HOW TO DEAL WITH AMBIVALENCE IN PSYCHOTHERAPY: A CONCEPTUAL MODEL FOR CASE FORMULATION

CÓMO LIDIAR CON LA AMBIVALENCIA EN PSICOTERAPIA: UN MODELO CONCEPTUAL PARA LA FORMULACIÓN DE CASO

João Tiago Oliveira, Miguel M. Gonçalves, Cátia Braga, & António P. Ribeiro

CIPSI -Psychology Research Centre, Psychotherapy and Psychopathology Research Unit, School of Psychology, University of Minho, Braga, Portugal

This article was published in Spanish. This is the English version.
Link to the Spanish version: (http://revistadepsicoterapia.com/rp104-06.html).

How to reference this article:

Oliveira, J. T., Gonçalves, M. M., Braga, C. & Ribeiro A. P. (2016). Cómo Lidiar con la Ambivalencia en Psicoterapia: Un Modelo Conceptual para la Formulación de Caso. [How to Deal with Ambivalence in Psychotherapy: A Conceptual Model for Case Formulation]. *Revista de Psicoterapia, 27*(104), 83-100.

Acknowledgements:

This study was conducted at Psychology Research Centre (UID/PSI/01662/2013), University of Minho, and supported by the Portuguese Foundation for Science and Technology and the Portuguese Ministry of Science, Technology and Higher Education through national funds via the doctoral grant to João Tiago Oliveira (SFRH/BD/92408/2013), under the POCH, and co-financed by FEDER through COMPETE2020 under the PT2020 Partnership Agreement (POCI-01-0145-FEDER-007653).

ISSN: 1130-5142 (Print) –2339-7950 (Online)

Received: May 10, 2016. Accepted: May 20, 2016.

Correspondence:
E-mail: mgonçalves@psi.uminho.pt
Postal address: Miguel M. Gonçalves, CIPsi - Psychology Research Centre, Psychotherapy and Psychopathology Research Unit, School of Psychology, University of Minho, Minho, 4710 Braga, Portugal.

© 2015 Revista de Psicoterapia

Abstract

Ambivalence has been considered to exert a determinant role in the therapeutic process and outcome. Throughout the process clients often adopt two opposite positions about change. On one hand, they think about the need for change, on the other, they reject it. Previous empirical studies have been suggesting that ambivalence is a common process both in poor- and good-outcome cases, however, when it's not resolved the therapeutic process tends to fail. In this sense the understanding of this phenomenon has the potential to promote better results in clinical practice. In this paper we present a transtheoretical conceptual framework that therapists from different approaches can use to conceptualize ambivalence in psychotherapy. Specifically, we discuss a) the movements towards change; b) the movements away from change, and; c) the processes involved in the ambivalence resolution. One psychotherapy case is used to illustrate our proposal and a set of guidelines is suggested to help therapists to conceptualize and deal with one of the processes most associated with therapeutic failure.

Keywords: *ambivalence, psychotherapy, change, innovative moments, case formulation*

Resumen

La ambivalencia se ha considerado que ejerce un papel determinante en el proceso y el resultado de la terapia. A lo largo del proceso, los clientes adoptan a menudo dos posiciones opuestas sobre el cambio. Por un lado, piensan acerca de la necesidad de cambio, por otro, lo rechazan. Los estudios empíricos previos han sugerido que la ambivalencia es un proceso común tanto en casos de buen y mal resultado, sin embargo, cuando la ambivalencia no se resuelve, el proceso terapéutico tiende a fallar. En este sentido, la comprensión de este fenómeno tiene el potencial de promover mejores resultados en la práctica clínica. En este artículo se presenta un marco conceptual transteórico que los terapeutas de diferentes enfoques pueden utilizar para conceptualizar la ambivalencia en psicoterapia. En concreto, se discuten a) los movimientos hacia el cambio; b) los movimientos en contra el cambio, y; c) los procesos que intervienen en la resolución de la ambivalencia. Se presenta un caso real de psicoterapia para ilustrar nuestra propuesta y se sugiere un conjunto de directrices para ayudar a los terapeutas a conceptualizar y lidiar con uno de los procesos más asociados con el fracaso terapéutico.

Palabras Clave*: ambivalencia, psicoterapia, cambio, momentos de innovación, formulación de caso.*

The role of psychotherapy as a healing practice is undeniable (Lambert, 2013; Wampold, 2010). Recently, studies about the effects of psychotherapy have multiplied, revealing effect sizes between .75 and .85 (Wampold & Imel, 2015). In fact, this effect is higher than many "evidence-based" medical practices, including some interventions in cardiology, geriatric medicine, asthma, among others (Wampold, 2007). However, at the moment, the most important question is not if psychotherapy actually works but, rather, "why and how does therapy lead to change?" (Kazdin, 2009, p. 418).

From the client's perspective, psychotherapy could be equated with climbing a big cliff, with no clear support points. After the decision to start climbing which, in itself, constitutes a major step, he or she has to deal with the challenge of each stage and to know and rely on the safety spots where he or she will put the hands and feet, in order to achieve the summit. The main problem is that, sometimes, the journey's end is perceived as unapproachable, leading the climber to turn back and give up the challenge. Similarly, despite the well-established effectiveness of psychotherapy (Lambert, 2013), about 50% of clients terminate the therapy prematurely (Leahy, 2012; Swift & Greenberg, 2012) and, even worse, about 5 to 10% present some level of deterioration at the end of therapy (Lambert & Ogles, 2004). This issue led several researchers to consider that the study of "Why don't people change?" can provide important clues in the pursuing of effective paths to foster behavior change (Arkowitz & Lilienfeld, 2007).

A robust body of research has been highlighting the importance of client's engagement with therapy in the achievement of good results (Orlinsky, Grawe, & Parks, 1994). On the other hand, high levels of resistance to change, reactance to change or noncompliance are associated with poorer outcomes in psychotherapy and higher dropout rates (Beutler, Harwood, Michelson, Song, & Holman, 2011; Engle & Arkowitz, 2006; Jin, Sklar, Min Sen Oh, & Chuen Li, 2008). Thus, the understanding of mechanisms that make it difficult to the client to comply with suggestions coming from others is crucial to understand how therapy leads to change (Beutler et al., 2011; Boutin, Dumont, Ladouceur, & Montecalvo, 2003; Callard, 2014; Rowa et al., 2014).

Change is an oscillatory process that implies time and effort, advances and retreats (Mahoney, 1991). Throughout therapy, clients often present behaviors, attitudes or goals that stand in the opposite direction of change or go against the suggestions of the therapist (resistance), even while they verbalize a desire for change (Hagedorn, 2011). In other words, clients often feel two different, and even opposite, ways about change. On the one hand, they think about the need for change. On the other, they reject it. These oscillatory movements, expressed as an approach-avoidance conflict (Dollard & Miller, 1950), suggest that the client is experiencing ambivalence towards change (Engle & Arkowitz, 2006).

Ambivalence is a natural process that could occur in all psychotherapy clients. However, when it is not resolved problems tend to intensify (Miller & Rollnick,

2002). Ambivalence implies an intrapsychic conflict between "I want to change" and "I don't want to change" (Button, Westra, Hara, & Aviram, 2014) or, as suggested by Kaplan (1972), a both favorable and unfavorable attitude to a given stimulus or object. Systematizing, we know that we are in the presence of ambivalence when the following can be observed: a) the client's belief that the change will be positive to his/her life; b) the client's knowledge about what is necessary to do in order to achieve change; c) the presence of behaviors that indicate a movement towards change; d) behaviors that indicate the movement away from change, and; e) negative emotions experienced by the client because he/she is not changing (Engle & Arkowitz, 2006).

Psychotherapy Case Formulation: A Conceptual Framework for Ambivalence

For any psychotherapy case formulation we need to design hypothesis about causes, precipitants and maintaining factors of a person's problem (Eells, 2011). Our purpose is not to develop a theory that explains human functioning but to present a transtheoretical conceptual framework that therapists from different approaches can use to conceptualize ambivalence in psychotherapy. Hence, in order to conceptualize a given client's ambivalence about change, after identifying where the client presently stands – the problem – and what is the scenario that we (therapist and client) want to achieve, we need to define: a) the moments when the client is moving towards change; b) the moments when the client cancels these movements, returns to the problem, and is stuck, and; c) how the client resolves this impasse. Figure 1 illustrates these processes.

Ambivalence: Cyclical movements towards and away from change

Our framework is inspired by Narrative Therapy (White, 2007), however, therapists can use this knowledge in the context of any other therapeutic approach (i.e. Cognitive-Behavioral Therapy, Emotion Focused Therapy) to guide the conceptualization. Next, we briefly present how the therapist can identify ambivalence towards change, considering the main aspect of the phenomenon: the cyclical movements towards and away from change.

Identifying the movements towards change. People give meaning to the self, the others and the world through the construction of self-narratives (e.g., McAdams, 1993; Sarbin, 1986; White & Epston, 1990). These structures work as implicit rules that guide the construction of meaning that emerges from experience, shaping behavioral, cognitive, emotional, and interpersonal processes (Ribeiro et al., 2014). An adaptive self-narrative must be flexible enough to incorporate different voices (perspectives) about the experience, even when they are discrepant from how the individual perceives him/herself. Clients in psychotherapy present self-narratives considered as problematic once they are rigid, disorganized and/or monothematic, failing to acknowledge important parts of one's experience (Lysaker & Lysaker, 2002; McAdams, 1993; Ribeiro et al., 2014). In this sense, change

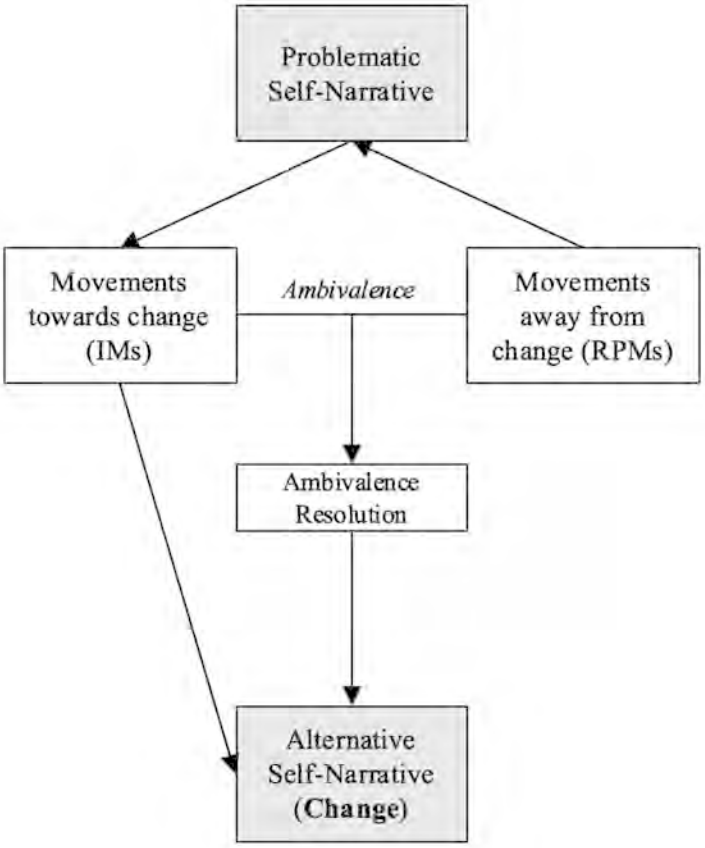

Figure 1.
Schematic representation of ambivalence throughout a process of change. IMs: Innovative Moments; RPMs: Return-to-the-Problem Markers.

happens through the emergence of exceptions to the problematic self-narratives´ rules, under the format of thoughts, emotions, actions or projects (White & Epston, 1990) that Gonçalves and colleagues (2011) called Innovative Moments (IMs; Matos, Santos, Gonçalves, & Martins, 2009). These occurrences give opportunity for the appearance and later on for the assimilation of the excluded voices that are crucial to the construction of a new, more adaptive self-narrative.

Results from empirical studies have suggested seven types of IMs: Action I and II, Reflection I and II, Protest I and II, and Reconceptualization (Table 1). These studies also suggested a consistent pattern of change across different therapeutic approaches and among different clinical conditions (e.g., Alves et al., 2013; Alves, Fernández-Navarro, Ribeiro, Ribeiro, & Gonçalves, 2014; Gonçalves et al., 2012; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2015; Matos et al., 2009; Mendes et al., 2010). Generically,

IMs tend to increase throughout treatment in good-outcome cases (e.g., Matos et al., 2009). Specifically, in early stages of therapy, both poor- and good-outcome cases present low-level IMs (action I, reflection I and protest I), while from the middle to the end of the psychotherapy process, only in good-outcome cases do more complex narrative novelties emerge significantly (action II, reflection II, protest II and reconceptualization) (Gonçalves, Ribeiro, Mendes, et al., 2011). Recent studies also suggest that IMs are a predictor of psychopathological symptoms reduction along treatment (Gonçalves et al., 2015).

Table 1
Innovative Moments with Examples

Types of IM	Subtypes	Definition	Examples (Problematic narrative: depression)
Low level IMs (Creating distance from the problem)	Action I	Performed and intended actions to overcome the problem	C: Yesterday, I went to the cinema for the first time in months!
	Reflection I	New understandings of the problem	C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself ... and it's more natural and more healthy to let some of these extra activities go...
	Protest I	Objecting the problem and its assumptions	C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!?
High Level IMs (Centered on change)	Performing change (Action II)	Generalization into the future and other life dimensions of good outcomes (performed or projected actions)	T: You seem to have so many projects for the future now! C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply.
	Reflection II	Contrasting Self (what changed?) OR Self-Transformation process (how/why change occurred?)	C: I feel positive and strong. It's okay to ask for these things [her needs], it's a new part of me, so I'm not going to turn it down.

Protest II	Assertiveness and empowerment	C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.
Re-conceptualization	Moments distanced from the experience (meta-positions) where the self is repositioned outside the problematic experience AND also understands the processes involved in this transformation	C: I feel differently nowadays. I don't worry about what others think about what I'm saying. I discovered that I need to respect my needs and opinions, even if other people disagree with me. Before to protect me from disagreeing with others I was always in conflict with myself – thinking one thing, saying another. What does the disagreement with others need to be worse than this internal fighting?

Note. Adapted from "Innovative moments, ambivalence and ambivalence resolution: Coding systems and main findings," by M. M. Gonçalves, A. P. Ribeiro, I. Mendes, D. Alves, J. Silva, C. Rosa, ... J. T. Oliveira, 2016, Manuscript submitted for publication.

Identifying the movements away from change. Consider the climber and his ascent to the summit. Some transitions between support points are less difficult and happen with little jolt. Others are more challenging, imply leaving a toehold where the climber feels safe, even if that security is only apparent, to try to reach a new point that, while closer to the goal, is unknown and therefore may be less secure. Sometimes, the climber tries to reach this new point by first placing his hand, to then transfer the entire body. But as he does not feel safe and does not feel able to do it without a certain amount of risk, he goes back to the initial point that, while not being ideal, is nonetheless the safer one.

In order to change, individuals need to move from a position where they see, mostly, the difficulties associated with change, to a new one where they realize both their advantages and difficulties (McEvoy & Nathan, 2007). However, all psychological changes introduce discrepancy, incongruity or inner contradiction (Engle & Arkowitz, 2007), and we know that, when identity is threatened, the greater the conflict, the greater the ambivalence (Montesano, Gonçalves, & Feixas, 2015). Thus, the elaboration and emergence of IMs has the potential to promote change but it also implies a difficult challenge to the individual since it threatens one's self-stability (Ribeiro & Goncalves, 2010). This sense of threat evokes a self-protective response and the IMs' power to promote change is devaluated by a quick return to the dominant self-narrative, reducing the discrepancy created by the innovation – Return-to-the-Problem Markers (RPM; Gonçalves, Ribeiro, Stiles, et al., 2011) – "*I want to be more secure in social relations*" (IM) "*but it is too difficult and painful*" (RPM).

In this sense, ambivalence can be conceived as a form of self-stability with two opposing parts that keep feeding into each other (Ribeiro et al., 2014). The client oscillates, first elaborating an IM, which temporarily disrupts the dominant self-narrative, then minimizing, depreciating or trivializing it, resulting in a return to the dominant self-narrative (Ribeiro & Goncalves, 2011; Ribeiro, Goncalves, Silva, Brás, & Sousa, 2015).

Previous results using RPMs as empirical markers of ambivalence suggested that: (a) ambivalence is a common process both in poor and good outcome cases independently of the therapeutic modality, and (b) a decrease in ambivalence throughout therapy in good outcome cases, and a maintenance or even an intensification in poor outcome cases (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2015; Ribeiro et al., 2014).

Ambivalence Resolution: The Dominance and Negotiation processes

In this context, ambivalence is an important process in the course of psychotherapy, one that should be properly identified, addressed and, more importantly, resolved, if sustained change is to take place (Miller & Rollnick, 2002).

The Ambivalence Resolution Coding System (ARCS; Braga, Oliveira, Ribeiro, & Gonçalves, 2016) was developed to allow for the study of the processes involved in the resolution of the conflict between opposing positions of the self (i.e., ambivalence). Studies with the ARCS (Braga, Oliveira, et al., 2016; Braga, Ribeiro, & Goncalves, 2016) have proposed that the paralyzing cycle of the meaning making process produced by ambivalence can be surpassed by means of, at least, two different processes:

1) The dominance of the innovative position and consequent inhibition of the problematic position.
2) The negotiation and engaging in joint action between both positions.

In the dominance process, the innovative position struggles to control the problematic position by affirming the innovative's position authority, in a process which suggests a role reversal: the previously dominated position (the new position) now seems to be the dominating one. In the negotiation process, the conflicting positions seem to be respectfully communicating with one another, promoting a dynamic flow between opposites, rather than the dominance of one of them (Braga, Oliveira, et al., 2016).

For example, assuming that a given client´s problematic position revolves around the theme of guilt, that is, the client constantly feels responsible and takes excessive responsibility for a large range of events happening in his or her surroundings, a dominance type of ambivalence resolution could be: *Now I know that it´s not my fault that this relationship did not work, I did everything I could, but he did not.* In this example, the innovative position severely imposes itself unto the problematic position by upholding its authority, producing a role reversal: the

previously dominated position (the new position) is now the dominating one.

On the contrary, an example of the negotiation process could be: *No one has a relationship on his own, so I guess we both are responsible for everything that happened. I think he could have done things differently but again, so could I.* In this case, both positions contribute to the resolution and establish a different kind of relationship: instead of the previously confrontational one, they now seem to considerably communicating and collaborating for the meaning-making process.

In the ARCS, these examples constitute what the authors name *micro-resolutions*, that is, *moments when there is an agentic and determined resolution of ambivalence, even if this is a momentary one* (Braga, Oliveira, et al., 2016). These can be expressed in reflections, actions, intentions, etc. It is suggested that it is the repetition of these micro-resolutions throughout treatment that enables the progressive dilution of the paralyzing relationship established between conflicting positions of the self that characterizes ambivalence.

Both dominance and negotiation processes of ambivalence resolution have been found in different psychotherapeutic approaches (Cognitive Behavioral, Therapy, Narrative Therapy and Emotion-Focused Therapy) (Braga, Ribeiro, et al., 2016) and clear progression tendencies have been shown, independently of the specific intervention models. Firstly, the dominance of the innovative position seems to be the most frequently used process of ambivalence resolution throughout treatment. However, while in recovered cases the dominance process tends to be less frequent and negotiation is gradually more common as treatment evolves, in unchanged cases this apparent gradual shift between dominance and negotiation does not seem to happen: Dominance is frequently used from the beginning to the end of treatment and negotiation is scarce at any stage of therapy.

These results are theoretically coherent with studies that have been suggesting an increasing integration of opposing elements of the self along the therapeutic process. For example, the assimilation model (Stiles et al., 1990; Stiles et al., 1991) suggests that successful psychotherapy cases tend to follow a pattern of change in which the problematic position is gradually incorporated in the community of voices. Consistently with the assimilation model, in the innovative moments´ model, reconceptualization IMs are related with successful psychotherapeutic processes. Reconceptualization is a form of insight in which a common language between the problematic and the innovative positions enables the dialogue between positions rather than a trial of strength between them. Finally, in Emotion-Focused Therapy (Greenberg & Watson, 1998) empty chair and two chair techniques enable the client to enact internalized positions of the self, promoting the dialogue between positions in order to enable emotional processing and integration and thus a more adaptive emotional experience.

In conclusion, studies on ambivalence resolution seem to suggest that, in order for ambivalence to be successfully resolved, (a) dominance is a very important process, probably because, at least in an initial stage, the innovative position needs

to win some ground in order to grow and consolidate itself and, due to the problematic position´s heavy authority, this can only be achieved by means of some harsh control of its power; (b) negotiation needs to enter the process at some stage, and grow in frequency as sessions develop, as sustained change means that the innovative position is not only well established, but is also capable of adapting and communicating with other important aspects of the self, promoting a flexible and dynamic self-narrative.

Case Illustration

Jan (pseudonym), a 42-year-old woman, participated in a randomized clinical trial where she was randomly assigned to Emotion-Focused Therapy (EFT) and seen for sixteen sessions (Greenberg & Watson, 1998). This is a psychotherapy case that has been used in several studies (Honos-Webb, Surko, Stiles, & Greenberg, 1999; Leiman & Stiles, 2001; Ribeiro et al., 2014) and used by Greenberg and Goldman (2010) to illustrate the therapist's task of case formulation in EFT (Honos-Webb et al., 1999).

The client comes to therapy referring feeling depressed, with frequent episodes of compulsive crying, without any apparent reason, and presenting psychosomatic symptoms (hives and difficulty swallowing):

"*I've been feeling quite depressed, I think, most of my life, but this has been a particularly bad year and I lost a few people who were close to me and helped me in my personal life*…" (Greenberg & Goldman, 2010, p. 396)

> […]
> Client: *I tend to start crying right away*
> Therapist: *mm-hm*
> C: *like, as I mentioned on the form, I have no control over - my crying (sniffs)*
> […]
> C: *I was having a lot of - I break out in hives*
> T: *uh-huh*
> C: *and I was having an attack that had been going on and on for about - - I guess was about five, six weeks*
> T: *mm*
> C: *and it was really getting worse and worse, and um - I've been trying so many things with my own doctor and medication and it wasn't really helping*
> T: *mm-hm*
> C: *and they're always telling me that it's due to stress and whatever…*

Being a daughter of quite absent parents, Jan always felt closer to her three sisters. After a problematic childhood and adolescence, she married when she was twenty years-old with a man with whom she had two children. She divorced after 5 years during which she and her children were physically abused by her husband.

Before long, she married for the second time and had been married for 15 years at the time she entered therapy.

She refers that her sisters have always been very important to her since they were her main source of support however, she also described herself as a protective figure since she was the eldest of four daughters.

C: *- I remember the first time I had gone to a - this goes back years and years, I had gone to a movie and at that time they used to draw tickets, they had matinees for Saturday afternoon for children - and my ticket was drawn - and I had won a doll*

T: *mm*

C: *and I was so proud of it, it was the first doll that was ever store bought or whatever, because I used to make myself rag dolls - when I was younger - and I brought it home, and I was ten years old (sniff) - and I brought it home and I was so proud of it - and sh- my sister, you know, saw it and she liked it and she started to cry. She wanted it. My mother took it away from me and gave it to her - she said I was too old to - play with dolls*

T: *- so kind of snatched it - right from you - and gave it to her - - - and*

C: *and+*

T: *it was your doll - you'd won it*

C: *- - and all of my life I remember things like that happening, yet if you speak to my sister about it - she feels that - I got everything because I was - the older one*

T: *mm*

C: *and I got first choice on everything and*

T: *- so she has her own story*

C: *well, everybody I guess interprets it*

T: *+mm-hm*

C: *you know, two different people - will describe an action in their own way*

T: *it sounds like you ah - - you really felt - as if she was - a favorite - and you were kind of the second - person*

C: *well, I was the oldest one, and it was - my responsibility to look after them*

At the moment that she came to therapy, Jan´s marriage was passing through several difficulties, mainly due to financial problems that her husband wouldn´t share with her, which made her very uncomfortable. However, she always tried to deal with it alone in order not to worry her husband:

C: *mm-hm - - well, my husband and I are at some - really difficult financial setbacks in the last couple of years*

T: *mm-hm*

C: *and he's not - - he's keeping things bottled in*

T: *mm-hm*

C: *- and I'm sure that it's not- it must be things that he's not dealing with and by us not talking about it - and I don't want to press the point thinking*

that I'm going to make him feel - guilty, or - - make him feel worse
T: *mm-hm*
C: *so I - leave the issues alone*
T: *so you don't want to sort of turn on that ground, eh? 'cause you think you'll upset him. so you keep it to yourself*
C: *mm-hm*

Throughout the first session Jan describes herself as a controlling person, assuming virtually all responsibilities related to her family, her marriage and her working place. She refers feeling the need to please and help others, relegating her needs and feelings to the offstage:

C: *I, over the years - I have (sniffs) guess this image of myself as super, you know, superwoman*
T: *mm*
C: *to be able to do everything and hold down a full-time job, a part-time job and look after all the house work and the cleaning and the cooking and everything else and doing a lot of volunteer work in our church at the same time, so*

In this sense, and right from the beginning of therapy, Jan's problematic self-narrative clearly revolved round the notion "I need to be a superwoman". This rigidified structure implies the necessity to be strong, independent, and also her need to please and receive approval from others. As suggested by Honos-Webb et al. (1999) these needs can be conceptualized as strategies to suppress feelings of vulnerability once she cannot acknowledge her own needs and weaknesses.

Very early in therapy, she presented some movements towards change, towards a new self-narrative that implied the acknowledgement of her own needs, the importance of feeling loved and the notion that she could not be held responsible for everything that happened in her daily life:

T: *hmm... it sounds like it must be really hard to cope with the day to day things, like you mentioned, your work*
C: *it's getting more difficult.* ***I actually took a step the other night and I let my husband know that I thought that my work load was a lot more than his was and that we should share our things more evenly and he thought that was a good idea and for me to write out all the things that need to be done around the apartment, which I did, and then he said he would look at it.***
(movement towards change)

However, these movements were often canceled by Jan´s need to please and receive approval from others, leading to an impasse:

C: [...] *he thought it was a good idea to hire somebody to help out*
T: *mm-hm*
C: *because it's a- it's a drain - - he doesn't seem to find the time to do his*

share - ***and I resent, you know, I will only sometimes I'll do my share and do his also***
T: ***mm***
C: ***but then I resent having done it***
T: ***mm, so you do it***
C: ***so now I'm not doing it also so I'm not doing his share or mine***
T: ***mm-hm***
C: ***and it's get- the messiness is getting to me***
T: ***mm-hm***
(movement away from change)

At the initial stages of therapy, Jan tended to resolve ambivalence essentially through the dominance of the innovative position and consequent inhibition of the problematic position. The following examples illustrate this process:

C: ***I can't be loved by everybody***
T: ***mm-hm***
C: ***It's a fantasy where, you know, ah you live in a world where everybody loves you and ador- you know, and likes you and ah, you get along well with everybody***
T. ***it sounds like…***
C: ***that's not realistic.*** **(session 3)**
[…]
C: ***so I lost my cool and yelled at everybody***
T: ***you did, eh?***
C: ***told them I was not really too pleased with it!***
T: ***mm*** **(session 4)**

In the first example, Jan acknowledges that she "can´t be loved by everyone" and that trying to be loved by everyone is based on a fantasy. This affirmation represents a dominance of the innovative position since it is a clear and decisive movement away from the need to be approved by everyone that is instigated by the problematic position. In the second example, this process is acted out, since Jan "loses her cool" and yells at everybody, expressing her thoughts and needs in the most blatant way. This is considered a dominance process of resolution since the client resolves the tension between wanting to be a *superwoman* and also wanting her needs to be met by overtly expressing her needs in a way that completely dismisses the problematic position´s desire to be able to take control of everything, and to do it without disturbing anyone.

In contrast with what happens in the beginning of therapy, by the middle and final stages of therapy, the process of ambivalence resolution is gradually more characterized by a symmetrical relationship between positions of the self. The following are examples of the negotiation process:

C: ***I said: I'm starting to like myself a lot more so it's not that important, you know, I'm not saying that it's not that important that people like me***

but I don't feel I have to buy it with…
T: ***right***
C: ***you know…***
T: ***right*** **(session 15)**
[…]
C: ***yeah, well I guess I had to more or less look at myself, what I had become and did I want to continue being that way. Sort of go through it in my head: what it is that I want for myself and what's the best way to get this, and how to approach it. I don't want to come across as gang busters, you know, and ah, you know, make things worse.***
T: ***mm-hm***
C: ***Because, the changes I've been going through are also changes for him, because he's seeing a new side of me that he hasn't seen before and as much as it's positive for me, he might see it in a negative way. Because he might feel threatened because I'm more positive and assertive***
T: ***mm, I see, kind of too much of a shift in the other way***
C: ***Yes, you know, so I don't want it to get to the point where… again I'm sort of going to hold back to protect him - because that's not what I want to do - but I want to approach it in a way that is clear in my mind.***

In the first example, Jan says that because she likes herself more, it is not that important that people like her. But, at the same time, she says that this does not mean that it is not also important for her that people still like her, it´s just that she is not going to do anything to "buy" this appreciation. This is a negotiation process because both position´s concerns are taken into account in a not mutually exclusive manner: it is possible to like and take care of herself and, at the same time, to be loved by others. Both aspects are important for her, the crucial change here is the abandonment of the (problematic) effort she used to put in being loved.

In the second example, once again both positions are taken into account in the meaning making process since on the one hand, Jan wants to keep being more assertive with her husband but on the other hand, she does not want to come across as "gang busters" because she acknowledges that the changes she has operated in herself will also impact on her husband. Thus, although she does not want to go back to hold herself back to protect him, it is also important to her to be assertive in a way that takes his position into consideration.

Besides being a good case to illustrate the process of ambivalence, Jan was one of the most successful psychotherapeutic processes in the EFT condition. For example, Jan's score on the Beck Depression Inventory (Beck, Steer, & Brown, 1996) improved from 30 at the beginning of the therapy to 5 after treatment and the gains were maintained at 18-month follow-up (Honos-Webb et al., 1999; Leiman & Stiles, 2001).

Final Remarks

Jan's case clearly illustrates the importance of overcoming ambivalence in order to achieve an effective change. In Figure 2 we can see some examples of movements towards change (IMs: "*... I let my husband know that... we should share our things...*") and how those instances were systematically interrupted by movements away from change (RPMs: "*… but then I resent having done it...*"), resulting in impasse and the maintenance of a problematic stability (anchored on the self-narrative: "*I need to be a superwoman*"). The tension produced by these movements, like two vectors in opposite directions (Abbey & Valsiner, 2005) was only resolved after several moments where more power was given to an alternative self that dominated or negotiated with the problematic one (in the figure 2, a dominance process is illustrated: "*I can't be loved by everybody... It's a fantasy...*"). The whole process led to higher levels of flexibility and to the emergence of a new, more adaptive, self-narrative: "*It's possible to like and take care of myself and to be loved by others*", associated with an effective change.

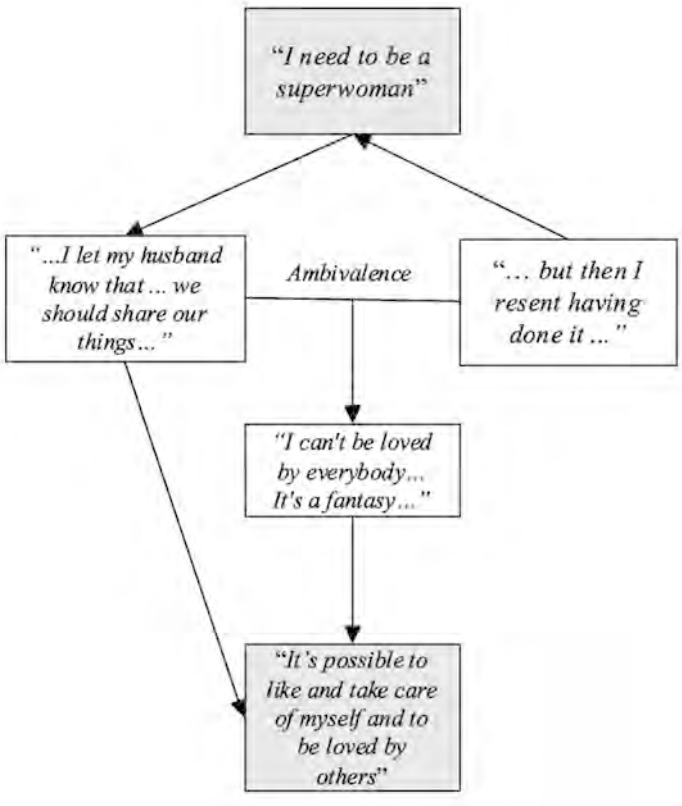

Figure 2.
Conceptualization of Jan's ambivalence.

A comprehensive approach to ambivalence is the first step in dealing with it in a proper manner throughout therapy. In Table 1 we suggest ten steps that may guide therapists in conceptualizing their clients' ambivalence. Despite some of them being close to specific intervention techniques (e.g., 10. Promote dialogue between the identified voices), it is not our intention with this article to focus on such strategies. Our proposal integrates some elements from different approaches to ambivalence (e.g., Engle & Arkowitz, 2006; Lewis & Osborn, 2004; Polster, 1995; Sato, Hidaka, & Fukuda, 2009) and some steps can be answered using well-established techniques like Two-Chair Work (Greenberg, Rice, & Elliott, 1993; Perls, Hefferline, & Goodman, 1951). In this sense, therapists from different approaches can use this approach.

Table 2
Guidelines to conceptualize client's ambivalence in psychotherapy

1. Define and gather information about the client's problematic self-narrative;
2. Define an alternative, more adaptive, self-narrative;
3. Identify movements towards change;
4. Identify movements away from change;
5. Conceptualize these oscillatory movements as a dialogue between voices;
6. Present both identified voices to the client (towards and away from change);
7. Isolate each voice and explore them separately;
8. Express validation regarding each voice;
9. When present, identify the processes used by the client to overcome ambivalence;
10. Promote the dialogue between the identified voices.

Revisiting the metaphor we have been using since the beginning of the article, climbing is carried out with the support of another person belaying from the ground, who identifies different ways to proceed and goes with both moments of progression and setbacks. In a psychotherapeutic process, the therapist should be able to early identify the presence of ambivalence, promote the knowledge of different perspectives that are in conflict (here conceptualized as voices) and constantly validate each one of them in order to clarify their existence to the client and decrease the emergence of resistance to change.

Bibliographic references

Abbey, E., & Valsiner, J. (2005). *Emergence of Meanings Through Ambivalence.* Paper presented at the Forum: Qualitative Social Research.

Alves, D., Fernández-Navarro, P., Baptista, J., Ribeiro, E., Sousa, I., & Gonçalves, M. M. (2013). Innovative moments in grief therapy: The meaning reconstruction approach and the processes of self-narrative transformation. *Psychotherapy Research, 24*(1), 25-41. doi:10.1080/10503307.2013.814927

Alves, D., Fernández-Navarro, P., Ribeiro, A. P., Ribeiro, E., & Gonçalves, M. M. (2014). Ambivalence and innovative moments in grief psychotherapy: The cases of Emily and Rose. *Psychotherapy, 51*(2), 308-321. doi:10.1037/a0031151

Arkowitz, H., & Lilienfeld, S. O. (2007). Why Don't People Change? *Scientific American Mind, 18*(3), 82-83.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/Reactance Level. *Journal of Clinical Psychology, 67*(2), 133-142. doi:10.1002/jclp.20753

Boutin, C., Dumont, M., Ladouceur, R., & Montecalvo, P. (2003). Excessive Gambling and Cognitive Therapy: How to Address Ambivalence. *Clinical Case Studies, 2*(4), 259-269. doi:10.1177/1534650103256297

Braga, C., Oliveira, J. T., Ribeiro, A. P., & Gonçalves, M. M. (2016). Ambivalence resolution in emotion-focused therapy: The successful case of Sarah. *Psychotherapy Research*. doi:10.1080/10503307.2016.1169331

Braga, C., Ribeiro, A. P., & Goncalves, M. M. (2016). *Ambivalence resolution in psychotherapy*. Manuscript in preparation.

Button, M. L., Westra, H. A., Hara, K. M., & Aviram, A. (2014). Disentangling the Impact of Resistance and Ambivalence on Therapy Outcomes in Cognitive Behavioural Therapy for Generalized Anxiety Disorder. *Cognitive Behaviour Therapy, 44*(1), 44-53. doi:10.1080/16506073.2014.959038

Callard, F. (2014). Psychiatric diagnosis: the indispensability of ambivalence. *Journal of Medical Ethics*. doi:10.1136/medethics-2013-101763

Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy; an analysis in terms of learning, thinking, and culture*. New York, NY, US: McGraw-Hill.

Eells, T. D. (2011). *Handbook of psychotherapy case formulation* (2nd ed.). New York.

Engle, D., & Arkowitz, H. (2006). *Ambivalence in psychotherapy: Facilitating readiness to change*. New York: Guilford Press.

Engle, D., & Arkowitz, H. (2007). Viewing Resistance as Ambivalence: Integrative Strategies for Working With Resistant Ambivalence. *Journal of Humanistic Psychology*. doi:10.1177/0022167807310917

Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A. P., Sousa, I., Angus, L., & Greenberg, L. S. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research, 22*(4), 389-401. doi:10.1080/10503307.2012.662605

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L. E., & Greenberg, L. S. (2010). Innovative Moments and Change in Emotion-Focused Therapy: The Case of Lisa. *Journal of Constructivist Psychology, 23*(4), 267-294. doi:10.1080/10720537.2010.489758

Gonçalves, M. M., Ribeiro, A. P., Mendes, I., Matos, M., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research, 21*(5), 497-509. doi:10.1080/10503307.2011.560207

Gonçalves, M. M., Ribeiro, A. P., Silva, J. R., Mendes, I., & Sousa, I. (2015). Narrative innovations predict symptom improvement: Studying innovative moments in narrative therapy of depression. *Psychotherapy Research*, 1-11. doi:10.1080/10503307.2015.1035355

Gonçalves, M. M., Ribeiro, A. P., Stiles, W. B., Conde, T., Matos, M., Martins, C., & Santos, A. (2011). The role of mutual in-feeding in maintaining problematic self-narratives: Exploring one path to therapeutic failure. *Psychotherapy Research, 21*(1), 27-40. doi:10.1080/10503307.2010.507789

Greenberg, L. S., & Goldman, R. (2010). Case formulation in Emotion-Focused Therapy *Handbook of Psychotherapy Case Formulation* (pp. 379-411). New York, NY, US: Guilford Press.

Greenberg, L. S., Rice, L. N., & Elliott, R. K. (1993). *Facilitating emotional change: The moment-by-moment process*. New York, NY, US: Guilford Press.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research, 8*(2), 210-224. doi:10.1093/ptr/8.2.210

Hagedorn, W. B. (2011). Using Therapeutic Letters to Navigate Resistance and Ambivalence: Experiential Implications for Group Counseling. *Journal of Addictions & Offender Counseling, 31*(2), 108-126. doi:10.1002/j.2161-1874.2011.tb00071.x

Honos-Webb, L., Surko, M., Stiles, W. B., & Greenberg, L. S. (1999). Assimilation of voices in psychotherapy: The case of Jan. *Journal of Counseling Psychology, 46*(4), 448-460. doi:10.1037/0022-0167.46.4.448

Jin, J., Sklar, G. E., Min Sen Oh, V., & Chuen Li, S. (2008). Factors affecting therapeutic compliance: A review from the patient's perspective. *Ther Clin Risk Manag, 4*(1), 269-286.

Kaplan, K. J. (1972). On the ambivalence-indifference problem in attitude theory and measurement: A suggested modification of the semantic differential technique. *Psychological Bulletin, 77*(5), 361-372. doi:10.1037/h0032590

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19*(4-5), 418-428. doi:10.1080/10503300802448899

Lambert, M. J. (2013). Outcome in psychotherapy: The past and important advances. *Psychotherapy, 50*(1), 42-51. doi:10.1037/a0030682

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). New York: Wiley.

Leahy, R. L. (2012). *Overcoming resistance in cognitive therapy*: Guilford Press.

Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11*(3), 311-330. doi:10.1093/ptr/11.3.311

Lewis, T. F., & Osborn, C. J. (2004). Solution-Focused Counseling and Motivational Interviewing: A Consideration of Confluence. *Journal of Counseling & Development, 82*(1), 38-48. doi:10.1002/j.1556-6678.2004.tb00284.x

Lysaker, P. H., & Lysaker, J. T. (2002). Narrative Structure in Psychosis: Schizophrenia and Disruptions in the Dialogical Self. *Theory & Psychology, 12*(2), 207-220. doi:10.1177/0959354302012002630

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy*. New York, NY, US: Basic Books.

Matos, M., Santos, A., Gonçalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19*(1), 68-80. doi:10.1080/10503300802430657

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

McEvoy, P. M., & Nathan, P. (2007). Perceived costs and benefits of behavioral change: Reconsidering the value of ambivalence for psychotherapy outcomes. *Journal of Clinical Psychology, 63*(12), 1217-1229. doi:10.1002/jclp.20424

Mendes, I., Ribeiro, A. P., Angus, L., Greenberg, L. S., Sousa, I., & Goncalves, M. M. (2010). Narrative change in emotion-focused therapy: how is change constructed through the lens of the innovative moments coding system? *Psychother Res, 20*(6), 692-701. doi:10.1080/10503307.2010.514960

Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Montesano, A., Gonçalves, M. M., & Feixas, G. (2015). Self-narrative reconstruction after dilemma-focused therapy for depression: A comparison of good and poor outcome cases. *Psychotherapy Research*, 1-16. doi:10.1080/10503307.2015.1080874

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy: Noch einmal. In A. E. B. S. L. Garfield (Ed.), *Handbook of psychotherapy and behavior change (4th ed.)* (pp. 270-376). Oxford, England: John Wiley & Sons.

Perls, F., Hefferline, R. F., & Goodman, P. (1951). *Gestalt therapy*. New York: Julian Press.

Polster, E. (1995). *A population of selves: A therapeutic exploration of personal diversity*. San Francisco, CA, US: Jossey-Bass.

Ribeiro, A. P., & Goncalves, M. M. (2010). Commentary: Innovation and Stability within the Dialogical Self: The Centrality of Ambivalence. *Culture & Psychology, 16*(1), 116-126. doi:10.1177/1354067x09353211

Ribeiro, A. P., & Goncalves, M. M. (2011). Maintenance and transformation of problematic self-narratives: a semiotic-dialogical approach. *Integr Psychol Behav Sci, 45*(3), 281-303. doi:10.1007/s12124-010-9149-0

Ribeiro, A. P., Goncalves, M. M., Silva, J. R., Brás, A., & Sousa, I. (2015). Ambivalence in Narrative Therapy: A Comparison Between Recovered and Unchanged Cases. *Clinical Psychology & Psychotherapy*. doi:10.1002/cpp.1945

Ribeiro, A. P., Mendes, I., Stiles, W. B., Angus, L., Sousa, I., & Gonçalves, M. M. (2014). Ambivalence in emotion-focused therapy for depression: The maintenance of problematically dominant self-narratives. *Psychotherapy Research, 24*(6), 702-710. doi:10.1080/10503307.2013.879620

Rowa, K., Gifford, S., McCabe, R., Milosevic, I., Antony, M. M., & Purdon, C. (2014). Treatment Fears in Anxiety Disorders: Development and Validation of the Treatment Ambivalence Questionnaire. *Journal of Clinical Psychology, 70*(10), 979-993. doi:10.1002/jclp.22096

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3-21). New York: Praeger Publishers/Greenwood Publishing Group.

Sato, T., Hidaka, T., & Fukuda, M. (2009). Depicting the Dynamics of Living the Life: The Trajectory Equifinality Model. In J. Valsiner, M. P. C. Molenaar, C. D. P. M. Lyra, & N. Chaudhary (Eds.), *Dynamic Process Methodology in the Social and Developmental Sciences* (pp. 217-240). New York, NY: Springer US.

Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 27*(3), 411-420. doi:10.1037/0033-3204.27.3.411

Stiles, W. B., Morrison, L. A., Haw, S. K., Harper, H., Shapiro, D. A., & Firth-Cozens, J. (1991). Longitudinal study of assimilation in exploratory psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 28*(2), 195-206. doi:10.1037/0033-3204.28.2.195

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80*(4), 547-559. doi:10.1037/a0028226

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*(8), 857-873. doi:10.1037/0003-066X.62.8.857

Wampold, B. E. (2010). *The basics of psychotherapy: An introduction to theory and practice*. Washington, DC: American Psychological Association.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*: Routledge.

White, M. (2007). *Maps of narrative practice*. New York, NY, US: W W Norton & Co.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*: WW Norton & Company.