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Ambivalence in emotion-focused therapy for depression: The maintenance of problematically dominant self-narratives

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Abstract
Objective: Ambivalence can be understood as a cyclical movement between an emerging narrative novelty—an Innovative Moment (IM)—and a return to a problematically dominant self-narrative. The return implies that the IM, with its potential for change is devalued right after its emergence. Our goal is to test the hypothesis that the probability of the client expressing such form of ambivalence decreases across treatment in good-outcome cases but not in poor-outcome cases. **Method:** Return-to-the-Problem Markers (RPMs) signaling moments of devaluation of IMs were coded in passages containing IMs in six clients with major depression treated with emotion-focused therapy: three good-outcome cases and three poor-outcome cases. **Results:** The percentage of IMs with RPMs decreased across therapy in good-outcome cases, whereas it remained unchanged and high in the poor-outcome cases. **Conclusions:** These results were consistent with the theoretical suggestion that therapeutic failure may be associated with this form of ambivalence.

Keywords: process research; experiential/existential/humanistic psychotherapy; narrative; ambivalence

We conceptualize ambivalence as a cyclical movement in which the emergence of novelties in a client's self-narrative, called *Innovative Moments* (IMs; Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011), is followed by a return to the client's problematically dominant self-narrative (usual way of understanding the world). That is, a novelty emerges in the therapy dialogue, but the client quickly devalues its implications for change by, minimizing, trivializing or contradicting it. The present study on ambivalence in emotion-focused therapy (EFT) for depression replicated a study by Gonçalves, Ribeiro, Stiles et al. (2011) that described how ambivalence developed in Narrative Therapy (NT) with women who were victims of intimate violence. Ambivalence was assessed using *Return-to-the-Problem Markers* (RPMs), which signal moments of such devaluation of IMs. In this study, we identified IMs followed by RPMs in six cases of major depression treated with EFT, three good-outcome cases and three poor-outcome cases. These cases had been previously analyzed with the *Innovative Moments Coding System* (IMCS; Gonçalves, Ribeiro, Mendes, et al., 2011) by Mendes et al. (2010), and we used those IMs codes as a starting point in the present study.

Narrative and Multi-voiced Conceptualization of the Self: Innovative Moments as Expressions of Non-dominant Internal Voices

We propose that people construct meaning from the ongoing flow of experiences in the form of self-narratives (Bruner, 1986; Hermans & Hermans-Jansen, 1995; Gonçalves, Matos, et al., 2009; McAdams, 1993; Polkinghorne, 1988; Sarbin, 1986; White, 2007; White & Epston, 1990) and

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that, simultaneously, these self-narratives work as implicit rules that constrain the meaning constructed from the experience, shaping behavioral, cognitive, emotional, and interpersonal processes. Self-narratives are conceived as the result of the continuous dialogue between the multiple internal voices, which we view as ways of being in the world grounded in traces of the person's past experiences (Honos-Webb & Stiles, 1998; Stiles, 1999, 2011). Constellations of similar or related experiences become linked and thus *assimilated* to form a *community of voices*, which is experienced by the person as their usual sense of self.

Self-narratives become problematic when they are too rigid and consistently exclude incongruent internal voices, that is voices representing experiences that are discrepant from how individuals typically perceive themselves (Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011). Typically, when clients present for psychotherapy, their dominant self-narrative is problematic in that it fails to acknowledge important parts of the client's life experience.

The excluded, non-dominant voices may be avoided or warded off, but they do not disappear. Instead, when they are addressed by external life events, they may emerge and express themselves. When they do, they typically cause distress, but they also constitute an IM. Change in psychotherapy occurs as clients move from a dominant self-narrative that excludes important internal voices to a more functional self-narrative that incorporates the previously excluded voices. We have proposed that this process occurs through the emergence, accumulation and articulation of IMs. When non-dominant voices express themselves during IMs, the current community of voices, organized according to the currently problematically dominant self-narrative, is disrupted, at least temporarily, and an opportunity for assimilating the excluded voices emerges.

Ambivalence as a Reaction to Innovative Moments

Although the emergence of IMs opens the possibility for change, allowing the novelty to be expanded in therapy, it also destabilizes a person's usual way of understanding and experiencing, thus creating unpredictability and uncontrollability, threatening clients' sense of self-stability (Ribeiro & Gonçalves, 2010).Whether or not IMs develop into a new self-narrative depends on the way this threat is managed: An IM can be amplified, or its meaning may be devalued by the client, thus reducing its potential to produce change. Amplification refers to the expansion of a given meaning present in an IM, creating an opportunity for development to occur, as in the following example.

> Agoraphobic client: Today, **I confronted my fears and went out [IM]**, and this made feel stronger and hopeful [IM amplification].

Conversely, devaluation refers to the minimization, depreciation or trivialization of a particular meaning present in an IM, resulting in the maintenance of the old problematic patterns, as in the following example.

> Agoraphobic client: **Today, I confronted my fears and went out [IM]**, but I'm sure tomorrow I'll feel miserable and weak again! [IM devaluation]

We have previously reported that in poor-outcome cases, as well as in initial and middle phases of good-outcome cases, clients tend to devalue IMs by bypassing, minimizing, depreciating, or trivializing their meaning, and quickly returning to the dominant self-narrative, promoting stability (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2011; Santos, Gonçalves, & Matos, 2010). For instance, in the beginning of therapy, when Jan (a good-outcome case of EFT from the York I Depression Study; Greenberg & Watson, 1998; Honos-Webb, Surko, Stiles, & Greenberg, 1999; Leiman & Stiles, 2001) expressed feelings of dependency or weakness (non-dominant voice)—that is, when she experienced IMs —she frequently restated the need to be strong and independent (dominant voice), thus returning to the problematic self-narrative (Figure 1). This sort of ambivalence is also illustrated by the reactions that emerge when clients hesitantly begin to face fears, saying, in effect: "I had enough of my fears and limitations. I will free myself from my fears, no matter what the implications are (IM) ... but I'm too weak for this." (Return to the problematically dominant self-narrative.)

Thus, IMs and the problematically dominant self-narrative can act as opposite self-positions in a negative feedback loop relation. In this repetitive process, the client oscillates, first elaborating the IM, which temporarily disrupts the dominant self-narrative (briefly freeing the client from its oppression), then returning to the dominant self-narrative, reducing the discrepancy created by the innovation along with the associated anxiety.

Ambivalence may thus result in a form of stability, which may be understood as two opposing parts of the self that keep feeding into each other, dominating the self alternately, producing distress as they do so. This conceptualization is congruent with other theoretical accounts of ambivalence. Engle and collaborators (Engle & Arkovitz, 2008; Engle &

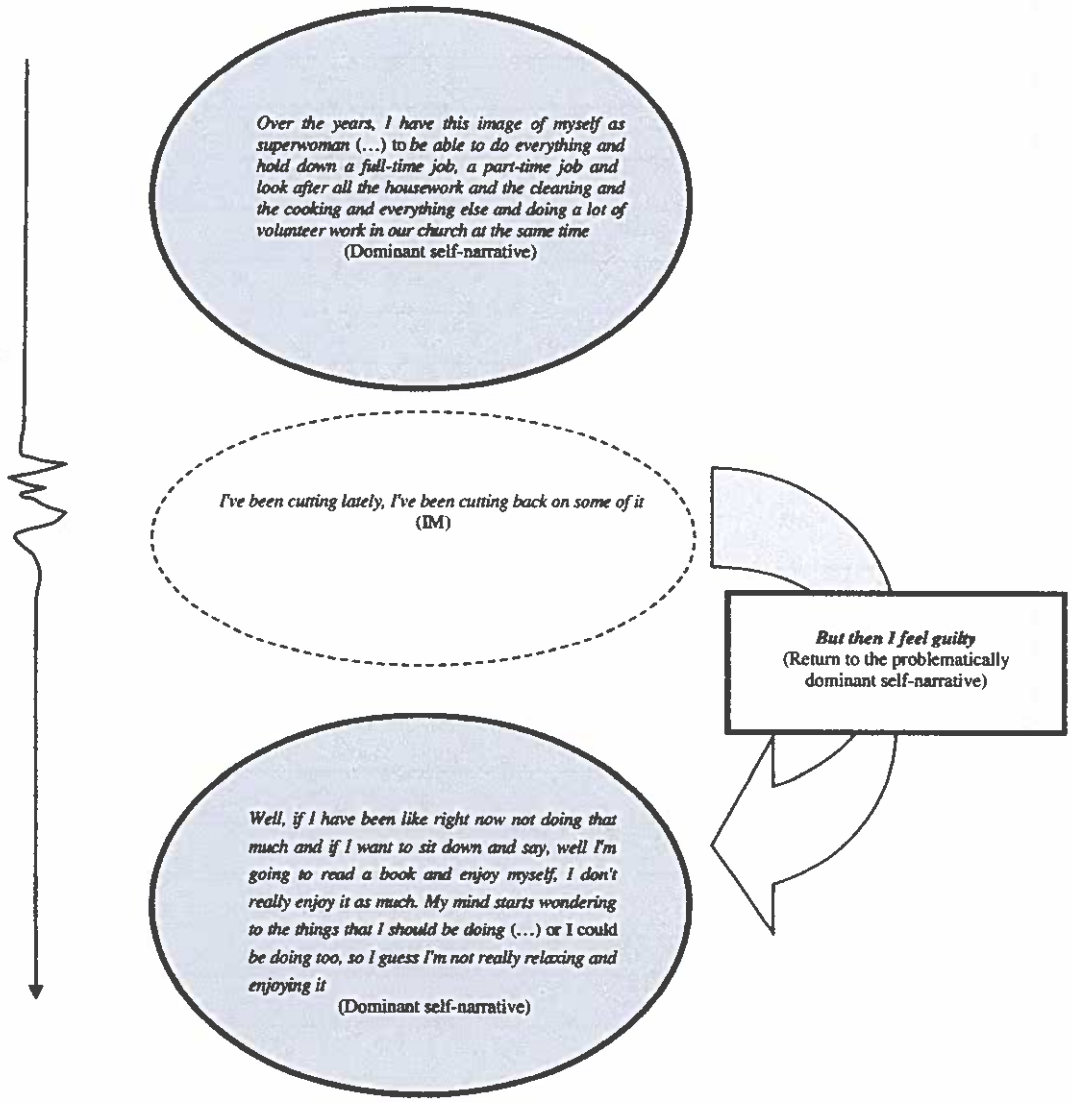

Figure 1. Avoiding self-discrepancy by returning to the problematically dominant self-narrative: The case of Jan (session 1).

Holiman, 2002) have emphasized, from a humanistic-experiential perspective, that psychological changes introduce discrepancy or inner contradiction. This discrepancy may be experienced as a threat, evoking a self-protective response in which the discrepant experience is "distorted, denied, or inadequately symbolized" (Engle & Arkovitz, 2008, p. 391), keeping clients safe from anxiety, as they respond to changing from something familiar into something unknown. From a dialogical point of view (Valsiner, 2002; see also Hermans, 1996), the client performs a cyclical movement between a voice (IM) and a counter-voice (problematically dominant self-narrative) that interferes with further development, leading to an "impasse or a state of 'stuckness' (cf. Perls, 1969)" (Honos-Webb & Stiles, 1998, p. 28). Brinegar, Salvi, Stiles, & Greenberg (2006) used the term *rapid cross-fire* to describe this oscillation between the overt expressions of two contradictory internal voices. As each voice triggers contradiction by the other, they seem "to fight for possession of the floor" (Brinegar et al., 2006, p. 170). EFT (Greenberg, Rice, & Elliot, 1993) uses the term *conflict splits* to describe this sense of struggle between two opposite aspects of the self that pull the person in different directions. In each of these characterizations of conflicting internal self-positions, the dialogue maintains the person's status quo and, when extended over time, can be conceptualized as forms of resistance to change.

Not all cases remain stuck in ambivalence, however. In some cases, clients move from rapid cross-

fire toward an inclusive system of meaning in which opposite internal voices respectfully listen to each other and engage in joint action (see Brinegar et al., 2006).

Measurement of Ambivalence

To measure the sort of ambivalence in which an IM emerges and is immediately followed by a return to the problematically dominant self-narrative, we have proposed a system for coding *Return-to-the-Problem Markers* (RPMs; Gonçalves, Ribeiro, Stiles, et al., 2011). The following example was drawn from the case of George, a poor-outcome case of EFT from the York I Depression Study (Greenberg & Watson, 1998; Honos-Webb, Stiles, Greenberg, & Goldman, 1998), whose depression was related to his feelings of inadequacy and inability to provide for his family. This view of himself as a failure permeated his relationships with significant others, particularly with his mother, with whom he had a distant relationship. When George experienced IMs, they were usually followed by a RPM, as in the following excerpt:

> Session 5
>
> **C: I don't feel so depressed about it [referring to his low income] as I had been in the past (IM)** *but it's frustrating that I still have to go through the anguish of the problem as far as the money is concerned.* (RPM)

In this example, George described an IM—"**I don't feel so depressed about it as I had been in the past**"—and then returned to the problematically dominant self-narrative by saying "*but it's frustrating that I still have to go through the anguish of the problem as far as the money is concerned.*" This clause introduced by the word *but* represented opposition or negation towards what was being said and hence constitutes a RPM.

The results obtained in the study of narrative therapy with women who were victims of intimate violence (N = 10; Gonçalves, Ribeiro, Stiles, et al., 2011) showed that IMs were much more likely to be followed by a RPM in the poor-outcome cases than in the good-outcome cases. The good- and poor-outcome cases had similar levels of symptom severity at intake, but the poor-outcome cases showed dramatically higher percentages of RPMs in the later parts of therapy. This observation is consistent with the theoretical suggestion that ambivalence between IMs and the problematically dominant self-narrative can interfere with the therapeutic progress.

Hypothesis

In this study we extended our method for coding RPMs to another type of therapy—EFT. We hypothesized that the probability of IMs containing RPMs decreases across treatment in good-outcome cases, as the novelties are expanded and assimilated, but not in poor-outcome cases.

Method

Data, including IMs codes, were drawn from the Mendes et al. (2010) study of IMs in EFT. Relevant parts of that study's method are summarized here; please see Mendes et al. (2010) for additional details.

Clients

We studied six clients who received EFT as participants in the York I Depression Study (Greenberg & Watson, 1998), a project designed to assess and compare EFT (then known as process-experiential therapy) with client-centered therapy for major depression (diagnosed according to the DSM-III-R; APA, 1987). The treatment in both conditions entailed 16 to 20 sessions of individual psychotherapy once a week. These six cases (three good and three poor outcome cases) were previously chosen from the 17 clients who received EFT in the York I study for intensive process analyses. Four were women and two were men (age range = 27–63 years, M = 45.50, SD = 13.78). Five of the clients were married, and one was divorced.

Therapists and Therapy

EFT incorporates the client-centered relational conditions (empathy, unconditional positive regard, and genuineness; Rogers, 1957) and adds experiential and gestalt interventions to facilitate the resolution of maladaptive affective-cognitive processing. These EFT interventions included focusing (Gendlin, 1981) at a marker of an unclear felt sense, systematic evocative unfolding for problematic reactions, two-chair dialogue for self-evaluative and self-interruptive conflict splits, and empty-chair dialogue for unfinished business with a significant other (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg et al., 1993; Greenberg & Watson, 2006).

Five therapists (four women, one man) conducted the individual therapy for the six clients analyzed in this study (two of the poor-outcome clients, numbers 4 and 6, were treated by the same therapist). Their levels of education varied from advanced doctoral students in clinical psychology to PhD

clinical psychologists. Four therapists were Caucasian and one was Indian. All therapists received 24 weeks of training according to the York I Depression Study manual (Greenberg et al., 1993): 8 weeks of client-centered therapy training, 6 weeks of systematic evocative unfolding training, 6 weeks of two-chair dialogue training, and 4 weeks of empty-chair dialogue training.

Measures

Beck Depression Inventory (BDI). The BDI is a 21-item self-report instrument assessing symptoms of depression (Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The items are rated on a 4-point Likert scale, from 0 to 3, with total scores ranging from 0 to 63. Internal consistency in this sample was α .92.

Innovative Moments Coding System (IMCS). The IMCS tracks IMs, that is, moments in which the problematically dominant self-narrative is challenged (Gonçalves, Ribeiro, Mendes, et al., 2011). Coders consensually distinguish facets of each client's problematically dominant self-narrative (e.g., lack of assertiveness, sense of inability) and then identify independently the moments in which these facets are challenged (e.g., moments of assertiveness, sense of empowerment). In previous studies, the IMCS has proved to be reliable; the average inter-judge percentage of agreement on overall IMs salience (the proportion of session occupied by each IM) ranged from 84% to 94% (calculated as the overlapping of the salience identified by both judges divided by the total salience identified by either judge; Gonçalves, Ribeiro, Mendes, et al., 2011).

Return-to-the-Problem Coding System (RPCS). As described in the manual for RPCS, (Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2009), this qualitative system analyzes the re-emergence of the problematically dominant self-narrative (through RPMs) immediately after the emergence of an IM or within the client's first speaking turn after the therapist's first intervention following the IM narration. Gonçalves, Ribeiro, Stiles et al. (2011) reported very good agreement between judges on coding RPMs, with a Cohen's k of .93.

Procedure

IM coding and reliability. Mendes et al. (2010) applied the IMCS to all session transcripts of the six selected EFT cases. Two judges participated; both were PhD students in psychology. One judge coded the entire sample and another judge independently coded 50% of the sessions of the sample (n = 53). Reliability indexes were computed on the 50% of sessions coded by both judges. The percentage of agreement on overall IMs salience was 88.7%.

Two steps in this process of coding IMs are relevant to the present analysis: (1) consensual definition of the facets of the problematically dominant self-narrative by the two coders and (2) identification of each IM, defining its beginning and end.

The first step of the process of coding therapy sessions involved a careful reading of all transcripts. Coders then independently listed the clients' problems (or facets of the problematically dominant self-narrative) and met to discuss their understanding of what constituted each client's problematically dominant self-narrative. The problems were identified and consensually defined (as close as possible to the client's discourse). To make this procedure clearer, we give the following example of problematically dominant self-narrative identified in the case of Lisa, a well-known EFT client from the York I Depression Study sample ("The Case of Lisa," 2008; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010). One of Lisa's problematic self-narrative themes was "resentment and difficulty in expressing her own feelings":

> L: Maybe that's why I don't tell him how I really feel inside (sniff) ... yeah, there's, or um, even though I express it, it's just kind of laughed at.
>
> As we already stated, an IM is, by definition, an exception to this theme:
>
> L: ...but then my feelings are my feelings and I'm entitled to them.

To allow coders to track what were identified as IMs within the client discourse, the sessions were independently coded in chronological order. When the client started to talk about any content that constituted an exception to the previously identified problematically dominant self-narrative, coders identified IM onset and offset.

RPM coding and reliability. The same two judges participated in the RPM coding procedure as participated in the IMCS coding. This coding was done 2 years after the IMCS coding had been completed. Training for RPM coding began with reading the manual for the RPCS (Gonçalves, Ribeiro, et al., 2009). Next, the two judges coded RPMs in a workbook that included transcripts of all IMs from one psychotherapy case. This step was followed by a discussion of discrepancies with a group of other RPM judges in training and/or with a skilled RPM judge. After this discussion, they coded

a second workbook that included transcripts of all IMs from a second psychotherapy case. Their codes were then compared with the codes of expert judges. Judges were considered reliable if they achieve a Cohen's *k* higher than .75, which was the case.

RPMs coding comprised two sequential steps: (1) independent coding and (2) resolving disagreements through consensus. Both judges coded the entire sample (1260 IMs), analyzing IMs coded by Mendes et al. (2010) for the presence of RPMs, following the RPCS manual. The sessions were coded from the transcripts in the order they occurred. Reliability of identifying RPMs, assessed by Cohen's *k*, was .85, based on the initial independent coding of a sample size of 1260 IMs. Throughout the coding process, the two judges met after coding each session and noted differences in their perspectives of the problems and in their RPM coding. When differences were detected, they were resolved through consensual discussion. During the collaborative meetings, the judges discussed the strengths of each other's coding and the criteria used to achieve them. Through this interactive procedure, the judges were able to integrate each other's strengths, which facilitated the coding of subsequent sessions (cf., Brinegar et al., 2006). The analysis was then based on the consensus between the two judges.

Good- and poor-outcome cases. Clients were previously classified by Greenberg and Watson (1998) as having good or poor outcome based on a Reliable Change Index (RCI; Jacobson & Truax, 1991) analysis of the BDI (Beck et al., 1961, 1988) pre-therapy score (assessment interview) and BDI post-therapy score (last session). Based on a BDI cutoff score of 11.08 and RCI criteria, three clients were identified as "recovered" (i.e., with a good outcome) and three were classified as "unchanged" (i.e., with a poor outcome) at treatment termination. BDI scores declined dramatically from pretest to posttest for the three good-outcome cases but change little for the poor-outcome cases (see Table I).

No significant differences between the good-outcome and poor-outcome cases were found for number of sessions. The level of symptom severity on the pretreatment BDI was significantly different between the two outcome groups, with good-outcome clients scoring significantly higher (greater severity) than poor-outcome clients. Mendes et al. (2010) reported that the global salience of IMs (proportion of session transcript involving IMs) was higher in the good-outcome group than in the poor-outcome group.

Results

Table I shows the percentage of IMs that were followed by RPMs along with the frequencies of IMs and RPMs in each of the six cases. There was a good deal of variation from case to case but no significant difference between good- ($M = 21.70$; $SD = 2.92$) and poor-outcome cases ($M = 29.77$; $SD = 10.38$; Mann-Whitney $U = 6.00$, $p = .51$) in the percentage of IMs followed by RPMs.

To test our hypothesis that the probability of IMs containing RPMs decreases across treatment in good-outcome but not in poor-outcome cases, we modeled the probability of IMs containing RPMs using a Generalized Linear Model (GLM). The GLM analysis allowed us to construct a longitudinal regression model of the probability of RPMs as a linear function of therapy outcome (good vs. poor outcome) and time (from session 1 to 20)—explanatory variables—through the logit link function (this function allows outcomes to vary between 0 and 1) (McCullagh & Nelder, 1989). We included a subject-specific random effect to take variability among individuals into account given that we expected that measurements (RPMs) from the same client would be correlated.

The results are presented in Figure 2, in which the *y* axis represents the probability of RPM occurring and the *x* axis therapy sessions over time. The estimated probability of RPMs at baseline was 35.9% for poor outcome and 48.7% for good outcome. Results indicated that these probabilities were statistically different ($p = .013$). With respect to the estimated probability of RPMs at the last session, the poor-outcome group presented 31.4%, whereas the good-outcome group presented 4.5%. Again, these probabilities were statistically different ($p < .0001$).

Moreover, the effect of interaction between time and outcome was statistically significant ($p < .001$). This means that the slopes of two outcomes were significantly different: the probability of RPM decreased in the good-outcome group, whereas it

Table I. Pre to post BDI scores, total of IMs, total of RPMs and percentage of IMs followed by RPMs.

Case	Pre–post BDI	Total IMs	Total RPMs	% IMs followed by RPMs
1	25–3	305	84	27.54
2	30–5	355	68	19.15
3	35–4	214	33	15.42
4	15–13	187	66	35.29
5	23–22	140	27	19.29
6	24–18	125	59	47.2

Note. Cases 1, 2 and 3 belong to the good-outcome group and cases 4, 5 and 6 constitute the poor-outcome group.

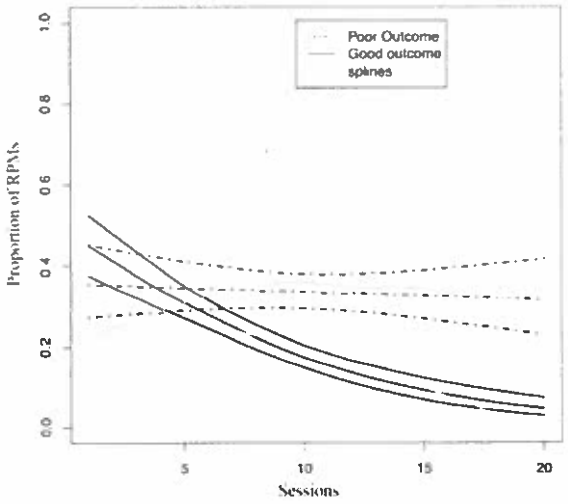

Figure 2. The evolution of RPMs in good- and poor-outcome groups.

remained unchanged in the poor-outcome group, as hypothesized.

Discussion

Our results showed that RPMs emerge in both groups, which is consistent with the theoretical suggestion that ambivalence—oscillation between novelty and problematically dominant self-narrative—might be an integral part of the change process (cf., Engle & Holiman, 2002; Mahoney, 2003). Whereas Gonçalves, Ribeiro, et al. (2011) found that IMs were much more likely to be followed by a RPM in the poor-outcome cases than in the good-outcome cases of narrative therapy, the good- and poor-outcome cases of EFT had similar overall proportions of IMs containing RPMs. This could reflect sample variation (numbers of clients in both studies were small) or different selection criteria operating in which clients entered these studies.

Replicating the finding that good- and poor-outcome groups followed different trajectories across treatment was consistent with the theoretical suggestion that therapeutic progress involves overcoming ambivalence. The probability of RPMs decreased in the good- outcome group, whereas it remained high in the poor-outcome group (Figure 2). These results are congruent with EFT's dialectical constructivist view of the self in which the awareness and "confrontation between two opposing prior self-organizations", facilitated, for instance, by chair work (Greenberg & Watson, 2006, p. 40), facilitates integration between discrepant parts of self and the construction and consolidation of new meanings into a new self-organization (Elliott et al., 2004; Greenberg & Watson, 2006). That is, it is plausible that the declining pattern of RPMs in the good-outcome cases reflected clients attaining a sense of integration between the innovative voice and the voice of the problematically dominant self-narrative. In contrast, the poor-outcome group's probability of RPMs remained high until the end, suggesting that clients did not resolve the conflicts between the two parts of the self.

Limitations and Conclusion

Characteristics of our sample, such as its small size, restriction to depression, and the requirement of willingness to participate in research, restrict generalizing results of the hypotheses tested. Also, the fact that the same therapist followed two out of three poor-outcome cases emphasizes the nonrandom selection of cases and hence uncertain representativeness of our sample. Our design does not, of course, admit any causal claims.

Nevertheless in a Bayesean sense, our observations in this study add a little confidence to the theory that (1) ambivalence might be a rather frequent process in both good- and poor-outcome cases due to the potential disruptive nature of IMs, and (2) ambivalence tends to decrease across treatment in good-outcome cases but not in poor-outcome cases. Clinically, overcoming ambivalence reflects therapeutic progress whereas the persistence of ambivalence in later stages of therapy may reflect a lack of therapeutic progress. Further, RPMs may offer an opportunity. They may indicate readiness for change in the sense that intruding and dominant voices are responding to each other. A therapist who can listen and respond to their separate expressions may be able to facilitate a successful negotiation between them.

This study's success corroborates the applicability of our method for coding RPMs to different therapeutic models (EFT) and to different problems (depression). It helps build confidence in RPCS coding as a transtheoretical method for identifying ambivalence in psychotherapy.

We have cast ambivalence as a kind of stuck conversation in which two competing voices are pulling in different directions. As the study and other studies (e.g., Brinegar et al., 2006) have shown, however, sometimes such ambivalence can be overcome. Future work might profitably investigate therapeutic strategies for addressing and overcoming ambivalence (cf., Ribeiro et al., in press.)

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Routledge

EMPIRICAL PAPER

Ambivalence resolution in emotion-focused therapy: The successful case of Sarah

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Abstract
Ambivalence can be understood as a cyclical movement between two opposing positions of the self: one expressed in a novelty —an innovative moment (IM)—and another one conveyed by a return to the maladaptive pattern. If not properly addressed and resolved during therapy, ambivalence can prevent change and lead to psychotherapeutic failure. Two processes of ambivalence resolution have been suggested: (1) the dominance of the innovative position and consequent inhibition of the problematic position and (2) the negotiation between both positions. **Objectives**: To empirically study both processes of ambivalence resolution in a successful case of emotion-focused therapy. **Method**: Sessions were independently coded with three coding systems—the IMs, the return to the problem and the ambivalence resolution. **Results**: Ambivalence tended to be resolved from the initial to the final sessions. Although resolutions through dominance tended to decrease and resolutions through negotiation seemingly increased along treatment, dominance was, nonetheless, the most prominent process of resolution along the whole treatment. **Conclusions**: Although it has been suggested that integrating opposing parts of the self is a necessary process for psychotherapeutic success, a less integrative process of ambivalence resolution may also be an important resource along the process.

Keywords: ambivalence; innovative moments; ambivalence resolution; Ambivalence Resolution Coding System

Introduction

In this article, we present a system that allows for the study of ambivalence resolution in psychotherapy—the Ambivalence Resolution Coding System (ARCS)—and report findings from the intensive analysis of Sarah, a successful case of emotion focused therapy from the York I Project on Depression Study (Greenberg & Watson, 1998), using this system.

Ambivalence and the Return to the Problem Marker

Ambivalence is probably a natural and even essential process in psychotherapeutic change as changing implies challenging the current, albeit dysfunctional, schemas, internal structures or constructs (Velicer, DiClemente, Prochaska, & Brandenburg, 1985). However, when people are not able to overcome ambivalence, problems can persist and even intensify (Miller & Rollnick, 2002), eventually leading to psychotherapeutic failure and increased psychological suffering.

Research on the innovative moments (IMs) in psychotherapy (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Gonçalves et al., 2011; Goncalves, Matos, & Santos, 2009; Matos, Santos, Gonçalves, & Martins, 2009; Mendes et al., 2010) led to the creation of an empirical measure of ambivalence—the return to the problem marker (RPM) (Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2009). Let us briefly characterize IMs in order to subsequently describe RPMs. IMs are moments during the therapeutic conversation in which a new way of feeling, thinking, and/or acting, that is different from the problematic pattern that brought the client to therapy, emerges (Gonçalves, Ribeiro, Mendes, et al., 2011). Studies have found that IMs are more frequent in

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recovered than in unchanged cases (Gonçalves, Ribeiro, Mendes, et al., 2011; Matos et al., 2009; Mendes et al., 2010), suggesting that changing in psychotherapy entails the emergence of IMs. While IMs are associated with successful change, RPMs are markers of ambivalence in psychotherapy. RPMs consist of the emergence of an IM that is subsequently devalued by the client, as the problematic pattern is reemphasized again. A simple example of this phenomenon could be illustrated by the following example: "I'm less depressed lately and I've been feeling more positive, seeing things from a different perspective (IM), but I don't believe this will last, I'm a depressed person after all (RPM)." In this sentence, the client produces an IM but just after its emergence, the change potential of the IM is aborted by its devaluation, emphasizing the dominance of the previous problematic pattern. Studies on ambivalence have shown that RPMs are more frequent in unchanged than in recovered cases (Gonçalves, Ribeiro, Stiles, et al., 2011), and that in recovered cases the frequency of RPMs decreases along treatment, while in unchanged cases it remains stable or even increases along treatment (Ribeiro et al., 2014).

From a theoretical perspective, understanding these differences between recovered and unchanged cases implies taking into account IM's potential to create discontinuity and uncertainty (Gonçalves & Ribeiro, 2011). Each IM can be considered a *bifurcation point* (see Valsiner & Sato, 2006), that is, a moment in which the client must resolve a tension between two opposing positions—one expressed in the IM and the other expressed in the problematic pattern. Clients can resolve this tension by expanding novelty (i.e., the IM) and creating an opportunity to change, or by minimizing novelty through a return to the problem (empirically observed through an RPM), which enables the client to avoid the discomfort generated by novelty and discontinuity and to keep stability, even if it is problematic. Recovered clients amplify the novelty potential present in the IMs, elaborating deeper the current IM or producing more IMs, while unchanged cases often minimize the change IMs' potential through an RPM.

The Resolution of Ambivalence

Based on the assumption that ambivalence is a major issue in psychotherapeutic change that must be resolved so that significant gains can be attained (Miller & Rollnick, 2002). Gonçalves and Ribeiro (2011) carried out an intensive qualitative exploration on how ambivalence can be resolved, from the perspective of IMs. This study made it clear that there are at least two different processes by which ambivalence can be overcome: (1) dominance of the innovative position and consequent inhibition of the problematic position, and (2) the negotiation between both positions. In the dominance process, the innovative position strives to regulate the problematic position by affirming the innovative's position authority, in a process which apparently implies a role reversal: the previously dominated position now seems to be the dominating one. In the negotiation process, the conflicting positions seem to be considerately communicating with one another, promoting a dynamic flow between opposites, rather than the dominance of one of them.

We hypothesize that as treatment develops in successful cases, negotiation between positions increases, while dominance of the innovative position decreases. This theoretical hypothesis is supported by studies that have been suggesting an increasing integration of opposing elements of the self along the therapeutic process. For example, the assimilation model (Stiles, 2002; Stiles et al., 1990) suggests that successful psychotherapy cases tend to follow a pattern of change in which the problematic position is progressively integrated in the community of voices, a sequence that is summarized in the eight levels of the Assimilation of Problematic Experiences Scale's. Studies have found that successful cases often reach level 4 or higher, whereas poor outcome cases seldom achieve this level (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006). According to Detert et al. (2006) a *meaning bridge* between opposing positions emerges only after level 4. A meaning bridge consists of a common language between the problematic and the innovative positions which enables the negotiation between positions rather than a trial of strength between them. Congruently with the assimilation model, in the IMs' model, reconceptualization IMs are associated with successful change. Reconceptualization is a form of insight in which a meaning bridge is established between the problematic position and the innovative position. Finally, in emotion-focused therapy (EFT) (Greenberg & Watson, 1998) empty-chair and two-chair techniques enable the client to enact internalized positions of the self in a way that promotes the dialogue between positions, in order to facilitate emotional processing and integration, since this is a central aspect of more adaptive emotional responses and experience.

Nonetheless, the exploratory study performed by Gonçalves and Ribeiro (2011) has suggested that successful cases can resolve ambivalence also through the dominance of the innovative position. Because the assimilation model predicts that a dominance process is present only in lower levels of assimilation

which must be overcome and give way to the negotiation between positions, important questions are raised about the process of ambivalence resolution: can ambivalence be solved only through the integration and dialogue between opposing positions of the self, or is there a less integrative way to resolve ambivalence—the dominance process? In this sense, the empirical study of the resolution of ambivalence is of central importance if we are to understand how this process evolves along treatment and consequently to successfully assist clients in their process of change. In order to make this possible we developed a coding system that allows for the tracking of ambivalence resolution in psychotherapy. In this article we present this coding system and illustrate its application to a successful case of emotion-focused therapy.

Method

Client

The case used for this intensive study with the ARCS integrated the York I depression sample (Greenberg & Watson, 1998). Sarah (fictional name) was a 35-year-old divorced Caucasian woman at the time of the York I Depression Study (Greenberg & Watson, 1998). She had been diagnosed with major depressive disorder, assessed using the Structural Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, Third Edition Reviewed (Spitzer, Williams, Gibbon, & First, 1989), had been randomly assigned to EFT and seen for 18 sessions. Sarah's problematic pattern was essentially related to a lack of assertiveness (passiveness) in all relationships and social contexts which among other consequences, kept her from being able to define and express her own desires and opinions and impelled her to "cater too much to other people" which in turn ended up engendering feelings of distrust in other people and ultimately led to a disinvestment in social relationships.

Therapy

EFT. EFT entails the fundamentals of client centered therapy in addition to interventions from experiential and gestalt therapies that target specific intrapsychological and interpersonal issues. A key argument of EFT is that emotions are essential to the construction and organization of the self. As a result, change can occur if people are assisted in making sense of their emotions through the awareness, expression, regulation, reflection, transformation and corrective experience of emotions in the context of an empathic relationship that facilitates these processes (Greenberg, 2010). Specific emotion-focus interventions of EFT are focusing on an unclear bodily felt sense; the imagined re-experience of a problematic situation; empty-chair dialogues which facilitate the communication of unresolved feelings to significant others and the two-chair dialogue where clients enact their critical inner voices (Greenberg & Watson, 1998). In Sarah's case, all of these have been used, except for the imagined re-experience of a problematic situation.

Therapist

Sarah's therapist was a female doctoral student in clinical psychology, age 33 at the time of treatment. Therapist training included a 24 weeks training according to the manual developed for the York I Depression Study (Greenberg, Rice, & Elliott, 1993). The training consisted of eight weeks of client-centered therapy, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue and four weeks for empty-chair dialogue.

Measures

Innovative Moments Coding System. Prior to the application of the ARCS, all sessions had been previously coded with the Innovative Moments Coding System (IMCS) (Gonçalves, Ribeiro, Mendes, et al., 2011) which comprises five different types of IMs: action, reflection, protest, reconceptualization, and performing change. We calculated the proportion of each IM type (the percentage of time dedicated to that specific type of IM) for each session and for the whole process as well as the total proportion of IMs (i.e., the sum of salience of the five types) as the percentage of time dedicated IMs in the session and throughout the process. The agreement between the two independent judges on overall IM proportion was .89. Reliability of distinguishing IM's type assessed by Cohen's κ was .86, showing strong agreement between judges (Hill & Lambert, 2004). The systems' validity was inferred through studies relating the presence and evolution of IMs (process) to case's outcome. These studies were carried out with different psychotherapeutic approaches: narrative therapy (Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2015; Matos et al., 2009), client centered therapy (Gonçalves et al., 2012), constructivist grief therapy (Alves et al., 2013), cognitive-behavioral therapy (Gonçalves et al., 2015) and emotion-focused therapy (Mendes et al., 2010). The system's reliability ranged from a Cohen's κ of .86 in narrative therapy (Matos et al., 2009) to .97

for client centered therapy (Gonçalves, Mendes, et al., 2012), indicating a strong agreement.

Return to the Problem Coding System. The Return to the Problem Coding System (RPCS; Gonçalves et al., 2009), also applied to all sessions prior to the study, is a qualitative system that examines the reappearance of the problematic pattern immediately after the emergence of an IM (RPMs). A .93 Cohen's κ value revealed a strong inter-rater agreement. Previous studies using the RPCS (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2013) also reported strong inter-rater agreement, with Cohen's κ of between .88 and .93.

The ARCS. The ARCS was constructed to allow for the empirical study of the resolution of ambivalence. The system identifies the two processes of ambivalence resolution (dominance and negotiation) and was constructed, refined and validated through a thorough analysis of 90 sessions of six EFT cases belonging to Greenberg and Watson's (1998) study.

The coding implies the sequential analysis of each IM. Each IM must be coded as *resolution* or *no resolution* and if a resolution is present, as *dominance* or *negotiation*. The category of *no resolution* is applied when neither dominance nor negotiation are present or when the IM is immediately followed by an RPM.

Development of the ARCS. Consensual definition of the problematic pattern (or problematic self-narrative). The definition of the problematic self-narrative was elaborated in accordance with the procedure used in the IMCS (Gonçalves, Ribeiro, Mendes, et al., 2011). First, the judges carefully read the entire sessions' transcripts. Next, they separately described the facets of the problematic self-narrative as close as possible to the client's words before they met and discussed these descriptions. From this discussion, a consensual definition of the facets of the problematic self-narrative was achieved.

Construction of Markers of Resolution. It is important to clarify that in this study, we are essentially concerned with the *process* of ambivalence resolution during psychotherapy. This means that we are not only looking for the final resolution of ambivalence (i.e., how the positions end up relating by the end of treatment) but also trying to understand how this process evolves along treatment. Therefore, we are mainly concerned with what we might term *micro-resolutions*, that is, moments when there is an *agentic and determined* resolution of ambivalence, even if this is a momentary one. This temporary nature of micro-resolutions means that the specific subject of ambivalence that is resolved in one session could be raised again in the next session, or even in the same one but they are nonetheless resolutions of ambivalence in a specific moment. We speculate that it is the repetition of these micro-resolutions along treatment that will allow for the understanding of the overall process of resolution.

In order to further facilitate the description of the resolution phenomenon and the coding of ambivalence resolution, and as a result of the cumulative discussions and adjustments made by the judges during the phase of coding dominance and negotiation, a list of markers of resolution was constructed (see Table 1). These are not categories to be coded but rather indicators of the presence of a moment of resolution.

Table 1. Markers of resolution.

Marker	Examples
Expressing desires/intentions/ limits (in course, projected or already taken attitudes or actions; expressing toward self or others)	*This is what I want now* *Maybe this will be different one day but right now this is what I want from them* *I know this would be good for him, but I also have to know what's good for me* *This is what I deserve* *I don't deserve this* *I don't want this (anymore)* *This I will do, that I will not* *I have to stop thinking of other people and start thinking about myself* *It will probably be hard, but I think I can do it* *This is how it is going to be* *I will never do that again* *I told her everything I had to tell her* *For the last two weeks all of a sudden it's like no, it's me, and what I need, and what can I put up with* *Self-instructions (don't do that, do this, so be it ...)* *Just back off, I have to pull it together for myself first* *I'll help you, which I do, but only if I can make things work for myself first*
Ultimatums	*Either this or that* *If this, than that*
Distancing	*This is not an issue anymore* *I don't care if she doesn't* *That's not my problem*
Conclusions, generalizations, lessons, maxims	*When people do this, I can do that* *That's just the way it is* *You have to take the good with the bad* *Let the chips fall where they will* *I can't be loved by everybody*

Construction of Markers of Types of Resolution (Dominance and Negotiation). In coding the different types of resolution, judges considered the definition of dominance and negotiation previously presented and first suggested by Gonçalves and Ribeiro (2011). After independently coding each session, the judges met to assess the reliability of the procedure and to detect differences in their ratings. Dissimilarities were resolved through discussion. During these meetings, the judges also discussed the procedures and criteria they used, a process which culminated in the formulated data-driven markers (see Table 2) of dominance and negotiation on that facilitate the identification and coding of both processes of ambivalence resolution.

Preliminary Validation of the ARCS. The ARCS was constructed, refined and validated through a thorough analysis of 90 sessions of 6 EFT cases belonging to Greenberg and Watson's (1998) study. Of the six clients in this sample, four were women and two were men (age range = 27–63 years, $M = 45.50$ years, $SD = 13.78$). Clients completed an average of 17.50 ($SD = 1.87$) sessions. Five of the clients were married and one was divorced. All the clients were Caucasian.

Three of these cases were recovered cases and three were unchanged cases. This distinction was based on a Reliable Change Index (Jacobson & Truax, 1991) of the Beck Depression Inventory (Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). To assess inter-judge reliability, two judges independently coded all the sessions of the six cases used to construct the ARCS. Cohen's κ values was .89 for the presence vs. absence of resolution and .82 for the dominance vs. the negotiation processes of resolution.

Table 2. Markers of dominance and negotiation.

Process	Definition	Examples
Dominance	The new self-position strives to regulate the problematic position by affirming its dominance, in a process which seems to imply a role reversal: the previously dominated position now seems to be the dominating one	*I'm never going to do that again; I was afraid but then I thought: so what?; My mind is made up, there is no turning back; I want you to take me as I am; I don't ever want to see him again*
Negotiation	The opposing voices seem to be respectfully communicating with one another, enabling a dynamic movement between the opposites, rather than a fixation on one of them	*Compromise*: The positions negotiate conditions (e.g., *I will do this but not that; there's only this much I will do*) *Support/encouragement*: The positions support/encourage each other (e.g., the (ex) self critic now encourages and supports the new position) *Acceptance*: The positions accept each other's differences and concerns (e.g., the new position understands and accepts the problematic position's concerns)

Procedure

Sarah's case was chosen from the same sample that was used to construct the system. We present an intensive analysis of a single case in order to illustrate the process of ambivalence resolution in a deeper, detailed manner that we believe can be more informative of the ambivalence resolution process. The decision to present a successful case had to do with the fact that successful cases have a significantly higher frequency of IMs, and thus they also represent a higher probability to find more resolutions, which contributes to the informational value of the present study. Finally, from the three successful cases that composed the sample, Sarah's case was arbitrarily chosen. For the sake of parsimony and intelligibility, we will focus the analysis on the three first, the three middle, and the three final sessions of treatment.

Results

Table 3 exhibits the fundamental contrast between Sarah's problematic and innovative positions. The positions oppose each other in a clear and intuitive

Table 3. Sarah's problematic and innovative self-narrative main topics.

Problematic self-position	New self-position
Difficulty defining own desires and opinions	Clearly defining own desires and opinions
Excessive need to be validated by others	Self-validation
Excessive need to "cater to others"	Desire to satisfy own needs
Fear of rejection	Self-acceptance
Disinvestment in social relationships	Investment in social relationships

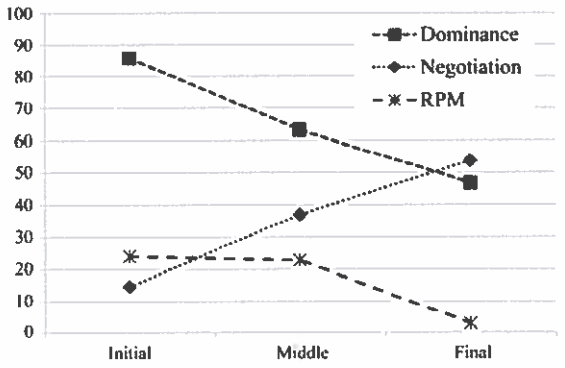

Figure 1. Mean percentage of IMs with RPM, dominance and negotiation for the initial (1st to 3rd session), the middle (8th to 10th session) and the final (16th to 18th session) sessions of treatment.

manner and the exposed items reflect their central tenets, achieved through a consensual analysis as described above.

Figure 1 illustrates the mean percentage of resolutions through dominance, through negotiation and the mean percentage of IMs with RPM for the initial (1st to 3rd session), the middle (8th to 10th session) and the final (16th to 18th session) sessions of treatment.

A decreasing tendency of IMs with RPMs from the initial (24%) to the final sessions (3%) was observed, indicating a decrease in ambivalence throughout treatment. In terms of resolutions, while the percentage of resolutions through dominance tended to decrease from the initial (86%) to the final sessions (47%), the percentage of resolutions through negotiation seemingly increased from the initial (14%) to the last (53%) sessions of treatment.

Initial Phase of Treatment (Sessions 1–3)

As previously mentioned, Sarah was essentially struggling between the need for others' approval and acceptance vs. the need to validate and accept her own wishes and decisions. Illustrating this ambivalent cycle, in excerpt 1 (session 2) Sarah is referring to her contradictory needs of (a) choosing someone to interact with whom she feels comfortable, disregarding what other people say about it, and (b) feeling accepted by everyone in the group by making an effort to spend time with other people with whom she does not feel comfortable.

Excerpt 1: Seeking to be validated by others and to fulfill their needs vs. validating herself and dismissing others "opinions and needs"

Sarah: I started to feel bad about that but then I thought: "This is a fun person, he makes me laugh, he is full of stories, this is what I want, this is what I need, this is one of the highlights of the day. Just go in there. Who cares what everybody else says?" **[IM]**

Therapist: *Hm, hm.*

Sarah: I guess they must have been wondering... And then Monday I kind of made sure that I split the time more evenly, so people don't feel whatever and I don't feel like I'm excluding myself. **[RPM]**

Thus, in this excerpt, Sarah attenuates the IM's innovative potential—to accept and validate her own needs and desires—by reaffirming the (problematic) need to be accepted and validated by others.

During these initial sessions, attempts to resolve ambivalence were achieved mainly (86%) by the dominance of the innovative position. In excerpt 2 (session 2), Sarah attempts to resolve the ambivalence between (a) the responsibility of arranging for her ex-roommate to get back all the things he left in the apartment and (b) not feeling responsible for her ex-roommate or his belongings. This resolution is attempted by a dominance of the innovative position, demonstrating Sarah's effort to control the problematic position essentially by harshly defining and asserting her will and limits in the relationships with others, independently of what others could think, want or need.

Excerpt 2: Dominance Process: Validating herself and dismissing others 'opinions and needs'

Sarah: *It's not up to me. Yeah, and not to worry about it anymore.*

Therapist: *Hm.*

Sarah: *It's just that there's nothing to think about, say about. Just cut it right there.*

Therapist: *Somehow all those shoulds and this and that... you were able to just stop those this time.*

Sarah: *Yeah, yeah.*

Therapist: *Uh huh. Just be sure that this is what I want and I'm entitled...*

Sarah: *Exactly. This is my life, I'm entitled to this, and I don't have to track down people, hunt down people, to make sure they get their things.*

Middle Phase of Treatment (Sessions 8–10)

The three middle sessions of treatment reflect what happens during the work phase of Sarah's process. Dominance is still quite frequent (63%), but negotiation seems now more common than in the beginning of treatment (37%). Excerpt 3 (session 8) illustrates the same process of dominance shown in the previous excerpt: in this particular example, Sarah is exploring her problematic need to justify herself to everyone and to make sure everybody is pleased with her actions. In the face of this, the new position harshly imposes itself by saying "No" to the

problematic position, controlling its power and effects in a way that seems to imply a role reversal since the ex-dominated position is now the dominating one.

Excerpt 3: Dominance: validating herself and dismissing others "opinions and needs"

Sarah:	For the last two weeks, all of a sudden it's like: "No! It's me and what I need, and what I can put up with, what suits my needs. And it's just like discovering a completely new world".
Therapist:	Hm-hm, it's like a new dimension that you were never really tuned into.
Sarah:	Yeah, yeah. Because I always have been just: "oh, what is it that you need?"
Therapist:	Hm-hm.
Sarah:	And it's just such a relief to get away from that.

On the other hand, negotiation is now more recurrent: the positions start to communicate in a different manner, negotiating conditions between them. In excerpt 4 (session 10), Sarah reveals that she is no longer completely dismissing other people's needs and opinions but, at the same time, she is not automatically "catering" to them and their needs anymore. As the therapists states, and Sarah agrees, there is now a stage where Sarah might accommodate other people. But only if this is also in line with her own needs.

Excerpt 4: Negotiation: Validating herself and her needs while also recognizing other people's needs

Sarah:	One of the things in the past is that I just really catered too much to other people and now when something comes up it's: "Do I really want to? Do I really feel like it? Does it really suit me?"
Therapist:	So there's sort of a new stage where you might accommodate people, but you first stop and check out if it's really what you want to do?
Sarah:	Yeah. If it really is okay with me, if it really suits me, yeah.
Therapist:	Yeah. It's not so automatic anymore, like you go on automatic pilot.
Sarah:	Yeah, yeah.
Therapist:	Now it's like: there's a little red light that says wait I'm going to check this out first.
Sarah:	Yeah.
Sarah:	Yeah, for sure. Whereas before I would have just catered no matter what my own circumstances were.

Final Phase of Treatment (Sessions 16–18)

In the final sessions of treatment, dominance is still quite frequent (47%) but negotiation now represents more than half of the resolutions of ambivalence (53%).

Right in the beginning of the 16th session Sarah tackles her own change process in what relates to the central topic of ambivalence: the need to be validated by others vs. the need to validate herself. In excerpt 5 (session 16) Sarah directly affirms that she feels that she started changing by being more "aggressive" in her approach to others and that at this point she would prefer to try a milder approach to them because other people are very important to her too. This "aggressive" approach to others can be equated with the dominance process of ambivalence resolution that was actually more frequent during the initial phases of therapy. And the "milder approach" can be equated with the negotiation process which takes in consideration both her needs and the needs of those who are important to her.

Excerpt 5: Negotiation: validating herself and her needs while also recognizing other people's needs

Sarah:	I think that at one point in time I was saying: "it's starting to change" and at first it was a little bit on the aggressive side of things.
Therapist:	Hm hm.
Sarah:	And I really wanted to get into what you would call an assertive behaviour mode.
Therapist:	Hm, hm.
Sarah:	And yeah, for some time I was a little bit worried that I wouldn't be able to find that balance. But it's coming along alright.
Therapist:	So you're finding a way to do it [validate her own needs] but also not to do it too aggressively. To do it in a way that works socially, works for you, works for them.
Sarah:	Yeah.
Therapist:	And isn't ... you know ... turning off everyone you meet.
Sarah:	That's, that's right.
Therapist:	Yeah, it's important to think about that too, sure.
Sarah:	Oh yeah, that is very important to me.

In excerpt 6 (session 18), in addition to the kind of examples illustrated above, negotiation seems to take a step forward since the positions not only negotiate conditions between them but also seem to fully accept and respect one another. The problematic position's needs and concerns seem to be acknowledged and understood, as opposed to what happened in the dominance process in which the problematic position's needs or concerns were rejected or confronted.

Excerpt 6: Negotiation: the new position understands, accepts and acknowledges the problematic position

Sarah:	Well, it seems a little bit crazy, but it still makes sense: all the feelings I had, that I really felt completely lost and out of control. This can happen, not only just to me, but to anybody at a certain stage in their lives.

Therapist: Hm.

Sarah: And not to hold it against other people.

Therapist: Hm, hm. So somehow there's some real acceptance for what you felt, whereas before it maybe scared you and meant some negative things. Now it's, kind of: "I'm entitled and I understand, and I was in a hard time and those feelings make sense".

Sarah: Yeah, and also that for me, it just took a long time. I mean I haven't really met any other people who have had an experience like that, but maybe they don't talk about it. But because of my personality, character, I don't know, just the way I am, it takes longer to work through it. And just, yeah, um, to come to terms with it almost.

Discussion

This was a theory-building case study (Stiles, 2009). The theory we are building is our account of how clients overcome ambivalence in psychotherapy. Theory-building case studies can make use of rich clinical material to assess and improve theories. As suggested by Stiles, 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). Nonetheless, it should be stressed that all the explanatory hypothesis we raise in order to understand this study's results should be taken into consideration with caution as they stem from a single case study. Despite this, intensive analysis of Sarah's case with the ARCS allowed some interesting insights into the client's process of ambivalence resolution.

Firstly, the dominance of the innovative position was clearly the most frequent process of ambivalence resolution in the initial phase and tended to decrease along the middle and final sessions of treatment. Conversely, the negotiation between positions tended to increase from the initial to the final sessions of treatment.

These results are in line with EFT's (Greenberg, 2010) assumption that the dialogue between positions contributes to successful therapy since this facilitates emotional processing and with the assimilation model's (Stiles, 2002; Stiles et al., 1990) proposal of a progressive integration of opposing elements of the self along successful therapeutic processes.

The increasing presence of common ground between both positions of the self may also help to understand the decreasing frequency of dominance along treatment: as the positions gradually negotiated conditions, the need for the innovative position to control the problematic position through an escalation of its dominance was progressively weakened. As Sarah puts it, she will *accommodate* other people, but only if she wants to, or feels like it or if it suits her. When these conditions are established, the need to accommodate other people is not so *automatic* anymore (as the problematic position is not so dominating), but the need to absolutely censor every urge to do so (the dominance process) is also not as necessary.

As these resolutions are taken and repeatedly rehearsed, RPMs tend to decrease along treatment, signaling that ambivalence is gradually resolved. Assuming that RPMs express the client's return to safety after an excursion to novelty (after the production of an IM), we can hypothesize that as conditions are negotiated between the "safe" (problematic) and the "risky" (innovative) positions, the new position seems gradually less threatening, allowing Sarah to progressively abandon the need to get back to safety.

This process culminated in a fundamental assimilation of the problematic position as Sarah reported to fully accept the problem—to "really come to terms with it"—reconciling both parts of herself as she accepts the difficulties and suffering she had gone through. This process climaxed in the possibility of using this experience as a resource as she now wishes to be more empathic with others facing similar problems, not holding it "against other people."

Nonetheless, and in spite of the theoretically coherent result of a growing common ground between conflicting parts of the self, we would still have to explain the relative high frequency of dominance throughout the whole treatment. This result suggests that even though a process of progressive integration of positions was required in order to allow for the resolution of ambivalence to take place, a parallel, less integrative way of resolving ambivalence was also important. This is an interesting and unexpected result that should be explored by future studies. As an attempt to understand it, we could refer to studies on the assimilation model (Stiles, 2002; Stiles et al., 1990). Developing a marker-based method for rating assimilation in psychotherapy, Honos-Webb, Stiles, and Greenberg (2003) found that a "Flexible Use of Voices" was one significant marker of change. A flexible use of voices implies that:

> the client may determine situations in which the dominant voice is appropriate and situations in which the non-dominant voice is more appropriate for guiding behavior. The client becomes able to discriminate between the two voices and the appropriateness of each rather than unthinkingly reacting from the dominant voice's perspective. (p. 195)

In this sense, if we consider that the new position constitutes the client's ideal way to cope with a problematic, suffering-generating position, its relative dominance along the process is probably necessary and adaptive.

Gonçalves and Ribeiro (2011) also suggested that, in successful therapy, dominance is a possible way of resolving ambivalence. The present study seems to support this since dominance is actually a very frequent process of ambivalence resolution along treatment. On the other hand, the present study also suggests that in order to ambivalence to be successfully resolved, a shift to a more dialogical (negotiation) way of resolving ambivalence is probably essential or necessary. Nonetheless, future studies will hopefully help us to confirm or refute this initial suggestion.

Primarily, future studies will hopefully help us to understand if this is a transtheoretical model of ambivalence resolution, if it can be used only in the context of EFT, or if it was specific just for this case. This is an important question to be answered as the model was created with the analysis of EFT cases and can be particularly useful in the context of this or other psychotherapeutic approaches (e.g., narrative therapy) where the distinction of different positions of the self is in some way systematically explored. When this is not the case, it is yet to be known if this is a useful model.

Future studies with different psychotherapeutic models may also clarify if the processes of dominance and negotiation have similar or different distributions along treatment. Specifically, particular strategies or exercises focused on promoting clients' reaction against the problem (e.g., cognitive restructuring in cognitive-behavioral therapy or externalization in narrative therapy) may facilitate the dominance process since therapists support a counter-position to the problem, while other strategies more centered on understanding and giving voice to different positions (e.g., two-chair dialogue) may enable a cooperative dialogue between the positions involved (Gonçalves & Ribeiro, 2011).

On the other hand, including clients with different problems and diagnosis will also be an important way of understanding if the resolution process is also dependent on these factors. As Sarah had been diagnosed with major depression and her central problem was related essentially to a lack of assertiveness, it would make clinical sense that a considerable part of the therapeutic process consisted of Sarah's self-assertion through a harsh imposition of the new position, as this could be the only way to deal with a particularly oppressive and silencing problematic position.

Finally, future studies should also address the therapist's role in the client's ambivalence resolution process. The ARCS was developed to study the client's process of ambivalence resolution, independently of therapist's interventions or techniques and thus the therapist's role has not been addressed in this study. However, the combination of the ARCS with systems that allow for the study of the therapists role in the change process could be of central relevance if we are to understand how therapists can facilitate ambivalence resolution.

Nonetheless, and though many questions are still to be answered by future studies, we believe this study constituted an important step by opening an empirical line of investigation on ambivalence resolution, a central—albeit under-investigated—phenomenon in the psychotherapeutic context.

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