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Towards a Sociocultural and Contextual Paradigm of Court-Mandated Client Resistance

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UNIVERSITY OF MIAMI

TOWARDS A SOCIOCULTURAL AND CONTEXTUAL PARADIGM OF
COURT-MANDATED CLIENT RESISTANCE

By

Adam D. Rosen

A DISSERTATION

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Doctor of Philosophy

Coral Gables, Florida

December 2017

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Towards a Sociocultural and Contextual
Paradigm of Court-Mandated Client
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This grounded theory analysis explored the perspectives of court-mandated psychological service providers to generate new theoretical explanations regarding the cultural and contextual influences on the resistance this clinical population often demonstrates towards their treatment. The study was conducted across multiple mental health care facilities across South Florida. A total of 9 local clinicians participated in interviews and provided feedback on the iterative analysis employed by the current investigation. The ultimate outcomes of the study entailed the co-construction of three major themes and sixteen categories outlining the most salient issues representing how clinicians understand and address resistance in the local context. Themes conceptualizing the phenomenon identified 1) a spectrum of resistance and the treatment process, 2) the vulnerability and disempowerment underlying clients' resistance, and 3) methods of successfully addressing resistance. Based on participant perspectives, a sociocultural and contextual paradigm for conceptualizing resistance is posited along with implications regarding clinical practice and considerations for future research.

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Chapter 1: Introduction

In the past 30 years, court systems across the United States have increasingly incorporated psychological treatments into the sentencing determinations of criminal offenders (Maxwell, 2000; Feder & Forde, 2000). Some of the major influences behind this trend have been cited as the overcrowding of prisons, the reduced costs of treatment programs compared to housing inmates, and a recognition that psychological services may represent a more promising route towards rehabilitation than incarceration (Clear, Clear, & Braga, 1993; Petersilia, Turner, & Deschenes, 1992; Lehmer, 1986).

Unfortunately, since the majority of clinical scholarship tends to focus on work with voluntary clients, understandings of effective work with clients mandated to treatment are limited (Harris & Watkins, 1987; Snyder & Anderson, 2009). It is therefore not always apparent how clinicians can utilize existing literature to inform their work with clients that are coerced by the legal system into treatment.

The underlying issue regarding the transfer of established clinical knowledge to remanded treatments is that the unique set of circumstances created by the interactions between the legal and mental health systems limit the ability to apply traditional clinical knowledge to an untraditional treatment context (Bitar et al. 2014; Honea-Boles & Griffin, 2001; Maxwell, 2000; Snyder & Anderson, 2009). Although a growing body of research has emerged attempting to explore the specific outcomes and efficacies of court-ordered interventions, only limited clinical guidance can be gleaned from the literature. Findings from systematic reviews of the research are consistently characterized by mixed results due to regional and contextual variables that make it difficult to synthesize and compare outcomes from multiple individual studies (Babcock, Green & Robie 2002;

Parhar et al. 2008). Although these studies point to the need for a more thorough understanding of the contextual influences on remanded treatments, continued use of conventional methods of quantitative outcome research may not be the most appropriate way to enhance our understanding of these issues. Instead, addressing the unique aspects of clinical work with court mandated treatment populations might require alternative methods of inquiry to push this area of clinical scholarship forward.

Despite the inconsistencies characterizing mandated treatment outcome research, one issue that is consistently identified in the literature relates to how this clinical population tends to be characterized. Court-ordered clients are often labeled as ‘treatment resistant’ and described as demonstrating negative attitudes towards therapy, lower levels of motivation, and/or problematic behaviors that interfere with the therapeutic process (Cavaiola, 1984; Snyder & Anderson, 2009; Taft et al. 2001). But how do clients become resistant to treatment and what can clinicians do to effectively address this clinical phenomenon? These questions are not easily answered by the available literature and are particularly unclear within the arena of court-remanded therapy.

Client Resistance

Since the inception of psychotherapeutic practice, clinicians have grappled with the fact that some clients will inevitably resist, reject, or otherwise fail to benefit from the therapeutic interventions intended to improve their well-being. This clinical phenomenon represents one of the greatest challenges practitioners will face in their work. Scholarship on the subject tends to converge on this point by recognizing the many problematic behaviors and characteristics of resistant clients. Specifically, discussions of resistance have labeled clients using a range of terms including, noncompliant, uncooperative,

oppositional, hostile, unmotivated, and/ or ambivalent (Beutler, Moleiro, & Talebi, 2002; Moyers & Rollnick 2002; Wachtel, 1982). Although there is a great deal of agreement in terms of describing the negative qualities of clients, the range of theoretical and historical perspectives applied to this issue vary considerably in terms of understanding causes of the phenomenon and associated methods for intervention. The collective scholarship related to client resistance therefore offers multiple, often conflicting explanations for a very broad range of potential behaviors.

In addition to generally discordant theories, the underlying principles and foci of most frameworks are often ill equipped to address the most salient features of court-mandated treatments. For instance, none of the major theoretical conceptualizations of client resistance adequately consider how involvement of the legal system might influence an individual's presentation. Moreover, scholarship attempting to understand resistance in court-mandated settings has only recently begun incorporating ideas from contemporary models of psychology that acknowledge the salience of culture and context on a client's presenting concerns and treatment experience (Baker, 1999; Waldman, 1999). This is a critical gap in the knowledgebase given the pervasive sociocultural disparities that pervade almost all levels of the U.S. criminal justice system (Baumer, 2013; Hunt, 2015; Primm, Osher, & Gomez, 2005; Travis Western, & Redburn, 2014). Most notable within the context of the current discussion is the disproportionate representation of sociocultural minorities within mandated treatment populations (O'hare, 1996; Snyder & Anderson, 2009).

Given the disconnect between existing clinical scholarship and the unique aspects of court-ordered treatments, there is currently no unified theory of client resistance that

can be used in the service of better understanding clinical work with the culturally diverse individuals comprising contemporary mandated treatment populations. Instead, the phenomenon has taken on different meanings across distinct conceptual frameworks and treatment contexts overtime. For the purpose of the current study, the construct of resistance will therefore be considered an umbrella term used to describe any aspect of a client's behavior or attitude that is perceived by the therapist as interfering with the processes and outcomes of treatment. This conceptualization places emphasis on the individual clinician's subjective experience, rather than the inconsistent issues and behaviors representing the foci of established theoretical frameworks.

Purpose of the Study

The purpose of this study is to develop the limited clinical knowledge base associated with clients' resistance to remanded treatments by attending to several salient issues and gaps in the relevant literature. The historical scholarship associated with both court-mandated intervention outcomes and theories of client resistance offer an incomplete understanding of how culture and context influence legally remanded psychological interventions (Arndt et al., 2013; Baker, 1999; Bitar, 2014; Babcock et al., 2008; Beutler et al., 2002; Moyers & Rollnick, 2002; Parhar et al., 2008; Waldman, 1999). Considering the shortcomings of previous scholarship in addressing these issues and the largely subjective definition of resistance posited above, alternative research paradigms capable of exploring the perceptions of clinicians hold the potential to advance our understanding of this clinical phenomenon within court-mandated settings.

The current research intends to employ a qualitative approach to inquiry guided by the principles of grounded theory (Charmaz, 2006; Corbin & Straus, 2008; Glaser &

Straus, 1967). By focusing on the experiences and perspectives of clinicians, this method is intended to facilitate the generation of new theory and explanatory frameworks for understanding the processes and products of remanded treatments. The investigation is specifically concerned with 1) exploring how clinicians of court-mandated treatments conceptualize the resistant client behaviors they may encounter, and 2) elucidating provider beliefs regarding the sociocultural and contextual factors surrounding treatment that might influence their work with a remanded population.

This approach represents an intentional departure from the largely quantitative and deductive paradigms characterizing the relevant knowledgebase, which have thus far been unable to delineate effective clinical practices. The anticipated outcome of this research will be a substantive-level theory of how clinicians conceptualize resistance and their beliefs regarding the sociocultural or contextual influences on court-ordered treatments. Grounded by the perspectives and insights of individuals directly engaged in this work within a specific regional context, findings might serve as the basis for making practical, theoretical, and critical contributions to the clinical knowledgebase.

Chapter 2: Literature Review

The chapter will summarize the most salient issues characterizing the state of court-ordered treatment research, as well as the clinical literature focused on resistance to psychological treatments that motivate the research focus and use of a qualitative paradigm. As an introduction to the context of mandated treatment, I begin with a brief discussion of the primary features of court-ordered therapies that differentiate this area of practice from more traditional clinical work. I then review examples of clinical outcome research focused on court-ordered treatments to highlight the challenges traditional quantitative methods of inquiry have encountered in attempting to establish a robust body of clinical knowledge regarding effective practice. Although findings associated with the treatment outcomes for court-mandated clients are historically mixed, one of the few themes cutting across the literature is the characterization of this population as being resistant to treatment (Begun et al, 2003; Cavaiola, 1984; Snyder & Anderson, 2009; Taft et al. 2001). Given the ubiquity of resistance being mentioned in the literature, I also review the predominant psychological theories that address this clinical phenomenon. Following this, I offer a discussion of how sociocultural perspectives of psychology might enhance our understanding of resistant client presentations within court-ordered treatment settings while reviewing some of the limited examples of scholarship that explicitly attend to the influence of culture and context in this area of clinical practice.

To close the gap between sociocultural theory and mandated treatment research, a qualitative research study will be proposed as a means for better understanding clinical practice with individuals from diverse backgrounds that are court ordered to receive

therapy. Specifically, a largely inductive approach focused on learning through the experiential knowledge of clinicians was specifically chosen because the primarily deductive nature of the extant literature typically fails to address many of the most salient issues characterizing court-ordered treatments. Moreover, as will be demonstrated throughout this chapter, the specific issues in the literature in need of further attention may not be adequately addressed via quantitative research paradigms or existing psychological theory.

What Makes Court-Mandated Treatment Unique?

Despite the apparent differences between many theoretical orientations to therapy, one significant assumption underlying most established models of practice is that the person receiving treatment is doing so voluntarily (Harris & Watkins, 1987, Weakland & Jordan, 1992). As a result, the vast majority of clinical research fails to account for clients that are mandated or otherwise coerced into treatment. This raises the question of whether traditional intervention strategies, which were developed for work with clients voluntarily choosing to participate in therapy, can be assumed to be effective or appropriate for work with mandated populations (Snyder & Anderson, 2009).

When a person is mandated to receive mental health services by the courts or other state agencies, the circumstances surrounding the client's life and their treatment differ considerably from traditional clinical presentations. Some of the most significant points of difference outlined in the literature include the questionable nature of informed consent, significant limitations to confidentiality, the threat of legal sanctions, and the potential for confusion surrounding the professional role of the therapist (Bitar et al.

2014; Honea-Boles & Griffin, 2001; Maxwell, 2000). Together, these issues highlight the need for more focused attention on the processes and context of court-ordered treatments.

To begin putting these issues into perspective, it is important to note that treatment mandates are often made in lieu of some harsher legal consequence (e.g. deferred prosecution programs) or as a condition of being released from custody (e.g. probation, parole). A person's participation in treatment is essentially the result of a forced choice imposed upon them. This calls into question the extent of informed consent as clients may not have an intrinsic motivation to participate in treatment, but simply find the alternative to therapy (e.g. incarceration) to be the more aversive option. Thus, it is argued that true voluntary consent does not exist in the context of the criminal justice system because there is always some degree of coercion or external pressure (Wild, 1999).

Another component of mandated treatment that distinguishes this clinical work from more traditional settings is the reporting of progress to a third party such as the courts, a probation officer, or other entity responsible for the initial referral. Bitar (2014) suggests that this contact with third parties about an individual's treatment creates an important limit to confidentiality with the added threat of legal sanctions. If the patient fails to comply with some aspect of therapy or discloses incriminating information, they can face serious legal consequences. This aspect of mandated treatment has been described as undermining both the goals of therapy and the client-therapist relationship (Bitar, 2014). In these situations, clinicians are faced with an ethical dilemma inherent in their dual role. On the one hand, the therapist is responsible to the client as their provider and tasked with treating the individual's mental health concerns. On the other, the

therapist is also in the position of social control agent responsible for taking into consideration the law and well-being of the community (Bitar, 2014). Burman (2004) highlights the consequences of these conflicting roles:

Combining roles and allegiances places [the therapist] in a double-bind- being simultaneously accountable to the client and the criminal justice system, with varying objectives and focal points. These can interfere with developing rapport and a trusting relationship that are so instrumental in facilitating the goal of client progress and treatment effectiveness. (p.2).

In sum, the unique aspects of court-mandated treatment create a set of conditions that potentially threaten some of the most fundamental conditions of therapy and the therapeutic relationship. Decades of clinical research suggests that issues related to voluntarily entering a trusting therapeutic relationship represent some of the most significant predictors of positive outcomes and thought to be essential ingredients of any effective treatment (Horvath et al. 2011; Wampold, 2010). Unfortunately, the circumstances surrounding mandated treatment seem to undermine these core components of applied psychological practice. It is therefore unclear whether the vast majority of clinical research and the associated practice recommendations generated through work with voluntary clients can be generalized to the unique features of therapy and the therapeutic relationship characterizing remanded treatments. Moreover, the research that does specifically focus on mandated treatments has yet to establish a robust body of knowledge related to treatment outcomes and best practices.

Mandated Treatment Outcome Research

Despite substantial evidence regarding the benefits of therapy with voluntary clients (Horvath et al. 2011; Wampold, 2010), research attempting to establish the efficacy of court-mandated treatments has been characterized by mixed and inconclusive

results (Babcock, Green & Robie 2002; Nicosia, MacDonald, & Arkes, 2013; Parhar et al. 2008). Whereas some studies have found mandated treatment to be equally or more effective than voluntary treatment in reducing criminal recidivism and increasing treatment retention (Prendergast et al., 2002; NIDA, 2000), other research suggests mandated treatments are less effective than voluntary treatments on these same outcome variables (Harford et al., 1976; Parhar et al. 2008). In light of historically inconsistent findings across individual studies, reviews of the literature via meta-analysis represent one methodological approach to making sense of an ambiguous body of clinical research (Roth & Fonagey, 2013).

Parhar et al. (2008) review the disparate findings of research related to remanded treatment outcomes and attempt to directly compare voluntary and coerced treatments via meta-analytic review. The authors center their discussion on conceptual and methodological challenges associated with mandated treatment research positing that the mixed findings of individual studies may be due to inconsistent terminology used to distinguish between mandated and voluntary treatments. The researchers suggest the need for a more precise measure of the level of coercion characterizing treatment. Rather than utilize the dichotomous conceptualization (i.e. mandated vs. voluntary) typically assessed in the literature, the authors created a scheme to assess multiple potential levels of coercion when comparing findings across previous studies. For example, attending a treatment program in response to a judge's order while in jail or some other custodial setting was deemed to represent a greater degree of coercion than treatment associated with a diversion program in the community. In general, results from the meta-analysis suggest that mandated treatments involving the highest levels of coercion had little to no

effect on recidivism rates, and this was particularly true in custodial settings. In contrast, treatments associated with lower levels of coercion produced significant treatment effect sizes that were similar in both custodial and community settings. Although these findings highlight the need to attend more closely to the setting or context of treatment, the authors focus their discussion on the clients and interpret findings through the lens of self-determination theory. Specifically, the authors suggest that offenders' perception of choice and freedom in the more voluntary treatments may account for higher levels of intrinsic motivation and improved outcomes.

Other attempts to systematically evaluate the ambiguous outcomes of mandated-treatment research involve more focused attention regarding the relative efficacies of different approaches used to treat specific offences. Babcock et al. (2002) conducted a meta-analytic review of controlled quasi-experimental and experimental studies in order to compare cognitive-behavioral treatment, Deluth model programs, and other existing domestic violence interventions. Outcome variables of included studies consisted of both official records and victim reports of recidivism. Findings indicated that, regardless of study design, method of reporting, and/or type of treatment, there were no significant differences in effect sizes across the different intervention models. Moreover, effects due to treatment were in the small range ($d = .34$) "indicating that treated offenders showed approximately one third standard deviation in improvement in recidivism as compared to nontreated batterers." (p. 1044). To contextualize their results, the researchers note that in clinical research with voluntary clients, average effect sizes are typically much larger (e.g. $d = .85$) (Smith, Glass, & Miller, 1980). In the discussion of findings and limitations, the authors indicate that the lack of difference between groups supports previous

scholarship suggesting that modern batterer programs tend to blend different elements from multiple approaches, which essentially dissolves meaningful differences when attempting to compare treatments based on their “brand name” labels (Davis & Taylor, 1999; Healy et al., 1998). As a result, several questions arise regarding how clinicians choose which elements they utilize from existing models and how interventions from multiple treatment models are synthesized to achieve positive outcomes. Additionally, the authors make note of the broader regional context of therapy by suggesting that there is likely considerable variation regarding the implementation of mandated treatments within the existing infrastructure of municipal court systems across the country. As a result, the levels of coordination between police, probation offices, and the courts, which vary significantly across different regions and court systems in the U.S., are described as having a potentially confounding influence on the assessment of reoffending and program retention.

These systematic reviews of the literature represent distinct attempts to make sense of the historically mixed findings associated with involuntary or coerced treatments. Although the studies offer limited empirical evidence to support specific clinical practices, the discussions highlight the challenges related to achieving a clear understanding of treatment via existing quantitative research paradigms and point to issues in need of additional inquiry. For instance, both studies underscore the significant implications of treatment context on a mandated client’s experience of treatment and any associated research outcomes. Parhar et al. (2008) underscores the way the therapeutic setting (e.g. custodial vs. community) can interact with the amount of coercion associated with treatment to impact outcomes. Additionally, Babcock et al. (2002) note that regional

differences regarding the level of collaboration between the mental health and legal systems represent a major confound that places serious limitations on attempts to compare mandated treatment outcomes across multiple studies. These contextual variables represent critically important issues for continued research, while also creating significant challenges to research paradigms that require quantifying and comparing outcomes of multiple studies conducted in different settings. As such, alternative methods of attending to the specific issues and circumstances surrounding the treatment in a particular place, or the various contextual influences on therapy are needed.

Another research challenge identified across the discussions of both aforementioned reviews, as well as other related scholarship, is that high rates of treatment attrition and difficulties retaining individuals in studies consistently plagues the outcome research associated with court-mandated substance abuse treatment and domestic violence intervention programs (Babcock et al., 2002; Feder & Forde, 2000; Gondolf, 1997; Parhar et al., 2008). This retention issue serves to further undermine the value of quantitative research since the final data sets being analyzed are comprised of only a portion of mandated treatment referrals. If large numbers of mandated clients fail to complete programs and/or demonstrate reticence to sharing personal information about long-term outcomes, a comprehensive understanding of remanded intervention outcomes will remain elusive.

Arndt et al. (2013) conducted a systematic review of substance abuse treatment programs across the nation in order to better understand the poor treatment completion rates often observed in these programs. Building off previous studies identifying regional and individual differences impacting treatment completion, the study examined

completion rates by state and racial/ethnic group membership. The study included a range of referral sources such as self-referred, employer-mandated, as well as court-ordered. Findings suggest in overall success rate differences among racial/ethnic groups, where Whites had the highest success rates followed by Latinos and blacks. However, there was a significant interaction of race/ethnic group and state, which suggests a differential impact of race across the nation. For example, in the state of Florida, Latino clients were identified as completing treatment somewhat more often than did White clients, while Black clients successfully completed treatment at the poorest rates. These trends persisted even when controlling for other significant client factors (e.g. sex, age, education, employment status, referral source etc.). This study is important because it provides support to one of the major concerns discussed in Babcock et al. (2002) meta-analysis regarding the potential for state-level differences in treatment delivery systems to impact outcomes. It also highlights the need for a more in depth understanding of how individual or cultural differences (i.e. race/ethnicity) can interact with the context and processes associated with state-sanctioned treatments. This is an issue that will be further expounded upon in later sections of the chapter.

Given the potential confounding influence of regional/ contextual variables, poor completion rates, and client differences, court-mandated treatment researchers have experienced significant difficulties collecting and analyzing meaningful quantitative data that is generalizable and capable of informing clinical practice (Arndt et al., 2013; Babcock et al., 2002; Parhar et al., 2008). As a result, synthesizing findings from multiple studies has not been the most effective approach to expanding our understanding of court-ordered treatments. Alternatively, a more focused approach attending to the

processes of therapy, local policies, and institutional infrastructure may be needed to make sense of the clinical practice issues in a particular region and treatment setting.

Despite the ambiguous findings characterizing the literature, one consistent theme running across several discussions of remanded treatment outcomes is that explanations regarding a client's failure to complete intervention programs or otherwise meet the expected levels of participation within the therapeutic process typically involve characterizations of the population as being 'resistant' to treatment (Begun et al, 2003; Cavaiola, 1984; Snyder & Anderson, 2009; Taft et al. 2001). In fact, research assessing this issue consistently identifies mandated clients as demonstrating greater resistance to the therapeutic process and having lower levels of motivation to change than those who seek out services of their own volition (Chamberlain et al., 1984; Rollnick & Miller, 1991). This line of scholarship paints the picture of mandated clients as being a particularly difficult or challenging population with whom to work. However, the tendency to highlight resistant client traits seems disconnected from some of the major findings associated with the systemic reviews of the research outlined above. For instance, a narrow focus on the personality characteristics of individuals seems to ignore the aforementioned potential influence of contextual (regional) and group-level (e.g. race) differences on treatment outcomes (Arndt et al., 2013; Babcock et al., 2002; Nicosia et al., 2013; Parhar et al. 2008). Nevertheless, reviewing the literature related to clients demonstrating resistance to treatment is important in order to become sensitized to existing frameworks for understanding the phenomenon so-often noted in the outcome research.

Traditional Theories of Client Resistance

Historically, several theoretical frameworks have been applied to conceptualizing resistance (Beutler, et al. 2002; Brehm & Brehm, 1981; Moyers & Rollnick, 2002; Chamberlain, et al., 1984). As a result, the definitions of resistance and underlying assumptions regarding why an individual might display resistance to psychological interventions have changed over time and vary considerably across different theoretical orientations. This lack of a unified definition poses a significant difficulty in utilizing scholarship to guide interventions. Nevertheless, tracing the evolution of thought directed at the theorized causes and methods of intervening to address resistance may help identify how to continue pushing understandings of the phenomenon forward, specifically within the context of court-ordered treatment settings.

Psychodynamic perspectives. The psychoanalytic perspective represents one of the earliest schools of psychology to emerge and conceptualize a client's resistance in therapy. Within this framework, resistance to the therapeutic process is often interpreted as the client's unconscious attempt to repress or avoid certain material via defensive transference (Schlesinger, 1982). In other words, resistance to particular issues or topics in therapy is considered as the client's attempt to minimize distress or protect against discomfort. From a psychoanalytic perspective, the resistant material is assumed to relate to a core component of the client's emotional problems. The traditional focus of intervention is to therefore pursue the material associated with the client's resistance in order to increase the person's awareness of the internal feelings and impulses that are being repressed, which are thought to be the cause of distress (Beutler, et al. 2002). Through this lens, the phenomenon is understood primarily as an unconscious and

intrapsychic issue that is resolved by placing the resistance at the center of treatment in order to bring it into the client's conscious awareness.

Behavioral perspectives. In contrast to a psychoanalytic approach of interpreting a deeper meaning to the client's resistance, behavioral models tend to view resistance as more of an inconvenience (Beutler, et al. 2002). When clients choose not to participate in the process of therapy or fail to comply with the requests of the therapist, their behavior interferes with the attainment of treatment goals. As such, the early behavioral approaches to client resistance focus primarily on the patient's noncompliance. Noncompliance is defined as any anti-therapeutic behaviors that undermine the effectiveness of the primary behavioral interventions comprising the treatment plan (Turkat & Meyer, 1982). An example of this within a behavioral paradigm might be a client failing to engage in a homework assignment intended to extend the work of therapy between sessions. Beutler et al. (2002) offer two potential perspectives as to the cause of client resistance from a behavioral orientation. First, noncompliance can appear as an enduring client trait as the specific resistant behavior is assumed to be the result of reinforcement throughout an individual's history of interactions with their environment. In addition, behavioral models also recognize that the specific demands of the therapeutic context may also serve to reinforce noncompliant behavioral responses in the client. Given the consistent role of reinforcement across these trait- and state-like explanations for resistance, behavioral models suggest that the primary method of overcoming treatment resistant behaviors is by modifying reinforcement contingencies that increase compliance within and between therapy sessions (Patterson, 1984).

Cognitive perspectives. More recently, cognitive theories have emerged that focus on a broader set of behaviors to be considered under the continually expanding umbrella definition of client resistance. For example, Brehm and Brehm's (1981) theory of psychological reactance draws on social cognitive theory to understand more intentional and severe forms of client resistance beyond what might arise outside the conscious awareness of clients or be interpreted as simple noncompliance. Psychological reactance is used to describe situations where clients actively rebel against the requests of a therapist or direct interpersonal conflict arises within the therapeutic relationship. Within this framework, the term reactance refers to a motivational state in the client that is likely when a person experiences a perceived loss of freedom or control. Applied to therapeutic contexts, the theory holds that clients are motivated to resist aspects of therapy that threaten their sense of autonomy. Suggested strategies for working with resistance involve maximizing clients' perceptions of free choice within the therapeutic process and minimizing perceptions of therapist coercion. The social cognitive theory of reactance therefore emphasizes the role of cognitions related to interpersonal power dynamics and freedom of choice, which in turn, influence motivations related to treatment.

Contemporary motivational perspectives. One of the most popular contemporary models for working with resistant clients has built on some of the main contributions of the social cognitive framework. Moyers and Rollnick (2002) describe Motivational Interviewing (MI) as "a person-centered, directive approach for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Moyers and Rollnick, 2002 p 185). The authors note that MI was designed to deal with the same type

of psychological reactance that occurs when treatment focused on altering drinking behaviors can threaten a client's sense of autonomy. The model conceptualizes resistance as the product of the interpersonal interactions between client and therapist, rather than a static client trait. MI also draws on learning theory, behavior therapy, and the work of Rogers (1966) in articulating a collection of concrete techniques and a general therapeutic stance towards addressing resistance in therapy. The approach emphasizes the value of reflective listening and expressing empathy when working with resistant clients.

Principles of MI suggest that questions from the therapist should be directed towards developing discrepancies between the client's values and current behaviors. Other fundamental components of the approach include actively avoiding arguments and promoting self-efficacy by conveying hope that change is possible. These therapeutic processes are assumed to ultimately lead to the client's self-generated resolution of their ambivalence and subsequent motivation for behavioral change. Although there is substantial empirical support for the effectiveness of MI strategies when working with substance use behaviors (Moyer et al., 2002), the theory is often assumed to represent a generally beneficial approach to address client ambivalence and other forms of client resistance in a broader range of therapeutic contexts (Mistler, Sheidow, & Davis, 2016; Romano & Peters, 2015).

Summary. The aforementioned models represent examples of the major developments of thought directed at the phenomenon of TR. Taken individually, they offer a somewhat fractured body of knowledge due to the myriad ways the construct has been defined and conceptualized. However, considering these different models as representing an evolving understanding of the phenomena may help identify future

directions for conceptualizing the construct. Whereas the initial models focused primarily on unconscious and intrapsychic explanations, more recent scholarship increasingly recognizes the potential influence of interpersonal dynamics and the demands of the therapeutic situation (Beutler et al., 2002; Moyers & Rollnick, 2002). This represents a shift away from an exclusive focus on individual client traits towards understanding the influence of the therapeutic process on the client's perceptions of autonomy and levels of motivation to change.

Given the continually changing definition of the construct, a client's resistance is best understood as a broad term that has referred to a variety of behaviors by different individuals and orientations overtime. It is therefore important to recognize that definitions of the construct can be influenced by guiding theory and an individual's direct experience with an interpersonal exchange that is perceived as resistant. For the current study, the construct of resistance will therefore be considered an umbrella term used to describe any aspect of a client's behavior or attitude that is perceived by the therapist as interfering with the processes and outcomes of treatment. This conceptualization emphasizes an individual's subjective interpretations while also remaining open to the potential influence of guiding theory or established frameworks that influence how a particular clinician makes sense of their experience.

Tracing the theoretical evolution of scholarship directed at client resistance with voluntary clients helps make sense of the literature and facilitates recognition of the largely subjective nature of the construct. However, it is also apparent that the foci of existing frameworks are ill equipped to address many important aspects of court-mandated treatment. In the aforementioned review of scholarship related to court-ordered

treatments, two important considerations for clinical research in this area were identified. First, the circumstances surrounding court-mandated treatments can exert a unique influence on the therapeutic process compared to voluntary treatments (Bitar et al. 2014; Honea-Boles & Griffin, 2001; Maxwell, 2000). Second, it is necessary to consider the way in which aspects of the treatment setting and regional differences related to the mental health and legal system can influence therapeutic outcomes (Arndt et al., 2003; Babcock et al. 2002; Bitar et al. 2014; Honea-Boles & Griffin, 2001; Maxwell, 2000, Parhar et al., 2008). Together, comprehensive understandings of the salient issues associated with court-ordered psychological intervention require a greater attention to the processes and context characterizing remanded treatments.

Although the development of theory related to client resistance also resonates with increasing attention to process and context, existing frameworks fail to go beyond the immediate therapeutic situation to consider the broader environmental, institutional, and cultural contexts within which the therapy takes place. In light of the expanding set of considerations characterizing the evolving body of clinical literature, a discussion of the sociocultural context of the justice system and models of psychology that are sensitive to these issues may therefore offer the opportunity to continue broadening the scope of analysis applied to client resistance. Specifically, the relationship between the client's culture and the larger systems and institutions influencing both their lives and their treatment.

Sociocultural Inequities of the Justice System

The criminal justice system in the United States has seen burgeoning growth in the last several decades with skyrocketing rates of the number of citizens being

incarcerated or otherwise involved in the legal system (NAACP, n.d.; Glaze & Palla, 2004; Beck, Karberg & Harrison, 2002). This rapid change is often attributed to legislation during the “tough on crime” era of the 1980s, which included the war on drugs and mandatory sentencing policies (Alexander, 2012). However, despite these broad developments at the institutional-levels of U.S. society, the implications of these changes have not had a uniform impact on the different groups comprising the country’s population. Racial minorities and other marginalized groups are consistently identified as being overrepresented within the U.S. criminal justice system and often receiving inequitable treatment compared to individuals from non-marginalized groups (Baumer, 2013; Hunt, 2015; Primm et al; 2005; Travis Western, & Redburn, 2014). It is important to note that racial differences can also interact with issues of social class by potentially affecting the quality of defense and ultimate legal outcomes an individual receives. The American Bar Association has concluded that the public lawyers assigned to low-income minority offenders “too often fail to maintain adequate client contact, and furnish services that are simply not competent.” (ABA, 2004 p. iv)

These circumstances create a backdrop for understanding many of the sociocultural disparities that characterize multiple levels of the justice system. For example, non-whites are often identified as receiving more punitive treatment across the various stages of the criminal justice process from higher rates of arrest to longer lengths of incarceration compared to white men in similar legal situations (Hamparian & Lieber, 1997; Harrison & Karberg, 2004; Spohn, 2013). Additionally, people of color make up about 37% of the total U.S. population, yet they represent 67% of the prison population (Sentencing Project, n.d.). These trends persist in terms of court orders to psychological

treatment as research has identified legally remanded clinical populations as being disproportionately comprised of sociocultural minorities (O'hare, 1996; Snyder & Anderson, 2009).

Although a discussion of possible causes for disparities is beyond the scope of the current investigation, the aforementioned demographic issues characterizing the U.S. justice system suggest that sociocultural identity can influence a person's outcomes moving through the legal system and the cultural diversity represented in court-mandated clinical populations. Scholarship concerned with the impact of these societal conditions on individuals and communities consistently describes how the members of marginalized groups often develop distrust, suspicion, and hostility towards the criminal justice system as well as other institutions of U.S. society (Anderson, 1994; Keyes, 2009). Thus, it is necessary to recognize that inequities at the systemic levels of society and sociocultural disparities represent a salient component of the broader context surrounding court-mandated treatment and that these conditions likely shape clients' experiences of any psychological intervention associated with their legal status. However, none of the major models of resistance offer guidance regarding how consideration of these issues can be incorporated into the conceptualization of a client's resistant treatment presentation. Fortunately, other areas of psychology may offer insights that facilitate the incorporation of sociocultural and contextual issues on court-referred clients' resistance.

Sociocultural and Contextual Perspectives of Resistance

Over the past several decades, critical attention directed at psychology has identified limitations to many of the theories and research findings that have historically dominated the field. Specifically, the Eurocentric values and individualistic perspectives

underlying many frameworks of psychology, which often reduce conceptions of psychological concerns as deficits located inside the individual, have been criticized for ignoring the influences of culture and context on well-being (Prilleltensky, 1989; Sue, Arredondo & McDavis, 1992). Bronfenbrenner (1989) posited a framework for addressing this shortcoming of the field, which moves away from historically individualistic conceptions of human psychology by recognizing multiple levels of a person's ecological context that shape development. This particular framework conceptualizes individual development and well-being as the product of interactions between aspects of the person (age, race, sex, etc.) and a series of nested systems that characterize their environment. The various systems comprising this multi-leveled model, include families, communities, institutions, systems and cultural ideologies that vary by historical time-period and place.

In-line with this shifting paradigm for understanding human development in context, entire sub-disciplines of psychology have emerged such as multicultural and community psychology. Although these two areas of study are characterized by distinct foci within the general field of psychology, they often reflect a shared emphasis on understanding people in the context of their environments, addressing cultural diversity, and promoting social justice (Goodman et al. 2004; Prilleltensky & Nelson, 2009; Sue & Sue, 2008). These fields have also expanded conceptions of psychological phenomena to consider the way in which sociocultural identity and societal institutions interact with each other to influence individuals' experience of the world and their general well-being. Although this type of sociocultural and contextual lens seems well suited for understanding the intersection of the criminal justice and mental health systems, these

areas of psychology have not been widely incorporated into the contemporary discourse of resistance in court-remanded treatment settings.

Multicultural psychology. Multicultural psychology is often associated with understanding how the research, training, and practice of psychology can be adapted to appropriately address sociocultural issues (APA, 2003 Griner & Smith, 2006; Sue & Sue, 2008). In the context of applied psychology, the concept of multicultural competence suggests that recognizing the influence of culture on well-being is not simply a method of enhancing clinical case conceptualization, but a critical component of ethical psychological practice (APA, 2003; Welfel, 2013). Several scholars suggest that considering a client's culture is essential to developing an accurate understanding of presenting concerns, the context in which they developed, and appropriate intervention strategies (Gallardo & Curry, 2009; Griner & Smith, 2006; Leong & Lee, 2006).

One of the earliest and most widespread frameworks for adapting professional practices to be multiculturally competent focuses on clinicians' developing knowledge, awareness, and skills related to the cultural dynamics of the professional relationship (Sue & Sue, 2008). That is, a clinician must acquire knowledge about the common values and experiences associated with their clients' cultures, develop self-awareness regarding their own potential cultural biases that might play out in the relationship, and demonstrate the skills to incorporate this information into culturally responsive practices (Pedersen, 2003; Sue et al., 1992). For example, the experience of racism and discrimination has been linked to adverse physical and psychological health outcomes (Pieterse et al., 2012). Ethical and culturally competent practice would therefore require ongoing consideration of a culturally diverse client's experience of discrimination in their everyday lives as well

as within the therapeutic relationship. Ultimately, attending to the cultural dynamics between the client and therapist, as well as the client and the broader society are thought to be fundamental to the development of empathy, a working therapeutic relationship, and a treatment plan that accurately addresses the client's concerns (Pederson, Crethar, & Carlson, 2008).

These aspects of multicultural psychology represent an expanded set of considerations that are able to account for both the unique contextual issues characterizing court-ordered treatments and the sociocultural disparities in the criminal justice system, which likely influence client experiences navigating the legal and mental health systems. A multicultural perspective also suggests that accurately understanding any client behavior in treatment requires attention to issues of cultural difference within the therapeutic relationship. According to this framework, it is assumed that failure to recognize these critical aspects of the client's experience can lead to the client feeling misunderstood or discriminated against by their therapist, the therapist selecting culturally inappropriate and ineffectual interventions, or other detrimental effects on the process and outcomes treatment (Pedersen, 2003, Sue & Sue, 2008). In other words, the lack of cultural competence could foster the same types of interpersonal misunderstandings and problematic client behaviors that could easily be interpreted as resistance. Unfortunately, these sociocultural considerations are very rarely applied to discussions of court-referred clients' resistance to psychological services.

Waldman (1999) offers one of the few attempts to incorporate principles of multicultural psychology into understandings of resistance. The author posits a set of guidelines for working with multicultural court-ordered clients with a case study of an

actual treatment experience with a Latin-American man ordered to counseling after physically disciplining his son. This blend of a conceptual article and qualitative case analysis identifies several cultural and contextual issues that facilitate conceptualizing the client's resistance during treatment. For example, the author notes that many of her court-ordered minority clients enter treatment with a tendency to blame the system or to see their culturally different therapist as an agent of the state responsible for overseeing a punishment. The author suggests that value differences existing between the client's culture and the U.S. legal system play an important role in how an individual might develop this perspective. In the case example, the author notes that, in the client's country of origin, physically disciplining a child would not be an issue for which the state would intervene or mandate therapy. This exemplifies the different attitudes that exist toward child rearing and state sanctioned mental health interventions across different cultures and areas of the world. The anger and resentment that can develop in clients when they are subject to an alternative set of norms and system of laws are recognized as critical factors in understanding the client's behaviors and experience of treatment. To overcome this form of client resistance, the author suggests that therapists must expand their professional role and serve as a mediator between the norms and values of different cultures. By exploring issues of acculturation and the client's worldview, the author frames the therapeutic process as a method of assisting the client in navigating the different value systems characterizing their own and the dominant culture. Some specific examples of additional useful clinical interventions posited involve educating clients about a number of issues including, how the dominant (Anglo-American) system

operates, what is expected of them throughout the legal process, and the potential benefits of therapy.

Baker (1999) offers another example of culturally sensitive clinical work with treatment resistant clients from diverse backgrounds. Also utilizing a case-example approach, work with an African American mother mandated to treatment for suspected child abuse/neglect is described. The author notes that during the initial stages of treatment, the client demonstrated a variety of treatment resistant behaviors, such as anger, denial, and suspicion towards the various caseworkers and social service professionals she encountered. However, adopting a systemic lens towards understanding the relationships between the client's culture, social agencies, and the therapist's own cultural biases helped reveal some of the iatrogenic effects of the social services intended to help the client. Specifically, the multiple state agencies, mental health professionals, and legal sanctions rapidly thrust upon the client's life contributed to her perceiving the services as controlling and aversive, rather than supportive and capable of promoting her well-being. The author also emphasizes the importance of therapist self-awareness. She describes coming to the realization that her own veiled racist and discriminatory attitudes, which were shaped by aspects of her culture and religion, informed her initial opinions of the client before they even met. Recognizing these cultural and contextual influences on the therapy is framed as critical for understanding how the client's resistance developed and identifying an appropriate course of intervention. First, the therapist recognized the need to identify and suspend her preexisting beliefs about the client and instead adopt a culturally curious approach to learning about the individual through their direct interactions together. The therapist then established a sense of "coordinated freedom" by

listening to the client's perspective of her situation and subsequently allowing the client to play a bigger role in determining the structure and content of therapy. These actions helped create a process that promoted the client's participation, avoided subjecting the client to discrimination, and provided the client a role in the identification of her needs. To meet these needs, the author describes taking on the role of negotiator between the client and the various professionals associated with the case. Facilitating communication between the client and the multiple agencies helped establish a common understanding of the situation. Specifically, the client's initial anger was reframed as a communication of her deep desire to regain custody of her children. Promoting this perspective across the organizations involved in the client's life facilitated the client's willingness to participate in the social services that would help her achieve her goal. In so doing, the client's relationship with the larger system also shifted as she came to be seen as successfully complying with her legal mandates, which fundamentally changed a major source of her psychological distress.

Community psychology. Whereas multicultural theory is primarily concerned with adapting existing practices of psychology to incorporate cultural information (APA, 2003), community psychology is often associated with a more critical stance towards the field and its impact on society (Society for Community Research and Action [SCRA], 2010). For instance, several scholars link the birth of community psychology to a lack of confidence in social institutions, such as the criminal justice and mental health care systems (Rappaport, 1977; Sarason, 1988). Since the discipline's inception, community psychologists have consistently challenged the status quo of conventional psychological interventions aimed at changing individuals while ignoring aspects of societal institutions

and systems that have adverse effects psychological well-being (Evans, Rosen, & Nelson, 2014). As such, the promotion of social justice is both a defining value and target outcome in community psychologists' work, which is typically concerned with critiquing and transforming the organizational, community, and institutional levels of society (SCRA, 2010).

Prilleltensky (2012) argues that issues of fairness and justice are a critical component of psychological well-being. The author proposes a more refined definition of social justice that distinguishes between distributive and procedural justice. Whereas distributive justice refers to the fair distribution of resources, obligations, and opportunities, procedural justice relates to fairness and respect characterizing the human interactions and decision-making processes by which those allocations are determined. In other words, procedural and distributive dimensions of justice are defined by their respective foci on fairness in process and fairness in outcome. The author further outlines multiple levels of analysis for considering the impact of these two aspects of justice on wellness. These levels of analysis include individual relationships (micro-level), organizations (meso-level), and the institutions of nations and society (macro-level). In light of the sociocultural disparities responsible for the overrepresentation of minorities within mandated treatment populations, community psychology's apropos focus on systems and social justice may offer valuable insights for understanding aspects of clients' experiences with the criminal justice and mental health systems. Specifically, in terms of the processes and outcomes that might influence resistance presentations. Unfortunately, no existing clinical model of resistance explicitly incorporates discussion of procedural and distributive injustices into understandings of the phenomenon.

Summary. The considerations associated with multicultural and community psychology offer valuable considerations and frameworks for understanding some of the most salient features of court-mandated psychological services. Although the relationship between systemic injustices and well-being associated with community psychology has yet to be incorporated into understandings of resistance, select examples of multicultural scholarship have begun outlining the way sociocultural considerations can enhance clinical conceptualizations. This suggests the potential value of continued incorporation of sociocultural and contextual issues into the research and practice associated with court-mandated treatments. It is also important to note that the specific research methodology employed by the aforementioned multicultural analyses involved qualitative analysis of clinicians' experiential knowledge. As such, discussion of qualitative research paradigms is warranted.

Qualitative Inquiry

Qualitative research is well suited to addressing situations in which a given phenomenon has not been fully developed or needs further exploration (Corbin & Straus, 2008). Despite a significant amount of previous scholarship on client resistance and court-mandated interventions, current understandings of the phenomenon in this setting remain incomplete. Moreover, the above review of issues related to both the relevant theoretical and empirical literature in this area consistently points to the need for more information regarding the influence of culture and context on the mandated treatment process (Arndt et al., 2013; Babcock et al., 2002; Moyers & Rollnick, 2002; Nicosia, et al., 2013; Parhar et al. 2008). Given the nature of this information and the difficulties

associated with quantifying and measuring these aspects of the therapeutic experience, qualitative methods of inquiry represent a promising way forward.

Previous qualitative research studies suggest that a significant amount of clinically valuable information can be gleaned by tapping into the practical knowledge of providers directly carrying out court-mandated treatments (Baker, 1999; Waldman, 1999). Within a qualitative research paradigm, the experiences of individual clinicians represent the primary source of data used to generate clinical insights about an area of practice. Thus, through exploring clinician perspectives of the sociocultural dynamics characterizing their clients' relationship to therapy and the larger systems surrounding treatment, novel frameworks for understanding sociocultural context and addressing client resistance in remanded settings might be identified. This approach to generating knowledge represents a significant point of distinction from the accumulated body of knowledge related to client resistance and court-mandated treatments. Whereas most previous scholarship tends to utilize a top-down approach of beginning with a theory and applying its underlying principles to the conceptualization of phenomenon, the case analyses by Baker (1999) and Waldman (1999) reverse the direction in which psychological knowledge is typically created. That is, learning from the perspectives of clinicians directly experiencing what happens on the ground and subsequently building up to treatment recommendations or theoretical explanations. Although the therapist-authors perspectives were likely informed by some of the major tenets of multicultural psychology, the concrete examples and real-world issues identified from practical experience lead to novel insights beyond that which is offered by existing theory.

Despite the apparent value of the qualitative information within the aforementioned cultural analyses, it is worth noting that there may be some limitations to the author-therapists' singular perspectives and their use of an individual case approach (Baker, 1999; Waldman, 1999). Although the authors' application of multicultural psychology revealed the value of these frameworks within remanded settings, it may also be a significant source of bias. It is important to note that the scholarship reflecting the perspectives of culturally competent clinician-authors is not likely to be representative of the majority of individuals working in the field. Most clinicians who work in remanded settings will inevitably vary in terms of the extent of their multicultural training. It would therefore seem to be critically important to hear from a variety of voices regarding the cultural dynamics of court-remanded treatments, including individuals who may not necessarily have the same strong multicultural orientation as individuals authoring articles on the subject. Despite these shortcomings of individual studies, qualitative research methods exploring the experiences of clinicians seem to hold potential to generate valuable information about the role of culture and context when working with court-mandated clients and the resistant behaviors they may demonstrate.

Current Study

The purpose of this study is to address the theoretical and methodological shortcomings of the literature related to resistance in court-mandated treatment settings with culturally diverse clients. In the absence of a unified theory of client resistance and limited attention to the sociocultural dynamics contextualizing remanded therapies, the current investigation seeks to better understand these issues by exploring clinician-perspectives of their work. Given the nature of this information, qualitative methods of

data collection and analysis will be used to focus on how actual clinicians of court-mandated treatments conceptualize resistance while also exploring their views regarding the potential influence of culture and context on treatment. When a theory is unavailable or fails to provide a full understanding of a phenomenon, an inductive approach guided by the principles of grounded theory can help address shortcomings in the knowledge base by generating information from the ground up (Creswell, 2007).

The grounded theory approach offers a systematic method of generating new explanations or theories of phenomena (Corbin & Straus, 2008). Although select case-examples by multicultural scholars have begun illuminating the value of considering culture and context when conceptualizing the treatment resistant behaviors court-ordered clients may demonstrate (Baker, 1999; Waldman, 1999), more information is needed regarding how a wider range of clinicians manage a variety of cultural differences, the actual intervention strategies being used in their work, and the range of sociocultural or ecological factors that potentially influence the treatment process. In exploring these issues, I hope to identify relevant barriers to treatment and practical strategies for achieving positive clinical outcomes with culturally diverse clients in remanded settings. The anticipated product of this research will be a substantive-level theory of how clinicians actually conceptualize client resistance that considers potential cultural and contextual factors associated with court-ordered treatments. Grounded by the perspectives and insights of individuals directly engaged in this work, findings might serve as the basis for new explanations for understanding and addressing the phenomenon in the local context and potentially beyond.

Research Questions

- How do clinicians define client resistance?
- What do clinicians believe to be the cause of resistant client presentations?
- What are clinician perspectives regarding the influence of culture and context on client resistance or other salient aspects of the treatment process?
- What is the impact of cultural differences/similarities in the therapeutic relationship on the process of therapy? And how might this affect treatment process and/or outcomes?
- Are there other salient local ecological or contextual factors affecting clients' lives and influencing treatment?

Chapter 3: Method

Researcher Positionality

Understanding how a researcher's identity determines their positionality, or situates their perspective, is a critical component of interpretive research projects. Several scholars call for specific attention directed towards a range of issues, including the researcher's personal history, sociocultural identity, values, philosophies, and the analytic framework(s) to which they subscribe (Denzin & Lincoln, 2005; Harry, 1996). These aspects of the researcher are important to consider prior to a discussion of the research design because they hold the potential to exert an influence on all stages of the research process. Both the questions being asked and the lens through which the data are interpreted can be shaped by these researcher characteristics. Harry and Rippey (2008) describe the development over time of how it has become necessary for researchers to "examine their role in the construction of knowledge through attaching their accounts to a personal analysis of how their own identity and cultural affiliations affected their interpretations" (p.17). The following discussion and many of the research procedures outlined below represent an attempt to remain transparent and mindful of the researcher's experiences that influence the outcomes of this interpretive researcher paradigm. As such, prior to outlining the specific aspects of the research procedures, the following discussion of personal history and experience is intended to situate my perspective towards the research that will inevitably be reflected in the study outcomes.

My interest in conducting research in the realm of court-ordered treatments stems from my own clinical training and employment positions providing a range of

psychological services to clients involved in the legal system. Some of my earliest experiences involved work within dedicated substance abuse programs comprised of both voluntary and legally remanded referrals in New York City. More recently, I have accumulated assessment, individual, and group therapy experiences with patients involved in several of the special problem-solving court systems in Miami-Dade and Broward counties, including family court, drug court, and the veteran treatment court. These experiences occurred across private practices in the community, university training clinics, and hospital settings. Practicing in these settings has allowed me to develop an insider's perspective of what it is like to be a clinician working with individuals coerced into treatment by the legal system. I have also witnessed first-hand many of the unique aspects of mandated treatment and the resistance clients often demonstrate. Through these clinical experiences I have established relationships with mental health professionals and various agencies associated with court-mandated treatment throughout South Florida. This experience and position within the community enhances my ability to access pertinent information from local providers in my current attempt to explore provider perspectives of court-referred clients' resistance. As will be outlined below, the specific sampling strategies used to identify participants leveraged my existing relationships to the individuals and settings within the local context.

Throughout my clinical experiences, I could not help but recognize that many of the concepts from my multicultural training and social justice orientation to counseling seemed well suited for an area of practice that lies at the intersection of the mental health and criminal justice systems. It is worth noting that I am a white male currently receiving

a graduate education. These dimensions of identity lie in stark contrast to many of the racial/ethnic minority clients that often do not have the same level of access to the educational and employment opportunities that I have experienced throughout my development. In light of these salient cultural differences characterizing the majority of my professional relationships with mandated clients, I attribute my ability to overcome resistance and achieve positive outcomes to my extensive multicultural training and orientation to practice. Despite my perception of the ways my own work was enhanced by explicitly attending to the sociocultural influences on well-being, it was apparent that these frameworks of psychology are poorly represented within the dominant clinical discourse of court-ordered treatment settings.

These aspects of my background represent the primary motivations for the current research project and will therefore be important to remain cognizant of during the implementation of the research procedures and interpretation of results. I continue to believe that sociocultural frameworks represent a set of considerations that may help expand the clinical knowledgebase. However, I have also witnessed many of my colleagues with little to no multicultural training achieve positive outcomes with their remanded clients. These experiences and preexisting beliefs hold the potential to influence the current project. As such, the inductive aspects of the project, the specific grounded theory approach, and the methodological considerations that will be outlined in this chapter were specifically chosen to help protect against potential researcher bias. Rather than utilizing existing sociocultural frameworks formulate a new explanation of client resistance, the current research paradigm begins by exploring other clinicians'

perspectives of their own work in order to build up to a theory that is grounded in actual experience with the local context.

In addition to these important aspects of my previous experience and motivation to conduct this research, Blumer's (1969) discussion of symbolic interactionism provides a useful framework for further understanding the intersubjective epistemological lens through which this investigation is conceptualized. The author defines symbolic interactionism as an orientation to the study of social life, which rests on the following three premises. First, the author posits that human beings' actions in the world are based on the meanings they ascribe to their experiences. Second, it is necessary to recognize that these meanings do not form in isolation, but arise through a social process of interacting with the self and others. Finally, the author notes that it is important to consider meaning making as an on-going process of interpretation and modification based on one's direct, first-hand experiences in the social world. This framework helps illuminate the role of intersubjectivity involved in clinicians' experiences of client resistance as well as the interpretive analysis of participant perspectives captured during interviews.

Although, I seek to learn more about the role of culture and context on the treatment process, the ultimate outcomes of this study are intended to accurately represent the perspectives of the clinician-participants. Being explicit about my own preexisting experiences, assumptions, and orientation towards generating new knowledge through research is intended to help the reader assess the extent to which the study represents a valid and authentic account of the participants' experiences. The following discussion outlines the research procedures carried out during this investigation.

Aim of the Study

In the absence of a unified theory of client resistance that is capable of accounting for the cultural and contextual issues surrounding court-ordered psychological interventions, the current investigation sought to begin addressing these gaps in the clinical knowledge base. The primary concern of this exploratory research was to: 1) learn more about how clinicians of court-mandated treatments understand and address the treatment resistant behaviors their clients may demonstrate and, 2) elucidate these clinicians' beliefs regarding sociocultural and contextual factors that might influence the processes and outcomes their work. Given the limitations of established theories in addressing these issues and the difficulties quantifying and measuring the aforementioned aspects of mandated treatment, a qualitative research approach was utilized to explore the perspectives of providers engaged in clinical practice. Guided by the principles of grounded theory, the research sought to generate new theory or explanatory frameworks that might be used to inform legally sanctioned treatments in South Florida.

Grounded Theory Approach

Glaser & Strauss (1967) developed the grounded theory methodology as a way to create new contextualized theories that are 'grounded' in data. Grounded theory represents a deviation from many traditional research paradigms that often attempt to impose the constructs of pre-existing theories onto the analysis and explanation of phenomena that exist in an ever-changing social world. The deductive nature of many traditional research paradigms can be problematic if the guiding theory of the investigation was developed without consideration of all pertinent issues surrounding the topic of research. Alternatively, a grounded theory is "discovered, developed, and

provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon” (Straus & Corbin, 1990, p.23). In other words, the inductive aspects of grounded theory require starting with the data and subsequently building up to a novel theory directly linked to the important issues characterizing the phenomenon of interest.

Although several different models of grounded theory have evolved over the last 50 years, the most fundamental feature of the approach involves an iterative process of data collection and analysis in order to abstract theory or identify novel explanations of phenomena in the social world (Charmaz, 2006; Glaser & Straus, 1967; Straus and Corbin, 1990; Corbin & Straus, 2008). Points of divergence between the various models of grounded theory often involve the details related to conducting the analysis and/or ontological and epistemological disagreements (Lauridsen & Higginbottom, 2014). With these potential differences in mind, the current study was informed by models of grounded theory that are best equipped to address the research questions. Given the research aims of learning about resistance and the influence of sociocultural/ contextual influences on remanded treatments through exploration of clinicians’ perspectives, research procedures influenced by both Charmaz’s (2006) and Corbin and Straus’s (2008) models of grounded theory will be integrated to address these specific concerns.

Procedures that align with Charmaz’s (2006) Constructivist Grounded Theory (CGT) will be incorporated into the current research due to the largely subjective nature of a clinician perceptions of resistance and the intersubjective epistemological orientation noted above. For example, CGT recognizes that findings of a grounded theory analysis are not intended to capture some objective aspect of reality, but instead represent an interpretation of the multiple realities co-constructed by the researcher and researched

(Laurisdson & Higginbottom, 2014; Wertz et al. 2011). As such, use of research methods posited by Charmaz (2006) reflects an acknowledgment of the interpretive and socially constructed nature of not only client resistance, but also the analysis and final research products. In addition, one of the guiding principles of CGT is to give voice to the participants, in this case the service providers, who's experiences are largely absent from both the theoretical literature related to client resistance and quantitative research related to remanded treatments. These additional considerations of CGT facilitate accessing a largely untapped source of data by exploring clinicians' perspectives and experiential knowledge for the purpose of building new theory.

Corbin and Straus (2008) propose a systematic analytic framework for grounded theory intended to facilitate the researcher's ability to capture human interactional processes experienced by the participants, while also attending to the potential influence of the greater context from which the data is derived. The model utilizes specific predetermined analytic categories to address these issues and places emphasis on the meaningful organization and structure of the data during the analysis. Given the current research questions related to exploring clinician perspectives of the sociocultural dynamics, contextual issues, and intervention strategies associated with their work, the employed methodology was influenced by Corbin and Straus's (2008) method. However, the analytic process of this research did not attempt to adhere to the highly structured, predetermined analytic categories associated with the axial coding paradigm outlined by the researchers. Instead, the axial coding process was utilized to address issues relevant to the research aims while also recognizing the value of a meaningful structure of the coded the data.

Several aspects of the current study's design and research procedures were informed by the recommendations and research processes noted by the aforementioned approaches to grounded theory. Specifically, the sampling, data collection, and analytic procedures utilized. Following a discussion of these issues, aspects of the research design intended to ensure the trustworthiness (Guba & Lincoln, 2005; Lincoln & Guba, 1986; Shenton, 2004), or methodological rigor of the qualitative study is reviewed.

Purposeful Sampling

In grounded theory research, sampling, data collection, and analysis are intimately linked. These aspects of the research were therefore carried out in way that created a cyclical process of identifying participants, collecting data, conducting analysis, and seeking out additional perspectives to further refine the emerging understanding of the phenomenon of interest (Charmaz, 2006; Corbin & Straus, 2008). Several purposeful sampling techniques were employed at distinct phases of the research project, which involved identifying individuals with relevant insights or experiences to facilitate the development and expansion of a theory (Bogdan & Biklen, 1998).

At the outset of the investigation, initial sampling was employed. Charmaz (2006) describes initial sampling as the first step in identifying individuals in the local context with the experiences or perspective that can speak to the research questions. Since the purpose of the current study was to learn more about clinicians' perspectives of their work facilitating treatment with court-remanded clients in South Florida, three local providers with whom I was acquainted were recruited for initial exploratory interviews. These clinicians were chosen based on having at least ten years of experience working with court-mandated clients in Miami-Dade County.

As the content from initial interviews was analyzed and preliminary properties of the data were revealed (see data analysis section for more information), additional theoretical sampling was employed. Theoretical sampling refers to seeking out additional participant perspectives to help explicate emerging understandings of the data, which serves the purpose of conceptual and theoretical development (Corbin & Strauss, 2008). Since contacts with participants during initial interviews revealed that a limited number of clinicians and organizations take the majority of court-mandated referrals in Miami, recruitment for additional participants employed networking techniques (Gal, Gall, & Borg, 2003). As such, previously interviewed providers were utilized in identifying additional individuals with relevant experience to contact for participation in the study. This process was repeated until theoretical categories were “saturated” (Corbin & Strauss, 2008). See data analysis section for more information regarding theoretical saturation.

Participants

A total of 9 individuals with experience providing court-referred psychological services in South Florida participated in this study. Participants’ practice experience in the local context ranged from 3-37 years; however, many had additional forensic psychology experiences in other regions of the country. In terms of professional backgrounds, participants included 5 clinical psychologists, 3 licensed mental health counselors, and 1 doctoral candidate in psychology. The doctoral candidate is currently working in the field due to a previously obtained terminal master’s degree in counseling. These individuals work across three different local agencies, one hospital, and several private practices. The primary treatment populations characterizing participants’

professional experience related to court-mandated substance abuse, domestic violence, and/or mentally disordered sex offender (MDSO) programs. Anger-management, parenting training, various in-home therapies, and multiple psychological assessment and evaluation experiences were also noted during participant interviews. The majority of these experiences focused on outpatient treatment contexts with only limited discussion referencing experiences with local custodial settings (e.g. jails). Table 1 presents pseudonyms and additional relevant demographic information for the nine study participants.

Table 1

Participant Information

Pseudonym	Age Range	Gender	Race/ Ethnicity	Years of Experience	Previous Contact
Annie	30-39	F	White/Latina	<15	Y
Crystal	30-39	F	White/Latina	<15	Y
Diana	30-39	F	Biracial	>15	Y
Derek	60-69	M	White/Euro	>15	Y
Fran	40-49	F	White/Latina	>15	N
Julia	30-35	F	White/Latina	<15	Y
Leo	40-49	M	White/Latino	<15	N
Mary	60-69	F	White/Euro	>15	Y
Summer	30-39	F	White/Euro	<15	N

It is important to note that due to my own extensive experiences working with court-referred clients in South Florida and the relatively small community of providers in this area, I had varying degrees of pre-study contact with six of the individuals participating in this study. The remaining three participants were individuals with whom I was not previously acquainted. These individuals were identified by participants interviewed during the initial and theoretical sampling phase of the data collection through the network sampling method noted above (Gal et al., 2003).

My preexisting relationships with participants have both positive and potentially negative implications for the current research. On the one hand, possible shared experiences within the same settings facilitated my ability to establish rapport and inform my interview questions due to my familiarity with the individuals and settings comprising the local treatment community. On the other hand, this also held the potential to exert a negative impact on my interactions with participants. For example, it is possible that a participant may have been uncomfortable sharing certain aspects of their perspectives or experience due to the nature of our preexisting relationship. This information is made explicit here to facilitate assessment of the processes and outcomes of the research.

In order to better contextualize individual participant perspectives and capture the sociocultural dynamics characterizing their experiences, a subsection of this chapter was initially created to present detailed participant profiles including information related to their previous experiences, training, and other aspects of their backgrounds. The intention was to have this information available for reference when encountering participant quotations included in the presentation of findings. Unfortunately, due to the relatively small number of providers in the local context, it seemed that certain background information could potentially reveal particular participant identities if encountered by other local clinicians. As such, this narrative was removed and only basic demographic information is directly associated with the participant pseudonyms as noted in Table 1.

Data Collection

Clinician interviews represented the primary source of data in the current investigation. All nine participants engaged in semi-structured interviews of at least one hour. Four of the nine participants engaged in a second follow-up interview to expound

upon content from their initial interviews or to further refine emerging understandings of issues identified within the iterative analysis. Researcher field notes were also utilized as a supplemental data point. Participants' interpersonal styles and affective reactions to certain topics of discussion were the primary examples of meaningful content captured through field notes, which were not always made explicit by participant discussions. Together, these data collection procedures focused on building an understanding of how clinicians perceive and experience the resistance their clients may demonstrate. A second interview focus was to pursue information regarding the clinician perspectives of sociocultural or contextual factors that might expand understandings of the salient human-interactional processes and client behaviors characterizing remanded treatment. These foci were considered during both the collection and analysis of data. Additionally, throughout the analysis, the researcher maintained theoretical sensitivity to existing scholarship reviewed in the previous chapter and the major issues associated with mandated treatment research, theories of client resistance, multicultural theory, and community psychology (Strauss & Corbin, 1998).

A semi-structured interview protocol (Appendix A) was created to facilitate participants' discussion of issues pertinent to the current research aims while also offering the opportunity to expand on issues that might not have been identified at the outset of the data collection process (Patton, 2002). Based on findings from the iterative analysis and participant feedback regarding findings, several issues of inquiry were pursued throughout the course of the data collection process in order to more deeply explore issues raised by participants and refine the developing theory. This blend of establishing a set of core issues to explore while maintaining a flexible approach to the

direction participants chose to take discussions helped ensure that findings were not constrained by the researcher's preconceived notions or data collection methods.

Efforts were made to conduct interviews at the actual settings in which the clinician-participants work or arrange other opportunities for on-site access by the researcher. Of the nine providers participating in this study, only two individuals were unable to meet at the site of their current clinical practice. One of these individuals was interviewed at a coffee shop, the other via phone. During the initial stages of the project, naturalistic observations and field notes were included as data collection procedures. As such, a systematic approach to observing the environments and processes characterizing the research setting was employed to develop a fuller understanding of the factors that contextualize remanded treatments (Lincoln & Guba, 1986; Corbin & Straus, 2008). However, given the complexity of collecting data in settings with patients and the risk of including potentially identifying information about providers based on their employment settings, none of this information was used in the final analysis.

Data Analysis

Interviews served as the primary data source for the current investigation. The content of participant interviews was recorded, transcribed, and converted into electronic documents. Relevant field notes were also digitized. All electronic documents were imported into NVivo 10 computer software (QSR International, 2012) for analysis. All background and identifying information shared by participants during the initial portion of the semi-structured interviews was separated from transcripts to preserve participant confidentiality. In addition, all audio recordings of interviews were destroyed upon completion of the analysis.

The analytic process was guided by principles of grounded theory and the constant comparison approach to handling data (Charmaz, 2006, Corbin & Strauss 2008, Harry Sturges & Klinger, 2005). This analytic method represented an iterative process of data collection and analysis that highlights the inductive components of developing a grounded theory (Charmaz, 2006; Corbin & Strauss, 2008). Starting at the most basic units of data and moving through several analytic iterations from the “ground” up, open codes, code families, categories, and themes were created to capture the meaning and relationships among findings. Following a description of these multiple levels of analytic coding and data organization, the role of memo writing, data audits, and the concepts of theoretical sensitivity and saturation will be reviewed as they relate to the employed analytic design.

Charmaz (2006) describes open coding as the first step to analyzing data in grounded theory research. Open coding of interview data involved taking each segment of digital text that represented a complete idea or action and giving that unit of information an initial descriptor code. Similar ideas or actions were grouped together and assigned the same codes. For instance, one participant noted that her “patients have antisocial traits” when asked to reflect on potential causes of client resistance. As such, “patients have antisocial traits” used as an “in vivo” open code since it captured a single unit of data that was both meaningful and vivid (Charmaz, 2006). Open coding was conducted on all interview transcripts

Following the open coding, a more focused coding process was used to create code families. Focused coding represented the first level of organizing the basic units of data and involved the beginnings of identifying the conceptual relationships in the data

(Charmaz, 2006). For example, when another participants' discussions referenced personality disorders as a perceived cause of client resistance, the "antisocial traits" and "personality disorders" codes were both organized into a "psychopathology" code family. Other participant data that referenced mental health problems contributing to resistance were grouped together under this same code family.

The third level of coding involved taking similar code families and grouping them together into conceptual categories that capture a common meaning. Corbin and Straus (2008) refer to this process as axial coding as it reflects the idea that common codes are grouped together at their "axes" or intersections. Harry, Sturges, and Klinger (2005) emphasize the increasingly interpretive nature of this step in the coding process as it reflects further movement away from simple description of the data towards increasing abstraction of meaning. Thus, categorization at the conceptual level attempted to identify the relationships between similar open codes and code families. As noted above, the interpretative process involved in identifying relationships during axial coding focused on the meaning assigned to human-interactive processes and sociocultural/contextual issues that clinicians perceived as influencing mandated treatment and their clients' resistance. The axial coding process therefore facilitated developing explanations regarding the influence of context on treatment, the way in which the therapeutic relationship develops in these settings, and the actual strategies clinicians use to achieve positive outcomes.

Once open codes and conceptual categories were refined, thematic analysis was conducted (Charmaz 2006; Corbin & Straus, 2008). This involved the creation of overarching theoretical or thematic groups, which describe the relationships among

conceptual categories. Thematic categories reflect the highest level of abstraction of the data. The final themes intend to offer a theoretical explanation for the primary research questions regarding how clinicians conceptualize court-mandated client resistance and their beliefs about the potential influence of culture and context in this area of practice.

Charmaz (2006) describes the use of analytic and reflective memo writing throughout the constant comparative process as an important analytic tool during the increasingly interpretive coding phases. The author notes that memos can be used to facilitate researcher reflexivity while conducting the research. As such, reflective memos allowed for documentation of researcher experiences and reactions to the research process. Additionally, the author states that analytic memos can be used to guide the developing organization and interpretation of data by elaborating the boundaries of emerging categories and specifying relationships among them. Memo writing was used throughout the analysis and directly influenced theoretical sampling. Specifically, memos facilitated the identification of additional information related to incomplete categories and the need to address lingering questions about the relationship between codes, code families, categories, and/ or themes (Corbin & Strauss, 2008). The analytic software utilized in the current study allowed for memos to be written and directly linked to relevant data, which facilitated the analysis. Moving back and forth between memo writing and theoretical sampling helped ensure that the codes and categories were robust and that relationships among them were fleshed out. As noted above, data from the additional theoretical sampling involved identifying new participants for interviewing, returning for follow up interviews with the existing participant group, and intentionally

seeking out the perspectives of clinicians with alternative points of view. Data from these processes underwent the same digitization process outlined above.

Strauss & Corbin (1998) offer a caveat regarding the influence of previous scholarship and experiences on a grounded theory investigation. The authors note that exposure to literature or other information through experience can threaten the inductive aspects of the project by creating a bias in the researcher, which can constrain the analysis to existing theories or personal beliefs. Nevertheless, other researchers highlight that qualitative investigations “cannot be conducted without the conscious or unconscious use of underlying theoretical perspectives. These perspectives inform methodology, guiding theory, questions pursued, and conclusions drawn” (Broido & Manning, 2002, p. 434). Review of the literature is therefore intended to develop theoretical sensitivity to the major issues influencing the conceptualization of the current study and the models or frameworks that will be considered when interpreting findings (Strauss & Corbin, 1998). Thus, the scholarship and findings outlined in the previous chapter were considered when interviewing participants and analyzing data, but significant efforts were taken to ensure the data-collection processes remained open-ended and interpretations of data were not biased.

In light of the iterative nature of moving back and forth between identifying new participants for data collection and analysis, the criteria set forth by Corbin and Strauss (1998) regarding theoretical saturation and the discontinuation of theoretical sampling was used. First, gathering fresh data no longer revealed new or relevant information. Second, the categories constructed in the analysis were well developed in terms of their

properties and dimensions. Third, relationships among categories were well established and validated by member checks.

Member Checks and Data Audits

After conducting a total of 13 interviews with nine providers, member checks and an audit by a third party researcher served as methods used to protect against misinterpretation of meaning and potential researcher bias. Specifically, two participants engaged in a formal member-checking process of reviewing the themes, categories, and code families constructed by the researcher (Lincoln & Guba, 1986). These member checks represented participant contacts that were distinct from the primary and follow-up interviews outlined above. The two participants that provided member checks of the data met separately with the researcher and confirmed fidelity of study findings with their reported experiences. Additionally, auditing of data by a third-party researcher was also used to solicit feedback from a researcher's perspective not involved in the data collection process. This procedure was intended to facilitate the identification of researcher biases or flaws in study procedures (Maxwell, 1996). For example, the primary researcher's advisor received deidentified transcripts and the member-checked coding structure in order to provide an additional review of the interpretive analysis. No major changes to the analysis were identified upon completion of the member checks or third-party research audit and no additional data was collected thereafter.

Trustworthiness

The aforementioned data collection and analysis procedures were guided by specific considerations outlined in the literature intended to ensure the rigor of qualitative investigations. The construct of trustworthiness is often used in qualitative research to

address the degree of confidence in a study regarding its ability to provide a comprehensive and accurate account of a phenomenon (Marshall & Rossman, 1995; Shenton, 2003). Lincoln and Guba (1986) set out four interrelated criteria for establishing the trustworthiness of a qualitative investigation including, credibility, transferability, dependability, and confirmability. Although more recent writings related to the validity of qualitative investigations have offered theoretical and philosophical critiques related to the best methods of determining a study's authenticity (Denzin & Lincoln, 2015), the following discussion provides a brief overview of the four components of trustworthiness and the associated ways in which they were operationalized in the current study design.

Credibility. Credibility is concerned with the 'truth value' of findings from a qualitative investigation (Lincoln & Guba, 1986). Given the constructivist epistemological underpinnings of the current study and the recognition that findings represent an interpretation of multiple realities co-constructed by the researcher and participants, several research considerations help ensure that the study's outcomes adequately represent those multiple constructions. These include 1) prolonged engagement, 2) persistent observation and thick description, 3) triangulation of data sources, 4) negative case analysis, 5) researcher reflexivity, and 6) utilizing multiple methods of auditing findings (Creswell, 1998).

Prolonged engagement refers to the need for researchers to spend a sufficient amount of time in the research setting and in contact with the phenomenon of interest. This form of immersion is necessary in order to gain access to both formal and spontaneous social processes that would characterize an emic, or insider's view of the phenomenon (Harry & Rippey, 2008). Lareau (2000) describes the way in which

extensive contact with the research setting facilitates the researcher's ability to construct complex descriptions of the interactions and processes that comprise social reality. My aforementioned experiences facilitating mandated treatments highlight the level of prolonged engagement within the context and phenomena associated with the research. This previous contact with the population, setting, and service providers was used in the service of identifying participants in the local community, and building rapport with the clinician-participants during data collection. Previous experience with the clinical population was also used to inform interview questions that might address the salient processes and experiences of client resistance in remanded settings.

Whereas prolonged engagement is associated with understanding the scope of the phenomenon under investigation, persistent observation has been described as a means of providing information in-depth (Lincoln & Guba, 1986). Documenting observations with thick description refers to describing the circumstances surrounding the phenomenon of interest in a detailed and nonjudgmental manner. Attending to the formal and informal interactions that take place in the research settings offered the opportunity to identify possible discrepancies between what participants say and do, or identify subtleties of their interactions in the setting that may not be articulated during interviews (Charmaz, 2006). Although a substantial portion of observations were not incorporated into the analysis, persistent observation of the settings and the interpersonal interactions during the interviews via field notes often served as the basis for reflexive memos that did influence the analytic outcomes of the study related to the relational style of participants.

Negative case analysis was also used as a strategy that further highlights the iterative nature of theoretical sampling in grounded theory and the importance of

considering multiple perspectives. Lincoln and Guba (1986) suggest that as the analysis of data leads to the identification of common experiences that might inform a developing theory, there is value in intentionally seeking out individuals who may hold alternative points of view or contrasting experiences. For example, although the initial interviews were conducted with providers working in the field for decades, subsequent theoretical sampling for additional participants specifically targeted individuals that were earlier in their careers to explore potential differences in perspectives linked to career stage development. This type of negative case analysis captured the level of complexity and nuance reflected within the actual experiences of individuals. Consequently, this led to a more comprehensive account and increased confidence in the study findings.

In recognizing the interpretive nature of qualitative inquiry and the researcher's role as the research instrument, reflexivity is another important consideration throughout the data collection process. Researcher reflexivity refers to systematically attending to the construction of knowledge taking place at every step of the research process (Harry and Rippey 2008). Inherent to this is the acknowledgement of the impressionistic, or subjective nature of any study's outcomes (Van Maanen, 1988). Enacting this during the current study required the researcher to attend to personal biases and interpretations that may influence interactions with participants or the analysis of findings. Reflexivity therefore represented an attempt to evaluate the degree to which findings reflect a neutral or biased account. As such, documenting reflective field notes, documenting observational comments on transcripts, and drafting analytic memos were utilized throughout the research. Information regarding shared aspects of participants' interpersonal styles during interviews represents one example of how reflexivity was

used to attend to the researcher's experiences during data collection. It also reveals how these reactions to the process were incorporated into the study findings.

Finally, methods of auditing the data collection and analytic process were incorporated into the study procedures. These activities were intended to protect against misinterpretation of meaning and potential researcher bias. As noted, participant member checks and an audit by a third party researcher served as the primary means of reviewing products of this interpretive analysis.

Transferability. The transferability criterion of trustworthiness relates to the question of whether the findings produced by a qualitative investigation are applicable to other situations or populations (Creswell, 1998; Shenton, 2003). It is worth reiterating that the primary focus of a grounded theory investigation is to generate novel theories or explanations of phenomenon in a particular context, rather than identifying some generalizable truth or set of facts. In the current study, the research sought to accurately represent the participant-clinicians' perspectives of their work in a particular time and place. Nevertheless, the potential to transfer the products of a grounded theory investigation to other settings depends on the degree of similarity between sending and receiving contexts (Lincoln & Guba, 1986). For example, information related to the types of treatment programs characterizing participant experience, demographics of the clinical population, backgrounds of clinicians, features of the clinical setting (i.e. outpatient vs. inpatient), and aspects of participants interpersonal style were intentionally noted throughout the data collection and analysis. This information is also described throughout the presentation of results. Attention to these issues served to document the circumstances and salient aspects of the environment surrounding the phenomenon of

interest with sufficient detail to allow the reader to consider the applicability of findings to an alternative receiving context (Lincoln & Guba, 1986).

Dependability. Shenton (2003) describes the dependability of a qualitative investigation as being related to enabling future researchers to repeat the work and assess the appropriateness of the research practices utilized. This author outlines two techniques that were used for meeting this criterion in the current study. First, thorough documentation of the research design and its implementation was intended to capture the minutiae of precisely what was done in the field. Secondly, attempts were also made to engage in ongoing reflective appraisal of the research process and its effectiveness. It is for these reasons that significant attention devoted to both detailed descriptions of the study procedures and researcher reflexivity. Outlining and justifying the specific research procedures (e.g. sampling techniques, member checks) was intended to enhance transparency regarding the research design. The aforementioned use of reflexive field notes and analytic memos enabled documentation and evaluation of how the researcher enacted the investigation and arrived at the conclusions reached.

Lincoln and Guba (1986) highlight the way auditing data can also be used in service of meeting the dependability criterion. The aforementioned detailed documentation of the study procedures facilitated the creation of an audit trail. This permitted the researcher's advisor, who was not directly involved in carrying out the project, to provide evaluative feedback. This notion of auditing findings also serves as the foundation of the final component of trustworthiness, referred to as confirmability.

Confirmability. The confirmability criterion is concerned with reducing researcher bias. Shenton (2003) notes that "steps must be taken to help ensure as far as

possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher." (p.72) All the aforementioned research processes related to the other components of trustworthiness also address the confirmability criterion. The detailed, data collection procedures that facilitate the creation of an audit trail for member checks and peer debriefing help describe how interpretations of data were co-constructed to ensure the final products of the research resonate with the participants perspectives. Additionally, the predispositions and salient experiences of the researcher were outlined at the beginning of this chapter to specifically enhance transparency of the investigation.

Chapter 4: Results

In order to review the findings of the current study, I begin by presenting the theoretical statements constructed to address the primary question of the overall investigation: *How do clinicians understand and address resistance demonstrated by court-mandated clients?* Following this, I provide an in-depth discussion of the three overarching themes used to organize findings and answer the following subquestions of the research:

- How do clinicians define client resistance?
- What do clinicians believe to be the cause of resistant client presentations?
- What are clinician perspectives regarding the influence of culture and context on client resistance or other salient aspects of the treatment process?
- What is the impact of cultural differences/similarities in the therapeutic relationship on the process of therapy? And how might this affect treatment process and/or outcomes?
- Are there other salient local ecological or contextual factors affecting clients' lives and influencing treatment?

Subsections within each thematic discussion represent the data codes and categories upon which the themes and theoretical statements are based. Appendix 1 includes the full list of themes, categories, and descriptions of code families that align with the structure of the current chapter. Poignant quotations from participant interviews are included throughout

the discussion to further explicate codes and code categories by staying as close to the data as possible. Additionally, sharing examples of the actual participant statements is intended to demonstrate the process by which the analysis and interpretation of data lead to the current hierarchical data organization.

A Grounded Theory of Court-Mandated Client Resistance

Based on participant-clinicians' shared perspectives and professional experiences with court-referred clients in the local context, the following theoretical statements were constructed. First, these local providers perceive client resistance as a critical issue that typically arises at the outset of the professional relationship within court-mandated settings. Resistance was conceptualized as a spectrum manifesting in a variety of forms and on a continuum of subtle to overt attitudes and behaviors, which often include a specific gendered dimension to the phenomenon. The root-cause of resistance was believed to be vulnerable and/ or disempowering affective states experienced by the client in response to complex interactions between the individual client's background and multiple levels of that person's sociocultural and ecological context as they move through the mental health and criminal justice systems. The most salient issues contributing to these feelings of vulnerability and disempowerment believed to be the antecedents of client resistance, include clients being subjected to values that conflict with their cultural beliefs, their negative previous interactions with the justice system, specific aspects of the mandated treatment process, and the social dynamics of their communities. Although perspectives regarding successfully addressing resistance placed emphasis on the value of certain provider qualities and the need to learn through clinical experience, participants identified the following strategies for reducing resistance that focus on building a

working relationship with their clients: 1) navigating cultural differences, 2) joining with the resistance, 3) explicit clarification of roles and responsibilities, 4) building rapport by distinguishing themselves from the system, 5) selling the potential benefits of services, and 6) leveraging group dynamics.

A Spectrum of Resistance and the Treatment Process

Given the lack of a unified definition of client resistance in the literature, I was specifically interested in how clinicians actually working in the field identify and describe this clinical issue. Interviews provided an overview regarding some of the general features associated with the process of court-referred mental health services, which situated resistance as a critical issue impacting the outset of the professional relationship. Participants outlined a range of experiences commonly encountered in their work and perceived as client resistance. Based on this information and feedback from participants, resistance was defined as a construct that can manifest in multiple forms. Descriptions of resistance ranged from subtle to increasingly overt attitudes and behaviors. There was also a gendered dimension to certain perceived experiences of resistance. The following discussion is intended to organize the information provided by participants regarding what they define as client resistance and when this issue arises during the course of treatment. It also establishes a mutually agreed upon definition for conceptualizing this clinical issue in the local treatment context.

Initial resistance and the process of treatment. Participant discussions aligned in their descriptions of the initial stages of the legally sanctioned psychological services they provide. In response to the open-ended inquiries about their experiences, participants consistently referenced their clients' resistance as a defining feature of their work that is

most typically encountered at the outset of the professional relationship. They also described experiencing this resistance as a challenging aspect of their professional activities and indicated the need to “work harder” or often experiencing a more “laborious” treatment process compared to work with self-referred clients. However, it was apparent that the resistance they experience is not always a constant component of their experiences with clients and that even initially resistant clients can experience changed attitudes towards treatment. Crystal succinctly described the variable course of her clients’ resistance suggesting that “with time, a lot of them break down their barriers and are able to be more open and objective about group, whereas others will be resistant the entire time they are in group.” The prevalence of resistance across participant discussions helps establish the ubiquity of this issue with court-referred clients in the current context and highlights its clinical significance at the outset of treatment. It is also important to note that although it was evident that resistance can, and often does decrease, several clinicians reported instances of their clients completing an entire course of treatment without any perceived benefit and remaining resistant across contacts.

Subtle manifestations of resistance. Several attitudes and behaviors were interpreted as implying a client’s resistance to treatment. Commonly experienced examples of the more subtle forms of resistance included failure to comply with treatment requirements and hesitance to engage in the treatment process. Missed appointments represented one of the most frequently identified issues. Additionally, participants noted that many clients that would otherwise be considered “treatment compliant” are often prematurely terminated from services due to absence, lateness, or failure to pay treatment fees.

In addition to these issues of compliance with attendance and payment requirements, slightly more direct examples of resistance related to clients' failure to demonstrate the expected levels of participation during provided services. Clients were often described as "unmotivated", not actively engaging in the process, sitting quietly and/or responding only to direct questions. Diana attempted to describe the underlying attitude believed to be responsible for her clients' limited participation as she shared:

I think the resistance can look like doing the bare minimum. When it comes to homework or showing up, they're told you have to attend at least X number of groups and you see them barely hit that mark with a real lackadaisical attitude.

Clients were also described as displaying reticence in terms of open and honest disclosure. Providers characterized their clients as often demonstrating "denial", "avoidance", or "guardedness" within clinical contacts, particularly when the focus of discussion relates to the underlying legal issues responsible for their referral for services. Mary described the difficulties this resistance to disclosure can create as she reflected on the difference between mandatory and voluntary substance abuse treatments:

I guess one challenge is trying to do the work when it's like pulling teeth to get them to talk about pretty standard stuff like what triggers them to use and how to cope with urges. And it shouldn't be because lots of these guys were smoking pot every day for years and now all of the sudden court says you need to stop, you need to be abstinent and we are going to randomly drug test you. Like that's a pretty big change in behavior patterns, but they often just deny ever feeling triggered and say they're all good. This is when you need to figure out what's actually going on. Sometimes they're afraid to talk, other times they think they are telling me what I want to hear or are just full of shit. It can be difficult to tell so yea that's definitely a common challenge.

This response highlights the ambiguity underlying several of the implicit manifestations of client resistance and the role of the provider's interpretation of attitudes and behaviors. It also touches on another common issue characterizing participant discussions, which was a general tendency to question the veracity of client disclosures or outright label the

population as dishonest. During the final contacts with participants reviewing the analytic findings, it was established that these implicit forms of resistance were grouped together because they were described as interfering with the provision of services while also requiring the clinician to make assumptions about the meaning or intentions underlying a client's behavior.

Overt manifestations of resistance. Although the aforementioned implicit manifestations of resistance were experienced across the various settings comprising participants' professional practice, the majority of participant discussions focused on more direct manifestations of the phenomenon. Several participants provided examples of their clients' expressing suspicion towards their providers. In describing her experiences with particularly resistant clients, Summer offered examples of the type of exchanges that clearly demonstrate a common form of resistant client attitude as she shared:

They might be explicit and say, 'What do you know about the legal system and what I'm dealing with' or 'You've never had to encounter crime in your life, how can you help me?' And then this attitude becomes a hurdle I need to jump over before I can even do my job. So, it takes the form of lots of questions. Questions about me. Questions about the value of therapy.

Other providers similarly noted that it was common for clients to take issue with the focus of their remanded services and they often demonstrated help-rejecting attitudes and behaviors. For instance, Julia described some of her most difficult experiences as being the facilitation of court-mandated parenting classes as she often experienced her clients say things such as "I don't need you to teach me how to be a parent. I don't need the courts to teach me how to be a parent."

Participants frequently referred to their clients as having difficulties taking responsibility for their behaviors by "externalizing" blame or "fighting" the

circumstances surrounding their arrest or referral. In the most extreme examples, words like “hostile” and “aggressive” were commonly used to describe direct interpersonal struggles between clients and providers. Many interviews contained discussions of clients being “openly challenging” or described instances of patients being “outright disrespectful” during clinical contacts. When asked to elaborate on the way his clients “push-back” or demonstrate resistance to their treatment, Leo shared:

Oh lord, I’ve seen some craziness in my forensic practice. I’ve been cussed out. I’ve only received one death threat come to think of it. I’ve had to call the police about a few patients for getting into physical fights with each other or coming here high. I think those are some good examples of what you might call resistance.

Indeed, throughout discussions, the participant group was consistently able to offer instances of directly experiencing challenging interpersonal conflicts with clients. Moreover, these experiences were described as defining feature of the field.

Gendered dimensions of resistance. In addition to the direct and indirect manifestations of resistance often experienced by participants, discussions revealed experiences of resistance that were perceived to be directly related to gender. In fact, both male and female participants specifically mentioned a need for women providers in this field to remain cognizant of sexually suggestive or inappropriate behaviors sometimes demonstrated by male clients. For instance, Crystal noted that she has experienced her clients “flirting or not respecting the professional boundaries of the relationship.” This gendered dimension of resistance was perceived to be so common in the local context that both male and female supervisors noted that they often directly address this issue with their female supervisees. Derek elaborated on this issue as he described the type of discussions he has in supervision:

We talk about boundaries, especially with the women. If they know you are new, our forensic patients have been known to ask out our providers, to ask personal questions, to have problems with physical boundaries. With the females, I cover all that up front.

Other participants made references to problematic power dynamics involving male clients having difficulties taking suggestions from women or trying to dominate young female providers. Although many of these client attitudes and behaviors reflected both implicit and explicit manifestations of resistance, these experiences were grouped into their own category as they were described as impacting only the women providers and therefore seemed to represent a unique dimension of resistance warranting its own discussion.

The Vulnerability and Disempowerment Underlying Clients' Resistance

As providers were asked to share their views regarding the causes of resistance, they often made assumptions about their clients' experiences and views of the world. This is an important issue to acknowledge as research findings that presume to describe the cognitive processes and affective experiences of court-mandated clients represent the subjective perspectives of participants', which in turn, are interpreted by the researcher. This underscores the inter-subjective nature of the study's analysis and outcomes. Nevertheless, participants' discussions of resistance consistently returned to vulnerable and/ or disempowering affective states thought to precede the resistant attitudes and/or behaviors of their court-mandated clients. For example, feelings of fear, being misunderstood, encountering value conflicts, and perceptions of injustice were often identified as the more primary experiences believed to foster resistant attitudes and behaviors. Thus, the content categories subsumed under this theme represent participants' perspectives of the salient person-environment interactions contributing to these vulnerable and/ or disempowered affective states, which are believed to be the underlying

issues responsible for client resistance. Figure 1 presents a tentative theoretical model of participant perspectives regarding the salient features of court-referred clients' experiences and the directional influences of these issues believed to create a pathway towards resistance.

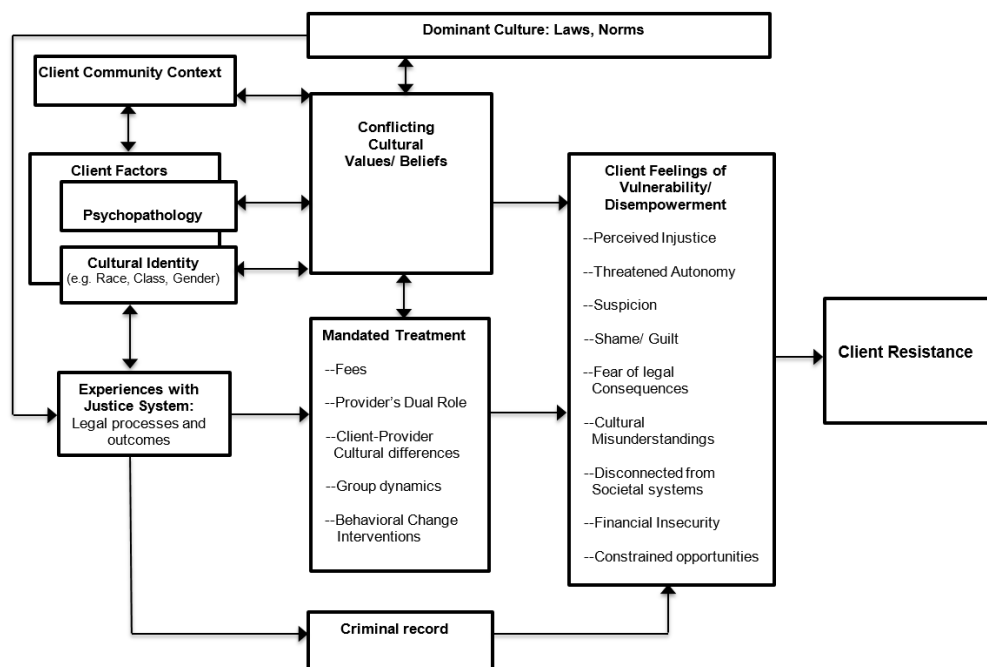


Figure 1. Providers' Identified Pathways of Client Resistance.

Conflicting cultural values. Participant discussions suggested that client beliefs, values, and norms related to their culture can lay a foundation for resistance prior to having any contact with a provider. This interpretation of interview data stemmed from several participants often highlighting the different values and norms between court-mandated clients and the dominant culture. In particular, issues related to therapy, psychology, and gender roles were often described as representing points of cultural conflict for many of the diverse individuals finding themselves coerced by the legal system into contact with mental health providers.

In an attempt to describe the treatment perspectives of her court-mandated clients that immigrated to the U.S. from South America and the Caribbean, Annie stated:

They saw therapy as something for someone who is crazy. It's for people who hear voices or violent. Things like that. It's not accepted because of these ideas, but also because in a lot of these places, therapy isn't really done or they just don't see it as a common practice that it is here. So those things together create a negative view towards therapy.

She continued to suggest the culture-bound nature of psychotherapy as she shared her belief that "it's a white sort of Caucasian idea to go talk to some stranger when you have a problem or issue." Many participants referenced the discomfort their clients experience related to the process of treatment such as disclosing personal information and expressing emotions in therapy. Julia shared the types of questions she asks herself to help empathize with initially resistant clients from culturally diverse backgrounds:

Do they even think therapy is a thing? Do they believe in therapy? Do they believe that therapy is something that can be helpful for them? There are a lot of people who think therapy is only for people that are crazy. For many cultures, you only go get help if something is really wrong with you, or you are weak, or crazy, or sick. Since they don't see themselves that way, it makes it challenging to get them to be open about the idea of participating in the process.

While exploring this issue of clients viewing the activities of therapy as foreign practices and/ or holding stigmatized views of treatment, it was apparent that this assumed client perspective was not thought to be exclusive to individuals from non-white ethnicities or those who emigrated from different countries of origin. Participants shared similar experiences with individuals born and raised in the United States from a variety of ethnic backgrounds.

To put these findings about the apparent value differences between court-mandated clients and the dominate culture into perspective, it is important to note that social class was consistently identified as a critical cultural variable referenced as

defining the local treatment population and contextualizing their lives. Participants noted that many court-mandated clients who share some aspects of their identity with the dominant culture still perceive psychological services as uncommon or unaccepted within their social groups. For instance, Leo seemed to capture the perceived importance of social class characterizing participant perspectives as he reflected on the field and his clients' backgrounds. He shared his belief that "therapy is a luxury for most people. The guys I work with are poor. I don't care if they are black, white, Hispanics, you don't go to therapy if you have trouble paying bills and feeding your kids." The inclusion of this quote is not intended to undermine the salience of race or ethnicity on clients' lived experiences. Instead, it serves to demonstrate the way social class was often perceived as a unifying aspect of the otherwise culturally diverse court-mandated client population comprising the local context. This aspect of clients' lives was often noted during discussions in order to explain why clients hold negative views towards the concept and processes associated with their mandated treatment.

In addition to negative perspectives of psychology and mental health treatment, cultural beliefs regarding gender roles were also used to explain the gendered dimensions of resistance in the previous theme. Participants discussed this issue in terms of their clients living much of their lives operating under a set of values and norms that conflict with those characterizing the dominant U.S. culture, enforced by the criminal justice system, and propagated within treatment. Crystal described experiences with clients emigrating from other countries to highlight the way attitudes towards women and behaviors in romantic relationships vary in different parts of the world and impact the treatment process:

So, for my domestic violence group, they will say that in their country, where they came from, it is acceptable for them to push or insult their wives because that's part of the culture they grew up in and they saw their parents doing it. So, when they came here and get in trouble for it, they kind of use it as a justification. It's like, 'well I've done that my entire life.'

In light of participants' acknowledgment of culture shaping attitudes towards gender roles and norms, Julia shared her experiences with certain male clients' reactions to having a female provider:

Some men are completely taken aback by an articulate or educated woman. This can be admiration or discomfort, but they often talk about the difference from what they are used to. I might be one of the few women that they encounter that interacts with them in a very different way.

Although Julia seemed to express mixed views towards the gender dynamics she experiences, many of the other female participants focused on the difficulties they encounter when their clients hold very traditional attitudes regarding gender roles. For example, Mary shared her beliefs regarding the impact of her domestic violence clients' socialized attitudes about relationships on the treatment process as she stated:

I think it's part of their programming throughout life. I mean they really view, the majority of guys, that relationships should be male dominated, that they don't have any accountability to their partner, that they have the right to say or do anything, that using intimidation is acceptable to get her to back down, but they're not really realizing the consequences of these and they really don't have the knowledge of what an equality based nonviolent relationship looks like.

She continued to suggest that these ideas about "male dominance" can play out in the professional relationship and create the power struggles related to gender that many participants referenced. Providers often focused on the ways clients' views have been "ingrained" over the course of their development or clients' tendencies to "generalize based on their experiences with women," which often impact their relationship with providers. These issues were consistently discussed as contributing to the previously

noted client tendencies towards sexualizing female providers or experiencing discomfort taking suggestions from a woman. It was therefore apparent that providers often shared the belief that many of their male clients are not accustomed to having a woman in a position of “authority” or power over them. The discomfort and disempowered feelings this dynamic causes in some men was described as fueling the resistant behaviors and power struggles identified as common between male clients and female providers within court-mandated settings.

Negative experiences with the criminal justice system. Clients’ previous interactions with the criminal justice system were also identified as potentially influencing resistance to court-referred treatments prior to their initial presentation to treatment. Participant discussions often reflected a perceived interaction between a person’s background and the processes and outcomes they experience navigating the legal system. As interviews consistently described the local clientele as being primarily poor or “lower SES,” Derek elaborated on his beliefs regarding the way social class can influence individuals’ trajectories in the legal system and contribute to resistance:

Well the more blatant ways I’ve seen is that for higher socioeconomic people, instead of going to prison, you pay a lump sum of money to the victim’s family. Or, if you have enough money, you hire a high priced private attorney who can have investigators, who can do depositions, who can, um, do all sorts of things that make it more likely you will be found innocent, well not guilty of the crime. Because the state attorney’s office is much more likely to negotiate a lighter plea. So, yea there’s statistics and articles about how higher socioeconomic people are treated differently in the court system, and I see it all the time. The people who don’t have these resources are also acutely aware of how their economic status played a role in where they ended up and are often angry about it.

Many providers were able to offer similar examples establishing this shared belief that individuals on the lower end of the social class spectrum and ethnic minorities not only receive differential treatment by the courts compared to individuals with greater financial

resources, but that their awareness of these injustices have significant implications on clients' views. For example, Annie stated "almost all of the populations I've worked with are minorities, so there was already a preconceived suspicion of the system. That the system is out to get them or at least doesn't work for them." Moreover, it was apparent that clients' awareness of these social inequities and recognition of injustice was believed as directly contributing to their resistance.

Summer further expounded upon this belief that certain groups develop a negative perspective towards the legal system and their mandate to treatment. As she reflected on her clients' reactions to their legal situations, she highlighted the cultural issues often identified by participants as causing clients to feel disconnected from the legal system and the punitive way in which their treatment is perceived:

I think that the criminal justice system and mandated treatment is probably intimidating. I think the court system is looked at as not representing the patients. It's got these elements of authority and money and power that the patients just don't have. Like a white wealthy system and they are coming in the court in a one-down position. If they are from a low SES or a different ethnic background, I think, from my experience, when clients talk about it they are already feeling a disconnect from the criminal justice system. The criminal justice system doesn't understand them or care about them. So even though they might have gotten treatment instead of incarceration, I don't think they see it as 'oh the system is looking out for me.' They view it as me versus them.

Other participants reinforced this idea that court-referred clients often view their referrals to mental health providers as punitive, rather than something capable of promoting their well-being. In an attempt to convey her clients' views of treatment, Julia stated:

They don't look at it like this is something you are getting in lieu of jail time, or to reduce your sentence, or to rehabilitate you once you are out of prison. They see it more as a part of their punishment and they certainly do not choose to be there. They were told to be there.

As interviews explored these issues, participants further revealed the far-reaching implications of the legal system coercing clients into treatment. Many participants discussed the way a legal mandate can threaten clients' sense of autonomy. Crystal shared experiences that highlight the impact of legal mandates on her clients' resistance as she shared "I do get a lot of resistance because they already feel I'm being forced to do this because of court, and I'm being charged, and now this lady is going to make me talk about my feelings, and make me talk about what I did over and over for whatever amount of time the program is." Other interviews often contained references to clients feeling "controlled" or "forced" to attend and participate in treatment that they would otherwise not seek out on their own volition. The ensuing threats to their autonomy or other negative emotions (e.g. frustration, fear, resentment) were consistently implicated in the development of initially resistant presentations.

Finally, interviews and analytic feedback from participants noted that upon getting involved with the legal system and having a criminal record, their clients experience constrained opportunities to find employment and provide for themselves or their families. This is significant because participants consistently referenced limited educational and employment opportunities when characterizing their clients' lives, which become further constrained upon receiving a criminal record. It was therefore clear that participants perceived these issues as further reinforcing the potential for clients to develop negative attitudes towards the criminal justice system and anything associated with their current legal circumstances (i.e. treatment mandate).

Aspects of treatment contributing to resistance. Participants continued to identify salient issues contributing to resistance related to clients' sociocultural

backgrounds and ecological context during the course of treatment. The most notable concerns related to professional role confusion, the cultural dynamics of the professional relationship, client interactions with other clients, the financial costs of treatment, and issues of psychopathology. Given the richness of interview content surrounding these topics, discussion of these issues will be divided into sub-categories.

Role confusion. One recurring point of discussion across contacts with participants related to their beliefs that court-mandated clients tend to view providers as being part of the criminal justice system. They further suggested that many of the aforementioned negative attitudes their clients hold towards that system can get projected onto providers when presenting to treatment. In discussing the way her clients' interactions with the legal system influence the therapeutic relationship, Crystal stated:

It takes time to build that rapport with them because when they come in, and because they are being ordered to attend by probation, by the judge, by other agencies, they come and they see me like one of those people. So, I'm there to continue to get them in trouble, to blame, to point the finger. And I'm not there to help them through this process.

Participants often expressed empathy for clients as they recognized the professional role confusion created by the unique circumstances of providing services to individuals involved in the legal system. Annie noted the negative impact of these circumstances on the therapeutic relationship and their potential to undermine the goals of treatment:

I think it impacts the relationship because at first, I'm viewed as an authority figure instead of someone in alliance with them or there to help them. I am seen as more of an authority figure to them because the procedures associated with a court mandate require me to communicate with the probation office or write a report for the courts. So, you're playing two roles. You're playing the therapist and the reporter. Forensic psychology is the only place I know where you play those two roles. For example, a dirty urine. You have that responsibility to turn them in instead of simply processing their use. Like understanding why they decided to pick up and use

Other providers shared similar sentiments that there is often an “external” motivation for clients to not be honest in therapy due to the significant legal consequences they can experience. Mary explicitly described experiences with clients prefacing their discussions in treatment with questions reflecting fear that they might go to jail as a result of what they disclose. Diana emphasized her beliefs about the threat of legal consequences on clients’ motivation to participate in therapy as she shared her thoughts that “the driving force for them is fear of losing everything, being incarcerated, punished, having something taken away, you know.” She continued to describe her thoughts regarding the way this extrinsic threat of legal consequences might pressure clients to present to appointments, but that this does not necessarily mean they are open to the concept of treatment. Follow-up discussions reflected the shared perspective that clients’ confusion and discomfort created by this dual role could foster many of the subtle and overt forms of resistance outlined in the previous thematic discussion. Of note, participants noted their own discomfort with the professional position this puts them in with split responsibilities between the courts and their clients. Fran framed this as a constant challenge defining her work stating, “We often face that big question: Do we do what the court is asking us to do or do we do what we want to do clinically?”

Client-provider cultural dynamics. Another major perceived influence on clients’ resistance related to the cultural dynamics between clients and providers as interviews highlighted the complexity of intersecting dimensions of identity within the therapeutic relationship. In particular, issues of gender, social class, age, and ethnicity were frequently referenced social group classifications deemed salient within the local context. Despite the varied experiences shared by the diverse participant group, clients’ negative

assumptions regarding cultural differences within the professional relationship were described as a primary source of resistance. Participants noted that cultural differences could cause clients to question both their providers' ability to understand their experiences and the potential benefit of services. Although this was a recurring point of discussion across several interviews, Summer captured the essence of the problematic assumptions she believed her clients make about culturally different providers as she reflected on her own identity:

So, I am a young, white, female, and I'm viewed by patients as someone who has probably never been involved in the legal system if you take a look at me. So, patients, they might not see me as someone who has knowledge of anything to do with the legal system, or knowing what it's like to be addicted to a substance, or just having questions about whether or not I can understand how they are feeling. So, I can understand if they don't feel like coming in to see a therapist who looks nothing like them, talks nothing like them, acts nothing like them. From the looks of her, she might not come from the same background, so how is this person going to help me overcome the things I did or have to deal with? Whether it be addiction, criminal behavior, whatever it is. How is this person going to relate to me? And if they feel that way based on gender differences, based on cultural differences, of course that's going to be part of the resistance.

Fran held a very similar perspective of the cultural dynamics of court-mandated treatments as she described her early experiences in the field:

If I think back to some of those experiences, especially in my master's program, I was in my very early 20s when I was in that program, I was demographically extremely different from the patient population. I was a white, 20 something year old female with an almost complete graduate degree at that point and I was trying to work with folks who came from low SES, who were ethnically diverse from me, economically diverse from me. So, I'm coming in there as someone who could easily be their kid, and who by all standards looks very privileged compared to them and I'm trying to rope them into treatment, not rope them that's not a good word, get them into treatment. So, there was certainly some resistance there. They were resistant to listening to someone like me because of those demographic differences I think in some cases.

Most participants shared experiences of clients explicitly questioning providers' capacity for empathy due to one or several points of cultural difference.

In the search for consensus and alternative perspectives regarding cultural differences between clients and providers, Julia noted her hesitance in making general statements about cross-cultural professional relationships due to the complexity of multiple intersection dimensions of identity. She stated that “it’s hard to describe because each individual client might have different beliefs about whatever ethnicity and gender combination they encounter in their provider.” Moreover, when asked if there are additional dimensions of her identity potentially influencing the professional relationship, her response suggested that cultural differences are not always necessarily negative. For example, when noting issues of social class and her advanced education as a source of difference, she stated:

They ask me questions like “Are you a doctor?” when many of them don’t even have a high school diploma. And that doesn’t mean they see themselves a certain way, but it does play a role in how they see me sometimes in both positive and negative ways. They may assume I know what I’m talking about because I’m educated, but they also may think I can’t relate or understand their life. I think the biggest thing is whether I can understand them.

Thus, participant perspectives suggest that the cultural dynamics of psychological services with clients involved in the legal system are complex and involve specific attention to the idiosyncratic identities and attitudes of the individuals comprising the professional relationship. Nevertheless, cultural differences were noted as a common issue within the therapeutic relationship that can contribute to resistance if clients question their provider’s ability to understand and relate to their experiences.

Client interactions. In addition to the dynamics between providers and clients, participants also noted the potential for interactions amongst the treatment population as a potential source of resistance. Given the prevalence of group interventions across participants’ professional activities, problematic dynamics between clients were often

experienced as having a detrimental impact on the group process. Mary noted that a single client can have a powerful influence on group dynamics as she shared that “sometimes I can have a perfectly good group, get one person in that’s really in a negative mindset, and it’s almost like their negativity has the power to suck everybody in.” Crystal expressed similar beliefs regarding the perceived power for one individual in a group setting to contribute to the resistance of other clients. She shared her belief that something as simple as a client having a bad day in court can have far reaching implications as she stated:

Sometimes something can just turn the attitude of one person and that one person says something that hits home with someone else and the group starts to turn. Then everyone starts to concentrate on that negativity and you’re trying to pull the group back.

Financial Costs. One participant indicated that a defining feature of this clinical population is that “they have serious money issues and their life, to some degree, revolves around money.” Indeed, the clientele served by participants was consistently described as being poor or having financial concerns that exert a powerful influence on their lives. Given these life circumstances, it was not uncommon for participants to describe experiences with clients demonstrating acute concerns about the financial requirements of attending and paying for psychological services. Providers cited examples of clients accusing them of “only being interested in money” or protesting the costs of their remanded services. Although participants had different reactions to this common client concern, Julia reflected on a previous experience with a client to underscore the financial implications of mandated treatments on clients’ lives:

I think about whether or not they have a job because their financial situation is a big factor on whether they see their 15 dollars a week as a waste. Because if you don’t have 15 dollars for diapers, and this is by the way something one of my

clients recently told me, she said ‘I don’t have 15 dollars for diapers and I have to pay you 15 dollars each week. I don’t want to do that. I can’t do that.’ And I understand that completely.

It was not uncommon for participants to describe similar examples of their clients being unable to pay and/or upset about treatment costs in light of an existing sense of financial insecurity. Thus, participants described their clients’ financial constraints as potentially resulting in a variety of resistant behaviors including, missed appointments due to transportation issues, termination due to non-payment, or interpersonal conflicts with providers about treatment costs.

Psychopathology. Participants often noted that, given the criminal backgrounds of clients, “anti-social” personality traits and personality disorders are particularly common throughout the clinical populations with which they work. Given the extensive assessment experience of participants, many discussions of client resistance seemed to incorporate a focus on issues of interpersonal pathology with descriptions of the population often referencing perceived tendencies towards “avoidance”, “externalizing”, “cynicism”, and “aggressiveness.” Derek shared his belief that many court-mandated clients in the local context have “trust issues” and he continued to hypothesize the various reasons behind this as he noted that “it could be caused by circumstances that have occurred in their life time, it could be that they have an attachment disorder, it could be any one of a number of things like they were abused when they were younger.” Although participants often reflected distinct views regarding the etiology of the pathology identified as prevalent within mandated treatment populations, preexisting mental health and personality disorders represented commonly identified issues noted when participants shared their beliefs regarding the causes of client resistance.

In addition to interpersonal psychopathology, other mental health concerns were also frequently incorporated into discussions of resistance. For example, Diana highlighted her belief that reactions to trauma represent a commonly ignored potential explanation for clients' resistant presentations:

I think the extent of these patients' trauma history is often overlooked. Emotional trauma, physical, sexual. I think there is a lot more trauma in this population that we overlook because we only care about addressing the offence. But reactions to trauma can look a lot like the anger and aggression we call resistance. So, we look at the offence. Domestic violence. Anger. Addiction. We think that this person needs a lot of help, but we sometimes lose sight of the possible things that cause those feelings and behaviors. And it's often really traumatic, vulnerable stuff. We also don't pay enough attention to strengths. Like, how much has this person gone through and accomplished and survived? How much trauma have they experienced and made it this far? How resilient is this person?

Clients' community context as a barrier to change. Participants frequently attributed their clients' resistance to aspects of their family and community contexts. These discussions highlighted the way providers view their clients' environments as "counterproductive" to the integration of treatment content. They also suggested limitations to the individual interventions used in most treatment programs. For example, Diana shared her beliefs regarding the influence of her clients' social context on treatment outcomes as she stated:

If a person comes to you and you teach them how to cope, manage anger, identify why they use drugs, but they go back to their same home, same family dynamic, same neighborhood, same cues, we know that person is fighting against a lot of variables. They often go back to what they know. I see them for maybe an hour a week for maybe 12 weeks, 15 weeks, that's not going to undo 20-30 years of being exposed to the same environment in which their issues developed. So, you're kind of fighting against the environment and the way it shaped their identity. So yes, it works because they can learn valuable resources or tools, but unless you change everything else there may not be a profound change.

Derek similarly suggested that "the biggest issues have to be with friends and support systems" when describing some of the difficulties his clients face making changes. Mary

offered additional insights regarding the perceived negative influence of clients' social groups as she recounted the type of poor outcomes her patients experience when attempting to practice the skills of therapy in their relationships:

Usually if like there's a concept, like time-out, I would come back the next week and say, who put that to practice in their relationship and what success did they have with that? This sometimes works. Sometimes they'll go 'oh, she said fuck you, you're not gonna use that psycho-bullshit on me.'

The primary issue underlying these discussions was an apparent mismatch between the behavioral change interventions of mandated treatment programs and the values and norms governing clients' interactions with the members of their communities. This seemed to portray court-mandated clients as being put in a conflicted position between the goals of their treatment and the realities of their social relationships.

In reflecting on her interactions with clients in light of the social- and community-level barriers to clients integrating therapeutic content, Julia seemed to suggest inherent limitations to the individual-level innervations of her treatments as she stated, "you have to convince them to change everything about themselves, but really, the environment is not going to change. If the family is on drugs, or criminal, or ill, that's not going to change." When asked to clarify her reported "mixed feelings" regarding the efficacy of remanded treatments, she stated:

I'm saying that we are only targeting one part of the problem with most interventions. Of course, the way they think and their behaviors need to be addressed. And yes, they can start identifying how these things affect their lives, but if they go back to the same environment that influenced many of their issues in the first place, they may not be able to put into practice all the things they learn in therapy. I think that interventions only target a piece of the client's presenting concerns.

Annie described a very similar sentiment stating:

I can't tell someone who has grown up in a violent neighborhood, where you have to be all the time looking over your shoulder, I can't tell them to just breath more or do progressive muscle relaxation and all your stress will go away. That's not realistic. So yea you can teach them PMR or breathing, but you have to get them to understand how their context plays a role in the level of stress they have and will continue to experience. If you don't do that, you're just giving them things that are disconnected from how they live.

As such, aspects of mandated treatment and the apparent inability of these programs to comprehensively address the clients' needs were often posited as explaining some of the resistance associated with the court-referred populations.

Successfully Addressing Client Resistance

Given the open-ended nature of the interview questions and data collection process, discussions of how to effectively address client resistance touched on a range of considerations that extend well beyond a set of intervention strategies perceived to be effective. Participants shared views about the personal characteristics of providers and professional development issues that they believe influence an individual clinician's capacity to overcome client resistance. In addition to these general considerations, participants also identified several shared strategies for successfully addressing resistant client attitudes and behaviors.

Important provider qualities. Participants demonstrated strong beliefs regarding personal qualities they believed were important for clinicians to effectively address client resistance and experience success in the field. In response to client criminal histories and the perceived prevalence of client resistance, participants often described reactions to their work as being constantly pulled between frustrating negative emotions and moments of significant reward. Derek eloquently captured the essence of this dialectic by suggesting that "if you can't deal with a whole lot of shit, don't be here. You gotta find

things you like about it.” He made this comment after reflecting on previous colleagues and supervisees that left the field in response to strong negative reactions to their clinical experiences. For example, these clinicians who changed career paths were described as experiencing difficulties when encountering their clients’ physical/sexual violence histories and the challenging interpersonal dynamics that can play out within treatment. However, even for the participants currently working in the field, negative emotional reactions in response to professional experiences were common issues discussed during interviews. Crystal offered a powerful example of her emotional reactions to facilitating domestic violence group interventions:

It’s very challenging. Honestly, sometimes I leave group and feel like a battered woman myself. It’s emotionally draining, it really is. I’ll have days when I come into group and everyone is on the same page, we cover the topic, and it’s a smooth conversation. Other days they’re just not having it. Someone is angry or upset or they want to challenge everything I say. You know sometimes it feels like an attack. Someone might come in with an angry attitude it’s just having to deal with that and having to manage their impact on the group once they’ve all turned. It’s really emotionally draining sometimes. It takes a lot out of me emotionally. I think that is the hardest part. The hard days.

There were several similar examples of participants explicitly sharing the intensity of their negative emotions to certain aspects of their work, but later describing the potential for contrasting emotional experiences. Diana seemed to exemplify the range of emotions experienced by clinicians. After describing a deep sense of frustration in response to certain elements of her professional work she noted:

It can also be a little more rewarding with the court-mandated patients because if they do buy into it, and kind of see the benefits of treatment, then the rewards are bigger for me. Because they came in with a ‘fuck this I’m not doing this bullshit’ attitude and then you see them kind of coming back and maintaining sobriety or changing their way of dealing with anger. Basically, maintain treatment gains. So yea a mixture of more frustrating and potentially more rewarding.

It was apparent that shifting emotional reactions followed people throughout their careers as Mary, one of the most experienced participants of the current study, described her own mixed feelings in no uncertain terms:

It's probably a constant struggle. Some days I'm just absolutely amazed at how open and honest some people will be, with their real sincere desire to gain new knowledge in order to improve relationships. Other days I feel like I was just gang raped.

The potential deep emotional impact of the work was woven throughout participant discussions and therefore identified as an important part of working with court-referred clients that providers must have the capacity with which to cope. The potential to experience a powerful sense of reward in achieving positive outcomes with clients seemed to protect against the challenging emotional reactions commonly experienced by providers.

Additionally, participants emphasized the importance of having a "thick skin" and the ability to "never take work home." Derek described this as "having the right personality for forensics." Indeed, many of the observations and researcher-reactions documented during the data collection process were in response to consistent aspects of the interpersonal interactions with the study participants. Participants frequently highlighted the importance of having a good sense of humor in order to be successful in the field. They also seemed to share a brusque, sometimes irreverent dimension of their interpersonal presentation and conversational style. Many of the interviews contained moments of laughter intermixed with discussions of intense emotion. Participants also freely colored their responses to questions with profanity and displayed a generally informal tone regardless of the extent or nature of our previous relationship.

Ultimately, content subsumed under this category helps to identify what individuals engaged in legally-sanctioned treatments identify as important personal qualities believed to facilitate their ability to tolerate client resistance and achieve success in the field. It also paints a portrait of some apparently shared characteristics and perspectives of individuals actually engaged in this work in this particular context. This information about the participants' relational styles and personalities was included in the analysis to better contextualize their perspectives of effective clinical practices.

The need to develop a personal approach through direct experiences. Despite the existence of certain common aspects of participants' relational styles, interviewees reflected significant variation regarding the different issues and frameworks used to inform their work. Additional content subsumed under this category further expounds upon limitations participants identify within their field. Specifically, shortcomings related to academic training and the established body of clinical knowledge related to resistance were noted as the reason providers developed an individualized approach to treatment.

Follow-up interviews attempting to make sense of the apparent theoretical pluralism of participants revealed their beliefs that direct experiences in the field were necessary in order to develop an approach to treatment that fits a provider's identity and personality. When asked about the way his training has prepared him to work in the field, Leo explained:

This is not one of those areas of practice that you can just read a book and expect to have everything you need to work successfully with this population. There are no manuals or step-by-step guides that fully prepare you to deal with some of the issues you face. The reality is way more complex, but especially when they have that mandate to come see you.

Participants that more recently completed their degrees confirmed that their academic training did not adequately equip them to deal with the unique issues that arise in court-referred treatment settings. Participants with several years of supervising nascent clinicians (e.g. Mary, Leo, Derek, and Fran) further reinforced the idea that trainees are often unprepared when they first begin training positions in the field.

In an attempt to explore the identified gap between training and the realities of court-mandated practice, additional interview questions were included during the iterative data collection process seeking to identify participant perspectives of the most efficacious models of treatment. Participants were clear in their shared perspectives regarding there being no single theory or preeminent treatment package available to rely on in any of the settings or populations with which they practice. As previously noted, the most common treatment populations characterizing participants' professional practices were substance abuse, domestic violence, and sex offenders. Yet, even experienced providers working within a single organization facilitating treatments with the same clinical populations described wildly varying approaches. For example, Mary characterized her groups as "primarily psychoeducational" utilizing worksheets and interventions associated with various treatment packages that she has found effective through her many years of providing treatment. In contrast, Derek, who works at the same clinic as Mary, cited research questioning the efficacy of didactic or psychoeducational approaches as he shared his experiences of clients having aversive reactions to structured activities like worksheets and homework. Participants in other settings similarly reflected significant variations in the theoretical orientations or treatments programs cited as informing their work. Mary shared her perspective regarding the need to blend elements from multiple

frameworks as she stated, “I’ve always thought that, if you work with a forensic population, if you say you’re anything but eclectic, you’re probably not telling the truth.” Across interviews, multiple distinct treatment models were referenced as informing different providers’ clinical conceptualizations. For example, cognitive behavioral therapy, motivational interviewing, reality therapy, ACT, dynamic models, relapse prevention, 12-step orientations, and harm reduction models of treatment represent a sample of the various frameworks mentioned during interviews. However, despite the theoretical pluralism reflected by participants, it is important to note that behavioral change was consistently identified as the primary goal of remanded treatments.

Another unifying element across discussions was the perceived need for clinicians to learn through experience and identify a treatment approach or style of practice that works for them as an individual. One of Julia’s interviews reflected this shared sentiment across providers as she shared:

“When you’re actually faced with an individual, you consider all your theories of establishing rapport and what you learned in clinical training, and then you make a decision about what feels good and genuine for you personally. You really need to find a way of dealing with that resistance and hostility that fits with who you are as a person.”

Gender continued to be a salient dimension of discussions described as influencing participants’ individualized approaches to treatment. Crystal shared that her clients often call her “strict” or “tough” during their interactions. She continued to acknowledge that she developed this approach in response to the sometimes “inappropriate” behaviors that would be associated with the previously noted gendered examples of client resistance. Many of the young women participants in their thirties similarly described the importance of balancing efforts to connect with clients while

maintaining a reserved or formal relational style. In contrast, both male participants in the study made multiple references to the perceived benefits of a less formal relational style in their professional contacts. For example, Leo shared his belief that his clients involved legal system “have enough authority figures telling them what to do, where they need to be” and he continued to suggest that he has “learned the importance of not being overly professional or rigid.” He further noted that “a less directive stance avoids that power struggle,” which often characterized client-provider interactions. Given the limited number of males interviewed, these apparent differences in participants’ experience of gender dynamics were noted and discussed during follow-up contacts in order to receive additional feedback for the current analysis. Ultimately, all providers recognized the value of incorporating some informal interaction dynamics in the service of establishing a genuine relationship, while maintaining clear boundaries with clients due to certain perceived relational tendencies associated with this population (e.g. dishonesty, manipulation). However, it is important to recognize that participant discussions revealed distinct issues or challenges for certain clinicians based on their gender. Whereas many of the women described the need to remain cognizant of sexually suggestive or inappropriate client attitudes when trying to establish the professional relationship, the two male clinicians interviewed indicated that these issues were not concerns influencing their own work.

Navigating cultural differences. As participants referenced cultural differences contributing to resistance, they also offered insights regarding how they address these issues within the professional relationship. Several core considerations seemed to run throughout participants’ described methods of navigating cultural difference. The first of

which builds off of the sociocultural and contextual issues believed to be involved in the causes and manifestations of resistance outlined above. Participants consistently noted the importance of knowing about clients' backgrounds and experiences so that empathic understanding can be conveyed by providers during treatment. Associated discussions painted a portrait of the local treatment population, while also noting the aspects of their clients' lives they believed to be salient.

Having worked across several regions of the country, Diana referenced her different professional experiences to highlight the defining features of the clinical population in South Florida. She stated that "it's always mostly minorities in the urban cities I've worked in. Black and brown faces usually make up my groups, but here, there's definitely a lot more Hispanics." Several participants noted that in addition to a significant representation of Latino and African American clients, individuals from European and Caribbean backgrounds also represent notable proportions of local referrals. Crystal touched on the most frequently cited dimensions of identity referenced across participant interviews as she described the composition of the local clientele:

Pretty much all males. I want to say the majority are minorities—Black and Latino. Mostly low income. Not the most advanced education. I guess blue-collar jobs. Actually, many don't have jobs because of their legal issues that limit their opportunities to find jobs and earn income. Well legal incomes at least.

This succinct description highlights the perceived overrepresentation of poor, racial/ethnic minority, male clients within the local community. It also speaks to the significance of clients' social class and what participants identified as sometimes constrained opportunities in life (e.g. education, employment). Participants often noted that many of their clients tend to struggle with issues related to their immigration experiences/ acculturation difficulties and violence within their communities. These

issues were believed to be some of the most powerful influences shaping court-mandated clients' experiences within the local context. Developing and expressing empathy related to these sociocultural and contextual aspects of clients' lives was consistently noted as a critical component of successfully navigating cultural differences by avoiding the aforementioned cultural misunderstandings that can contribute to resistance.

Although providers described a variety of ways the sociocultural dynamics of the professional relationship can play out, they frequently noted the importance of not personalizing resistant attitudes or behaviors. For example, Julia discussed how she responds to male clients that question her ability to understand their experiences or demonstrate inappropriate behaviors based on gender differences as she stated:

So, the most important thing to handle this stuff is not to take it personally. I remind myself it's cultural and not a personal attack. This is something that is just part of their worldview. Since I don't take it personal, I can separate them as a client from the beliefs they might have.

Other providers similarly confirmed the value of recognizing the different cultural and developmental experiences shaping client perspectives and the importance of not personalizing clients' resistance. Since a range of negative affective states were identified as preceding resistance, participants highlighted the importance of maintaining awareness of the disempowered and vulnerable feelings underlying clients' problematic attitudes and behaviors.

Diana suggested that her clients sometimes "test" her by expressing stereotypical beliefs about women's roles. She also shared her thoughts regarding the importance of not perceiving these client interactions as a "personal attack." She further noted that she tries to use these moments as opportunities for education and to engage clients in open discussions of different societal and cultural values. Multiple participants' descriptions of

navigating cultural difference reflected attempts to “find a balance” between acknowledging sociocultural influences on client values and worldviews with the need for clients to take personal responsibility for changing behaviors associated with their mandated treatment.

Another method of responding to questions about a providers’ ability to understand or relate to client experiences involved explicit acknowledgment of cultural differences and maintaining a curious approach towards learning about the client’s perspective. Crystal shared the way she attempts to both diffuse resistance and foster participation in response to a clinical impasse caused by clients questioning her ability to understand their lives. She stated:

I accept that. You know possibly it’s true. You’re right. I don’t understand that situation, so why don’t you explain it to me so that I can get a better understanding of your experience and your perception. And I kinda go from there, so they don’t feel like they’re being attacked. It’s kind of open ended. You can express your situation to me and we will see where it takes us.

She continued to frame the nature of her response and its impact on clients as she stated, “I just kind of invite them to then share their experience so that I can understand it a little better. That usually gives them the floor to feel like ‘ok she wants to know’ and then they start opening up and sharing.” Summer, Fran, and Derek, three clinicians who underscored the salience of racial/ ethnic differences between themselves and their predominately Latino clinical populations, also highlighted the value of this culturally curious stance towards exploring client experiences within cross-cultural professional relationships.

Joining with the resistance. A related strategy identified as effective for reducing resistance involved “joining” with client resistance or validating their aversive

reactions to the various issues and experiences contributing to their resistant presentation. Throughout contacts with participants, they consistently acknowledged the challenging circumstances surrounding their clients' lives believed to be linked to resistant presentations. As noted above, providers often referenced the value of directly expressing empathy for the difficulties and stressors their clients' experience. Participants often specifically referenced going beyond recognition of client experiences and "normalizing" their suspicions or recognizing how their resistant attitudes and behaviors are "understandable" in light of client circumstances. Leo seemed to epitomize the rationale for joining with the resistance as he reflected on his clients' negative perspectives towards therapy and his methods for overcoming resistance stating:

I mean, it makes a lot of sense that these guys show up less than thrilled to see me. Sometimes their lives are falling apart or close to it. They're afraid of going to jail, they have a P.O. on top of them, they need to show up to court and let strangers watch them piss. That's gotta be rough and I tell them I know it sucks. So, acknowledging it goes a long way to show that I get it. I get why you're not happy about having to show up here. If you just act like a person and treat them like a person, the resistance fades away quick. If you fight them or take everything personal you're going to have a bad time.

This participant quotation reflects many of the salient issues identified across the major themes of the study. The strategy of joining with clients appeared to directly counteract many of the perceived causes of resistance by establishing common understanding with clients about the source of their distress, validating their experiences, and avoiding a potential source of interpersonal conflict.

Clarifying roles and responsibilities. One of the most consistently identified priorities during initial contacts with patients was clarifying roles and responsibilities. Participants' discussions suggested that being explicit about the expectations and nature of the professional services is a critical task that lays the foundation for a relationship

capable of overcoming resistance. Participants emphasized the need to outline the specific requirements associated with attendance, payments, and the consequences associated with failure to comply with these expectations. Participants also noted the value of thoroughly reviewing the additional limits of confidentiality in court-mandated settings and providing detailed information regarding exactly what type of information will be reported to the courts or other third parties associated with clients' referrals. For instance, Diana explained the perceived benefits of these efforts to clarify roles and responsibilities as she stated:

I try to let them know right from the get go what the rules are. I let them know what I will and won't report. Setting the rules from the outset so they know what happens based on what they tell me. Whatever the case may be, I think that is the easiest way to make it clear and cut and dry from the outset what will be communicated to the courts.

She continued to suggest that she spends extra time discussing aspects of her dual role so that patients recognize her obligations to the court and avoid seeing her as "the enemy."

One particular strategy referenced across multiple interviews was to be transparent regarding the specific information that will be communicated to third parties. Annie shared her reasoning behind the salience of this practice as she explained how she approaches progress reporting with her mandated clients:

Any notes that would go to the court, I would allow them [clients] to look it over and ask them what they felt. So right off the bat I would let them know about the limits of confidentiality, the fact that I have to report to the court, but I also talk about what is going in the report and discuss any reactions. I think taking the time to show them what's happening "behind the scenes" and potentially processing this aspect of their treatment helps demystify my relationship with the courts and reduce their suspicions.

Building rapport by distinguishing self from the system. Despite the varied training models and theoretical orientations underlying participants' approach to

treatment, the client-provider relationship was consistently recognized as a critical issue related to successfully addressing resistance. Interviews often focused on the importance of quickly establishing rapport with this population given the various influences that can contribute to client resistance prior to presenting to services and the negative views clients often hold towards their mandated treatment. Discussions outlined several strategies to accomplish this goal with clients. Specifically, utilizing humor, maintaining a nonjudgmental stance, and judicious use of self-disclosure seemed to represent the primary strategies described as helping the client differentiate the provider and services from the criminal justice system.

Humor was consistently described as a tool for connecting with clients and establishing a relationship dynamic that differs from the interactions clients experience with other individuals encountered within the legal system. Many participants indicated that they use humor for reducing avoidance, helping clients feel as though they are not being judged, and diffusing some of the interpersonal conflicts that often arise with court-referred clients. Julia shared her perspective of the many benefits of humor as she stated:

I like to use humor and to be very honest with them. You know, they might make a comment like “Why do I have to be here?” Honestly, I don’t know. I wasn’t in the court with you. I just got a paper with your name on it. They often think you have a direct phone line to the judge and they think you’re part of the system. And I guess you kind of are, but not in the way they often think you are. So even just acknowledging that you don’t know everything about what happened or what’s true or what isn’t. I like to do this with humor because it helps them see that you’re not there to chastise them or punish them. So just cracking a joke and recognizing the limited information you have about who they are and why they are here, it helps them realize you are there to do a job and it helps them realize you’re not jumping to conclusions about who they are as people and what they’ve done. The humor helps them not feel that they are being judged. It also shows respect. Lots of clients say they feel like they are being treated like children by the judge, PO, or other people they encounter through the courts. So, this helps distinguish me as a person and not another part of the system.

Derek noted additional clinical benefits of humor as he described his reasons for incorporating a jocular approach towards interacting with clients:

I try to get people to see that what they view as catastrophes are not. They are mistakes, lapses in judgment, a lack of skills, what have you. But they are all things that can be addressed and changed.

As such, humor was described as a method for addressing not only the negative perspective clients often have towards their court-referred services, but also the vulnerable feelings (e.g. shame, frustration, etc.) potentially associated with their emotional reactions to their current life circumstances and legal concerns. Specifically, this seemed to be achieved through normalizing client problems and efforts to avoid clients feeling judged by their providers.

In light of the stigma associated with criminality and client interactions with the legal system believed to be experienced as punitive, it was clear that participants placed additional clinical significance on maintaining a non-judgmental stance towards the relationship. In particular, these discussions often identified the perceived need to avoid making judgments about the particular client offense as well as clients behaviors in treatment. A notable aspect of these discussions indicated that the ability to avoid placing judgment is separate from having positive regard toward clients. Derek frequently suggested that that “you don’t have to like your patients” when describing the field of court-mandated treatment. As the data collection process progressed, it became apparent that other participants shared a similar sentiment regarding their ability to disagree with their clients’ past behaviors, while recognizing the need to provide an accepting, nonjudgmental therapeutic space for the provision of services.

Another common strategy for reducing resistance involved judicious use of therapist self-disclosure. Multiple participants emphasized the need to be cautious when engaging in this behavior due to the “dangers” associated with the clinical populations’ potential for manipulation and dishonesty. Nevertheless, interviews highlighted the perceived benefits of both explicit self-disclosure and finding indirect ways to communicate the provider’s ability to empathize with clients through shared experiences. Diana described the value she places on self-disclosure as she stated the following:

I think self-disclosure changes the dynamic between you and the client because it makes you more of a human person, not just a shrink who doesn’t mess up. It’s kind of like hey, just because I’m in this position where I’m your therapist-slash-reporter-slash-assessor, it doesn’t mean I haven’t experienced some of the struggles you might be dealing with. I think it eases them and makes the client better able to trust you and possibly more likely to disclose in the relationship.

She provided the example of disclosing to her substance abuse clients the fact that she is also “in recovery” in order to demonstrate her ability to relate with client experiences germane to the focus of their treatment.

Other commonly cited examples of therapist self-disclosures involved aspects of cultural identity. Participants frequently described the value of disclosing information regarding their sociocultural identity with clients from the same or similar cultures. For instance, Julia stated:

When I have a client that is Cuban and they find out I am Cuban, it’s like OK sold. As soon as they find this out, they often turn around and their attitude changes significantly. It doesn’t matter if they’ve been here for 25 years or just got to the US after living most of their life in Cuba, it has a very positive impact on the relationship and it translates to the course of therapy.

However, she highlighted the need to be cautious regarding this type of explicit self-disclosure and described her preference for less direct methods of expressing her capacity to identify with client experiences:

I believe in being genuine but I don't believe in too much self-disclosure. If I understand what it's like growing up being poor, I can communicate that understanding of financial struggles and the stress this can cause without explicitly saying I grew up poor too. So, yea, self-disclosure is something I use to help the person understand I am a real person, and I do understand the real problems they are coming to see me with. Sometimes just acknowledging the stress financial problems cause goes a long way because many other people they encounter like the judge and prosecutors for example, they don't always demonstrate concern for the financial costs of having to pay fees for the legal and mental health services.

Thus, self-disclosure seemed to represent a valuable clinical tool that providers used to humanize themselves and further express empathic understanding of client circumstances in the service of building the professional relationship.

Selling the potential benefits of services. Given the coercion associated with court-referrals and the apparent treatment ignorance of many court-ordered clients from diverse cultural backgrounds, providers consistently described their clients as not having “intrinsic motivation” to participate in mental health services. Participants therefore often discussed the need to “sell” clients on the concept of therapy. This was described as another one of the critical first tasks at the outset of the professional relationship.

Participants listed several strategies to achieve client “buy in” though attempting to change their perspectives of the services they are being required to attend. Educating clients about the treatment process and rationale underlying therapeutic activities represented especially important tasks when working with clients who have no previous experience receiving mental health services. Additionally, providing an entertaining or engaging experience for clients was also frequently noted as reducing resistance. Derek described his treatment approach as he attempted to empathize with his clients being mandated to long periods of treatment stating:

I'm entertaining. I mean I hate to say it, but if you don't want to be here, and you have to come here, and you're here for an hour, hour and a half, two hours, it's going to be sheer drudgery. You have to endure this. If you can entertain them it's not so bad.

Many of the participants shared the various ways they structure the services they offer to promote client engagement and participation that further reflect the diverse individualized treatment approaches developed by individual providers. In addition to the previously noted benefits of therapists using humor to distinguish themselves from other individuals in the justice system, humor was also described as facilitating clients' engagement in the treatment process.

Finally, one of the most notable methods of selling services to reduce client resistance involved describing the potential benefits client might experience from receiving services. Providers shared that this can be achieved through "conveying success stories" of previous clients with similar situations that achieved positive outcomes at the conclusion of treatment. These efforts aimed at the "instillation of hope" that clients will experience meaningful improvements in their lives by participating in treatment. Focusing on the benefits of treatment was often discussed as a way of counteracting clients' negative views towards mental health services and the punitive nature of a court mandate.

Leveraging group dynamics. As group interventions represented the primary treatment modality of participants' professional activities, their discussions revealed the potential influence of clients' interactions with each other during treatment on understanding resistance. Although client dynamics were identified as a potential source from which resistance can spread throughout a group, providers also highlighted the ways group dynamics can be leveraged to reduce resistance. For example, participants

described using established therapeutic alliances with clients to reduce resistance of other group members. Julia demonstrated this idea as she shared:

It also helps when a new person enters a group and since you've already developed rapport with other members, the more senior people actually have a big impact on the new people. They often kind of vouch for you when a new client is still resistant. The members often say listen she's actually pretty cool, she's not out to get you, etcetera. That actually plays a big role in making new people more open and comfortable with me.

Mary framed this issue as "when new guys enter the group, the old-timers keep them in check for me." In addition to capitalizing on these existing relationships with clients, participants also noted that group members experiencing positive treatment outcomes can serve as an example for newer members. It was noted as particularly meaningful for clients to hear perspectives of treatment from their peers to help shift an individual's perspective of their mandated services.

Chapter 5: Discussion

Through in-depth qualitative exploration of participant perspectives, several linked theoretical statements were co-constructed to explain how clinicians understand and address client resistance during the provision of court-mandated psychological services in South Florida. It was apparent that issues related to clients' sociocultural and ecological contexts were at the forefront of providers' clinical conceptualizations. The three overarching themes created organize information related to the types of client attitudes and behaviors clinicians identify as resistant, their beliefs regarding the causes of resistance, and perceived methods of successfully overcoming this barrier to treatment. The sixteen content categories subsumed under the major themes reflect what participants believed to be the most salient clinical issues of consideration when working with resistant clients. Together, findings offer an explanatory theory of how local providers understand and address resistance. In order to demonstrate the relationship between the three overarching themes of the study, Table 2 outlines select examples of particular forms of resistance, the more primary emotional reactions believed to be underlying resistance, and relevant intervention strategies.

Table 2

Hypothetical Examples Demonstrating the Link Between Manifestations of Resistance, Vulnerable/ Disempowering Emotions, and Associated Intervention Strategies

Manifestation of Client Resistance	Potential Vulnerable/ Disempowering Feeling(s) Underlying Client Resistance	Provider Interventions to Address Underlying Affect as a Means of Reducing Resistance
Client directly questions provider's ability to understand lived experiences.	Client feels misunderstood based on assumptions regarding cultural differences in professional relationship	<ul style="list-style-type: none"> • Express empathic understanding of client circumstance • Demonstrate empathy through relevant self-disclosures • Adopt a culturally curious approach asking client to elaborate concerns and participate in process
Client is hostile towards provider and angry about having a mandate to treatment.	Clients' autonomy threatened by court coercion	<ul style="list-style-type: none"> • Join with resistance by normalizing aversion to feeling forced to attend and pay for treatment
Client expresses anger about provider reporting to courts and/ or remains quiet during treatment.	Fear of legal consequences and/or suspicious of provider's dual role	<ul style="list-style-type: none"> • Clarify roles, treatment expectations, and information being reported to third parties. • Differentiate self from system by incorporating humor or other more personal, humanizing professional interactions.
Client suggests therapy is for "crazy" people.	Stigmatized	<ul style="list-style-type: none"> • Educate client on potential benefits of therapy
Client justifies physical aggression in relationships (e.g. children, spouse) based on previous developmental experiences.	Client feels misunderstood due to perceived value incongruences	<ul style="list-style-type: none"> • Avoid personalizing • Balance sociocultural explanations with recognition of client's need to take responsibility for behavior

The ultimate outcomes of this study have several implications regarding clinical work with court-referred clients within South Florida as well as several related areas of scholarship. The subsequent discussion will expound upon the potential utility of the grounded theory and the clinical issues highlighted in the previous chapter. Aspects of participant discussions will be reviewed in terms of points of resonance and dissonance

with the extant literature. This information will be used to outline relevant sociocultural and contextual issues that might expand frameworks for understanding how resistance to court-mandated treatment develops within the local context based on providers' direct experiences of the field. Additionally, clinical practice recommendations will be offered to facilitate translating study findings into practical strategies for reducing resistance. Following this, limitations of the current study will be acknowledged. The chapter concludes with a brief review of potential future research directions. Throughout this chapter, principles of multicultural and community psychology will be used as lenses through which the cultural and contextual issues woven throughout participant discussions will be discussed.

Towards A Sociocultural and Contextual Model of Resistance

Findings of the current study represent continued movement towards the development of a sociocultural and contextual paradigm for conceptualizing resistance in court-mandated settings. As previously reviewed, the historical development of thought directed towards resistance with voluntary clients has represented a shift away from purely intrapsychic explanations of the phenomenon towards increased recognition of the interpersonal dynamics of the professional relationship that threaten clients' sense of autonomy and motivation to change (Beutler et al., 2002; Brehm & Brehm, 1981; Moyers & Rollnick, 2002). Indeed, findings from the current study lend credence to many of the issues outlined in these models of resistance developed through work with voluntary clients. However, exploration of local clinicians' views regarding the sociocultural and

contextual issues influencing their mandated clients suggest the value of an expanded set of considerations for conceptualizing resistance.

In terms of situating findings within current understandings of resistance, participants identified several aspects of clients' internal psychological experiences believed to represent the underlying causes of resistance within the local population. Consistent with models of resistance developed through work with voluntary clients that emphasize autonomy threats within clients' manifestations of resistance (Moyers & Rollnick, 2002), providers in the current study believed that court-ordered clients' mandate to treatment and feeling forced to attend and pay for psychological services indeed contribute to client resistance in these settings. However, exploring providers' views regarding the salient sociocultural and contextual issues influencing clients revealed that a variety of vulnerable and disempowering affective states experienced by clients were often cited as explaining resistant attitudes and behaviors. The value of these qualitative findings is not only the identification of what additional psychological mechanisms may be implicated in resistant client presentations, but also the identification of sociocultural and systemic issues that seem to offer explanations of how and why these negative affective experiences are so common throughout the mandated clinical population of South Florida. Accurate conceptualization of resistance appears to benefit from pushing the scope of analysis beyond understanding the individual client's experiences in relation to the immediate therapeutic situation and instead considering the client in relation to multiple levels of their sociocultural cultural context. Through situating participant perspectives of their clients' resistance within relevant areas of scholarship, additional support can be garnered for a new paradigm of resistance that

incorporates the potential influences of sociocultural context and the process by which the phenomenon develops in the local context.

Cultural and contextual foundations of resistance. One aspect of participant discussions with significant theoretical implications for frameworks of resistance was their shared sense that the seeds of culturally diverse clients' resistance are often planted prior to having any contact with a provider. As is evident across the interview excerpts shared throughout the previous chapter, the South Florida mandated treatment population was described as consisting of large numbers of Latino and Black clients from poor and working-class backgrounds. This descriptive information about the local context is consistent with court-mandated treatment populations across the country, which are typically comprised of individuals from marginalized social groups (O'hare, 1996; Snyder & Anderson, 2009). Many of the specific issues implicated in the manifestation of resistance within the local setting resonate with previous scholarship focused on the cultural and contextual influences on well-being. As such, a review of the salient client experiences identified by participants that are germane to work with clients from Latino, Black, and lower social class backgrounds can help flesh out contextualized explanations of court-mandated client resistance.

A substantial body of literature suggests that the values imbedded within traditional psychotherapeutic practices represent the dominant cultural group of society and therefore often fail to align with the cultural norms and practices of clients from sociocultural minority, economically disadvantaged, or other marginalized groups (Alegrie et al., 2008; Gallo et al., 1995; Leong & Lee, 2006). It was apparent that many participants believed that their clients would not participate in psychological treatments if

it were not for their legal circumstances mandating services. Previous research supports this as Latinos, African American's and other marginalized groups in the U.S. tend to underutilize mental health services relative to Whites (Wells et al., 2001). Scholarship attempting to make sense of these general trends increasingly acknowledges the role of stigmatized views towards mental health and discrimination experiences as critical factors contributing to sociocultural minorities negative perspectives towards psychological treatments (Kouyoumdjian, Zamboanga, & Hansen, 2003; Richman, Kohn-Wood, & Williams, 2007; Snowden, 2011). In the current study, participants outlined similar issues related to their clients' cultural beliefs about mental health treatment and experiences of systemic injustices.

Waldman (1999) suggests that different values and norms between court-mandated clients and the dominate culture offer insights for understanding resistance in Latino clients. The author explores these issues through the acculturative conflicts Latinos often experience upon immigrating to the U.S. and encountering norms and societal values that sometimes fail to align with those of their culture and country of origin. Participants of the current study described their clients that grew up in Cuba and other South American countries as being socialized to develop specific attitudes regarding child rearing, gender roles, and the purpose of mental health treatment, which conflict with the values and norms of the U.S. dominant culture and sometimes explain how their clients become involved in the legal system. For example, participants described encountering clients confused and upset about their mandated treatment in response to using physical means of disciplining children. They noted that clients describe these practices as accepted and normal within the communities and contexts of

their development. As many of these Latino clients were described as associating mental health treatment with “crazy” or “sick” people, a mandate to therapy focused on changing socialized attitudes and behaviors represents one example of the many value incongruences identified between clients in the local context and the dominant culture. The ensuing sense of punishment, cultural alienation, and feelings of being forced to participate in foreign mental health treatment practices were noted among the various vulnerable and disempowering experiences identified as preceding resistance.

The historical relationship between African Americans and the broader context of the United States may provide additional insights regarding the cultural origins of certain forms of client resistance identified by the current study. The concepts of cultural mistrust and cultural paranoia have been used to describe a general tendency for Black members of society to be suspicious of the systems and institutions of the dominant culture due to historical and contemporary experiences of racial oppression and discrimination (Bell & Tracey, 2006; Grier & Cobbs, 1968;). Research suggests that this mistrust can result in Black clients being suspicious of the mental health care system and hesitant to disclose personal information to White therapists (Whaley, 2001). These issues seem to explain findings related to participants experiencing their court-mandated clients’ as suspicious of providers as well as the subtle manifestations of resistance involving client failure to demonstrate the expected levels of participation in remanded treatments.

In addition to client cultural beliefs shaping generally negative views towards mental health care and their mandated treatment, another issue identified as setting the foundation for resistance involved a perceived interaction between court-mandated

clients' backgrounds and specific experiences with the criminal justice system. Prilleltensky's (2012) discussion of the link between fairness and wellness offers additional insights for understanding how an individual client's relationship to the systems of society can influence the resistance observed in mandated treatment settings. For instance, the sociocultural disparities that pervade the criminal justice system represent inequities in terms of how Latinos, Blacks, and economically oppressed groups are treated (procedural injustice) and the legal outcomes they incur (distributive injustice) relative to members of the dominant cultural groups in the United States (Hamparian & Lieber, 1997; Harrison & Karberg, 2004; O'hare, 1996; Sentencing Project, n.d.; Spohn, 2013; Snyder & Anderson, 2009). Findings from the current study suggest that these systemic issues also characterize the local context and influence client perspectives of treatment. Clients' experience of these injustices and their proposed relationship to well-being explains why sociocultural minorities and individuals from marginalized groups have been described as demonstrating anger and hostility towards the criminal justice system by both the current study's participants as well as previous scholarship (Anderson, 1994; Briggs et al.; 2011 Keyes, 2009). In line with the proposed model of resistance, these disempowering affective reactions may contribute to negative views towards the compulsory psychological services associated with a client's legal situation.

Although a substantial body of scholarship exists that aligns with participant perspectives regarding the racial and ethnic dimensions of their clients' experiences, it is important to note that one of the most consistently identified features characterizing the local treatment population was their position on the lower end of the social class spectrum. Participants consistently discussed their poor clients' lives as being defined by

financial struggles, difficulties meeting basic family needs (e.g. buying diapers), and having generally limited opportunities in life. Goodman et al. (2013) provides an extensive discussion regarding the material and psychological deprivation experienced by individuals living in poverty that might further enhance understandings of resistance in the local population. The authors review research outlining the chronic stress (e.g. violent/ unsafe environments), social isolation (i.e. classism), and subsequent sense of powerlessness that characterizes the context of poverty. Moreover, since issues of social class interact with other dimensions of identity (e.g. race, country of origin, etc.), being poor and living in poverty represents an additional source of stress, vulnerability and disempowerment beyond the aforementioned issues conceptualized as influencing the lives of Latino and African American clients in the United States (Smith et al., 2013).

Together, clients' cultural beliefs about mental health and their relationship to the systems of society represent two novel considerations for understanding the resistance of court-mandated clients. The influence of these interacting sociocultural and systemic issues were believed to leave clients feeling disempowered and disconnected from the societal systems they are forced to interact with, which often conflict with the values and norms of clients from diverse cultural groups. Experiences of injustice, cultural mistrust, and stigma represent additional affective experiences in need of consideration. These aversive reactions in response to the compulsory and punitive nature of how clients are thought to perceive their treatment supports previous discussions of the potential iatrogenic effects of mandated social services being thrust on to an individual's life (Baker, 1999). Although these findings recognize the salience of threats to client autonomy outlined in frameworks of resistance with voluntary clients (Brehm & Brehm,

1981; Moyers and Rollnick, 2002), it is clear that a wider variety of vulnerable and disempowering affective states may represent the potential antecedents of resistance demonstrated by court-mandated clients. Importantly, these cultural and contextual dimensions of clients' experiences seem to be critical to fully understanding how clients develop treatment resistant attitudes prior to presenting to treatment.

Sociocultural and contextual influences on the treatment process. Upon entering a professional relationship, participants identified several issues related to clients' experiences across the course of mandated treatment that continue to expand understandings of issues potentially influencing resistance. These discussions often explicitly mentioned the unique features of court-mandated therapy and the cultural dynamics between clients and providers. Many of these findings therefore offer insights regarding an additional set of considerations for understanding resistance, of which clinicians have substantially more influence on relative to the aforementioned sociocultural foundations of client resistance.

Some of the most salient issues outlined within previous literature conceptualizing the differences between mandated and voluntary treatments were explicitly noted when participants shared about their professional experiences. In line with previous scholarship, providers' dual role as therapist and agent of the state responsible for progress reporting and the associated potential legal consequences of client disclosures (i.e. sanction threat) were identified as critical issues contextualizing client treatment experiences and any associated resistance within remanded settings (Bitar et al. 2014; Honea-Boles & Griffin, 2001; Maxwell, 2000). These elements of court-ordered services were described as issues believed to be responsible for court-mandated clients' suspicion

of providers and their hesitance to engage in the treatment process. Participant discussions regarding the impact of these circumstances on the professional relationship further resonate with previous scholarship suggesting that clients often view their clinicians as being part of the legal system, responsible for implementing an aspect of their punishment, and holding the power to impose serious legal consequences on their lives (Baker, 1999; Waldman, 1999). The associated role confusion and disempowered position experienced by clients are therefore critical aspects of the mandated treatment encounter proposed as influencing resistance.

Other salient provider-client dynamics identified by participants during interviews denote additional limitations of frameworks for resistance that fail to consider issues of culture and context. For instance, differences in terms of dimensions of identity within the professional relationship were believed to contribute to resistance if these differences cause clients to question their provider's ability to understand and relate to their experiences. participant discussions suggest that court-mandated clients' frequently make assumptions about their providers' cultural identities and associated capacity for accurately understanding client lives. In contrast, shared dimensions of identity within the professional relationship were described as potentially reducing resistance. These findings are consistent with multicultural theory suggesting that attention to the cultural dynamics between the client and provider, as well as the client and the broader society are essential to developing an accurate conceptualization of presenting concerns, the context in which they developed, and the ability to express empathic understanding in the service of building a working relationship (Gallardo & Curry, 2009; Griner & Smith, 2006; Leong & Lee, 2006; Pederson, Crethar, & Carlson, 2008). Results related to the

benefits of shared dimensions of identity also support previous meta-analyses indicating that clients display strong preferences for providers of similar backgrounds, or racial/ethnic matching within the professional relationship (Cabral & Smith, 2011; Coleman, Wampold, & Casali, 1995). Given the prevalence of Latino providers within the current study, this may be a particularly important issue that might explain why Latino clients in Florida have been identified as experiencing superior rates of mandated treatment completion relative to Black and White clients (Arndt et al., 2013).

The gender dynamics of the local treatment context represent another notable feature of the local context as most participants were women providing mandated services to men. The gendered dimensions of resistance discussed throughout interviews were often central to providers' discussion of their professional experiences. Catlett, Toews & Walilko (2010) explored men's gendered constructions of intimate partner violence and identified many of the same manifestations of resistance identified as particularly frustrating by the current study's participants. The authors described a general tendency for men to minimize and deny responsibility for violence, while simultaneously rationalizing and justifying their violent behaviors. This was particularly notable within low income males' constructions of masculinity. The authors continue to posit that these males' views of their own violent behavior represent attempts at expressing the power, control, and authority embedded within their constructions of masculinity when alternative expressions of power are subverted. For example, a mandate to attend treatment is interpreted as a subversion of interpersonal power, which in the context of current study findings, may help explain the male clients' hostility and the problematic power dynamics described with many female providers.

Additional social processes that take place within mandated treatment settings believed to influence resistance relate to client interactions within group treatment settings. The potential for one client's attitude or behavior to contribute to other group members' resistance underscores an influential aspect of the mandated treatment context not typically incorporated into existing frameworks of the phenomenon. That is, the social interactional dynamics amongst clients during group interventions have not been adequately incorporated into models of resistance created through work with voluntary clients (Beutler et al., 2002; Brehm & Brehm, 1981; Moyers & Rollnick, 2002), nor do these considerations appear within the select multicultural case analyses focused on individual treatment interventions (Baker, 1999; Waldman, 1999). Although findings from the current study did not explicitly implicate the cultural backgrounds of clients as factors responsible for these negative influences of client interactions within treatment settings, participants seemed to conceptualize group treatment settings as having their own unique culture that can be shaped by the individual clients. Within these discussions, resistance was framed as an attitude that can spread throughout the group and influence the norms and standards governing members' behavior during treatment.

The final category of issues identified by participants of this study that are unaccounted for within existing frameworks for resistance relate to broader levels of court-referred clients' ecological context and experiences during the course of treatment. Participants consistently referenced their clients' interactions with members of their families and social communities as contributing to resistance by undermining the effectiveness of interventions. Participant discussions indicated that clients are often met with resistance from members of their family and community when attempting to

integrate treatment content. A wide range of examples were provided regarding the way clients' community contexts can represent a barrier to treatment. Interviews identified instances of family members being unreceptive to clients attempting to incorporate new communication strategies into their relationships as well as the negative influence of clients' communities consisting of deviant peer groups. Clients' social relationships were therefore often believed to be "counterproductive" to the integration of behavioral change.

Given the racial/ethnic (e.g. Latino, Black) and social class (e.g. poor, working class) minorities comprising the treatment population, the underlying issue related to the influence of clients' community on resistance seems to once again relate to a misalignment between the specific behavioral changes many mandated treatment programs seek to enact and the norms and values characterizing clients' community and cultural contexts (Waldman, 1999). For instance, participant discussions of their clients' developmental context frequently noted their clients' historical exposure to violence and previous experiences in jail. It is important to note the physical aggression in these settings may represent a learned strategy that facilitated client coping and survival. Intervention programs that fail to recognize the realities of client contexts run the risk of pathologizing behaviors based on norms and values of the dominant culture, which might otherwise be considered adaptive under certain circumstances. Additionally, participants often noted perceived limitations of the interventions associated with court-mandated treatment programs in terms of their ability to address the full scope of clients' presenting concerns (e.g. education, employment). These views are consistent with community psychologists' critique of traditional psychological interventions aimed at individual-

level change while ignoring aspects of a person's environment and community that hold powerful influence on human behavior and psychological well-being (Evans, Rosen, & Nelson, 2014).

Summary. This study's findings represent promising new directions for understanding court-mandated clients' resistance to psychological services within South Florida and potentially beyond. While recognizing the role of internal psychological experiences of clients and the interpersonal demands of the therapeutic situation outlined in previous research (Beutler et al., 2002; Brehm & Brehm, 1981; Moyers & Rollnick, 2002), this study's findings confirm the value of pushing the scope of analysis beyond that of traditional theories of resistance and their decontextualized focus on clients' characteristics or reactions within treatment. A sociocultural and contextual paradigm of resistance therefore recognizes the need to conceptualize the client in relation to multiple levels of their ecological context. In particular, understanding clients' resistance seems to require consideration of the complex interactions between a client's social identity and their experiences resulting in feelings of vulnerability and disempowerment as they move through the criminal justice and mental health systems.

Clinical Recommendations

Given the qualitative nature of this investigation, it is important to note that the strategies outlined in the grounded theory cannot be interpreted through a lens of efficacious interventions capable of predicting client outcomes across mandated treatment settings. Findings are intended to represent points of participant-providers consensus related to the issues they view as enhancing their conceptualization and the intervention strategies they believe reduce resistance in the local context. The results and

applications of these results are therefore delimited by the perspectives of providers and did not take into account client perspectives. The following clinical recommendations are necessarily limited and tentative.

Despite the inherent limitations in making recommendations as noted above, issues identified across the three primary themes of the grounded theory offer insights regarding what clinicians actively working in the field of mandated psychological services believe to be the necessary considerations for effectively addressing the resistant clients they encounter within South Florida treatment populations. Previous multicultural research has similarly utilized the perspectives of experienced clinicians or experts as a means of illuminating relevant sociocultural issues of consideration for clinical conceptualization and practice (Lee & Tracey, 2008). The following section organizes strategies outlined by participants to formulate a process for how and when to address resistance in the professional relationship.

Adopting a sociocultural and contextual paradigm. Given the expanded understanding of resistance achieved through participant perspectives of their clients' culture and context, there appears to be value in adopting a conceptual lens that actively considers these influences on clients lives. In general, this requires clinicians accumulating knowledge about the issues and experiences associated with the culturally diverse and often marginalized groups represented within a given mandated treatment population. Understanding the current events, political forces, and contemporary issues impacting the lives of the local treatment population represents a critical component of culturally competent practice (Sue, Arredondo, & McDavis, 1992). For example, changing immigration policies and accelerating deportations of alleged criminals may be

an especially important issue impacting the well-being of Latino clients involved in the legal system and their families. An analysis of deportations between 2009 and 2014 revealed that more than 60% of deportations involved people who had committed minor infractions (e.g. traffic violations) or had no criminal record at all (Thompson & Cohen, 2014). Additionally, increased public attention to the deaths of young black men by police and calls for criminal justice reform are emblematic of the contemporary societal conditions that likely maintain cultural mistrust of U.S. institutions. Providers being knowledgeable about these issues is important as they represent elements of the broader societal context within which mandated treatments take place.

Although participants shared detailed information about their clients' backgrounds and experiences in the current study, providers in other settings might also reference the clinical literature associated with the cultural groups to which their clients belong. For example, Sue & Sue (2008) summarize decades of multicultural research outlining traditional values, characteristics, and common experiences associated with Hispanic/Latino-American clients. Some relevant issues identified by this scholarship suggest that individuals from Latin-American cultures often have a strong family orientation and traditional gender/sex role expectations. Additionally, individuals from Latino cultures are described as often experiencing racism and acculturation conflicts within the United States. These cultural issues closely align with participant discussions regarding the gender differences in the professional relationship and value differences between clients and the dominant culture perceived as contributing to resistance. However, it is important to consider that significant within group variations exist amongst Hispanic populations across the United States in terms of nationality, level of

acculturation, language proficiencies, and social class (Castro, Rios, & Montoya, 2006). Accordingly, clinicians must balance recognition of common experiences associated with a particular population, while avoiding stereotyping. Participants in the current study also described maintaining a culturally curious approach to learning about clients by actively seeking opportunities to have clients share their beliefs about cultural differences and relevant experiences impacting the relationship to learn more about their clients' sociocultural contexts.

There are several potential benefits of accumulating knowledge regarding the relevant cultural and contextual issues impacting the lives of court-mandated clients. First, this information facilitates understandings of not only important factors contributing to resistance, but also client experiences and potential treatment needs more generally (Gallardo & Curry, 2009; Leong & Lee, 2006). Second, explicit consideration of a client's culturally shaped worldview was described as helping providers cope with the resistant attitudes and behaviors they may encounter. Participants often noted the emotionally taxing element of their professional experiences with resistant clients. Providers described themselves as facing the brunt of mandated clients' frustrations with their circumstances, examples of which can take the form of overt hostility and/ or negatively biased attitudes towards women. Recognizing these issues as being the product of socialization and only a part of multiple layers of experience was noted as facilitating providers' abilities to avoid personalizing negative attitudes. This also facilitates identification of the more vulnerable feelings (e.g. misunderstood) and disempowering experiences (e.g. trauma, discrimination) thought to be the more primary psychological mechanisms that lead to resistant presentations. These considerations have

significant implications for the body of clinical knowledge as sociocultural and contextual explanations of resistance undermine the hostile or difficult personality portrait of court-mandated populations typically presented in the literature (Beutler et al., 2002; Moyers & Rollnick 200; Wachtel, 1982). Providers are therefore encouraged to actively search for cultural, contextual, or other external explanations of their clients' problematic attitudes or behaviors.

Thus, accumulating knowledge of clients' cultures and remaining cognizant of the sociocultural context shaping their lived experiences promotes providers' ability to accurately understand their clients' circumstances. Providers' ability to incorporate this information into expressions of empathy was identified as the foundational strategy for successfully addressing resistance in the local context and is consistently described as a critical component of culturally competent practice (Gallardo & Curry, 2009; Griner & Smith, 2006; Leong & Lee, 2006; Pederson, Crethar, & Carlson, 2008). As such, these overarching sociocultural considerations facilitate navigating the salient cultural dynamics of remanded treatments when attempting to implement the following specific clinical strategies.

Building the relationship at the outset. Based on participant perspectives, resistance is most likely to arise during the initial interactions with clients. As such, addressing the attitudes and behaviors that can interfere with establishing a working professional relationship and the processes of treatment represent a critical priority during initial contacts with court-ordered clients. Many of the methods outlined by participants in the current study focus on the processes believed to establish a productive relationship between clients and providers. Specific provider tasks include: 1) clarifying roles and

responsibilities, 2) building rapport by distinguishing self from the legal system, 3) joining with resistance, and 4) selling or conveying the benefits of treatment. Of note, prioritization of these different techniques will likely vary in order to appropriately respond to the specific needs and sociocultural context of individual clients.

Knowledge of the client's culture can facilitate identifying how and when the aforementioned strategies might be incorporated into initial professional contacts. For instance, Hays (2016) describes important considerations for developing professional relationships with individuals from Latino cultures. The author's discussion of the Latino cultural value *personalismo* suggests that clients from Latino cultures tend to appreciate informal social interactions that establish an authentic, personal connection within the client-provider dynamic prior to enacting formal processes associated with psychological services. This may be particularly valuable in mandated settings to assuage client suspicions or negative views towards their court-ordered services. It is therefore recommended that initial efforts towards building rapport with Latino clients consider some of the strategies identified in this study intended to distinguish providers from the criminal justice system. Incorporating humor into professional interactions, maintaining a nonjudgmental stance, and appropriate use of self-disclosures can be used in the service of responding to this important cultural value by incorporating authentic aspects of the provider's personality into the professional relationship.

Counseling relationships with African American clients mandated to treatment may also benefit from prioritizing rapport, but for alternative reasons. As outlined above, African Americans' may enter professional healthcare relationships with a healthy amount of suspicion towards their providers due to previous experiences of

institutionalized race-based oppression and social injustices (Bell et al., 2006; Whaley, 2001). Providers may therefore take extra efforts to differentiate themselves and their services from the broader systems of societies. Here again, self-disclosure can represent a valuable tool for establishing trust within the relationship as it involves providers engaging in the specific behaviors that are typically expected of clients.

The far-reaching benefits of therapist disclosures described in the current study closely align with previous research on this issue. Bitar (2014) suggests that therapist self-disclosures hold the potential to strengthen the professional relationship, normalize client problems, and model the act of disclosing in therapy. Although the author identified these benefits through examining Mexican American clients' perspectives of Anglo American providers, the diverse group of participant-clinicians in the current study seemed to identify the same relationship building potential of therapist disclosures across a range of client-provider sociocultural differences. Moreover, current study findings regarding therapist disclosure suggest that this technique is perceived to be beneficial not only within cross-cultural relationships, but also when clients and providers share dimensions of identity. As noted, participant discussions often described intentional disclosures regarding ethnicity, social class, or other issues of shared experiences to convey accurate empathy towards clients questioning their providers' ability to understand or relate to their concerns. These findings lend further support to the use of self-disclosure as a culturally competent intervention strategy for reducing resistance and establishing a working relationship with court-ordered clients.

Following these initial efforts to establish genuine trust and/ or a more personal relational style with Latino and African American clients, the more formal strategies for

establishing the professional relationship may be pursued. Although it is important to be clear about the roles and responsibilities associated with any psychological service (APA, 2002), addressing these aspects of court-mandated treatments seems to be a particularly critical issue in light of the unique circumstances contributing to clients' resistance during an initial encounter. Provider's should take extra care to ensure clients understand the purpose of therapy and nature of the relationship given the perceived lack of familiarity with psychological services characterizing participant descriptions of the population. Explicitly noting the dual role characterizing the clinician's position and joining with clients in recognizing the way this aspect of the relationship or other sociocultural experiences can impact views of mandated treatment represent potentially valuable issues to address early on within the first encounter. During this discussion, providers may want to process the status of the professional relationship to assess resistance and provide clarification of any questions. This opportunity for clients to share reactions can help establish the tone and purpose of a professional relationship, which depends on client disclosures of personal thoughts and feelings. This process also maintains the provider's authentic and invested stance towards the relationship. Following incorporation of these issues into the discourse, it is important to ensure that documentation of consent and professional services cater to clients' language preferences and level of proficiency (APA, 2003). It may also be beneficial to consider the level of match between client-counselor identities when connecting referrals to appropriate treatments. Similar to research regarding racial/ ethnic matching in the professional relationship, clients may have preferences for counselors along other salient dimensions of identity deemed salient in the current study (e.g. social class, gender, etc.). The apparent value of these

considerations stem from participants' consistent discussions of client concerns related to being misunderstood in therapy and the perceived importance of providers' ability to express empathy.

Ultimately, the collection of strategies outlined by participants suggest the value of having open and honest conversations about the powerful forces contributing to client resistance in order to convey understanding of client experiences. Whether it be explicit discussion of the roles and responsibilities of therapy, highlighting the rationale and potential benefits of therapy, or exploring cultural differences, perspectives of successfully overcoming resistance seem to coalesce in the recognition of giving special attention towards building the professional relationship. The value of addressing these topics within the initial contact with a client was consistently described as a necessary precursor for reducing resistance and facilitating providers' ability to implement the primary interventions associated with the mandated treatments they facilitate.

Limitations

Given the qualitative methods employed in the current investigation, caution must be taken when considering the applicability of findings to other settings. Although true of qualitative findings in general, this is an especially important issue impacting court-mandated treatments as previous research suggests the confounding influence of regional differences on remanded treatment processes and outcomes (Arndt et al. 2013; Babcock et al., 2002). Determinations regarding the transferability of the theory and specific intervention strategies must consider the level of congruence between sending and receiving contexts (Lincoln & Guba, 1986). Unfortunately, many of the observations about the treatment environments that provided detailed contextual information were not

included in the final analysis in order to maintain participant confidentiality. However, documented aspects of participants' interpersonal style during the data collection, as well as the sociocultural and contextual information outlined within participant discussions, may facilitate evaluations of the transferability of findings.

Other limitations relate to the research procedures involving theoretical sampling and auditing of the data. In terms of theoretical sampling, it became clear early on during the data collection process that the gender dynamics between male clients and female providers were perceived to be a salient issue related to resistance. Despite several attempts to identify and interview additional male providers and explore potential differences based on clinician gender, only two males with an appropriate level of local experience were able to provide data for the current study. In attempting to utilize participants' professional networks to identify more men for interviews, several providers shared their belief that women represent the majority of court-mandated clinicians within the local context. This issue impacted the auditing of data as only one of the two males was available to provide feedback during the middle and final stages of the project. As such, findings might represent a biased perspective towards the issues and experiences faced by women providers. Additionally, although the vast majority of participants were responsive to multiple follow-up interviews or informal emails to provide feedback during the development of the theory, audits by third party researchers were not nearly as extensive. The researcher's advisor was the only individual not involved in carrying out the research procedures to review full data transcripts with the final products of the investigation. The research procedures may therefore have been improved by utilizing a greater number of third party researchers to implement research procedures. Ideally,

multiple researchers would be involved in the data collection and interpretive analytic processes to protect against researcher bias (Lincoln & Guba, 1986).

Future Directions

Given the rich information generated through exploration of clinicians' experiential knowledge, additional research using qualitative methods seems to represent a valuable means for advancing an area of scholarship that has been stymied by barriers to traditional quantitative paradigms (Arndt et al., 2013; Babcock et al., 2002; Parhar et al., 2008). In particular, more research attending to aspects of court-mandated clients' lives that cause vulnerable and disempowering affective states and additional exploration of the antecedents of resistance represent especially important issues in need of further exploration given their salience within the current investigation. In addition, more research is needed regarding the intersections of client and provider identities as well as the ecological influences on the treatment process. Since a substantial portion of participant discussions represent providers' assumptions regarding the views of their clients, follow up studies focusing on clients' perspectives of resistance would be critical in order to develop a more comprehensive understanding of resistance that reflects the experiences of both sides of the professional relationship. Identifying the issues and experiences clients deem responsible for reducing their resistance and promoting positive outcomes can be used in service of further refining the current grounded theory and continued identification of practical intervention strategies.

The open-ended nature of the research procedures identified that attention to providers' reactions to their professional experiences may also be an important line of additional inquiry. As providers described the powerful emotional impact of their work,

issues of burnout were occasionally referenced. It is possible that negative affective responses to prolonged challenging experiences in the field could negatively impact the professional relationship and influence client resistance. Similarly, in light of the multicultural lens used to situate findings within the literature, discussion of providers' potentially biased attitudes and assumptions towards cultural difference was conspicuous in its absence. Frameworks of multicultural counseling and associated research on mandated treatment with culturally diverse clients emphasize the importance of providers' developing awareness of their own culturally shaped worldviews and the potential for biased attitudes to negatively impact the therapeutic relationship with culturally diverse clients (Baker, 1999). Many of the reflexive memos generated throughout the data collection process documented researcher reactions to the sometimes biased or discriminatory attitudes participants demonstrated during their discussions of culturally different clients. However, participants rarely acknowledged the potential for their own attitudes or assumptions about clients as clinically significant issues of consideration. As such, more research regarding the influence of providers' reactions to their work and attitudes towards clients with different backgrounds may further refine sociocultural conceptualizations of resistance.

Finally, it was apparent that considerations associated with community psychology facilitated discussion of findings in terms of the processes and outcomes court-mandated clients experience across multiple levels of their ecological context. Given the value of adopting principles of community psychology to interpret the salient systemic influences on wellbeing and conceptions of justice into the current discussion, the critical lens often defining this sub discipline may also be worth applying to the arena

of mandated treatment. In discussing the historical emergence of the legal system's incorporation of mental health services into sentencing determinations, Klein (1997) notes that court-mandated intervention programs were not initially adopted in response to evidence that they worked, but because of systemic pressures to find alternative placements for and methods of dealing with offenders. As a result, legally mandated treatments initially emerged through the criminal justice system co-opting the field of psychology into providing mandated treatments. It is important to remember that evidence of the effectiveness of these programs remains elusive to this day and several concerns arise regarding the ethics of mandated interventions and their ability to promote the well-being of individuals and communities (Harris & Watkins, 1987; Snyder & Anderson, 2009). In particular, there seems to be a disconnect between state-sanctioned interventions aimed at changing aspects of individuals and their behaviors, while ignoring the disparities within the justice system and other societal forces that are inimical to the well-being of individuals from certain groups. As noted above, findings from the current study and previous research underscore the potential iatrogenic effects of mandated services on clients lives (Baker, 1999). Thus, although the current study advocates increased use of qualitative methods for better understanding the legally mandated treatments being carried out across the country, it is important to maintain a critical stance towards this societal practice. This can help ensure that the field of psychology is used in the service of improving the lives of mandated clients, rather than a tool of state sponsored social control.

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Appendix A

- How long have you been facilitating court-mandated treatments?
- What regions/ court systems?
- Tell me about your education/training
- What is it like for you to facilitate treatment with a client who is court-ordered versus a voluntary client?
 - How is the process similar?
 - How is the process different?
- What are the target treatment outcomes for court-ordered clients?
- As you conceptualize your treatment, what processes do you believe facilitate achieving target outcomes?
- How have you experienced your clients, who are mandated, demonstrating resistance (if at all)?
- What do you think causes this resistance?
- How does resistance impact the process of therapy?
- How does resistance impact the therapeutic relationship?
- How do you address or overcome this resistance to achieve positive outcomes?
- What theories or research (if any) guide your conceptualization of treatment resistance?
- How do you **engage** your court-mandated clients in the therapeutic process?
- How do you **motivate** your court-mandated clients to make change?
- What **motivates you** to do this work, or what do you enjoy about it?
- Are there any issues you do not enjoy or find challenging? How do you deal with this?

Context

- How might a client's involvement in the legal system impact
 - the treatment you provide?
 - the therapeutic relationship?
 - treatment resistance?

- Are there other factors affecting these client's lives that are important to consider in providing effective treatment with them?

Culture- How would you describe the cultural background or demographic characteristics of the court-mandated clients you work with in south Florida?

- How might your client's background or culture influence their experience in dealing with the legal and mental health systems?

- How do you conceptualize the impact of potential sociocultural differences between you and your clients on the therapy you provide?

- Age, Race, Social Class, Gender, Sexual Orientation, Religion, etc.
- Values
- Worldview
- Lived experiences

Other

- Can you tell me a about your most successful experience with a client?

- What factors/processes facilitated outcomes?

- Can you tell me about your least successful experience with a client?

- Factors factors/processes created barriers to achieving outcomes?

- Are there any other important issues related to working with court-mandated clients that you believe more people should be made aware of?

Throughout the interview, probes will be used to facilitate participant elaboration on the following aspects of treatment:

- Therapeutic Process
- Therapeutic Outcomes
- Personal Reactions

Table 3: List of Themes, Categories, and Code Family Descriptions

Category	Description
A Spectrum of Resistance and the Treatment Process	
Initial Resistance and the Process of Treatment	
At the outset	Situated resistance as critical clinical issue at the outset of the professional relationship.
Challenging Process	Treatment identified as more challenging/ difficult process
Variable outcomes	Identified that resistance can, but does not necessarily, decrease over time.
Subtle manifestations of Resistance	
Noncompliance	Clients fail to meet attendance or financial expectations.
Minimal participation	Clients fail to demonstrate expected levels of participation during services.
Overt Manifestations of Resistance	
Questioning	Clients question their provider's ability to understand or offer help.
Externalizing and denial	Clients demonstrate difficulties taking responsibility, externalize blame, denial.
Conflicts	Overt interpersonal conflicts in professional relationship.
Gendered Dimensions	
Boundaries	Clients demonstrate sexually inappropriate attitudes towards female providers.
Stereotypes	Clients express biased or stereotypical attitudes regarding gender
Power struggles	Identified male client tendencies to dominate or reject help from female providers.
The Vulnerability and Disempowerment Underlying Clients' Resistance	
Conflicting Cultural Values	
Foreign cultural practice	Clients perceive psychological services as foreign cultural practices.
Mental health stigma	Clients hold stigmatized views towards mental health problems.
Male dominance	Clients hold traditional views of gender roles and male dominance
Negative Experiences of the Criminal Justice System	
Cultural disconnection	Clients feel disconnected from the systems of society
Treatment as punishment	Clients experience treatment as punitive
Autonomy threat	Clients experience treatment mandate as threat to autonomy.
Criminal Record	Criminal record limits clients' employment opportunities.
Aspects of treatment contributing to resistance	
Psychopathology	Psychopathology contributes to resistance.
Dual Role	Clients confused about professional roles/ view providers as part of justice system.
Client-Provider Culture Dynamics	Clients question providers' ability relate due to cultural difference.
Client interactions	Interactions between group members influences resistance.
Financial costs	Clients concerned about treatment fees.

Client Community Context as a Barrier to Change

- Interventions limited
- Social barriers to integration
- Limitations of individual-level interventions/ unable to address all of clients' concerns
- Family and social relationships identified as a barrier to integrating treatment content

Successfully Addressing Resistance

- Important Provider Qualities**
 - Tolerating mixed emotions
 - The right personality
- The Need to Develop a Personal Treatment Approach Through Direct Experiences**
 - Limitations of the field
 - Eclectic
 - Gender
- Navigating Cultural Differences**
 - Sociocultural Empathy
 - Curious
 - Avoid personalizing
 - Find a balance
- Joining with the resistance**
 - Empathizing with resistance
 - Normalizing resistance
- Clarifying Roles and Responsibilities**
 - Expectations
 - Dual role
 - Transparent reporting
- Building Rapport by Distinguishing Self From The System**
 - Alliance
 - Humor
 - Avoid judgment
 - Self-disclosure
- Selling**
 - Education
 - Engaging
 - Instillation of hope
- Leveraging Group Dynamics**
 - Clients vouch
 - Client examples
- Professional experiences emotionally taxing/ Pulled between frustration and reward.
- Personality traits/ and interpersonal styles that facilitate success with mandated populations.
- Limitations to existing theory and/ or training related to addressing resistance.**
- Blending multiple practice frameworks/ eclectic treatment approach.
- Gender impacts providers' approach to treatment.
- Express empathy for experience of clients' sociocultural and contextual circumstances
- Described a curious approach to differences in order to facilitate discussion
- Identified the importance of not taking client biases personally
- Acknowledged a balance between sociocultural explanations and personal responsibility
- Suggested the value of acknowledging various experiences contributing to resistance
- Suggested the value of validating clients' resistant attitudes and behaviors
- Must be explicit regarding expectations.
- Acknowledging providers dual role and limits of confidentiality.
- Transparency regarding information reported to third parties.
- Establishing professional alliance as critical early priority
- Benefits of incorporating humor into treatment process/ client interactions
- Emphasized need to maintain nonjudgmental stance towards clients
- Benefits of judicious use of therapist self-disclosures
- Educating clients about treatment and rationale of interventions
- Strategies for engaging clients into the treatment process
- Efforts to convey the potential benefits of professional services
- Utilizing existing therapeutic alliances as reducing resistance in new group members
- Using clients experiencing positive outcomes as an example