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Early Therapy Interpersonal Process Differentiating Clients High and Low in Outcome Expectations

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Abstract

The present study compared early interpersonal process, during resistant and cooperative segments of session 1, between clients who went on to have low (n=9) versus high (n=8) treatment outcome expectations. Baseline outcome expectations were assessed prior to any therapist contact. During resistance episodes, there was substantially less affiliative reciprocity (i.e., complementarity), and greater client separation and hostility in the low versus high expectations group. During cooperation episodes, therapists of low versus high outcome expectation clients engaged in lower levels of affirming and understanding, and higher levels of control. These findings suggest a potentially potent association between in-session interpersonal process and early client outcome expectations.

Keywords

Cognitive-Behavioural Therapy; Generalized Anxiety; Interpersonal Process; Outcome Expectations; Resistance

Frank and Frank (1991) contended that a major factor in the efficacy of all forms of psychotherapy, despite their explicit aims, lies in combating clients' demoralization or inducing a positive expectancy set for change. This contention has been echoed by others (e.g., Kirsch, 1990; Asay & Lambert, 1999) and substantiated by the growing body of research, which shows that higher early outcome expectations are consistently related to better treatment outcomes (for a review see Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011). While nurturing positive expectations for treatment benefit has been identified as an important clinical goal, little empirically developed guidance currently exists regarding how to achieve this goal.

Most recommendations and models on enhancing outcome expectations include a pivotal role for therapist empathy and, more generally, a positive therapeutic alliance (Constantino & Westra, in press; Frank & Frank, 1991; Kirsch, 1990; Lopez, Floyd, Ulven, & Snyder, 2000). Moreover, some empirical work has linked the therapeutic relationship with client expectations. For example, Cutcliffe (2004) found that clients in therapy for bereavement identified freedom of expression, without feeling judged, as inspiring hope for completing their process of grieving. Similarly, Larsen and Stege (2010) found that a focus on the therapeutic relationship, including validation of client experiences and providing a sense of acceptance, were regarded by therapists as key strategies for facilitating hope. Moreover, ruptures in the therapeutic alliance have been demonstrated to have a significant negative impact on client outcome expectations (Westra, Constantino, & Aviram, 2011).

While existing theory and research tell us that important relationships likely exist between the therapeutic relationship and expectations, they do not tell us what specific aspects of the relationship or elements of momentary interpersonal process might be associated with increases or declines in early outcome expectations. Research to empirically delineate relational processes that are helpful and hindering to client outcome expectations is essential to informing therapy practices focused on facilitating client belief in the possibility of symptom relief. Moreover, conducting such research at varying points in the treatment process (e.g., in the absence and presence of alliance tensions) is indicated.

The present study sought to identify whether there is differential early (session 1) interpersonal process between client and therapist for clients who go on to have high versus low expectations for therapy outcome. Toward this end, the present study utilized an intensive interpersonal process coding system, the Structural Analysis of Social Behavior (SASB; Benjamin, 1974), to quantify therapist and client in-session behaviors.

The majority of SASB-based process studies to date have been conducted with psychodynamic and interpersonal therapies. Generally, these studies indicate that poor versus good outcome cases show greater evidence of negative interpersonal process (e.g., Henry, Schacht, & Strupp, 1986, 1990; Najavits & Strupp, 1994; Tasca & McMullen, 1992). In good outcome cases, therapists generally engage in significantly more affiliative control and autonomy-granting, while clients respond with greater friendly autonomy and less hostile separation. In contrast, therapists in the poor outcome cases generally display greater hostile control and are significantly less autonomy granting, while clients respond with decreased affiliative autonomy-taking and greater hostile separation. Only one study to date has used SASB to examine interpersonal process in Cognitive Behavioral Therapy (CBT) for anxiety. Critchfield, Henry, Castonguay, and Borkovec (2007) examined client and therapist interpersonal interactions in three variants of CBT for generalized anxiety disorder (GAD). No significant differences between good and poor outcome groups were identified and this was attributed to low rates of interpersonal hostility in the sample as a whole.

In addition to examining dyadic psychotherapy exchange (i. e., client process toward self and toward therapist, therapist process toward self and toward client), SASB also allows examination of an additional parameter of interpersonal process (i.e., interpersonal complementarity). In particular, according to contemporary interpersonal theory (Sullivan, 1953; Keisler, 1996), two people's behaviors are thought to be mutually and causally interconnected. That is, one person's behaviors evoke "restricted classes" of reactions from the other interactant. In general, in order for interactions to proceed smoothly, perpetuate, and be satisfying, our actions are designed to influence others to respond to us in ways that reciprocate (or complement) our interpersonal actions or "bids." Interpersonal transactions that incorporate such complementary behaviors reduce anxiety, while those that incorporate noncomplementary behaviors exacerbate anxiety. Thus, noncomplementary interactions tend to put interactants into a state of relational conflict or system imbalance stemming from a perceived threat to the interpersonal needs of either or both members of the relationship (Villard & Whipple, 1976).

Examining interpersonal complementarity using SASB, Henry et al. (1986) found that therapist-client dyads in good outcome cases demonstrated greater positive (i.e., affiliative) complementarity and less negative (i.e., hostile) complementarity than poor outcome cases. Others have since replicated these findings (e.g., Tasca & McMullen, 1992; Von der lippe, Monsen, Ronnestad, & Eilertsen, 2007). Moreover, client-therapist positive complementarity in early sessions has been found to be a significant predictor of midtreatment client change (Tracey, Sherry, & Albright, 1999) even beyond therapist competence (Svartberg & Stiles, 1992).

The Present Study

The aim of the present study was to examine early (session 1) client-therapist moment-to-moment interpersonal process between two groups who were equivalent in their outcome expectations at baseline, but then differed in their outcome expectations at the end of session 1. Data were derived from a larger randomized controlled trial (RCT) in which clients received CBT for GAD either with or without a motivational interviewing pretreatment (Westra, Arkowitz & Dozois, 2009). In the present studies, to avoid any impact of having received motivational interviewing on therapy process in the subsequent CBT, therapy dyads were selected from the CBT alone arm of the larger RCT. Given previous research linking alliance ruptures to subsequent client outcome expectations (Westra et al., 2011), it was of interest to sample therapy segments that reflected client opposition or resistance to the direction of the therapist/therapy (i.e., alliance tensions), as well as segments where such resistance was not present (i.e., cooperation).

Thus, in the present study, session 1 segments where resistance was present and where it was absent, were systematically sampled and analyzed using the SASB. Consistent with previous SASB studies, therapist and client behaviours were analyzed both independently and together (i.e., interpersonal complementarity or reciprocity). These process indices were then compared for clients groups who went on, immediately after the first session, to have high versus low outcome expectations.

Based on previous research it was hypothesized that in dyads where clients go on to have low versus high outcome expectations after the first session: (1) *clients* would exhibit more separation from the therapist, more disaffiliative behaviors (hostility), and less friendly connection (i.e., disclosure), (2) *therapists* would grant less friendly autonomy and exhibit more attempts to control the client in hostile ways, and (3) client-therapist dyads would exhibit less positive (affiliative) complementarity in responding to the other's interpersonal bids. Given that resistance segments, by definition, reflected moments of interpersonal tension, it was expected that these effects would be more pronounced during resistance, compared to moments of cooperation.

Method

Participants

Dyad selection—The sample consisted of 17 client-therapist dyads selected from therapy completers who received CBT alone in the Westra et al. (2009) RCT. Clients in the larger RCT, who all met criteria for a principal diagnosis of GAD, were recruited from community advertisements in the greater Toronto. Informed consent was obtained for all study procedures at the time of initial study intake, and the internal review board of the sponsoring university approved the study.

The high outcome expectations group ($N = 8$ dyads) consisted of clients that reported post session 1 outcome expectations between 70% and 100% expected improvement. In contrast, the low outcome expectations group consisted of clients who reported expecting only 10% to 50% improvement immediately after session 1 ($N = 9$ dyads). These outcome expectancy cutoffs were both rationally derived (i.e., clearly high and clearly low) and based on other research (e.g., Westra et al., 2011; Ahmed & Westra, 2009), which has found that baseline outcome expectations exhibit a stepped function in relation to process outcomes (i.e., are above or below a critical value). For example, clients with outcome expectations of less than 70% at baseline have been found to be far more vulnerable to the negative impact of alliance ruptures compared to those with outcome expectations of 70% or higher (Westra et al., 2011). The two groups in the present study were matched on baseline outcome expectations

in order to ensure that the post session 1 expectation groups were not confounded with initial expectations. In selection of dyads, with respect to initial outcome expectations, selection began with clients with the lowest baseline expectations.

Between group comparisons confirmed that outcome expectations at baseline (using the Anxiety Change Expectancy Scale discussed below) did not differ significantly between the low and high (post session 1) outcome expectations groups, $t(15) = .026, p = .801$ (high expectations group: M ACES = 71.00, $SD = 9.52$; low expectations group: M ACES = 69.78, $SD = 10.06$). The scores on the ACES in the present study were in the average range compared to previous studies using anxiety samples (e.g., Ahmed & Westra, 2009). Further, the two expectations groups differed significantly in their predicted percent improvement (using an item from the Credibility/Expectancy Scale discussed below) after session 1 of CBT, $t(15) = 7.60, p < .001, d = 3.62$ (high expectations group: $M = 77.05, SD = 7.07$, low expectations group: $M = 38.89, SD = 12.69$).

Therapists—Four therapists (2 female, 2 male) provided the CBT treatment in the larger RCT and included one Ph.D. level psychologist, two senior and one junior clinical psychology graduate students. Two of the four CBT therapists in the larger RCT delivered the therapy for clients in the high outcome expectations group, while the clients from the low outcome expectations group were seen exclusively by the other two CBT therapists. It was originally intended to control for therapist by selecting clients from each therapist for each expectations group. However, this proved impossible, as therapist seemed to be nested within client outcome expectations group. This is consistent with findings from the larger RCT that, even when therapists were using the same therapy manual, clients differed in their outcome expectations (Westra, Constantino, Arkowitz, & Dozois, 2011). Moreover, the two therapists with clients who went on to have higher outcome expectations post session 1 were more senior (one Ph.D. level psychologist and one senior clinical psychology graduate student) and were also significantly more effective in terms of client worry outcomes in the larger clinical trial (Westra et al., 2011).

Self-report measures

The Anxiety Change Expectancy Scale (ACES; Dozois & Westra, 2005)—The ACES is a 20-item instrument that assesses expectations for being able to successfully manage anxiety as a result of treatment. Each item is rated on a 1 to 5 Likert scale (1 = strongly disagree, 5 = strongly agree). The ACES has 11 items that are reverse scored. The possible range of scores is from 0 to 100. Higher scores indicate greater positive expectations for anxiety change. The ACES demonstrates high internal consistency (alphas = .89 to .92), as well as good convergent and divergent validity (Dozois & Westra, 2005). The ACES is also predictive of treatment related change in CBT for anxiety (Dozois & Westra, 2005) and engagement with CBT as measured by homework compliance (Westra, Dozois, & Marcus, 2007). Sample items include, “I feel pessimistic that my anxiety problems could ever change for the better”, “My problems with anxiety are too severe to benefit from treatment”, and “I am optimistic that my anxiety can change for the better”.

Credibility and Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000)—The CEQ is a 6-item scale for measuring treatment credibility (3 items) and client expectancy for improvement (3 items). In the larger RCT (Westra et al., 2009), following Borkovec, Newman, Pincus, and Lytle's (2002) adapted scoring strategy, outcome expectations were assessed by clients' responses to an item asking how much they expected to improve by the end of treatment on an 11-point scale (from 0% to 100% in 10-point increments). Previous studies have used a single item to assess outcome expectations and

have found the single expectations item to predict post-treatment outcome (Borkovec et al., 2002; Price, Anderson, Henrich, & Rothbaum, 2008).

Process measures

Client Resistance Code (CRC; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984)—Resistance in the CRC is defined as any behavior that opposes, blocks, diverts, or impedes the direction set by the therapist. The client can express resistance by disagreeing, ignoring, interrupting, etc. but each instance must reflect opposition to or diversion of the direction of the therapist. The CRC has been shown to possess good construct and predictive validity (Chamberlain et al., 1984; Patterson & Forgatch, 1985; Tracey & Ray, 1984), as well as good face and content validity (Bischoff & Tracey, 1995). The present study used an adapted version of the CRC for rating resistance in CBT for GAD (Westra, Aviram, Kertes, Ahmed, & Connors, 2009). Although 11 categories of resistance are defined by the CRC (e.g., challenging, disagreeing, sidetracking, etc.), only an overall rating of the level of resistance was coded in the present study given that the presence of resistance in any form was of primary interest, not the particular type of resistance. Also, in the present study, client interruptions or talking over the therapist in order to oppose, were coded as resistant behavior.

Structural Analysis of Social Behavior (SASB; Benjamin, 1974)—The SASB is a circumplex model of interpersonal relationships that consists of separate surfaces, which represent a particular focus of interpersonal behavior. The *Focus on Other* surface reflects actions that are to, for, or about another person. These behaviors are prototypically parent-like and examples include, affirm, protect, blame, and ignore. The *Focus on Self* surface includes reactions to what is going to be done to, for, or about the self in relationship to someone else. These behaviors are prototypically child-like and examples are separate, disclose, trust, submit, and sulk. In general, during therapy transactions the therapist predominantly focuses on the other (i.e., the client) and the client predominantly focuses on the self.

Each SASB surface consists of two interacting dimensions: a horizontal dimension that represents the degree of affiliation (from friendliness/love to attack/recoil) and a vertical dimension that represents the degree of interdependence (from enmeshment to differentiation). In the SASB cluster model (illustrated in Figure 1) each surface is divided by the two axes into eight possible clusters of behavior that represent different combinations of affiliation and interdependence (Benjamin & Cushing, 2000). The structural fidelity of SASB has been well-established by factor analysis, circumplex analysis, dimensional analysis, and autocorrelation (Benjamin, 1974; Benjamin, Rothweiler & Critchfield; Pincus, Gurtman, & Ruiz, 1998), and the system has been effectively applied to the study of psychotherapy dyads (Constantino, 2000).

Treatment and Training

CBT was based on the manual developed by Borkovec and colleagues (Borkovec & Costello, 1993; Borkovec et al., 2002) and focused on the core features of GAD: chronic hyperarousal, uncontrollable worry, and inhibited emotional reprocessing secondary to worry. The techniques used included thought records, worry exposures, self-monitoring, relaxation training, behavioral approach tasks, and exposure to worry and worry cues. Therapy sessions consisted of six weekly 2-hour sessions, followed by two 1-hour sessions, for a total of 14 hours (see Westra et al., 2009). Therapists were trained as a group. Training consisted of readings, at least 30 hours of discussion and role-play, and weekly group supervision including regular review of videos. Two highly experienced CBT therapists trained and supervised the therapists. In the first session (i.e., the focus of this study),

sessions typically consisted of the client conveying their story and presenting problems, the therapist gathering information about the client's problems (e.g., history, severity, etc.) and the client's treatment goals, presentation of the CBT rationale (typically toward the end of the session), discussion of the structure of therapy (e.g., setting an agenda, reviewing homework, frequency of meetings, etc.), and assignment of homework (e.g., self-monitoring).

Procedure

In the Westra et al. (2009) RCT, clients were randomly assigned to therapists. The ACES was used as a measure of initial expectations and completed at baseline, prior to any therapist contact. The CEQ was completed immediately after the first session of therapy. The CEQ was not administered at baseline since it measures both treatment credibility and outcome expectations simultaneously, and treatment credibility can only be validly assessed upon therapist contact.

Resistance Coding Training and Procedure—The team of resistance coders consisted of four graduate students (all females; 3 Caucasian, 1 South Asian) in clinical psychology (3 doctoral, 1 Master's level) who were trained to criterion over a period of one year by reviewing, coding, and discussing therapy session videos from the larger RCT (Westra et al., 2009) in bi-weekly meetings until adequate inter-rater reliability was achieved (as assessed by coder agreement at 85 percent with the gold standard coder). Sessions were randomly assigned to coders and were coded independently for resistance by each coder. Also, coders were blind to the expectation group status of clients and coded approximately an equal number of sessions across the two expectations groups.

Using, Observer XT coding software (Version 9.0; Noldus Information Technology, 2009), all sessions were divided into 30 second time bins. The length of the time bin was selected based on a review of session tapes that indicated that most resistance episodes could be adequately captured within the time frame of 30 seconds. Each time bin was rated for peak resistance on a four-point rating scale ranging from 0 to 3. A code of 0 indicated the absence of resistance (i.e., co-operation). A score of 1 indicated minimal or qualified resistance (e.g., highly abbreviated or “polite” responses where the client is being evasive or non direct, “Huh?” “Hmmm”, or statements reflecting qualified agreement with the therapist such as “I do the breathing and it helps... but it doesn't fix it”). A score of 2 indicates clear, unqualified resistance (e.g., talking over the therapist in order to oppose, ignoring the therapist, or clear and unqualified statements of disagreement). A score of 3 indicates hostility, combativeness, or confrontation (e.g., client is being overly firm, sarcastic, or directly or indirectly critical of the therapist/therapy). Note that in the extremely rare circumstance where the therapist was speaking for the entire 30 second time bin, resistance was coded based on client non-verbal behavior.

To reduce the possibility of coder drift, reliability was examined continuously throughout the coding process. Inter-rater reliability was calculated by double-coding 20% of all tapes. Intra-class correlation coefficients (ICCs) ranged from .73 to .87, indicating good to excellent agreement. The video for the entire first session of CBT was first coded for the presence of resistance. Following this, resistance and cooperation segments were selected for each dyad. Resistance segments consisted of one or more consecutive time bins that contained a resistance score of at least 2 (i.e., clear, unequivocal resistance). In longer episodes of resistance, the first time bin selected contained a resistance score of 2 and consecutive subsequent time bins with a score of at least 1 or higher were included. Resistance episodes were consecutively selected beginning from the start of the session. The high and low expectations groups did not differ significantly ($t(15) = .74, p = .466$) in the

total session time that was extracted to represent resistance segments (M high expectations = 5.93 min, SD = 3.31, 12 time bins; M low expectations = 6.55 min, SD = 3.48, 14 time bins). Also, the average resistance score across the selected resistance segments did not differ between high and low expectations groups (high expectations: M resistance = 1.70, SD = .284; low expectations: M resistance = 1.69, SD = .241), $t(15) = .09$, $p = .928$.

The cooperation episodes were extracted for each therapist-client dyad by selecting one or more consecutive time bins containing a resistance score of 0 (i.e., absence of resistance or cooperation). Cooperation episodes were consecutively selected after the first 5 minutes of the session (to avoid small talk or orientating comments) until a total of 12 cooperation time bins (i.e., six minutes of videotape) were obtained for each dyad.

SASB coding training and procedure—Coders consisted of three graduate students (females; 2 Caucasian, 1 South Asian) in clinical psychology (2 doctoral level, 1 Master's level) who had received extensive training in SASB coding over a period of two years from the third author who was trained to criterion in the use of the SASB. Training involved an intensive two-day workshop, which included a didactic presentation, as well as coding and discussion of sample materials. Following this, the instructor and trainees met for monthly 2-hour meetings. After training, each of the three SASB coders in the present study met standards for competence in SASB coding (i.e., achieved a weighted Kappa of .65 or greater in comparison to a set of criterion codes). Coding for the present study was conducted using the Benjamin and Cushing (2000) coding manual. Coding was done in pairs, who arrived at a consensus code for each thought unit (i.e., expression of one complete thought). A sample of 100 thought units for each therapist-client dyad were double coded independently by coders to determine reliability. The weighted kappas were good to excellent and ranged from .81 to .94 (M = .88). Coders were blind to clients' expectation group membership and to the hypotheses of the study.

Although there was some overlap in the individuals coding for both measures, a threat to validity is unlikely. Resistance coding involved coding the entire session for multiple clients, whereas the SASB coding was on a much smaller sample of selected clients and selected session segments. Moreover, the resistance coding was done at a separate point in time (a year earlier), compared to SASB coding. Moreover, coders were blind to client outcome expectation status.

SASB data were analyzed in two ways. First, the frequency (percent of total) of each therapist and client behavior served as the unit of analysis. This was calculated by tallying the frequency of each SASB cluster for a given interactant and dividing by the total number of thought units for that interactant. This controls for differences in overall activity levels between client and therapist, as well as between dyads. Here, only therapist data on the Focus on Other surface and client data on the Focus on Self surface are presented. This is because the vast majority of therapist activity was on the Focus on Other surface (i.e., therapist engaging in behavior toward the client such as asking questions, making reflections, offering information, etc.). And the vast majority of client activity was on the Focus on Self surface (i.e., client responding to therapist activity by answering a question, disclosing, etc.). A very low frequency of activity was observed for therapists on the Focus on Self surface (Resistance: range 0% to 2.6% across cluster codes; Cooperation: range 0% to 0.74% across cluster codes) and for clients on the Focus on Other surface (Resistance: range 0% to 3.4% across cluster codes; Cooperation: range 0% to 0.52% across cluster codes).

The second way the data were analyzed involved the calculation of an index of interpersonal complementarity. Here, rather than examining each interactant's behavior independent of the

other interactant, the complementarity index considers the reciprocity between the behaviors of the client and the immediate behaviors of the therapist (and vice versa) on a moment-to-moment basis.

Using the SASB model, complementarity is defined as a response of one interactant to the other interactant that is (1) reciprocal in focus (i.e., participant is focused on self and the respondent is focused on other, or vice versa), (2) correspondent in affiliation, where both participants express the same type and intensity of affect (i.e., friendliness pulls for friendliness, hostility pulls for hostility), and (3) reciprocal in interdependence, where both participants express the same type and intensity of interdependence (i.e., dominance pulls for submission, submission pulls for dominance; Benjamin, 1984; Keisler, 1996). For example, if a client is disclosing and expressing (focus on self, affiliative, taking autonomy), a complementary response for the therapist would be affirming and understanding (focus on other, affiliative, submitting or granting autonomy). If the therapist is nurturing and protecting (focus on other, affiliative, taking autonomy or dominating), a complementary response for the client would be trusting and relying (focus on self, affiliative, submitting).

For each dyad, units of interaction between therapist and client were evaluated for the presence or absence of complementarity. Following Henry and colleagues (1986), for each client and therapist turn at talk, the last thought unit of the speaker and the first thought unit of the responder was included. A complementary interaction unit was considered one that met all 3 criteria for complementarity (outlined above). All others were considered noncomplementary. For each dyad, the percentage of complementary interchanges was derived by dividing the total number of complementary interaction units by the total number of interaction units for the dyad. Further, following Henry et al. (1986), interaction units were separated based on positive complementarity (i.e., affiliative) and negative complementarity (i.e., hostile). No instances of negative complementarity were found and therefore, only positive complementarity was considered in the present study.

Results

Table 1 presents the client demographics as a function of the low and high outcome expectation groups. There were no significant between group differences on any demographic variable. Consistent with other research using the SASB (e.g., Critchfield et al., 2007), there was marked variability in the SASB data. A number of variables were significantly skewed. When the data violated the assumption of normality of the underlying distribution needed for parametric tests, the non-parametric Mann-Whitney U statistic was used to evaluate group differences.

Interpersonal Process During Resistance Episodes

Client behavior—The mean frequency percentage and standard deviation of each SASB cluster of client behaviors on the Focus on Self surface (typical client surface) and between group significance tests comparing low and high outcome expectation groups during resistance are presented in Table 2. Large between group effects were apparent for asserting and separating, disclosing and expressing, and disaffiliative behavior. Each of these between group effects was statistically significant.

To elaborate, the low expectation group separated from the therapist over three times more often (23%) during resistance episodes compared to their high expectation counterparts (7%). In other words, during moments of resistance (i.e., tension in the therapy relationship) clients that went on to have low expectations reduced their affiliative contact with the therapist to act independently and state their own ideas and beliefs, as well as asserting beliefs opposite to therapist suggestions. Moreover, only 38% of the total responses of

clients with low expectations involved disclosing and expressing during resistance episodes, compared to nearly 62% of the responses of the high expectation clients. That is, clients who went on to have low versus high outcome expectations were less likely to openly and affiliatively share their ideas, experiences, and feelings with their therapist during moments of resistance.

Finally, during resistance episodes, clients who went on after the session to have high expectations never engaged in any form of disaffiliative behavior, while those who went on to have low expectations did exhibit such behaviors (5 of 9 clients displayed at least one instance of hostility) and at a significantly higher frequency. Given the low prevalence rate of client disaffiliative behavior, a predictive power analysis was conducted to examine the possible relationship of *any* instance of disaffiliative behavior to outcome expectations post-session. Positive predictive power reflects the proportion of all dyads in which disaffiliative client behavior occurred that went on to have low outcome expectations. Here, positive predictive power was 100%, indicating that if there was any hostile client behavior, there was a 100% likelihood that the client would go on to have low outcome expectations. Negative predictive power reflects the proportion of all dyads in which no disaffiliative client behavior occurred that went on to have high outcome expectations. Here, negative predictive power was 66%, indicating that in the absence of client hostility, there was a 66% likelihood that the clients would go on to have high outcome expectations.

Therapist behavior—The mean frequency percentage and standard deviation of each SASB cluster of therapist behavior on the Focus on Other surface (typical therapist surface) and the between group significance tests during resistance are presented in Table 3. Therapist behaviors during resistance were far less differentiating of expectation groups than client behaviors at these times. No statistically significant between group effects were observed for therapist behavior during resistance episodes.

Interpersonal complementarity—During moments of resistance, dyads in the high outcome expectations group were characterized by positive complementarity in their interactions for the majority of the time ($M = 78.81\%$, $SD = 6.82$), while low outcome expectation dyads showed evidence of positive complementarity only about half the time ($M = 52.33\%$, $SD = 12.24$), $t(15) = 5.41$, $p < .001$. The between group effect size was large at $d = -2.63$, ($CI_{.95} = -3.76$ to -1.22). In short, dyads in the high outcome expectations group exhibited much stronger evidence of positive complementary interactions (client responding to therapist interactional bids and therapist responding to and reciprocating client interactional bids) in the presence of client resistance. The low expectations dyads, in contrast, had more difficulty remaining in affiliative, complementary contact during periods of resistance. Stated differently, at these times, the low versus high outcome expectations group showed substantially more evidence of relational instability and interpersonal tension.

Interpersonal Process During Cooperation

Client behavior—During cooperation, no statistically significant between group effects for client behaviors were observed in the low versus high outcome expectations group. In both groups, clients spent the majority of their time disclosing (low expectations: $M = 74.99\%$, $SD = 18.64$; high expectations: $M = 86.35\%$, $SD = 9.97$, $t(15) = 1.59$, $p = .137$) during cooperation episodes.¹ The remainder of their time was spent trusting and relying on the therapist (low expectations: $M = 24.80\%$, $SD = 12.78$; high expectations: $M = 12.78\%$,

¹During Cooperation, only two client SASB codes were observed. Clients were either disclosing and expressing or trusting and relying. Therefore, increased trusting and relying in the low outcome expectations group suggests that they were engaged in relatively less disclosing and expressing.

$SD = 10.43$, $t(15) = 1.66$, $p = .121$). Also, unlike during resistance, during episodes of cooperation no instances of client movement away from affiliation were observed (e.g., hostile separation). In terms of effect sizes, moderate effects in the expected direction were found for client disclosing and expressing ($d = -.75$, $CI_{.95} = -1.69$ to -0.27) and for client trusting and relying ($d = .78$, $CI_{.95} = -0.24$ to 1.73). In general, clients who went on to have low versus high outcome expectations engaged in somewhat less disclosing and expressing, and somewhat more trusting and relying on the therapist during cooperation episodes.

Therapist behavior—Therapist behavior during cooperation segments of the session were much more differentiating of expectation groups than client behaviors. Large between group effects were observed for therapist affirming and understanding ($d = -1.64$, $CI_{.95} = -2.64$ to -0.47), $t(15) = 3.51$, $p = .004$, and also for therapist attempts to influence by nurturing and protecting ($d = 1.62$, $CI_{.95} = 0.45$ to 2.62), $t(15) = 3.47$, $p = .005$. On average, 93.17% ($SD = 7.32$) of therapist behaviors in the high expectations group were focused on understanding during times of cooperation, compared to 72.16% ($SD = 16.19$) in the low expectations group. Also, therapists of clients who went on to have high expectations spent substantially less time ($M = 6.16\%$, $SD = 7.78$) during cooperation episodes attempting to influence by nurturing and protecting (i.e., teaching, guiding, directing) than therapists of clients who went on to have low expectations ($M = 27.20\%$, $SD = 16.21$). In short, during times of cooperation in the session, therapists of clients who went on to have high versus low expectations spent substantially more time communicating empathy, actively listening, and validating client experiences (i.e., affirming and understanding), while simultaneously relinquishing efforts to control or influence the client.

Interpersonal complementarity—During cooperation, no significant differences in rates of positive complementarity between low and high outcome expectations groups were observed. Both groups evidenced high rates of positive complementarity (high expectations: $M = 85.25\%$, $SD = 12.39$; low expectations: $M = 87.44\%$, $SD = 6.02$), $t(15) = 0.47$, $p = .643$) during cooperation segments of the session.

Discussion

The present study found multiple and marked differences in early therapist-client interpersonal process between clients who went on to have low versus high outcome expectations; despite clients being equivalent in expectations for change prior to therapist contact. This supports the potential significance and possible potency of the therapeutic relationship in relation to client outcome expectations. This study examined the first session of therapy, and the segments of process extracted for intensive analysis generally occurred in the first half of that session. These findings suggest that clients may be formulating and revising expectations from the opening moments of contact with the therapist. Such findings are also broadly consistent with the larger literature on the predictive significance of early treatment factors, such as early alliance (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Pos, 2006; Pos, Greenberg, & Warwar, 2009), early expectations (Constantino et al., 2011), and other early interpersonal processes (e.g., early resistance; Aviram & Westra, 2011; Jungbluth & Shirk, 2009). Taken together, such findings support the significance of even very early therapy contact as important opportunities to potentially influence key proximal outcomes that may go on to impact more distal therapy outcomes.

In treatments such as CBT for example, technical aspects of therapy (e.g., presentation of a treatment rationale, specific interventions), are relatively more emphasized than interpersonal process factors, especially those occurring very early in treatment. The findings of the present study suggest that interpersonal process, even very early process, should not be neglected in initiating clients into, or setting up, an effective treatment

experience. And broadly, to the extent that future research replicates these findings and shows a causal connection, the present study suggests that nurturing client optimism about treatment requires sensitivity to interpersonal process.

What was Happening During Resistance that Differentiated Expectations Groups?

Marked differences in interpersonal process during resistance were present between clients who went on to have low versus high outcome expectations. Most notably, during moments of resistance, the low expectation dyads demonstrated markedly less affiliative complementarity or reciprocity to the other's interpersonal bids. Stated differently, there was much greater evidence of relational conflict and instability during resistance in the dyads who went on to have low versus high outcome expectations. These findings are consistent with previous studies in which good outcome cases demonstrate greater positive complementarity (Henry et al., 1986; Tasca & McMullen, 1992), even in early therapy sessions (Svartberg & Stiles, 1992; Tracey et al., 1999). And the findings of the present study extend such observations to differentiating outcome expectation groups particularly when resistance is present.

Moreover, these findings are also consistent with other studies of CBT indicating that during moments of alliance tensions, CBT therapists can be out of sync with, or nonresponsive to the client (while persisting with their own agenda). For example, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that CBT therapists' tended to persist with the cognitive rationale and techniques (i.e., challenging cognitive distortions) to resolve alliance ruptures (e.g., client avoidance of therapeutic task or unresponsiveness to intervention). And this in part, explained why higher protocol adherence in their study was negatively correlated with outcome (Castonguay et al., 1996). Similarly, a qualitative study of alliance ruptures and rupture resolution in CBT demonstrated that only when CBT therapists attended to ruptures, by being more collaborative and focusing on issues important to the client, did this lead to successful resolution of ruptures (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008).

In interpreting this effect, it is important to note that rates of therapist affiliative behaviors during resistance did not diverge markedly between the expectations groups. For the most part, therapists in both groups were demonstrating predominantly affiliative behaviors in the presence of client resistance (either affirming and understanding, or nurturing and protecting). However despite this, there were marked differences in relational reciprocity (i.e., complementarity). This means that despite being generally equally affiliative to the therapists of high expectations clients, therapists of the low expectations clients were often unable to effectively draw their clients into reciprocating their friendly interpersonal bids when resistance was present. For example, the therapists' efforts to affirm and understand during resistance in the low expectations group were not consistently followed by client disclosure (the complementary response). In general, rather than emitting the expected complementary behaviors, clients who went on to have low versus high expectations were much less likely to stay in friendly harmony with the therapist in the presence of resistance. In contrast, these same friendly interpersonal bids of the therapists in the high expectations dyads were quite consistently effective in inviting and eliciting the client to reciprocate; in essence these therapists were more effective at getting clients to remain affiliative and collaborative in the face of alliance threats (i.e., client opposing, challenging, disagreeing, etc.).

It may be possible that some other quality of therapist affiliative behaviors, not captured by the SASB, is responsible for findings of greater interpersonal reciprocity (complementarity) during resistance in the high versus low expectations dyads. In the SASB, there is not a complex demarcation among responses that qualify as therapist affirming and understanding

(i.e., empathy) for example. That is, therapists' minimal encouragers (i.e., "mm-hmm", "right"), as well as more complex reflections (i.e., deeper attempts to convey understanding) are all coded as affirming and understanding. While minimal encouragers indicating that one is following the client may elicit a complementary response (i.e., client disclosure) when alliance tensions are not present, they may be inadequate in the face of threats to the alliance (i.e., client challenging or opposing the therapy or therapist). And here therapists may need to more deeply and sufficiently communicate understanding of the client's concerns or disagreements. This is similar to Miller and Rollnick's (1995) concept of "words without music" (i.e., the therapist may be saying some of the right things but these responses lack something, or fall flat interpersonally). Also, timing of the affirmation by the therapist has also been suggested as important for therapy process and outcome (Karpiak & Benjamin, 2004). Thus, perhaps during moments of client resistance and alliance tensions, the quality, depth, or complexity of therapist efforts to affirm and understand (verbally and nonverbally) may be particularly important in eliciting the client to remain in friendly, collaborative contact. Interpersonally, such behaviors may communicate that the client is free to oppose the therapist without fear of alienating the therapist. Research further differentiating therapist behaviors during resistance is required to investigate this possibility further.

Client behaviors during resistance—While the high expectancy clients were complementing therapists' friendly interpersonal bids during resistance, the low expectancy clients were much more likely to move away from the therapist (i.e., move away from being affiliative). And this was manifested by: 1) lower rates of disclosing and expressing (an affiliative behavior), 2) higher rates of separation behaviors (which are neutral on affiliation), and 3) the presence of disaffiliative or hostile behavior. These findings are consistent with Henry et al. (1986) who found that clients in poor outcome cases exhibited significantly less disclosure and more trusting and relying. Interestingly, when low expectancy clients in the present study were not disclosing during resistance, they were *not* remaining affiliative (e.g., by trusting & relying), but rather, they were either less affiliative or disaffiliative.

In terms of being less affiliative, low versus high expectancy clients often separated or acted independently by firmly stating their own ideas and beliefs, or asserting beliefs opposite to therapist suggestions. These rates of separation in the clients who went on to have low outcome expectations are particularly high when benchmarked against the only previous study of SASB in CBT for GAD (Critchfield et al., 2007). In the Critchfield and colleagues study, client asserting and separating was relatively rare and occurred at a rate of about 4%. When compared to the rate of nearly 23% in the present study for low expectancy clients during resistance, this is a very large effect size of $d = 3.03$. That is, the rate of client separation behavior during resistance in the present study was substantially higher than the "base rate" of client separation in CBT for GAD (for randomly sampled session segments). This likely underscores the potential of resistance (alliance tensions) to move clients away from remaining affiliative and toward stating their concerns in a more interpersonally distancing manner; an effect which seems to be particularly pronounced among clients who go on to have low versus high outcome expectations. It also underscores the importance of theoretically important therapy episodes in studies investigating in-session therapy processes (Greenberg, 1986).

In addition, clients who went on to have low versus high outcome expectations were observed to exhibit substantially greater disaffiliative or hostile behaviors during resistance. Even though such behaviors were very rare (at a rate of less than 2% of all client behaviors), it is quite remarkable that they were observed as early as session 1 of therapy. Moreover, the predictive power analysis indicated that if any hostile client behavior was present, there was a 100% likelihood the client would go on to have low outcome expectations. These findings

are consistent with other SASB studies, which indicate that even minimal levels of client hostility are highly predictive of lack of engagement with treatment (Macdonald, Cartwright, & Brown, 2007) and poor outcome (Henry et al., 1986).

Taken together, these findings suggest that during moments of resistance, when clients find themselves not having the freedom to oppose the therapist and not talking about or processing their concerns in a friendly, harmonious, and affiliative environment, that this may have important implications for their beliefs in the effectiveness of treatment. Rather, when clients find themselves communicating their disagreements/concerns in a more assertive and distanced fashion, or even behaving in a hostile manner toward the therapist, this may be associated with reduced belief in the ability of treatment to be helpful. Stated differently, maintaining positive client beliefs in treatment may in part, depend on the therapist's ability to create a warm, friendly, and harmonious environment in which the client can freely and openly oppose the therapist/therapy. In such an autonomy-protective context, clients may be able to more effectively raise and process their disagreements and objections without fear of alienating the therapist.

What was Happening During Cooperation that Differentiated Expectations Groups?

During cooperation, marked therapist differences separating clients who went on to have low versus high outcome expectations, were also apparent. Here, expectations groups were differentiated, not on affiliation, but on therapist bids for control. In particular, therapists of clients who went on to have high versus low outcome expectations engaged in substantially more early efforts to actively listen, communicate empathy, and understand the client. Stated differently, therapists of clients that went on to have low versus high expectations engaged in more early attempts to control or influence their clients and were much less exclusive in their early focus on understanding the client.

Thus, the present study highlights the importance of empathy, active listening, and validation of client experiences early in the therapy process. These conclusions are consistent with findings that instruction, advice, and explanation by the therapist in session 1 of CBT were negatively correlated with treatment outcome (Keijsers, Schaap, Hoogduin, & Lammers, 1995). Contrary to the findings from the present study, therapist nurturing and protecting behavior (i.e., affiliative attempts to influence, guide, or teach) has been associated with good outcome in the SASB literature (Henry et al., 1986, 1990). However, the majority of the studies in the SASB literature have assessed later sessions in treatment and have not examined session 1. The findings from the present study suggest that early attempts to control and influence may have negative implications for client early outcome expectations. Stated differently, moving toward proposed solutions prematurely, before having a firm understanding of the client's concerns and experiences, may reduce the credibility of the therapy or therapist; much like a physician who presents a treatment plan before fully understanding the patient's presenting complaints.

Clinical Implications

To the extent that the results of the present study are replicated and causal directions are more firmly established in future research, some specific clinical recommendations in enhancing client outcome expectations can be derived from these findings. In general, enhancing client early expectations for a positive treatment outcome may require a sensitivity to interpersonal process, as well as skill in alliance development. The present study moves beyond previous research by testing *specific* elements of interpersonal process that may be associated with outcome expectations. Very early in therapy, therapists need to actively listen, communicate empathy and make nearly exclusive attempts to understand, rather than seeking to influence or control the client at this early stage. This may be

particularly relevant within CBT, which is typically more directive than other therapies (i.e., encourages therapist control; Blagys & Hilsenroth, 2002).

Equally importantly, a major recommendation that emerges from the findings of the present study involves the detection and management of resistance. Here, therapists need to be careful observers of client responses during moments of client opposition, doubt, or challenging of the therapy/therapist. Therapists should explicitly and continually gage the level of harmony, collaboration, and affiliation in the relationship at these times. In particular, therapists should be watchful of moments when clients are not disclosing their concerns in a friendly manner, but rather are separating by acting independently, asserting beliefs that are opposite to therapist suggestion, and/or are behaving in a hostile manner. When such disharmony, opposition, or client separation/hostility are noted, these can serve as signals for the therapist to shift their behavior in order to stay connected with the client and remain open to hearing client disagreements, objections, or concerns. In essence, at these times, the therapist needs to make it clear that the client is free to oppose, challenge, and redirect the therapist, without fear of jeopardizing the safety (i.e., warmth, friendliness) of the relationship. Even though such moments or resistance are relatively rare, especially early in therapy (Aviram & Westra, 2011), how such tensions are navigated may have important implications for client belief in treatment and, ultimately, for client outcomes.

While it may be very difficult and challenging to hear messages that oppose one's suggestions or preferred directions (due to negative reactions engendered in the therapist at these times, e.g., Binder & Strupp, 1997), being able to do so may be important to preserving and enhancing client belief in the ability of treatment to be useful. This recommendation is consistent with other recommendations in the literature that detecting and effectively managing resistance or alliance tensions is a key clinical skill (Binder & Strupp, 1997; Safran & Muran, 1996). Here, recent efforts to add and integrate Motivational Interviewing (MI; Miller & Rollnick, 2002) into more action-based treatments such as CBT, for a variety of different problems including anxiety, may be particularly useful (e.g., Arkowitz, Westra, Miller, & Rollnick, 2008; Westra, 2012). MI offers therapists systematic instruction in the effective management of resistance (i.e., reframing resistance as nonthreatening and learning to stay affiliative at these times). More broadly, MI also involves adopting a client-centered style in which the therapist consistently expresses empathy and unconditional positive regard, while encouraging client autonomy throughout the therapy process (Rogers, 1957). The findings of the present study support the explicit integration of such skills into more action-oriented therapies such as CBT, by both demonstrating the potential of resistance to derail good therapy process, and linking reduced affiliation and lack of interpersonal responsivity to client optimism about treatment.

Limitations and Future Studies

In terms of limitations, because the research design is correlational, one cannot make causal claims about the interpersonal processes identified in the present study and client outcome expectations. For example, even though baseline expectations were controlled, it is possible that the process differences observed in the present study are the product of changing expectations early in the session. Experimental studies are now needed that involve random assignment of clients equivalent in baseline expectations, to different therapist resistance management styles as well as different therapist behaviors (i.e., empathic versus directive). Such studies should also attempt to measure changing expectations during the session in order to more firmly establish the causal (and likely reciprocal) relationships between expectations and interpersonal process during the therapy session.

Furthermore, the present study had a small sample size (both in terms of clients and therapists), with significant variability on some SASB indices. It is possible that significant

relationships between certain SASB indices and outcome expectations were not observed due to the small sample size. Conversely, because the study was largely exploratory, multiple comparisons were conducted, inflating the probability of Type I error. Future studies, using larger samples (using higher numbers of both clients and therapists) are also needed to increase confidence in the generalizability of the findings. The findings of the present study could be used to make more focal hypotheses in such studies, thus increasing study power. Also, in the present study, therapists were nested within client outcome expectations group. As such, various characteristics differentiating more and less effective therapists (e.g., collaborativeness, warmth, empathy, flexibility; Ackerman & Hilsenroth, 2004; Orlinsky, Grawe & Parks, 1994;) or therapist effects (Wampold, 2001) may be responsible for the findings observed in the present study. Even if this were the case however, the findings continue to suggest that therapist behavior may be related to client outcome expectations and further, that the interpersonal processes observed in the present study may be a mechanism of transmission of therapist effects.

Importantly, the larger RCT from which the data were extracted did not use the same measure of change expectancy at baseline and then again post session 1. Thus, the process differences observed could possibly be due to a client effect that might have been apparent if the same measure of outcome expectations was used repeatedly. Future studies should examine client expectations pre to post session using the same measure in order to more fully control for the possibility of client effects. Moreover, such possible client effects are also of interest in their own right. For example, future studies should also examine individual differences in client pre-treatment outcome expectations (i.e., low expectations as a client factor) and how that may influence interpersonal process. Such investigations are supported by findings of Westra et al. (2011) that clients low in baseline outcome expectations were much more sensitive to the negative impact of alliance ruptures. Also, future studies could investigate other relevant client factors that may be correlated with low outcome expectations and might influence interpersonal process, such as interpersonal style, comorbid disorders (e.g., depression), attachment history, or reactance. Finally, it should also be noted that absence of resistance does not necessarily indicate client cooperation as clients are often reluctant to share their negative reactions with their therapists.

In conclusion, the findings of the present study found that the relational quality between the client and therapist early in treatment is a potentially potent influence on early client outcome expectations. While these findings support future investigation of other factors posited to influence outcome expectations (e.g., presentation of a treatment rationale, hope inspiring statements, highlighting strengths, etc.), the present findings strongly suggest that future investigations of other hope facilitating methods should not neglect the significance of the interpersonal context. For example, the timing of introducing explicit hope promoting methods might be an important consideration. It is possible that presenting a treatment rationale or hope-inspiring statements in the wrong context (such as very early in the session or while the client is disclosing concerns about treatment) might negatively influence outcome expectations. Thus, the findings from the present study suggest that substantial differences in interpersonal process may be associated with client outcome expectations. To the extent that future research replicates these findings and establishes a causal connection, delineation of factors influencing clients' beliefs in the effectiveness of treatment in the context of interpersonal process, may help in identifying strategies for enhancing early client outcome expectations.

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Figure 1.

The Structural Analysis of Social Behavior (SASB), cluster version.

Note. Each surface describes a behavioral focus (on Other or on Self). Vertical axis represents degree of Interdependence; horizontal axis represents degree of Affiliation. This figure is from “Use of the SASB Dimensional Model to Develop Treatment Plans for Personality Disorders, I: Narcissism” by L. S. Benjamin, 1987, p. 53, *Journal of Personality Disorders*, 1, 43–70. Copyright 1987 by Guilford Press. Adapted with permission of Guilford Press, which has been approved by L.S. Benjamin. The words “surface 1” and “surface 2” have been added, while the words “transitive” and “intransitive” have been deleted.

Table 1
Client Demographics as a Function of Outcome Expectations Group

	Low Expectations	High Expectations
Age	$M = 45.33$ ($SD=11.72$)	$M = 40.38$ ($SD = 13.02$)
Gender	6 Female	7 Female
	3 Male	1 Male
Highest Level of Education	4 High school	0 high school
	2 some post secondary	4 some post secondary
	3 post-secondary	4 post-secondary
Ethnicity	6 Caucasian	5 Caucasian
	0 Asian	2 Asian
	1 Hispanic	0 Hispanic
	2 Caribbean	1 Caribbean
Comorbidity	2 anxiety disorder	3 anxiety disorder
	4 depression	2 depression

Table 2
Client Behavior During Resistance as a Function of Outcome Expectations

	Low Expectations		High Expectations				
	Mean	Percent (SD)	Mean	Percent (SD)	Significance Test	Effect Size	95% Confidence Interval
Asserting & Separating	22.93	(12.11)	6.89	(6.80)	$t(15) = 3.42, p = .005^*$	$d = 1.61$	0.44 to 2.61
Disclosing & Expressing	38.13	(22.49)	61.46	(22.37)	$t(15) = 2.14, p = .049^*$	$d = -1.04$	-2.00 to .02
Joyfully Connecting	0		0.15	(.41)	$U = 31.50, p = .289$	$d = -.54$	-1.48 to .05
Trusting & Relying	35.22	(18.64)	28.63	(18.31)	$t(15) = 0.73, p = .474$	$d = .36$	-0.62 to 1.30
Deferring & Submitting	1.26	(2.52)	0		$U = 28.00, p = .169$	$d = .06$	-.033 to 1.63
Hostility Index**	1.74	(2.14)	0		$U = 16, p = 0.017^*$	$d = 1.11$	0.04 to 2.07

Note: Totals do not sum to 100% since therapist and client behavior on the infrequently used surfaces are not included;

* $p < .05$;

** Due to the low base rate of disaffiliative cluster codes (sulking & scurrying: 1.03%, walling off & distancing: 0.71%), they were collapsed together to form a single hostility index

Table 3
Therapist Behavior During Resistance as a Function of Outcome Expectations

	Low Expectations		High Expectations		Significance Test	Effect Size	95% Confidence Interval
	Mean Percent (SD)	Mean Percent (SD)	Mean Percent (SD)	Mean Percent (SD)			
Freeing & Forgetting	1.02 (1.84)	0.0 (0.0)	0.0 (0.0)	0.0 (0.0)	$U = 24.00, p = 0.83$	$d = .76$	- 0.26 to 1.70
Affirming & Understanding	59.59 (16.74)	68.40 (17.04)	68.40 (17.04)	68.40 (17.04)	$t(15) = 1.07, p = .301$	$d = -.52$	- 1.46 to 0.47
Loving & Approaching	0.0 (0.0)	0.63 (1.76)	0.63 (1.76)	0.63 (1.76)	$U = 31.50, p = .289$	$d = -.52$	- 1.46 to 0.47
Nurturing & Protecting	35.01 (11.04)	26.69 (17.01)	26.69 (17.01)	26.69 (17.01)	$t(15) = 1.18, p = .261$	$d = .59$	- 0.41 to 1.53
Watching & Controlling	2.89 (5.94)	0.07 (0.20)	0.07 (0.20)	0.07 (0.20)	$U = 31.5, p = .51$	$d = .65$	- 0.36 to 1.59
Hostility Index*	0.16 (0.47)	0	0	0	$U = 32.00, p = .346$	$d = .47$	- 0.52 to 1.41

Note: Totals do not sum to 100% since therapist and client behavior on the infrequently used surfaces are not included;

* Due to the low base rate of the disaffiliative cluster codes (belittling & blaming: 0.16%, ignoring & neglecting: 0%), they were collapsed together to form a single hostility index