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HOMEWORK ASSIGNMENT AND COMPLIANCE REVIEW FROM A BEHAVIOURAL PERSPECTIVE: THE VERBAL SEQUENCES BETWEEN THERAPIST AND CLIENT

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Abstract

Therapeutic (homework) tasks are a characteristic strategy in behavioral psychology to achieve clinical change. The aim of the present study is to determine how behavioural therapists assign therapeutic tasks and review their compliance. Observational methodology was used to analyse the verbal interaction of therapists and clients in 211 recorded sessions (19 complete successful cases) using a validated coding system (SIST-INTER-INSTR). The values for inter- and intra-judge reliability were from good to excellent. The study shows that behavioural psychologists offer motivating verbalisations when assigning therapeutic tasks. During the review of task compliance, therapists frequently provide positive reinforcement when clients report complete compliance with the assigned task but stop the review of tasks when clients report non-compliance or only partial compliance with the task. These sequences provide information about how behavioural therapists provide instructions for therapeutic tasks and review their compliance. This is a first step to study how these verbal sequences favour the establishment of TC and the effectiveness of treatment.
KEY WORDS: *instructions, therapeutic tasks, compliance, therapeutic collaboration.*

Resumen

Las tareas terapéuticas (tareas para casa) constituyen una estrategia propia de la psicología conductual para conseguir el cambio clínico. El presente estudio tiene como objetivo determinar cómo los terapeutas conductuales asignan las tareas terapéuticas y cómo revisan el cumplimiento. Se analizó la interacción verbal entre el terapeuta y el cliente en 211 sesiones grabadas (19 casos completos de éxito) mediante metodología observacional, a través del uso de un sistema de categorización (SIS-INTER-INSTR). Los valores de fiabilidad inter e intrajueces fueron entre buenos y excelentes. Los resultados muestran que los psicólogos conductuales emiten verbalizaciones motivadoras cuando asignan tareas terapéuticas. En la revisión del cumplimiento, frecuentemente refuerzan el cumplimiento de las tareas, pero dejan de evaluar el cumplimiento cuando el cliente informa que las ha realizado de forma parcial. Las secuencias verbales obtenidas proporcionan información sobre cómo los terapeutas conductuales dan

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instrucciones sobre las tareas terapéuticas y como revisan su cumplimiento. Esta información es un primer paso en el estudio de cómo esas secuencias pueden predecir o contribuir al establecimiento de una óptima colaboración terapéutica y a la eficacia del tratamiento.
PALABRAS CLAVE: *instrucciones, tareas terapéuticas, cumplimiento, colaboración terapéutica.*

Introduction

In psychotherapy, therapeutic collaboration (TC) has been defined as the alliance of the psychologist and the client in therapeutic work (Ribeiro et al., 2013). Rather than placing responsibility solely on the client, some authors regard TC as the result of therapeutic action occurring during the clinical session between therapist and client. This methodology involves, among other questions, the setting of shared objectives by the psychologist and the client taking place during the clinical encounter (Horvath, 2013; Ribeiro et al., 2018; Tryon y Winograd, 2011).

Studies have shown that therapeutic collaboration has significant impact on the development of the therapeutic relationship. Specifically, this relationship can be considered appropriate when an optimum degree of TC is established (Ribeiro et al. 2014). Furthermore, TC has proven to be important not only in the building of an effective therapeutic alliance but has also been found effective in achieving positive results in clinical interventions (Bachelor et al., 2007). For example, a study by Taveira et al. (2017) found that collaborative work is associated with client progress and, thus, with positive clinical change. Similarly, Ribeiro et al. (2019) found more non-collaborative episodes in cases considered therapeutic failures in comparison with those considered successful.

Beyond the success of clinical intervention, the abandonment of therapy has also been shown to have a relation with the maintenance, or rupture, of TC between therapist and patient. For example, a study by Cardoso et al. (2020) found that the proportion of ruptures of TC was higher in cases where therapy was discontinued. A study by Pinto et al. (2018), analysing seven cases where therapy was discontinued, observed how TC had diminished over the course of the intervention. Similar results have been found in cases of different therapeutic perspectives (e.g., Ferreira et al.; 2015; Ribeiro et al. 2014; 2016).

These studies reveal the importance of therapeutic interaction (or therapeutic conversation) in building a therapeutic relationship and ultimately achieving positive therapeutic outcomes (Pinto et al. 2018). This idea contrasts with a vision focused on the client's diagnosis or symptomatology as the causal agent of the therapeutic relationship. Consequently, this approach highlights the interdependence between therapeutic processes and the results of clinical intervention, two areas of research which have been traditionally at odds within the field of psychology (Froján et al., 2006).

From a behavioural point of view, this interdependence between processes and results is reflected in the instructions provided for therapeutic tasks, aimed at applying behaviour modification techniques and, ultimately, achieving positive

clinical change. However, these tasks cannot be understood without taking into consideration how TC and the therapeutic alliance contributes to achieving these outcomes. (Kazantzis et al., 2003).

It is therefore essential to study the micro-processes within the clinical context, analysing, moment to moment, the interaction of the therapist and the client (Taveira et al., 2017). Nevertheless, the majority of research into the assignment of tasks focusses on clinical recommendations, constructed on the basis of what the therapists and clients say happens in the clinical context through the use of questionnaires (e.g., Coon et al., 2002; Cronin et al., 2015; Kazantzis & Lampropoulos, 2002; Startup & Edmons, 1994). However, these methodologies are at odds with the guidelines of the Task Force on Evidence Based Relationship and Responsiveness of the American Psychological Association, which recommend the use of an observational methodology for research in the field of therapeutic relationship (Norcross & Lambert, 2018).

Following this methodology, some researchers have offered a descriptive study of how psychologists provide instructions on therapeutic tasks from a behavioural perspective. For example, Ruiz et al. (2015) found that after receiving task instructions, clients tended to show greater acceptance or ask for further information on the instructed task; a study by Galván et al. (2020) found that therapists generally provide instructions for therapeutic tasks as a response to anti-therapeutic verbalisations by the client. Beyond these descriptive studies, de Pascual and Trujillo (2018) conducted a correlational study in which they found greater compliance with therapeutic tasks by clients when therapists provided instructions accompanied by verbal motivators.

Despite the importance of these findings, these studies analyse the entire therapeutic process and not specifically the moments when the therapist assigns and reviews therapeutic tasks. Consequently, the coding systems used by the authors do not identify the particularities of these specific moments in clinical sessions. Considering this limitation, and the importance of therapeutic tasks within the context of behavioural therapy, the present study aims to further the understanding of therapeutic processes from a behavioural perspective. The goal, therefore, is to answer the question: what is the verbal interaction between therapist and client when therapeutic tasks are assigned and reviewed? Thus, the specific aim of the present study is to describe the verbal sequences between therapist and client when therapist assigns and reviews the therapeutic tasks.

Answering this question represents a first descriptive step, focussing on the specific TC taking place when therapeutic tasks are assigned and reviewed. This first step will serve as a point of departure for future studies to analyse the role of TC during compliance with therapeutic tasks and, ultimately, the outcome of the clinical intervention.

Method

Participants

The sample consisted of 211 clinical sessions with a duration of approximately one hour corresponding to 19 cases treated by 11 therapists with varying degrees of experience. All the cases were considered successful because the therapeutic goals were achieved, and the clients discharged from therapy. The cases were selected using a non-probability, convenience sampling. The therapists were staff at a private clinic in Madrid and they were not aware about the aim study. The psychologists used behavioural therapy methodology and all cases involved adults receiving individual psychological treatment. The most relevant characteristics of each case are provided in Table 1.

Table 1
Characteristics of the sample

Case	Number of sessions and average duration	T	Sex	Age	Condition
1	13 (00:58:48)	1	F	29	Depression
2	10 (00:48:54)	1	F	32	Marital problems
3	8 (00:39:20)	1	F	36	Agoraphobia
4	10 (00:48:00)	2	M	42	Anxiety
5	12 (00:59:21)	2	M	58	Depression
6	13 (00:48:36)	3	M	36	Anxiety
7	8 (00:46:17)	3	M	18	Panic attacks
8	12 (01:01:55)	4	M	48	Anxiety
9	9 (00:56:44)	5	F	29	Anxiety
10	12 (01:07:00)	6	M	34	Hypochondria
11	11 (01:04:31)	7	F	24	Family conflicts
12	7 (00:48:47)	2	F	25	Eating disorders
13	8 (00:43:38)	4	M	21	Arachnophobia
14	11 (01:01:23)	5	F	34	Marital breakup
15	8 (00:52:20)	8	F	19	Social skills deficit
16	10 (01:09:29)	9	M	22	Anxiety
17	19 (00:53:00)	10	M	22	Anxiety
18	16 (01:01:25)	10	M	22	Social skills deficit
19	14 (00:56:48)	11	F	22	Jealousies
Total	211 (196h 12m 23s)		M= 53% F= 47%	*M*= 30.15 *SD*= 10.6	

Note. T= Therapist number; M= Male; F= Female.

Instruments

The *Categorization System of the Therapist and the Client's Verbal Behaviour During the Instructions Emission and Compliance Review* (SIST-INTER-INSTR) was created to codify the verbal exchange during sessions. The coding system is divided into two parts or blocks: instruction blocks, corresponding to the moments when the therapist is providing instructions for the assigned therapeutic task; and review blocks, corresponding to the moments when the therapist is reviewing compliance with the assigned task.

The instruction blocks were deemed to start when the therapist began to talk or assign the homework task and provide instructions. The block was considered concluded when the clinician or the client changed the subject of discussion or when the therapist began instructing a different task. In this latter case, a new block was opened.

Similarly, the review blocks were deemed to start when the therapist began to evaluate the compliance with the tasks. These blocks were considered concluded when the therapist or the client changed the subject of the discussion or when the therapist began to evaluate the compliance of a different task. In this latter case another review block was opened.

These instruction and review blocks contain the specific verbalisations of the therapist and client according to their content. The category criteria and examples are provided from Tables 2 to 5.

Table 2

Categories of therapist verbalisations in the instructions blocks of the SIST-INTER-INSTR

Categories	Description	Example
Instruction	Verbalisation of the therapist assigning the client an extra-clinical therapeutic task (homework).	"This week you have to expose yourself to the next item: to take the subway. Once a day…"
Discriminative of viability	Verbalisation to evaluate the feasibility of the client carrying out the instructed task.	"Would you have time this week to make an enjoyable activity from the list we made?"
Discriminative of difficulty	Verbalisation to evaluate the potential difficulties of the task foreseen by the client.	"Tell me, do you think this task will be difficult for you?"
Discriminative of opinion	Verbalisation to evaluate the opinion of the client regarding the instructed task.	"Do you agree with the task? What do you think?"
Discriminative of execution	Verbalisation to evaluate how the client will perform the instructed task.	"How will you do it? How will you tell him?"
Discriminative of comprehension	Verbalisation to evaluate if the client understands the instructed task.	"Do you understand what you have to do this week? It is clear?"
Establishing operation	Verbalisation to increase the probability the client will carry out the instructed task.	"It will help you", "If not, you will feel bad"

Table 3
Categories of client verbalisations in the instructions blocks of the SIST-INTER-INSTR

Categories	Description	Example
Anticipation of compliance with instructions	Verbalisation indicating the intention to carry out the instructed task.	"Yes, I will do it, I need to change the way of do this"
Anticipation of non-compliance with instructions	Verbalisation indicating the intention to not carry out the instructed task.	"Sincerely, I think I won't be able to do it"
Showing acceptance	Verbalisation in which the client indicates agreement with the therapist.	"Okay", "Perfect", "No problem".
Showing disagreement	Verbalisation in which the client indicates disagreement with the therapist.	"No, please, don't ask me that"
Providing information	Verbalisation which provides information relevant to the instructions of the therapist.	"That's exactly what I think have to do, but I don't know how"

Table 4
Categories of therapist in the review blocks of the SIST-INTER-INSTR

Categories	Description	Example
Discriminative of specific compliance	Verbalisation to evaluate compliance with a specific task.	"Have you exposed this week to take the subway?"
Discriminative of non-specific compliance	Verbalisation to evaluate compliance of tasks in general.	"Have you done the homework?"
Compliance discriminative of difficulty	Verbalisation to evaluate the existence of client problems in complying with instructed tasks.	"Did you have any problem with breathing technique?"
Compliance discriminative of execution	Verbalisation to evaluate the manner in which the client carried out the instructed task.	"Tell me, how did you criticise him?"
Reinforcement	Verbalisation of approval, agreement, or acceptance with the verbalisation of the client on compliance of the task.	"That is great, congratulation! It is a big step!"
Punishment	Verbalisation of disapproval, disagreement, or denial with the verbalisation of the client on compliance of the task.	"It is not an excuse, that's not right"

Table 5
Categories of client in the review blocks of the SIST-INTER-INSTR

Categories	Description	Example
Total compliance with instructions	Verbalisation indicating total compliance with the instructed task.	"Yes, I did the list of pleasant activities, here you have"
Partial compliance with instructions	Verbalisation indicating partial or occasional compliance with the instructed task.	"Well, I did not practice relaxation every day, only three days"
Non-compliance with instructions	Verbalisation indicating non-compliance with the instructed task.	"I am sorry, but this week it was impossible for me"
Verbalisation of achievement	Verbalisation indicating the therapeutic objectives achieved through the treatment.	"I got it; I can't believe I drove alone"
Verbalisation of failure	Verbalisation indicating the failure to achieve therapeutic objectives or a specific task.	"It was a disaster, I feel disappointed"
Providing information	Verbalisation which provides information relevant to compliance with the task.	"This time was easier for me to practicing the relaxation"

Procedure

The present work is based on the identification of verbal instructions provided by the therapist using a categorisation system developed by Froján et al. (2008). During the initial stage, in order to refine the category system, an expert in behavioural therapy (Observer 1) observed the clinical sessions to propose categories for the verbalisations of the therapist and client during the instruction and review blocks. A second observer (Observer 2), also experienced in behavioural therapy, encoded the same clinical sessions as Observer 1 in order to refine the categorisation system. Any discrepancies were discussed in periodic meetings of a team of experts in observational methodologies and categorisation systems for verbal behaviour. The result was an agreed system of categories which took into account the theoretical and clinical questions raised during the meetings. This refinement phase was considered completed when the Cohen's kappa value was between "good" and "excellent" in 10 consecutive sessions (Bakeman, 2000; Landis & Koch, 1977).

After the refinement phase, the sample was selected. To ensure the reliability of the coding system, the percentage of inter- and intra-judge agreement and the Cohen's kappa were calculated. As indicated in the "Researchers" section above, after the encoding of a complete case by Observer 1, a randomly selected session and the following session were encoded by Observer 2. This same procedure was performed for intra-judge comparisons. A total of 38 inter-judge comparisons and 38 intra-judge comparisons were carried out. For all these inter- and intra-judge comparisons the Cohen's kappa remained as in the refinement phase (between .7 and 1 for inter-judge comparisons and between .7 and .95 for intra-judge comparisons). Finally, the data was exported for analysis using an appropriate software.

Prior to recording, observation and analysis of the sessions, all participants gave their authorisation in writing by means of a model informed consent form, approved by the Research Ethics Committee of the Autonomous University of Madrid.

RESEARCHERS

Two observers with prior experience in the use of observational methodology and coding systems acted as judges in the study. Both observers had clinical and research background in behavioural therapy and at least five years of experience. After independently coding, the observers met to resolve any disagreements. Two sessions were chosen at random from each completed case. In both sessions, the percentage of inter-judge agreement and the Cohen's kappa were calculated to ensure a level of reliability between "good" and "excellent" (Bakeman, 2000; Landis & Koch, 1977).

Similarly, intra-judge agreement and the Cohen's kappa were calculated for Observer 1. After coding a complete case, two sessions were chosen at random and re-coded by Observer 1. These two sessions were re-coded after all the sessions of the following case were coded. That is, after all the sessions of case 1 were coded by Observer 1, two of these sessions were chosen at random and then re-coded by the same Observer after coding all the sessions of case 2.

Data analysis

A sequential analysis was carried out to evaluate the verbal sequences. This analysis was based on observed frequencies, determining the probability an event will occur before and after another event (from now on, latency -1 and latency +1). In terms of verbal categories, we analysed the probability of each verbal category occurring before and after another selected category (chosen by the researcher). For example, we can explore which client verbalisation is most likely (and statistically significant) to occur before and after an instruction. This type of analysis uses *z* scores to determine if the associated probability is statistically significant. Thus, a *p* value of $p < .05$ or $p < .01$ indicates a significant statistical association between these verbal categories. Additionally, Yule's *Q* is used as effect size, indicating the strength of association between verbalisations from 0 to 1, being 1 the maximum association (Bakeman & Quera, 1994).

The Observer XT software was used to encode all the sessions and GSEQ v.5.1. software was used to analyse the verbal sequences in the interaction between the therapist and the client.

Results

Firstly, regarding the instruction blocks shown in Table 6, these start directly with the category of instruction (e.g., "Practice the relaxation for ten minutes before going to take the car") as this is the most common occurrence in latency -1. The next categories with significant association prior to the instructions were,

from highest to lowest: establishing operation (e.g., "You've checked that relaxation technique make you feel quieter, it helps you…[1]"), discriminative of viability (e.g., "Would you have 10 minutes before to take the car to practice the relaxation? ...") and execution (e.g., "How could you practice relaxation technique before to take the car? On the sofa? ...").

Table 6
Verbalisations of the therapist before and after the instructions

Latency		I. B.	E. O.	D.	D. Diff.	D. Opi.	D.Via.	D. Exe.
Before (-1)	*Q*	.90	.77	.03	.31	.25	.48	.48
	z	54.84**	38.40**	.15	1.04	1.92	-3.73*	2.78*
After (+1)	*Q*	.35	.86	.62	.61	.63	.39	.84
	z	12.80*	48.39**	5.30*	2.54*	6.28*	2.83	6.64**

Notes: I. B.= Start/stop instruction block; E.O.= Establishing operation; D. Com.= Discriminative of comprehension; D. Diff.= Discriminative of difficulty; D. Opi.= Discriminative of opinion; D. Via.= Discriminative of viability; D. Exe.= Discriminative of execution. ***p*< .01; **p*< .05.

The most probable verbalisations occurring after instruction (latency +1) were the establishing operation category (e.g., "…and you will feel better"), followed by the discriminative of execution (e.g., "… tell me, how will you do it?"), opinion ("… what do you think about this task?"), comprehension ("… it is clear for you?") and difficulty ("… do you think you will have any problem with this task?").

Regarding the client categories after instructions sequences (latency +1), Table 7 shows the only category with statistically significant association was acceptance ("perfect"/"okay").

Table 7
Verbalisations of the client after the instructions of the therapist

Latency		Request information	Provide information	Anticipation of compliance	Show acceptance
After (+1)	*Q*	.20	-.57	.25	.20
	z	.33	-6.86	1.12	3.19*

Note: **p*< .05.

Secondly, Table 8 shows the most frequent category occurring after (latency -1) the verbalisation of total compliance with instructions by the client (e.g., "Yes, I did, I have exposed myself to riding the subway") was the discriminative of specific and non-specific compliance (e.g., "Have you exposed to the subway?/Have you done the tasks?"). It was also found that the review block frequently starts directly

[1] Ellipsis indicates where instruction is located within the verbal sequence.

with the verbalisation of total compliance of the client (e.g., "I had a conversation with her as you asked me last week!"). The next most frequent category before the total compliance is the start of the review block.

After total compliance with instructions (latency +1), reinforcement was the most statistically significant association (e.g., "Well done!"); other categories in descending order of frequency were: compliance discriminative of difficulty (e.g., "Did you have any problem with the task?"), execution (e.g., "Tell me, how did you do"?), and the discriminative of specific compliance (e.g., "And have you practice the relaxation every night before bed?").

Table 8
Verbalisations of the therapist before and after the verbalisations of total compliance with instructions by the client

Latency		R. B.	D. Sp.	D. N-Sp.	D. Diff.	D. Exe.	Reinf.	Pun.
Before (-1)	*Q*	.56	.97	.98	-1	-1	.25	-1
	z	14.12*	60.61**	32.08**	2.65	-3.12	3.53*	-.67
After (+1)	*Q*	-.95	.29	-.16	.90	.78	.95	-1
	z	-8.37	4.89*	-.85	16.91**	12.16**	48.75**	-.67

Note. R. B.= Start/stop review block; D. Sp.= Discriminative of specific compliance; D.N-Sp.= Discriminative of non-specific compliance; D. Diff.= Compliance discriminative of difficulty; D. Exe.= Compliance discriminative of execution; Reinf.= Reinforcement; Pun.= Punishment. $^{**}p < .01$ $^{*}p < .05$.

Regarding partial compliance with instructions (e.g., "I have practiced relaxation, but not every day as you recommended"), Table 9 shows the categories most likely to be associated to it. As was the case with total compliance, the discriminative of specific and non-specific compliance are the categories that precede it most frequently (latency -1.). No therapist category showed any statistical significance preceding partial compliance, given that the next most likely occurrence was the start of the review block. This sequence indicates that homework review often started directly with the verbalisation of partial compliance with instruction by the client.

In contrast to total compliance, the categories most frequently occurring after the verbalisation of partial compliance (latency +1) are varied, the most probable being that the therapist ends the review block. However, other statistically significant categories occurring after the verbalisation of the client, by the degree of association, were reinforcement, punishment (e.g., "That's not right!"), compliance discriminative of execution or the discriminative of specific compliance to assess compliance of a different task.

Finally, Table 10 shows the categories that most likely preceded (latency -1) non-compliance with instructions (e.g., "I am sorry, but I did not talk to her as you asked me, I could not"). Prior to non-compliance category, the discriminative of specific and non-specific compliance are the most probable categories. The most likely category following the verbalisation of non-compliance (latency +1) is for the therapist is to end the review block. That is, the therapist changes the subject of the discussion. However, the next most probable option is for the therapist to

punish non-compliance or, lastly, to emit a discriminative of specific compliance, that is, to start reviewing compliance of a different task.

Table 9
Verbalisations of the therapist before and after the verbalisations of partial compliance with instructions by the client

Latency		R. B.	D. Sp.	D. N-Sp.	D. Diff.	D. Exe.	Reinf.	Pun.
Before	*Q*	.47	.95	.52	-1	-1	.02	-1
(-1)	*z*	3.77*	24.94**	2.04*	-.82	-.96	.10	-.21
After	*Q*	.93	.45	.01	.21	.65	.69	.64
(+1)	*z*	6.26**	3.35*	.02	.43	3.30*	6.96*	4.67*

Note. R. B.= Start/stop review block; D. Sp.= Discriminative of specific compliance; D.N-Sp.= Discriminative of non-specific compliance; D. Diff.= Compliance discriminative of difficulty; D. Exe.= Compliance discriminative of execution; Reinf.= Reinforcement; Pun.= Punishment. ***p*< .01 **p*< .05.

Table 10
Verbalisations of the therapist before and after the verbalisations of non-compliance with instructions by the client

Latency		R. B.	D. Sp.	D. N-Sp.	D. Diff.	D. Exe.	Reinf.	Pun.
Before	*Q*	.09	.97	.69	-1	-.21	-.74	-1
(-1)	z	.60	36.00**	5.02**	-1.06	-.42	-2.19	-0.27
After	*Q*	.99	.33	-.25	.05	.14	-.24	.74
(+1)	*z*	14.80**	2.68*	-.51	-.10	.40	-.97	11.66**

Note. R. B.= Start/stop review block; D. Sp.= Discriminative of specific compliance; D.N-Sp.= Discriminative of non-specific compliance; D. Diff.= Compliance discriminative of difficulty; D. Exe.= Compliance discriminative of execution; Reinf.= Reinforcement; Pun.= Punishment. ***p*< .01 **p*< .05.

Discussion

The goal of our research was to identify the sequence of verbalisations between behavioural therapists and clients when instructing and reviewing compliance with therapeutic tasks. This goal has been achieved satisfactorily. This aim is in line with the importance behavioural therapy assigns to homework in the development of new skills within a natural context by which clinical change will take place (Kazantzis & Lampropoulos, 2002).

Results show that therapists usually dedicate moments of the sessions to provide instructions on the therapeutic tasks. These moments generally start directly with an instruction, for example "practice breathing technique as we have done in the session…". This is usually followed by the client expressing their agreement, for example, with an "okay" or an "alright". This sequence may be considered the prototypical form in which behavioural therapists assign homework and reflects the directive character of the behavioural therapy (Marinho et al., 2003). However, this is at odds with the TC methodology, which highlights the importance of the therapist-client alliance to build agreement and shared goals (Ribeiro, 2009).

However, other significant sequences indicate that in behavioural therapy the therapist-client collaboration is also present, generally in the form of motivational verbalisations (establishing operation category) before providing instructions for the task. For example, "After eating you automatically light a cigarette. You do not think about it and only realise it once you have lit the cigarette. That's why we need other behaviour to counteract this…". The therapist may follow this with the instruction: "…When you finish eating, I want you to brush your teeth immediately". This strategy is in line with what researchers suggest about the importance of explaining to clients the logic underlying therapeutic tasks before assigning them (Addis & Jacobson, 2000).

This use of motivational verbalisation was also found after the instruction of the task, for example, "Practice breathing techniques as we have done in the session and gradually you will find you can reduce nervousness at those moments when you feel overwhelmed". This strategy shows that therapists are aware of the positive effect of explaining the relation between task compliance and the consequences for clinical change (de Pascual & Trujillo, 2018; Eder & Dignath, 2017; Froján & Ruiz, 2013).

However, the best indication of the collaborative relationship between therapist and client is that the therapist will often pose questions to encourage task compliance, especially related to the client's perception of the feasibility of carrying out the task (e.g., "Do you think you could find an hour every day to look at spiders' pictures?"), and how the client will perform the task (e.g., "So, tell me how you could tell him without bothering him"). Both strategies usually take place before and after instructing the task. Additionally, after providing instruction, therapists also ask the clients about their opinion about the task (e.g., "What do you think? Do you agree with the task?"); whether they have understood the task (e.g., "Any doubt about the task?"), or their anticipation of potential difficulties in the performance of the task (e.g., "What difficulty do you think you will have to talk to her").

Beyond specific types of verbalisations, these sequences show that the moment of homework assignment during clinical sessions is a space for negotiation and shared collaboration in pursuit of a common goal. This suggests that behavioural therapists generally apply the strategies recommended by researchers when assigning homework (Conoley et al., 1994; Cronin et al. 2015; Freeman & Rosenfield, 2002; Garland & Scott, 2002; Kazantzis & Deane, 1999; Kazantzis & Lampropoulos, 2002).

This collaborative work between therapist and client is also reflected in the review of task compliance. The therapists usually evaluate the degree of task compliance of the client, reflected in the use of discriminative of specific (e.g., "Have you practice the stop-thinking technique?") and non-specific ("Have you done the tasks?") compliance which always occurs immediately before the client's compliance report (total, partial or non-compliance). This active evaluation of compliance by the therapist denotes a common interest in achieving therapeutic goals. This shows that the tasks assigned by therapists are not merely helpful advice but rather specific skills that the client must work to develop in the extra-clinical context, and which are the key to behavioural change. These actions on the

part of therapists are in line with the clinical guidelines regarding the importance of being systematic when evaluating compliance (Johnson & Kazantzis, 2004; Kazantzis & Deane, 1999; Shelton & Levy, 1981).

More relevant from a clinical view are the findings about what therapists do when clients talk about compliance: to provide positive reinforcement (e.g., Well done! That's great!") when clients report they have fully implemented the task, or to assess difficulties in implementing the task (e.g., "Did you have any problem when you practice the relaxation technique?" or "Tell me how you told her"). These findings suggest that therapists want to consolidate task implementation through positive reinforcement and to identify potential obstacles to future compliance. Both strategies are considered clinically relevant in adapting future tasks to the client (Coon & Gallagher-Thompson, 2002; Cronin et al. 2015; Garland & Scott, 2002; Kazantzis & Lampropoulos, 2002; Startup & Edmons, 1994).

Contrary to situations of full compliance, therapists generally do not continue talking about task compliance when clients report having only partially completed or not completed a task. But, in other moments, therapists reinforce, reprimand (e.g., "That's not good!") or assess the way of implementing the task (e.g., "Tell me how you did it") when the compliance is only partial, and they also reprimand clients for non-compliance. This range of responses to client verbalisations is in line with studies that offer recommendation about how to respond to compliance in order to favour future compliance (Burns & Auerbach, 1992; Cronin et al. 2015; Datilio, 2002; Garland & Scott, 2002; Leahy, 2002). From a clinical perspective, we hypothesise that the range of responses take into account the real progress of the client. Thus, for example, therapists sometimes reinforce the partial compliance reported by the client, but other times they reprimand it, as a shaping process to motivate and engage the client to promote future compliance.

Despite these findings, it is important to note some significant limitations of the present study: firstly, it was based on interventions considered to be successful, although no measurements of outcomes were taken. Thus, future studies should include other measurements of clinical change beyond merely the achievement of therapeutic goals. Similarly, the absence cases of therapeutic failure make it impossible to identify and contrast any differences in the instruction and review of therapeutic tasks. Due to these limitations, the present study is descriptive and does not establish a clear relationship between processes and outcomes. Finally, another important limitation is the use of a sample from a single private clinic where the therapists may use similar methods and practices. Thus, it is difficult to extrapolate the findings to other behavioural therapists. These limitations lead us to view the results with caution and interpret the results as an invitation to further studies.

Beyond these considerations, it is important to highlight the clinical implications of the present study, which offers valuable insights into the verbal interaction between therapist and client when instructing and reviewing the compliance of therapeutic tasks. As noted in the justification, this aspect is particularly relevant from a behavioural perspective given that therapeutic tasks are essential to achieving clinical change. Thus, considering that some researchers

regard non-compliance of tasks as common in psychotherapy (Hansen & Warner, 1994; Helbig & Fehm, 2004), identifying how therapists assign homework tasks and review compliance is a necessary first step in researching therapeutic compliance.

Related to this, some studies have shown that TC, which also includes task compliance, is associated with therapeutic outcomes (Essoe et al. 2021; Hara et al., 2017; Mausbach et al., 2010; Shirk et al., 2018). Thus, improving task compliance will enhance the effectiveness of psychological interventions (LeBeau et al., 2012). From this perspective, the findings of this study may help provide psychotherapists with techniques to promote CT when assigning homework and reviewing compliance. Additionally, this could help improve the training of psychologists, providing them with the collaborative skills which evidence shows can have positive therapeutic effects (Plantade-Gipch et al., 2021). Thus, improvements in these aspects could have an impact on task compliance, and ultimately, on treatment outcomes. Although we are still far from achieving this goal, this is a promising start to a line of research which will no doubt be fruitful in the future.

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