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Therapist interventions and client ambivalence in two cases of narrative therapy for depression

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Abstract

Aim: We understand *ambivalence* as a cycle of opposing expressions by two internal voices. The emergence of a suppressed voice produces an innovative moment (IM), challenging the dominant voice, which represents the client's problematic self-narrative. The emergence of the IM is opposed by the dominant voice, leading to a return to the problematic self-narrative. This study analyzed therapist and client responses to each other in episodes of ambivalence. **Method**: The therapeutic collaboration coding system (TCCS) assesses whether and how the therapeutic dyad is working within the *therapeutic zone of proximal development* (TZPD) by examining client responses to therapist interventions. We applied the TCCS to episodes in which a good- and a poor-outcome client in narrative therapy expressed ambivalence. **Results:** In both the good- and poor-outcome cases, the therapist responded to the emergence of ambivalence similarly, balancing challenging and supporting. The good-outcome case responded at the developmental level proposed by the therapist when challenged, while the poor-outcome case lagged behind the level proposed. **Discussion**: This supports the theoretical explanation that the therapist did not match client's developmental level in the poor-outcome case, working beyond the client's current TZPD and contributing to the maintenance of ambivalence.

Keywords: ambivalence; assimilation; process research; narrative

As applied in psychotherapy, the term ambivalence is often used to describe the client's resistance to a new perspective proposed in the therapeutic context and his/her persistence in a problematic perspective (Arkowitz & Engle 2007; de Liver, van der Pligt, & Wigboldus, 2007; Engle & Arkowitz, 2008), opposing the client's will to change (McEvoy & Nathan, 2007). Thus, ambivalence can be understood as an expression of internal conflict between two opposing tendencies of behaving, thinking or feeling, one favoring change and another one favoring stability (Engle & Arkowitz, 2008). Clients often see the advantages in changing but also have concerns about it, such as fear of failure, of responsibility or that change will confront them with the unpredictable or the unknown (Arkowitz & Miller, 2008). Ambivalence must be dealt with, since when clients are not able to overcome it, problems can persevere or be exacerbated (Miller & Rollnick, 2002), eventually resulting in poor psychotherapeutic outcomes (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011; Ribeiro et al., 2014).

We investigated episodes of ambivalence in the therapeutic dialogue of two clients treated for depression with narrative therapy by the same therapist in a clinical trial. Relative to other clients in the trial, one client had a good outcome and one had a poor outcome. We framed our investigation within an integration (Ribeiro et al., 2014) of the innovative moments (IMs) model (Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2009; Gonçalves, Ribeiro, Stiles, et al., 2011) and the assimilation model (Stiles, 2002, 2011; Stiles et al., 1990).

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Ambivalence as Opposing Expressions by Two Internal Voices

According to this theoretical integration, an episode of ambivalence can be understood as a cycle of opposing expressions involving two internal voices, where voice is a metaphor for the internal traces of experiences the person has had in the past. On the one side, is a voice representing the client's usual self, which is understood as a community of voices in the assimilation model. The community of voices consists of assimilated experiences, held together by semiotic constructions, such as narratives, that organize and give access to the voices (Stiles, 2011). On the other side, are nondominant voices representing experiences that were painful or incompatible with the usual self, which lack the semiotic links with the community of voices.

Whereas the assimilation model focuses on the person's constituent voices in describing this opposition, the IMs model focuses on the semiotic, narrative glue that binds the respective voices together. Thus, on the one side of the ambivalence is a dominant narrative that represents the client's usual self, and on the other side is an alternative narrative that integrates the nondominant voice. An expression of such an alternative narrative is called an IM.

Partly as a result of these different emphases, the assimilation and IMs models make different uses of the term *problematic*. The assimilation model describes the nondominant voice, representing the internal traces of painful, avoided experiences, as problematic. The IMs model regards the community of voices itself—or at least the dominant narrative that binds it together—as problematic for not being able to integrate an innovative voice. To put it another way, the assimilation model sees nondominant voices as problematic from the perspective of the person's usual self, whereas the IMs model sees the dominant narrative as problematic from the perspective of the therapist, who can see how it fails to give smooth access to the nondominant, innovative experiences, as well as from the innovative perspective itself. These different uses of the terms problem and problematic are embedded in the established names of some of the respective measures, the assimilation of problematic experiences sequence (APES) and the return-to-the problem marker (RPM), as described later.

Although, the words problem and problematic are used differently in the two traditions, the two conceptualizations are compatible. Both understand people's experiences as bound together by semiotic links (e.g., narratives), and both regard problems as reflecting a lack of communication or integration between dominant (usual) and nondominant (inno-vative) parts of the person. As Dimaggio, Salvatore, Azzara, and Catania (2003) argued, when the internal dialogue fails to include the internal states of the important characters, or to get them involved in negotiating the meaning of events, we are probably facing a problematic or psychopathological narrative.

In the context of the IMs model, the ambivalence cycle has been described as a return to the problematic narrative. It begins with an expression by the innovative voice—an IM—which is immediately followed by an expression by the problematic voice, marking a return to the usual problematic narrative. In a coding system developed to assess ambivalence, this sequence has been coded as an RPM (i.e., return-to-the-problem marker; Gonçalves, Ribeiro, et al., 2009).

As an example of this type of ambivalence, a client may say,

> 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. I just want to be with him, who cares what everybody else says? [IM]

and then neutralize the change potential present in this IM by emphasizing the problem: "But the next day I tried to avoid him because I'm afraid people will start talking too much about it and then I will get excluded for spending too much time with him" [RPM]. In studies of Emotion Focused Therapy and Client-Centered Therapy for depression, the percentage of IMs that were followed by RPMs decreased across treatment, suggesting declining ambivalence, in recovered cases while remaining high throughout treatment in unchanged cases (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2014).

The Therapeutic Zone of Proximal Development and Ambivalence

The assimilation model suggests that in successful therapy a client may assimilate avoided, distressing, or difficult experiences so they can become available as resources. This process appears to follow a sequence that is summarized in the eight stages of the APES (i.e., assimilation of problematic experiences sequence; Stiles, 2002; Stiles et al., 1991; Stiles, Meshot, Anderson, & Sloan, 1992). The APES stages, numbered 0–7, anchor a continuum of assimilation that describes the changing relation of the nondominant voice to the dominant community of voices: (0) Warded off/dissociated, (1) unwanted thoughts/active avoidance, (2) vague awareness/emergence, (3) problem statement/clarification, (4) understanding/insight, (5) application/

working through, (6) resourcefulness/problem solution, and (7) integration/mastery. Each problematic experience is understood to be at some level on this continuum at each point in time.

Theoretically, therapeutic work should take place within a segment of the APES, which we call the *therapeutic zone of proximal development* (TZPD; see Leiman & Stiles, 2001). The TZPD is an extension to psychotherapy of Vygotsky's (1978) concept of the zone of proximal development, a working zone on the continuum of children's intellectual development between what the child can currently accomplish independently (their actual level) and what the child can accomplish with the aid of an adult (their potential level). Theoretically, working with an adult, the child can master the proximal stages and advance their actual level of accomplishment toward their potential level. Analogously, our integrated model suggests that by working within the TZPD, nondominant voices representing problematic experiences can advance along the developmental APES sequence. As the experience is assimilated, the TZPD shifts up the APES.

The TZPD is thus a working zone for psychological problems; exceeding it can be considered as a clinical error (Stiles, Caro Gabalda, & Ribeiro, in press). The concept appears to have wide applicability, from depression (as in the present study) and anxiety (Meystre, Kramer, De Roten, Despland, & Stiles, 2014) to personality disorders (Dimaggio & Lysaker, 2015) and even neurological assessments (Tikkanen, Stiles, & Leiman, 2011). It may vary in breadth; an overly narrow TZPD may impede therapeutic work (Zonzi et al., 2014). It refers to many of the same sort of observations as the concept reflective or mentalization capacity, which is considered as a limiting factor in the treatment of serious disorders such as borderline personality disorder (Bateman & Fonagy, 2010) and psychosis (Lysaker & Dimaggio, 2014), though it adds the suggestions that the zone (capacity) may be specific to particular content and that it may shift during successful therapy.

Therapeutic skill, then, resides in continuously assessing the current limits of the TZPD and working within it by adjusting the degree to which interventions support the dominant voice (i.e., the usual self-narrative), support the nondominant voice (i.e., the innovative narrative), or challenge the client to move beyond the current developmental level. The success of these assessments and adjustments can be assessed by observing the whether and how the clients accepts or rejects the therapist's interventions.

Theoretically, therapist interventions aimed below the TZPD will be rejected as uninteresting or unhelpful. Interventions above the TZPD will be rejected as too threatening. Interventions that are well within the TZPD will be accepted as safe and potentially productive. Based on these theoretical expectations, the therapeutic collaboration coding system (TCCS; Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, 2013) assesses whether and how the therapeutic dyad is working within the TZPD by examining client responses to therapist interventions.

The TCCS codes a client response as ambivalent when, in the same speaking turn, the client first accepts and then rejects the therapist's proposal. This juxtaposition is interpreted as indicating that the client is working at the limit of the TZPD. Ambivalent responses are further subdivided as lower limit or upper limit ambivalence depending on the last focus of the client's speaking turn (dominant or nondominant voice). Ambivalence at the upper limit ends with an expression by the dominant voice and can be coded as an RPM, as the client first accepts the therapist's guidance and then retreats in the face of felt risk. Ambivalence at the lower limit represents the reverse process, ending with an expression by the nondominant voice; the client advances in the face of disinterest. Further details of TCCS coding are described later.

Previous TCCS studies of narrative therapy have found episodes of ambivalence at the upper limit (RPMs) were most often preceded by therapist challenging and that most often the therapist responded to the ambivalence with further challenging. When the therapist responded to ambivalence with a challenging intervention, the intervention seemed to push the client beyond the upper limit of the TZPD, escalating the clients' felt risk to an intolerable level, indicated by rejection of the therapist's proposal (Ribeiro et al., 2014).

Study Goals and Questions

Our purpose in this study was to test and improve our theoretical understanding of the cycle of ambivalence measured by RPMs. We were particularly interested in exploring the impact of therapist interventions on the collaboration between client and therapists in episodes of ambivalence. To this end, we contrasted a good- and a poor-outcome case with high incidence of ambivalence (measured by RPMs) treated by the same therapist. From each case, we extracted all episodes of client ambivalence. Each episode was a four-turn sequence centering on an expression of ambivalence, in which the client's nondominant voice was followed immediately by a return to the dominant voice (understood as indicating that the client had reached at the upper limit of the TZPD). We used the TCCS to examine the therapist interventions that preceded and followed each such expression

of ambivalence, along with the client response to that following intervention. Thus, we addressed three questions:

(1) Which types of therapeutic intervention preceded expressions of ambivalence?
(2) How did the therapist respond to client expressions of ambivalence?
(3) How did the client react to the therapist's intervention?

This was a theory-building case study. That is, we were looking for confirmation or disconfirmation of our understanding and also for unexpected observations that could suggest modifications, elaborations, or extensions of the theory (Stiles, 2009). The theory we were building was our integration of the IMs model and the assimilation model, particularly as it applies to manifestations of and therapeutic responses to ambivalence.

Method

Data for the current study were drawn from the Gonçalves, Ribeiro, Silva, Mendes, and Sousa (in press) study of IMs in narrative therapy for depression and had been previously coded for RPMs as markers of ambivalence by Ribeiro, Gonçalves, Silva, Brás, and Sousa (in press). Relevant parts of these studies' method are summarized here; see Gonçalves et al. (in press) and Ribeiro et al. (in press) for further details.

Clients and Client Selection

We selected one good-outcome case and one poor-outcome case from a group of clients who received narrative therapy (White & Epston, 1990) in a clinical trial that compared narrative therapy with cognitive-behavioral therapy (Beck, Rush, Shaw, & Emery, 1979) for depression (Lopes et al., 2014). Good and poor outcome was defined as whether or not the client met criteria for reliable and clinically significant improvement, as described by Jacobson and Truax (1991), on both the Beck Depression Inventory II (Beck, Steer, & Brown, 1996) and the Outcome Questionnaire (OQ-45.2; Lambert et al., 1996).

Thomas (pseudonym), the good-outcome client, was a male undergraduate student, aged 22, who presented with feelings of guilt and despair after ending a relationship. Gisela (pseudonym), the poor-outcome client, was a female Ph.D. student, aged 30, married, with no children. She felt unhappy with her marriage, but was not sure about ending the relationship, as she feared being alone.

Thomas and Gisela met the inclusion criteria for the Lopes et al. (2014) clinical trial, which were a diagnosis of major depressive disorder according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 2000), and willingness to provide written informed consent, to answer the questionnaires and to allow the researcher to videotape the sessions. They received individual psychotherapy sessions in a Portuguese university clinic. Sessions had a mean duration of 1 hr and were provided at no charge, scheduled once a week from sessions 1 to 16 and every 2 weeks from sessions 17 to 20, for a maximum of 20 sessions (plus follow-up at 1, 3, 6, and 12 months). Thomas and Gisela were each seen for 20 sessions.

Of the 34 clients who received narrative therapy in the trial, 5 good-outcome and 5 poor-outcome cases were randomly selected for the Gonçalves et al. (in press) study of IMs and the Ribeiro et al. (in press) study of ambivalence in narrative therapy. Thomas and Gisela were selected for having the most episodes of ambivalence in these good- and poor-outcome subgroups, respectively.

The Therapist and the Therapy

Both clients were treated by the same therapist who at the time of the study was a Ph.D. student in clinical psychology. He had seven years of experience conducting psychotherapy and three years of experience conducting narrative therapy. He had received extensive training on a manual of narrative intervention based on the model of White and Epston (1990), which involved three main phases and was flexible enough for the therapist to attend to the clients' idiosyncratic characteristics and individual progress during the therapy: (1) Deconstruction of the problematic self-narrative (e.g., externalization, reauthoring conversations, and social reactivation of conversations); (2) reconstruction of the alternative/emergent self-narrative (e.g., working on the expansion of unique outcomes), and; (3) consolidation of the alternative/emergent self-narrative and finalization (e.g., documenting the process of change, social validation, and defining ceremonies). Objectives and strategies for the follow-up sessions were also defined within the manual.

The first author of the manual served as a supervisor throughout the Lopes et al. (2014) trial, meeting regularly with the therapist to ensure his adherence to the narrative model of intervention. At the end of the therapeutic process, the therapist's adherence to the narrative therapeutic model was assessed according to the *Adherence and Competence Scale for Narrative*

Table I. Therapist intervention coding subcategories.

Supporting subcategories	Definitions/markers
Reflecting	The therapist reflects the content; meaning or feeling present in the client's words. He or she uses his/her or client's words but does not add any new content in the reflection, asking for an implicit or explicit feedback
Confirming	The therapist makes sure he/she understood the content of the client's speech, asking the client in an explicit and direct mode
Summarizing	The therapist synthesizes the client's discourse, using his/her own and client's words, asking for feedback (implicit or explicit)
Demonstrating interest/attention	The therapist shows/affirms interest on client's discourse
Open questioning	The therapist explores clients experience using open questioning. The question opens to a variety of answers, not anticipated and/or linked to contents that the client doesn't reported or only reported briefly. This includes the therapist asking for feedback of the session or of the therapeutic task
Minimal encouragement	The therapist makes minimal encouragement of client's speech, repeating client's words, in an affirmative or interrogative mode. (ambiguous expressions with different possible meanings are not codified, like a simple "Hum … hum" or "ok")
Specifying information	The therapist asks for concretization or clarification of the (imprecise) information given by the client, using closed questions, specific focused questions, asking for examples

Challenging subcategoires	Definitions/markers
Interpreting	The therapist proposes to the client a new perspective over his or her perspective, by using his or her own words (instead of client words). There is, although, a sense of continuity in relation to the client's previous speaking turn
Confronting	The therapist proposes to the client a new perspective over his or her perspective or questions the client about a new perspective over his or her perspective. There is a clear discontinuity (i.e., opposition) with in relation to the client's speaking turn
Inviting to adopt a new perspective	The therapist invites (implicitly or explicitly) the client to understand a given experience in an alternative
Inviting to put into practice a new action	The therapist invites the client to act in a different way, in the session or out of the session
Inviting to explore hypothetical scenarios	The therapist invites the client to imagine hypothetical scenarios, that is, cognitive, emotional and/or behavioral possibilities that are different from client's usual way of understanding and experiencing
Changing level of analysis	The therapist changes the level of the analysis of the client's experience from the descriptive and concrete level to a more abstract one or vice-versa
Emphasizing novelty	The therapist invites the client to elaborate upon the emergence of novelty
Debating client's beliefs	The therapist debates the evidence or logic of the client's believes and thoughts
Tracking change evidence	The therapist searches for markers of change, and tries to highlight them

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

and Cognitive-Behavioral Therapy (ACS-N-CBT; Gonçalves, Bento, Lopes, & Salgado, 2009). The results showed this therapist's adherence to be adequate (Lopes et al., 2014).

Measures

Innovative moments coding system (IMCS; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). The IMCS tracks IMs, that is, moments in which the problematic self-narrative that brought the client to therapy is challenged by the nondominant voice. The IMCS has been used to study a variety clinical problems and models of intervention (Alves, Mendes, Gonçalves, & Neimeyer, 2012; Gonçalves et al., 2012; Matos, Santos, Gonçalves, & Martins, 2009), and it has proved to be reliable. The average inter-judge percentage of agreement on overall IM proportion (the proportion of the session occupied by each IM) ranged from 84% to 94% (calculated as the overlapping of the proportion identified by two independent judges divided by the total proportion identified by either judge; Gonçalves, Ribeiro, Mendes, et al., 2011).

Return-to-the-problem coding system (RPCS; Gonçalves, Ribeiro, Stiles, et al., 2011). An RPM is defined the re-emergence of the problematic self-narrative (i.e., a dominant voice and representing the client's usual self) immediately after the emergence of an IM or within the client's first speaking turn after the therapist's first intervention following the IM emergence. The *Return-to-the-Problem Coding System Manual* (Gonçalves, Ribeiro, et al., 2009) give detailed criteria for coding RPMs. Gonçalves, Ribeiro, Stiles, et al. (2011) reported reliable agreement between judges on RPM coding, with a Cohen's k of .93.

Table II. Client response coding subcategories.

Validating subcategories	Definitions/markers
Confirming	The client agrees with the therapist's intervention, but does not extend it
Extending	The client not only agrees with the therapist intervention, but expands it (i.e., going further)
Giving information	The client provides information according to therapist's specific request
Reformulating oneself perspective	The client answers the therapist's question or reflects upon the therapist's prior affirmation and, in doing so, reformulates his or her perspective over the experience being explored
Clarifying	The client attempts to clarify the sense of his or her response to the therapist prior intervention or clarify the sense of the therapist's intervention itself.

Invalidating subcategories	Definitions/markers
Expressing confusion	Client feels confused and/or states his or her inability to answer the therapist's question
Focusing/persisting on the maladaptive self-narrative	Client persists on looking at a specific experience or topic from his or her standpoint
Defending oneself perspective and/or disagreeing with therapist's intervention	Client defends his/her thoughts, feelings, or behavior by using self-enhancing strategies or self-justifying statements
Denying progress	Client states the absence of change (novelty) or progress
Self-criticism and/or hopelessness	Client is self-critical or self-blaming and becomes absorbed in a process of hopelessness (e.g., client doubts about the progress that can be made)
Lack of involvement in response	Client gives minimal responses to therapist's efforts to explore and understand client's experience
Shifting topic	Client changes topic or tangentially answers the therapist
Topic/focus disconnection	The client persists in elaborating upon a given topic despite the therapist's efforts to engage in the discussion of a new one
Non meaningful storytelling and/or focusing on others' reactions	Client talks in a wordy manner or overly elaborates non-significant stories to explain an experience and/or spends inordinate amount of time talking about other people
Sarcastic answer	The client questions therapist's intervention or is ironic toward therapist's intervention

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

Therapeutic collaboration coding system (TCCS). We used the TCCS (Ribeiro et al., 2013) to study the therapist's reaction to RPMs and its impact on therapeutic collaboration. The TCCS is a transcript-based coding system designed to analyze therapeutic collaboration on a moment-to-moment basis. Therapist interventions are coded to a subcategory of either supporting (7 subcategories) or challenging (9 subcategories) the client; these are shown in Table I. Supporting interventions are further classified as supporting either a dominant voice (usual narrative) or a non-dominant voice (alternative narrative). Client responses are coded to a subcategory of either validating (5 subcategories) or invalidating (10 subcategories) the therapist's intervention; these are shown in Table II. The position of the nondominant voice (the problematic experience) within the TZPD is inferred from the client's response. An initial study (Ribeiro et al., 2013) showed good reliability, with mean Cohen's Kappa values of .92 for therapist interventions and .93 for client responses.

The TCCS is applied to delimited sequences of talk (Figure 1):

(1) The sequence can begin with any client expression, which is then classified as an expression by the dominant voice (the usual, problematic narrative) or by the non-dominant voice (an IM, the problematic experience).

(2) The therapist intervenes by *supporting* either the dominant—working close to the client's actual level within the TZPD (i.e., confirming and elaborating upon client's usual narrative), but supporting the nondominant voice, or by *challenging*—intervening closer to the upper limit of the TZPD (i.e., moving beyond the client's usual narrative), using one of the subcategories shown in Table II.

(3) The client validates (accepts and elaborates) or invalidates (rejects and avoids) the intervention using one of the subcategories shown in Table II. The client's experience can then be inferred and classified as follows (see Ribeiro et al., 2013, for further details):

(4) *Working within the TZPD: (a) Safety (low in TZPD) or (b) Tolerable risk (higher in*
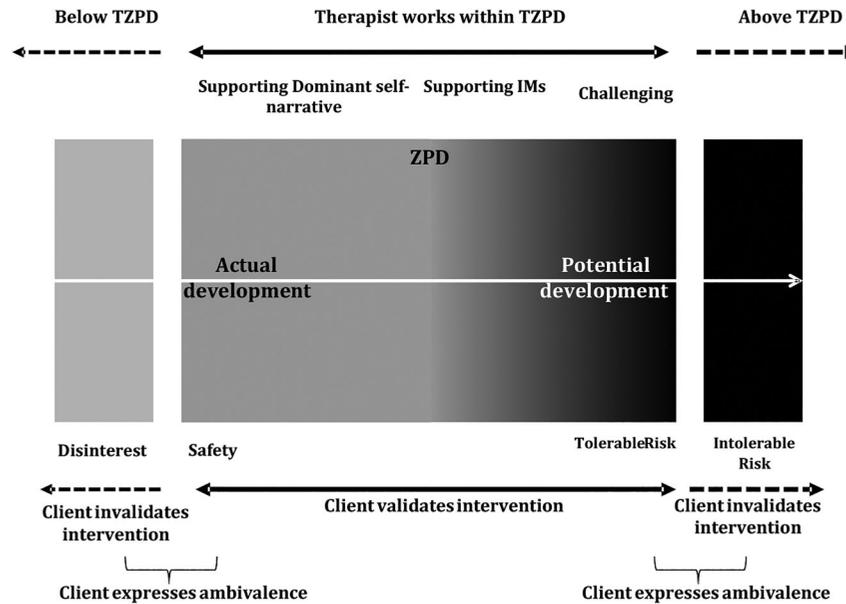
Figure 1. Segment of the therapeutic developmental continuum showing the therapeutic zone of proximal development (TZPD). *Note.* From: *How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system*, by Ribeiro et al. (2013). Adapted with permission.

TZPD): The client may respond at the same developmental (APES) level as the therapist, which may be closer to the *actual developmental level* or closer to the *potential developmental level*. The client may that lag behind the level the therapist intervention. Or, the client may move beyond the level the therapist proposes.

(5) *Working at the limit of the TZPD: (a) Moving towards safety (upper limit of TZPD) or (b) moving towards risk (lower limit of TZPD)*: If the therapist works closer to the upper limit of TZPD, client's ambivalence response (i.e., to begin to accept the perspective proposed by the therapist but then take an opposite perspective, an RPM) may indicate he or she lags behind the proposed level, *moving towards safety*. In

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

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

Table III. Therapist interventions preceding expressions of ambivalence.

Case	Therapist intervention		
	Supporting problematic self-narrative	Supporting IMs	Challenging
Good-outcome case	34%	18%	48%
Poor-outcome case	31%	12%	57%

Procedure

IM coding. After the clients provided written consent, the psychotherapeutic sessions were video-taped and transcribed. Each session was coded independently by two experienced coders (one male Ph.D. student, late 1930s, and one female Master student, early 1920s) according to the IMCS (Gonçalves, Ribeiro, Stiles, et al., 2011). The coders were unaware of the cases' outcomes. Disagreements were resolved through consensus at regular discussion

meetings. For a detailed description of the IM training and coding process, see Gonçalves, Ribeiro, Mendes and colleagues (2011). Reliability based on the entire Gonçalves et al. (in press) sample, from which Thomas and Gisela were drawn, resulted in an agreement on overall IMs proportion of 89.9%.

RPM coding. For the Ribeiro et al. (in press) study, based on the same sample as Gonçalves et al. (in press), three judges—a male Ph.D., early 1930s (judge A), a female Ph.D., late 1930s (Judge B) and a female Master student, early 1920s (judge C) participated in the RPM coding procedure: Judges A and B coded five cases, and Judge C and Judge B coded five cases. All coders were unaware of the cases' outcome; judges A and B were expert coders, and judge C was trained before coding the sample. Training in the RPM coding system involved the following steps (1) reading the RPCS manual (Gonçalves, Ribeiro, et al., 2009) and (2) coding RPMs in two workbooks that include transcripts of all IMs from one psychotherapy case and subsequent discussion of discrepancies with a skilled RPM judge. At the end of this training, the judge's coding are compared with those of expert judges. Judges are considered reliable if they achieve a Cohen's *k* higher than .75, which was the case here.

RPM coding comprised two sequential steps (1) independent coding and (2) resolving disagreements through consensus. The judges coded the entire sample (180 sessions), evaluating each of the IMs previously coded by Gonçalves et al. (in press) for the presence of RPMs, following the RPCS manual. The sessions were coded from the transcripts in the order in which they occurred. The reliability of identifying RPMs, assessed by *Cohen's k*, was .89 based on the initial independent coding of a sample of 5257 IMs. Throughout the coding process, the three judges met after coding the first two sessions, and if the agreement was high (as was always the case), they would meet again after completing the coding

for that particular case. Across these meetings, the differences between their codings were identified and then resolved through consensual discussion. This interactive and collaborative procedure allowed the judges to integrate each other's strengths, which facilitated the coding of subsequent sessions (cf., Brinegar, Salvi, Stiles, & Greenberg, 2006).

As reported previously (Ribeiro et al., in press), this procedure identified 120 RPMs out of the 684 IMs (17.5%) in the good-outcome case and 201 RPMs out of 577 IMs (34.8%) in the poor-outcome case . The proportions of IMs that involved RPMs changed across sessions as shown in Figures 2 and 3, in which the *y* axis represents the proportion of IMs that were followed by RPMs and the *x* axis represents therapy sessions over time. In the good-outcome case, there was a clear tendency for RPMs to decrease across sessions, whereas the poor-outcome case presented a more irregular pattern, with no clear directional tendency. Thus, one focus of this study was to investigate differences in how episodes of ambivalence were dealt with by the therapist in these two cases.

TCCS coding and reliability. Two trained judges (a male Ph.D., early 1930s, and a female Master student, early 1920s) watched the video recordings of each of Thomas's and Gisela's sessions in their entirety and read the transcripts. The judges then independently listed the client's problems (themes from the maladaptive self-narrative that brought the client to therapy) and met to discuss their assessment of the client's problematic self-narrative. Following this, the client's problematic self-narrative was consensually characterized in a way that sought to remain faithful to the client's words. Next, the judges independently classified each therapist's speaking turn before and after each episode in which there was an IM followed by an RPM, into a Supporting subcategory or a Challenging subcategory (see Table I). For Supporting categories, they
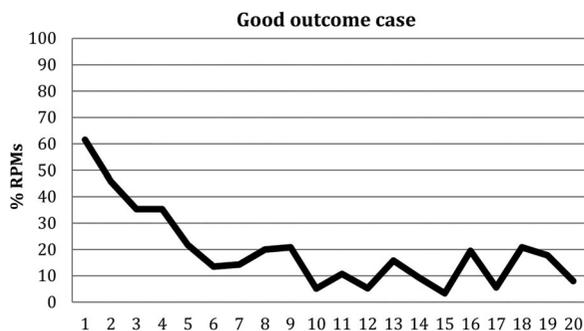
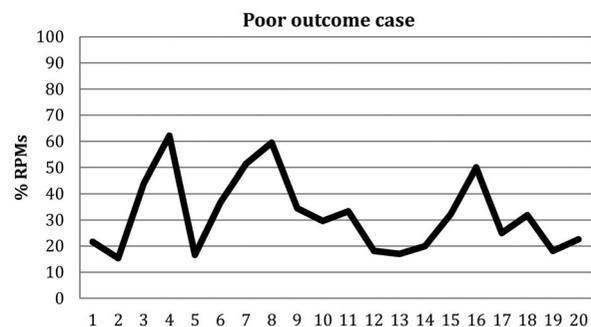Figure 2. Ambivalence evolution across sessions in the good-outcome case.

Figure 3. Ambivalence evolution across sessions in the poor-outcome case.

further decided whether it focused on the problematic self-narrative (dominant voice) or focused on the IM (nondominant voice).

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

The pair of judges met after coding each session to assess their rating's reliability (using Cohen's Kappa) and to note any differences in their perspectives on their coding. When differences were detected, they were resolved through consensual discussion. Reliability of identifying therapist's intervention, assessed by Cohen's *k*, was .93. Reliability of identifying client's response, assessed by Cohen's *k*, was .92. The consensus version of the TCCS coding was audited by an external auditor (fourth author) who then met with the pair of judges to discuss his feedback. His role was one of "questioning and critiquing" (Hill et al., 2005, p. 201).

Results

Which Type of Therapeutic Intervention Preceded Expressions of Ambivalence?

As expected, ambivalence tended to occur when the therapist worked closer to the upper limit of the TZPD, favoring innovation over the usual narrative. As shown in Table III, in both cases, nearly 70% of the expressions of ambivalence (RPMs) occurred

Table IV. Therapist interventions following expressions of ambivalence.

Outcome	Therapist intervention		
	Supporting problematic self-narrative	Supporting IMs	Challenging
Good outcome	48%	6%	46%
Poor outcome	43%	12%	45%

following interventions in which the therapist challenged the client or supported the nondominant voice (the IM).

How Did the Therapist Respond to Client's Expressions of Ambivalence?

As shown in Table IV, results indicated that the therapist did not respond differently to expressions of ambivalence in the two cases. In both cases, he used a similar balance of interventions supporting the usual self-narrative (48% in Thomas's case and 43% in Gisela's) and challenging interventions (46% in Thomas's case and 45% in Gisela's).

How Did the Client Respond to the Therapist's Intervention Following Expressions of Ambivalence in the Good-Outcome Case?

As shown in Table V, when the therapist responded to Thomas's RPMs by supporting the dominant voice (i.e., the usual narrative), Thomas moved beyond the level proposed by the therapist 43% of the time, elaborating the preceding IM. The following excerpt illustrates one way that the therapist supported the dominant voice.

Session 7
C: *… during the day I'm more distracted. But it also has to do with the fact that I know that at night I will be inevitably alone. Actually today I had lunch all by myself and I was ok.* [This IM reflects on the fact that the depression gains some space when Thomas is alone at night and that during the day he feels ok when he is alone]. ***But it is actually depressing*** [This was an RPM labeling the experience of being alone itself as depressing]
T: *Ok, if I got it right, it is as if your fear of being alone ended up opening a space or ended up being a breeding ground for depression. It makes depression come back again, the night enables depression to come back because you are alone. It got me thinking how depression feeds itself of you being alone …* [the therapist supported the dominant voice, the usual narrative, by summarizing—see Table I; he synthesized the statement using the client's own words, implicitly asking for feedback]
C: *I guess so because when I am with someone, even if I think about all this, I start talking about it to whoever is with me. On the other hand, I end up distracting myself. And this I have been able to do, which is a great victory for me because I've really been having some fun, in spite of having all this in my mind. Some time ago I was not even able to speak.* [Thomas validated the therapist's intervention—giving information; he agreed with the therapist and also gave further information about the question, ending up elaborating his IM]

Table V. Client response following therapist intervention following expressions of ambivalence in the good-outcome case.

Therapist intervention following ambivalence	Client response indicated a feeling of			
	Safety	Tolerable risk	Ambivalence	Intolerable risk
Supporting problematic self-narrative (48%)	30%	43%	6%	21%
Supporting IMs (6%)	20%	20%	0%	60%
Challenging (46%)	24%	39%	21%	16%

As shown in Table III, when the therapist responded to expressions of ambivalence by challenging, Thomas validated therapist's intervention only minimally 24% of the time, lagging behind the level proposed by the therapist. More often (39%) he validated the therapist's intervention, elaborating the IM, as illustrated in the following example.

Session 1

C: *Sunday, for example, I felt ok during the day, I was actually ok* [Here, Thomas's expression was an IM, acknowledging that there are periods when the guilt was not present which enabled him to feel good] ***but at night, after arriving to the apartment, I could not even wash the cup that I had left there with some tea in it. I felt so many things … I missed him. I felt guilty. I guess I don't have the right to do anything.*** [This was an RPM emphasizing moments where he does not feel so well, and by expressing that he does not feel worthy of doing anything that could add to his wellbeing]

T: *Could that be one of the guilt's consequences?* [The therapist challenged the client by externalizing the problem and inviting him to change the client's level of analysis of the experience from a descriptive and concrete level to a more abstract one]

C: *I guess so … it could really be. Sometimes I even tell him to go out. I don't think I deserve to go out. But it is not because of him, because he actually wants to see me well …* ***And I really want to leave town with this friend of mine because I know that it will be great for me, we actually have a lot of fun together.*** [Thomas validated the therapist's intervention; not only did he agree with the therapist but he also provided further information about the question, ending up elaborating his IM by stating that he would actually like to have fun with a friend because it would be positive to him.]

How Did the Client Respond to the Therapist's Intervention Following Expressions of Ambivalence in the in the Poor-Outcome Case?

As shown in Table VI, results indicated that when the therapist responded to expressions of ambivalence by supporting the dominant voice (the usual narrative), Gisela moved beyond the level proposed by the therapist only, 9% of the time. Most of the time (72%), she responded at the same level proposed by the therapist, which likely indicated that she experienced safety. The following excerpt illustrates one way she indicated this latter sort of validation.

Session 6

C: *Sometimes he calls one, two, three times and I don't pick up the phone* [This was an IM by stating that Gisela managed not to yield to her fear of being alone by answering her boyfriend's calls] ***but even if I don't, he always follows me wherever I go and when he finds me he's going to talk to me and I will have to answer. Because he cannot stop you know, he tries in every way he can.*** [This was an RPM minimizing the value of innovation and expressing helplessness]

T: *And that makes you feel bad?* [the therapist supported the dominant voice, the usual narrative, by specifying information—see Table I; he asked Gisela to specify by asking a concrete question]

C: *Yes, it does because, in a way, I don't like to see him sad, you know? I don't like to see him that way.* [Gisela validated the therapist's intervention—giving information; she not only agreed with the therapist but also elaborated on the reasons why she felt uncomfortable with the situation]

When the therapist responded to expressions of ambivalence by challenging Gisela, she responded

Table VI. Client response following therapist intervention following expressions of ambivalence in the poor-outcome case.

Therapist intervention following ambivalence	Client response indicated a feeling of			
	Safety	Tolerable risk	Ambivalence	Intolerable risk
Supporting problematic self-narrative (43%)	72%	9%	2%	17%
Supporting IMs (12%)	67%	25%	0%	8%
Challenging (45%)	57%	13%	12%	18%

at the level proposed by the therapist only 13% of the time. Most of the time (57%) she only minimally validated therapist's intervention, lagging behind the level proposed by the therapist. The following excerpt is an example of this process.

Session 10

C: *I think I would be happier* if I could think about it in a different way [This was an IM accepting that changing perspective on the problem would bring positive results] **but I don't really believe that momentary happiness. Today I'm ok, and everything is fine but tomorrow I will not have any of this and I will probably suffer much more.** [Gisela produced an RPM by minimizing the innovation's positive potential, stating that even if she could change the perspective on the problem, happiness would not last long because she would eventually feel much more alone and consequently, much worse]

T: *Ok. Do you think that that's why this relationship and these cycles end up wrapping you up? Because of the fear of making a decision and the fear that this decision can make you suffer?* [the therapist challenged Gisela with an interpretation; he proposed a new perspective using his own words. There was, nonetheless, a sense of continuity in relation to Gisela's previous speaking turn]

C: *Hum Hum. Yes.* [The client validated the therapist's intervention minimally, confirming the interpretation, but she did not extend or elaborate it.]

Discussion

The observation that most of Thomas's and Gisela's expressions of ambivalence occurred after challenging interventions is in line with previous findings using RPMs (Ribeiro et al., 2014) and also with Caro-Gabalda, Stiles, and Pèrez Ruiz (in press, this issue) study of setbacks in the assimilation process. A setback refers simply to the client regressing from a more advanced to a less advanced stage in the assimilation process. Caro-Gabalda et al. (in press) reported that most setbacks were generated by interventions coded as empathizing with a nondominant voice (i.e., with an innovation) or by challenging a dominant voice (the usual narrative). This converges with the present study's observation that the combination of supporting IMs and challenging preceding most RPMs, supporting the theoretical expectation that that ambivalence in the psychotherapeutic process are tends to be elicited by therapists' focus on innovation, that is, pressing clients toward the upper limit of the TZPD.

In responding to clients' ambivalence, the therapist tended to use challenging and supporting interventions in a balanced way in both the good- and the poor-outcome case. When the therapist responded to ambivalence by supporting the dominant voice, Gisela, the poor-outcome case, tended to work at the level proposed by the therapist, expressing safety, whereas Thomas, the good-outcome case, tended to move beyond the level proposed by the therapist, producing an IM. When the therapist responded to ambivalence, by challenging, Thomas usually validated the intervention (i.e., producing a further IM), whereas Gisela only minimally accepted these interventions (i.e., lagging behind the level proposed by the therapist).

To highlight this contrast: The therapist tended to respond to ambivalence, in a similar manner in the good- and poor-outcome cases, but Thomas and Gisela responded differently. Thomas, the good-outcome case, responded at the level proposed by the therapist when challenged and moved beyond when supported. In contrast, Gisela tended to lag behind the level proposed by the therapist when challenged and to respond at the same level when supported.

This seems to suggest a problem in therapist's responsiveness. Responsiveness (Honos-Webb & Stiles, 1998; Stiles, 2009; Stiles, Honos-Webb & Surko, 1998) essentially means that the therapist is capable of adapting and self-correcting interventions and interactions to the client's specific needs or responses. This was probably not the case as the therapist did not match Gisela's developmental level or readiness to change when responding to the client's expressions of ambivalence, persistently working beyond her current TZPD instead, and perhaps unintentionally exacerbating the ambivalence.

In a previous study using TCCS to study ambivalence episodes in a poor-outcome case of narrative therapy, we found that the therapist usually responded to client's RPMs by challenging (75% of instances). In that poor-outcome case, the client tended to invalidate the therapeutic intervention (Ribeiro et al., 2014), whereas this did not happen to a great extent in Gisela's case. Perhaps Gisela's more moderate response reflected a nonetheless better balance between challenging (45%) and supporting the dominant voice (usual problematic self-narrative; 43%). It is tempting to wonder if the outcome would have been more positive in this case if the therapist responded to ambivalence at the upper limit of the TZPD using fewer challenging interventions. Of course, this is a *post hoc* reasoning, and as such must be offered tentatively.

Interestingly, Thomas tended to respond to interventions supporting the dominant voice (the usual self-narrative) by moving beyond the level proposed by the therapist, producing a further IM. Consistent with Bohart and Tallman's (1999) view that clients are largely responsible for their own healing, Thomas proactively created opportunities for his own change

rather than just reacting to the therapist's facilitation of change. He used the challenging interventions as scaffolding and creatively used the therapist's supporting of his usual self-narrative interventions as opportunities to move beyond, manifesting a readiness to change and a tendency for growth.

Limitations and Recommendations

Of course, our observations on these two particular cases of narrative therapy for depression cannot be generalized on their own. The point of a theory-building case study is not to generalize from the observations directly but rather to show what is possible, so that the theory can be adjusted or elaborated to accommodate the observations (Stiles, 2009). Any generality resides in the theory and is always tentative, subject to confirmation or disconfirmation by further observations in further cases. The goal is to assess and improve a particular theory, not to compare theories, even though any delimited set of observations, including ours, might be explained in other ways.

Our observations on the cases of Thomas and Gisela generally support but also suggest tentative elaborations of the assimilation/IM model's account of how dyads can work successfully or not-so-successfully within the TZPD. Successful work may be characterized by coordinated action in which therapist interventions are calibrated to work within the TZPD limits for that particular client, disorder, and problem, pressing those limits only to an extent that the client can tolerate. Unsuccessful work may involve interventions that exceed the client's tolerance for risk. How to apportion responsibility for unsuccessful interventions between therapist miscalculation and lack of client readiness is a question for future theoretical and empirical work.

Clinically, our observations support the theoretical suggestion that dealing with ambivalence requires a sensitive and responsive therapeutic approach since the way clients respond to similar therapist's interventions can be very different. Challenging or supporting (whether innovation or the problematic position) must be continually adjusted in accordance with the problem's current TZPD, as indicated by the client's responses. Thus, paying attention to the way clients repeatedly respond to the therapist's intervention and adjusting positions and techniques as the TZPD shifts is of crucial importance.

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References

Alves, D., Mendes, I., Gonçalves, M., & Neimeyer, R. (2012) Innovative moments in grief therapy: Reconstructing meaning following perinatal death. *Death Studies*, 36, 795–818. doi:10.1080/07481187.2011.608291

American Psychiatric Association. (2000). *DSM-IV-TR: Diagnostic and statistical manual of mental disorders* (4th rev. ed.). Washington, DC: Author.

Arkowitz, H., & Engle, D. (2007). Understanding and working with resistant ambivalence in psychotherapy. In S. G. Hofmann & J. Weinberg (Eds.), *The art and science of psychotherapy* (pp. 171–190). New York: Routledge.

Arkowitz, H., & Miller, W. R. (2008). Learning, applying and extending motivational interviewing. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems* (pp. 1–25). New York, NY: Guilford Press.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry*, 9(1), 11–15.

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy for depression*. New York, NY: Guildford Press.

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

Bohart, A., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, DC: American Psychological Association.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology*, 53, 165–180. doi:10.1037/0022-0167.53.2.165

Caro Gabalda, I., Stiles, W. B., & Pérez Ruiz, S. (in press) Therapeutic activities in the assimilation process. Manuscript submitted for publication.

Dimaggio, G., & Lysaker, P. (2015). Metacognition and mentalizing in the psychotherapy of patients with psychosis and personality disorders. *Journal of Clinical Psychology: In Session*, 71, 117–124. doi:10.1002/jclp.22147

Dimaggio, G., Salvatore, G., Azzara, C., & Catania, D. (2003). Rewriting self-narratives: The therapeutic process. *Journal of Constructivist Psychology*, 16, 155–181.

Engle, D., & Arkowitz, H. (2008). Viewing resistance as ambivalence: Integrative strategies for working with resistant ambivalence. *Journal of Humanistic Psychology*, 48, 389–412. doi:10.1177/0022167807310917

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

Gonçalves, M. M., Bento, T., Lopes, R., & Salgado, J. (2009). Manual da Escala de Adesão e Competência para Terapia Narrativa e Cognitivo-Comportamental [*Adherence and Competence Scale for Narrative and Cognitive-Behavioral Therapy*]. Unpublished manuscript.

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

Gonçalves, M. M., Ribeiro, A. P., Santos, A., Gonçalves, J., & Conde, T. (2009). *Return to the problem coding system – Version 2.* Unpublished manuscript. Braga: University of Minho.

Gonçalves, M. M., Ribeiro, A. P., Silva, J., Mendes, I., & Sousa, I. (in press). Innovative moments as predictors of symptom change in narrative therapy for depression. *Psychotherapy Research.*

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

Hill, C. A., Knox, S., Thompson, B. J., Nutt Williams, E., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52*(2), 196–205. doi:10.1037/0022-0167.52.2.196

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35*, 23–33.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19. doi:10.1037/0022-006X.59.1.12

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the outcome questionnaire. *Clinical Psychology & Psychotherapy, 3*, 249–258. doi:10.1002/(SICI)1099-0879(199612)3:4 < 249::AID-CPP106>3.0. CO;2-S

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 Jane revisited. *Psychotherapy Research, 11*, 311–330.

de Liver, Y. N., van der Pligt, J., & Wigboldus, D. H. J. (2007). Positive and negative associations underlying ambivalent attitudes. *Journal of Experimental Social Psychology, 43*, 319–326.

Lopes, R., Gonçalves, M., Machado, P., Sinai, D., Bento, T., & Salgado, J. (2014). Narrative therapy vs. Cognitive-behavioral therapy for moderate depression: Empirical evidence from a controlled clinical trial. *Psychotherapy Research, 24*, 662–674. doi:10.1080/10503307.2013.874052

Lysaker, P. H., & Dimaggio, G. (2014). Metacognitive capacities for reflection in schizophrenia: Implications for developing treatments. *Schizophrenia Bulletin, 40*, 487–491. doi:10.1093/schbul/sbu038

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

McEvoy P. M., & Nathan, P. (2007). Effectiveness of cognitive behaviour therapy for diagnostically heterogeneous groups: A benchmarking study. *Journal of Consulting and Clinical Psychology, 75*, 344–350.

Meystre, C., Kramer, U., De Roten, Y., Despland, J. N., & Stiles, W. B. (2014). How psychotherapeutic exchanges become responsive: A theory-building case study in the framework of the assimilation model. *Counselling and Psychotherapy Research, 14*, 29–41. doi:10.1080/14733145.2013.782056

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

Ribeiro, A. P., Mendes, I., Stiles, W., 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*, 702–710. doi:10.1080/10503307.2013.879620

Ribeiro, A. P., Gonçalves, M. M., Silva, J., Brás, A., & Sousa, I. (in press). Ambivalence in narrative therapy: A comparison between recovered and unchanged cases. *Clinical Psychology & Psychotherapy.*

Ribeiro, E., Ribeiro, A. P., Gonçalves, M. M., Horvath, A. O., & Stiles, W. B. (2013). How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy, 86*, 294–314. doi:10.1111/j.2044-8341.2012.02066

Stiles, W. B., Caro Gabalda, I., & Ribeiro, E. (in press). Exceeding the therapeutic zone of proximal development as a clinical error. *Psychotherapy.*

Stiles, W. B., Meshot, C. M., Anderson, T. M., & Sloan, W. W., Jr. (1992). Assimilation of problematic experiences: The case of John Jones. *Psychotherapy Research, 2*, 81–101.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York, NY: Oxford University Press.

Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy, 5*(3), 9–22. Retrieved from http://jrul.libraries.rutgers.edu/index.php/pcsp/article/view/973/2384

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367–384. doi:10.1080/10503307.2011.582186

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5*, 439–458.

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, 27*, 411–420. doi:10.1037/0033-3204.27.3.411

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

Tikkanen, S., Stiles, W. B., & Leiman, M. (2011). Parent development in clinical child neurological assessment process: Encounters with the assimilation model. *Psychotherapy Research, 21*, 593–607. doi:10.1080/10503307.2011.594817

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes.* Cambridge, MA: Harvard University Press.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York, NY: W. W. Norton.

Zonzi, A., Barkham, M., Hardy, G. E., Llewelyn, S. P., Stiles, W. B., & Leiman, M. (2014). Zone of Proximal Development (ZPD) as an ability to play in psychotherapy: A theory-building case study of very brief therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 87*, 447–464. doi:10.1111/papt.12022