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Therapeutic collaboration and resistance: Describing the nature and quality of the therapeutic relationship within ambivalence events using the Therapeutic Collaboration Coding System

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EMPIRICAL PAPER

Therapeutic collaboration and resistance: Describing the nature and quality of the therapeutic relationship within ambivalence events using the Therapeutic Collaboration Coding System

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Abstract

Objectives: We understand ambivalence as a cyclical movement between two opposing parts of the self. The emergence of a novel part produces an innovative moment, challenging the current maladaptive self-narrative. However, the novel part is subsequently attenuated by a return to the maladaptive self-narrative. This study focused on the analysis of the therapeutic collaboration in episodes in which a relatively poor-outcome client in narrative therapy expressed ambivalence. **Method:** For our analysis we used the Therapeutic Collaboration Coding System, developed to assess whether and how the therapeutic dyad is working within the therapeutic zone of proximal development (TZPD). **Results:** Results showed that when the therapist challenged the client after the emergence of ambivalence, the client tended to invalidate (reject or ignore) the therapist's intervention. **Conclusions:** This suggests that in such ambivalence episodes the therapist did not match the client's developmental level, and by working outside the TZPD unintentionally contributed to the maintaining the client's ambivalence.

Keywords: alliance; process research; ambivalence; narrative

Therapists of all orientations report phenomena that can be understood as resistance (Wachtel, 1982, 1999). We conceptualize resistance as an interpersonal phenomenon that reflects both the client's ambivalence, or degree of internal conflict regarding change, and the way the therapist responds to this ambivalence (Moyers & Rollnick, 2002). The therapist's response to the client's expressions of ambivalence is critical because robust empirical evidence indicates that higher levels of resistance are consistently associated with poor therapy outcomes, as well as premature termination of treatment (for a review, see Beutler, Rocco, Moleiro, & Talebi, 2001).

Wachtel (1999) claimed that the quality of the therapeutic relationship plays a central role in

determining the level of resistance. Increased resistance can be a sign that the patient feels unsafe, which can reflect the therapist relating to the client in a way he or she experiences as threatening (Wachtel, 1993). Attention to the therapeutic relationship is thus a crucial factor in reducing resistance (Wachtel, 1999).

We used a moment-to-moment analysis of therapeutic collaboration of a case of a relatively poor-outcome client in narrative therapy to study ambivalence and resistance with the *Therapeutic Collaboration Coding System* (TCCS; Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, 2013). The TCCS was developed to assess whether and how the therapeutic dyad is working within the *therapeutic zone of proximal development* (TZPD). TZPD is the

interval between the client's actual developmental level and the potential developmental level that can be achieved in collaboration with the therapist. We shall elaborate this concept in a later section.

Our Theoretical Framework of the Self and Concept of Change

We construe narratives as tools individuals use to join together life events into coherent units (Dimaggio et al., 2003). Human beings are able to reconstruct their experiences in the form of narratives and then use them as schemata to make sense of the continuous flow of events.

These narratives are the result of the continuous dialogue between multiple parts of the self, which we describe as internal *voices*. Theoretically, voices are constructed from the traces of the person's experiences, including experiences passed to them through other people by signs and stories (Stiles, 2011). Each voice is agentic and possesses its own characteristics and ways of being in the world (Hermans, 1996, 2001a, 2001b; Hermans & Dimaggio, 2007; Hermans & Kempen, 1993; Leiman, 1997, 2002; Osatuke et al., 2004). Insofar as the self is composed of voices, each utterance or action by a person is the action of some internal voice or the coordinated action of several voices.

In line with the assimilation model (Stiles, 2002, 2011), we consider that constellations of similar or related internal voices become linked or *assimilated* and constitute a *community of voices*. This community is experienced by the person as their usual sense of self, personality, or center of experience. Theoretically, psychological distress is a product of the disconnection or exclusion of certain voices from community. The self-narrative is the *meaning bridge* among members of the community of voices. A meaning bridge is a semiotic framework—a system of words and other signs that can represent, link, and encompass the previously separated voices, binding the experiences/voices together, thus allowing smooth mutual access to experiential resources, and enabling joint action (Stiles, 2011). An experience/voice may be disconnected from the community, and thus problematic, if the self-narrative is too rigid and excludes it (Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011). For example, if a self-narrative has no place for active self-promotion, then experiences of ambition may be unrecognized, distorted, or distressing. Viewed from this theoretical perspective, a client's initial (presenting) dominant self-narrative may be maladaptive because it fails to acknowledge important parts of the client's life experience.

In line with Gonçalves and co-workers' narrative perspective, instances in which unassimilated voices

express themselves constitute exceptions to the maladaptive self-narrative and are identified as *innovative moments* (IMs) (Gonçalves, Matos, & Santos, 2009; see also Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). The accumulation and elaboration of IMs facilitate the development of an alternative self-narrative; when unassimilated voices express themselves, the dominance of the current community of voices is disrupted, at least temporarily, opening an opportunity for *meaning bridges* to develop.

In sum, we construe change in psychotherapy as a developmental process in which clients move from a maladaptive self-narrative—ways of understanding and experiencing that are dysfunctional since they exclude important internal voices—to a more functional self-narrative, one that integrates the previously excluded problematic voice. Such narratives are co-constructed through psychotherapeutic dialogue by building meaning bridges.

Ambivalence as a Reaction to IMs

We have proposed that the emergence and elaboration of IMs in therapy challenge and destabilize the maladaptive self-narrative, threatening the client's sense of self-stability. This threat often generates an increased level of anxiety which in turn evokes a self-protective response in which the client returns to the maladaptive self-narrative, suppressing the innovative way of feeling, thinking. In such cases we may observe that the client minimizes, depreciates, or trivializes the IM's meaning or significance. Such actions work to reinstate the maladaptive self-narrative, promoting stability at the cost of change, and eventually lead to therapeutic failure (Gonçalves, Ribeiro Stiles, et al., 2011; Gonçalves & Ribeiro, 2012; Ribeiro, Cruz, Mendes, Stiles, & Gonçalves, 2012).

We conceptualize this cyclical movement between opposing parts of the self—the client's currently dominant but maladaptive self-narrative and IMs—as ambivalence. This cyclical movement interferes with the development of an inclusive and coherent system of meanings in therapy in which these internal voices respectfully listen to each other and engage in joint action (cf., Brinegar, Salvi, Stiles, & Greenberg, 2006).

We have developed a measure of therapeutic ambivalence that grew from our observations of therapy passages in which an IM was immediately followed by a return to the maladaptive self-narrative. We label these events a *return-to-the-problem's marker* (RPM; Gonçalves, Ribeiro, Stiles, et al., 2011). The following is an example of such event:

Client: I've been facing my issues, bringing them into the open ... and that is fine (IM), but then I feel that going beyond that point, confronting people is dangerous ... dangerous in terms of losing God knows what (RPM).

Research on cases of Emotion-Focused Therapy, Client-Centered Therapy, and Narrative Therapy showed that the incidence of IM-RPM sequences decreased across therapy in good-outcome cases, whereas it remained unchanged and consistently high in poor-outcome cases (Ribeiro, 2012). This suggests that ambivalence between the maladaptive self-narrative and the alternative perspective may interfere with therapeutic progress or at least that it is associated with therapeutic stagnation.

The TCCS and the Therapeutic Zone of Proximal Development

The TCCS (Ribeiro et al., 2013) was designed to micro-analyze the TCCS which emerges from a negotiation and meshing of therapists' and clients' contributions to the alliance (Hatcher, 1999; Safran & Muran, 2000, 2006). It offers a way to assess how ambivalence is addressed and dealt with within the therapeutic relationship. The TCCS is conceptually based on our integration of the assimilation model (Stiles, 2001, 2011) and the IMs model (Gonçalves et al., 2009). A central theoretical concept in the construction and application of the TCCS was the notion of the *therapeutic zone of proximal development* (TZPD; see Leiman & Stiles, 2001).

The TZPD is an extension of Vygotsky's (1978) concept of the *zone of proximal development* (ZPD). The TZPD assumes that progress in therapy proceeds along a developmental sequence such as that described by the assimilation model (Stiles, 2002, 2011). According to the assimilation model, problematic voices pass through some part of a sequence of stages that ranges from completely disconnected and alienated from the self to completely integrated and part of the self as they are assimilated in successful psychotherapy: Warded off/dissociated, unwanted thoughts/active avoidance, vague awareness/emergence, problem statement/clarification, understanding/insight, application/working through, resourcefulness/problem solution, and integration/mastery. The TZPD is the segment of this therapeutic developmental continuum that extends from the client's current or *actual* developmental level to the *potential* developmental level that can be achieved in collaboration with the therapist at a particular moment in therapy. Theoretically, then, productive therapeutic work takes place within the client's TZPD. The TZPD itself continues to shift to higher levels in the therapeutic developmental sequence as

progress is made. Therapeutic interventions within the TZPD are likely to succeed, whereas interventions outside it are likely to fail.

Therapeutic Interventions and the TZPD

In line with our conceptualization of the TCCS (Ribeiro et al., 2013), clients usually enter therapy with a limited capacity for experiencing the world in alternative ways. As a consequence, the intrusion of new or unassimilated voices, that is, IMs, is most often painful or threatening. Therapists need to develop a climate in which new experiences can be better tolerated, considered, and integrated. Thus therapists must balance the activities of *supporting* and *challenging* (see Table II). In our model supporting consists of working closer to the client's actual level within the TZPD; confirming and elaborating upon the client's perspective of his or her experiences. If the client feels that the therapist validates his or her experience, he or she will likely experience a sense of *safety*. Supporting can be focused on the current (maladaptive) self-narrative that brought the client to therapy, as when the therapist tries to understand the role the problem plays in the client's life from the client's perspective. Alternatively, therapists may focus on emerging novelties in supportive ways, as when the therapist tries to understand how IMs emerged. Support focused on the current self-narrative, however, is more likely to generate safety than is support focused on IMs, whereas focusing on IMs is likely to be experienced as *risky*.

Challenging is conceptualized as working closer to the TZPD potential level within the TZPD, i.e., moving beyond the client's maladaptive narrative. However, focusing on the new or unassimilated voices (IMs) may amplify the contrast with the current framework, triggering a felt sense of contradiction or self-discrepancy, challenging the old framework and creating dysphoric feelings of unpredictability and uncontrollability (Arkovitz & Engle, 2007).

The success of supportive or challenging interventions depends on the therapist's ability to correctly assess the client's tolerance for risk, that is, the limits of the client's TZPD. The client's response to the therapeutic intervention may indicate whether the therapist worked within, outside, or at the limit of the TZPD. In the following examples we explore these interactional possibilities. We theorize that these components of collaboration must remain in balance. The therapist must keep working within a zone in which the client feels safe but is also able to explore the emerging different perspectives. Too much support risks maintaining the client's

maladaptive narrative, precluding change; too much challenge risks creating excessive anxiety, fostering resistance.

The point of balance between support and challenge evolves as therapy progresses along a developmental continuum. As the client's self-narrative gains flexibility in accommodating the client's emerging experiences, the TZPD moves, turning what was formerly a potential level into an actual one and extending the client's potential level towards greater ability to accommodate the challenging novelties.

Clients' Responses as Indicators of the TZPD

Scoring categories for the TCCS, along with the rationale for each category, have been presented elsewhere (Ribeiro et al., 2013). In this section we provide a summary of the salient features of the instrument.

Working Within the TZPD

When the therapy discourse is within TZPD, clients feel either *safe* or at *tolerable risk* following supporting or challenging interventions. In either case, clients tend to validate the therapist's intervention. *Validation* refers to the client explicitly or implicitly accepting the therapist's support or invitation to

look at his or her experience from the proposed (new) perspective (see Table III).

The client may validate the therapist's intervention implicitly by responding within the TZPD near the developmental level proposed by the therapist (see Figure 1):

- (1) The client may respond at the same developmental level as the therapist. For example, if both therapist and client are closer to the *actual developmental level*, a sequence might be as follows: The client elaborates the currently maladaptive self-narrative; the therapist supports it; and the client keeps elaborating that framework. If therapist and client are closer to the *potential developmental level*, the sequence might be as this: The client elaborates upon the maladaptive self-narrative; the therapist challenges; the client accepts the therapist's intervention, elaborating an IM and extending it.
- (2) The client may provide a response that lags behind the level of the therapist's intervention. For example, if the therapist is closer to the *potential developmental level*, whereas the client is closer to the *actual developmental level*, a sequence might be as follows: The

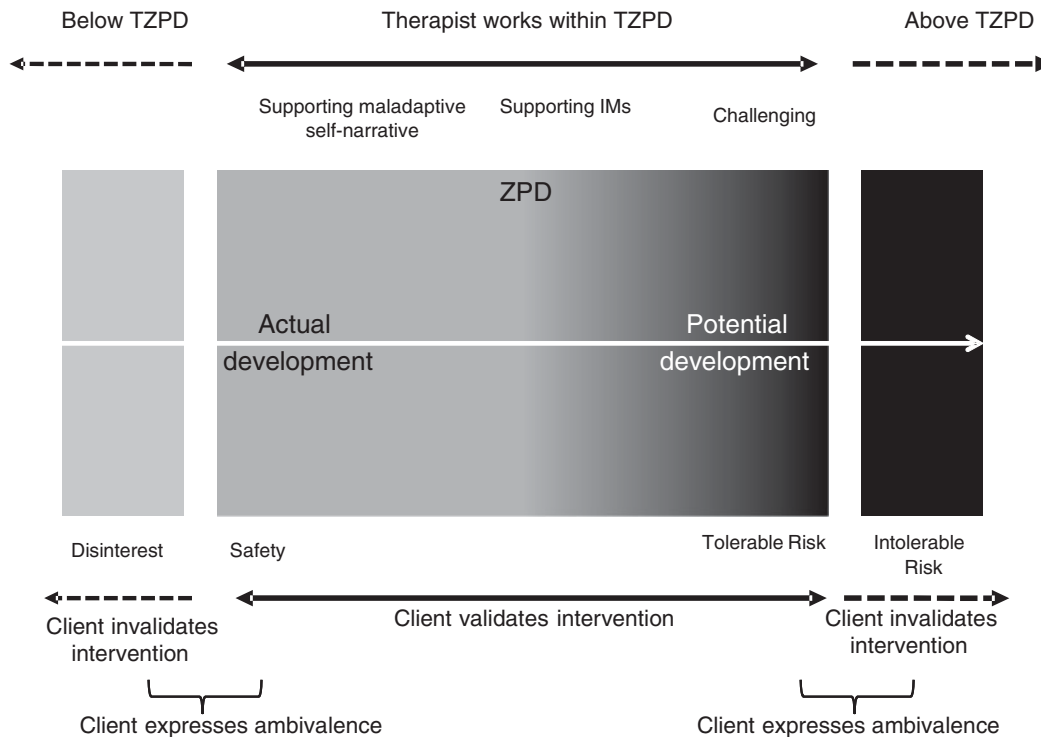


Figure 1. Segment of the therapeutic developmental continuum showing the therapeutic zone of proximal development (TZPD).

Note. From: *How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system*, by E. Ribeiro et al. (2013). Adapted with permission.

client elaborates upon the maladaptive self-narrative; the therapist challenges it; the client accepts the therapist's intervention, elaborating an IM, but does not extend it.

- (3) Finally, the client may provide a response that moves beyond the level the therapist proposes. For example, if the therapist is closer to the *actual developmental level* whereas the client is closer to the *potential developmental level*, then a sequence might be as this: The client elaborates upon the maladaptive self-narrative; the therapist supports it; the client accepts the therapist's intervention but follows up by raising an IM.

Working Outside the TZPD

We theorize that when the therapist works outside the TZPD, the client will probably invalidate the intervention. *Invalidation* refers to declining an invitation to look at his or her experience from the perspective offered by the therapist (see Table III).

When the therapist pushes the client above the upper limit of the TZPD, the client is likely to experience *intolerable risk* and, thus, will invalidate therapist's intervention, for example by changing the subject, misunderstanding, or becoming defensive as a self-protective mechanism. Invalidation may also occur when the therapist works below the lower limit of the TZPD, since the client may feel that the therapist is being redundant (not getting anywhere) and may become bored and disengaged.

The TZPD constantly evolves throughout the therapy; its limits are redefined moment by moment. What was risky (closer to the potential level) for the client early in therapy may later become safe (closer to actual level). On the other hand, as setbacks inevitably occur (Caro-Gabalda & Stiles, 2009, 2013), what seemed safe at one moment may become risky in the next. New perspectives co-constructed in psychotherapy are fragile, and the safety experienced by the client is usually temporary or provisional.

Working at the Upper or Lower Limit of the TZPD

We argue that when the therapist works at the limit of the TZPD, the client is more likely to exhibit ambivalence than invalidation—to begin to accept the perspective proposed by the therapist but then take an opposite perspective. This can happen whether the therapist is working at the upper limit or at the lower limit of the TZPD.

If the therapist works closer to the upper limit of the TZPD, by challenging the client or supporting

IMs, the client's ambivalence response may indicate he or she lags behind the proposed level, *moving towards safety*. Such behaviors are akin to what we described above as an RPM (Gonçalves & Ribeiro, 2012; Gonçalves, Ribeiro, Stiles, et al., 2011). IMs and TCCS markers of ambivalence are equivalent, although the IMs formulation is intrapersonal, whereas the TCCS one is interpersonal.

In contrast, if the therapist works closer to the lower limit of the TZPD, by supporting the maladaptive self-narrative, the client's ambivalence response may indicate he or she extends beyond the level proposed by the therapist, *moving towards risk*.

Study Goals and Questions

Our purpose in this study was to assess and improve our theoretical understanding of the impact of the therapist's responses in situations where clients present evidence of ambivalence (RPMs). We were particularly interested in exploring the impact of these interventions on the collaboration between client and therapist in these situations.

This was a theory-building case study (Stiles, 2009). The theory we are building is our account of how self-narratives change in psychotherapy. It is based on our integration of the IMs model and the assimilation model. This model was also used to construct the TCCS (described above and in Ribeiro et al., 2013). Theory-building case studies can make use of rich clinical material to assess and improve theories. Whereas statistical hypothesis-testing compares observations on many cases with one theoretically derived statement, theory-building case studies compare many observations on one case with many theoretically derived statements (Campbell, 1979; Stiles, 2009).

To obtain a rich cross section of events demonstrating ambivalence, we selected a case with relatively poor outcome, one which presented the lowest incidence of IMs and the highest incidence of RPMs in our sample. We thought that a poor-outcome case might show us how therapists may inadvertently contribute to ambivalence by responding at inappropriate TZPD levels.

We focused on three questions:

- (1) Which types of therapeutic intervention precede the emergence of RPMs (understood as empirical markers of ambivalence)?
- (2) How did the therapist respond to the client's RPMs? In other words, how did the therapist try to restore collaboration or keep the dyad within the TZPD?

- (3) How did the client react to the therapist's response to RPMs? To put in another way, was the therapist's intervention successful in restoring collaboration or placing the dyad within the TZPD?

Method

Data for the current study were drawn from the Matos, Santos, Gonçalves, and Martins (2009) sample of IMs in narrative therapy. This relatively poor-outcome case of narrative therapy had been previously coded for RPMs by Gonçalves, Ribeiro, Stiles, et al. (2011). Relevant parts of these studies' method are summarized here; please see Gonçalves et al. (2011) for further details.

Client

Maria was a 47-year-old retired industrial worker, married for 20 years. Maria's treatment outcome was relatively poor, as compared to the rest of a sample of women who were victims of intimate violence (Matos et al., 2009). Maria was recommended for therapy by an institution for crime victims. She presented severe symptoms of depression (e.g., sadness, hopelessness, social withdrawal, isolation). She also had relational problems with her oldest son, and she blamed herself for not being a good mother. Her intent was to leave home with her youngest child and move to a temporary crime victims' shelter. Her main obstacles were lack of financial independence and the impossibility of taking her oldest son with her.

Therapy and Therapist

Maria attended psychotherapy in a Portuguese university clinic, where she received individual narrative therapy (White & Epston, 1990). This case involved 15 sessions, initially four weekly sessions and then twice a month, plus one follow-up (after 6 months). She was treated by a female therapist who had a master's degree in Psychology and 5 years of experience in psychotherapy with battered women. The therapist was supervised to ensure adherence to the narrative model.

Planned therapy interventions included (i) externalization of problems, (ii) identification of the cultural and social assumptions that support women's abuse, (iii) identification of unique outcomes (the narrative therapy term for IMs), (iv) therapeutic questioning around these unique outcomes, trying to create a new alternative to the narrative that was externalized, and (v) consolidation of the changes through social validation, trying to

make more visible the way change happened (see Matos et al., 2009, for a detailed description of the narrative therapy guidelines).

Researchers

The TCCS analysis was conducted by the first author, co-author of TCCS, and the third author, a master's student in clinical psychology. The fourth author served as auditor of the TCCS coding, reviewing and checking the judgments made by the judges.

Measures

Brief Symptom Inventory (BSI). The BSI (Derogatis & Melisaratos, 1983) is a 53-item self-report rating scale of distress, using a 5-point Likert scale. We used the Portuguese adaptation by Canavarro (2007), which has good psychometric characteristics (Cronbach's alpha for the nine symptom subscales ranges from .62 to .80).

Severity of Victimization Rating Scale (SVRS). The SVRS (Matos, 2006) assesses abusive actions received (physical, psychological, and/or sexual), their frequency, and their severity on a 3-point scale (low, medium, high); it is completed by the therapist based on the client's report.

Working Alliance Inventory (WAI). The WAI (Horvath, 1982) is a 36-item questionnaire, which uses a 7-point Likert scale to assess therapeutic alliance quality. The Portuguese version (Machado & Horvath, 1999) has good internal consistency (Cronbach's alpha .95).

Return-to-the-Problem Coding System (RPCS). The RPCS (Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2010) is a qualitative system that assesses the re-emergence of the maladaptive self-narrative immediately after the emergence of an IM. Previous studies using the RPCS (e.g., Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2011, 2012) reported a reliable agreement between judges on RPM coding, with a Cohen's kappa between .85 and .93.

Therapeutic Collaboration Coding System (TCCS). The TCCS is a transcript-based coding system designed to analyze therapeutic collaboration on a moment-to-moment basis. An initial study (Ribeiro et al., 2013) showed good reliability, with mean Cohen's kappa values of .92 for therapist interventions and .93 for client responses. Sequences of therapist's intervention and client's response

categories are interpreted as reflecting the position of the exchange relative to the TZPD.

Procedure

Analytical strategy. Our research strategy involved the analysis of therapeutic exchanges immediately before and after RPMs using the TCCS. This comprised three tasks: (i) categorization of the therapist's intervention that occurred immediately before the client's RPMs; (ii) categorization of therapist's intervention that occurred immediately after the client's RPMs; and (iii) categorization of the client's reaction to it (interpreted as its impact on therapeutic collaboration).

Outcome and alliance measures administration. The BSI was administered in sessions 1, 4, 8, 12, and 16 and at 6-month follow-up. This study used the Global Severity Index (GSI) of the BSI, which considers responses to all items; this index is considered to be the best single predictor of level of distress (Derogatis, 1993). Like the BSI, the SVRS was recorded every fourth session, starting with the first. The WAI was administered in sessions 4, 8, 12, and 14 and at 6-month follow-up. Versions for client (WAIc) and observers (WAIo) (two independent observers, who were psychotherapists with 2 years of clinical experience, coded recordings of sessions) were applied (see Table I).

Criteria for case categorization and selection. Maria was considered a relatively poor-outcome case because: (i) although her symptom intensity declined from her initial to post-therapy assessments, it had returned to clinical levels at follow-up (initial GSI 2.66; final GSI = .62; follow-up GSI = 1.64; GSI cut-off score of ≤ 1.32 ; Matos, 2006); and (ii) there was no change in the level of intimate violence measure (SVRS) from the beginning to the end of therapy. In comparison to the rest of the sample, Maria showed the highest value on the GSI at the

follow-up session (Matos et al., 2009). The quality of alliance assessed by both the self-report and observer version of the WAI was high and stable across therapy (see Table I).

RPMs coding and reliability. Two trained judges independently coded session video recording, analyzing IMs for the presence of RPMs, following the RPCS manual. The reliability of identifying RPMs, assessed by Cohen's k , was .90 (Gonçalves, Ribeiro, Stiles, et al., 2011).

TCCS coding and reliability. Two trained judges (the first and third authors) watched the video recordings of each session in their entirety and read the transcripts. The judges then independently listed the client's problems (themes from the maladaptive self-narrative that brought the client to therapy) and met to discuss their assessment of the client's maladaptive self-narrative. Following this, the client's maladaptive self-narrative was consensually characterized in a way that remained faithful to the client's words. Next, the judges independently classified each therapist's speaking turn before and after each episode in which there was an IM followed by an RPM, into a Supporting subcategory or a Challenging subcategory (see Table II). For Supporting subcategories, they further decided whether it focused on the maladaptive self-narrative or focused on the IM.

Finally, the judges independently classified the client's speaking turn after each therapist response to an RPM, into a Validation/Invalidation subcategory (see Table III). In coding a Validation category, judges further assessed whether clients *lagged behind* the intervention on the therapeutic developmental continuum, responded *at the same level* as the intervention, or extended *beyond the level* of the intervention, using the specific subcategories of client response shown in Table III. In coding an Invalidation category, judges assessed whether the therapist worked below the lower limit or above the upper limit of the TZPD (the distinctive feature of exchanges below the TZPD is the presence of markers that indicated that the client experienced the therapist as being redundant).

Sessions 8 and 9 were not coded due to technical problems with the video. The follow-up session was not analyzed, since its nature, goals and structure were very different from the regular sessions. The last session was not coded for therapist's interventions and client's responses because it did not include any RPMs. The pair of judges met after coding each session to assess their rating's reliability (using Cohen's κ) and to note any differences in their perspectives on their coding. When differences were

Table I. Outcome and alliance measures

	BSI(GSI)	WAI Observer A	WAI Observer B	WAI Client
Session 1	2.66			
Session 4	1.35	5.4	5.3	5.71
Session 8	1.2	5.5	6	6.41
Session 12	1.41	5.7	5.9	6.11
Session 15	0.62	6.2	5.5	6.55
Follow-up	1.64	6.5	5.9	6.63

Note: BSI: Brief Symptom Inventory; GSI: General Severity Index; WAI: Working Alliance Inventory.

Table II. Therapist intervention coding subcategories

Supporting subcategories	Definitions
Reflecting	The therapist reflects the content; meaning or feeling present in the client's words. He or she uses his/her or the client's words but doesn't add any new content in the reflection, asking for an implicit or explicit feedback.
Confirming	The therapist makes sure he/she understood the content of the client's speech, asking the client in an explicit and direct mode.
Summarizing	The therapist synthesizes the client's discourse, using his/her own and the client's words, asking for feedback (implicit or explicit)
Demonstrating interest/attention	The therapist shows/ affirms interest on client's discourse.
Open questioning	The therapist explores the client's experience using open questioning. The question opens to a variety of answers, not anticipated and/or linked to contents that the client hasn't reported or only reported briefly. This includes the therapist asking for feedback on the session or on the therapeutic task.
Minimal encouragement	The therapist makes minimal encouragement of the client's speech, repeating the client's words, in an affirmative or interrogative mode (ambiguous expressions with different possible meanings aren't codified, like a simple "Hum ... hum" or "ok").
Specifying information	The therapist asks for concretization or clarification of the (imprecise) information given by the client, using closed questions, specific focused questions, asking for examples.
Challenging subcategories	Definitions
Interpreting	The therapist proposes to the client a new perspective over his or her perspective, by using his or her own words (instead of the client's words). There is, although, a sense of continuity in relation to the client's previous speaking turn.
Confronting	The therapist proposes to the client a new perspective over his or her perspective or questions the client about a new perspective over his or her perspective. There is a clear discontinuity (i.e., opposition) in relation to the client's speaking turn.
Inviting to adopt a new perspective	The therapist invites (implicitly or explicitly) the client to understand a given experience in an alternative way.
Inviting to put into practice a new action	The therapist invites the client to act in a different way, in the session or out of the session.
Inviting to explore hypothetical scenarios	The therapist invites the client to imagine hypothetical scenarios, i.e., cognitive, emotional and/or behavioral possibilities that are different from the client's usual way of understanding and experiencing.
Changing level of analysis	The therapist changes the level of the analysis of the client's experience from the descriptive and concrete level to a more abstract one or vice versa.
Emphasizing novelty	The therapist invites the client to elaborate upon the emergence of novelty.
Debating client's beliefs	The therapist debates the evidence or logic of the client's beliefs and thoughts.
Tracking change evidence	The therapist searches for markers of change, and tries to highlight them.

Note: From: *How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system*, by E. Ribeiro et al. (2013). Adapted with permission.

detected, they were resolved through consensual discussion. Reliability of identifying therapist's intervention, assessed by Cohen's k , was .95. Reliability of identifying client's response, assessed by Cohen's k , was .95. The consensus version of the TCCS coding was audited by an external auditor (the fourth author) who then met with the pair of judges to discuss his feedback. His role was one of "questioning and critiquing" (Hill et al., 2005, p. 201).

RPMs' Evolution Across Therapy

In the previous study involving this case, 114 RPMs were identified (Gonçalves, Ribeiro, Stiles, et al., 2011). The frequency of RPMs showed an increasing trend, as shown in Figure 2, except that the last session did not include any RPMs. The authors interpreted this pattern as suggesting that

ambivalence was not resolved in this case. The absence of RPMs in the final session appeared not to reflect ambivalence resolution but instead to reflect the nature of the last session: The dyad reviewed the client's change process and did not engage in specific therapeutic work (Gonçalves, Ribeiro, Stiles, et al., 2011).

Results

Which Type of Therapeutic Intervention Precedes the Emergence of RPMS?

The results are presented in Figure 3, in which the y axis represents the proportion of therapeutic interventions and the x axis therapy sessions over time. Results indicated that challenging was the most common type of therapeutic intervention preceding

Table III. Client response coding subcategories

Validation subcategories	Definitions
Confirming	The client agrees with the therapist's intervention, but does not extend it.
Extending	The client not only agrees with the therapist's intervention, but expands it (i.e., going further).
Giving information	The client provides information according to the therapist's specific request.
Reformulating one's own perspective	The client answers the therapist's question or reflects upon the therapist's prior affirmation and, in doing so, reformulates his or her perspective over the experience being explored.
Clarifying	The client attempts to clarify the sense of his or her response to the therapist's prior intervention or clarify the sense of the therapist's intervention itself.
Invalidation subcategories	Definition
Expressing confusion	Client feels confused and/or states his or her inability to answer the therapist's question.
Focusing/persisting on the maladaptive self-narrative	Client persists on looking at a specific experience or topic from his or her standpoint.
Defending one's own perspective and/or disagreeing with the therapist's intervention	Client defends his/her thoughts, feelings, or behavior by using self-enhancing strategies or self-justifying statements.
Denying progress	Client states the absence of change (novelty) or progress.
Self-criticism and/or hopelessness	Client is self-critical or self-blaming and becomes absorbed in a process of hopelessness (e.g., client doubts about the progress that can be made).
Lack of involvement in response	Client gives minimal responses to therapist's efforts to explore and understand client's experience.
Shifting topic	Client changes topic or tangentially answers the therapist
Topic/focus disconnection	The client persists in elaborating upon a given topic despite the therapist's efforts to engage in the discussion of a new one.
Non-meaningful storytelling and/or focusing on others' reactions	Client talks in a wordy manner or overly elaborates non-significant stories to explain an experience and/or spends an inordinate amount of time talking about other people.
Sarcastic answer	The client questions the therapist's intervention or is ironic towards the therapist's intervention.

Note: From: *How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system*, by E. Ribeiro et al. (2013). Adapted with permission.

the emergence of an RPM (mean = 92.6%). Supporting IMs preceded only 7.4% of the RPMs. There were no occurrences of RPM following an intervention coded as supporting the current (maladaptive) self-narrative. The following example illustrates the most frequent type of therapeutic exchange preceding RPMs. This and the examples in the next two sections are successive excerpts from the same interaction in session 1 (translated from Portuguese by the first author), selected to illustrate our main results compactly and coherently.

T: *You said that 'partly' there's a voice that says there's no use making any effort because you will never get anywhere* [The therapist refers to the dominant community of voices]. *But is there another voice* [The therapist challenges the client by searching for alternative voices—emphasizing novelty subcategory]?

C: *Yes, there's another part that seems [to say] that I can [do] everything!* [The client elaborates an IM, by acknowledging the existence of an alternative voice] ***But suddenly, it falls down! Like a castle of cards that we build and then suddenly falls apart!*** [The client elaborates an RPM by emphasizing the alternative voice's lack of power].

How does the Therapist Respond to the Client's RPMs?

As shown in Figure 4, results indicated that the therapist more often responded to RPM using a challenging intervention (mean = 75.0%) than using a supporting maladaptive self-narrative (mean = 11.2%) or a supporting IMs intervention (mean = 9.1%).

The following excerpt illustrates the most common type of therapist intervention following RPMs:

C: *I would be less impaired if this voice's strength were 5 and the other 5 too (...)* [The client elaborates an IM, by reflecting upon the importance of both the dominant community of voices and the unassimilated voice expressing themselves and guiding her action] ***But the other voice is so weak, so weak ... my husband has destroyed me! And if I leave him, he will try to convince everybody that it was my fault!*** [The client elaborates an RPM, by expressing hopelessness and emphasizing the negative consequences of leaving the abusive relationship].

T: *I understand this is important to you, but look ... if you are prepared to fight him, even if he does that he will*

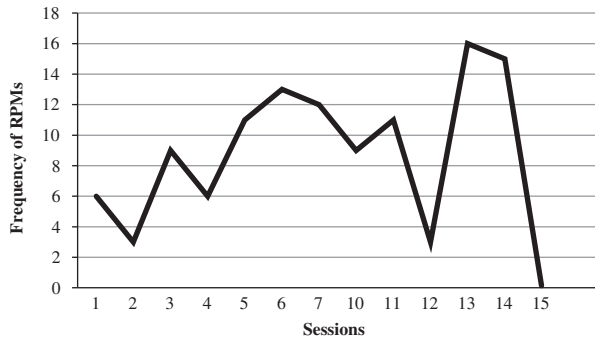


Figure 2. Emergence of return-to-the-problem markers (RPMs) across therapy.

not be able to destroy you. You have to create some defenses, some barriers [The therapist challenges the client—*confronting* subcategory; she proposes to the client a new perspective and there is a clear discontinuity (i.e., opposition) in relation to the client’s prior speaking turn].

How Does the Client Respond to the Therapist’s Intervention Following RPMs?

When the therapist responded to RPMs by challenging the client, as in the previous excerpt, the client tended to invalidate the therapist’s intervention (mean = 61.8%), which may indicate she experienced intolerable risk. The following client response, which occurred immediately after the therapist intervention above, illustrates this pattern:

C: *I just can’t, he has a lot of power ... I can’t leave him; it is not worth it ... I just can’t!* [The client invalidates therapist intervention—*expressing hopelessness* subcategory; she doubts about the progress that can be made].

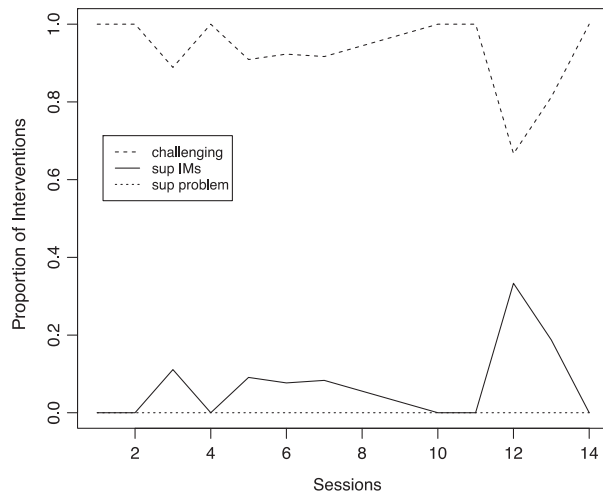


Figure 3. Therapeutic intervention before return to the problem markers (sup = supporting; IMs = innovative moments).

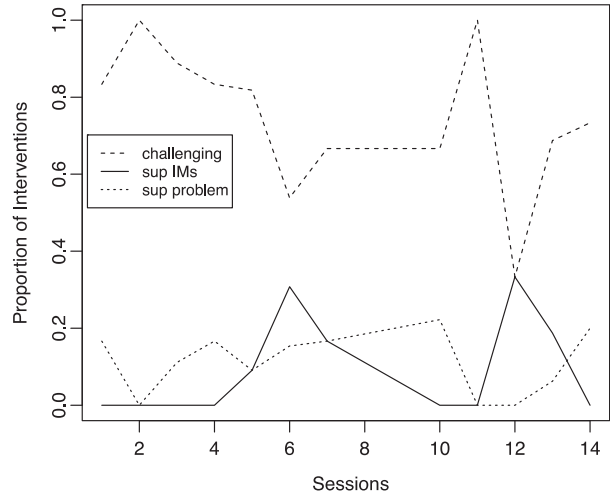


Figure 4. Therapeutic intervention after return to the problem markers (sup = supporting; IMs = innovative moments).

Alternatively, the client minimally validated therapist intervention (mean = 33.1%), lagging behind the level proposed by the therapist, as in the example below. Only, 3.9% of the times did the client respond at the level proposed by the therapist, by elaborating an IM.

T: Let’s explore the voice whose strength is 10. Let’s try to reduce its strength because it makes you suffer [The therapist challenges the client by emphasizing the need to reduce the constraining power of the dominant community of voices so that the unassimilated voices can emerge and express themselves—*Inviting to put into practice a new action* subcategory].

C: Yes [The client agrees with the therapist’s intervention, but does not extend it—*confirming* subcategory].

As shown in Table IV, results indicated that when the therapist responded to RPMs by supporting the current (maladaptive) self-narrative, the client invariably validated the therapist’s intervention (100%), which likely indicates that she experienced safety, working at the level proposed by the therapist.

When the therapist responded to RPMs by supporting IMs, Maria tended to validate the therapist’s intervention (mean = 61.7%), which may indicate she experienced safety, working at the level proposed by the therapist. Alternatively, Maria expressed ambivalence, by elaborating a new RPM (mean = 21.7%), lagging behind the level proposed by the therapist and moving towards safety.

Discussion

Maria’s ambivalence responses (RPMs) tended to emerge after challenging interventions, that is, when the therapist worked close to her potential

Table IV. Therapist intervention and subsequent client response

	Supporting maladaptive self-narrative Mean	Supporting IMs Mean	Challenging Mean
Client's response	100%	61.67%	33.14%
Safety			
Tolerable risk		6.67%	3.90%
RPM		21.67%	1.19%
Intolerable risk		10.00%	61.77%

Note: IMs: innovative moments; RPMs: return-to-the-problem markers.

developmental level (upper limit of the TZPD). This pattern is consistent with our hypothesis that RPMs act as a self-protective mechanism to manage the felt risk of contradicting the maladaptive self-narrative. These observations add confidence to our theoretical model of therapeutic collaboration.

Most often, the therapist responded to Maria's RPMs with further challenging. Interestingly, after instances in which the therapist responded to an RPM with a challenging intervention, the therapeutic dialogue tended to move out of the TZPD, producing an escalation of the clients' felt level of risk. That is, not only did the therapist fail to restore collaboration, but she also seemingly contributed to a (momentary) deterioration in the quality of the therapeutic collaboration. There were also instances in which the client only minimally validated the therapist's intervention, lagging behind the level proposed by the therapist within the TZPD. In both of these types of therapeutic exchange, the therapist worked beyond the client's level. These alternatives elaborate the theoretical suggestion that therapy is most likely to be effective within the TZPD.

Our observations converge with previous work in suggesting that when therapists challenge their clients, trying to stimulate or amplify IMs in ways that do not match the clients' developmental level, they may unintentionally contribute to ambivalence; to the oscillatory cycle between the IMs and the maladaptive self-narrative (Santos, Gonçalves, & Matos, 2010). Also they may unintentionally reinforce the dominance of the maladaptive self-narrative. If therapists respond to a clients' RPMs by insisting that they revise their maladaptive self-narrative or by trying to convince them that they are changing, the clients may feel misunderstood, invoking a "strong reactance on the part of the client, often hardening the client's stuck position" (Engle & Arkovitz, 2008, p. 390). This is consistent with research suggesting that higher levels of therapist demand or directiveness toward change are associated with higher levels of client resistance, whereas more supportive approaches diminish resistance (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985; see also Beutler, Harwood, Michelson, Xiaoxia, & Holman, 2011, for a meta-

analysis of the interaction between client reactance and therapist directiveness).

Maria's invalidation responses could be interpreted as a marker of needing more support before being able to accept challenges. Supportive responses were relatively successful. Both supporting interventions that focused on the maladaptive self-narrative and supporting interventions that focused on the IMs were followed by responses on the level proposed by the therapist. That is, when the therapist supported Maria's IMs she seemed able to keep working within the TZPD, validating the therapeutic intervention and even extending it, responding with tolerable risk.

It is important to note that Maria evaluated the therapy as being helpful and did not prematurely terminate the process. Perhaps Maria needed more time to change. As suggested by developmental models of change (Prochaska & DiClemente, 1982; Stiles et al., 1990), our results illustrate how a poor-outcome case began with lower readiness for change and might have benefited from a greater amount of therapeutic work.

Maria's positive informal evaluation of her therapy and her consistently high ratings on the WAI contrast with her relative failure to maintain gains on the GSI at follow-up and the continuing problems indicated on the SVRS. Our findings were consistent with the latter; she exhibited high levels of IM-RPM sequences throughout therapy, and there were many events in which Maria showed the signs of not being able to cope with the levels of risk generated by her therapist's interventions. How do we reconcile this relatively negative TCCS description of the process with Maria's positive reports of her experience of therapy and the alliance? One possibility is that this was simply a discrepancy between external and internal perspectives—behavioral resistance to therapeutic progress even though the alliance was strong. Some studies on alliance ruptures have found similar discrepancies between observer systems and client self-report perspectives on quality of alliance (Eubanks-Carter, Gorman, & Muran, 2012; Safran, Muran, & Eubanks-Carter, 2011; see also Coutinho, Ribeiro, Sousa, & Safran, 2013). Perhaps Maria's deference or compliance toward the therapist protected her view of the

therapeutic relationship, yielding strong alliance ratings in spite of the resistance to change and transient breakdowns in the collaboration. Most of the time the dyad worked within the TZPD, and perhaps Maria's global perception of alliance was based on her spending most of the time in the collaborative zone of the TZPD. If so, her global perception was confirmed by the observers, who also gave high WAI ratings (see Table I). That said, the discrepancy remains a conundrum that deserves further empirical and theoretical attention.

Implications, Limitations and Future Directions

Client resistance in the ongoing therapy process on a moment-to-moment basis is a consistently potent predictor of treatment outcomes (Aviram, Westra, & Kertes, 2010). Thus, building a better understanding of the process of maintaining resistance, as we have attempted in this study, is an important research priority. Insofar as theory-building case studies do not assess isolated hypotheses, all generalization is through the theory (Stiles, 2009). The present study supports aspects of our theory and, through the theory, allows us to draw some implications for training and practice.

Maria's therapist offered more empathy to Maria's alternative perspective or unassimilated voice than to her maladaptive self-narrative or dominant community of voices. Stiles and Glick (2002) suggested that therapists should adopt an attitude toward client's multiple internal voices similar to multilateral partiality in family therapy (Boszormenyi-Nagy & Spark, 1973), in order that conflicting internal voices can be heard and come to respect each other, a central step on the way to developing internal meaning bridges. To do so, with Engle and Arkovitz (2008), we might suggest "therapists need to monitor their frustration" and "resist the temptation to 'help' the client by pushing for change" (p. 391).

In particular, a therapist may "direct his or her efforts toward an understanding of what it is in the client's experience that prevents easy change" (Engle & Arkovitz, 2008, p. 391; Ahmed, Westra, & Constantino, 2010; Binder & Strupp, 1997; Miller & Rollnick, 2002). Put differently, therapists whose clients show resistance by continually returning to the perspective of a maladaptive self-narrative may need to decrease the level of risk experienced by the client by reducing the degree of challenging, and increasing the degree of supporting.

Of course, we cannot be confident that if Maria's therapist had responded to her RPMs by supporting her perspective instead of challenging it that this would lead to a positive outcome. Further research is

needed. Intensive analysis of how therapists responded to RPMs in cases in which RPMs decreased across treatment might support our suggestion. It would aid such research if alliance and outcome measures were administered at every session.

Although the TCCS was developed as a research tool, we think that it might also be useful for training. It could be used to help sensitize trainees to the dyad's position in relation to the TZPD, allowing them to intervene accordingly. Likewise it might, with further validation and development, serve as a diagnostic tool to identify challenges that are mis-timed or too threatening for clients, or, conversely, situations where there are opportunities for more challenging exploration.

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