday thing to me that I see every day, but not pertaining to me though."	Client irritation grows at exploring the hypothetical scenario which they consider to be irrelevant to them, suggesting low level client resistance.

Prolonged client resistance.

In the following sections, excerpts of narrative from Segments 7-12 (shaded in red in Figure 18) showed examples of client-therapist dialog in segments where there was prolonged client resistance.

Segment 8 (onset of prolonged client resistance).

Therapist empathy dropped to low on both measures (2), and there was an onset of both therapist resistance (low-level) and client resistance (high-level).

Table 35

Narrative Excerpts from Segment 8

Narrative	Analysis of Narrative
	Therapist continues to talk the client through a hypothetical example of an offence chain, and encourages the client to recognise the psychological processes that may be occurring. Therapist is referring to a drawing on a piece of paper, and is doing most of the talking.
T: "It was about what you are saying just now, about "getting back" at her partner."	Therapist makes a link between the hypothetical example and the client's situation.
C: "Mmm."	
T: "And here she kind of blames him."	
C: "Well, look at the beginning."	
T: "Mmmm, mmm it says it up there those thoughts, those thoughts that you were picking up about 'Now I'm even worse off' and "it's all his fault'."	
C: "Mmm."	
T: "Mmm."	
C: "Yeah" (questioning)	
T: "Okay, so what is this next box, what happens, so she carries on drinking."	Therapist is attempting to explore the client's perspective on the hypothetical example.
C: "Mmm."	
T: "What do you reckon she is trying to achieve there."	

C: [Slightly aggressive] “Getting back at him.”

T: “Mmm.”

C: “Really, this has really got nothing to do with me anymore, I know it is just an example, but can we get onto me.”

Client has appears irritated at the tasks being irrelevant to her situation, and that it is hypothetical, and now voices this annoyance, indicating high-level client resistance.

T: “Yeah, sure...yep. So one of the reasons we are looking at this is just to see the links between the events.”

Therapist briefly acknowledges the client’s irritation, but then moves to offer her perspective for undertaking the hypothetical example, but the client did not ask for an explanation of this. It has a feel of forcing the issue and justifying the tasks. Therapist appears out tune with the client, indicating low E-a.

C: “Mmm.”

Client appears irritated.

T: “Ummm, so that when we start looking at yours, it is sometimes easier if we have seen the links between what happened to someone else.”

Therapist continues with the justification from her own perspective, doesn’t acknowledge/try to understand the client’s viewpoint (low E-p) and there is a sense it is against the client’s wishes. Indicating low-level therapist resistance.

C: “Mmmm, yeah, I have got a fair idea of what we are going into.”

Client communicates that she already knows the rationale for the tasks, and there is a tone of cynicism, indicating client resistance.

Segment 11 (escalation of client resistance).

Therapist E-p was medium (3) and E-a was low (2). Therapist resistance was high (2) and client and therapist resistance was very high.

Table 36

Narrative Excerpts from Segment 9

Narrative	Analysis of Narrative
<p>T: “Because last week we were thinking back to what happened, and you were telling me all about it, and what we know is that sometimes when you go away and think about it, we suddenly go – ‘oh yes that happened as well, and we didn't talk about’ “.</p>	<p>Therapist asks if the client has had any further thoughts on previous week’s conversations, indicating medium E-p. Therapist also suggests her own viewpoint on how clients can sometimes forget things.</p>
<p>C: [Interrupts and is irritated] “No, everything I said is what happened.”</p>	<p>Client is irritated and clearly tells the therapist there is no more information, as she previously communicated, indicating client resistance.</p>
<p>T: “Yeah so there was”</p>	<p>The therapist sounds like are questioning the validity of the client’s perspective and may force this issue, indicate possible therapist resistance.</p>
<p>C: [Interrupts] “No.”</p>	<p>The client interrupts again and emphasises there is no more information, indicating client resistance.</p>
<p>T: “Nothing else that suddenly came back to you?”</p>	<p>Therapist pushes this issue in a way that suggests the client’s answer may not be correct, indicating therapist resistance. Therapist is undertaking this exploration from within her own perspective.</p>
<p>C: “No.”</p>	<p>Client again emphasises there is no more</p>

information.

T: "Okay, that's cool."

C: "If there was I would have said."

Clients reply has a feel of "I've already told you this"

T: "Yeeahhh, it's just sometimes we remember afterwards you know."

Therapists reply has the feel of disputing the validity of the client's previous response, and justifying the repeated questions against the client's wishes, suggesting high-level therapist resistance. This is also detracting from the client's perspective, indicating low E-p.

C: "Hmmm."

Segment 12 (cessation of client resistance)

Therapist empathy increased to medium on both measures (3), therapist resistance ceased, and client resistance ceased.

Table 37

Narrative Excerpts from Segment 12

Narrative	Analysis of Narrative
T: "Then you had the accident, and the police arrived."	Therapist continues to walk through the events at the specific time of the offence.
C: "Mmmhmmmm."	
T: "And breath tested you."	
C: "Mmmhmmmm."	
T: "Those were kind of key events in me, what	

are your thoughts on it?"

C: "Well, that's everything that happened."

T: "Yeah, so that makes sense does it."

Therapist is attempting to understand client's perspective indicating medium E-p, and no TR.

C: "Yes."

Client is brief and unenthusiastic, but there is not client resistance.

T: "Yeah."

C: "Okay, so what we need to do today is fill in a bit more detail for each of these, and then look and see what you think the links for each of them, so that's kind of how did this lead to this lead to this, lead to offending."

The therapist guides the focus of the therapeutic task from the hypothetical example to the actual chain of events leading up to the client's offending.

C: "Mmmm."

T: "Yeah, so that's kind of an entirely up to you, would you like to fill in the details, or would you like me to?"

Therapist attempts to collaborate with the client indicating no TR.

C: "Yeah yeah."

Client is reasonably agreeable, indicating no CR.

T: "OK. So we think about the first event it was around 530 in the morning."

Summary of analysis for Dyad 6.

In this section of the DVD, the client was unhappy about undertaking a task they considered irrelevant (working through a hypothetical offending scenario), and the therapist's refusal to

truly acknowledge this (low E-p), and alter the therapeutic task, elicited client resistance in Segment 5. Although explicit client resistance briefly ceased, it reappeared again as the therapist continued with this hypothetical task in opposition to the client's wishes. The therapist's behaviour was not coded as therapist resistance, as the language she used was not explicitly resistant, however the behaviour could be considered resistant. Client resistance escalated in Segment 8 and then again in Segment 11, when the therapist invalidated the client's perspective on multiple occasions and imposed her own perspective. In these segments the client's voicing of a difference in opinion to the therapist appeared to elicit therapist resistance, in the form of re-emphasising her own perspective and subtly undermining the client's perspective (low E-p, TR). The client responded negatively to this invalidation with client resistance, which seemed to further elicit low E-p and TR. Client resistance ceased in Segment 12 when the therapist re-focused the conversation, and the level of empathic perspective taking increased.

Dyad 7

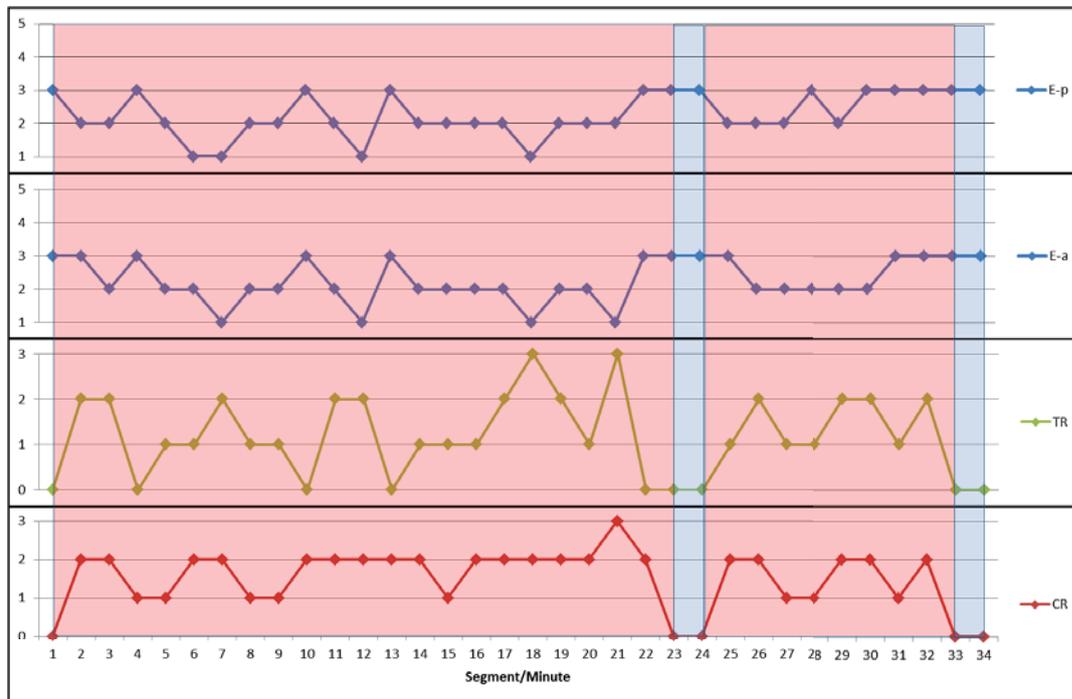


Figure 19. Scores for Dyad 7 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink).

The analysis for Dyad 7 was undertaken on the fifth (final) session of the SMP, and featured the same therapist who featured in Dyad 1. Session 5 of the SMP aims to strengthen commitment for change by translating goals into a change plan. It is suggested as being MI based, and as not including cognitive behavioural content (Anstiss, 2003; Steyn & Devereux, 2006). As was seen in the Table 7, the average scores for Dyad 7 across the session were 1.18 for therapist resistance (range = 0 to 1.18) and 1.50 for client resistance (range = 0 to 1.50). These scores ranked the dyad first highest out of the eight dyads in terms of both client and therapist resistance. Average therapist empathy scores for the session were below the mid-point for both empathy scales, and average working alliance inventory scores were well below mid-point on the measure (4). The scores indicated there was more client resistance than therapist resistance in the session. Figure 19 plots the scores on each measure, for each segment, for Dyad 7. It is notable that this dyad and Dyad 1 ranked first and second in terms of client resistance, and that these two dyads featured the same therapist. There are some clearly synchronous patterns between the measures, and these will now be discussed.

Visual analysis of graph for Dyad 7.

Table 38

Descriptive statistics for Dyad 7

Scenario	Frequency
CR present when TR exists	100%
CR present when TR absent	44%
E-p and E-a at or above medium (3) when CR absent	100%
E-p and/or E-a below medium (3) when CR exists	79%

What was the relationship between client and therapist resistance?

Figure 19 clearly show that both client and therapist resistance dominated most segments in this dyad, and that there was synchrony between therapist measures and client resistance. In the 25 segments featuring therapist resistance, client resistance was also present (Table 38). There was also synchrony of the *timing of change* with regards to the onset and cessation of resistance. The *onset* of client resistance occurred on 2 occasions and on one occasion the onset of therapist resistance also occurred, with the remaining occasion showing client resistance preceded therapist resistance by one segment. The *cessation* of client resistance occurred on 2 occasions, and on 1 occasion therapist resistance ceased in the same period, and in the remaining case therapist resistance reduced one segment prior to client resistance. There was also a relationship

between the *levels* of the measures. High levels of therapist resistance (>1) only ever occurred where there were high levels of client resistance (>1).

What was the relationship between therapist empathy and client resistance?

The graphs showed therapist *empathy* scores were inversely related to client resistance. When client resistance was absent, both empathy scores were always medium or above, and when client resistance was present E-p and/or E-a were generally below medium (Table 38). There was also a relationship between the *level* of these measures: very low levels of therapist empathy (1) always coincided with high levels of client resistance (>1). Synchrony between *timing of change* on the therapist empathy and client resistance measures was not clearly discernible.

What were the broad relationships uncovered across the graphed measures (E-p, E-a, TRC, and CRC)?

It was somewhat difficult to compare the different section types in this DVD, because the session was dominated by prolonged client resistance. However, it was clear that sections with an *absence of client resistance* (shaded in blue) featured the least therapist resistance, and consistently included the highest therapist empathy scores. Furthermore, sections of *prolonged client resistance* (shaded in pink) featured the highest levels of both client and therapist resistance for the session, and the lowest levels of therapist empathy. There were no sections of *brief client resistance*.

Narrative analysis of Dyad 7.

Absence of client resistance.

In the following section, excerpts of narrative from Segment 1 were used to provide an example of client-therapist dialog in segments where there was an absence of client resistance.

Segment 1.

In this segment client resistance was absent (0), therapist resistance was absent (0), and therapist empathy scores were medium (3) on both measures.

Table 39

Narrative Excerpts from Segment 1

Narrative	Analysis of Narrative
T: "Well welcome to the last programme, last session of this programme."	
C: "Yeah."	
T: "So, ummm, just to recap quickly."	Therapist appears to immediately establish an early focus on the content of the session.
C: "Yep."	
T: "oh, well how are you first?"	Therapist changes tack and makes small talk.
C: "yeah, nah, good."	
....	
T: "So recognising the problem thinking that might lead to offending. Anything that came up with you around that?"	Therapist directs the focus of the conversation, with slightly stigmatising language. Therapist is asking for the client's perspective, suggesting E-p.
C: "Nah."	Client denies they have had any further thoughts since the previous session.

Prolonged escalation of client resistance.

In the following section, excerpts of narrative from segments 2-23 (shaded in red in Figure 19) showed examples of client-therapist dialog in segments where there was *prolonged client resistance*.

Segment 2 (onset of client resistance).

There was a notable change this segment. Therapist E-p decreased to low, E-a remained medium, and there was an onset of both therapist resistance and client resistance to a high level (2).

Table 40

Narrative Excerpts from Segment 2

Narrative	Analysis of Narrative
<p>T: "...and you seemed fairly clear that, ummm, after all that there were some things that were coming up, because initially you were struggling to see whether there was any problem thinking at all, these kind of things, 'it was just the way I was brought up' "</p>	<p>Therapist uses quite stigmatising language and suggests client is now recognising their "problem thinking", and that previously they had used excuses. The therapist is offering their own perspective on events, not exploring the client's perspective. There is a sense that the therapist is using these past comments from the client to impose their own views of the client. The therapist been quite directive and established a clear (and perhaps premature) focus for the session. Low E-p.</p>
<p>C: "That's not an excuse, that's just how it is."</p>	<p>Client rejects the therapist's perspective, indicating possible client resistance.</p>
<p>T: "Yeah."</p>	
<p>C: "That's just justifying how it was."</p>	<p>Client re-emphasises his point.</p>
<p>T: "Yeah, and it might be the reality of how you were brought up, <i>however</i> when you are saying that to yourself, that's kind of giving yourself permission to keep doing what you've always done."</p>	<p>The therapist briefly acknowledges the client's view, but in the same sentence confronts the client with advice and argues for another perspective, which actually detracts from the view the client has just given, indicating low E-p.</p>
<p>C: "Oh, yeah."</p>	
<p>T: "So therefore, you are justifying what</p>	<p>Therapist continues to argue for their own</p>

you've all done, you've done, or what you are doing, kind of saying that is what I've always done so am going to keep on doing it. ”

C: "No, not necessarily." [laughs]

T: "Yeah, that's right. So how might you change that then?"

C: "Oh, just don't worry about woman any more, just give up on them really."

T: [Disbelieving tone] "Mmm, what's the reality of that?"

C: "The reality of it?"

T: "Yeah."

C: "Oh, it's pretty good."

perspective, without checking for the client's thoughts or whether the client is tracking him, indicating **low E-p**.

Client mildly challenges the therapists view, indicating **low-level client resistance**.

Therapist is not really tracking/understanding the client's perspective. They ask for the client's view on how they might change, but the client has not given any indication they want to change. This indicates **low E-p and CR**. The therapist is pushing the conversation in that direction and at a pace that the client is not ready for.

Client suggests they will just give up on women. The client is a domestic violence offender, so this would not be addressing underlying issues. The client is not on board with the therapist's previous comments about changing.

The therapist does not try and understand the clients perspective (low E-p), but instead challenges the client in a disbelieving and confronting tone, indicating **high-level therapist resistance**.

There is a negative and slightly menacing tone, indicating **client resistance**.

The client affirms their commitment to giving up on women.

Segment 21 (escalation of client resistance).

The theme of the debate continues and intensifies, with each party rejecting the others perspective, and emphasising their own view. Therapist empathy dropped to very low for E-a (1) and remained low on E-p (2). Both client resistance and therapist resistance increased to very high (3).

Table 41

Narrative Excerpts from Segment 20

Narrative	Analysis of Narrative
T: [Interrupts] "...go back to the relationship."	Therapist is still interrupting and imposing their view that the client may go back into a previous relationship.
C: [Interrupts] "But that relationships over."	Client interrupts and rejects the therapist's perspective, and re-emphasises their own perspective indicating high-level client resistance .
T: "That relationships over but"	Therapist begins to argue against client's perspective, indicating high-level therapist resistance .
C: [Interrupts] "It's been over for ages"	The client's resistance continues. The client appears to be resistant towards the therapist's invalidation of his perspective, and imposition of the therapist's perspective.
T: [Interrupts] "You might enter into"	Therapist again interrupts and argues against client's perspective, indicating low E-p and therapist resistance . The therapist is completely out of tune with the clients high level of irritation, indicating very low E-a . Therapist is taking role of expert and imposing their own perspective.

C: [Interrupts] "She was the one that left me for a kiddie fucker, not me leaving her."

The client's tone is strongly challenging of the therapist indicating very **high level client resistance**.

T: "Mmmm."

C: [Interrupts] "At the end of the day"

T: [Interrupts] "What I heard from you last week and the week before was"

Therapist challenges the client, in a tone that suggests **very high level therapist resistance**. Although the therapist is supposedly drawing on the client's perspective from previous sessions, they are not exploring the client's perspective with regards to their current utterances (**low E-p**).

C: [Interrupts] "Yeah, yeah, yeah, yeah"

T: [Interrupts] "The door could still be open."

Segment 22-23 (cessation of therapist and client resistance).

In Segment 22 (narrative not included) therapist resistance ceased, therapist empathy increased to medium on both measures, and client resistance reduced from very high to high. In Segment 23 scores remained the same on therapist measures, and client resistance ceased. Narrative examples were not included here. The therapist appeared to have given up trying to communicate their perspective, and simply sat and listened to the client (medium E-p). The client then communicated their perspective at length, regarding his issues with an ex-partner and difficulties accessing his children.

Summary of prolonged client resistance for Dyad 7.

The therapist's authoritative style was manifested in their discussion of the client's issues from within their own perspective, rather than the client's, and their use of the client's comments from previous sessions to support their own perspective (low E-p). The therapist also repeatedly took the position of an expert and invalidated and resisted the client's perspective (low E-p,

TR). The client reacted negatively towards this approach, by repeatedly dismissing the therapist's perspective and emphasising their own viewpoint (CR). The session initially started with low therapist empathy, but the client's resistance to the therapist's perspective appeared to elicit therapist resistance and further low empathic perspective taking. This in turn further elicited client resistance, and a negative interpersonal dynamic was established, with each member of the dyad dismissing the other's perspective and emphasising their own perspective. The therapist also repeatedly confronted the client (TR and low E-p), with their perspective on the client's offending behaviour, and attitude towards the therapist's suggestions regarding change, which elicited a negative reaction from the client (CR). These attempts to confront the client regarding their behaviour were undertaken at a time where there was already client resistance, and where therapist empathy had been low, and these confronts were negatively responded to by the client with client resistance.

Although the topic of the client-therapist discussions was sometimes with regards to addressing or changing offending related behaviour (e.g., addressing relationship issues), the client resistance appeared to be towards the therapist's imposing of their own perspective, and unwillingness to hear and explore the client's perspective, rather than resistance to change per se. In other words, it was important to consider whether the client resistance was towards the topic being discussed (e.g., behaviour change) or towards the therapist's manner and interpersonal style. In these segments it appeared to be client resistance towards the therapist's interpersonal style.

Dyad 8

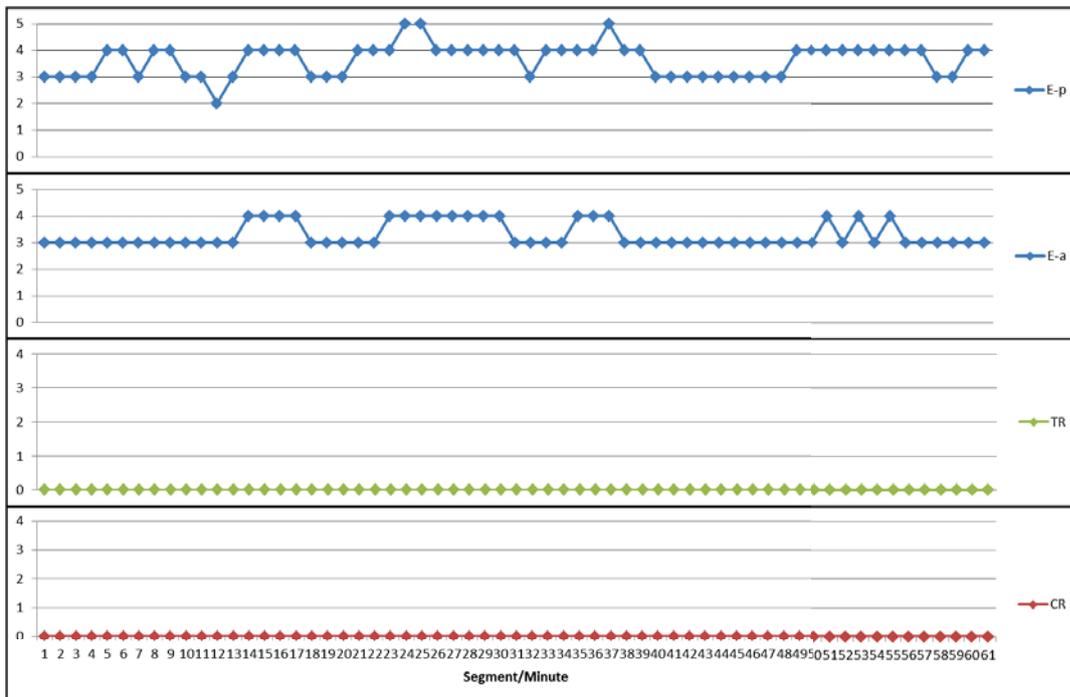


Figure 20. Scores for Dyad 8 for each segment in the session, for all measures. Coloured sections represent Absence of Client Resistance (blue), Brief Client Resistance (yellow), and Prolonged Client Resistance (pink). No TR or CR was noted, hence no coloured sections.

The analysis for Dyad 8 was undertaken on the third session of the SMP. Session 3 of the SMP is generally thought to focus on the use of MI methods, and not to contain cognitive behavioural content (Anstiss, 2003; Steyn & Devereux, 2006). This is partly reflected in the methods employed during session three: a time projection exercise and a costs and benefits analysis (decisional balance). As was seen in Table 7, the average scores for Dyad 8 across the session were 0.00 for therapist resistance (range = 0 to 1.18) and 0.00 for client resistance (range = 0 to 1.50), indicating there was a complete absence of both client and therapist resistance in this session. These scores ranked the dyad eighth out of the eight dyads in terms of client resistance and therapist resistance. Average therapist empathy scores for the session were above the mid-point (>3) on both empathy scales, and average working alliance inventory scores were also above mid-point (>4). Figure 20 plots the scores on each measure, for each segment, for Dyad 8.

Visual analysis of graph for Dyad 8.

Table 42

Descriptive statistics for Dyad 8

Scenario	Frequency
CR present when TR exists	NA
CR present when TR absent	0%
E-p and E-a at or above medium (3) when CR absent	98%
E-p and/or E-a below medium (3) when CR exists	NA

Neither client or therapist resistance occurred in this Dyad, so there was a limited amount of visual analysis that could be undertaken. The graphs in Figure 20 and the descriptive statistics in Table 42 showed client and therapist resistance scores in synchrony, in that they were both completely absent. Therapist empathy was medium or above (≥ 3) in all segments except for Segment 12, and high or above (>3) in 67% of segments.

Narrative analysis of Dyad 8.

Absence of client resistance.

In the following sections, excerpts of narrative from Segments 1, 4, and 36 were used to provide an example of client-therapist dialog in segments where there was an absence of client resistance.

Segment 1.

In this segment, therapist empathy was high on E-p (4), medium on E-a (3), and there was an absence of both client resistance and therapist resistance (0).

Table 43

Narrative Excerpts from Segment 1

Narrative	Analysis of Narrative
T: "Sweet, let's go. I think I'll still have to switch around in about half an hour, sorry about that wait brother, I just had to sort that out. So, so let's have a think where we are up to, can you remember what we covered last week?"	Therapist apologises and quickly and directly sets the focus of the conversation, although the tone is friendly. He starts by enquiring as to whether the client remembers what they covered in the previous session, indicating medium E-p .
C: "We just went over the manoeuvres I did that morning."	Client responds openly to therapist's question, indicating no client resistance .
T: "So what have we looked at from umm start to finish so far I suppose. What did we start with and the first session, can you remember any of that stuff?"	Therapist further explores client's perspective on previous sessions, indicating medium to high E-p .
C: "Oh, the first session."	
T: "Yeah."	

Segment 4.

In this segment, therapist empathy was high on E-p (4), medium on E-a (3), and there was an absence of both client and therapist resistance (0).

Table 44

Narrative Excerpts from Segment 4

Narrative	Analysis of Narrative
T: "The offending supportive associates, you talked about your partner at the time saying or encouraging you, there was lots of times she was encouraging you to drive."	Therapist recalls their view on the perspective the client has previously expressed.
C: "Ummm, not so much encouraging me."	Client disagrees with therapist, but this is not quite resistance, just a correction of the therapist's perspective.
T: "Putting you in situations that would lead you to drive and, is that what you said last time?"	Therapist is careful to make sure they correctly understand the client's meaning, and corrects their own perspective to be in line with the client's.
C: "Yeah yeah."	Client communicates their understandings are aligned.
T: "Something along those lines or?"	Therapist again works to ensure they correctly understand the client's meaning.
C: "Yeah yeah, not so much encouraging though aye."	Client corrects the therapist, but client and therapist are tracking together.
T: "Yep."	Therapist facilitates client's communication of his perspective.
C: "It's just letting me."	
T: "Letting you drive."	Therapist corrects his own understanding to be in line with the client's perspective, and correctly reflects the client's statement, indicating medium E-p.
C: "Drive."	
T: "Mmm, sweet, what else can you remember	Therapist affirms the client's offering of his

about last week, about these things you picked up?"

own perspective and asks if he has any more information to communicate.

Segment 36.

In this segment, therapist empathy was high on E-p (4), medium on E-a (3), and there was an absence of both client and therapist resistance (0).

Table 45

Narrative Excerpts from Segment 36

Narrative	Analysis of Narrative
T: "Mmm"	
C: "If I had a licence I'd be pretty much full time."	
T: "So full-time work could probably go on that side there."	Therapist is working with the client on the advantages and disadvantages of drink-driving.
C: "On this side aye."	
T: "Is that what you mean?"	Therapist checks they understand the client's perspective correctly, indicating medium E-p, no TR.
C: "Ummm, yeah, full-time work, and then the disadvantages."	Client acknowledges therapist's perspective is the same as their own, indicating no CR.
T: "Mmm."	Therapist listens and facilitates.
C: "As having no full-time work""	
T: "Yeah."	
C: "Until."	
T: "Yeah, until you get it sorted aye."	

C: "Because they just won't hire me back aye, until I get a licence."

T: "So you can see, so what you're saying is this, please correct me if I'm wrong, so what you're saying is that everything that you are looking at, and looking at all the work that you've done, you can see that it is, ummm having these issues are related to that entitlement, and your attitude towards driving has cost you quite a lot."

Therapist reflects back their understanding of the client's perspective from the session so far, and does so while checking with the client that they are on the right track, indicating high level E-p.

Summary of segments with an absence of client resistance for Dyad 8.

There was no client or therapist resistance in this dyad, and therapist empathy was medium or above on both measures in nearly all segments. Although the therapist was directive in setting the focus of the conversation and the therapeutic tasks, they did this collaboratively with the client, and consistently elicited the client's perspective (E-p). When the therapist offered their own recollection of the client's perspectives from previous sessions, the client disputed the therapist's viewpoint. However, this never escalated into client resistance, perhaps because the therapist never resisted the client's perspective, but instead continued to elicit the client's viewpoint with regards to their drinking and driving, and continued to check that their own understanding was in line with the client's understanding (medium to high E-p). The very collaborative style of the therapist was consistently manifested in their exploration of the issues being discussed from within the client's perspective, and their willingness to reconsider their own perspective to be in line with the client's when appropriate.

Consideration of Contribution of Different Content across Different Sessions

Although it was not a central focus of the study, consideration was given to the possibility that a particular SMP session number may have been related to the variables measured (particularly therapist resistance and client resistance). The small number of dyads studied did not allow for a definitive conclusion to this question, but the results suggested the session number was not related to the variables measured (see Table 7). In the main sample, 5 out of the 8 dyads featured SMP Session 3. The results showed client resistance scores ranged widely across these dyads (range = 0 to 0.88), as did therapist resistance scores (range = 0 to 0.75). This suggested that the session number had little to do with the scores on the measures. An additional observation was that Dyad 7 scored very high scores for therapist resistance and client resistance, and this was the only dyad featuring Session 5. However, these scores were believed to reflect the particular therapist's style, rather than the session number. This was further evidenced by the fact that the same therapist also featured in Dyad 1, which also received very high resistance scores.

These tentative findings coincide with research by Austin (2012) which found that there was no relationship between measures of MI relational skills and particular SMP sessions, nor was there a relationship between therapists' use of MI inconsistent methods and particular SMP sessions. The researcher did find a connection between SMP session number and offenders' sustain talk (a subset of resistance), but the particular reason for this was not known. The researcher noted that the general pattern was for sustain talk to increase across the SMP sessions.

Consideration of Maori Interests

There was a mix of offender ethnicities across the dyads (Maori = 40%; New Zealand European/Pakeha = 30%; Pacific Island / Maori = 10%; Unknown = 10%). Because of the importance of maintaining the confidentiality of all participants, the data regarding ethnicity for individuals in this study could not be revealed. However, a post hoc investigation by the author (not included here) showed that the strong relationships amongst the variables measured existed across all dyads, including dyads featuring Maori clients. Furthermore, Maori offenders featured in Dyads with both high and low levels of client resistance. Therefore, it is believed that the findings can reasonably be said to apply to Maori offenders.

CHAPTER 9: DISCUSSION

In this chapter, the major findings of this study are presented and discussed in reference to the current literature. This research made use of a multiple methods design, which meant that some of the research questions were answered through multiple sources of evidence, including: the group analysis, the visual analysis, and the narrative analysis. The layout of the discussion is therefore multi-tiered, and in the early stages of the discussion the drawing of conclusions is kept minimal, until the contributions from all evidence sources can be considered. Initially, the extent of client resistance and therapist resistance within this sample is discussed, and then consideration is given to the relationship between the two variables, primarily from the perspective of the group analysis and the visual analysis. The same process is then undertaken with therapist empathy and client resistance as the focus. Following this, the results from the narrative analysis are discussed, with a focus on the differences in the interpersonal dynamics between dyads where there was very limited client resistance, and those that featured prolonged client resistance. In addition to highlighting the patterns in these contrasting sets of dyads, there is a discussion regarding some specific features within a number of dyads, such as therapist confrontation. Following this, the above discussion points are considered as a whole and an integrated view of all the findings is presented, as well as how they fit with the current literature. The discussion then turns to the limitations and strengths of the study, practical applications, and suggestions for future research.

Findings from the Group Analysis and Visual Analysis

The Extent of Client and Therapist Resistance

The group analysis showed that the frequency of both client resistance and therapist resistance, and the average session level scores for these variables, varied widely between the dyads. The sample in this study was preselected, and effort was made to select a wide range of interpersonal therapist styles, and to include a wide range of client resistance levels. However, the non-random dyad selection process limits the conclusions that can be drawn from the aggregated data with regards to the mean scores in this sample, and how representative these scores are of the wider population of offenders. Notwithstanding these limitations, a somewhat surprising result was the high frequency and levels of resistance in some of the sessions. Furthermore, some dyads which had been selected because they were thought likely to feature greater therapist MI skills and lower levels of client resistance (Dyads 8, 6, 5, 4, and 2) sometimes scored quite highly for client and/or therapist resistance.

There were very few studies with which these findings could be compared, firstly because this was the first time therapist resistance had been measured, and secondly because there are very few studies which have directly measured “in-session” client resistance on a moment to moment basis. However, the client resistance scores in the current study appear to be high in comparison to previous studies. Aviram and Westra (2011) found mean client resistance scores across a sample of clients with generalised anxiety disorder to be .26, in comparison to the sample in this study where the mean client resistance score was more than twice as high (.57). Watson and McMullen (2005) found that client resistance occurred in between 12 to 24% of a client’s “talk turns”, compared to the current study which found the frequency of client resistance ranged from 0% to 85%, with an average of 38%. The results showed that client resistance was relatively high in the present sample in comparison to these prior studies. The client resistance scores here coincided with Austin’s (2012) study investigating an offending population, that showed a positive trajectory of *sustain talk* (one component of client resistance), both across and within SMP

Notwithstanding the preselected nature of this sample, it is clear that some therapist-client dyads in this population featured sizable levels of therapist resistance and client resistance. These findings are important, because previous research has found a strong link between client resistance and treatment outcome in non-offending populations (Miller et al., 1993; Westra, 2011), as well as a relationship between client’s sustain talk and programme attrition with offending populations (Austin, 2012).

The Relationship between Client Resistance and Therapist Resistance

The group analysis showed that therapist and client resistance were closely related at the global level of the session. The more finely grained visual analysis of the graphs showed the relationship between the two variables was also temporally proximal, within a one minute timeframe. Furthermore, there was also clear synchrony in terms of the onset and cessation of client and therapist resistance, as well as the level (intensity) of client and therapist resistance scores. High scores on client resistance almost solely occurred in the presence of therapist resistance, and in the majority of these cases therapist resistance scores were also high or very high. It is believed that this is the first study investigating the relationship between these two variables, and showing that this relationship exists at the level of a one minute timeframe.

These results are consistent with findings of sequential proximity between therapist MI inconsistent behaviours and sustain talk found in other studies (Moyers & Martin, 2006). However they extend these findings in terms of being more specific with regards to the therapist behaviours involved, and also show that the client’s resistance is not just towards a change in their behaviour, as will be discussed further on. There were some prominent patterns that were

noticed with regards to the sequential occurrence of client and therapist resistance within the visual analysis of the graphed data. In sections where client and therapist resistance occurred together, their *onset* was generally in the same segment. When their onset was not synchronised, there was a fairly even number of times where either therapist or client resistance occurred first. This suggested that therapist resistance may at times precede and elicit client resistance, or follow and be reactive to client resistance. Client and therapist resistance also tended to cease in synchrony within the same one minute segment. However, on occasions where they did not cease in synchrony, it was more likely that therapist resistance would cease before client resistance, and there were almost no occasions where client resistance ceased first. This suggested that an absence of therapist resistance was a necessary condition for the cessation of client resistance. The sequential occurrence of client and therapist resistance and the apparently bi-directional nature of their relationship coincided with previous research (Gaume et al., 2010), however, these results provide more specific evidence for this relationship, and the specific ways in which it manifests.

A noticeable pattern across the dyads was the grouping of segments of client resistance with regards to their level (intensity) and duration. There were three broad patterns of client resistance noticed within the dyads: *absence of client resistance*, *brief client resistance*, and *prolonged client resistance*. These three patterns were analysed for their relationship to therapist relational skills. In sections of SMP sessions containing brief client resistance, both client and therapist resistance were generally at a low level. This compared to sections of prolonged client resistance, which almost always featured higher intensities of both client and therapist resistance. In sections of prolonged client resistance almost all segments featured therapist resistance, in contrast to sections of brief client resistance where the presence of therapist resistance was more variable. When considered in the context of the narrative, this suggested that sometimes therapists would not respond in a resistant manner to the client's resistance, and the client resistance would therefore be brief. However, when therapists did respond in a resistant manner to the client's resistance, both types of resistance were likely to escalate in intensity, be of a prolonged duration, and not cease until therapist resistance ceased. It is believed that this is the first study investigating client resistance in a level of detail great enough to reveal these patterns.

It is well recognised that in offending populations the clients often present as resistant or unmotivated to engage in therapy, or as pre-contemplative with regards to changing their behaviour (Anstiss et al., 2011; Farbring, 2008; McMurrin, 2002). The above results with regards to client resistance seem to support this stance. However, the findings provide some of the first evidence to support suggestions by various authors (Cordess, 2002; Leahy, 2001; Moyers & Rollnick, 2002) that therapists, perhaps particularly those working with offending

populations (Cordess, 2002), can for various reasons be pulled to react to a client and their sometimes difficult behaviours, in ways that are resistant or reactant towards the client. Furthermore, the relationship between therapist and client resistance supported the proposition within MI that the *interpersonal dynamic* between a client and therapist contributes to the level of client resistance (Miller & Rollnick, 2012; Patterson & Forgatch, 1985), including—or perhaps especially—within offending populations (Farbring & Johnson, 2008; Ross et al., 2008). The current study is unique in providing evidence of the above suggestions, and specifying a particular behaviour that is related to client resistance, i.e., therapist resistance, and in showing this relationship exists at the level of a one minute timeframe.

The Extent of Therapist Empathy

There was considerable variation in the scores on the empathy measures across the different dyads, suggesting a wide diversity of skill in empathic perspective taking and empathic attunement amongst the therapists. There were only three dyads selected for the main sample to represent lower MI interpersonal skills, but five out of the eight therapists in the main sample were found to score below the mid-point score on the empathy measures. This suggests it can often be difficult for therapists to maintain empathic-perspective taking and empathic-attunement, perhaps especially within this client population. However, it is important to re-emphasise the limitations of any conclusions drawn with regards to the aggregated scores across this small number of pre-selected dyads, and whether they are representative of the wider sample of offenders (see limitations section below).

There were no norms available with which to compare the scores on these empathy measures. However, the E-p measure is 1 of 5 subscales on the Motivational Interviewing Treatment Integrity (MITI; Moyers, Martin, Manuel, et al., 2007) Code, and the authors suggest that an average score of 3.5 across the five components (range = 1-5) represents beginning proficiency, and an average score of 4 represents competency. These scores contrasted with the average score on E-p in the present study of 2.86 (SD=0.55). A review of recent MI research suggested that in many studies the empathy scores are above the mid-point on the measures. For example, in a study by Gaume et al. (2009) featuring 5 therapists and 95 clients, the mean score and standard deviation for each therapist on the empathy measure (Likert scale 1-7) was: 5.9 (0.3), 5.1 (0.5), 4.7 (0.4), 6.0 (0.3), and 4.8 (0.9). These scores all fell well above the mid-point of 4 on the empathy measure. In a study by Moyers et al. (2005) investigating 103 MI sessions with different clients and therapists, the mean score on an empathy scale (range = 1-7) was 5.36 (SD=1.27). The lower empathy scores in the present study were more in line with those found in research by Farbring and Johnson (2008) within an offending population. These researchers found that lower levels of training in MI correlated with lower empathy scores (below mid-point

on the measure), and the authors suggest that a 3-5 day workshop in MI was not sufficient to develop proficiency in MI. The fact that a number of therapists did not score above the mid-point on the empathy measures in the present study also coincides with Austin's (2012) research investigating the same offending population, which demonstrated that therapists did not achieve competence with regards to the recommended ratio of therapist reflections to questions.

These findings coincide with the well-known difficulties of working with and creating a relationship in offending populations (Ross et al., 2008), and the challenges many therapists have with maintaining genuine empathy for offenders (Farbring, 2008). They also coincide with the well-recognised tenet that the interpersonal skills fundamental to MI are not as easy to develop as is often assumed (Miller & Rollnick, 2012; Moyers & Houck, 2011). These findings are important, because empathy and active listening are fundamental aspects of therapy that need to be present in all interactions with offenders (Farbring, 2008), and are critical to ensuring the effectiveness of MI (Miller & Rollnick, 2012; Miller, Taylor, & West, 1980; Moyers et al., 2005), and potentially reducing recidivism (Anstiss et al., 2011). The findings are also unique in providing evidence that empathy is not simply a global construct that exists broadly across a session. The current results show that empathy can fluctuate in important ways throughout a session.

The Relationship between Therapist Empathy and Client Resistance

Therapist empathy and client resistance were found to be closely and inversely correlated across the dyads, at the level of a session. The more finely detailed visual analysis of the graphs showed that this relationship was temporally proximal at the level of a 1 minute segment. In the majority of segments when there was client resistance therapist empathy was low (< 3) on at least one measure, and in sections with an absence of client resistance therapist empathy was generally medium or above (≥ 3). A closer investigation of the graphs showed that the relationship was particularly strong in sections of *prolonged client resistance* (coloured in pink in the graphs), and somewhat more variable in sections with an *absence of client resistance* or *brief client resistance*. The discussion of the narrative findings investigates these observations more fully.

There were no known studies that have found a relationship between low levels of therapist empathy and client resistance. A study by Catley et al. (2006) found that therapist reframes were sometimes related to resist-change talk, suggesting that reframes may sometimes be seen as non-empathic. Previous studies have also found a link between MI inconsistent behaviours (e.g., confronting and giving advice without permission) to sustain talk (Austin, 2012; Moyers & Martin, 2006), and some of these behaviours could be seen as reflecting low empathy. However, the current study's results specifically show that therapist empathy can fluctuate across a

session, and that lower levels of therapist empathy are related to higher levels of client resistance (broadly defined to include both sustain talk and relationship discord). Furthermore, the results show that the specific component of empathy, empathic perspective taking—also known as intellectual empathy—has a strong and temporally proximal relationship with client resistance. These results could not clarify the direction of the relationship, but the narrative analysis will consider in more detail how exactly the low therapist empathy scores were related to client resistance.

The Extent of the Working Alliance

There was considerable variation in scores on the WAI-SR-O between the different dyads. The mean score on the WAI-SR-O across all dyads in this study was just below the mid-point score on the measures, with five out of the eight therapists scoring below the mid-point. Normative data provided by Horvath and Greenberg (1986) showed a relatively high mean score on the WAI in a non-offending population, which reached 82% of the total possible score. There was no comparable data available from studies in offending populations where *individuals* had been rated using the WAI. However, a study by Taft, Murphy, King, Musser, and DeDeyn (2003) found the mean WAI score across 13 *group* therapy sessions for partner violent males was well above the medium possible score. Caution is needed in interpreting information in the present study, because although efforts were made to select a variety of interpersonal styles, this was a small and preselected sample and cannot be assumed to accurately reflect the wider population of SMP dyads. Notwithstanding this limitation, the data suggest that in this population it can sometimes be very difficult for therapists to establish a working alliance with their clients. This is important, because a robust relationship has been proven between the working alliance and treatment outcome in the general population (Horvath et al., 2011; Taft et al., 2003) and between improvements in alliance and positive change in offending populations (Polaschek & Ross, 2010).

Across all therapists, the results from the WAI-SR-O analysis showed that the task and goal subscales on the WAI-SR-O scored considerably lower than the bond scale, although the bond scale scores were still below the mid-point in half of the SMPs. There appeared to be very little focus on collaborating with client's on the goals and tasks in therapy within these DVDs, and this is reflected in the scores on these subscales. The SMP is a manualised programme with fairly specific goals, and it is likely that this contributed to the low focus on task and goal negotiation. A number of authors have pointed out that it can be challenging to create a working alliance in offending populations (Polaschek & Ross, 2010; Ross et al., 2008), although Polaschek and Ross suggest it is possible if therapists are flexible in how they negotiate the tasks and goals with clients.

The Relationship between the Working Alliance and Client Resistance

The WAI-SR-O scores were found to be inversely related to client resistance, which coincided with a previous study in a non-offending population (Watson & McMullen, 2005). The relationships between specific therapist relational skills and the working alliance were not a focus for this research, but it has been pointed out that the apparently simple WAI concept actually measures a very complex construct, and that there is still a limited theoretical understanding of how the alliance actually develops within a session (Ross et al., 2008). Horvath (2005) has suggested that further research is needed to elucidate the interactive elements between a client and therapist that are related to the formation of the alliance. The present study's findings of a relationship between empathy and client resistance as well as the working alliance and client resistance, support the findings of Boardman et al. (2006) who found adherence to the Spirit of MI to be positively related to development of the working alliance and client engagement. A further consideration is that even dyads with very low scores on client resistance (Dyads 4, 5, and 8) had fairly low scores on the task and goal subscales of the WAI-SR-O. It appears that a lack of collaboration with regards to setting therapy tasks and goals may not necessarily contribute to increased client resistance, so long as the therapist utilises a client-centred guiding style, where therapist resistance is low and therapist empathy is high.

Summary of Findings from the Group Analysis

In summary of findings from the group analysis, it was clear that there was a strong positive relationship between client resistance and therapist resistance, and that the relationship was temporally proximal at the level of a 1 minute timeframe. Therapist and client resistance appeared to mutually elicit and escalate one another, and high levels of client resistance never occurred without high levels of therapist resistance and vice-versa. Therapist empathy had a strong inverse relationship with client resistance. However, the temporal proximity of the relationship between therapist empathy and client resistance was not as clear as that between therapist resistance and client resistance, although it was particularly clear in sections with prolonged client resistance. The direction of the relationship between the therapist's relational skills and client resistance could not be definitively established from the group analysis, although the results clearly showed that an absence of therapist resistance was a necessary condition for the reduction of client resistance. The WAI-SR-O measure was inversely correlated with client resistance, although not as strongly as therapist resistance or empathy. The subscales scores showed there was little focus in the sessions on collaborating with the clients with regards to setting tasks and goals, and it is believed this may be contributed to by the manualised nature of the programme. The scores on the measures of therapist relational skills

(TRC, E-p, E-a) suggested many of the therapists found it challenging to limit their resistance levels and maintain an empathic approach in these sessions, and perhaps particularly with this population. Notwithstanding the preselected and small nature of the sample, this coincides with the suggestion that it can be difficult to maintain empathy when working in offending populations (Farbring, 2008), and that the interpersonal skills fundamental to MI are not easy to develop (Farbring & Johnson, 2008; Miller & Rollnick, 2012).

Findings from the Narrative Analysis

The strong and temporally proximal relationship amongst therapists' interpersonal skills and client resistance raised the question of what exactly was happening between the therapist and the client when client resistance was present. For instance: what specifically was being resisted in segments of client and therapist resistance, and how did the onset and escalation of client and therapist resistance unfold, especially in sections of prolonged client resistance? The discussion of findings from the narrative analysis is undertaken by firstly considering Dyads 4 and Dyad 8, where there was very little client resistance, and then contrasting the narrative in these dyads with the remaining dyads which showed higher levels of client resistance. There are also a number of relevant findings from within specific dyads that are highlighted and discussed, for example with regards to therapist confronts.

Dyads with Low Levels of Therapist and Client Resistance (Dyads 4 and 8)

Excerpts of narrative from Dyad 4 and Dyad 8 showed a considerable contrast in language style compared to the other dyads, and also featured the lowest levels of client resistance. The narrative showed the therapists provided structure to the sessions in terms of the broad direction and tasks. However, within this broad structure the moment to moment exploration of issues and undertaking of tasks was predominantly from within the clients' perspectives. The therapists made active and repeated efforts to elicit and understand the clients' perspectives, and continuously checked and clarified that their understandings were correct. On the occasions that they varied from this approach and offered their own perspectives, therapists made it clear that they were offering an alternative perspective, and they then made considerable effort to understand the client's view point with regards to this perspective. They also remained curious and open to the client's responses, and provided space for the client to communicate their perspectives. Importantly, disagreement by clients were met by the therapist asking specific questions to clarify where the differences between their understandings of the issues were, and then integrating these new understanding into their own perspective. It seemed that these interactions did not evolve into sections of prolonged resistance because the therapist had not resisted the client's differing perspective, thus not providing any therapist behaviour for the

client to resist. The therapists' approach had a non-authoritarian feel, and avoided what Miller and Rollnick (2012) have referred to as non-mutuality, one of the biggest threats to engaging a client. In broad terms this could be referred to as a guiding style that is both client-centred and directional, as recommended by Miller and Rollnick (2012). This style and its relationship to client resistance will be discussed further on. It is believed that this is the first time these therapist interactional styles have been specifically investigated for their relationship to client resistance.

Therapist confronts.

A noticeable feature of Dyad 8 was that on two occasions the therapist made somewhat confrontational observations regarding the client's offending behaviour, and the narrative suggested that the therapist had some success in getting the client to consider the therapist's perspectives. A confront has been defined by Forrest (1982, as cited in White & Miller, 2007) as "the process by which a therapist provides direct, reality-oriented feedback to a client regarding the client's own thoughts, feelings or behaviour" (p. 2). However, there appears to have been little or no research on the idiosyncrasies of therapist confronts, and the particular interpersonal styles that may contribute to their effectiveness/ineffectiveness. There were a number of unique features of these confrontations that were in contrast to confrontations seen in other dyads where the interventions appeared to evoke considerable client resistance. Firstly, they were delivered at a time when there was no pre-existing client resistance or therapist resistance, and therapist empathy had previously been high. Secondly, the therapist posed the confronts more as a question he was curious about rather than a perspective he expected the client to take on board. In other words there was no communication of non-mutuality. Thirdly, once the therapist had confronted the client with his own therapist-centred perspective (although not in a confronting manner), he then switched back to genuinely exploring and actively listening to the client's perspective on the information put forward in the confrontation, and continuously clarified and ensured that he understood the client correctly. The therapist also left space for the client to talk, encouraged and facilitated the client's exploration of the issues, and did not come across as having a specific predetermined response he required from the client. Fourthly, on the one occasion where the client was resistant to the confrontation by the therapist and his perspective, the therapist responded to this resistance by facilitating the client's exploration of his alternative perspective, and asked for more specific information with regards to the client's thoughts. The therapist did not resist the client's resistance, and the client's resistance did not escalate.

Dyads Featuring Higher Levels of Therapist and Client Resistance

The narrative examples from within Dyads 4 and 8 generally stood in contrast to the narrative examples from the remainder of the dyads, where client resistance was considerably greater. Although there was a wide variety of therapist styles and language in the remaining dyads, in many ways these appeared to be variations in intensity of a number of underlying processes. Furthermore, these processes were seemingly opposite to those seen in the narrative from Dyad 4 and Dyad 8 above.

Dyads 1, 7, and 3.

Dyad 1, Dyad 7, and Dyad 3 featured higher levels of therapist resistance and client resistance, as well as lower therapist empathy scores. These DVDs were seen as involving the least functional interpersonal dynamics, and the narrative from each of these DVDs illustrated how the therapist-client interaction evolved in sections of prolonged client resistance, and the contribution of each member of the dyad to this outcome. There was a fairly typical dynamic which these three dyads broadly followed. Initially the therapist would offer an observation (their own perspective) on some aspect of the offender's situation or offending event, or something the client had said. The client then offered their own perspective, which was counter to the therapist's. At this point the therapist supposedly had a choice of whether to try and understand the event from within the client's viewpoint, or to react by further exploring or imposing their own perspective, and it was the latter which the therapist did in sections of prolonged client resistance. From herein, the above interpersonal dynamic was essentially repeated (with slight variations) and escalated. Typical behaviours of the therapists in these segments featuring high client resistance levels were as follows: negating and disputing the client's perspective, communicating inaccurate understandings of the client's view point, imposing their own perspective, and using the client's utterances from previous sessions to substantiate their own arguments. These behaviours were all manifestations of low empathic perspective taking, high therapist resistance, or both, and showed how therapist perspective taking was closely related to therapist resistance. In essence, the resistance by the therapist was predominantly in regards to the client's perspective. These behaviours can be seen as reflecting a power struggle in which the therapist is engaging in many of the "12 Roadblocks" to active listening and self-exploration (as cited in Miller & Rollnick, 2012, p. 49).

There were also some commonalities seen across the dyads in terms of client and therapist behaviours when client resistance *ceased*. Firstly, it was noticeable that the therapists recognised the growing discord, and explicitly changed their behaviour towards the client. The changes in behaviour generally involved recognising the elevated discord in the relationship,

more accurately reflecting the client's perspective, simply listening to the client without interrupting or arguing, and changing the focus of the discussion.

Therapist confronts in Dyads 1, 7, and 3.

On various occasions the therapists in Dyads 1, 7, and 3 confronted the client with regards to some aspect of their thoughts, feelings or behaviours, and these therapist behaviours elicited considerable client resistance. The confrontations were generally framed in a way that they were actually exploring or even imposing the therapist's perspective, rather than the client's. They were also predominantly delivered at a time when there was already considerably low empathic perspective taking, and when client and therapist resistance were already present. The narrative suggested that the therapist's behaviours were a reaction to the client's resistance and unwillingness to agree with their perspective, rather than carefully thought through and empathically delivered interventions to help the client face their realities and the consider possible behaviour changes. In other words, they were therapist-centred confronts (rather than client-centred) and they were undertaken using a confrontational style, rather than an empathic manner. These results provide further specific evidence for the idiosyncrasies of therapist confronts, and particular strategies which may contribute to these being effective or not.

Discussion of Dyads 2, 5, and 6.

The narratives excerpts featuring client resistance from Dyads 2, 5, and 6 contained similar patterns of therapist behaviour and client resistance to Dyads 1, 2, and 7, albeit of a lower level of intensity. However, there were some specific features of note relevant to the occurrence of client resistance in these dyads. Dyad 2 and Dyad 5 featured the same therapist, and a noticeable feature of this therapist's interpersonal style was that she made regular use of reflections (an MI technique), but that these reflections often reframed and stretched the perspective of the client too far, or imposed the perspective of the therapist through a reframe. The therapist seemed to have established a good bond with the clients (the score on bond scale of the WAI-SR-O was high), and her style was not overtly authoritative. However, her reflections were not always accurate with regards to the client's perspective. The importance of accurate empathy is well established in MI, and this subtly therapist-centred style appeared to be a key factor in the considerable client resistance in these sessions. This appears in line with research by Catley et al. (2006) who found that reframes were positively correlated with resist-change talk, and provides specific evidence for why this may be happening. It suggests that clients may sometimes perceive reframes as showing a lack of empathy.

Dyad 6 showed an example of the client being resistant to a specific task included in the SMP session. The client resisted the seeming irrelevance of the task, and this eventually escalated into an argument between the client and the therapist. Miller and Rollnick (2012) have pointed out that paying more attention to a manual than to a client is not good MI, and studies have suggested that MI delivered without a manual had twice the effect size of a manualised approach. These results show that therapist inflexibility with regards to a therapeutic task can elicit client resistance. It is possible that a strictly manualised approach may exacerbate a therapist-centred style and therefore increase client resistance.

Integrated Discussion of Findings

The group analysis provided evidence for a link between therapist interpersonal skills and client resistance at the level of the session, the visual analysis found this at the level of a one minute segment, and the narrative analysis showed that the relationship was evident within the language of dyad members from one utterance to the next. The narrative also showed that client and therapist resistance escalated even within a segment, as one member of the dyad resisted the other's perspective and emphasised their own, and vice-versa. The following are the key findings drawn from across all the results.

Client Resistance as a Product of Interpersonal Interaction

The three levels of analysis (group analysis, visual analysis, and narrative analysis) provide some of the most detailed evidence to date of the well-recognised tenet of MI (Miller & Rollnick, 2012): that client resistance is a product of an interpersonal dynamic between a client and a therapist. The results also support and extend the more specific idea put forward by Moyers and Rollnick (2002); that client resistance is the product of a multiplication equation. Moyers and Rollnick suggest the first value in the equation is the client's initial level of resistance, and the second value in the equation is the therapist's response. The therapist's "counter-resistance" is critical in determining the final level of client resistance in the equation. A further point of note is that the instances of client resistance seen here can be seen as a normal and understandable reaction by a client to a particular interpersonal style that a therapist is engaging in at that point in time.

The current study supports and extends this idea by providing evidence of specific details of these interactions and the unfolding of client resistance. These findings also reflect the observations of a number of other authors: Engle and Arkowitz (2008) suggest that the locus of resistance lies neither entirely with the client or the therapist, but in the interaction between

them; Leahy (2001) points out that when resistance occurs in therapy it is important to understand what is being expected of the client so that the resistance can be understood.

Bi-Directional Effects of Dyadic Interaction

The narrative analysis provided a clear illustration of the interpersonal dynamics contributing to the unfolding of client resistance. A key feature of these interactions was the bi-directional effects of both the client's and therapist's behaviour on the other dyad member. The therapist's lack of perspective taking affected the client, the client's resistant response affected the therapist, the therapist's further resistance to the client and imposition of their own perspective affected the client, and so on. The bi-directional effects of both members of the therapeutic dyad have been noted by Patterson and Forgatch (1985). Previous studies have also shown that not only do therapist behaviours strongly influence client sustain talk (an element of resistance), but also suggest that client's sustain talk may elicit behaviours by therapists that are counter to an MI therapeutic style (Gaume et al., 2010). Although the present study does not allow any definitive conclusions with regards to causation, the findings provide some of the strongest support to date for the idea of a bi-directional effect between therapist and client. The bi-directional effect findings also broaden the ideas of Moyers and Rollnick (2002) with regards to client resistance being the product of a multiplication equation, and provide what is believed to be the first evidence for Miller and Rollnick's concept of the *righting reflex*, which proposes that therapists often get the desire to take the side of change, and fix what seems wrong with people, particularly through being directive. They note that when the therapist meets resistance from the client, this triggers the righting reflex, and therapists often respond by turning up the volume of persuasion and convincing. The results are somewhat unique in that they show a pattern where *either* party may be the first value in this equation, and also that the therapist's responses are critical in determining how long client resistance lasts, how intense it becomes, and when client resistance ceases. Furthermore, it appears that client resistance (more broadly defined than simply sustain talk) can elicit both therapist resistance and reduced therapist empathic perspective taking.

Client-Centred Guiding vs. Therapist-Centred Directing

An important finding in this study is that when the researchers stood back from the labels of "therapist resistance", "therapist empathy", and "client resistance", a dominant underlying feature of sections containing prolonged client resistance was the concept of *perspective taking*. In times of therapist and client resistance, the therapist was generally exploring or imposing their own perspective and/or blocking the client's perspective, and the client was responding to this by re-emphasising their own perspective and disagreeing with the therapist's perspective.

This pattern was maintained until the therapist changed their behaviour. Both the client's and the therapist's resistance were predominantly against the other's perspective, and appeared to be an attempt to have their own perspective heard. Notably, this did not appear to be so much client resistance towards change, but more client resistance towards the therapist's lack of perspective-taking. This finding is important. Previous research has suggested that client resistance is related to therapist directiveness (Beutler et al., 2011; Beutler, 2001), but this relationship has been variable and authors have recommended that more specific research should investigate the particular interpersonal skills that reduce or increase client resistance (Watson and McMullen, 2005). The results from this study highlight that resistance often occurs when a client's perspective is not being heard, or the therapist's perspective is being imposed on them. The importance of the Rogerian concept (Rogers, 1965; Truax & Carkhuff, 1967) of *accurate empathy* is well-known, as is its relationship to therapeutic outcome, and Miller and Rollnick (2012) note that the opposite of this stance is for the therapist to impose their own perspective. This research provides evidence that a particular mechanism through which empathy may work is by increasing the therapist's perspective taking and reducing client resistance.

These factors provide evidence for two important—and opposing—concepts categorised by Miller and Rollnick (2012) as a *therapist-centred* style as opposed to a *client-centred* style. Miller and Rollnick outline a group of behaviours that reflect poor listening skills (grouped under the term roadblocks), and suggest that these behaviours can be seen as reflecting a therapist-centred style, rather than a client-centred style. The results from the present study suggest an inverse relationship between a client-centred therapy style and client resistance, and a positive relationship between a therapist-centred style and client resistance. It is important to recognise the difference between the client-centred style suggested by Miller and Rollnick, and the well-known Rogerian client-centred therapy style. Miller and Rollnick describe the client-centred style as both *guiding* and *directional*, but not *directive*, and the authors outline a wide range of behaviours within each of these different styles. Some therapists in the present study appeared to have had considerable difficulty utilising a client-centred and guiding approach, and difficulty undertaking the therapeutic tasks from within the client's internal frame of reference. They were often pulled to a more therapist-centred and directive style, offering their own perspectives, and resisting the client's perspectives. This therapist-centred and directive style was closely involved in eliciting client resistance. The therapist centred and directive style often featured the roadblocks outlined by Miller and Rollnick, as well as what they describe as a sense of non-mutuality.

Therapist-Centred Exploration, Client Autonomy, and Client Resistance

As previously noted, client resistance was found to primarily be a response to a therapist-centred and directive style of interaction. Miller and Rollnick (2012) have emphasised that one of the biggest threats to actively engaging a client is for a therapist to communicate a sense of non-mutuality, and the researchers describe MI as “a collaborative partnership that honors [sic] and respects the other's autonomy, seeking to understand the person's internal frame of reference” (p. 36). The narrative analysis suggested that when a therapist does not seek to understand the person's perspective, or imposes their own perspective (therapist-centred), a client's autonomy is undermined, which can elicit client resistance. Miller and Rollnick (2012) have often drawn on the theory of reactance (Brehm & Brehm, 1981) to explain client resistance, and in their most recent book suggested that the opposite of empathy is the imposition of one's own perspective. The findings in the present study coincide with Brehm and Brehm's reactance theory. The results extend the current research base with evidence that specifically suggests that when a therapist limits the capacity for a client to put forward their perspective and have that perspective heard, whether explicitly or implicitly, they limit the perceived freedom of that individual. The limiting of the client's freedom triggers reactance, and this reactant behaviour often involves rejecting the therapist's perspective and re-emphasising their own perspective. This behaviour could be seen as a means of re-asserting one's perceived freedom to communicate a perspective and have it heard. These findings extend previous research which has focused on more explicitly authoritative (non-mutual) therapist behaviours, such as giving clients strong directives and offering advice (e.g., Patterson & Forgatch, 1985).

These findings could also be viewed through the lens of self-determination theory (SDT; Deci & Ryan, 2000) which a number of authors (Markland et al., 2005; Vansteenkiste & Sheldon, 2006) have suggested may provide a theoretical explanation for some of the active mechanisms of MI. In SDT, the provision of autonomy support by a therapist is seen as critical if a client is to develop self-regulated (autonomous) motivation for change or task engagement (Ryan et al., 2011; Vansteenkiste & Sheldon, 2006). A critical component of autonomy support is for the therapist, who is in a position of authority, to make efforts to understand and acknowledge the perspective and world view of the client, in order to enhance the client's self-regulated motivation to engage in the task at hand. The present study suggests there is a close relationship between a therapist's autonomy support and client resistance. The imposition of a therapist's perspectives and unwillingness by a therapist to consider a client's perspective can be seen as a lack of autonomy support, and these behaviours were closely related to client resistance in this study.

A number of authors have made the connection between empathic perspective taking and client autonomy (Deci & Ryan, 2000; Elliott et al., 2004). For example, Elliott, Watson, Goldman, and Greenberg (2004) noted that therapist empathy can play a critical role in supporting client autonomy, and in enabling the exploration and deconstruction of client's perspectives and beliefs about themselves, the world, and others. Watson and McMullen (2005) suggest that it may be important to differentiate a client's resistance as an expression of a client's lack of autonomy, as opposed to an attempt to block the therapy process. The present study supports findings by these researchers, and suggests that empathic perspective-taking may be a critical factor in supporting a client's autonomy, and thereby limiting client reactance. Furthermore, it appears that this same phenomenon also applies to therapists, when their perspectives are not recognised by clients. This would suggest therapists need to monitor themselves and be aware when reactance is triggered, and work to ensure they maintain high levels of interpersonal relational skills in these circumstances. With regards to the SMP in an offending population, the results on the WAI-SR-O previously discussed suggest that the manualised programme may provide relatively less opportunity for collaboration on tasks and goals with clients. This may make it even more important to collaborate with a client by allowing them to communicate their perspective and have this perspective genuinely listened to and considered, in order to limit client resistance.

Therapist Directiveness and Therapist Confronts

Previous research has linked fairly overtly directive therapist behaviours (e.g., confronting and teaching) to client resistance (Patterson & Forgatch, 1985). However, there is variability in definitions of directiveness (Beutler et al., 2011), and studies show conflicting results regarding whether directive behaviours such as confronting clients are harmful to therapeutic outcomes (Miller et al., 1993), or potentially helpful if delivered with the requisite interpersonal skills (Moyers et al., 2005; Watson & McMullen, 2005). The results from the present study showed a range of different responses from clients when they were confronted by therapists, and the narrative analysis was suggestive of the specific interpersonal skills that distinguish a good confrontation from a poor one. Firstly, confrontations that elicited less resistance and more consideration from the client were delivered in a timeframe where there had been no previous client resistance or therapist resistance, and where therapist empathy was high. In contrast, confrontations eliciting greater resistance from the client were often delivered amongst existing client resistance and therapist resistance, and where there was low therapist empathy. In other words, the tone of the interaction at the time of the confrontation is important. Less effective confrontations also appeared to be a reaction by a therapist to a client's previous statement, rather than a well thought through and timed intervention. They were also often undertaken in sessions where there was a sense of non-mutuality being communicated by the therapist. More

successful confronts were followed by a very client-centred approach, with an explicit exploration of the client's perspective regarding the issues confronted.

These findings are consistent with the suggestions of Polcin (2003) that there is an important difference between a confront as a therapeutic goal, versus a confront as a therapeutic style, with the latter being contra-indicated. In other words, although the client is having to come face to face with (confront) challenging issues, the material needs to be delivered in a non-confrontational and client-centred guiding style (from within the client's internal frame of reference), and delivered at a time when there is no existing client or therapist resistance, and when therapist empathy is high. The findings also coincide with research suggesting that higher levels of client resistance can elicit therapist confrontations (Francis et al., 2005). They are also consistent with suggestions by Levenson (2010) that therapists should maintain empathy and equilibrium when there are troubling conflictual interpersonal dynamics in therapy, and ensure that that an appropriate affective environment exists before addressing challenging issues for clients.

Motivational Interviewing and Client Resistance

Miller and Rollnick (2012) have suggested that resistance can be broken down into two categories, ambivalence about change, and discord in the relationship. The narrative analysis suggested that much of the resistance in these DVDs was towards the therapist's perspective, the therapist's unwillingness to consider the client's perspective, or the therapist's imposing of their own perspective. In other words, the resistance was towards a therapist-centred and directive style. Even where the discussion was about behaviour change, it still appeared that the client's disagreement was resistance to the therapist's perspective, rather than change per se. These findings provide what is believed to be the first specific evidence for these concepts, and support Miller and Rollnick's suggestion that an important component of client resistance is discord in the therapeutic relationship.

Consideration of Maori Interests

A key consideration in this study was ensuring the research was of relevance and benefit to Maori. The number of dyads included in this study was very small, and therefore did not allow comparisons between Maori and non-Maori. However, there were Maori clients in dyads featuring both high and low levels of client resistance, and the relationships found between the therapist relational skills and client resistance appeared to apply to all the dyads, regardless of their ethnicity. This suggests that the findings in the present research—of a strong relationship between therapist relational skills and client resistance—are equally relevant to therapeutic dyads featuring Maori offenders. This finding is encouraging, because a previous meta-analysis

found that the positive effects of MI were twice as large in minority groups within US populations (Hettema et al., 2005). Miller and Rollnick (2012) suggest that MI may have differentially positive effects within systems where there has traditionally been more authoritarian and directive approaches used, and the authors posit that those from a minority background may have been less likely to encounter a stance of compassionate listening. A number of authors have suggested that an empathic and autonomy supportive approach is an important factor when working cross-culturally (Miller & Rollnick, 2012; Ryan et al., 2011). Ryan et al. point out that although the ideal is to have a good understanding of a client's culture, therapists and resources are often stretched, and it is therefore very important to support a client's autonomy and understand and acknowledge their values and internal frame of reference. MI appears to offer an approach where Maori offenders can be delivered treatment in a style that is respectful, supports their autonomy, and values their unique perspectives. Furthermore, there is the potential for this approach to reduce recidivism amongst this population.

What can be said about the Two Different Measures of Empathy?

The two different empathy measures were highly correlated, and this may partially be accounted for by the considerable crossover between these two constructs. The Empathy-perspective taking measure is designed to measure what some have called intellectual empathy. However, the Empathy-attunement measure also features intellectual empathy, although it also places a significant focus on attending to client's affect.

A further consideration with regards to the Empathy-perspective taking scale was in regards to findings in Austin's (2012). Austin's study used the MISC measure and coded empathy once for a one hour session for each dyad. This was a very different process than that undertaken in the current study, where the DVDs were coded on a minute by minute basis. The use of measures on a minute by minute basis was felt to have developed a very different understanding of the client-therapist dynamics for the researchers, and highlighted a number of factors. Firstly, empathy can vary considerably throughout a session, in ways that are related to other variables such as client resistance, and this is not captured by a global measure. Secondly, the micro coding called for a more detailed analysis of the language, and in particular, a deeper consideration of the therapist's narrative with regards to perspective taking. This process revealed that what sometimes appeared—at a global level—to be considerable interest in the client's worldview by the therapist, was often an exploration of the client's challenges through the therapists own perspective, or an exploration of the therapists own agenda with regards to the client, and could not truly be considered empathic perspective taking (Miller & Rollnick, 2012). These findings also highlighted that micro-coding and global coding are very different

processes, which detect different aspects of behaviour, and provide potentially very different results.

Limitations

This study has a number of limitations. Firstly, the sample was both small in size and non-randomly selected (both facilitators and offenders). This ensured the inclusion of therapy sessions featuring a range of client resistance levels, as well as a range of therapist interpersonal skills, but obviously creates limitations. The focus on client resistance makes it possible that the aggregated scores across all dyads are higher for therapist and client resistance and lower for therapist empathy, than in the general population of offenders. The results from the group analysis (e.g., aggregated means) cannot therefore be automatically assumed to be generalizable to the wider offending population, or outside of an offending population. More weight should therefore be given to the strong relationships found amongst the variables, rather than the aggregated scores across this small sample of dyads. The results in general also cannot be assumed to be generalizable outside of the SMP or an offending population. Secondly, the two coders were not blind to the research questions and both coders coded all measures, including both the client's and the therapist's responses. It is possible this could have created an unconscious bias towards coding desired responses from the dyad members. Thirdly, the link between the therapist's relational skills and client resistance appeared very strong, but other variables cannot be completely ruled out. However, this potential threat to internal validity is thought to be less likely because of the large number of data points that were continuously collected (424). Fourthly, the results with regards to narrative findings in general, and the therapist confrontations specifically, are limited by the small and selected nature of the sample of these narrative excerpts. Fifthly, the initial pool of DVDs from which this sample was drawn consisted of the entire population of approximately 125 facilitators. The sample of 12 facilitators was established from this wider population through their consent to participate in the research. It may be that the self-selected nature of this sample created a bias in some way, although the data suggest the final sample was heterogeneous with regards to the variables measured. Sixthly, the results could not provide definitive answers regarding the possible causal nature and direction of the relationship between the therapist and client variables. Seventhly, there were a number of limitations with regards to the measures. The validity of the empathy measures has not specifically been proven for the idiosyncratic manner in which they were used in this study. Neither measure has had its validity established for coding moment to moment interactions (micro-coding), and the validity of the Empathy-perspective taking measure is unknown when used in isolation from the MITI code, as it was in this research. Furthermore, the TRC was created for the purposes of this research, and although it is based on the CRC, which

does have established validity, this validity cannot be assumed to generalise to the TRC. A final limitation to this research is the fact that outcomes were not measured. Although client resistance is increasingly being linked to poor outcomes, it cannot be assumed that dyads with high levels of resistance in this sample would actually have had poorer outcomes (higher rates of re-offending).

Strengths

There were a number of strengths to this research. A considerable strength was the use of a mixed methods design, which combined the use of both quantitative and qualitative methods. The quantitative analysis allowed the investigation of possible relationships between the variables measured. The qualitative analysis allowed the relationships uncovered to be more closely investigated, through use of a qualitative analysis of the narrative, in order to understand more deeply the specific details of these relationships. The measurement of both therapist and client variables on a continuous basis, rather than the use of global measures, also had a number of advantages. Firstly, it was possible to investigate moment to moment fluctuations in the variables measured, and then explore whether the fluctuations on a given measure coincided with fluctuations on other variables measured. Secondly, the continuous capturing of data considerably lessened any threats to internal validity, and strengthened the argument that it was indeed the variables measured that were affecting each other, and not an unmeasured confounding variable. Furthermore, although the sample size was small in terms of the number of participants (8), the number of data points collected was large (424), with an average of 53 data point captured per dyad. This research was also benefited by having a large number of transitions from high therapist skill to low therapist skill, as well as many transitions between levels of client resistance. This allowed more definitive conclusions regarding the relationships between the therapist and client variables at these transition points. A final strength of the study was that there was considerable variability amongst the participants with regards to therapist relational skills and client resistance. Previous researchers have noted the difficulty finding associations between therapist relational skills and client resistance when there is limited variability in the participants, and where there is extensive training and control procedures with regards to counsellor MI fidelity (Boardman et al., 2006; Catley et al., 2006).

Practical Applications

This research suggests a number of practical applications. Although the findings are most validly applicable in an offending population, they support and extend findings with regards to client resistance in research from other populations (Hal Arkowitz, Westra, et al., 2008;

Patterson & Forgatch, 1985), and may also be applicable to client resistance in other populations.

Broadly, therapists should consider using a client-centred and guiding style (Miller & Rollnick, 2012) in order to minimise the occurrence of client resistance, and to deal with any client resistance that arises. Therapists should attempt to explore client's challenges and possibilities for rehabilitation from within the client's own frame of reference, which supports a client's autonomy, and should avoid communicating a sense of non-mutuality. Therapists should be wary of pushing client's beyond their current level of engagement, or establishing a premature focus. Specifically, the findings suggest that therapists need to maintain an awareness of possible client resistance, which often manifests in the client's narrative in the form of resistance towards the therapist's perspective. When client resistance is recognised, therapists may wish to consider their possible contribution to the interpersonal dynamic at that particular time, and especially whether they may themselves be resisting the client's perspective or in some way imposing their own (or the wider system's) perspective. Even when a therapist has not contributed greatly to the initial occurrence of client resistance, it is important to recognise that whether the resistance ceases, is maintained, or escalates has a great deal to do with the therapist's response (Moyers & Rollnick, 2002).

In line with self-determination theory (Deci & Ryan, 2000; Ryan et al., 2011), therapists need to be aware of the power dynamics that exist within the environments in which they work. They also need to be aware of the expectations that the broader systems, and the individual therapists themselves, may have of the client. It may be useful for therapists to consider the three core features of autonomy support when engaging with clients: the importance of the person in the one-up position (therapist) taking and acknowledging the perspective of the client; the providing of as much choice as possible for a client; and the provision of a meaningful rationale for situations where it is not possible to provide choices to a client.

Therapists should also stay alert for the possibility that certain client behaviours may elicit a more therapist-centred and directive approach (Francis et al., 2005) from themselves. No matter how unwarranted a client's resistance appears, therapists should keep in mind that client resistance will be unlikely to cease until a therapist utilises a client-centred guiding style, involving empathic perspective taking and minimal therapist resistance.

With regards to confronting clients regarding non-desired behaviours, it appears important to undertake this task in a non-confrontational manner. The confrontation may be given more consideration by a client if delivered in a client-centred and guiding style, ensuring that the client's perspective is both heard and considered with minimal resistance from the therapist. Confrontations may be better received by client when delivered at a time where therapist

relational skills are high and there is low client resistance. It is important to note that a client-centred and guiding style can still be directional, and does not equate to an approach which is permissive, unstructured, or lacking in direction (Miller & Rollnick, 2012; Vansteenkiste & Sheldon, 2006)

The results showed a number of facilitators exhibiting levels of therapist resistance and therapist empathy that raised the question of whether they could actually be said to be practising MI. Notwithstanding the small and preselected nature of the sample, this coincides with observations that learning to practise MI competently is not easy (Farbring, 2008; Miller & Rollnick, 2012), and cannot be achieved from one or two workshops and self-learning alone. The authors emphasise that learning MI is an on-going process, and suggest that training programmes should include an initial comprehensive training in four broad components (MI Knowledge and Spirit, Engaging, Planning and Integration, and Focusing and Evoking). They highlight that this needs to be followed up with on-going supervision and coaching that incorporates direct observation of practise, and feedback based on these observations.

Future Research

To the best of this author's knowledge, this was the second study to investigate the process of MI in an offending population, and the first to investigate client resistance in an offending population. A replication of the present study would be therefore valuable, and could aim to address some of the limitations outlined above.

An important area for future research is the investigation of therapeutic strategies that enable a client-centred and directional style of exploration, and thus minimise resistance. Miller and Rollnick suggest exploration of a client's goal and values in order to both develop motivation and to uncover positive client behaviours which are discrepant with their non-adaptive (e.g., offending) behaviour. This approach promotes engaging the client from within their own frame reference, and allows the clients themselves are uncovering their non-adaptive and discrepant behaviour. However, there has been no research undertaken into whether including the exploration of a client's goals and values can act as a factor in reducing client resistance.

The present study showed a link between therapist relational skills and client resistance, but did not include a measure of outcome (re-offending). It has been suggested that the efficacy of MI may at least partially be due to a reduction in reduced client resistance (Miller & Rollnick, 2012; Miller & Rose, 2009), and there is evidence for this in non-offending populations (Westra, 2011). Future research could investigate whether there is a causal pathway from MI (incorporating low therapist resistance and high empathic perspective taking) to client resistance

and from client resistance to recidivism, in an offending population. A study of this type may also wish to consider the level of intensity and duration of client and therapist resistance, and their influence on outcome.

It has been suggested that the efficacy of MI may at least partially be due to a reduction in client resistance (Miller & Rollnick, 2012; Miller & Rose, 2009). Miller and Rollnick have suggested resistance is composed of both ambivalence regarding change (manifested as sustain talk) and discord in the relationship. Researchers could investigate the differential relationship strength between both of these types of client resistance and client behaviour change.

This research has shown a strong link between therapist resistance and client resistance. Miller and Rollnick (2012) have emphasised the importance of structured coding to gain a detailed understanding therapist client interactions. Researchers investigating MI in the future may wish consider incorporating a measure of therapist resistance.

Previous research has highlighted the importance of client language, the ability of a therapist to alter this language, and the relationship of client language to behaviour change (Miller & Rollnick, 2012). The present study showed that the language of the therapist is also important, especially with regards to therapist resistance. The study raises questions regarding of the underlying reasons that move therapists towards or away from empathic perspective taking and therapist resistance. Future research could investigate therapist language, with the aim of uncovering particular therapist language styles linked to client resistance. A study of this kind could attempt to identify reasons why therapists may be engaging in contra-indicated interpersonal styles. Studies investigating the language of client-therapist interactions with regards to client resistance may also wish to consider discursive psychology (Potter & Wetherall, 1987) and positioning theory (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). Positioning theory studies aim to evaluate the cognitive processes that are instrumental in supporting the people's action's, and give explicit consideration to the current meaning of a person's actions in any given moment.

Future research could investigate the ability of targeted training programmes (including supervision with direct observation and feedback) to increase therapist perspective taking, reduce therapist resistance, and thereby potentially reduce client resistance. These programs could help therapists become more aware of when they are and are not utilising a therapist-centred style, situations that draw them into this style, and how they can better deal with these situations.

Miller and Rollnick (2012) suggest that it is important to deliver MI with a certain state of mind (an uncluttered internal state), which is emotionally aware, thoughtful, and responsive. In the

present study it was observed that therapists in dyads with less resistance appeared to embody this still and thoughtful style, compared to therapists in dyads where there was greater therapist and client resistance, where therapists often appeared more reactive to the client's behaviours. Future research could investigate the usefulness of Mindfulness programmes for therapists (Siegel, 2010), and whether these enhance the ability of therapists to be more mindful of their interactive style, and less reactive towards difficult client behaviours.

Miller and Rollnick (2012) have suggested that reflective listening involves responding to clients with a statement, rather than a question, and that the statement is often a guess as to the true meaning behind a client's utterance. The authors suggest that a reflection delivered in this way is a "statement of understanding" (p. 53), and has the advantage of maintaining a client's connection to what they are experiencing, thus promoting further exploration and being less likely to evoke defensiveness. Although no empirical measurements were taken, the therapists in these DVDs appeared to more often deliver reflections as a question. Future research could investigate the difference in the two interventions with regards to resistance and change talk.

The SMP combined both motivational interviewing and cognitive behavioural approaches. Within sections of DVDs featuring client resistance there were therapist behaviours which are contra-indicated from both an MI perspective (Miller & Rollnick, 2012a) and a contemporary CBT perspective (Westbrook et al., 2011). For example, Westbrook et al. strongly emphasises the use of Socratic questioning and guided discovery, and suggest a therapist's role is that of a guide and mentor who has a genuine interest in the client's perspectives, who should not try and persuade a client or argue with them. Westra and Arkowitz (2011) suggest that good CBT may be more client-centred, and Flynn (2011) suggests that MI may be synergistic with CBT in that it provides a specific framework for learning foundational psychotherapeutic skills such as client-centred active listening. Future research could investigate specific difficulties therapists may have in taking a client centred and guiding approach, and potential solutions to these challenges.

Conclusion

The potential to increase the efficacy of psychotherapy by developing a better understanding of client resistance, and clear evidence-based practise principles, is increasingly being recognised (Hal Arkowitz & Miller, 2008; Engle & Arkowitz, 2006; Leahy, 2001). There has been very little research into the concept of client resistance (Aviram & Westra, 2011; Engle & Arkowitz, 2006; Apodaca & Longabaugh, 2009). In line with this, the importance of looking at the specific in-session therapist-client dynamics which contribute to client resistance has been noted (Gaume et al., 2010; Karno et al., 2002), and that which does exist is often conflicting (Moyers et al., 2005; Watson & McMullen, 2005). There are few studies which have investigated the therapist factors related to client resistance, and where this has been done, client resistance has often been narrowly operationalised resistance, or therapist factors investigated have been restricted to technical skills. Where therapist interpersonal skills have been investigated, they have generally measured at the global level of a session, thus restricting the ability to understand their moment to moment in-session relationship to client resistance.

The present study contributed to this knowledge gap by using a multi-method research design to investigate the link between therapist relational skills and client resistance within an offending population. No other studies have directly investigated the link between these variables, and therefore the study makes a valuable contribution to psychotherapy literature in general, and especially in regards to populations where low client motivation and resistance are seen as a prevalent issue. Furthermore, the relationship between therapist behaviours and client resistance is thought to be bi-directional, although there is little known about how these interactions unfold within a therapy session (Gaume, Gmel, & Daepfen, 2008).

Therapist resistance and client resistance were found to be strongly related across the dyads. The relationship was also found to be temporally proximal at the level of a one minute segment, with evidence of clear synchrony between the onset, cessation, and level of each of the variables. Therapist empathy and client resistance were also found to be strongly related across the dyads. However, the temporal proximity of the relationship between these two variables was more variable, and was found to be strongest in sections of prolonged client resistance.

Client resistance was found to be the result of an interpersonal dynamic between a client and therapist. A therapist-centred and directive style was found to contribute to the onset and escalation of client resistance, and was often evidence by authoritative and expert approach which communicated an element of non-mutuality. In contrast, a client-centred and guiding style, which was collaborative and supported the client's autonomy, was found to be inversely related to client resistance. The results supported the idea that there are bi-directional effects

between therapist and client. It appeared that therapist-centred and directive therapist behaviours often elicited client resistance, and client resistance often elicited further therapist-centred and directive therapist behaviours. It was also found that client resistance would predominantly continue until the therapist changed their approach to a more client-centred and guiding style. The results clearly showed that the therapist's response is critical in determining how long client resistance lasts, how intense it becomes, and when client resistance ceases. Confronting clients was found to be best undertaken in a non-confrontational manner, in a client-centred and guiding style, and at a time when there was an absence of client resistance.

The non-random selection of dyads, and the small sample size, meant that caution was needed in interpreting aggregated scores, and making any claims about these scores being representative of the wider population. Notwithstanding this important consideration, a majority of dyads featured relatively high therapist resistance and client resistance scores, and low scores on therapist empathy. This suggested a number of possible factors: this is a particularly difficult population to work with in which client resistance may be a common factor; therapists can often be pulled to react to client resistance in a therapist-centred and directive manner; MI interpersonal skills are not easy to develop.

The strong relationships between the measures were found across all dyads, both Maori and non-Maori. This suggests that the client-centred and guiding style outlined within motivational interviewing may be useful in limiting client resistance within psychotherapy treatments for Maori and non-Maori clients.

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Appendix A: Ethics Research Approval



MASSEY UNIVERSITY
ALBANY

11 April 2012

Hagan Provan
c/- Dr Dave Clarke
College of Humanities and Social Sciences
Massey University
Albany

Dear Hagan

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 11/063
Motivational Interviewing and Client Resistance

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

A handwritten signature in black ink, appearing to read 'R Bathurst'.

Dr Ralph Bathurst
Chair
Human Ethics Committee: Northern

cc: Dr Dave Clarke & Dr Mei Williams
College of Humanities and Social Sciences

Te Kunenga
ki Pūrehuroa

Research Ethics Office
Private Bag 102 904, Auckland, 0745, New Zealand Telephone +64 9 414 0800 ex 9539 humanethicsnorth@massey.ac.nz

17 April 2011

Hagan Provan
School of Psychology
Massey University,
Private Bag 102 904
North Shore City
Auckland 0745

Dear Hagan

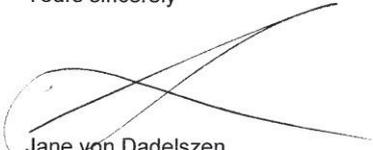
Approval for research proposal

I am pleased to advise that all permissions for your proposal '**Motivational Interviewing and Client Resistance in an Offending Population**' have been completed, and I am now able to give formal approval for your research. Please read and sign the enclosed Research Agreement, and return it in the prepaid envelope provided. A second copy is provided for your own records.

Please liaise with Sally Faisandier in Strategic Analysis and Research at the Department of Corrections to discuss any logistical or administrative issues. Sally can be contacted on 04 460 3087 or email sally.faisandier@corrections.govt.nz.

I wish you well with the research, and look forward to hearing of the outcomes.

Yours sincerely


Jane von Dadelszen
General Manager
Strategy, Policy and Planning

Enclosures Research agreement x2
 Postage paid envelope

Appendix B: Measures

Empathy – Perspective Taking (E-p)

1	2	3	4	5
<p>Therapist has no apparent interest in the C's worldview. The therapist gives little or no attention to the client's perspective.</p>	<p>Therapist makes sporadic efforts to explore the client's perspective. The therapist's understanding may be inaccurate or may detract from the client's true meaning.</p>	<p>The therapist is actively trying to understand the client's perspective, with modest success.</p>	<p>Therapist shows evidence of accurate understanding of the client's worldview. Makes active and repeated efforts to understand the client's point of view. Understanding is mostly limited to explicit content.</p>	<p>Therapist shows evidence of deep understanding of the client point of view, not just for what has been explicitly stated but what the client means but has not yet said.</p>
<p>Additional guidelines created by researchers in this study</p>				
<p>This is coded for more extreme behaviours outlined in the adjacent guidelines for level 2.</p> <p>The client may give a perspective, and the therapist may completely ignore this.</p>	<p>Some very minimal perspective taking/ exploration, but the therapist predominantly is not understanding/trying to understand the client. The perspective taking maybe superficial.</p> <p>Segments where therapist is 'rabbiting on', have their own agenda, and are not in some way checking to see if the client is with them. There was or should have been opportunity to take perspective.</p>	<p>Some success, modest success. Therapist may be task focused, but appropriately so. Interaction may be a little clumsy.</p>	<p>The client can provide information as to how accurate the understanding there is.</p>	

Empathy – affective attunement (E-a)

1	2	3	4	5
<p>Brief Guide Doesn't listen, understand, show attunement to feelings.</p> <p>Detailed Guide T does everything but express he is listening, understanding, being sensitive to feelings of client and so detracts significantly from communications of C. The verbal and behavioral expressions of the T either do not attend to/ detract significantly from verbal and behavioral expressions of the C in that they communicate significantly less of the C's feelings than the C has communicated himself. E.g. T shows no awareness of even the most obvious, expressed surface feelings of C. T may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the C.</p>	<p>Brief Guide Some awareness of feelings, often inaccurate, or surface.</p> <p>Detailed Guide T tends to respond to other than what the C is expressing or indicating. While T responds to expressed feelings of the C, he does so in such a way that he subtracts noticeable affect from the communications of the C. E.g. T may communicate some awareness of obvious surface feelings of the C, but his communications drain off a level of the affect and distort the level of meaning. The T may communicate own ideas of what may be going on, but these are not congruent with the expressions of the C.</p>	<p>Brief Guide Expressed feelings interchangeable. Minimal level of interpersonal functioning.</p> <p>Detailed Guide A minimal level of facilitative interpersonal functioning. T is responding so as to neither subtract from nor add to the expressions of the second person; but does not respond accurately to how C really feels beneath the surface feelings. Expressions of T in response to the expressed feelings are essentially interchangeable with C- essentially the same affect and meaning. E.g. The T responds with accurate understanding of the surface feelings of the C but may not respond to or may misinterpret the deeper feelings.</p>	<p>Brief Guide High level of attunement / accurate responding to what C clients affect/expressions</p> <p>Detailed Guide The responses of the T add noticeably to the expressions of the C in such a way as to express feelings a level deeper than the C was able to express himself. E.g. The T communicates his understanding of the expressions of the C at a level deeper than they were expressed, and thus enables the C to experience / express feelings he was unable to express previously.</p>	<p>Brief Guide Comprehensive and accurate empathic understanding of deepest feelings.</p> <p>Detailed Guide Responding with a full awareness of who the other person is and a comprehensive and accurate empathic understanding of deepest feelings. T's responses add significantly to the feeling and meaning of the expressions of the C in way as to (1) accurately express feelings levels below what C himself was able to express or (2) in the event of ongoing deep self-exploration on the C's part to be fully with him in his deepest moments. E.g. T responds with accuracy to all of C's deeper as well as surface feelings. He is "together" with the C or tuned in" on his wave length. The T and the C might proceed together to explore previously unexplored areas of human existence.</p>
<p>Additional guidelines created by researchers in this study</p>				
	<p>Therapist is trying but doing very poorly. Therapist may be bringing issues the client is not ready for. Affect is not congruent, therapist is not where the client is at.</p>	<p>Paying attention to clients feelings. Feels like therapist and client are in tune. Ticking along, tit for tat, no or little deeper exploring.</p>	<p>Therapist keeps the talk going and advancing.</p>	

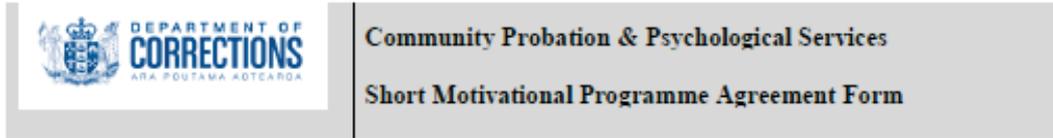
Client Resistance Code

0	1	2	3
no resistance/ co-operation	minimal, qualified resistance	clear, unqualified resistance	hostility/confrontation
<p>All responses that are neutral, cooperative, or following the direction set by the therapist</p> <p>Short utterances indicating attention or agreement</p>	<p>1. Interrupt/talkover: Coded only when the client is obviously cutting the therapist off or talking over the therapist (in other direction...not interrupting in same direction or in agreement)</p> <p>2. Negative attitude: Responses indicating unwillingness/inability to cooperate with therapist's suggestions (e.g., blaming others, statements of hopelessness, defeat, disagreement)</p> <p>3. Challenge/confront: Responses challenging the therapist's qualifications and/or experience; responses that indicate that the therapist doesn't know what s/he is doing</p> <p>4. Own agenda: Bringing up new topics/concerns to avoid discussing or to block the issue(s) that the therapist was on</p> <p>5. Not tracking: Inattention, not responding, answering a question directed to another, disqualifying a previous statement</p>		
<p>Interruptions which are inagreement/generally in the same the direction (agreement) as the task/conversation, are coded as no resistance.</p> <p>It is not resistance if the client interrupts just to make a clarification.</p>	<p>Is it hard to know, But not neutral or agreement...score it as 2.</p> <p>Interrupting in a way that is oppositional to the current taks/conversation = 1 at least.</p> <p>Is it clearly resistance....put it in 2 at least.</p>		

Therapist Resistance Code

1	2	3	4
no resistance/ co-operation	minimal, qualified resistance	clear, unqualified resistance	hostility/confrontation
<p>CORE GUIDELINES</p> <p>All responses that are neutral or co-operative. Short utterances indicating attention or agreement</p>	<p>CORE GUIDELINES</p> <p>Interrupt/talkover: Coded only when the Therapist is obviously cutting the client off or talking over the client, or as a way to change direction. (Interrupts need to be in the other direction, against the client...not interrupting in the same direction or in agreement with the client.)</p> <p>Negative attitude: Responses indicating unwillingness/inability to explore the client suggestions (e.g., questioning validity of clients statements, judging the clients action, disagreement)</p> <p>Challenge/confront: Responses challenging the Clients ideas when the client is obviously in disagreement; responses that indicate that the client doesn't know what s/he is doing</p> <p>Own agenda: Bringing up new topics/concerns to avoid discussing or to block the issue(s) the client was on</p> <p>Not tracking: Inattention, not responding, disqualifying a previous statement, resisting talking about what the client wants to talk about - especially if the client is strong on importance.</p>		
<p>FURTHER GUIDELINES</p> <p>Responses where the therapist is “walking beside the client”. Therapist may be lead the way in terms of session structure, but there is no sense of forcing the direction against the client’s wishes. If therapist interrupts, the purpose is to enable the conversation, or interrupt is in essentially same direction as the client’s conversation. It needs to be fairly clear that there is no resistance to get a 1. If therapist is moving the conversation on...therapist gives the client choice, or gives attention to resolving the client’s current issue first.</p>	<p>Guide: The above grades of 2, 3 or 4 are given for segments where the behaviours listed occur. Segments where the behaviours are more intense are rated higher. Segments where there are multiple behaviours may also be rated higher (e.g. an interrupt may gain a 2, whereas an interrupt with negative attitude may gain a 3).</p>		

Appendix C: Offender SMP Consent Forms



AGREEMENT TO DO THE SHORT MOTIVATIONAL PROGRAMME

I agree to do the Short Motivational Programme.

The Programme:

The programme involves me meeting with a programme facilitator to help me think about why I offended and what I can do to stop offending.

There are five sessions in the programme.

Each session is for one hour commencing at (*time*) on Monday, Tuesday, Wednesday, Thursday, Friday (*mark as appropriate*) fromto.....(*date*).

I understand that:

- I have to go to sessions and might have work to do outside session time.
- I have the right to leave any session or the programme altogether after discussion with the programme facilitator. I understand the consequence of this.
- The programme facilitator has the right to dismiss me from the programme if I am violent, drunk, on drugs, or my attitude and behaviour undermine the sessions.
- Sessions will be recorded (e.g. videotaped), for the purpose of programme facilitator supervision, performance management, training or monitoring the work of the programme. This may be undertaken by the Department of Corrections, or by a person appointed by the Department of Corrections. The use, storage, and erasure or destruction of the recording will be controlled by the Department of Corrections subject to its obligations under the Privacy Act 1993.
- Reports about how I am doing in the programme will go on my file, and may be used in a report to the New Zealand Parole Board or other authorised Department of Corrections" report. I have the right to read, and agree or disagree before they are sent. I shall get a copy of the report.
- I have the right to access and ask for the correction of any information collected about me during the programme in terms of Principle 7 (of the Information Privacy Principles contained in the Privacy Act 1993). If any change requested by me is not made, I have the right to request that my written statement about that information be attached to it.

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To make sure the programme is working, research will be done. Any personal details collected about me will not identify me in the report.

I understand that confidentiality cannot be agreed to in the following circumstances:

If I say I am about to seriously harm myself or someone else (either emotionally or physically) the facilitator will take action (tell other people) immediately to prevent this.

If I talk about **current or planned** offending the programme facilitator *might* have to pass the information on to authorities. This will usually be discussed with me first. If I talk about serious **past** offences I have not been convicted of I will be encouraged to report those offences to the appropriate authorities. If I don't report those offences, this information may be passed on to authorities but will be discussed with me first.

I agree to:

Come to all sessions on time and take part in every session.

Be open and honest with the facilitator.

Turn up sober and drug free every time.

Complete all homework.

The sessions being recorded (e.g. videotaped) with me in it, as part of the process for facilitator supervision, performance management and training, and monitoring the programme.

Take part in the evaluation of the programme (no personal details will identify me in the report).

If I decide to leave the programme I also agree to talk with the programme facilitator about why I am leaving before I leave.

OFFENDER TO COMPLETE

My signature below shows that I have read, understood and accept these conditions, or that I have had them explained to me, and that I accept them.

Offender.....

Date.....

Programme Facilitator..... **Date**.....

Appendix D: Rehabilitative Needs Details

Specific targeted criminogenic needs – full definitions

Specific Targeted Criminogenic Needs (STCNs) are criminogenic needs that have a specific focus that can be targeted or addressed directly through accessing community resources. Thus, offenders who are sufficiently motivated to address these needs, should be able to access community resources/programmes that are specifically designed to target these areas. The STCNs and their identification criteria within the context of SMP are listed below:

Violence propensity (VP)

Violence Propensity should always be identified when the index offence(s) include violent offence(s) or if any violent behaviour is linked to an index offence.

Violence is defined as either:

physical violence (including destruction of property);

psychological violence (including threats and intimidation), or

sexual violence [Note: While all sexual offending can be viewed as a form of violence, sexual violence should only be identified when there is clear use of violence that could be considered a separate offence in its own right. For example: threatening a victim with a weapon; threatening a victim with physical harm if they do not comply, physically assaulting a victim to gain compliance; using restraints (e.g. rope, handcuffs etc) to obtain compliance; using force to deal with resistance etc.]

Community resources available to target this need include:

Community Stopping Violence Programmes

Community Anger Management Programmes

Alcohol and drugs (A&D)

A&D should always be identified for direct alcohol related offending (e.g. Excess Breath Alcohol)

A&D would usually be identified in cases where the effects of alcohol and/or drug usage can be clearly linked to an index offence. Links will usually be related to either reducing inhibition or to negatively affecting judgement leading to poor or impaired decisions.

However, A&D can also be identified in situations where the index offending behaviour was primarily motivated by a desire to obtain drugs and alcohol for personal use. For example, a burglary offence is specifically committed to obtain money to purchase drugs and/or alcohol; a chemist shop is burglarised to obtain drugs (for personal use) etc.

A&D refers to alcohol and/or other drug *usage*, - not to alcohol/drug-related offending that does not specify use (e.g. supplying alcohol to minors; possession for supply; or theft of chemicals to manufacture drugs for profit.).

Community resources available to target this need include:

Community Alcohol and Drug Programmes

Residential Alcohol and Drug Programmes

- Individual one-on-one Alcohol and Drug Counselling

Illicit substance using associates (ISUA)

For the ISUA need to be identified, an offender needs to have been using illegal drugs in the company of other people who either actively or passively endorsed the offender's use of the illegal substances.

This need can only be identified in conjunction with the Alcohol and Drug (drug) criminogenic need. This means that the active or passive support that the offender gained in relation to their illegal substance use can be linked to their level of intoxication which in turn was linked to their index offending behaviour (via the Alcohol and Drug Criminogenic Need).

The underlying assumption contained in the ISUA need is the assumption that offenders are more likely to partake in illicit drug taking behaviour (or higher levels of illicit drug taking behaviour) when in the company of other people who either actively or passively endorse this behaviour.

Community resources available to target this need include:

- Community Alcohol and Drug Programmes
- Residential Alcohol and Drug Programmes
- Individual one-on-one Alcohol and Drug Counselling

Gambling

Both positive and/or negative gambling related thoughts and feelings can be linked into to an index offence. For example; a theft is committed to enable gambling behaviour to take place; or a domestic assault is committed after an offender loses at gambling which causes a domestic dispute over the offenders lack of responsibility.

No actual episode of gambling needs to have occurred leading up to the index offence for this criminogenic need to be assessed. However, a clear association between the motivation to engage in an index offence and gambling desire needs to be established.

Community resources available to target this need include:

- Community Gambling Programmes
- Individual one-on-one Gambling Counselling

Relationship difficulties

The SMP relationships need specifically relates to domestic situations. Thus this need is concerned with relationship issues within close, interpersonal, romantic (and/or sexual) relationships with either a current partner and/or an ex-partner.

An offender must have been involved in a romantic/sexual relationship with their partner for at least one week for an association to be considered a relationship.

Relationships do not include casual acquaintances (e.g. irregular sexual liaisons).

For the relationship need to be identified, negative relationship-related thoughts and feelings need to be linked to an index offence.

The need reflects the absence of relationship skills (including the inability to helpfully manage negative relationship related thoughts and feelings).

- It exists when the offender's absence of relationship skills (in relation to a specific relationship situation) contributed to the index offending behaviour.
- No actual episode of a relationship interaction needs to have occurred in the OP for this need to be assessed.
- The relationships need should always be identified where the offender's partner/ex-partner is the victim of their offending.

Community resources available to target this need include:

- Relationship Services
- Family Therapy/Relationship Counselling

Offence related Sexual arousal (ORSA)

- ORSA should always be identified when the index offending includes a sexual offence.
- This rule is based on the assumption that every sexual offence has some degree of sexual arousal or sexual desire/excitement associated with it.
- ORSA can be assessed in the absence of a sexual conviction when offence related sexual thoughts, feelings and actions can be linked into the index offending (e.g. following a domestic burglary conviction the offender acknowledged sexual excitement at the possibility of a sexual encounter while in the house).

Community resources available to target this need include:

- STOP Programme
- SAFE Programme
- Individual one-on-one Sexual Behaviour Counselling

Mood management problems (MMP)

- For the MMP need to be identified, negative (low) mood-related thoughts and feelings need to be linked to an index offence.
- Essentially MMP reflects the presence of low mood/mood disturbance and the absence of appropriate (non-offending) mood management skills (including the inability to helpfully manage negative thoughts and feelings in a pro-social manner).
- This need exists when the offender's absence of mood management skills contributed to the index offending behaviour. For example; an offender reports that he was feeling depressed about his situation to the degree where he had stopped caring about the consequences of his behaviour. He then stated that he decided to engage in an episode of exhibitionism in an attempt to lift his mood and to feel better.
- MMP is not to be identified in relation to primarily negative "anger" related feelings. An ability to manage angry feelings is likely to result in violence and should be identified via the Violence Propensity need.

Community resources available to target this need include:

- Mental Health Services
- GP
- Individual one-on-one Mood Management Counselling

Lifestyle choice criminogenic needs – full definitions

Lifestyle Choice Criminogenic Needs (LCCNs) are criminogenic needs that are related primarily to an offenders' deliberate lifestyle choices. In theory, while these are things that an offender has a degree of control over (and permeate through an offenders lifestyle and general background environment), they are not specifically targeted by normal community programmes and resources. While these types of criminogenic needs are addressed to various degrees in the Department's medium and high intensity Criminogenic Programmes, it is unlikely that an offender is going to be able to "self-refer" to a community programme that specifically targets these needs. Thus, these LCCNs need to be considered as being unique from STCNs in that there is no "easy" intervention pathway to guide offenders towards and that the essential intervention is likely to be based purely upon the motivational component contained in SMP, with a goal of having the offender decide to address these lifestyle issues internally, without necessarily accessing further outside assistance (i.e. community programmes and resources). The LCCNs and their identification criteria within the context of SMP are listed below:

Unhelpful lifestyle balance (ULB)

- ULB refers to a situation where an offender has a significant lack of purposeful, meaningful, or constructive *structure* in their daily routines; or where their usual routines involve engaging in a number of negative, unhelpful, or illegal *activities*.
- Thus, this need looks at how an offender typically uses their time. It is assumed that a lack of lifestyle balance increases an offender's pre-disposition towards offending and places them at increased risk of engaging in illegal behaviours.
- ULB occurs when where an offender's usual routine does not involve using their time in a structured, purposeful way that is self-enhancing or positive for them; or when their usual pastimes involve engaging in negative, unhelpful or illegal activities (e.g. substance abuse).
- ULB should not be automatically identified just because an offender is unemployed or on a benefit. It is what a person does with their time that is important. For example an unemployed person who gets up at a normal time and engages in positive routines (e.g. engages in exercise, works in the garden, maintains the property, actively seeks employment; attends their appointments; maintains positive social connections; belongs to a club; engages in volunteer work etc.) would not be considered to have an unhealthy lifestyle balance despite being unemployed. Conversely, an unemployed person who gets up when they wake up, engages in regular substance use, associates with other drug users, watches tv / dvds / "play-station" all day and does not seek employment would be considered to have an unhealthy lifestyle balance.

Offending supportive associates (OSA)

- OSA should always be identified when an index offence(s) involved a co-offender as this suggests that the offender's associates are offence supportive.
- OSA can also be identified if the offender acknowledges regularly associating with individuals who are involved in illegal activities (e.g. gang members; associates involved with either using or selling illegal drugs etc.)

□ Focus should be on the social influence towards offending in general, but offending needs to involve more than just illicit drug (or alcohol) use. For example, an offender who has some mates who smoke cannabis together but who do not engage in any other illegal activity together (including selling drugs) should not be considered offence supportive associates. However, an offender whose cannabis smoking mates also assist with burglaries and or the distribution of stolen property (or drugs) would be considered offence supportive associates.

□ Thus, OSA is primarily reserved for offending beyond the range of offending involved with recreational substance use/abuse.

□ With OSA, the social influence towards committing offences can either be active (i.e. directly endorsed) or passive (not discouraged).

Offending supportive attitudes and entitlement (OSA&E)

□ OSA&E reflects an general anti-social /pro-criminal attitude where engaging in illegal activity may be considered a “legitimate pathway” or as an occupation. Alternatively it may reflect individuals who simply do not consider that the law applies to them (i.e. that they are exempt from needing to following societies rules and laws.) These offenders often have a strong sense of entitlement and an egocentric perception.

□ There is a general sense of an individual criminal based lifestyle choice, where the decision to engage in the illegal activity is a deliberate and often pre-planned decision.

□ Offending patterns reflect recidivist offending with little concern about legal consequences or Court sentencing (i.e. Court sentences have little impact with regards to changing OSA&E and subsequent offending behaviour).

□ OSA&E should be identified for individuals actively associated with organised crime (i.e. where offending is considered a business) and/or individuals actively involved with gangs. However, it could also incorporate lifestyle burglars, drug dealers, and recidivist driving offenders (including drunk drivers).

Appendix E: Facilitator Consent Forms



MASSEY UNIVERSITY CENTRE FOR PSYCHOLOGY

21 September, 2011.

Dear [Facilitators Name]

I have been working with Kevin Austin on his research into the Short Motivational Programme (SMP). I am very excited about the positive and practical aspects to this research, and I am hoping I might be able to get your approval to continue the study further, along with Kevin and the Massey Staff (Clinical Psychologists) who supervised him. We are seeking your approval both to continue with the research, and to keep hold of your DVDs for an extended period in order to undertake the research. My training is similar to Kevin's - I am currently a Clinical Psychology trainee in the Massey University Doctoral programme.

The tapes you allowed us to view provided a unique opportunity to understand how therapeutic activities actually affect change talk with offending populations. There is not a lot of research into MI in the forensic setting, and we think this is really important to investigate. The research I am asking you permission to undertake would be very much a continuation of Kevin's. We would look at the therapeutic activities undertaken in the sessions "through the lens" of various theories of psychotherapy - such as Motivational Interviewing, Cognitive Behavioral Therapy, and recent developments in motivation such as Self Determination Theory. We would be primarily focused on finding therapist activities that are linked to in-session change in clients, and understanding how these fit into current theories of motivation and change.

Programmes like the SMP consist of many complex tasks which counsellors need to consider (MI, CBT, the relationship, complexities of the forensic environment, risk etc...) and there is a lot of multitasking which occurs throughout therapy sessions! There are also many specific aspects of working with offenders which are not well understood within existing research into motivation, which often deal with non offender populations (e.g., those who are depressed or anxious). Ideally this research would provide a step forward in understanding more deeply the aspects of a therapy session which have the greatest impact on an offender's motivation, so we as counsellors can be more targeted in our sessions.

Thank you for considering this. Kevin Austin would again be involved, and the strict confidentiality guidelines he has put in place to protect the identities of all facilitators would be maintained. All DVDs will continue to be stored safely and securely. No aspects of the research would allow identification of individual facilitators. The research would be supervised by the same Massey University staff members Kevin worked with - Dave Clarke and Mei Williams, Senior Lecturers at Massey University and Registered Clinical Psychologists. It is supported by the Department Of Corrections, who are keen to improve the SMP programme. An application to the Massey University Human Ethics Committee will be presented in October.

If you have any questions you would like to discuss, please contact me by either email or phone (you can text or email me and me and I will phone you back).

The key points we are requesting your agreement to are ...

AGREEMENT TERMS 1

I give consent to retaining the DVDs until July 2012.

AGREEMENT TERMS 2

I give consent to retaining the DVDs until July 2012 and also to the transcription of the DVDs for a qualitative analysis of the text.

Thank you for considering this!

Kind Regards

Hagan Provan
Doctoral/Clinical Trainee
Massey University

Ph | xxx
Mob | xxx
Email | xxx