Personal Reconstruction Processes in Personal Construct Therapy for Implicative Dilemmas

Joana Margarida dos Reis Torgal Senra da Costa

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Universidade do Minho
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Personal Reconstruction Processes in

Personal Construct Therapy for Implicative Dilemmas

ABSTRACT

In a personal construct psychology perspective, human beings are continually construing their experience of themselves and their reality, and continuously reconstructing it to make sense of new events. Psychological disorders represent some failure in this ongoing process, as the individual cannot make sense of the world with their constructions nor change them. Therapeutic change is of itself a form of reconstruction that allows clients to recover their ability to create alternatives.

Implicative dilemmas are one kind of blockage in construction, characterized by the association between a problematic construction and some positive dimensions of the self. Thus, change in the problematic areas implies undesired changes in other aspects of the self. Previous research has shown that implicative dilemmas are quite prevalent in general population, but significantly more frequent in people seeking psychotherapy. Implicative dilemmas are cross-sectional to clinical syndromes, representing a matter of structure of the construction system more than one of content. It has also been shown that implicative dilemmas tend to diminish with psychotherapeutic intervention.

Departing from previous proposals, we have developed a manual for the intentional and systematic treatment of implicative dilemmas, standing on personal constructivist assumptions

and techniques. This treatment proposal has been applied to psychotherapy in a university clinic, and eight clients have completed the treatment and research procedures, including a variety of qualitative and quantitative measures of therapeutic process and outcome, assessed at several moments of their treatment.

This thesis presents a detailed study of one of those cases, analysed through hermeneutic single case efficacy design, which shows that the treatment proposal was helpful for the treatment of this client, causing significant changes. In addition, we constructed an explanation for the observed changes, in light of personal construct theory.

A clinical replication series added seven more cases to that first study in order to refine our explanation of the personal reconstruction processes that occur while resolving an implicative dilemma in personal construct therapy for implicative dilemmas. In addition, it found positive signs of this treatment's efficacy when applied to clinical practice.

In our final study, we tried to identify and understand the processes of personal reconstruction that occur while resolving an implicative dilemma, at the episode level. We focused on significant events identified by clients to create a tentative model of dilemma reconstruction. Our findings were generally consistent with the previous theory, applying it at a micro-analytic level.

Processos de Reconstrução Pessoal em

Psicoterapia Construtivista Pessoal centrada em Dilemas Implicativos

RESUMO

Na perspectiva da teoria dos construtos pessoais, o ser humano continuamente constrói a sua percepção de si e do mundo, e continuamente a reconstrói para dar sentido às novas experiências. A perturbação psicológica representa uma falha neste processo, já que o indivíduo não é capaz de dar sentido ao mundo com as suas construções, nem de as mudar. A mudança terapêutica é em si mesma uma forma de reconstrução, que permite aos cliente recuperar a sua capacidade de criar alternativas.

Dilemas Implicativos são um tipo de bloqueio no processo de construção, caracterizado pela associação entre uma construção problemática e algumas dimensões positivas do self. Assim, mudar nas áreas problemáticas implica mudanças indesejadas em outros aspectos do self. Estudos prévios mostraram que os dilemas implicativos são bastante prevalentes na população geral, mas significativamente mais frequentes em clientes de psicoterapia. Os dilemas implicativos são um fenómeno transversal às diferentes síndromes clínicas, uma vez que se trata mais de uma dimensão de estrutura do sistema de construtos do que de conteúdo. Também tem sido demonstrado que estes dilemas tendem a diminuir com a intervenção psicoterapêutica.

A partir de propostas prévias, desenvolvemos um manual para o tratamento intencional e sistemático dos dilemas implicativos, baseado nos pressupostos e técnicas da psicologia dos construtos pessoais. Esta proposta de tratamento foi aplicada à prática numa clínica universitária, e oito clientes completaram o tratamento e procedimentos de investigação, incluindo uma variedade de medidas qualitativas e quantitativas de processo e resultados terapêuticos, avaliados em diferentes momentos do tratamento.

Esta tese apresenta o estudo detalhado de um desses casos, analisado através da metodologia hermeneutic single case efficacy design, que demonstrou que o tratamento foi útil para o tratamento desta cliente, causando mudanças significativas. Construímos também um modelo explicativo das mudanças observadas, à luz da teoria dos construtos pessoais.

Uma série de replicação clínica considerou mais sete casos, com o objectivo de refinar o nossa explicação dos processos de reconstrução pessoal que ocorrem na resolução de um dilema implicativo em terapia construtivista pessoal centrada em dilemas implicativos. Esta série deu também sinais positivos relativamente à eficácia deste tratamento quando aplicado à prática clínica.

O nosso último estudo tenta identificar e compreender os processos de reconstrução pessoal que ocorrem na resolução de um dilema implicativo, ao nível episódico. Centramo-nos em eventos importantes identificados pelos clientes para criar um modelo tentativo de reconstrução dos dilemas. Os resultados foram em geral consistentes com a teoria, aplicando-a ao nível micro-analítico.

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INTRODUCTION

People seek therapeutic help when they find difficulties in their life that they are not able to overcome on their own. In some cases, they do have the knowledge or the resources to make the necessary changes but some kind of blockage keeps from doing that movement. Implicative dilemmas are one type of such blockages, defined and studied in the context of personal construct psychology (PCP; Kelly, 1955). When a person faces an implicative dilemma, their desired change brings negative implications, due to an incompatible association between personal constructs of opposite values.

A therapeutic program focused in resolving these dilemmas could make it easier for clients to overcome such blockages and therefore attain their desired changes. In this project, we defined such a treatment program and studied its application to clinical practice, trying to understand if it helped clients and in what ways.

This thesis consists in a compilation of four articles submitted for publication in scientific journals, here transformed in chapters.

Theoretical background

This project is framed in the perspective of Personal Construct Psychology (PCP; Kelly, 1955), a total theory of human experience (Fransella & Dalton, 1990) developed from the clinical experience of a psychotherapist with psychoanalytic and behavioural backgrounds. Not satisfied with any of those schools, Kelly created his own conceptualization of the human psychological functioning, its disturbances and their treatment.

PCP stands on the epistemological assumption of *constructive alternativism*, according to which there are many possible ways to construct ourselves, others and the world. No one has a

direct access to the truth: each person sees it through their particular point of view and the events we encounter can be constructed in as many ways as we are capable to conceive (Feixas & Villegas, 2000; Kelly, 1969c).

Our constructions do not need to be disconfirmed for us to consider alternatives to them: assuming they are just hypotheses, we can always raise new alternatives. This perspective liberates us from the weight of established knowledge, bringing us new possibilities. According to Feixas (2001, p.9),

> All our constructions are no more than conjectures. The best have not yet been invalidated, but that does not mean we can trust them to reveal us the true nature of facts… All constructions can eventually be revised.

The human being is compared to a personal scientist, who creates theories to make sense of reality. Each experience we encounter works as an experiment, where our expectations or hypotheses are put to test. The hypotheses that are confirmed become stronger, while the ones our experience invalidates need to be revised.

Thus, we are active in our construction of knowledge, rather than mere observers of an outside reality. The ways in which we construct events are conditioned by our previous knowledge: we tend to construe the meaning of experience according to a coherent pattern, a sense of identity that allows us to feel the same through the different situations of life (Feixas,

2001; Fernandes, 1993; Kelly, 1969c). Learning takes place in the successive reconstruction of events. Human development is then a continuous process of meaning creation.

The basic unit of construction is the personal construct, a bipolar distinction between two or more elements (Kelly, 1955; 1970; Patrick, 2005). Constructs are organized in a complex system, sharing hierarchical as well as horizontal relations, so that changes in one construct may entail changes in several other points of the system. Our construct system constitutes our personality, and the most central constructs define our identity, being highly resistant to change. The optimal functioning is marked by a balance between the preservation of the system's stability and its change as we are exposed to new experiences.

Change is a central aspect of PCP. Every time we experience a new event, our constructions that apply to it change in some way: as they become stronger due to their confirmation, or as they are reformulated due to their disconfirmation. Hence, change is constant and it is fundamental for our adaptation to the world. Psychological dysfunction rises when subjects are incapable of changing, when "any personal construction… is used repeatedly in spite of consistent invalidation" (Fransella & Dalton, 1990, p.12). In that case, the person is not able to adequately understand events, or to create alternatives to deal with them in a more effective way. Symptoms appear as the person's attempt to make sense of events that would otherwise be chaotic. Although they cause suffering, they are the best possibility the person can find at that moment (Fransella & Dalton, 1990; Tschudi, 1977).

To help clients overcome their problems, therapists need to understand their personal perspective, from which their behaviour does not seem irrational, but is coherent with the person's constructions. The path for change is walked side by side with the client, in a respectful and collaborative relationship, which validates the client and her difficulties. Only in that context alternative ways of dealing with the world can be conceived and experimented. That should be done, however, in a hypothetic, *as if*, stance that preserves the client's current constructions until she is comfortable to replace them with new ones. The ultimate goal of therapy is to help the individual get back to the healthy movement of construction and reconstruction (Fransella & Dalton, 1990; G.J. Neimeyer, 1995).

Implicative dilemmas. When symptoms or aspects the client wants to change correlate with positive aspects of her identity, the person faces a dilemma, as she is obliged to choose between two undesired situations: maintaining the current problem, or abandoning it at the cost of some positive aspects of the self (Feixas, Ávila, Saúl, & Sánchez, 2001; Hinkle, 1965, Tschudi, 1977). In this situation, the person is stuck, as there are no satisfactory alternatives: changing the problematic construct means also changing a positive and some times nuclear aspect of the self. From this point of view, maintaining the problem is a wise choice, as it allows the survival of the client's identity.

This blockage is a type of problematic organization of the individual's construction, which could involve all types of construct contents. Consequently, it is not particularly related to any mental health syndrome (APA, 1994), but can appear in any clinical condition. It can be

evident in the client's discourse, but it is more often unknown to the person. According to Feixas et al. (2001), implicative dilemmas may play an important role in psychotherapy, by helping define its focus and clarifying the problematic of resistance to change. The identification of the clients' dilemmas may help therapists understand the clients' difficulties in changing and therefore improve the quality of the therapeutic relationship.

The notion of implicative dilemma was first presented by Dennis Hinkle, in his dissertation about construct implications (1965), as an ambiguous implication between constructs. Several authors have used that concept since (e.g., Ryle, 1979; Tschudi, 1977) and a line of research has been developed on this topic. Concretely, the Multicenter Dilemma Project (Feixas & Saúl, 2004), has been created in 1999 and counts with the collaboration of research units in Spain, Portugal, the United Kingdom, Italy and South America. This group has conducted research on the prevalence of implicative dilemmas, finding that this is a quite common structure in general population, but significantly more prevalent in psychotherapy clients (Feixas, Saúl, & Ávila-Espada, 2009). Implicative dilemmas have also been found to decrease with psychotherapy, along with the decrease of symptoms (Feixas, Saúl, Winter, & Watson, 2008; Fernandes, 2007; Saúl, 2005). However, we still do not know the processes by which dilemmas are resolved or reduced and the client's movement of personal reconstruction is restarted.

Objectives

The main goal of this project was to develop an explanation of the process of resolution of implicative dilemmas. This was pursued through four more specific objectives: (1) To develop a semi-structured manual for constructivist psychotherapy for implicative dilemmas, with the double purpose of allowing systematic and rigorous research on this topic and, if proved effective, to facilitate the training of therapists in the treatment of implicative dilemmas; (2) to obtain preliminary data on the efficacy of the treatment manual designed; 3) to understand the process of change along personal construct psychotherapy for implicative dilemmas, through the detailed analysis of a series of case studies; and (4) to develop a model of micro-change in moments of reconstruction taking place within constructivist psychotherapy for implicative dilemmas, through a comprehensive analysis of important events identified by clients.

Methodology

Treatment manuals in psychotherapy research. The use of treatment manuals has become a standard in psychotherapy research, as it allows more defined and replicable interventions to be used, making research more controlled and rigorous. Therapeutic manuals also allow an easier dissemination of new treatment proposals and are a useful tool for the training of new therapists (Dobson & Shaw, 1988; Luborsky & DeRubeis, 1984; Wilson, 1996). Although they were initially predominant in behavioral therapies, their use has gradually extended to other schools, and personal construct therapy (PCT) has also begun to adopt this resource (e.g., Winter & Metcalfe, 2005).

However, their extensive use has been criticized by many authors who fear for the establishment of an adequate therapeutic relationship and the attention to client's individual characteristics. For these questions to be attended to, treatment manuals shall be used in a flexible way, and the therapists' skills cannot be replaced by the defined interventions, but need to be assisted by them (Addis & Krasnow, 2000; Addis, Wade, & Hatgis, 1999; Wilson, 1996).

In Chapter 1 we present a manualized treatment proposal that should be used in a flexible and conscious way by therapists familiarized with the personal constructivist assumptions that underlie that model. All techniques are described in detail and illustrations from a clinical case help clarify them. This detailed presentation intends to facilitate its use for therapists' training as well as the replication of the subsequent research that lies on that intervention program.

Case-based research. Evidence based practice has been a growing movement in psychotherapy in the last decades, due to the need to demonstrate the usefulness of psychological treatments (Goodheart, Kazdin, & Sternberg, 2006; Tanenbaum, 2005). However, it has focused mainly in randomized clinical trials (RCTs), due to the general assumption that this is the only empirical method to assess a treatment's value. Although it is a useful tool to confirm effective treatments, it is far from being the only one (Edwards et al., 2004).

In fact, it is usual that an RCT is only implemented after other methods have shown good prospects concerning the treatment's worth (Moras, Telfer, & Barlow, 1993). The predominance of RCTs in psychotherapy research has been criticized by authors who point out the limitations of that kind of studies (e.g., Edwards et al., 2004; Edwards, 2007; Elliott, 2002; Westen, 2005). One

argument is that RCTs can only show that a given treatment has been effective for a majority of clients with a certain condition. That means that something within that treatment has worked, but it doesn't explain why that particular treatment worked for that kind of problem, or what ingredients of the treatment caused change. In addition, it is difficult for clinicians to know if it would work with their particular clients and in the conditions in which they conduct therapy, as the conditions in which those studies are conducted are quite different from the usual circumstances of clinical practice.

Therefore, it has been argued that other methods, closer to the clinical practice, are fundamental for a more complete understanding of treatment proposals. Case-based studies allow for the refinement of treatment models and the theories they derive from. Although they cannot fully attest the efficacy of a treatment in the way RCTs do, case-based studies provide answers to more complex questions about the therapeutic process and make it possible to understand each client's distinctive process. The unique features of a single case can put a theory in question. While statistical methods neglect individual phenomena, case studies can use each case's singularities to improve theory (Edwards et al, 2004; Eels, 2007; Elliott, 2002; Jones, 1993; Stiles, 2007). Case based research tends to be longitudinal in nature, allowing for an intensive analysis of how the therapist's interventions and the client's responses contribute for therapeutic change (Hilliard, 1993).

Elliott (2002) defends the case study as an alternative causal design, when it uses quantitative systematic data collected at different moments along the therapeutic process. This

kind of research can make prove of causality for example when it shows clear effects immediately after intervention or change in long-lasting problems (Elliott, 2002). Also Aveline (2005) defends that case studies are a rich source of ideas about causation and process, which inform practice and research. Thus, case-based research can be a useful tool both for theory building and hypothesis testing (Jones, 1993; Stiles, 2009). As Edwards and colleagues (2004) exclaim, "case-based methods are also empirical" (p.590). Psychotherapy research should take advantage of both approaches, as they are complementary (Caspar, 2007; Eels, 2007; Edwards, 2007).

Chapters 2 and 3 in this work represent case-based research, with that double focus: on one hand, they intend to establish the causality of the treatment used in the changes observed in clients, through the case analysis with Hermeneutic Single Case Efficacy Design (Elliott, 2002); in addition, the cases are compared to the theoretical frame used in this work, PCP, and an explanation of the change process is built through the elaboration of that theory in comparison with the observations from the cases.

In case-based research, generalization is not achieved by case aggregation, but through case by case replication, which can reinforce or help refine the findings from the original case (Edwards et al., 2004; Hilliard, 1993; Stiles, 2009). Thus, we present our first case study, in Chapter 2, as an example of the work done in each of the eight cases analyzed. In Chapter 3, we show the results of its replication in a case series.

Change process research. In Chapter 4 we adopt a more micro-analytic approach, in an effort to understand the specific, in-session events in which change takes place. Thus, we look into client-identified important therapeutic moments, examining them in a comprehensive manner and taking into account the clients', therapists' and observers' perspectives. This study is framed in the significant events paradigm (Elliott, 2010; Greenberg, 1986; Greenberg, 1999; Rice & Greenberg, 1984), a discovery-oriented approach that tries to identify the mechanisms of therapeutic change, through the use of complex designs that allow a detailed examination of the episodes examined.

This line of research has gained importance since its emergence in the 1980's (Rice & Greenberg, 1984), and several methods of analysis have been developed within this logic (Elliott, 1984; Elliott et al., 1994; Greenberg, 2007; Stiles et al, 1990). However, it is still scarcely used, due to the exigency of its methods, which typically consume much time and are technically complex to implement (Elliott, 2010). Our work within this approach uses comprehensive process analysis (Elliott, 1984; Elliott et al., 1994) to study the reconstruction events involved in the resolution of implicative dilemmas.

CHAPTER 1

Personal Construct Therapy for Implicative Dilemmas: A therapeutic manual[1]

Abstract

According to personal construct psychology, people face psychological distress when their (re)construction processes are interrupted, so that they cannot validate nor revise their anticipations. Implicative dilemmas express a blockage in the construct system because one (or more) construct for which change is needed is associated with some core constructs of the subject's identity. In this article we present a therapeutic manual focused on resolving implicative dilemmas, as identified through the repertory grid technique. This is a structured intervention proposal, intended for use in research and psychotherapy training. A more flexible use is recommended for experienced psychotherapists. For a better understanding, the manual is illustrated through a case example.

[1] This work was submitted for publication in co-authorship by Joana Senra, Guillem Feixas and Eugénia Ribeiro

Personal Construct Therapy for Implicative Dilemmas

Personal construct psychology (PCP; Kelly, 1955) is based in the epistemological assumption that there are many possible ways to make sense of the world. No one has a direct line on the truth; rather every individual sees it from his or her personal point of view. For the author, we are "personal scientists," building micro-theories about everything we encounter. Day after day we conduct experiments to test our hypotheses: all behavior is in and of itself an experiment, a question posed in a more or less conscious way. If these experiments confirm our hypotheses, the theory is validated; if the hypotheses are disproven, they must be reformulated, that is, reconstructed. Learning occurs during the successive reconstruction of events. Human development is, then, a continuous and cyclical process of building meanings (Kelly, 1955; Raskin, Weihs, & Morano, 2005).

The construction of personal science is represented by the cycle of experience (Kelly, 1970), comprising five steps: (1) anticipation, when the person makes a prevision about what she is about to encounter, (2) implication, when the person invests in the experiment to be done, (3) encounter, when the individual faces the anticipated event, (4) validation or invalidation, where the experience is associated to the previous hypothesis and the subject verifies if those are confirmed or not, and (5) constructive revision, in which the person reviews the construction system according to the previous assessment: in case of validation, the construction is fortified, in case of invalidation it is revised and an alternative construction is developed (see figure 1).

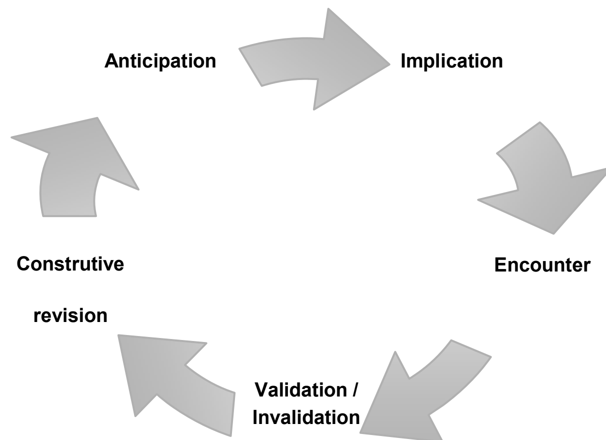

Figure 1. The cycle of experience

Psychological distress arises when the person is not able to successfully complete this cycle. The constructs can be continuously invalidated, but they are not reconstructed and continue to be repeatedly used (Kelly, 1955). The subject's system of constructs can no longer make sense of the events that it faces and might need some help to reframe her experimenting paradigms.

Symptoms are seen as an effort the person is making to give sense to otherwise incomprehensible events. A person whose behavior seems odd to us is probably working to enhance their ability to anticipate events. Only by understanding the individual's personal perspective can we understand the reasons of their behavior, and then try to help them change (Fransella & Dalton, 1990).

Principles of personal construct therapy

Contrary to other therapeutic approaches, which focus on the symptom and on eliminating it, constructivist perspectives focus on looking for the implied meanings in the problem, in other words, on understanding the way the client constructs himself, his problems, and the world (Feixas & Villegas, 2000; Neimeyer, 1993a; Neimeyer & Mahoney, 1995).

For PCP, while the human being is compared to a scientist, the psychotherapist is a scientific advisor, who assists clients in their experiments, giving them control, limiting the number of variables and their complexity (Tschudi, 1977). The tehrapist uses the therapy room as a laboratory (Kelly, 1969a). Therefore, the constructivist assessment is based on a credulous attitude, in which the client is considered the utmost expert on their own construct system. The idea is to try to understand the dimensions used by the person to understand and structure their reality. The therapist needs to understand the point of view from which the client solves their problems. Such a solution, while symptomatic, is neither stupid nor irrational, it is the best they have been able to find up until the moment. However, there is always an alternative form of construction, which may turn out to be more functional and less invalidating (Fransella & Dalton, 1990).

The therapeutic relationship stands on a collaborative attitude, “between experts” (Feixas, 1995; Kelly, 1969a). The therapist has a curious perspective, similar to that of the scientist, in which the client’s constructs are hypotheses that must be explored and tested (Chiari & Nuzzo, 2005). Nevertheless, starting down new paths can leave the client lost and without direction — in

other words, without constructs available to make sense of experience, which constitutes Kelly's (1955) definition of anxiety. It is important to give the client the security of knowing that he is not obligated to abandon his old constructs (Tschudi, 1977).

On a technical level, personal construct therapy encourages the use of all techniques, as long as they are framed within a constructivist comprehension of the client (Kelly, 1969b). Each technique should be subject to the client's approval, as he is the main researcher on the project.

Implicative dilemmas

The notion of implicative dilemma first appeared in the Dennis Hinkle's doctoral dissertation (1965), directed by George Kelly himself. Hinkle explains that "a polar position in a given construct determines polar positions in other constructs" (p. 17). The expression *implicative dilemma* is used in his work to refer to a form of ambiguous implication between constructs, caused by confusion between the contexts in which the constructs are used, or by using the same label for two different constructs.

But Kelly (1969c) had already discussed dilemmas in comparison to the classic idea of *neurotic paradox*. The author defended that when a behavior does not stop, despite not being balanced, or even being destructive, that is because the individual does not have more appropriate alternatives: "within his own system of constructs, the client finds himself faced with a dilemma, not a paradox" (p. 70).

Later, Ryle (1979) defined implicative dilemmas as false dichotomies which restrict the possibilities of choice (for example, "*you are calm or are you sensitive*") or false implications which inhibit change (for example, "*if I am happy then I will be fake"*). Tschudi (1977) had also discussed the notion of implicative dilemma, when the client wants to make a change in a construct, but there is another construct that makes such a movement impossible. The system is blocked, the person is stuck or forced to go in circles.

It is in this same sense that we currently use the expression, taking into account the way in which the subject constructs himself and how he wishes to do so, that is, how he defines his ideal self. These data inform us about the subject's areas of satisfaction (when his "present self" and his "ideal self" are at the same pole of the construct) and of dissatisfaction (when his "present self" and his "ideal self" are at opposite poles). Thus, we are talking about an implicative dilemma when the problem, or an aspect that the subject wishes to change, is strongly associated with positive dimensions of their self-construction. In other words, when we find a strong link between a discrepant construct (in which the subject wants to change) and a congruent construct (in which the client is satisfied with their current position). This association means that the change of pole in a construct also implies change in the other. In this case, the client cannot make the desired change in a given construct because this would also imply an undesired change in the other construct. He/she is stuck between the desire to abandon the problem and the desire to maintain its positive implications (or avoid the negative implications of the desired pole).

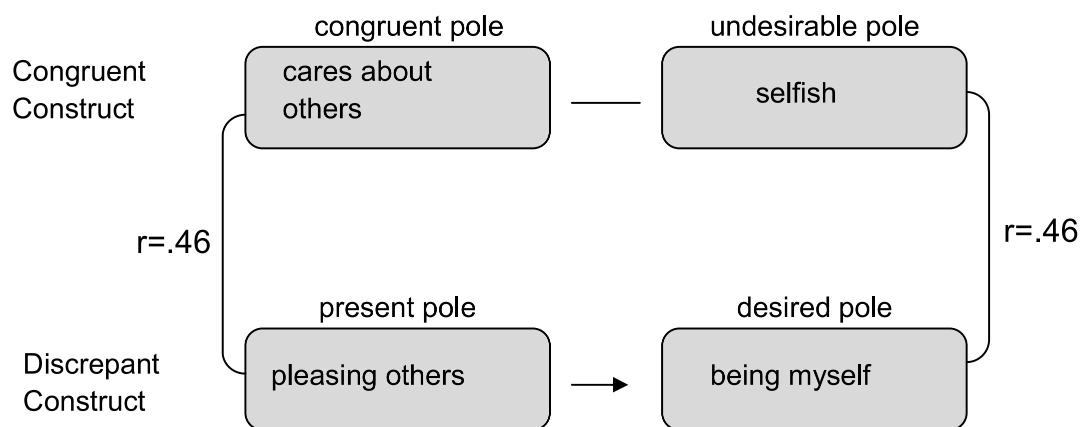

Figure 2. One of Susan's implicative dilemmas

The idea of a dilemma can be better understood by an example, as the one found in the case of Susan, whose therapeutic process provided us with illustrations for this treatment manual. For that client, the dilemma in focus involved the congruent construct "cares about others" *vs* "selfish" and the discrepant construct "pleasing others" *vs* "being myself" (see figure 2). In other words, this client desired to be able to act accordingly to her own wishes instead of her current tendency to do what others wanted. On the other hand, she saw herself as someone who cared about other people and was satisfied with that characteristic of hers. But the grid analysis provides us with another piece of information: these two constructs correlate, in other words, they are associated in the sense that the desired change in the discrepant construct would also imply a change, in this case undesired, in the congruent construct. This is why it is called an "implicative dilemma"; the desired change entails negative implications and thus brings about a dilemma that we could formulate in the following way: "if I stop pleasing others and start to be myself, I will

also stop caring about others and become selfish." Or the opposite: "If I want to avoid being selfish, I should continue to please others". However, these dilemmas cannot always be verbally expressed by the client. In fact, it is possible that she has never even thought about it. It is part of the way she has structured her self and her interpersonal word, which does not mean that she is aware of it.

Attempting to bring about a direct change in clients that find themselves in this situation would be not only difficult but also undesirable. The client, wisely, will resist change, as a way of protecting her identity from massive invalidation (Sánchez & Feixas, 2001). Instead of fighting against the so-called "resistance", when detecting dilemmas and working with them we validate the subject's sense of self-protection, and we can improve the quality of the therapeutic relationship, thereby obtaining a better point of departure to seek change (Feixas, Ávila, Saúl, & Sánchez, 2001). By recognizing the coherence of the client's position, we protect her dignity, by not using a label of deficit or incompetence on her part. On the other hand, if we know what aspects prevent the client from changing, we will finally be able to stop fighting against her, and actually fight alongside her to reach her goals in a way that is acceptable to her.

The notion of implicative dilemma is cross-sectional with respect to clinical diagnosis. It refers to a particular cognitive structure which may be found in clients presenting with different diagnoses. The content (or label) of the constructs involved in the dilemmas vary across subjects and diagnostic categories.

The Multi-center Dilemma Project. In 1999 a research project was created, with the eventual participation of different research centers in Spain, Portugal, the United Kingdom, Italy and South America. Its purpose was to study the role of dilemmas in different health problems (physical and mental), as well as to develop and implement therapeutic methods focused on resolving such dilemmas (Feixas & Saúl, 2004). The study of Feixas, Saul & Ávila-Espada (2009) indicates that dilemmas can be identified in a third (34%) of subjects in a non clinical sample, while in a clinical sample (people seeking psychotherapy) (52.4%) of the subjects presented dilemmas. Other studies have been conducted with patients fitting into diverse diagnostic categories, all of them finding a higher proportion of implicative dilemmas in the clinical group as compared to the control group: fibromyalgia (76.7% vs. 46.7%, Compañ, Feixas, Varlotta, Torres, Aguilar, Dada, & Saúl, in press), bulimia nervosa (71.9% vs. 18.8%, Feixas, Montebruno, Dada, Del Castillo & Compañ, in press); and functional digestive disorders (68% vs. 39%; Benasayag et al, 2010). Research also indicates that clients who do not present dilemmas at the beginning of therapy do not tend to exhibit them at the end of therapy either, while more than two thirds of the sample that presented dilemmas at the beginning of therapy did not have them at the end. These data suggest that psychotherapy, even when not specifically oriented toward resolving dilemmas, brings about a significant reduction in the number of implicative dilemmas (Feixas, Saúl, Winter, & Watson, 2008; Saúl, 2005). The Multi-center Dilemma Project is being developed at different working levels, including researchers training, creating a grid database or studying the frequency of dilemmas in specific populations. But "the

last step of the project is to develop a protocol for intervening in implicative dilemmas" (Saúl, 2005, p. 199). The proposal we present in this paper is framed within this last objective.

Psychotherapeutic manuals

The use of therapeutic manuals has been considered a small revolution in psychotherapy research (Luborsky & DeRubeis, 1984), with a dramatic increase in their development and use. In fact, manualized training has become a standard in psychotherapy research and is also becoming one in therapists' training (Beutler, 1999; Dobson & Shaw, 1988). According to Moras (1993), therapeutic manuals are very useful in the training of novice therapists, as long as the manual in use presents sufficient quality and specificity.

As the first manuals appeared in behavioral therapies, they traditionally reflected some of the basic principles of that approach. For instance, techniques and procedures were supposed to be executed with precision and were typically more valued than therapist and relationship variables. Nevertheless, there has been a growing number of manuals developed in other therapeutic approaches, such as interpersonal (e.g., Klerman, Weissman, Rounsaville & Chevron, 1984) or systemic (e.g., Jones & Asen, 2000) therapies. The more recent development of non-behavioral therapeutic manuals introduced some flexibility in the treatment guidelines (Dobson & Shaw, 1988).

The use of therapeutic manuals has allowed for the development of a more controlled and sophisticated psychotherapy research, as it defines specific and replicable treatments to be

studied. They also facilitate the training and supervision of therapists in the type(s) of therapy in study and the monitoring of adherence to the model, thus reducing the variability in treatment administration within a group. To the clinical setting, the manuals' structure and time-limit bring an increased focus to therapeutic work. They also potentiate the dissemination of new therapeutic models and the therapists' acquisition of new competences. In addition, manualized treatments can be revised according to research results, improving their quality and functioning as a vehicle of communication between psychotherapy research, therapist's training and clinical practice (Dobson & Shaw, 1988; Kazdin, 1994; Wilson, 1996).

However, the growth of the manual movement has not been pacific. The idea of a manual is conflicting with a more traditional view of the therapist and therapeutic process, and many clinicians and researchers criticized the use of manuals (Addis & Krasnow, 2000). For instance, it has been argued that the strict adherence to a manual can impair the therapeutic relationship, which would also endanger the therapeutic outcome. However, the research has pointed to the possibility of using a therapeutic manual and still forming a strong therapeutic alliance (Addis, Wade & Hatgis, 1999). Another criticism is that manuals neglect the individual case conceptualization, proposing a same treatment to all cases in a given category (Wilson, 1996; Addis *et al*., 1999; Addis & Krasnow, 2000). In order to avoid overgeneralizations, therapists using therapeutic manuals should seek a balance between clinical flexibility and keeping with the protocol. That was in fact the view of most therapists in a study by Najavits et al. (2004), after receiving intensive training and achieving mastery in one of several different treatment manuals.

They perceived the treatment quite positively, but intended to use it in their practice with some modifications, mostly adding some more sessions to the original protocols. Other studies indicate that clinicians are interested and have a positive attitude towards treatment manuals although they do not tend to use them in their “pure” form (Cook, Biyanova & Coyne, 2009; Najavits et al., 2000).

In a personal construct psychology’s perspective, one could initially say that the theory’s focus on personal meaning drives it apart from the development and use of a previously determined intervention proposal. Yet, the current need to demonstrate the efficacy of therapeutic models and to communicate with a wider community make the manual an almost mandatory element of therapeutic practice and psychotherapy research. As Watson and Winter (2005) argue, “those dodoesque theorists who decline the opportunity to engage in research that demonstrates the validity of their espoused therapeutic approach are in danger of extinction” (p. 335).

In this sense, some steps are already noticeable in the direction of manualizing and developing outcome and process research in PCP. For example, Winter and Metcalfe (2005) have developed a six-session long manual of personal construct psychotherapy for agoraphobia. Indeed, the use of therapeutic manuals is not contradictory with the personal constructivist approach. It should not be forgotten that George Kelly himself originally conceived PCP (1955) as a therapeutic manual, which he later reformulated as he felt the need to make the principles underlying his practice explicit in a detailed manner (Kelly, 1955).

In conclusion, although they do present limitations, therapeutic manuals can be valuable tools for psychotherapy research, therapist's training and clinical practice (Kazdin, 1994; Strupp, 1997). The advantages found for psychotherapy research suggest that the development of a therapeutic manual may be an important step for a deeper study of implicative dilemmas, their therapeutic implications and resolution processes.

Objectives of the manual

Taking into account the preliminary data of the Multi-center Dilemma Project (see above), it seems clear that dilemmas, while not exclusive to the clinical population, are more prevalent in clinical cases, and they tend to disappear or be reduced in number due to the effect of psychotherapy, in parallel with the reduction in symptoms. These data have been obtained with psychological therapies not oriented toward dilemma resolution, leading us to the questions: what would be the effects of a psychotherapy specifically oriented toward solving those dilemmas? Would a more direct approach toward dilemma resolution be more effective? What will the relationship be between dilemma resolution and symptomology? What difficulties can be expected from a psychotherapy focused on implicative dilemmas? Would such an approach favor the therapeutic relation?

To answer these questions, it was necessary to create a brief and semi-structured intervention manual, to facilitate the training of therapists in this type of work as well as studying the process and results of this therapy. Although PCP defends technical eclecticism (as long as a theoretical coherence is respected), for research effects an intervention guide is needed, so that it

may be applied in a controlled manner, with greater structure and definition. This may also be an advantage for the training of new therapists, who can benefit from structure in their psychotherapeutic practice.

This manual is based on the original proposal of Feixas and Saúl (2000), respecting its basic structure. Some case reports have presented and illustrated the application of this approach (Feixas, Hermosilla, Compañ & Dada, 2009; Feixas & Saúl, 2005; Fernandes, 2007). This early version included a high number of possible therapeutic strategies to be freely selected and organized by the therapists. A working group was later created with the purpose of organizing a sequence of strategies that would allow a greater uniformity among the therapeutic applications of the work with dilemmas. The techniques were refined and combined into a manual which will be presented here in a more detailed way. A previous version of this proposal was published in Spanish (Author, 2007). This paper presents a revised version of the manual, taking into account the experience gathered from its first applications to clinical practice at the University of Minho, from which the case that provided our illustrations is a representative.

Range of applicability. This manual is meant for use with adult clients of psychotherapy who present implicative dilemmas as identified with the repertory grid technique. Following the principles of PCP and in keeping with the interest of fostering a good therapeutic alliance, the client must be interested in working on those dilemmas, an aspect which can be agreed upon at different points in the therapy protocol. The client's lack of interest in working on dilemmas requires suspending the application of the protocol and focusing the therapy on other topics,

which the client approves. The techniques proposed in this manual are not exclusive to the work on implicative dilemmas and can be used with clients that do not present that structure or do not find it important, by changing the focus from the constructs involved in the dilemma to other constructs relevant to the person's concerns.

This therapeutic manual can be applied to different types of psychological problems or disorders. In some more serious mental disorders, such as personality disorders or problems with a chronic history, this proposal should probably be included as a part of a broader therapeutic process. In fact, some clinical situations could not easily be thoroughly treated with a short and specific protocol such as this one. Clients in crisis situations are not likely to qualify for this kind of therapy either, as it focuses on a concrete cognitive aspect that is not always immediately apparent or prioritary to the client. Thus, it is expected that in a situation of crisis, the client would not be ready for analyzing her dilemmatic structure, at least not before solving more pragmatic and urgent matters.

Recommendations

The application of this protocol must follow constructivist principles in terms of the therapeutic relationship, evaluation and conceptualization of the client's problems. Therapists should be familiar with constructivist theories and share their basic assumptions. Clinical supervision from a constructivist perspective is recommended for those new to that approach. The manual is designed for sixteen one-hour sessions, with a weekly frequency, except for phase 4 — alternative experimentation — which is planned for two sessions per week. A flexible use of

the manual is advised, so that the client's time is respected. In that sense, the number of sessions anticipated for each stage can be adapted whenever necessary. In the same sense, in cases where a given strategy is not accepted by the client or does not seem to work in the form described in the manual, the therapist could make the option of adapting it to the client or even skipping it, moving to the next step in the protocol.

The therapeutic manual

The therapy protocol follows a structure of 5 stages, as showed in table 1: (1) initial assessment, (2) reformulating the problem as a personal dilemma, (3) dilemma elaboration, (4) alternative experimentation and (5) treatment termination. Re-assessment moments are recommended not only for research purposes, but also for monitoring of the client's progress. It is based on the information provided by those re-assessments as well as clinical judgment that a decision should be made about when to terminate therapy: after stage 3, after stage 4 or later on, after further therapeutic work.

Table 1.

An overview of Personal Construct Therapy for Implicative Dilemmas

Stage	*Sessions*	*Objectives*	**Strategies**
1.Initial assessment	1-3	Establishing the therapeutic relationship	Clinical interview
		Definining therapeutic goals	Elaborating the complaint
		Assessing the client's self construction	Self-characterization
		Identifying implicative dilemmas	Repertory Grid Technique
2.Reformulating the problem as a personal dilemma	4	Co-constructing a perspective of the client's problem	Giving feedback of the assessment results to the client
		Reframing the problem in terms of a dilemma	Presenting the dilemma to the client
		Defining the therapeutic approach to be adopted	Negotiating the therapeutic approach
Symptoms and constructions re-assessment			
3.Dilemma elaboration	5-10	Understanding the super ordinate and subordinate implications of the constructs involved in the dilemma	Laddering
			Pyramiding
		Elaborating the meaning and impact of the dilemma in the client's life	Tschudi's ABC
			Controlled elaboration of experience in dilemmatic episodes
		Understanding the relational implications of the dilemma	Historical reconstruction of the dilemma
		Developing a historical perspective of the genesis	Developing alternatives to the dilemma

		and evolution of the dilemma Developing and expanding alternatives to the dilemma Integrating the experience of the dilemma with the aspects worked on in therapy up until the moment	Writing the dilemma's story
		Symptoms and constructions re-assessment	
4.Alternative experimentation	11-15	Elaborating alternatives to the dilemma Assisted experimentation with alternative attitudes and behaviors Reflection on the alternative experimentation's experience, meaning and implications	Fixed role therapy of the resolved dilemma Letter to the fixed role character
		Symptoms and constructions re-assessment	
5.Treatment termination	16	Evaluating and consolidating the benefits of therapy Concluding the therapeutic process	Review of the therapeutic process Evaluation of the progress from the client's and the therapist's perspective Projecting the new constructions into the future

Each therapeutic technique proposed is explained hereafter, aided by illustrations from a clinical case. The purpose of the clinical vignettes included in this paper is to promote a better understanding of how techniques can be used in therapeutic practice, rather than to present a case study. Hence, we only provide the information about the client and her problems that is necessary to make the examples understandable. Session excerpts were edited for confidentiality, space economy and clarity.

Susan (as we shall call her here) came to therapy feeling lost and stuck in time, looking for increased self-knowledge and self-understanding. She had just quit a job and got back to studying and felt some difficulty in dealing with that decision. She received 20 sessions of psychotherapy following this manual, going through all the previewed stages.

Phase 1 - Initial Assessment

Therapy begins by the establishment of a therapeutic relationship, as well as gathering and exploring the client's request for help. This first phase counts with three sessions, in which the initial assessment is done, including the clinical interview, symptomathology assessment, and the repertory grid technique, which allows the identification of implicative dilemmas. In the event that no such dilemmas are found, this protocol cannot be applied.

Elaborating the complaint. The therapeutic process usually begins with the development of a request for help, or something equivalent to a demand (Kelly, 1955). According to Villegas (1996), this demand tends to present in psychotherapy as similar to the request for medical help, i. e, the client often assumes the passive position of a patient waiting for an external entity to cure him/her. When this is the case, it is necessary to reformulate the request as a preliminary condition for psychotherapeutic work. Thus, the therapist should listen to the client's objective

and assess its adequacy for the psychotherapeutic context. When necessary, the complaint could be renegotiated in terms of a shared responsibility for change. The final request for help should be stated in personal psychological terms that allow for further elaboration and for a clear work openly geared to psychological dimensions of the client, such as the work with dilemmas. In Susan's case, for example, the goal for therapy was defined as "getting to know myself, understanding who I am and what I want".

Self-characterization. "If you do not know what is wrong with a person, ask him; he may tell you" (Kelly, 1955, p. 241). The purpose of the self-characterization technique is to understand the client's world from his own perspective. As the author describes it, it is a simple but effective way to achieve a clinical understanding of clients. This task promotes the client's reflection and urges him to choose how to present himself in therapy: what themes to highlight, what positive aspects to value and what difficulties to uncover.

It is requested from the client with the following instructions (adapted from Kelly, 1955):

> I would like you to write a description of Susan, as if it was written by a friend who knew her very well, perhaps better than anyone really knows her. Write it in the third person. For example, begin with: Susan is…

When analyzing the resulting text, the therapist should pay attention to a number of aspects, such as thematic content and organization (What areas of his life did the client highlight?

What comes first, what is left for the end?), emerging constructs (what dimensions are chosen by the client to speak of herself?), significant others (who does the client refer to? How does she relate to these people?), etc. A more developed presentation of the self-characterization technique can be found in Kelly's work (1955), as in subsequent literature in the field (e.g., Neimeyer, 1993b). The result can be something as seen in Susan's case:

> Susan is an extreme person. "Yes or no". All or nothing. … She's full of contradictions and constantly sees herself in a dilemma between what she wants and what she should do. She values too much other people's opinions and lets them prevail over her own opinion. She is a thorough person, a fighter, determined and hard-working. However, she has an extreme need for approval … . What moves her are not material things, it is the feeling of belonging, of doing well to others and of self-fulfillment. She has always tried to please others, leaving pleasing herself to a second plan. She's a sincere person, trusting and inspiring, and she reflects the feeling that she is someone you can count on. …
>
> At present, she assumes a more selfish attitude that makes her more distant, more "disconnected" from the world… more absent. … Right now, she resembles a soldier fighting with all her strengths in an already long battle, where she starts to loose hope. However, there is something in her that still believes that victory is possible, that still resists and doesn't let her give up.

Dilemma Identification – Repertory Grid Technique. Implicative dilemmas can be identified in the clinical situation in different ways, but Guillem Feixas' team (Feixas et al., 2001; Feixas & Saúl, 2005; Feixas, Saúl, & Avila-Espada, 2009) has developed a structured method based on the Repertory Grid Technique (Feixas & Cornejo, 2002; Fransella, Bell, & Bannister, 2004).

This structured interview has evolved since Kelly's (1955) first proposal and has been featured in a great number of research studies. In its most usual version, it reveals a sample of the individual's personal constructs and its application to the closest people of her interpersonal environment. It provides the clinician with some relevant dimensions the client uses to understand people and to define him/herself, as well as some structural measures of his construing activity.

Dilemmas are detected through the identification of congruent and discrepant constructs: the dilemma occurs when there is an association (Pearson's $r > 0.20$ for clinical purposes, $r > 0.35$, a more strict criterium, for research) between a congruent construct and a discrepant one, in the sense that if the desired change occurred in the discrepant construct, an undesired change of pole would also happen in the congruent one. The *GRIDCOR v. 4.0* (Feixas & Cornejo, 2002) software provides many data of interest from the repertory grid, among which the correlations between all the constructs, the identification of discrepant constructs and the signaling of the existing implicative dilemmas. In our case example, the repertory grid revealed 7 implicative dilemmas, involving 3 discrepant constructs: "fears frustration vs tolerates error" (4 dilemmas),

“tendency to please others vs being myself” (2 dilemmas) and “pessimistic vs positive” (1 dilemma).

When identifying the client’s implicative dilemmas, it is useful to pay attention to the elements in the grid that better represent this impasse – the dilemma’s prototypical figures (Feixas & Saúl, 2005). A prototypical figure is someone who, like the client, is at the present and congruent poles of the involved constructs (e.g., “pleasing others” and “cares about others”, in figure 2) or, on the contrary, someone who is at the position where the client wishes but also fears to be, the desired and undesirable poles (e.g., “being myself” and “selfish”). These elements help to demonstrate the dilemma to the client and to keep it concrete during the exploration of the involved constructs. Also helpful for the therapeutic process is the identification of alternative figures, those who represent an exception to the dilemma as they achieve the combination of the desired pole in the discrepant construct with the congruent pole in the congruent construct (e.g., being myself and cares about others). They represent hope as they prove it is possible to achieve the client’s goals.

Phase 2 - Reformulating the problem in terms of a dilemma

Stating the presenting problem as a dilemma implies offering the client a major reconceptualization of her concerns and difficulties in achieving change. Thus, although this intervention is proposed here as a first step in a sequence aimed at developing a bigger understanding and reconstruction of the dilemmatic structure, it can by itself promote significant change in some clients. However, when this reformulation is not accepted by the client, as it does

not make sense for her or it is not seen as important enough to be the focus of therapy, this psychotherapy proposal should be abandoned in favor of a kind of work that better meets the client's needs. This way, presenting the dilemma to the client is the critical stage, where the decision is made about whether or not the present constructivist intervention for implicative dilemmas is to be used with this particular client, at this particular time.

This stage is planned for a single session, the fourth of the protocol. It consists of giving the client a summary of the results of the initial assessment, focusing especially on presenting the dilemma to be worked on.

Presenting the dilemmas to the client. The fourth session is dedicated to giving the client feedback about the results of the initial assessment and sharing the therapist's conceptualization of her problems. After dealing with the results of symptoms assessment and the integrated perception of the problem's manifestations and development, attention shall be centered on the client's repertory grid, sharing the most relevant measures found and their interpretation. Finally, a considerable amount of time should be reserved to the presentation of the implicative dilemma(s) found, through the following procedure:

Choosing the dilemmas to work on. This step is only pertinent when there are more than one discrepant construct implied in dilemmas; if this is not the case, proceed directly to the next one. Start by presenting the different discrepant constructs involved in dilemmas to the client. Then, ask her how important each one of them is or to what extent does she want to change in that dimension, and what is its relevance to the current problem or the reason for her consultation.

Finally, ask the client if she thinks it would be useful to work on these dimensions in therapy; if she says “yes” to more than one, ask which one is more important or which one she would like to start with.

Presentation of the dilemma based on the grid’s elements. Having selected a discrepant construct, explore the meaning of each of its poles for the client. Also explore other constructs that relate to this one. Then comment on the prototypical figure’s scores in the discrepant and congruent constructs to show the pattern of implication. At last, propose focusing therapy on the dilemma. This procedure can be seen in Susan’s example, next:

> Therapist – [showing the client’s grid] We can see here a group of aspects in which what you are and what you want to be are significantly different, right? For instance, you are extremist and you would like to be balanced; […] You have the tendency to please others and you want to ‘be yourself’; […] you fear frustration and you want to tolerate error better; You are pessimistic and want to become more positive.
>
> [Client nods affirmatively]
>
> T – I’d like to talk a little more about these last three dimensions. [repeats the three constructs involved in dilemmas] I’d like you to choose, between them, the one you find more important for us to work on. […]
>
> C – The first one.
>
> T – The first one. Tendency to please others versus ‘being yourself’.

C – Yeah. Because if I'm aware of how I am it will be easier to manage everything else. I need to find myself. [laugh]

T – Mhm-mhm. […] Being yourself would be the most important thing. That is, leaving the tendency to please others.

C – Exactly.

T – Mhm-mhm. The person you chose for the grid because you didn't like her very much, Maggie, from work, […] she's an example of what you don't want to be, really. […] And she is someone you said was totally herself.

C – Oh, she is! Too much… [laugh]

T- But she works as little as possible, she's "me above all things", she's selfish, she's very impulsive…

C - [nods affirmatively] Oh, that's how I see her! Totally…

T – So she has one characteristic […] that you wish you'd also have, but there's a bunch of them that you hate! [laugh]

C – Yes, no one is totally bad, right? We all have good and bad qualities...

T – Exactly. But this is like a pack…

C – Exactly.

T – A pack that you don't like. You want one item, but not the rest of them.

C – Yes, the rest of them I'll pass, I'll pass…

T – […] The pack you have at present is just the opposite. You're someone who works hard, who is careful, emotional, determined, but with some aspects you're not happy with.

One of those is this one, in which you are the opposite of Maggie: being concerned about pleasing others.

C – Exactly.

T – This shows a little […] that some things seem to bring others with them, right?

C – Oh, yeah, yeah.

T – […] I would say you are facing a dilemma, between the aspects you want to change and the ones you don't want to change.

C – Mhm-mhm.

T – […] It's not always easy to make changes, and it's normal that you feel that difficulty, that you might feel lost and that you haven't been able to make that change by yourself, because there is a strong association between the things you want to change and some things you don't want to change.

C – Mhm-mhm. So I'm normal? [laugh]

T – You are normal! If, in order to be yourself, you would have to be selfish and stop caring about others… you stop right there! Right?

C – Right… [Client nods affirmatively]

[…]

T – This idea of a dilemma between wanting to be more yourself and being afraid of becoming a little more selfish with it… does it make sense to you?

C – Yes.

T – Do you think it's relevant to spend our next sessions working on this?

C – Yes. [laugh]

T – We'll work on that, then. We'll try to better understand these dimensions and […] then analyze concrete situations in your life, see how they apply, how we can change them…

C – Mhm-mhm. Ok.

Phase 3 - Dilemma Elaboration

The constructs involved in the client's primary dilemma are further explored in approximately five sessions, through the use of several strategies both in session and in homework assignments. The general objective is to increase the person's understanding of the dilemma, so that she can identify its influence on specific life situations and, progressively, envisage alternative constructions, in which the impasse is not felt.

Laddering. This technique was developed by Hinkle (1965) with the goal of accessing the super- ordinate constructs of a given construct of a client or research subject. The term *laddering* was later proposed by Bannister and Mair (1968). Its flexibility, simplicity and ability to access the person's more central constructs has given this method great popularity. Additionally, it also tends to be very interesting for the subject who responds, as it gives him a greater understanding of his own psychological processes.

Neimeyer, Anderson, and Stockton (2001) carried out the first large scale study (n=103) intended to assess the construct validity of the laddering technique as a measure of the

hierarchical structure of the system of constructs, obtaining support to the assumption that the laddering technique effectively reaches super-ordinate or core dimensions of personal meaning systems.

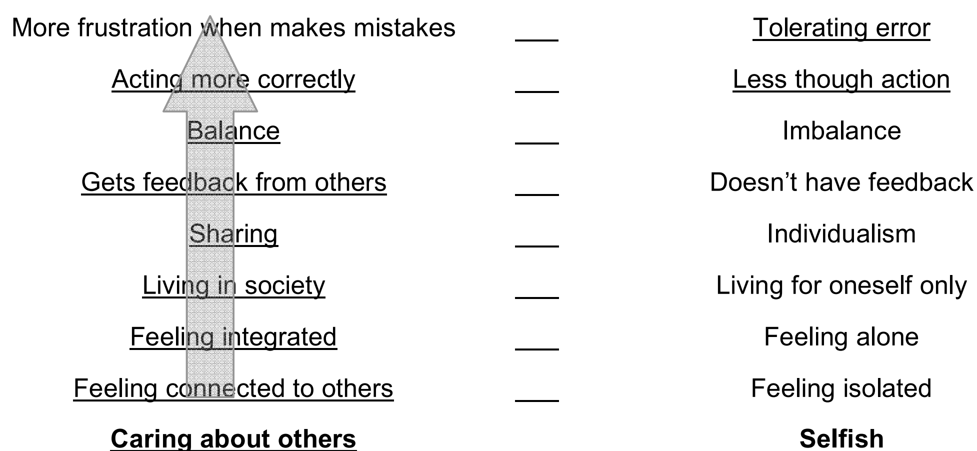

Figure 3. Susan's congruent construct laddering

Procedure. Take the discrepant construct and write it down at the center of a piece of paper, underlining the desired pole. Next, ask the client why that pole is preferable to the other (present) pole. The answer to that question makes up the next rung of the ladder; then, it is necessary to ask for the opposite pole – the contrast to this advantage. Considering the two poles, ask which one the person prefers, and underline it. Once again, ask why that pole is preferable and what would the opposite of that advantage be. This is another rung in the ladder. This

sequence continues until the person is not able to explain why she prefers a given pole, or only gives small variations to the answers given at previous levels. The result is a hierarchy of several layers of personal meanings, such as in figure 3. This procedure is repeated for the congruent construct. In Susan's case, laddering up from the congruent construct took the following form:

> T- So, today I'd like to suggest that we work on this dimension: you care about others, [writes] which is the opposite of being selfish. So, between these two, which one do you prefer?
>
> C – Caring about others is important! Very important!
>
> T – Ok. Why? Why is it important?
>
> C –I think it makes us feel good. It makes us feel useful. It makes me feel connected to other people. We have some connection.
>
> T – Mhm-mhm. Ok. Feeling connected to others.
>
> C – That's it. We don't feel… so alone. […]
>
> T – Ok. So the opposite would be feeling alone, is that it? […]
>
> C – No, the opposite of feeling…
>
> T – Connected to others…
>
> C – …is feeling isolated.
>
> T – Mhm-mhm. [writes] Ok. So, between feeling isolated and feeling connected to others, you prefer…

C – Feeling connected to others. That’s an easy one!

T – Mhm-mhm. Someone who feels connected to others… what advantages does she have?

C – I think we always… grow more! We get to know ourselves a little more and to know the others, and then it’s like… I’m not so different after all!

T – Mhm-mhm. […] There are several ideas coming up here, right? You grow, you get to know more of yourself and others, you feel you are like others…

C – Yeah, I think… more integrated maybe. That’s kind of it. […]

T – Mhm-mhm. [writes] Not feeling integrated is feeling… how?

C – Lonely.

T – Ok. Do you prefer feeling integrated than feeling lonely?

C - Oh, yeah, no doubt.

T – Ok. Why is it important for you to feel integrated?

C – It makes me feel good. I don’t feel lonely, that’s the thing, and I don’t feel lonely, I don’t live only for myself… or in my little world. I live in society.

T – Mhm-mhm. Ok, do you prefer to live in society or to live only for yourself?

C _ In society. But sometimes it’s important to… have a while just for us. But that’s what I have some difficulty managing…

T – Is there a doubt here between both sides, or do you clearly prefer society?

C – Yes, yes, living in society! […]

T – Why is it better to live in society than living only for yourself?

C – I like to share the good and the bad things. If I live only to myself I won't have anyone to share with. And that makes me feel sad. I like it when I have some news to tell, I have the need to find someone I feel connected to, to tell it. To smile… Alone it's not fun! Its strange…

T – Ok. To share. And not sharing is… what?

C – Not sharing. I think it's individualism to its extreme.[…]

T – Mhm-mhm. So do you prefer to share or to be individualist?

C – To share.

T – Why?

C – Because it makes me feel good.

[Here the client's answer is a report of an emotion that confirms the validation involved in the preferred pole, but does not really represent a move in the ladder, so the therapist includes this answer in a new effort to move up the ladder.]

T – Why does it make you feel good?

C – Because when I have something to share it's good to share it with a smile and to get a smile back! Or to hear "I'm happy for you, you did it, congratulations, another goal attained…" When it's something sad it's also good because we have the tendency to end up seeing everything very dark, and there's always someone to tell us "ok, this is just a phase, it will be over. It went wrong this time, but you can try again".

T – Mhm-mhm. So I see it's important for you to share because you get something back from others. […] Not getting this feedback from others is…?

C– It’s living alone. For me it’s sad… […] For me it’s imbalance. It’s decontextualization. It’s…

T – Mhm-mhm. So […] it’s important for you to get feedback from others because that helps to your balance. Is that what you said?

C – Yes. It helps to balance things.

T – Mhm-mhm. Do you prefer balance or imbalance?

C – Balance. Balance.

T – Why does balance make you feel good?

C – [laugh] Eh… Why? […] I think with balance we do things more correctly than with imbalance. With imbalance it’s like “I’m going to do it that way, and that way only” and sometimes it can be the most difficult way and it may not work out, and if we had thought a little more… We would have found another way… simpler and with better results.

T – Ok. So balance allows you to act more correctly. And what would be the opposite to acting correctly?

C – […] Not thinking so much! It’s more impulsive. Yeah, a little… a little by chance! […] It’s less thought through; we don’t have so many chances as we do when we are balanced!

T – Between this less thought through action, which gets right or not by chance, and acting more correctly, which one do you prefer?

C – Acting more correctly. But I confess I think the less thought through action is also necessary. If you act correctly only because you’re supposed to, it limits you. It takes away your freedom. When an action is less thought through, it might not be correct but sometimes it even gives a sense of relief: it is human to make mistakes! And I think when

you make a great effort to act correctly you lose a little that sense that it is human to make mistakes. It’s more frustrating.

T – It’s more frustrating when you always act correctly?

C – It could be. When you fail, it is... So much effort and then…

T – So sometimes you prefer a less thought action…

C - […] It can’t be 100% acting correctly. Acting correctly is good but sometimes we need some little mistakes!

T - […] It’s interesting this discussion we got into!

C – I’m not balanced, I know that. But sometimes I like that! Although I try to be balanced… until a while ago it was very frustrating when I failed because I went to the extreme. […] Then, I got to think it over: other people make mistakes too, why can’t I? That’s why I don’t want to be that perfect girl who does everything right… that’s what everyone expects from me… I can’t always get it right. I don’t want to always get it right, because I’m not perfect. I don’t want to be perfect. No one is, and I think it’s fair not to, if other people can make mistakes, so can I! They don’t have to tell me “oh, you did that, it’s not like you!”. I don’t like that!

T – Ok. So acting correctly, doing the right thing, has this disadvantage of trying to be perfect, is that it?

C – I guess, in a way…

T – While acting in a less thought way might have an advantage in that aspect, that is to tolerate mistakes better.

C – Yes. In the end that’s it.

Discuss the exercise with the client: how did she experience it, aspects that caught her attention, discoveries made… Discuss aspects that the therapist has noted, too: doubts, peculiar constructs, change of preferred pole in a construct hierarchy, etc.

Repeat the whole procedure with the congruent construct. At the end, comment on subordinate or superordinate constructs repeated in the two ladderings.

Pyramiding. In order to obtain the subordinate constructs of a given dimension, Bannister and Mair (1968) propose "laddering down", as a parallel to the previous technique. This method was later described in greater detail by Landfield (1971) who called it pyramiding. It is based in the same principles as laddering and can be seen as complementary to that technique aimed at the exploration of the lower part of the construct's hierarchy, that is, the more concrete dimensions.

Procedure. Take the discrepant construct and request that the client thinks of concrete aspects of each pole, asking for example: "How can you tell that someone cares about others?"; "What is someone that cares about others like?"; "How do people know that you have the tendency to please others?". For each answer, ask about the opposite pole. It is common that several subordinate constructs come up, which will give the shape to the pyramid. However, we recommend a flexible use of the technique, in which it is possible to have a simple ladder as well as a pyramid of three or four branches (more would probably be difficult to manage). Continue

exploring the branch(es) of the pyramid that seem important to the client and/or those which are most related to the problem, asking again for concrete aspects, and their opposites. Continue this process until the answers are sufficiently concrete, i.e., behavioral or sensorial, and it no longer makes sense to seek subordinate constructs. The result is a descending hierarchy of personal meanings, such as in figure 4.

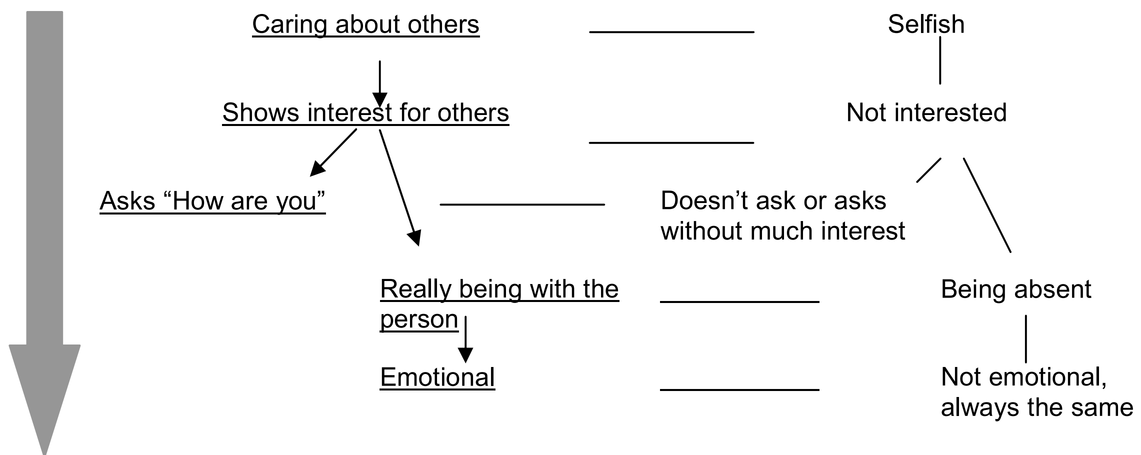

Figure 4. Susan's congruent construct pyramiding

Tschudi's ABC. From a Kellyan perspective, all behavior is a question. Tschudi (1977) defends that symptoms often have to do with poorly formulated questions, situations in which one or more constructs prevent the person from changing. His ABC technique has the objective of helping people clarify their goals and pose more direct questions. It originally focuses on

implicative dilemmas and it is a relatively simple way of representing the impasse. It also allows for elicitating other implications, often more concrete and pragmatic, not found through the repertory grid. When the person understands all the aspects involved in the dilemma she is in a better condition to decide whether or not she wants to change.

Procedure. In this manual, this is proposed as an intersession assignment. The client is given a piece of paper with a table representing the ABC. On top is her discrepant construct (A). With that dimension in mind, she is invited to clarify why her present position in this construct is considered a problem, i.e, what are the advantages of moving towards the desired pole, and what are the disadvantages of the present pole. This will bring out the constructs B. What prevents the person from changing? To obtain the C construct(s), the client shall think about the advantages that the present pole could have, and also the disadvantages of the desired pole.

On receiving the client's completed ABC, specify the goal of therapy according to this exercise: finding other ways of maintaining the advantages of the problem other than the problem/symptom itself, or a way of combining the desired pole with the advantages of the problem. For the application of this technique in the case of Susan, see figure 5.

A:	Tendency to please others	Being myself
B:	Makes me annihilate myself Makes me suspicious about why other people like me Constant effort	Allows me to express my opinions with confidence Feeling free Liking me more and showing it
C:	Easier relationships with others Being accepted by more people	More confrontation with others Less friends Risk of selfishness/ egocentrism

Figure 5. Tschudi's ABC in Susan's case

Controlled elaboration of experience in dilemmatic episodes. In Kelly's work (1955), controlled elaboration refers to the conjoint work of therapist and client to promote movement in the later's construction system. Feixas & Saul (2005) propose the pursuit of this goal through the therapeutic exploration of the cycle of experience. Derived from the experience corollary (Kelly, 1955), the cycle (see figure 1) represents the process of human construction, unfolding from anticipating an event and getting implicated in that anticipation to encountering the event, and validating or not the anticipation made, which leads to a revision of our construction of that event, either to confirm it or to change it. It is a continuously ongoing process through which we give meaning to our moment-to-moment experience.

In this technique, the client's experience of problematic events is analyzed step by step along the experience cycle, in order to help the client to become aware of what hypothesis she is testing and what results she is getting, as well as to consider alternative constructions that could achieve better results. Our constructions develop in relation with others, who serve as a source of inspiration for the elaboration of our theories and as samples for experimenting and testing them. Hence, the inclusion of the client's construction of others in this task can serve as a means to expand the range of alternatives considered by the client.

Procedure. Ask the client for an episode in which the problem was felt and have her describe it from beginning to end. Then, limit the episode to its most central meaning and ask the client for the different stages of the cycle. Draw the cycle of experience in a piece of paper, leaving space for the client's answers. In order to find the anticipation (1), ask the client what she expected before this episode occurred, or at the beginning of the episode, as the situation was set; next, explore how the client felt with that anticipation, in order to understand how implication occurred (2); what actually happened or what the client did constitutes the encounter (3); The validation or invalidation of the anticipation (4) is assessed by asking how the person felt upon the encounter; finally, the conclusions the client took or could take from the experience give form to the constructive revision.

Having completed the experience cycle, ask the client where she would place herself in each of the constructs in the episode under focus. A graphic representation of each construct is achieved by drawing a straight line and writing each pole label at one end of it. Next, explore

alternatives to the lived cycle – what could have been different that would lead to a more satisfying conclusion? At what point of the circle could things have changed? Explore the client's construction of the prototypical and alternative figures applied to the same cycle of experience, asking: "what would x (insert the name of the figure explored here) have done in this situation?"; "How would she feel?"; etc.

As an intersession assignment, we suggest asking the client to gather new experiences in which the dilemma is visible and, in turn, episodes that constitute exceptions to the dilemma. Next is the controlled elaboration of experience as done in Susan's case:

> T – I'd like you to remember an episode in which this problem has been manifest, I mean this tendency to please others.
>
> C – Mhm... The most flagrant, the most recent was that one with my boss. I didn't want to go to work, it came in a bad time for me, but I ended up going. And afterwards I was very upset for having gone.
>
> […]
>
> T – So, when he called you and told you what he wanted, what did you think was going to happen? Did you figure out what he wanted right away?…
>
> C – Right. I figured it out. But for me, the fact that I already had plans - and I had an English class - was a good reason to say no. But I still could work for two hours. Even though I had things to do in those two hours, and I should have used that time for that, and I didn't, and…

T – [writes] […] Mhm-mhm. So at first you were convinced you‘d say you couldn't go to work.

C - Yes. That was the idea, at first.

T – Very well. […] Let's try to see step by step here how it all happened: first eh… you said you wouldn't go. How did that thought make you feel?

C – While I don't hear the other part, I feel good! When I start to hear the other part, I start to feel guilty. In that case, in those two hours I was supposed to take care of the applications for the scholarships. But I also knew it was very likely that I wouldn't actually do that. But it doesn't matter; I had that time for myself, it was supposed to be for that. Then, I finally gave in because it was only a supposition… Maybe if I was really going to do it I wouldn't give in. It's confusing. I'm not very coherent!

T – So you anticipated you would say no and work on the applications.

C – Yes.

T – However, you were not so… committed to that decision.

C – No. I wasn't… it was not a goal, like: today I'll definitely do this. No. It wasn't. It was an opportunity. It was "I should do it, but"…

T – Ok. So maybe you would do it, maybe not.

C – Exactly. […]

T – […] Then your ex-boss insisted and you ended up accepting to go to work.

C – Yes.

T – How did you feel after you accepted it?

C – Upset. Then I was upset. Because if I had decided at first that I wouldn't accept because I had things to do, I shouldn't have accepted. I should have said no.

T – Mhm-mhm. What conclusion did you take from this episode?

C – Oh! [laugh] I'm still conflicted! I'm still confused. I think I can have the perception of what I want, or what I need to do to attain some, some objective or some goal I'm thinking of. But it's difficult for me: if I establish it as a fixed objective then I'll get it. In that case it's fine; others can't move me from it. But if the goal is not so well defined it's easy… it's relatively easy for others to make me change my mind, even if I know that's not what I want to do, or that I want to do something else. I don't know if I explained myself…

T – I think so. So the conclusion is kind of: when things are not defined enough for you, others can change your mind… […] You don't maintain your position, and you end up pleasing others…

C – Yes. It's kind of that.

[…]

T – So this started here [showing the experience cycle diagram]: you had an idea, then you changed it, and when you got here you were upset about that. You concluded: "I don't have my goals well defined and because of that I'm easily manipulated". […] What could have been different in this cycle that would make you get validated instead of invalidated?

Historical reconstruction of the dilemma. People give meaning to experience in an effort to make life coherent and avoid ambiguity and caos. The narrative structure can be a way

of imposing some coherence on the immense plurality of experience. That coherence is built in two levels: the meaning of each particular experience or episode, and the meaning of life as a whole, which results from a process of coherence among the different narratives in life (Gonçalves, 2002). When building his own history, the individual needs to maintain her sense of identity through the different episodes of her life (Gonçalves, 1998).

The historical reconstruction allows for the client's construct system to be understood at different moments of her history, and to reveal its continuity through time. One goal of this technique is to identify the emergence of the dilemma across time and the different ways of experiencing it over the years, promoting a sense of coherence in the client's personal history. According to Kelly (1955), this kind of exploration tends to facilitate the tightening of constructions. A second goal is to promote time-binding, that is, to help the client put in perspective some of her constructions that might have been helpful in a given moment in her life, but may be causing problems at present, in a different moment and/ or context (Walker & Winter, 2005). Those constructions are thus reduced to a more impermeable state, in which their impact on the person's life will be much smaller.

Procedure. Ask the client to remember, throughout his life, episodes in which the congruent construct is relevant. Progressively focus on each approximate decade of the client's life: childhood, adolescence, 20's, 30's, and so on. Try to get nearly three episodes for each phase. Focusing on each episode, explore the meaning of the congruent construct. Then search for the presence and meaning of the discrepant construct. Verify if the dilemma was present or in

what other ways the congruent and discrepant constructs related. After exploring all the episodes, discuss it with the client: How has the dilemma taken shape over time? What moments are associated with its solidification? Who and what contexts have been important in that consolidation? Having understood the dilemmas emergence and development, discuss what function it might have had in a determined moment of the client's life; is it still useful in the current context?

Developing alternatives to the dilemma. Even in stories that are more saturated with problems, there are moments in which those have not dominated. The identification and exploration of these exceptions opens a path for an alternative way of constructing reality, in which they can become increasingly more frequent (White & Epston, 1990).

Procedure. During the exploration carried out on the previous sessions, as well as in intersession assignments, alternative ways of functioning have most certainly have been detected. Ask the client to reflect on the exceptions to the dilemma that have occurred until this moment and describe the course of their onset and development. Then, extend these exceptions to other moments and contexts, inviting the client to consider the following questions: What would be necessary for this alternative way of functioning to occur more often? In what ways could we make that happen?

Writing the dilemma's story. This strategy is based on the assumption of narrative as a powerful organizer of human experience (Sarbin, 1986). Also, writing about one's own problems has shown to bring benefits to physical and mental health. An explanation for this is that writing

helps people to reorganize their thoughts and feelings, and to create more coherent or meaningful narratives about the events of their lives (e.g., Graybeal, Sexton, & Pennebaker, 2002).

After the historical reconstruction of the dilemma, the client has come to a new understanding of how this structure has come to block her construction. The writing of this personal story should promote a better integration of that development. For this purpose, it is suggested that the client writes the story of the dilemma, focusing on the following topics: how it came up, what influence it had on her life, how it changed through time, how she sees it now.

Phase 4 - Alternative Experimentation

This phase consists in the use of a single technique, Fixed Role Therapy (Kelly, 1955), to be carried out over approximately five sessions. The goal is for the client to experiment what it would be like to live without the dilemma (or without the problem), with the security of the understanding that she will not be required to eliminate it: if change appears to her as something too threatening, she can go back to her previous way of functioning.

This phase appears as optional in this protocol, as it does not have to be applied in cases in which the dilemma has been resolved and symptoms have remitted in the previous stage. It is intended to promote practical changes in the client's life, after a work of elaboration has been done in the previous phase. However, if the client has already made clear improvements, it's the therapist's place to assess whether it is useful to continue working with the client to consolidate

the outcomes or if it is time to end therapy (or at least, this piece of therapy working with dilemmas).

This stage of therapy is planned for two sessions per week, during two weeks.

Fixed Role Therapy. Fixed role therapy is proposed in Kelly's magnum opus (1955), but he had already been using it since the late 1930s. It is considered the most distinctive personal construct therapy technique, and a practical and radical way of achieving change (Neimeyer et al., 2003). It consists of an experiment, designed by the therapist and proposed to the client, in which a new character is created: a fictitious person who faces similar challenges to those of the client, but who approaches them from a different perspective. This alternative role is built by the therapist as the description of a character based on the client's self-characterization (described above). The client plays this character for a given period of time (usually two weeks), with the goal of finding out what it would be like to construct the world differently from the way she usually does.

The client gets to experiment in a "as if" context, where she does not need to make decisions or abandon her characteristic features in order to try something different. At the end of the experiment, therapist and client evaluate the results and the latter decides whether or not she wants to keep some of the features of the character she has played. Although the enactment is suggested as a mere experiment, "looking through glasses that are not your own can permanently affect your eyesight" (Kelly, 1962, p. 90., as cited in Walker & Winter, 2007). Proceed as follows:

Writing the fixed role sketch. Using the client's self-characterization as a frame, create a new character that shares some of the client's characteristics, yet is different enough to be clearly distinguished. Be sure to provide her with a name, some flaws and some beliefs about life. It should not be an ideal character or someone who has all the answers, just someone who deals with things in a different way than the client usually does (Epting & Nazarro, 1987; Kelly, 1955).

In this manual, the fixed role is meant to explore the possibility of living without the dilemma, i. e., achieving the desired changes without losing other characteristics that are important to the subject's identity (as represented by the congruent constructs). These possibilities should have already been explored during the previous tasks, and the therapist should use the constructions expressed during the therapeutic process in the elaboration of the character sketch.

The client's self-characterization provides a sample of the most important themes to approach, and of the constructs she uses to describe herself. The changes prescribed should focus on those constructions that appear to be less central to the client's identity, and hence more permeable to change. Although it is a character description, the sketch should include implications for action, as a way of facilitating the testing of new hypothesis. Susan's example shows what a character sketch could be like (based on the self-characterization presented before):

> It's not easy to describe Nora. She has a complex personality, with several contrasts and nuances. She doesn't always behave in the same way, and she might even not think in a

constant manner. This constitutes the richness of her way of being. She's a flexible person with different possibilities to choose from.

She's dedicated and hard-working, always fighting to get what she wants. She sometimes feels tired and even lazy, but she fights against that by making specific plans […]. She makes agreements with herself, and she sticks to them. […]

She's concerned about the people she likes and always tries to help them as much as she can. This is important for her, and she doesn't mind spending some of her time whith friends when they need her. She's sensitive to other people's feelings and tries not to hurt anyone, but she doesn't let other people's wishes or needs to shatter her own. After all, if she doesn't take care of herself, who will?

She's very determined and always stands for what she believes. Others don't always agree or understand her, but Nora defends her position. She's actually a little stubborn, she argues until exhaustion! But when you're right and you explain her your point of view, she eventually changes her mind…

Although she might sometimes strike you as incoherent, Nora is just a person with many different interests, dreams and values, articulated through a very personal logic.

Presenting the fixed role sketch to the client. Give the character sketch to the client and ask her to read it. Then, ask her two questions: Whether the character seems real to her; Whether the character looks like someone that she would like to meet. Working with the client, make the necessary adjustments to the character sketch, until getting positive answers to the two previous questions.

Enactment proposition. Propose the enactment of the character, according to the following instructions (adapted from Kelly, 1955):

> In the coming weeks, instead of trying to directly treat your problems, I would like to suggest something different. Let's suppose Susan is going on a vacation, and Nora will take her place. You shall act like Nora, talk like her, and even think like her. You shall do everything she would do, eat what she would eat, and if possible, dream what Nora would dream. Keep this copy of Nora's script and read it several times a day (especially at night and in the morning when you wake up), and any time you have some difficulty playing the role.
>
> During this time we will see each other twice a week, to help you play this role, anticipating some situations so that you can play the role of Nora as well as possible. Don't worry about Susan during this time, we don't even need to think about her for now — she is on vacation and doesn't want to be bothered. She will be back in a few weeks and we'll be able to talk to her then.

Once the client has accepted the challenge, propose the first trial depending on the client's activities in the coming days. Prioritize professional or academic interactions for the first

experiments. Rehearse some of the situations in which the new role can be put into practice, using role play.

In the next session, evaluate how the client executed the fixed role during the previous days: "When did she do best? When was it most difficult to incorporate the character? How did others react? How did she feel?" Then, prepare the upcoming trials and anticipate difficulties. Help the client anticipate what it would be like to be the character in aech particular area of life.

Repeat this procedure with the successive levels of the trial. From work acquantainces, pass to friends, spouse or romantic partner and finally parents. A last level is representing the role with oneself, as defining life projects or engaging in spiritual activities.

Ending the fixed role enactment. Ask the client to assess the experience of the fixed role during the previous weeks. Reflect on behavior changes, feelings, expected and unexpected reactions from others, advantages and disadvantages compared to the usual self. Explore what the client might have learned and whether there are some aspects of the fixed role character that the client wants to keep in her "real life". The client shall decide what to do with the character: saying goodbye, continuing to use it, elaborating on it to get to a next, preferred level, etc.

Letter to the fixed role character. Writing a goodbye letter is typical in the work of some constructivist therapists (Mahoney, 2003). This is a strategy to prepare the closure of the therapeutic process, in this case of the work on the dilemma. At the same time, its continuity with fixed role therapy makes it function also as closure for that activity. The client's decision on what

to do with the character sketch will guide the format of this letter, which can be a “goodbye” as well as a “keep in touch”.

Procedure. As an intersession assignment, ask the client to write a letter to the fixed-role character, telling how it was to spend that time with her, what has changed with it and what she expects their relationship to be like from this moment on.

Phase 5 – Treatment termination

This phase consists of only one session, in which the work with dilemmas, and possibly the therapy process, will be concluded. Where this falls in the present therapy protocol depends on the results obtained, possibly fitting in after the 3rd or 4th phase, depending on the amount of work needed to develop alternatives with the client. It can represent the end of the therapeutic relationship or just the closure of one segment of therapy, when the process is to continue with a different kind of work and possibly with new objectives.

The closure of a therapeutic process represents the recognition of the client’s improvement and readiness for subsequent autonomous development, but also the interupton of an important interpersonal relationship. There fore, it should always be prepared by therapist and client (Fransella & Dalton, 1990).

Review of the therapeutic process. In order to integrate and consolidate the therapeutic work, the therapist asks the client for a reflection about the therapeutic process, focusing on the client’s experience, progress with respect to initial objectives, changes felt by the client, and

objectives still not attained. If the therapy is to continue, this is the moment to set new goals for the next phase.

Projection of new constructions into the future. The changed constructions and the (re)construing methods learned in therapy should be tools that the client takes on from therapy to her future life. At the end of the therapeutic process, it is important to help the client anticipate new challenges and how these new learnings can be used to deal with them, so that an impasse is not so likely to occur again.

Conclusions

Implicative dilemmas are a kind of problematic construction structure which prevents individuals to attain desired goals due to their negative implications. This type of impasse is quite frequent in psychotherapy clients and tends to diminish with successful therapeutic work. The ways in which this process occurs are not yet known.

The development of a therapeutic manual to address implicative dilemmas can open a number of possibilities for psychotherapy research, increasing our knowledge about dilemma resolution in therapeutic context. In addition, it can be a useful tool for therapists' training and for therapeutic practice in general, by providing a structured pathway through which to address the clients' impasses and resistance to change.

Our therapeutic proposal is framed in the spirit of personal construct therapy and uses some of its most popular techniques. Through five different phases, clients are invited to

elaborate their personal constructions and to explore alternative ways of making sense of the world and, hence, living their life. As any effective therapy, it should be used in the context of a secure therapeutic relationship that validates the client and creates an atmosphere where novelty can be experimented.

Final notes

This manual has been created as a first step in a more extensive research, aimed at understanding dilemma resolution in terms of clinical process and outcome. As a pilot study, aimed at putting the present manual into practice, a group of clients have been treated according to this proposal and participated in a process-outcome research program. Most of them showed improvement in symptoms as well as in their subjective perception. They described their therapeutic process as an important factor for their changes. The process of change for one of these clients is described in detail in a case study (Senra & Ribeiro, 2010).

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CHAPTER 2

The Process of Change in Implicative Dilemmas:

A Systematic Case Study[3]

Abstract

We present a case study of personal construct therapy for implicative dilemmas, a manualized treatment for this blockage in the personal process of construction. We used qualitative and quantitative measures of process and outcome to systematically study this therapeutic process. Through a Hermeneutic Single Case Efficacy Design analysis we found that this client improved significantly and that therapy was decisive for this change. An explanation-building approach showed how the reconstruction of the client's view of herself and her interpersonal behavior took place, resulting in the resolution of the client's dilemma and symptoms.

The Process of Change in Implicative Dilemmas: A systematic case study

Constructivist metatheory emphasizes the self-organizing and proactive nature of human knowledge and develops on its implications for human change (Lyddon, 1995; Neimeyer, 1993). Concretely, George Kelly's personal construct psychology (1955) emphasizes change as a constant in our continuous process of construction and

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[3] This work was submitted for publication in co-authorship by Joana Senra and Eugénia Ribeiro

reconstruction of our selves, our worlds and our relations with them. Personal constructions represent subjective distinctions humans use to understand experience, make choices and conduct their behavior. These constructions are bipolar, making a discrimination, i.e., naming something as similar to one thing and different from another (Patrick, 2005). The individual's identity is based on a set of choices between poles in a group of nuclear constructs.

Personal construct systems evolve in our contact with the world. We perceive experience through the lenses our system provides us and, in turn, new experiences progressively change our view of things. This process is permanent and applies to all types of events. It is described by Kelly (1970) through the experience cycle: based on our existing constructions we have expectations about things and events (anticipation); when we engage in experience, we commit ourselves and become open to being influenced by the event (investment); we then confront our expectation with reality by living the actual experience (encounter), so our anticipations may be confirmed or denied (validation or invalidation); whatever is the case, our construct system suffers some level of change (constructive revision), via strengthening or revision of the used constructions and the ones that might be related to those. The revised constructions are then used to make new anticipations.

Psychological adjustment results from a balance between stability in one's core meanings and the ability to change according to new experience. When this balance is disrupted psychological problems may arise, as when the subject has trouble making sense of new experience with a too rigid construction system or when he loses his sense of self in the process of adapting to novelty, among other processes (see Winter, 2003). According to the theory, disorder occurs when there is a failure to adequately test one's

constructions and consequently revise the invalidated structures. The individual is then "stuck, immobile, unable to move forward, and unable to reconstrue" (Walker & Winter, 2005, p.27).

Personal construct therapy (PCT) sets as a general goal to get the individual back on the construing movement. For that to happen, the therapeutic setting must provide a balance between validation and invalidation. Validation is achieved by the establishment of a secure, accepting relationship, in which the therapist does not present himself as an expert, but as a research fellow with genuine interest in the client's enterprise. Kelly (1955) has described the therapist's posture as a credulous approach, where the therapist is curious about the client's ways of relating to the world. He provisionally accepts her constructions and departs from them to the subsequent exploration process. Invalidation, on the other hand, occurs while elaborating the client's constructions and exploring new possibilities. These two major processes constitute the core of personal construct therapy (G.J. Neimeyer, 1995; Walker & Winter, 2005). In order to create novelty, the subject must reconstrue, that is, invalidate some of her previous constructions. That process has the potential to threaten the client, as she faces the possibility of loosing her way of life (Fransella, 2003), and therefore trigger her resistance to change. The secure, validating relationship allows for the tentative exploration of alternatives in the form of hypothesis or experiments, without the early abandonment of the existing structures. This formulation has the advantage of diminishing threat, and consequently resistance. This balanced, accepting but also challenging environment sets the scene for the client's active exploration, without which therapy cannot be successful (G.J. Neimeyer, 1995).

Implicative dilemmas

Implicative dilemmas represent a form of blockage in the individual's constructing activity, where an undesired construction is strongly related to other, positive and self-defining, construction(s). As a result, the person cannot move towards a desired construction as that would imply abandoning some nuclear features of the self, or embracing some undesired aspects that correlate with the wanted one. Understanding this kind of blockage may help therapists connect to the client's difficulty and even reluctance to change. This way, clinicians could be more sensitive to the need of working in collaboration with the clients and respecting their resistances. Therapy should focus in searching for an alternative way of functioning which is acceptable to the individual, that is, which is compatible with his nuclear constructions.

Feixas, Saúl, & Avila-Espada (2009) present a clear description of what occurs in an implicative dilemma:

> the construction system generates two different personal goals (i.e., becoming social and remaining unselfish and considerate). But according to the structure (network of implications between constructs) of the system, these two goals are incompatible within that system …, so that accomplishing one is incompatible with the other (p. 147).

The individual deals with this conflict by privileging to the most super-ordinate construct (or goal), as a way of protecting the core of the system from invalidation. Although this is the best solution the client can find at the moment, it has great costs, as she can neither abandon nor be at peace with a symptomatic position.

This situation was operationalized by Feixas, Saúl, and Sánchez Rodríguez (2000; see also Feixas & Saúl, 2004) in terms of the positions of the self and ideal self elements in the Repertory Grid. Constructs in which these two elements are placed at the same pole are named *congruent* and constructs in which they are at opposite poles are called *discrepant*. An implicative dilemma is identified when a congruent and a discrepant construct are significantly correlated.

These authors' previous research on implicative dilemmas (Feixas & Saúl 2004; Feixas et al., 2009) has found that dilemmas are a common phenomenon to both clinical and non-clinical populations, though significantly more prevalent in clinical cases. Clinical populations also presented a higher number of implicative dilemmas than non-clinical subjects. Within clinical cases, clients with dilemmas presented higher symptom severity than those without this kind of structure. Moreover, this study noticed that dilemmas tended to decrease in number and often disappear when the subject underwent psychotherapy. Following these findings, the development of a specific treatment for intentionally solving these impasses in the clients' constructions seemed to be a natural next step in the way to increasing our understanding of dilemmas and maximizing the benefit of this knowledge (Feixas et al., 2009). After some clinical cases have been presented approaching implicative dilemmas in therapy, with quite positive results (Feixas & Saúl, 2005; Fernandes, 2007), a manual for directly approaching these dilemmas in a brief therapy was recently organized (Senra, Feixas, & Fernandes, 2007; Senra, Feixas, & Ribeiro 2010). As a constructivist therapy, this proposal adopts a hermeneutic and phenomenological perspective, using predominantly explorative interventions, privileging reflection and elaboration of the client's personal meanings. Quoting Robert Neimeyer (1993), constructivist therapeutic goals are "more creative

than corrective” (p.224). They aim at a global development of the person’s construction system that gives space for an alternative position towards the problematic experiences.

In this paper we present a case treated with personal construct therapy for implicative dilemmas. Our goals are to assess the efficacy of the intervention for this particular client and to elaborate an explanatory model of Caroline’s process of change.

Method

Participants

The Client. Caroline was a 20 year-old university student who lived with her mother and siblings and worked part-time. She came to therapy at a university clinic after indication by the university’s social services, where she had asked for help with some depressive symptoms. In her request for therapy, the client described feeling depressed following her entrance in the university and the beginning of a romantic relationship. In her own words, she was suffering from “a strong pessimism that continuously wears me out“. During the first sessions Caroline reported difficulties in preparing for the exams at the university and in the relationship with her boyfriend. She also said she considered herself pessimistic and wanted to change her “view of things”, becoming more optimistic. These three issues were defined as her therapeutic goals.

The therapeutic model used did not require the establishment of a DSM (APA, 1994) diagnosis. Rather, the client’s presenting problems and dilemmatic structure were the guidelines for case conceptualization and intervention.

In her contact with the researcher, Caroline seemed motivated and enthusiastic about her therapist and the therapeutic process.

The therapist. The therapist was a 25 year-old woman with 3 years of clinical experience who had received training in the therapeutic model and attended weekly group supervision for this case. She was briefly interviewed about the case at the completion of the treatment.

The researchers. Both authors are psychotherapists as well as researchers, have a constructivist background and are authors of the personal construct therapy for implicative dilemmas manual, used in this case. The first author, a female PhD student in her late twenties, assumed the researcher role with both client and therapist, explaining the research procedures and conducting all interviews and analyses. The second author, a female senior researcher, assumed the auditor role, checking all analyses. Both authors provided training and supervision to the therapist.

A team of five judges was used to decrease subjectivity in one part of the case analysis. That team was composed by the first author and four other graduate students, all trained in qualitative research procedures.

The treatment

Personal construct therapy for implicative dilemmas (Senra, Feixas & Fernandes, 2007; Senra, Feixas & Ribeiro, 2010) consists of a brief psychotherapy manual of personal constructivist orientation, organized in five stages: (1) initial assessment, (2) dilemma presentation, (3) dilemma elaboration, (4) alternative experimentation and (5) treatment termination. Phases are structured in terms of goals and tasks, but there is time flexibility for their completion. The fourth stage of treatment – alternative experimentation – is optional, not necessarily taking place when clients

solve their dilemmas and symptoms in the previous phases. This way, the treatment might last approximately from 10 to 20 sessions.

Caroline participated in 12 sessions of personal construct therapy focused on implicative dilemmas. The treatment terminated by mutual decision after phase 3 of the manual (dilemma elaboration) as therapist and client agreed that the main goals had been achieved and symptoms had remitted. Thus, phase 4 (alternative enactment) did not take place. Two follow-up sessions followed, along the next three months, with the goal of verifying the maintenance of the client's improvement and well-being.

Measures

Outcome. Brief Symptoms Inventory (BSI; Derogatis & Melisaratos, 1983) was used in the Portuguese adaptation by Canavarro (1999), who found good psychometric characteristics, discriminating normal from clinical population with 92% to 95% efficacy comparing with the clinical method. To make such a discrimination, we used the criteria of bigger closeness to the mean of the normal population than to the mean of clinical population, using Jacobson & Truax's (1991) formula to determine the cut-off point for clinical population. However, not having a standard deviation value for clinical population on the Global Symptoms Index (GSI), we considered the value of normal population mean plus standard deviation as a limit for this index.

OQ-45.2 (Lambert et al., 1996) monitored the variation of the client's distress along therapy, in three dimensions: subjective discomfort, interpersonal relationships and social role functioning. This quantitative measure was designed for repeated use along treatment and follow-up, being particularly sensitive to short-time symptom variations. It is used at the beginning of each session. We used the Portuguese version, on which validation for the Portuguese population Machado & Fassnacht (in

preparation) are currently working on. The values for clinical case threshold and Reliable Change Index (RCI) for this population are shown in table 1.

Table 1. OQ45 reference scores for the Portuguese population

	RCI	Cut-off Score
Symptom Distress	12	29.87
Interpersonal Relations	8	16.34
Social Role	7	14.16
Total	18	67.82

Construction system. To get some insight into the client's constructions, Repertory Grid Technique (Kelly, 1955; see also Fransella, Bell, & Bannister, 2004) was used in its most common form, i.e., using a set of the subject's acquaintances as elements. Constructs were elicited through the dyadic method, i.e., subjects were presented the elements in pairs and asked about similarities and/or differences between each pair. Elements were then rated concerning each construct in a 7-point scale, where values 1 to 3 correspond to one pole of the construct, 5 to 7 to the other pole and 4 is a neutral score. The grid data was treated with the Gridcor v.4.0 software application (Feixas & Cornejo, 2002), which provides a number of measures of the subject's construction system's structure and reveals implicative dilemmas. For this study we considered only some of the measures available from this source, namely: the number of implicative dilemmas; the self - ideal self correlation, considered a measure of self-esteem; the self - others correlation, considered a measure of perceived social isolation; the weigh of the element self in the first factor (from a factor analysis of constructs and elements); the percentage of variance explained by the first factor (PVAFF), considered

a measure of cognitive differentiation; and the total polarization index, which represents the amount of extreme rating values in the grid and is considered a measure of rigidity (Fransella et al., 2004; Feixas & Cornejo, 1996; Feixas, Bach, & Laso, 2004).

Helpful therapeutic events. The HAT Form (Llewelyn, 1988), was used in a shorter adaptation of the Portuguese version by Sales et al. (2007). This qualitative measure asks the participants to describe the moments they considered most helpful in the session they have just finished, explaining why they were relevant and giving some information to help track them on the session record. A rating of how much the event has helped is also included, in a visual scale varying between 1 – "not helpful at all" and 5 – "extremely helpful".

Working alliance. Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was used in therapist and client versions. The Portuguese version (Machado & Horvath, 1999) presents good validity and reliability indicators (Cronbach's alpha .95). To make sense of the results, we considered the mean values of the responses for the total score as well as for the three subscales, thus having a range of scores from 1 (very weak) to 7 (very strong alliance).

Client's perspective on the therapeutic change process. At the end of the therapeutic intervention the client answered to a Change Interview (Elliott, 1999; Elliott, Slatick, & Urman, 2001; Portuguese version by Sales et al., 2007), where her perception of therapeutic change was explored. This semi-structured interview focuses on changes attained and not attained, as well as on factors responsible for them, considering both therapeutic and extra-therapy events. Apart from the free answers, the identified changes are rated in terms of importance, expectedness and probability of happening without therapy in three 5-points Likert scales.

Therapist's perspective on the client's change process. The therapist was also briefly interviewed at the end of the treatment about her view of the client along the treatment, her experience working with the treatment manual in this case and her perspective on the client's change using an adaptation of the above mentioned Change Interview. In addition, she provided us a copy of the client's therapeutic request form and was available to give us further information on the case in several occasions.

Procedure

In her first therapeutic session, Caroline met the researcher, was asked to participate in a research program about processes of change in psychotherapy and signed an informed consent (appendix A). The client's participation in research included not only the measures described above, but also two Brief Structured Recall (Elliot & Shapiro, 1988) interviews for another study, conducted in the mid-therapy and final assessment points. All sessions were videotaped starting from session two. The therapeutic process was monitored by the researcher in weekly supervision meetings with the therapist, in order to enhance and verify adherence to the manual (Kazdin, 1994).

Caroline and her therapist provided a number of quantitative and qualitative measures in different moments of the therapeutic process, as shown in figure 1. The combination of the many available sources of information allowed a detailed analysis of Caroline's therapeutic process, suiting the pursuit of our research objectives. Thus, we started by preparing a description of the observed changes, reporting the results from the different quantitative and qualitative measures available as sources of information from this case.

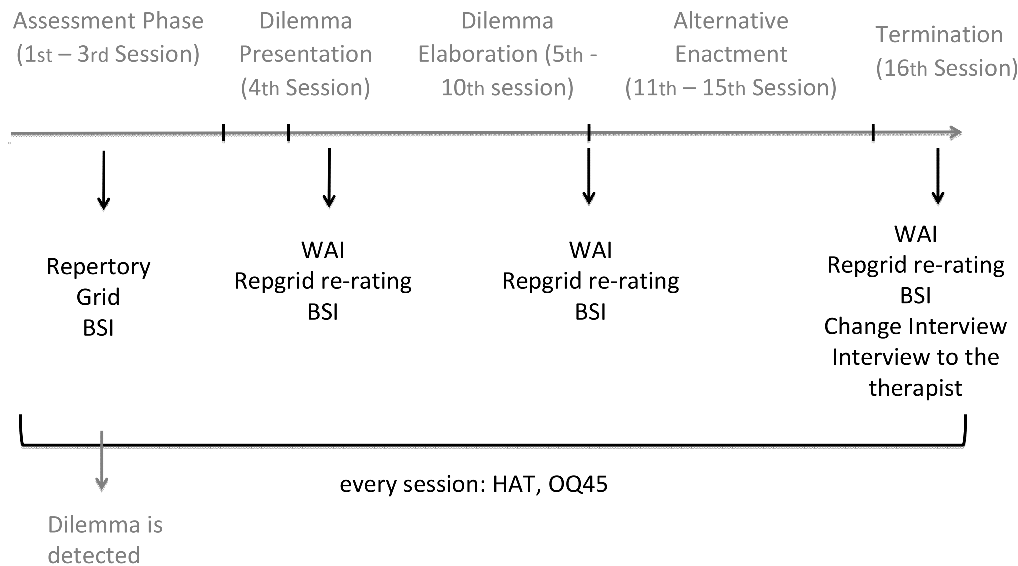

Figure 1. Treatment phases and data collection procedure.

In order to test the treatment's efficacy, we examined the case through Hermeneutic Single Case Efficacy Design (HSCED; Elliott 2002), a method conceived for use with systematic case studies, where a considerable amount of information is available from qualitative as well as quantitative measures. With this methodology the author tries to overcome some of the limitations felt in research based on randomized clinical trials, such as the assumption of causality being void of explanation or the difficulty in applying the findings to real individual cases. Departing from some previous proposals in single-case research design such as Kazdin's (1981), this alternative inquiring design searches for evidence of treatment efficacy as well as for hints on the specific ingredients responsible for change in single cases of non-behavioral psychotherapies. The case for efficacy is made upon corroboration of the

found changes and exclusion of possible alternative explanations for those changes. The procedure is designed to answer three major questions: (1) Has the client changed? (2) Can this change be attributed to psychotherapy? And (3) What specific factors are responsible for change?

While the two first questions establish the effectiveness of the treatment for this particular case, the last one looks for some clues for the understanding of the change process experienced by the client. We tried to answer it in an explanation building (Yin, 1994) or theory building logic (Stiles, 2007), i.e., we interpreted the findings from the case and compared them with personal construct psychology's view of therapeutic change, producing an explanation of Caroline's process of change.

Results and discussion

Rich case record

Caroline's symptom values in BSI show a clear reduction from pre to post treatment assessments (see figure 2), with an even bigger difference in follow-up. In fact, in the first session Caroline presented an elevation of the General Symptoms Index (GSI) and five of its nine subscales (anxiety, depression, hostility, interpersonal sensitivity and psychoticism), as seen in figure 2. At the post-treatment assessment, however, no index or subscale was higher than normal population standards. Calculating a reliable change index (RCI; Jacobson and Truax, 1991) for the GSI, we found a significant change from pre to post-treatment at an 80% confidence level ($p<.2$) (Elliott, 2002) and from pre-treatment to follow-up at a 95% confidence level ($p<.05$). RCI have also been found for the subscales *depression*, *anxiety*, *hostility*, *obsessive-compulsive* and *psychoticism*.

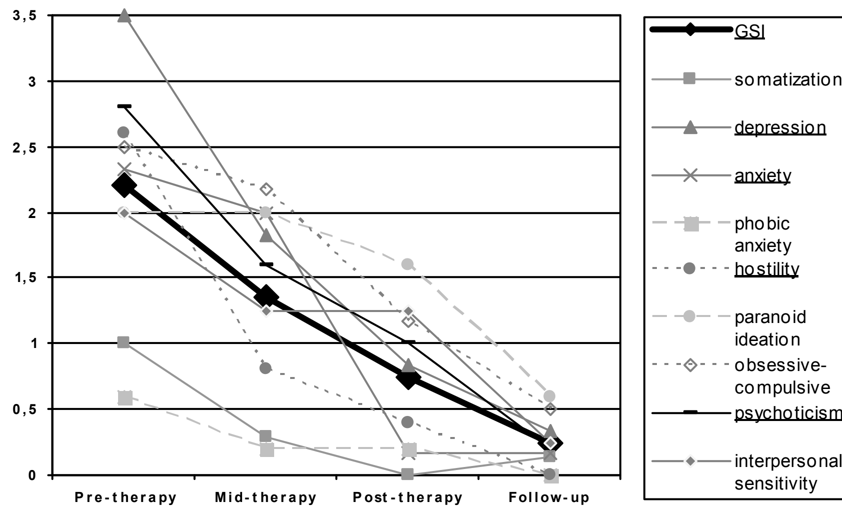

Figure 2. BSI results.

Caroline's initial OQ45 scores were high, with remarkable elevations of the total score as well as the *subjective discomfort* and *interpersonal relations* subscales. However, all of these scores came down the threshold during the treatment and stayed low. A RCI was found for the OQ45 total score as soon as session 3 (see figure 3), with a decrease of more than the required 18 points, maintained until the end of treatment and follow-up. RCI were also found for *subjective discomfort* and *interpersonal relations*.

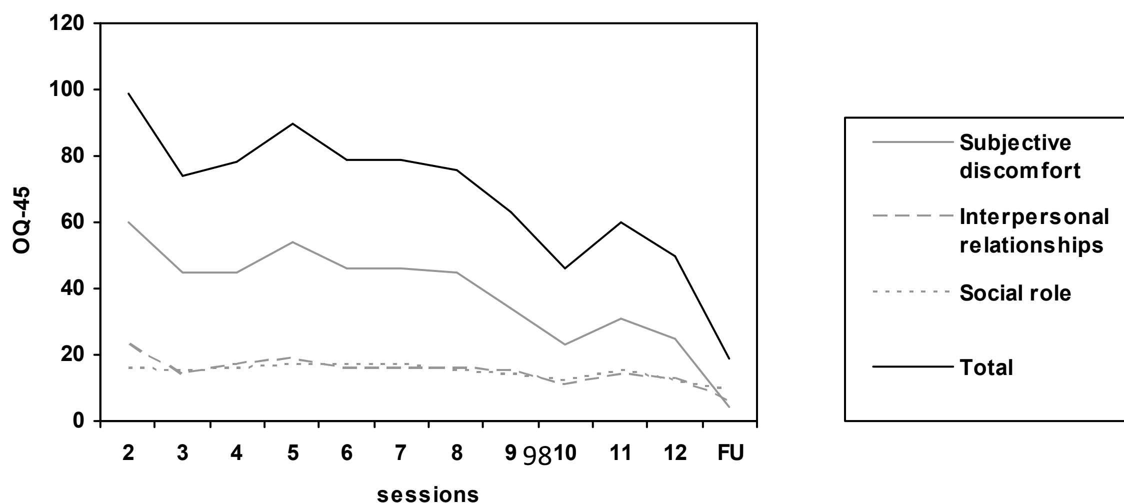

Figure 3. OQ45 results.

The client's HAT forms (figure 4) show the client identified important events in every session. Nevertheless, from session 4 onwards the events tended to be considered more important. Beyond session 6 more than one event was identified in each session, with an exception in session 11, when only one event was reported.

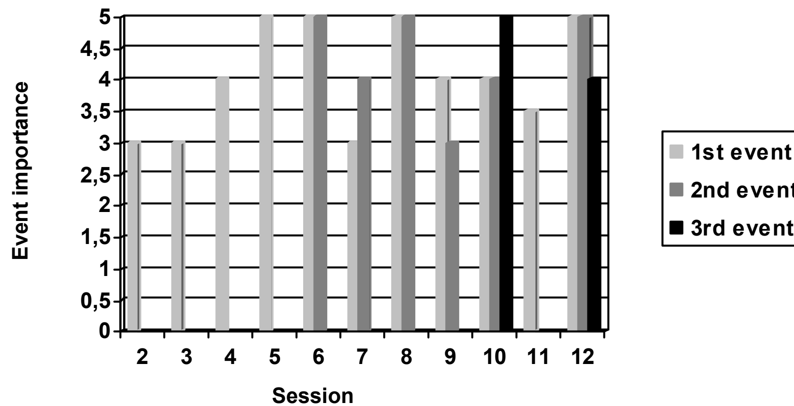

Figure 5. Client's HAT form results.

As part of the clinical assessment the client completed a Repertory Grid (Kelly, 1955), where we could identify an implicative dilemma involving the discrepant construct most related to the client's problem: pessimistic/ optimistic. This construct was kept from changing by its association (r =.28) with the congruent construct cold/ hypocritical, where Caroline explained that cold meant not faking affect or friendliness (see figure 5). Although the dilemma's correlation was not very strong, it was enough to be considered clinically significant (Feixas & Saúl 2004; Feixas et al., 2009). In addition, the dilemma's clear relation with the presenting problem encouraged the therapist to pursue an intervention focused in this kind of conflict.

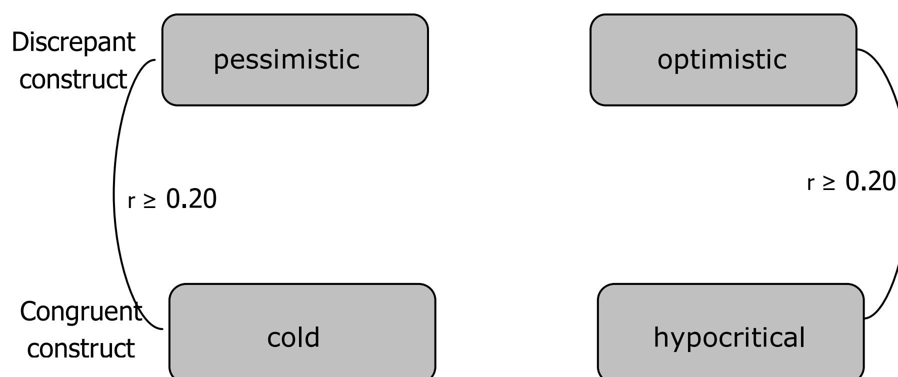

Figure 4. Caroline's dilemma.

Along the therapeutic process, the repeated repertory grids showed some changes in the structure of the client's construction system (see table 2). The dilemma receiving therapeutic attention was solved by the mid-therapy assessment, and no other dilemmas emerged. In fact, the discrepant construct involved in the dilemma (pessimistic -optimistic) was no longer discrepant from the mid-therapy assessment on, as Caroline already perceived herself as *a little* optimistic. However, the distances between the two constructs remained low, especially between the desired pole (optimistic) and the undesirable one (hypocritical). This distance only increased clearly at the final assessment. The client's self-esteem (self - ideal self correlation) and perceived closeness to others (self -others correlation) were almost the same at the beginning and end of therapy, with clear increases in follow-up. However, at the mid-therapy assessment the client's identification with others had decreased to a close to zero level. Looking at more structural measures, we see that the PVAFF has increased in a gradual way through the assessment moments, and so have the total intensity and total polarization indexes. In other terms, we find an increase in the system's tightness and integration and a decrease in cognitive complexity. Looking at the first factor,

which explains such a high percentage of the total variance, we see that the self element has passed from a null weight to having some contribution to the client's most important dimension of meaning, in the most positive side of the axis.

Table 2. Repertory grid's results

	Nº dilemmas	self - ideal correlation	self - others correlation	Weight of self on the 1st factor	PVAFF	Total Polarization	self-therapist distance	Therapist – ideal distance	Distance congruent pole – present pole*	Distance indesirable pole – desired pole**
Pre-therapy	1	0.554	0.307	0	66.63%	36.19	0.15	0.07	0.35	0.24
Mid-therapy	0	0.477	-0.017	0	64.92%	37.619	0.20	0.13	0.25	0.10
Post-therapy	0	0.535	0.344	3	70.31%	39.524	0.02	0.02	0.66	1.26
Follow-up	0	0.891	0.688	3	71.21%	43.810	0.13	0.12	0.48	0.44

Note. * cold – pessimistic, ** hypocritical – optimistic

The distances between self and therapist and between therapist and the ideal self were always very small, indicating a strong positive view and identification with the therapist. In the same sense, the client's WAI values were always high with a total score of 6.31 at mid-therapy assessment and 6.42 at the end of treatment. The therapist's version also presented high results, growing from 6.42 to 6.81.

In the Change Interview, the client identified twelve positive changes and none negative (although asked about it). She also identified an unmet goal, namely overcoming her academic difficulties (see table 3). Changes were first freely described and later summarized in a single sentence. Some of the changes' final phrasings are

quite straightforward, while others may need some clarification: the first change, *becoming less inhibited,* can be better understood by the following extract of the interview: “if I need to say something to someone… showing my sincerity: my discomfort or my satisfaction… not being afraid to pronounce it, to say it. Eh… if I don’t feel well, if I don’t think it’s correct, I’ll say it!”; *More confidence in myself* had to do with thinking “I gave my best, I believed in myself, … I believe I did my best. I can try to help the person recognize it, but if the person doesn’t want or isn’t able to, it’s not up to me”; *Thinking more in myself* was described as making choices “without harming anyone, … but without harming myself either”; *Liking me more* was elaborated in the interview as follows: ”when I look in the mirror … I like to see myself, I like it more to see myself”; *Bigger balance in my relationship with my boyfriend* meant mostly “not idealizing so much… letting things happen naturally”; *Bigger balance in my relationship with my father* was described as follows: “I think that if my father still hasn’t realized that he needs to change, I can try to help, … but it has to be him to want that. Eh… so I try to have a friendly relationship with him…”

After identifying what changed, the client was also asked about the possible causes of those changes. Caroline pointed out dimensions of self-knowledge and construction, as follows: “it was a period of getting to know myself”, “I was able to make an analysis that I had never done until that moment”. “It was a construction, right there”. She also highlighted the collaborative nature of therapy: “I experienced a method of me being the one trying… to reconstruct myself, so to say, from… myself, from what I thought”; “[the therapist] was there to guide my speech, … making questions, questions that I know were strategic, that were meant to get somewhere…”; “First I talked and said everything I had to say about an issue, … then she helped me to

concretize it … . She shared it with me, I took it home, examined it once again, and then… I was driven, I started step by step, day by day". Moreover, the client valued the absence of diagnostic labels, as we can observe from her words: "I never got a diagnosis, […] I got treated knowing that I was a sane person".

Table 3. Change Interview results: Identified changes

Identified changes	1 – Totally expected 2 – Somewhat expected 3 – Neither expected nor surprising 4 – Somewhat surprising 5 – Totally surprising	1 – Would definitely NOT have happened 2- Would probably NOT have happened 3 - I don't know 4 – Would probably have happened 5 – Would definitely have happened	1 - Not important 2 – A little important 3 – Moderately important 4 - Very important 5 - Extremely important
1. Becoming less inhibited	2	1	4
2. More confidence in myself	1	1	5
3. Thinking more in myself	2	1	5
4. Being more affective at home	2	1	5
5. Understanding that other people are not always as we wish they were	4	2	4
6. More predisposition towards friendship	2	2	4
7. More joy and laughing	1	1	5
8. Liking me more	4	2	5
9. Learning that change depends on ourselves	4	2	4
10. Bigger balance in my relationship with my boyfriend	1	1	5
11. Not taking work home	3	3	3
12. Bigger balance in my relationship with my father	1	1	4

Not changed: Academic difficulties

The therapeutic relationship played an important role for Caroline, as she explains: "It's very important to feel that you have someone there that really cares for you, someone who's there for you". The therapist's informal personal style was also well accepted by the client, as she refers in the example: "She often criticized me! When I said something like: 'oh, maybe I won't make it', or something like that; 'There you are with the pessimism!' She said. That's also a way of helping."

Therapist's perspective

In the therapist's final interview she described the client as very engaged in therapy, motivated and actively collaborating. She identified as the most problematic areas a conflictive relationship of the client with her father and a submissive position towards the boyfriend. In her point of view, Caroline had started therapy "completely stuck, blocked" and showed a clear change by the end of the treatment, mostly in her "attitude" and in becoming "much more active". According to her, change started to appear in the dilemma elaboration phase, after the use of the controlled elaboration task. At that moment, the client "was already capable of concentrating in her studies". The therapist also referred that Caroline "realized that she didn't have to solve all of [her boyfriend's] problems, and when he broke up with her she somehow didn't feel so bad". She considered this an example of the client being able to "generalize", starting with a focus on academic issues and broadening changes to other areas of her life, some of which were not worked on until the final phase of therapy, as was the case of her intimate relationship.

Has the client changed?

Both quantitative outcome measures used (OQ45 and BSI) show a decrease from clinical to non-clinical levels of distress from the beginning to the end of therapy. Moreover, we calculated clinically significant change indexes (RCI; Jacobson and Truax, 1991), finding significant pre-post changes for OQ45 at 95% confidence level ($p<.05$), and at 80% confidence level ($p<.2$) for BSI values. Although the traditional standard is $p<.05$, Elliott (2002) proposes the use of the $p<.2$ level for clinically significant change, as a "reasonable assurance" level, "more realistic and useful" for use in data from a clinical setting (p.7).

When looking at qualitative measures, we found that no negative changes were reported by the client, even though she was directly asked about it. From the positive changes she did identify, 5 were considered "extremely important", 6 "very important" and only one "moderately important". No changes were considered "not at all important" or even "slightly important". Additionally, changes were stated by the client in a detailed, subjective yet non-ambiguous manner, as seen for example in this extract: "It used to be very difficult for me. I thought I had to be that person, I had to achieve every goal, I had to give all the answers at the right moment… but I'm not super-woman, right, so if I make it, great, I'm very happy; if I don't, I won't make a big problem out of that".

Considering all this information, we conclude that the client did change in a clear and consistent way.

Can this change be attributed to psychotherapy?

When performing the causal analysis we sometimes found contradictory or mixed evidence for some of the criteria. Although this is a characteristic of the process

of analysis, we found it sometimes hard to make the decision towards positive or negative indicators. To preserve the study's thoroughness, we chose to decide for negative in the case of doubt**.**

Corroborative evidence of treatment's efficacy

Starting with direct evidence, we looked for indicators that change happened, that it was significant and that it was due to therapy.

Retrospective attribution. For this criterion we considered the client's Change Interview, namely her rating of the identified changes in a 5-points scale concerning the question: "how likely you think this change would have been if you hadn't been in therapy?". We found that the client considered most changes to be due to therapy as she rated 7 of the 12 identified changes with "clearly would not have happened", 4 with "probably would not have happened" and only 1 with "no way of telling". No changes were rated as probably or clearly happening without therapy. When asked about her explanations for the changes, she answered: "What I think caused these changes […] was me, […] based on this here. I think here I learned the theory, so to say… and then I took the responsibility of changing." We considered this enough to say that there was a retrospective attribution of change to therapy on the part of the client.

Process-outcome mapping. The 12 changes Caroline identified after therapy were compared to the helpful events reported across therapy. Taking the qualitative description of those events in the HAT form, five judges contrasted them with each of the 12 final changes reports and searched for correspondence (appendix B). We assumed there was matching when at least 3 of the 5 judges signaled it. For example, in session 8 the client affirmed: "I could realize that being optimistic and sincere doesn't bring me more problems and is more beneficial for me; and that being hypocritical

ultimately brings more happiness to the others than to myself". All five judges considered this description to be an evidence of the "thinking more in myself" change happening during the process. Each event could serve as evidence to more than one change, whenever that was the case.

Half of the changes the client identified in the change interview were already mentioned in the HAT forms along the process. Concretely, "Learning that change depends on ourselves" was supported by six events, in sessions 6, 7, 8 (twice), 11 and 12; "More joy and laughing" was supported by three events, in sessions 8, 9 and 12; "Thinking more in myself" was supported by two events, in sessions 4 and 8; finally, supported by one event each, we found "becoming less inhibited", referred in the HAT in session 2, "more balance in my relationship with my boyfriend" in session 11, "gaining more confidence in myself" and "liking me more" both in session 12. This way, we considered the process-outcome mapping premise verified.

Early change in stable problems. Caroline's change seems to be due to therapy also when we look at the problem's duration: according to the client's statement in her request for therapy, it had lasted for one year before the beginning of the process, but once in therapy it changed quite quickly. In fact, before session 3 we noticed a reliable change in OQ45. At the mid-therapy assessment (after session 5) the dilemma was no longer present and BSI's IGS was down to non-clinical levels.

Within-therapy process-outcome correlation. This criterion would be assessed by a comparison of session to session symptom variation with the amount of therapeutic work done in each session, as assessed through the therapist's self-report of having used the treatment principles, tasks and response modes characteristic of the therapeutic approach (Elliott, 2002). In our study, however, no such self-report measure was used;

instead, supervision was provided to the therapist with the objective of monitoring and increasing treatment adherence. The session's videotapes were used to verify the application of the therapeutic tasks prescribed by the manualized intervention at each session, finding that there were no "detour" sessions: all appointments were used to work on the prescribed therapeutic tasks. The lack of variation across sessions in this respect did not allow establishing a relationship between amount of therapeutic work and symptom decrease, at a session level. Thus, we did not consider this condition verified.

Event-shift sequence. This item looks for immediate effects of significant therapeutic events in weekly symptoms measures. In Caroline's case, the biggest decreases in OQ45 scores were seen at the beginning of sessions 3, 9 and 10. The previous sessions don't present more significant events, or more important ones than the rest of sessions in the process. The events signaled in those sessions don't differ from the rest of events in their relation with therapeutic tasks or to client's self-reported changes. Thus, the points of most pronounced symptomatic improvement are not corroborated by other measures, so that this criterion was not confirmed.

Exclusion of alternative explanations

As described, we found evidence for three of the five possible direct indicators of therapy's efficacy. As a minimum of two is required to support the efficacy hypothesis, we moved further to the analysis of indirect evidence. That is, we searched for alternative explanations that could possibly account for the reported change. If these were enough to explain change, we could not affirm that therapy was effective.

First of all, it was necessary to verify whether we were facing real improvement, rather than *trivial or even negative change*. This gave us the answer to our first

question, i.e., if the client has changed. As exposed above, both quantitative and qualitative measures show us that change was clear, positive and relevant to the client.

Another alternative explanation could be that the change we found was actually due to *statistical artifacts*. For example, experiment wise error could have occurred since we used different measures of results; but change was recurrently found in OQ45 and BSI, further confirmed by the qualitative measures. Moreover, as stated above, quantitative changes in symptoms from pre-therapy to follow-up assessments were statistically significant. Even though we didn't use more than one pre-test as recommended (Elliott, 2002), having found a stable change in a one year-old problem reduces the likelihood of that being the case.

Undoubtedly, *relational questions* may play a role in the client's assertion of improvement, as clients who feel close to therapists may want to give a positive evaluation of their work. Sympathy for the researcher may also lead clients to inflate change reports in order to please the researcher. In Caroline's case, we did find very positive descriptions of both the therapy and the therapist and didn't use any measure to assess social desirability. The client was found to be somehow identified with the therapist and showed a high therapeutic alliance. However, the client's descriptions of change were detailed and idiosyncratic enough to suggest a genuine account of her experience and she did refer to a not achieved goal in therapy. The fact that she was interviewed by an independent researcher rather than her therapist and explicitly asked about negative changes felt in therapy aided to diminish the effects of relational artifacts in the research.

The client's positive expectations concerning therapeutic efficacy might have played a role in her perception of change, as can be deducted from the fact that she

didn't consider any change to be totally surprising: only three of the identified changes were quite surprising and one was neither expected nor surprising; four changes were somewhat expected and four totally expected. Still, the client's descriptions of changes were convincing enough to consider that *expectancy artifacts* may have played a role, but were hardly sufficient to explain the observed changes.

Self-correction processes may play an important role in clients' change, rather than therapy. In Caroline's case self efforts were described as an important factor in the client's improvement, but always combined with therapy, as seen on this extract: "What I think caused these changes… I think it was me, after all. Or me based on this here. I think here I learned the theory, so to say… and then I took the responsibility of changing. It was my job out there, day-to-day, at the moments, at the occasions, to change." In fact, most changes are attributed to therapy by the client and we found a sustained change in a previously stable problem, which argue in favor of the therapy's relevance, as the client had not achieved these changed by herself before therapy.

No significant changes in the client's life occurred during the treatment. When asked about *extra-therapy events*, Caroline referred the support of family and friends: "those people cared to know what I heard here, what… how I lived it, and they also helped in impelling me to action, in causing that change". She also mentioned "the conjuncture" as well as her own efforts. The fact that these factors were already present before change happened indicates they were not a probable cause of Caroline's improvement, but rather positive conditions that might have favored therapy's efficacy.

No *psychobiological* interfering processes were observed since the client didn't present any significant medical conditions before or during therapy and follow-up time, nor took any psychotropic medication in that period.

The fact of participating in *research* could have caused some enhancement of therapeutic results, especially recall interviews where the client had the opportunity of watching her own therapy sessions. Indeed, she referred to that experience as “a joint work” between herself, the therapist and the researcher. This is not surprising if we consider that research always interferes with its objects. In fact, the constructivist epistemology sees this as an inherent condition of every investigation (Guba & Lincoln, 1994). Psychotherapy process research methods typically require reflection about the process in study, by repeatedly answering questions about what was important in the therapeutic session, why it was important, how they feel about the therapy and the therapist, and generally how they feel in their lives. Repertory grid completion has also been suspected to influence therapeutic outcome (Watson & Winter, 2005) and tape assisted recall interviews may have an even stronger effect on clients (as exemplified in Gale, 1992). By watching themselves in video clients become aware of aspects of their expression, behavior or speech that they might not have been aware of. Having the interviews delayed in some weeks after the session, as was the case for Caroline, clients can make comparisons between how they were in the session and how they see themselves at the moment of the recall, realizing how much they feel different already. This kind of understanding may have impacted the client by reinforcing the changes caused by therapy.

In summary, some of the alternative explanations, such as self efforts, relational aspects and enhancing effects of research, might have played a part in the changes found. However, we do not think they are enough to account for Caroline’s improvement.

What specific factors are responsible for change?

Looking at the weekly variations in the OQ45 scores and comparing them to the sessions' content, we found that the points where bigger drops in symptomathology occurred followed the tasks of constructing the repertory grid, controlled elaboration and historic reconstruction of the dilemma, suggesting a stronger impact of that work.

Although the repertory grid technique was included in the assessment phase of the treatment, it is known that "the client often starts to look at life from a different perspective when completing procedures designed primarily to provide the counselor with insights into her construing" (Fransella & Dalton, 1990, p. 79). In fact, Caroline improved early on the therapeutic process, as symptoms had decreased significantly by session 3 and the dilemma was no longer present at the intermediate assessment that took place at the beginning of phase 3, *dilemma elaboration, i.e.,* when the intervention phase of treatment, aimed at the elaboration of the client's dimensions of meaning, had just begun. This early resolution might have been made possible by the fact that the dilemma's intensity, that is, the correlation between the congruent and the discrepant constructs, was not very high (r = 0.28). We would expect that more intense dilemmas need a more extensive therapeutic work to achieve resolution.

Controlled elaboration and historic reconstruction of the dilemma were the other two techniques with most impact in Caroline's therapy. These were part of the *dilemma elaboration* phase, suggesting that this type of work has also been relevant for the client. That importance is corroborated by the fact that more events started to emerge from session five onwards, and being rated as more important, showing that Caroline began to experience therapy as (even) more helpful in that phase of the treatment. We consider that although change occurred very early on the process, the remaining sessions played an important role in consolidating the early changes and developing the

client's ability to shift perspectives (G.J. Neimeyer, 1995), which allowed her to achieve many other novelties (the client describes 12 changes by the end of therapy, even though she had only established 3 goals to start with) and keep improving after the end of therapy.

Looking at the grids' results, we see that the client solved her dilemma early on the process and no other conflicts emerged, but changes in her construction system are overall not striking. In fact, self-esteem and perceived closeness to others stayed at nearly the same values during the treatment and only improved in follow-up. This may be due to the fact that these measures already showed quite positive values at the initial assessment point.

Construct differentiation has been related to psychological health (Feixas et al., 2004), leading us to expect its increase in a successful therapeutic process as Caroline's. However, the client not only didn't gain differentiation along the therapeutic process, she became less complex and more extremist – as the PVAFF and polarization indexes increased. These results are consistent with previous research that found a tendency to grid tightening with repeated administrations (Feixas, Moliner, Montes, Mari, & Neimeyer, 1992). After a more attentive analysis we understand that Caroline's movement consisted in an improvement since she was functioning in a less ambiguous way after solving her conflict. This interpretation is coherent with the self-reported gain of self-confidence and assertiveness to others, as Caroline's constructions gained predictive strength when they became less flexible and more integrated. In the same sense, the weight of the element *self* in the first factor passed from zero to three. Although this isn't a dramatic change, it shows a movement from an initial state of being irrelevant to her own most prominent dimension of meaning to taking a clear

position in that first axis – in the most positive direction. Actually, having a weight of zero means not being able to choose one side for the self in the axis that gives sense to most of the individual's interpersonal world; by choosing one side, the client has made a decision about who she is. These findings suggest that loss of differentiation does not necessarily represent deterioration.

The results also suggest to us that Caroline's change included a process of temporarily separating from others, while elaborating alternative ways of relating to them. This is seen in the grid's measures concerning identification with others: at the mid-therapy assessment Caroline's self-others correlation had decreased to a close to zero level, going back to near the starting level at the end of the treatment and increasing into follow-up. This movement is compatible with some of the changes reported in the change interview, as "understanding that other people are not always the way we wish they were", "bigger balance in my relationship with my boyfriend", "bigger balance in my relationship with my father", or "more confidence in myself". According to the client's descriptions, these changes had to do with feeling less responsible for other people's behaviors or problems, as well as being more able to assert her own wishes and opinions to others. When alternatives were available, in the form of the achieved changes, the client's correlation with others started to increase, going back to the starting point and later evolving towards a bigger identification. Actually, most of the changes identified by Caroline in the change interview had to do with interpersonal themes. While gaining a more meaningful place in her own world, the client also gained a voice in her relationships with significant others.

The dilemma resolution visible at the intermediate assessment was still incipient, as the client still construed the poles *optimistic* and *hypocritical* in related ways more

often than not. She was able to be *a little optimistic* as she was an exception to the rule, different from other people. She was still trying for fit the possibility of these constructs being compatible. Only by the end of the process she could use the two previously conflicting constructs independently, with herself and with others as well, attaining a stronger satisfaction with herself (quite optimistic, very cold) and restoring her perceived closeness to others.

The therapeutic relationship was a fundamental aspect of therapy, establishing the necessary conditions for its success, as predicted by PCT (e.g., G.J. Neimeyer, 1995) and psychotherapy research in general (e.g., Horvath, 2001; Lambert & Barley, 2001). Expectancy aspects have also been found to be relevant in this case, as expected according to the literature on psychotherapy research (e.g., Joyce, Ogrodniczuk, Piper, & McCalum, 2003; Lambert & Barley, 2001). Caroline's enthusiasm about therapy points to the probability of her having high expectations about therapy, which could indeed have lent a hand to the therapy's efficacy. These two factors – alliance and expectancy – have been associated in the literature, suggesting that having positive expectations about therapy benefits the therapeutic relationship, which in turn promotes therapy's efficacy (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004; Joyce et al, 2003).

Coherently with the PCT theory, personal efforts to take benefit of therapy played an important role in the change process. In fact, the treatment model used is meant to promote reflection and agency by the client, rather than directing her movements. The collaborative nature of constructivist intervention and its great respect for the clients' way of making sense of the world and themselves encourages clients to construct their own solutions, making change a very personal movement, like the kind

we find in Caroline's case. Her comments (transcribed above) show how she took responsibility for her own process of change, with the therapist's help.

The therapeutic process prompted the client's process of change and personal development, ending while it was still in progress, which didn't by any means stop the ongoing process. The client appears to have completed therapy more capable of and/or more motivated to pursuing her own goals. Therapy must have provided her with enough confidence and self-knowledge to go on with it by herself, as with the skills of challenging her own point of view and considering alternative ways of looking at her reality (G.J. Neimeyer, 1995). The different quantitative measures, namely BSI, OQ45 and the Repertory Grid, constitute evidence of this phenomenon, as they consistently show improvement occurring during therapy and going on after the treatment into follow-up, with more dramatic results at this last assessment point.

Still other aspects of therapy referred by Caroline as enabling her change have a strong connection with the presuppositions of the therapeutic model used in her treatment: The fact of not receiving a diagnosis is related to a vision of clients as capable, coherent people, and the rejection of a deficit label frequently associated with diagnosis. Promotion of self-knowledge and development of new ways of thinking are some of the general goals of constructivist therapy (R. Neimeyer, 1993, R.A. Neimeyer, 1995). The client's mention of therapy as a process of construction is a final attestation that the therapy respected its personal constructivist principles.

A summarized explanation of change in the case of Caroline

The therapeutic relationship and the elaboration work of PCTID promoted the client's increased self-knowledge and the generation of new ways of thinking. Caroline's commitment to therapy and active exploration summed to those factors in

allowing the implicative dilemma and symptoms to be overcome early in therapy, and for changes to be consolidated and amplified along the therapeutic process.

The dilemma in focus disappeared as the discrepant construct became congruent, i.e., as the client was able to attain her desired pole, first timidly and later in a clear way, rating the self as *quite optimistic*. The congruent construct remained so, and even became more salient, with self and ideal coming to an extreme polar position. Considering this, we can say the dilemma was solved in a satisfactory way, that is, the blockage disappeared.

However, the conflicting constructs were still very close (or closer) when the dilemma first disappeared. Caroline was able to reconstrue herself as *optimistic* by temporarily isolating her vision of herself from that of others, finding the space to build a novel way of relating to them. When a more coherent and defined construct system was achieved, the client came back closer to others, with an increased self-confidence and assertiveness. In was only then that the two constructs previously involved in the dilemma came apart, showing a clear resolution of the conflict.

The client's movement to the desired pole in the discrepant construct was accompanied by a tightening of her construction system. Her psychological confusion, showed by the weigh zero of the self in the first dimension of construction, was resolved when the impasse was solved.

By the end of the treatment, Caroline was capable of generating change by herself, as was patent in her continuous improvement into follow-up assessment, showing that the therapeutic process provided the client with the tools that got her back into the construing movement.

Study’s strengths and limitations

The richness of a clinical case makes it impracticable to analyze and report the data from all the available material (Aveline, 2005). The HSCED methodology helped us focus on one part of the information and we prioritized data from the quantitative and qualitative instruments over session videos or therapist’s notes. Within the choices done, we tried to produce a comprehensive and systematic analysis of all information of the selected types. Nevertheless, other approaches to the material would certainly have uncovered new and relevant information on Caroline’s process of change.

To enhance the quality of our work, we attempted to comply with some recommendations for case-based and qualitative research (Aveline, 2005; Barker, Pistrang & Elliott, 1994; Edwards, Dattilio, & Bromley, 2004; Morrow, 2005; Stiles, 2007). The use of several standardized measures of outcome at different moments of the therapeutic process and its complement with measures of the therapeutic process created the conditions for the systematic study of a single case. Further, we tried to include in this paper the relevant information concerning the researchers, research context, processes, participants and researcher-participants relationships as a way of clarifying any biases that could have influenced our work. The provision of detailed information on the study’s procedures was also meant to assure its replicability. The variety of sources of information used allowed us to corroborate the observations and we provided transcripts of the client’s report to fundament our analysis. The collaboration of peer researchers as co-judges was used when we felt a particular judgment was more subjective, namely the verification of the process-outcome mapping criterion of efficacy. All the analyses were audited by the second author. Moreover, the analysis methodology selected, HSCED, includes a negative case analysis, which looks for other

possible explanations that might account for the findings, thus strengthening the findings from the case (Morrow, 2005; Yin, 1994). A quality criterion we failed to comply with was having the results verified by the participants, as contact with the client had been lost by the time the analyses were completed.

As a single-case, the findings from this work cannot be directly generalized to other therapeutic processes (Stiles, 2007; Willig, 2001). However, it is our assumption that our observations from this case have the potential to occur in the therapeutic processes of other individuals facing dilemmas. Namely, that (1) personal construct therapy for implicative dilemmas is a helpful and effective treatment for clients with such conflicted structure; that (2) the therapeutic relationship, the dilemma elaboration work and the client's active efforts are fundamental ingredients of this therapy; that (3) dilemma resolution is manifest by the discrepant construct becoming congruent, while the congruent construct remains congruent; and that (4) dilemma dissolution is associated with symptom reduction and with overcoming of personal confusion, as observed in repertory grids showing an increased weigh of self in first factor and tightening of construction. Further research would be needed to assess those hypotheses.

Conclusion

Both of our study's objectives were achieved, as we confirmed the efficacy of the treatment manual in Caroline's case and built an explanation of the process by which that change happened, based on personal construct theory. We mostly confirmed the theory's application to our case, namely the relevance of aspects as the therapeutic relationship, elaboration, the client's active role in the process, the promotion of self-knowledge and the development of new ways of construing. The theory's perspective on therapy termination was also confirmed by the case of Caroline, who kept changing

after therapy was over, showing that she had became capable of generating change by herself. The client's experience of her change process was clearly close to the theoretical assumptions of the treatment manual used in her therapy.

The application of the theory to a case of personal construct therapy for implicative dilemmas contributed to its expansion in some aspects, concretely bringing some light on the ways in which the clients' construction systems move to allow implicative dilemmas to be overcome. Caroline's dilemma was solved allowing the client's achievement of her desired pole, so that the discrepant construct became congruent. To make that reconstruction, the client passed through a phase of relative psychological isolation, until alternative ways of being were available and she could use the two constructs independently. Tightening of her construct system and increase of the weight of the element self in the first factor were the structural results of this change, showing the resolution of the client's previous state of confusion and the increase of her system's usefulness to predict events.

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CHAPTER 3

Processes of change in personal construct therapy for implicative dilemmas[4]

Abstract

In a personal constructivist perspective, psychological distress represents a blockage in the client's cyclic process of construction of the self and the world. Implicative dilemmas are one type of such blockages, where the problem is significantly correlated to constructs that are central to the subject's identity.

A new treatment was proposed for the direct approach of implicative dilemmas, expecting to help clients to get back on the construing movement. In this paper we present a multiple case study of personal construct therapy for implicative dilemmas.

With the replication series of 8 cases, we contributed to the understanding of the personal reconstruction processes that occur while resolving an implicative dilemma as personal construct theory was applied to the cases and a specific change model was built. In addition, we found positive signs of this treatment's efficacy when applied to clinical practice.

Processes of change in personal construct therapy for implicative dilemmas

Kelly's (1955) personal construct psychology sees individuals as actively construing their reality through the building of meaning upon their experience.

[4] This work was submitted for publication in co-authorship by Joana Senra and Eugénia Ribeiro.

According to its philosophic assumptions, there is no correct knowledge; only theories that have not yet been invalidated. The same situation can be perceived in as many different ways as there are individuals perceiving it. All of our perceptions are subject to revision, and things that seem obvious are only that way because we have not yet been capable of conceiving an alternative point of view to it (Feixas & Villegas, 2000; Fransella & Dalton, 1990; Kelly, 1970).

By the detection of similarities and differences between events (or things), human beings give meaning to the world, through a basic unit: constructs. These meaning units are bipolar in nature, that it, by recognizing a similarity between two events, we are implicitly identifying a difference between that pair and other events, which do not share that common feature. For example, when we say December and January are *cold* months, we have in mind their contrast with other months, which we construct as *warm*. Constructs relate to each other within each individual's personal network, forming a hierarchical system, where some meanings imply others. Thus, change in one construct usually brings change in other, related dimensions of meaning.

Like a personal scientist, each person creates hypotheses concerning their experience. Those hypotheses are to be tested in the confrontation with events, leading to their refining, revision or elaboration (Kelly, 1970). Every action we take is an experiment, designed to develop our personal theories. Or, as Kelly said, every action is a (research) question. As our theories are never completely accurate, they are in constant evolution as a consequence of their (and our) confrontation with events. This way, change is a constant in the healthy individual's personal construct system.

The cycle of experience (Kelly, 1970) describes the process through which our theories (or anticipations) are used to predict events. For every event we encounter, we try to apply our existing constructions to make sense of it. That way, we make some predictions about what we are about to experience (1 – anticipation). By doing so, we open ourselves to the experiment we are about to make, putting our previous knowledge at skate (2 – implication); When we actually come across the event (3 – encounter), our theory can either be confirmed or falsified (4- validation/ invalidation), leading to its strengthening or reformulation (5 – constructive revision). So, through any experiment, we may consolidate our constructions, but we may also question our vision of things, leaving us the need to replace it with an alternative view that better fits the new evidence. However, this happens within some limits, those of the possibilities that our system is capable of construing.

As explained, people don't need to change because they have problems. Rather, they have problems when they cannot change. Change is health. Conversely, psychological distress is seen as the impossibility of completing the natural cycle of change. Some constructs may be repeatedly used in spite of their invalidation. The system may not be able to accommodate to the events it is facing, as suitable alternatives of construction are not available to the subject. The person is stuck, or forced to walk in circles. The symptoms presented are the solution the individual has been able to find, even if it is too high a price to pay. The therapist needs to understand the perspective from which the client's behavior is not stupid or irrational, just the better solution she has been able to conceive until that moment (Fransella & Dalton, 1990; Tschudi, 1977). In this logic, PCT's diagnoses have more to do with the processes and structure of the clients' construction than with groups of symptoms.

Successful therapy, then, is one that can restart the individual's continuous change movement. Personal construct therapy (PCT) does not prescribe stages clients must go through or themes that must be explored (Fransella & Dalton, 1990). It is essentially eclectic in terms of techniques, as long as those are used within a theoretically coherent conception of the case.

PCT emphasizes the therapeutic relationship as the secure environment that allows for the development of the two fundamental aspects of therapy: exploration and experimentation (G.J. Neimeyer, 1995). It happens that change, although natural and healthy, is often lived as a threat by individuals. When a significant change is about to happen, a considerable part of the person's current constructions faces invalidation. If this happens, the subject could be left without valid constructions to make sense of her experience, which constitutes Kelly's definition of anxiety. Therefore, individuals understandably develop resistance to change until a satisfying alternative set of constructions is available.

In order to respect this difficulty, constructivist therapists start by accepting and supporting the client's existing constructions, to then provide nonthreatening ways to explore alternatives. This way, an experimental context is created, through the use of a hypothetical language that allows for the previous constructions to stay intact while new possibilities are developed and tested. Experiments are proposed in a hypothetic, "as if", context meant to diminish threat and the consequent resistance.

Given these conditions, the client's active exploratory behavior is the remaining fundamental component of therapeutic success (G.J. Neimeyer, 1995). It is not the

therapist's place to change the client or to teach him how to live; it is the client who must actively elaborate his constructions and create new possible selves.

Implicative dilemmas

Implicative dilemmas are one particular type of blockage that can appear in the construction process. They draw from the association between constructs of different value to the individual. That is, the problem or the aspects the client wants to change (discrepant constructs) are correlated to constructs in which she is contented with her current position. This is more of a problem when these positive (or congruent) constructs are central to the subject's identity. The subject cannot perform the desired change, because that would imply another, undesired, change (Feixas & Saúl, 2004; 2005). It is to expect, than, that clients presenting implicative dilemmas will present great resistance to change (Sánchez & Feixas, 2001). An implicative dilemma is a form of organization of the individual's construction system, i.e., it is a matter of structure more than content. Thus, it is cross-sectional to DSM (APA, 1994) diagnoses.

Implicative dilemmas have been present in personal construct psychology literature from early times (for example Hinkle, 1965; Tschudi, 1977) and can be expressed in different ways in the therapeutic context. However, clients are often unaware of these conflicts. Therefore, a method for the identification of implicative dilemmas was developed by Feixas' team (Feixas, Ávila, Saúl & Sánchez, 2001; Feixas & Saúl, 2005), based on the repertory grid technique (Kelly, 1955; Fransella, Bell & Bannister, 2004). These authors also found that this is a very prevalent situation, especially in people who seek therapeutic help, affecting more than half of the clinical population and about a third of non-clinical subjects (Feixas, Saul & Ávila-Espada,

2009). Their research also showed that the number of implicative dilemmas tends to decrease significantly with successful psychotherapy. Saúl (2005) found that 69.4% of clients with implicative dilemmas had resolved them at the end of a psychotherapeutic intervention not directly oriented to the work of dilemmas.

Personal construct therapy for implicative dilemmas (PCTID) was developed by Senra, Feixas and Fernandes (2007; also Senra, Feixas & Ribeiro, 2010) as a treatment manual for directly approaching and seeking resolution of this kind of personal conflict. A systematic case study was conducted on its first application to clinical practice (Senra & Ribeiro, 2010). In this paper, we present the results of a clinical replication series of that case study. Our goals were (1) to perform a preliminary test of the treatment's efficacy; (2) to verify the application of personal construct theory of change to the treatment of implicative dilemmas and to elaborate a specific model of change as observed in clients presenting implicative dilemmas and participating in PCTID.

According to Kelly (1970), one of the possible ways in which a person's construction system can change is through the modification of the relations between constructs, as their implications or hierarchical position within the system vary. We hypothesized that dilemmas would be solved by this type of movement, concretely by the reduction or elimination of the problematic implication between the involved constructs, which would allow for the individual to move along the discrepant construct in the direction of the desired pole.

Method

Participants

Therapists. The authors provided a group of therapists a 16 hour-long training program focused on the constructivist therapy for implicative dilemmas manual and offered them supervision for the manual's implementation. From 13 therapists starting the training program, eight initiated the manual's application and data gathering with at least one client. The first author also participated as a therapist, receiving supervision from the second author. A total of 4 therapists, here identified with letters A through D, conducted the cases analyzed in this study. Their individual presentation is displayed in table 1.

Table 1. *Therapists' individual characteristics.*

Therapist	Gender	Age	Experience (in years)	Complete cases followed in the study
A	F	25, 26*	2, 3*	3
B	F	30	6	1
C	F	25	3	1
D	F	28	2	3

Note. * Therapist A participated in the study during two years. Case 1 was treated one year before cases 4 and 5.

Clients. Thirty clients signed informed consent forms for participation in this research, in their first therapeutic session. Eight of them completed the treatment program and participated in our study during and after their therapeutic processes. Some of their characteristics are presented in table 2. The remaining 22 clients either didn't present implicative dilemmas, didn't agree to focus their therapeutic work on them,

Table 2. *Clients' individual characteristics.*

Client	Therapist	Gender	Age	Occupation	Presenting problems	Diagnosis (DSM IV)*	Process length**
Caroline	A	F	20	University student	academic difficulties; depressive symptoms	adjustment disorder with depressive symptoms	12 + 2
Ashley	B	F	21	University student	anxious symptoms; difficulty in impulse control	None	19 + 2
Lily	C	F	19	University student	shyness, social difficulties; lack of concentration	None	12 + 0
Albert	A	M	49	Clerk	difficulties facing ageing; marital problems; interpersonal problems at work	adjustment disorder with anxious symptoms	16 + 0
Melanie	A	F	25	Unemployed	anxiety; history of panic disorder	generalized anxiety disorder	17 + 0
Christine	D	F	32	Factory employee	depression; marital problems; headaches	Major depression	18 + 3
Linda	D	F	22	University student	episodes of depressive affect and easy crying; excessive worrying with others	generalized anxiety disorder	14 + 14
Susan	D	F	23	University student	feeling lost and stuck in time; career indecision; difficulty in accepting adulthood responsibilities	adjustment disorder with anxious symptoms	20 + 7

Note. * Diagnostic and statistical manual of mental disorders (APA, 1994).
The therapeutic model used does not require the attribution of DSM diagnoses, and therefore not all therapists used those. We present the diagnosis when therapists did attribute them, as a way to summarize the type of symptoms presented.
** Number of sessions within the therapeutic manual + number of sessions that took place after the manualized treatment.

dropped out of treatment at any point or their therapists decided other treatments were more relevant to their conditions at any point before completion of the treatment protocol.

Researchers. The first author conducted the data collection procedures for the other therapists and their clients. Three colleagues conducted the change interviews with the first author's clients (one interviewer per client). All of them were psychotherapists and PhD students with experience in qualitative research procedures.

The treatment

Personal construct therapy for implicative dilemmas (PCTID; Senra, Feixas & Ribeiro, 2010) is a manualized intervention program designed for intentionally addressing an implicative dilemma, elaborating on the implied constructs and exploring alternative construction forms that allow the individual to overcome the blockage and achieve a preferred position for the self.

It is structured in 5 stages, aiming at a total treatment length of approximately 16 individual therapy sessions. It is planned for weekly, 50 minutes-long sessions, except for the last stage, for which the manual suggests a frequency of two sessions per week. The plan begins by an *assessment* phase (1) in which the client's demand is shared and negotiated with the therapist and the therapeutic relation is established. In the 3 sessions that comprise this phase, symptomology and personal constructions are sampled by the use of clinical interview, self-report questionnaires, repertory grid and self-characterization (Kelly, 1955) techniques. Session 4 is dedicated to *reframing the client's problem as a dilemma* (2), through the examples of significant others dropped

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sessions centered on the client's meanings, her current experience and life history. Next comes an *alternative enactment* (4) phase, in which a fixed role therapy is implemented with the client through approximately 5 sessions. This is considered an optional stage, which shouldn't take place when both therapist and client consider that change has already been attained and prefer to continue directly to stage 5 – *termination*. In this last session, a reflection is proposed about the therapeutic experience, changes felt and implications to the client's future.

Measures

Clients' construction system. The client's construction system was assessed through the Repertory Grid technique, a structured interview method evolved from Kelly's (1955) work, which has been widely applied in clinical practice as in research. Fransella and colleagues (2004) provide a complete description of the technique and the main measures derived from it. This interview provides a sample of the clients' constructs and of the ways they use them to make sense of their interpersonal relations, through the creation of a personalized instrument. In the version used in this study, the clients were asked to provide a number of people to represent a pre-established set of roles (e.g., father, friend, partner, disliked person) and then to compare them, two at a time, in order to find differences and commonalities between them – the dyadic method of construct elicitation. The two axis of the grid are obtained from this procedure: elements - the people (including some preset elements: present self, ideal self, self before problems and self six months into the future) - and constructs - the characteristics found and their opposite poles (including the aspect or aspects the client wants to change). The center cellules of the grid are to be completed with numeric scores,

representing the client's assessment of each person on each construct. These scores vary between 1- *very much like pole "a"* and 7 – *very much like pole "b"*. The resulting grid can be analyzed by qualitative as well as quantitative methods.

The clients' grids were analyzed with the Gridcor v.4.0 informatics' application (Feixas & Cornejo, 2002), which calculates a number of measures of the subject's construction system's structure. Among them is the identification of congruent and discrepant constructs and their association in implicative dilemmas. For this study we considered only some of the measures available from this source, namely: the presence of implicative dilemmas; the self-ideal self correlation, considered a measure of self-esteem; the self-others correlation, considered a measure of perceived social isolation; the others-ideal self correlation, considered a measure of the perceived adequacy of others; the therapist–ideal correlation; the weigh of the element self in the first factor (from a factor analysis of constructs and elements); the percentage of variance accounted by the first factor (PVAFF), considered a measure of cognitive differentiation; and the total polarization index, which represents the amount of extreme rating values in the grid and is considered a measure of rigidity (Fransella et al., 2004; Feixas & Cornejo, 1996; Feixas, Bach, & Laso, 2004).

Client's distress. Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) is a self-report questionnaire used to asses the level and type of distress felt by clients and to differentiate between clinical and non clinical populations. It consist of 53 items, organized in 9 subscales – depression, anxiety, phobic anxiety, psychoticism, obsessions-compulsions, paranoid ideation, hostility, somatization and interpersonal sensitivity – and three global indices – Global Severity Index (GSI), Positive Symptom

Distress Index (PSDI), and Positive Symptom Total (PST). A 5-point Likert scale is used to score the items. We used the Portuguese adaptation by Canavarro (1999), which presents good psychometric characteristics, discriminating normal from clinical population with 92% to 95% efficacy compared to the clinical method.

The Outcome Questionnaire (OQ-45.2; Lambert et al., 1996) is a measure of psychological distress conceived for repeated use along treatment and follow-up, being particularly sensitive to short-time symptom variations. It is completed by clients at the beginning of each therapeutic session and monitors their progress in three dimensions: symptom distress, interpersonal relationships and social role functioning, plus a total score. We used the Portuguese version, currently being validated by Machado & Fassnacht (in preparation). The authors provided us with cutoff levels for clinical population (67.82) and reliable change indexes (18 points decrease).

Significant events. The Helpful Aspects of Therapy (HAT) form (Llewelyn, 1988) is a qualitative measure that asks the participants to describe any moments they considered helpful in each session, explaining why they were important and rating their relevance in a visual scale varying between 1 – *not helpful at all* and 5 – *extremely helpful*. Additionally, some information is asked to help track the events on the session record, namely the approximate moment within the session where it took place and the event's length. In this study we used the Portuguese version by Sales et al. (2007) with the clients.

The clients' qualitative descriptions of the events and their importance were analyzed in order to decide, for each event, whether it referred to a manualized task or to other aspects of the therapeutic session.

Working alliance. The therapeutic alliance was assessed through the Working Alliance Inventory (WAI; Horvath and Greenberg, 1989; Horvath, 1994). This self-report questionnaire uses a 7-point Likert scale to rate 36 items about the therapeutic relation. It provides global therapeutic alliance values as well as three subscales, representing agreement on therapeutic goals, tasks and bond between client and therapist. We used both therapist and client versions, in the Portuguese adaptation by Machado & Horvath (1999). To make sense of the results, we considered the mean values of the responses for the total score as well as for the three subscales, thus having a range of scores from 1 to 7. We considered mean scores of 1 or 2 to represent low alliance, 3 to 5 moderate and 6 to 7 high alliance.

Clients' perspective on their therapeutic change. In the Change Interview (Elliott, 1999; Elliott, Slatick & Urman, 2001), clients are invited to talk about their experience of the therapeutic process, focusing especially on the changes they consider to have occurred and on the factors – in and outside of therapy – they think have contributed to those changes. Not attained and negative changes are also asked for. All identified changes are rated in terms of importance, expectedness and probability of having happened without therapy, in three 5-points Likert scales.

Therapists' perspective on clients' change. At the end of each process therapists were interviewed about their experience working with the treatment manual in this case and their perspective on the client's problems and observed changes.

Procedure

The study was conducted in a university clinic, open to the outside community. The treatment manual was taught to therapists and applied to psychotherapeutic practice with some clients who agreed to participate in research. The first cases required some decision making to clarify some detail in the way the intervention should be delivered. These specifications were incorporated into the manual and used in all cases.

The data were gathered in several moments of the therapeutic processes, as shown in figure 1. Each case was analysed separately, in a case-by-case logic (Moras, Telfer & Barlow, 1993), and later integrated in a composed model of change. Our study's objectives, stated above, can be put in other words as: to observe if and how the treatment brought about change. To address the *if* question, we used a systematic case study design with a causal approach: Hermeneutic Single Case Efficacy Design (HSCED; Elliott, 2002). The *how* was dealt with through an explanatory, theory-building, case study design (Stiles, 2007; Yin, 2003).

Efficacy analysis. The analysis of a first case study (Senra & Ribeiro, 2010) had revealed that personal construct therapy for implicative dilemmas was a helpful and effective treatment for that client. In order to produce preliminary results on the treatment's efficacy (Moras et al, 1993), we replicated that case study with seven new cases and integrated their results with the first one's.

Each case was analysed through Elliott's (2002) Hermeneutic Single Case Efficacy Design (HSCED), a method conceived for the analysis of systematic case studies of non-behavioural psychotherapies. This is a causal design, aimed at establishing a relation between treatment and change, using data from a number of quantitative and qualitative measures of the therapeutic process and outcome. That

purpose is achieved through the corroboration of the changes by different measures, on one hand, and the exclusion of rival explanations for the results, on the other. Three main questions are asked in this method: Has the client changed? Was change caused by therapy? What specific factors were responsible for change?

Explanatory analysis. After the efficacy analysis was conducted, a case report was written for each case, following a predefined protocol (see appendix A). It consisted in the description of the client, the results from each measure used and from HSCED analysis, including an explanation of the process of change for that particular client.

In an explanation building (Yin, 2003), or theory-building logic (Stiles, 2007), the first case report was compared to the PCT's perspective on human and therapeutic change, in order to find out in what aspects it reflected the existing theory and in what features, if any, it suggested the need to expand it. This way, an explanation of change in constructivist psychotherapy for implicative dilemmas was constructed, from the comparison of previous TCP theory and observation from the case. Several aspects of the theory were confirmed by the case study, especially in the change factors identified by the client: the therapeutic relationship, elaboration, the client's active role in the process, the promotion of self-knowledge and the development of new ways of construing. The client's experience of her change process was also coherent with the theoretical assumptions underlying her therapy. Finally, TCP's perspective on termination was also confirmed, as the client kept improving on her own after leaving therapy, demonstrating she had learned to change her constructions by herself. The case

study also contributed to the definition of the theory, elaborating the ways in which implicative dilemmas can be overcome:

> Caroline's dilemma was solved allowing the client's achievement of her desired pole, so that the discrepant construct became congruent. To make that reconstruction, the client passed through a phase of relative psychological isolation, until alternative ways of being were available and she could use the two constructs independently. Tightening of her construct system and increase of the weight of the element self in the first factor were the structural results of this change, showing the resolution of the client's previous state of confusion and the increase of her system's usefulness to predict events (Senra & Ribeiro, 2010, p.30).

Cross-case analysis. As new cases were analyzed, some aspects of the initial explanation became strengthened, as they were confirmed by several case observations, while others began to look like particular aspects of an individual case, not replicated by others (Willig, 2001). These were considered as possible variations of the model, which was built mainly on the aspects that were repeatedly observed, as well as on the contrast between good and poor outcome cases. While variations are not neglectable, and should be considered when general statements are made and when new cases are compared to this sample, it is not viable to present all possible variants in our attempt to build a model that accounts for change in PCTID. Hence, we chose to present most variations

in the results section of this paper, but to then condensate the results in a model that takes in consideration the features shared by at least half of the good outcome cases, and their comparison with the poor outcome cases.

Results

This results section focuses on the compound vision of the eight therapeutic processes studied. The results are organized by the three questions guiding HSCED.

Have the clients changed?

The therapeutic processes using PCTID promoted significant change for five cases, according to the HSCED analysis performed.

All clients and therapists considered therapy successful and identified relevant positive changes, including the achievement of some of the initial therapeutic goals. However, we required the confirmation by at least one outcome measure to answer to this question affirmatively. Each case's symptoms scores in BSI are presented in figure 2. A reliable change index (RCI, Jacobson & Truax, 1991) was only found in the case of Christine. However, Caroline and Ashley made clear decreases in that measure, crossing the clinical case threshold. OQ45 results are displayed in figure 3. RCI were found in this measure for Caroline, Ashley, Lily, Albert, Christine and Susan. These were named *good outcome* cases.

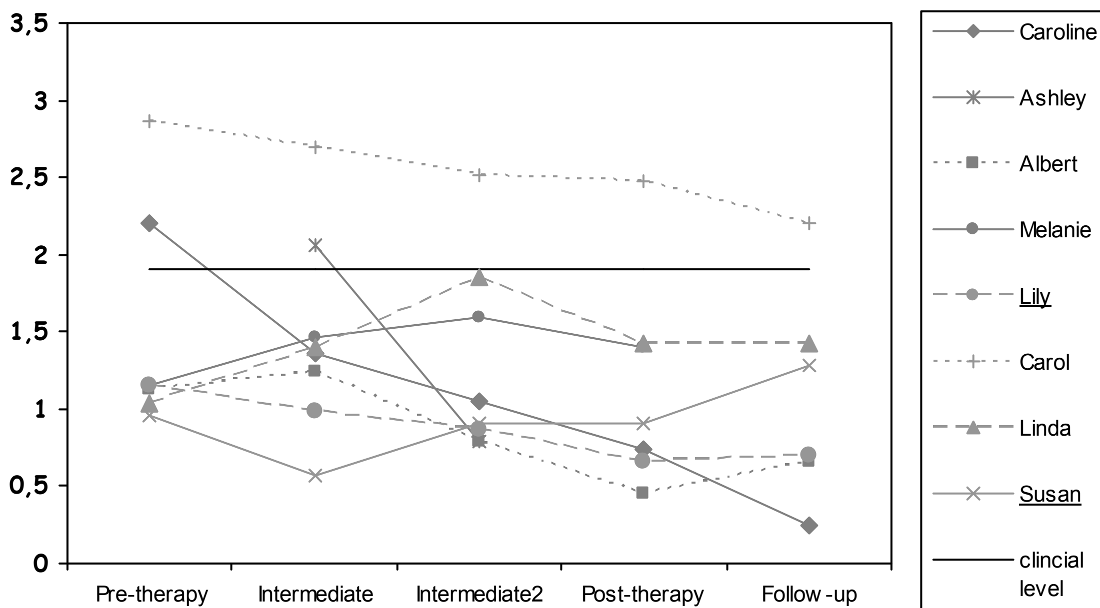

Figure 2. BSI results.

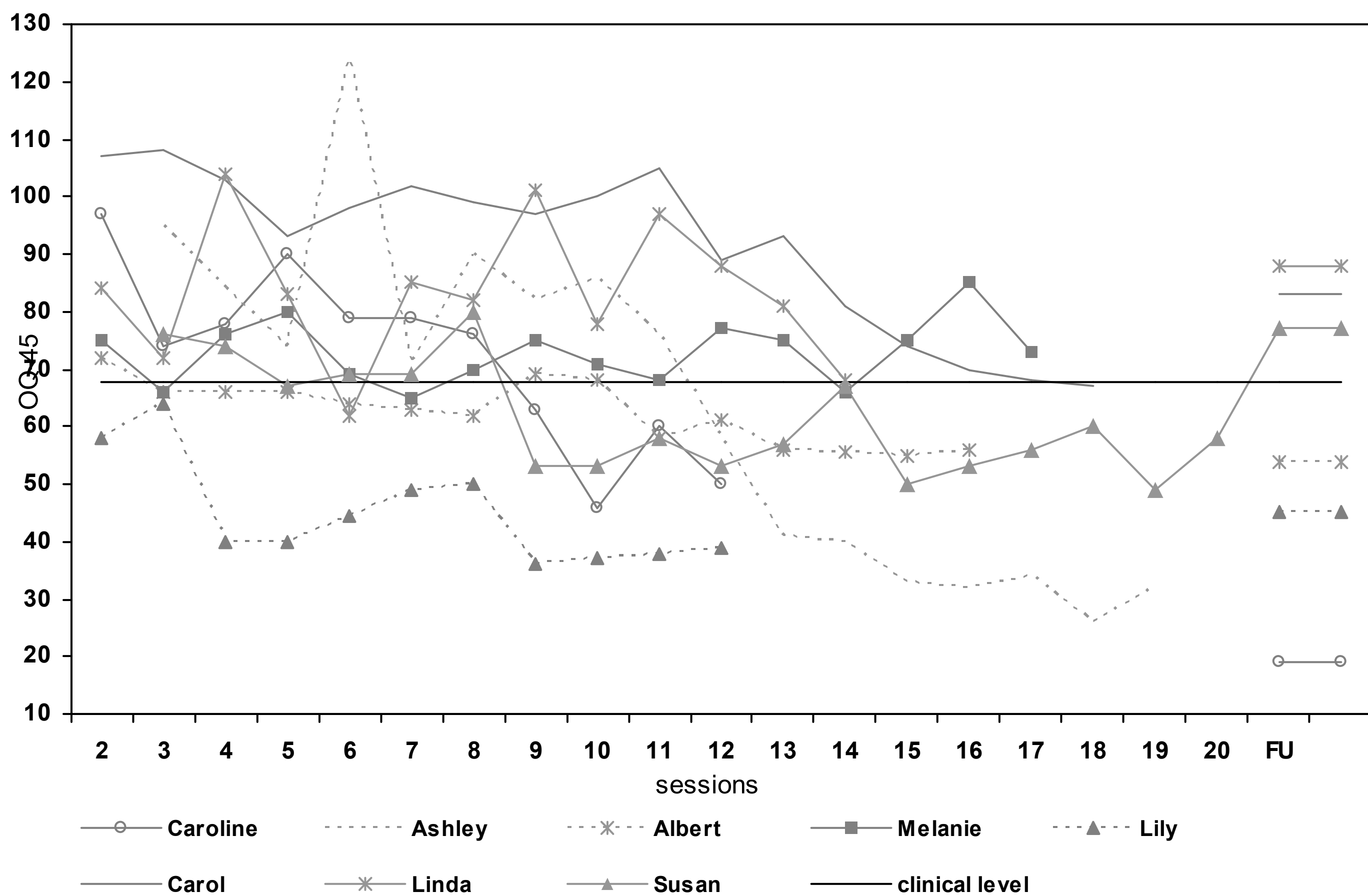

Figure 3. OQ45 total results.

Melanie and Linda's perceived improvement was not corroborated by any of the outcome measures, that is, they did not improve significantly in terms of their symptoms and their cases were therefore considered to have a *poor outcome*. In the case of Christine, although she improved significantly, her final levels of distress were still higher than the clinical case thresholds, so that we couldn't consider her therapy successful. This was thus labelled a case of *limited success*.

Change stability. Two good outcome clients maintained or improved their outcome results in follow-up. Lily showed an increase in symptoms in follow-up in OQ45, although those were still clearly lower than the initial values. She maintained her changes in BSI and the repertory grid. Susan showed an increase in symptoms in follow-up, both in OQ45 and BSI, but her grid measures remained improved (e.g. self-esteem, no dilemmas). The fifth client, Ashley, never returned her follow-up assessment.

Christine worsened in follow-up. Melanie never returned her follow-up assessments, and Linda showed no changes at that moment, although she continued in therapy.

Was therapy responsible for the clients' changes?

For most cases, evidence was found for the treatment being most likely responsible for change, mostly through the clients' *retrospective attribution*, *process-outcome mapping* and *early change in stable problems* (Elliott, 2002; Carvalho, Faustino, Nascimento, & Sales, 2008). However, therapy was found to have worked in

the context of other change factors, especially self-help efforts, relational issues, expectancy and research enhancing effects.

In two of the cases (Albert and Melanie), applying HSCED did not give us enough information on change factors, leaving us only with the indication that therapy seems to have been the most important factor.

In Linda's case, HSCED analysis found therapy to be responsible for the changes attained. However, some negative extra-therapy events might have played an important role in her process, helping explain the lack of significant change.

What aspects of therapy caused the reported changes?

Since change was only confirmed in five of the cases, we should focus on those to answer this question. Yet, the less successful cases are useful as they can give us hints of what made the difference from the good outcome cases. Table 3 summarizes the contribution of each case to the elaboration of this explanation of change.

Good outcome cases. The successful PCTID established a moderate to strong therapeutic alliance with their therapists and assumed a collaborating attitude, committing to applying therapy to their daily lives. These clients reported significant events in almost every session, most of which referred to the PCTID tasks. We observe this for example in Susan's HAT from session 9, which reads "The analysis of concrete episodes in which my dilemma is present, seeking to understand how I can live them in a positive way, validating my anticipations", which we considered a reference to the task of *controlled elaboration of experience in dilemmatic episodes*, from the *dilemma elaboration* phase of therapy.

Table 3 - Summary of cases' results.

Client / Observation	Caroline	Ashley	Lily	Albert	Melanie*	Christine[+]	Linda*	Susan
Working alliance (intermediate assessment1; intermediate assessment2; final assessment)								
Client	6,3 - 6,4	6,3 6,2 missing	5,2 5,8 5,6	5,2 5,0 5,2	5,4 5,8 missing	6,0 6,1 6,4	5,2 5,4 5,9	6,2 6,4 6,4
Therapist	6,4 - 6,8	6,0 5,7 5,9	missing missing 5,8	6,1 6,6 6,6	6,2 6,3 missing	5,8 5,7 6,1	5,8 6,0 6,3	5,9 6,0 6,3
OQ45: more pronounced decreases								
Phases of treatment	Assessment Dilemma elaboration	Dilemma elaboration	Dilemma elaboration Alternative enactment	Dilemma elaboration Alternative enactment	Assessment Dilemma elaboration	Assessment Dilemma elaboration Alternative enactment	Dilemma elaboration Alternative enactment	Dilemma elaboration Alternative enactment
Therapeutic tasks followed by more pronounced decreases	Repertory grid; Cycle of	Historic reconstructi on	Laddering; Fixed role therapy	Historic reconstructi on;	Repertory grid; Life history	Life history interview; Historic reconstructi	Laddering; Fixed role therapy	Cycle of experience; Fixed role

Observation \ Client	**Caroline**	**Ashley**	**Lily**	**Albert**	**Melanie***	**Christine**[+]	**Linda***	**Susan**
	experience			Fixed role therapy	interview; Laddering	on; Fixed role suggestion		therapy
Dilemma resolution								
Worked dilemma not visible at 1st intermediate assessment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dilemmas at the end of therapy	No	No	No	No	Yes	Yes	Yes	No
Worked dilemma came back (same or very similar)	No	No	No	No	Yes	Yes	Yes	No
DC became congruent	Yes	Yes	Yes	Yes	No	No	No	Yes
Process of dilemma resolution (visible at first intermediate assessment)	Temporary isolation from others; Weight 0 of self in first factor	ideal self is scored with 4 on DC	ideal self is scored with 4 on CC	present self is scored with 4 on DC	Decreased association between constructs; replaced by similar dilemma.	CC became CD	CC became CD	Weight 0 of self in first factor
Creation of new constructs		Yes						
Other changes in construct system								

Client / Observation	**Caroline**	**Ashley**	**Lily**	**Albert**	**Melanie***	**Christine**[+]	**Linda***	**Susan**
PVAFF	Increased	Increased slightly	Decreased	Increased	Increased	Maintained	Increased	Increased
Polarization	Increased	Maintained	Decreased	Maintained	Decreased	Increased	Decreased	Decreased
Weight of self in first factor	Increased	Maintained	Increased	Maintained	Maintained	Decreased	Decreased	Maintained
Increased self-esteem	Yes	Yes	Yes	Yes	slightly	No	slightly	Yes
Perceived closeness to others	Maintained	Increased	Increased	Increased slightly	Increased	Increased slightly	Increased	Increased
Significant events								
Number of significant events signaled along the therapeutic process	More events in dilemma elaboration phase	No pattern	No pattern	No pattern	No pattern	No pattern	No pattern	More events in dilemma elaboration and alternative enactment phases
Events referring to manual tasks /total	14 /19	7 /12	8 /12	10 /14	6 /20	25 /41	5 /11	19 /23
Most highly rated events in terms of importance	Dilemma elaboration	Dilemma elaboration	Alternative enactment	Reframing the problem as	Dilemma elaboration	Assessmen t	Dilemma elaboration	Dilemma elaboration

Observation / Client	Caroline	Ashley	Lily	Albert	Melanie*	Christine+	Linda*	Susan
	Treatment termination			a dilemma Dilemma elaboration	Alternative enactment	Dilemma elaboration Alternative enactment Treatment termination		Treatment termination
Client's perspective - Change Interview								
Significant changes were achieved	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Presenting problems	Solved 2 of 3; Reported not changing 1	Solved 2 of 4; Reported not changing 0	Solved 2 of 3; Reported not changing 1	Solved 3 of 4; Reported not changing 1	Solved 1 of 4; Reported not changing 1	Improved 2 of 3	Solved 1 of 2, but in an unstable manner	Solved 2 of 3; Reported not changing 0
Change factors	Therapist; Self-knowledge; Absence of diagnostic labels; Develop-	Self-knowledge; Development of new construc-tions ; Extra-therapy	Therapist; Self-knowledge; Client's active role.	Therapist; Task: fixed role.	Therapist; Client's active role; Extra-therapy event.	Therapist; Task: letter to the fixed role.	Self-knowledge; Client's active role.	Therapist; Self-knowledge; Develop-ment of new construc-tions;

Client / Observation	Caroline	Ashley	Lily	Albert	Melanie*	Christine+	Linda*	Susan
	ment of new construc-tions ; Client's active role.	event.						Client's active role; Tasks: self-characterization and fixed role.
Therapist's perspective								
Client's description	Motivated Collaborating	Motivated Collaborating	"had to extract the information from her"; "chaotic"	"lack of focus"	"Resistant" "stuck in complaining about the past"	Motivated Collaborating "disorganized speech"; "confusing	Motivated Collaborating "Identified with problem"	Motivated Collaborating
Significant changes achieved	Yes	Yes	Yes	Yes	Yes	Yes "unfortunately those changes didn't last long"	Yes "changes were still not consolida-ted"	Yes

Note. * Poor outcome cases; + limited success case; CC – congruent construct; DC – discrepant construct; Cycle of experience - controlled elaboration through the cycle of experience

Their implicative dilemmas were solved by the first intermediate assessment, although they often kept evolving towards a more complete resolution until the end of the process. These clients resolved their dilemmas satisfactorily, i.e., in a way that allowed them to achieve a congruent position in the formerly discrepant construct.

The *dilemma elaboration* and, to a minor degree, *alternative enactment* phases of the treatment witnessed the most significant decreases in symptoms and the most highly rated significant events. That is, the overcoming of the dilemma allowed for symptomatic improvement and for other important events to unfold: the clients were back to their construing movement.

By the end of treatment, these clients registered a significant decrease of their symptoms, as assessed through OQ45 - coming to non-clinical levels - and a clear increase in self-esteem and in their perceived closeness to others, showing improvement at personal and interpersonal levels. Their construct systems tightened during the therapeutic process, producing more confident predictions.

The good outcome clients considered that the therapeutic process helped them and reported achieving some but not all of their goals. For example, Lily, who came to therapy due to shyness, social difficulties and lack of concentration, stated at her change interview that she had become more affectionate, impulsive and talkative, while she had stopped worrying so much about what other people thought. However, she felt no changes in her concentration ability. The most important change factors referred by these clients in their change interviews were: The effects of the therapeutic relationship, as seen in Lily's report: "talking to someone that could understand"; the development of self-knowledge and the construction of alternatives, as explained for example by Caroline: "I experienced a method of me being the one trying… to reconstruct myself,

so to say, from… ah… myself, from what I thought"; and their own active efforts to benefit from therapy: "Than I thought about it until the next session. And I think… changes happened like that. Than it was a little putting it to practice" (Susan). Their therapists also considered the cases successful and described relevant changes. For example, therapist A stated that Albert "was more reserved… he started to share more" and that his most relevant improvement "was finding his equilibrium again".

Poor outcome cases. The poor outcome clients suffered from long-lasting generalized anxiety which was worsened by their life contexts and they were somewhat identified with their symptoms, having difficulty in conceiving themselves differently. Although they were motivated for therapy, their therapists saw them as somewhat "difficult" clients.

They did perform some movement in their dilemmatic structure, and the dilemma in focus was not present at the first intermediate assessment. However, they were not able to achieve the desired pole of their discrepant construct, and new dilemmas rose during their treatment.

These clients subjectively experienced therapy as beneficial and identified some positive changes. For example, Linda stated at her change interview she was already able of "worrying more about me and less about the family problems", representing an improvement in her initial "excessive worrying with others". However, at the end of treatment they had not managed to resolve their symptoms nor had they achieved clear changes in their self-esteem. They had nonetheless increased their perceived closeness to others and tightened their construction system.

The process of dilemma resolution. The cases analysed showed that the apparent resolution of a dilemma at a given moment of assessment may not represent a real resolution. For a dilemma to be truly resolved, it is necessary that the discrepant

construct becomes congruent. When that does not happen, the expected decrease in symptoms and increase in self-esteem do not take place. The individual does not really overcome the blockage, and new dilemmas rise to take over the first one.

The necessary change of the discrepant construct into a congruent one can be achieved by a change of position of the self towards the desired pole, or through a change of the ideal self towards the present pole, i.e., the clients may become what they want, or they may come to want what their already are. In addition, that can be done by changing the construct itself, giving it a new and more acceptable desired pole as an opposite to the present, unwanted situation.

Moreover, for the discrepant construct to become congruent, the blockage that prevented it from changing has to be removed in some way. That can happen in several different ways, but a common pattern was identified: clients temporarily suspended judgment about some part of their construing while experimenting with the self, which allowed them to elaborate and experiment alternative ways of construing: In some cases, it is the client's vision of what is ideal that is suspended, being rated with a neutral score at the intermediate assessment moment, other times it is the view of the self; In yet other cases, the clients separate their perception of themselves from that of others in order to experiment 'living outside the dilemma' before solving it. This is seen for example in a reduced perceived closeness to others or in the element self having a weight of zero in the client's most important axis of construction. That suspension creates an opportunity for elaboration and experimentation of non dilemmatic ways of construing, which are applied to the rest of the system when sufficiently elaborated.

This explanation of change in implicative dilemmas is condensed in figure 4.

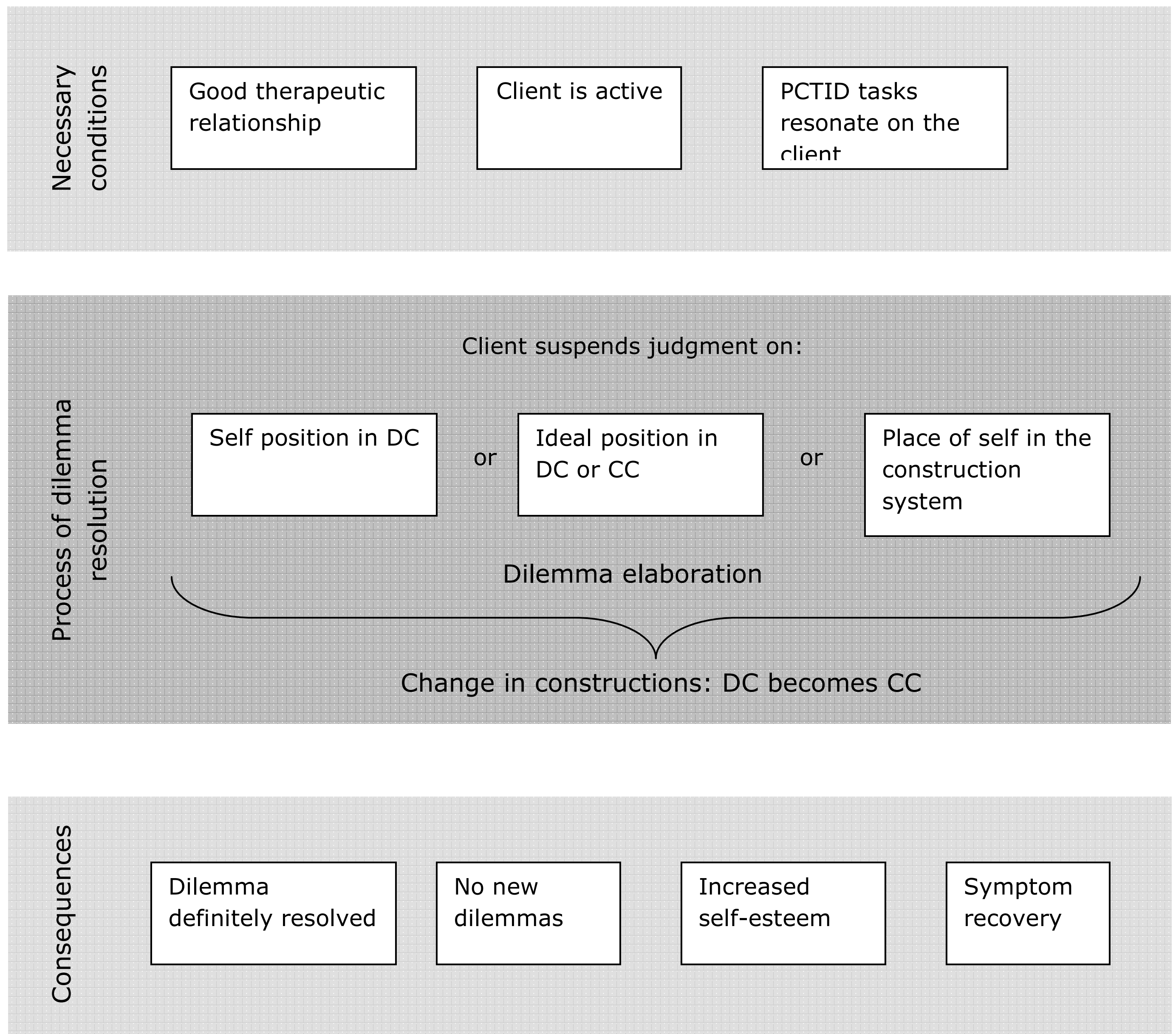

Figure 4. A model of dilemma resolution.

Discussion

Our first goal, to obtain preliminary data on the efficacy of PCTID, was achieved with good results, since we found significant decreases in symptoms as assessed through the OQ45 for six of the eight cases, attaining non-clinical levels of symptoms in five of them, which supports the hypothesis of the treatment's efficacy in

reducing client's distress. The clients' and therapists' subjective account corroborated those findings. Moreover, the causal analysis methodology used, HSCED, took in consideration a number of qualitative and quantitative measures to find evidence of the treatment's role in generating the observed changes. That evidence was found for five of those six cases. However, only two good outcome cases sustained their symptomatic improvement into follow-up, leaving some doubts about the durability of the treatment's effects. Further research would be necessary to affirm this treatment's efficacy. This study is a first step, and it suggests that it might be worth the effort of a larger, comparative efficacy study of PCTID.

One of the outcome measures used in this study, the BSI, didn't prove to be very useful in this series of cases, as most clients never presented clinical levels in its global index - the GSI. Hence, it was not surprising that reliable change indexes were not found for most cases using this instrument. As referred earlier, the Portuguese version that we used (Canavarro, 1999) is presented as discriminating normal from clinical population with 92% to 95% efficacy compared to the clinical method. However, that was not what happened with our clients, who were all psychotherapy clients and did present clinical population values in OQ45. Lily was an exception to this, as her initial symptom level was slightly below the clinical population threshold.

Our second goal was to verify the application of personal construct theory of change to the treatment of implicative dilemmas and to elaborate it into a specific model of change in personal construct psychotherapy for implicative dilemmas. That goal was achieved as we found some of the model's features in the case series analyzed, and developed a particular explanation of the process of dilemma resolution.

Dilemma resolution

The assessment of implicative dilemmas in intermediate moments of the therapeutic process showed that, in our sample, therapy always caused some changes in the clients' dilemmas. This might reflect the fact that they were being directly worked on through several therapeutic tasks. However, a particular change was crucial, allowing for the dilemma to lastingly disappear, for new dilemmas not to emerge, for the client's symptoms to decrease and for the client's self-esteem to rise: The implicative dilemmas were only effectively solved when the clients achieved their desired pole, i.e., when the discrepant construct became congruent. Whenever that did not happen, the dilemmas were not really resolved, even if they were not visible at a given assessment moment. This notion of a non satisfactory or apparent resolution of a dilemma is our newest contribution to the study of implicative dilemmas. Of course, further research would be necessary to confirm this finding. If it is confirmed, it raises a question about the type of dilemma resolution observed when a simple pre-post research design is used. It would be relevant to take in consideration the change of the discrepant construct whenever dilemmas are observed to disappear, in order to differentiate real resolution from temporary movements with the appearance of dilemma resolution.

The transformation of the discrepant construct's value can happen at least in the three different ways observed in this study: the most common, when the self moves toward the desired pole; the opposite movement, when the ideal moves close to the self, in a movement of self-acceptance, or by the transformation of the discrepant construct, which gained a different desired pole as an opposite to the problematic present pole. The two first possibilities represent slot changes, i.e., the change from one pole of a construct to another, which is seen in PCP as a more superficial type of change (Fransella & Dalton, 1990). However, these apparently simple changes could only take place because the dilemmatic implication had been removed, i.e., because the relations

between the constructs had changed. Those changes took place in several different forms, but were in general compatible with our hypothesised type of movement, i.e., the change of the relations between constructs, removing their conflictive association.

The third process consists in other of the types of change predicted by Kelly (1970), when constructs are transformed into slightly different distinctions, for example through the change of one of their poles.

Therapeutic process

The observation of our eight cases showed consistency between dilemma resolution and symptom decrease, as expected from the results of previous research (Saúl, 2005), as well as from theoretical assumptions. In fact, implicative dilemmas are theoretically related to resistance to change, and their definition has some implications in the relation between their resolution and symptomatic change. Logically, problems involved in dilemmas cannot in principle be solved without dilemma resolution. On the other hand, if the related symptoms are solved the dilemma necessarily disappears, as the discrepant construct ceases to be so.

In the cases analysed, the success of the intervention did not depend on the severity or duration of problems. Although the poor outcome cases present problems of long duration, they are not the only ones, and their symptom severity is not higher than the other cases' in general. This finding does not confirm the results of some previous research on the efficacy of PCT, which associated stronger effects with a smaller severity of problems (Holand & Neimeyer, 2009).

Decreases in symptoms happened mostly in phases 3 and 4 of the manual, as one could expect from the treatment's objectives. In fact, those are the phases most dedicated to elaboration and experimentation, the two fundamental aspects of personal

construct therapy (G.J. Neimeyer, 1995). The client's construction system became slightly tighter in almost all cases, which had been observed in previous research as an effect of the grid repeated administration (Feixas et al., 1992).

In our study, all clients showed moderate to high therapeutic alliance in all assessments, independently of their outcome. A secure therapeutic relationship is an essential prerequisite for PCT (Kelly, 1969; G.J. Neimeyer, 1995), and the PCTID treatment manual in particular has as an objective to enhance the therapeutic alliance, by understanding and working with the clients' difficulties in changing (Senra, Feixas & Ribeiro, 2010). The fact that it was always positive could be an indicator that this was achieved.

On the other hand, the fact that there are no differences in alliance between good and poor outcome cases does not sustain the formerly reported association between alliance and outcome in psychotherapy research (e.g., Castonguay, Constantino, & Holtforth, 2006; Horvath, 1994b; Lambert & Barley, 2002; Luborsky, 1994). However, in this study we only considered cases that completed the treatment. It is expected that cases with lower alliance values dropped out of therapy earlier. Another hypothesis is that implicative dilemmas could constitute an exception to the formerly proved relationship between alliance and outcome, as that kind of conflict is thought to cause some particular difficulties in attaining change (Sánchez & Feixas, 2001). Research including drop-out cases could shed some light into this matter.

Independently of their outcome, most clients signaled relational factors as important aspects of their therapy and therapists described most of them as involved and collaborating from the beginning of the treatment. These elements add to the hypothesis that the therapeutic relationship was an important factor of therapy in this group of clients, although it did not make the difference between good and poor outcome clients.

It seems to be a really necessary condition (Rogers, 1957) for clients to complete treatment and for therapy to work, but not a guarantee that the dilemmas will be resolved and symptoms overcome.

The perceived importance of the PCTID tasks made a difference between good and poor outcome cases, as the successful clients found that type of work to be more important than the unsuccessful clients, who valued more other events in therapy. This suggests that the treatment used had more impact in the clients to whom it made more sense. Theoretically, this relates to one of the components of the working alliance: agreement on the therapeutic tasks (Bordin, 1994). However, that relation was not visible in our cases. If a good therapeutic relationship was an essential prerequisite for clients with dilemmas to complete therapy, the proposed tasks having resonance in the clients could be a second step, without which the dilemmas are not effectively overcome, even if the alliance resists that disagreement.

The aspects of therapy referred by most clients as change factors (in the change interview) are generally congruent with the constructivist approach of therapy. Apart from the identification of relational variables as change factors, the clients' reports also suggest that the treatment manual has fulfilled the constructivist objective of promoting self-knowledge and development of new ways of thinking for this group of clients (R.A. Neimeyer, 1993; 1995). Finally, the client's active role in putting therapy in practice relates to one of the requirements of constructivist therapy, that is, that the client assumes an actively experimenting stance (G.J. Neimeyer, 1995). This is also congruent with psychotherapy research literature that shows a relation between client's collaborative involvement and therapeutic outcome (Tryon & Winograd, 2002).

The observed congruence between the client's reports and PCP helps validate the treatment, as it shows that its application to practice turns out to reflect the

principles it is based on. Specifically, the development of new constructions is the one factor of change that stands out, as it is exclusive of good outcome clients. The clients' perspective of change is consistent with PCP: according to the theory, it is exactly the construction of alternative forms of living that allows people to overcome their difficulties.

Unsuccessful processes

Both poor outcome cases were clients suffering from generalized anxiety disorder (APA, 1994). Although the data are not representative of the clinical population, it raises the hypothesis that the treatment used might not work so well in this kind of problem.

These clients' life histories of long duration and acceptance of the symptoms as part of the self suggest us these two clients might be construing anxiety as their way of living, similarly to Fransella's (1972) stuttering clients. To perform the desired changes, they would probably need more therapeutic work than the other clients, in order to develop new possible selves almost from scratch. In fact, Linda did continue in therapy after the treatment and showed some improvement two months after the final assessment.

In Melanie's case, a high self-esteem co-existed with the problems at the beginning of therapy, which could be a factor of some resistance to change. The client saw herself in a very positive way, attributing her problems to external causes. Taking her problems into her own hands could imply changing her view of things, and put at risk her positive view of herself. In fact, high self-esteem has been associated to resistance to change, for example in battered women (Camps, Calle, & Feixas, 2000). It

seems that people can protect their view of themselves by taking the role of victims and assuming the impossibility of changing their situation.

Limitations and future directions

In this study we intended to conduct a clinical replication series of cases treated through personal construct therapy for implicative dilemmas. However, we failed to conform to the methodological prescriptions that the same number of cases per therapist and gender should be analyzed. Instead, we used all complete cases available, as they didn't make a large number.

The option of re-rating the repertory grids with the constructs elicited by each client at the beginning of the treatment did not allow the observation of changes in the constructs themselves, but only in the way they were applied. This choice had the objective of allowing the comparison of structural measures in the different moments, as well as the pragmatic one of alleviating the burden of research procedures to the clients.

Having found preliminary evidence of personal construct therapy for implicative dilemmas being useful, a comparative study would be required to confirm those findings and clearly attest this treatment's usefulness. In addition, this treatment proposal came from the realization that psychotherapy not directed to the work of implicative dilemmas was quite effective in reducing them (Saúl, 2005). It would be of major relevance to perform a comparative efficacy testing to verify the advantages of a specific therapy program like this one.

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CHAPTER 4

Reconstruction events in the resolution of implicative dilemmas[5]

Abstract

Personal construct psychology sees individuals as continuously construing and reconstruing their view of themselves and others. Reconstruction is necessary for personal constructions in general to evolve, and in particular for disorders to be overcome. Implicative dilemmas are a type of blockages in the continuous construing movement, leaving people stuck with constructions that are not fitting them. Therapeutic change is of itself a form of reconstruction that allows clients to recover their ability to create alternatives.

In this study we tried to identify and understand the processes of personal reconstruction that occur while resolving an implicative dilemma. We focused on significant events identified by clients to create a tentative model of dilemma reconstruction. Our findings were generally consistent with the previous theory, applying it at a micro-analytic level.

Reconstruction events in the resolution of implicative dilemmas

Reconstruction is a central aspect of personal construct psychology (PCP; Kelly, 1955), a global theory of individual development, personality and interaction with others and with the world in general. From this point of view, people experience reality

[5] This work was submitted for publication in co-authorship by Joana Senra and Eugénia Ribeiro.

by construing it, basing their anticipation of events on their previous constructions. Construing takes the form of bipolar dimensions of meaning, the personal constructs, which relate to each other in a complex and hierarchical network (Kelly, 1970). Thus, every time we attribute a meaning to an event, we implicitly reject other possible meanings which are, in our way of viewing the world, incompatible with the first one. At the same time, we assume that other related constructs would also apply to that event.

While similar events can be understood in light of our existing constructions, new events require the reformulation of the previous knowledge in order to encompass them. This process has been described through a sequence of five steps known as the cycle of experience (Kelly, 1970). The aforementioned anticipation (1) is followed by the person's implication (2) in the event, which allows her to truly experience it and ultimately learn from it, which does not happen when events just occur beside us. When people actually encounter (3) the event, the anticipation made is proven either right or wrong, that is to say, it is validated or invalidated (4), causing the emergence of positive of negative emotions. Disconfirmed anticipations need to be revised through reconstruction (5), giving place to new, better adapted constructions. However, confirmed anticipations are also reconstructed into stronger constructions or theories about the world. Reconstruction gives place to new anticipations, on a continuous construing movement.

Therefore, reconstruction is essential for human healthy functioning. Problems arise when the cycle of experience fails to be completed, so that the person may test the same constructions repeatedly without effective reconstruction (Fransella & Dalton 1990; Walker & Winter, 2005; 2007). Psychotherapy has the goal of helping the individual back on the construing movement. This is made possible through the

reconstruction of whatever constructs, or relations between constructs, are impeding the cycle of meaning-making. Several different processes may be involved in reconstruction. For instance, it may be necessary to help the client tighten or loosen her way of construing, i.e., making judgments about events or, on the contrary, freely experimenting with possibilities. In other cases, it could be useful to diminish the use of a certain construct or on the other hand to promote its application to a new area of life. Other types of movement would be replacing constructs that are proving ineffective or bringing pre-verbal constructs to conscience (Fransella & Dalton, 1990; Kelly, 1955; 1970).

However, if change is an essential aspect of being human, it is often experienced as threatening, as it means abandoning our current, well elaborated knowledge of the world to be left with sometimes only incipient alternative ways to make sense of it (Hinkle, 1965). Some core dimensions of the self may be jeopardized by the imminence of change, leading the person to resist it, regardless of the costs of stagnation (Tschudi, 1977).

Change in personal construct therapy (PCT) is achieved through two major operations: The basic condition for a therapist to help a client is establishing a bond with her, in an accepting and trusting relationship, which has been compared to Bowlby's notion of a "secure base" (as cited in Neimeyer, 1995; Mahoney, 1991). That foundation will allow for the client's exploration of new possibilities and the elaboration of alternative forms of construction (Neimeyer, Saferstein, & Arnold, 2005). These two ingredients represent a balance between validation and invalidation that should be kept through the therapeutic process. Expecting that change might be difficult for clients, constructivist therapists accept and support the clients' current constructions, while presenting hypothetical means for exploration that do not threaten the integrity of

the individual's construction system (Neimeyer, 1995; Ribeiro, 2009; Walker & Winter, 2007; Winter and Watson, 1999).

Thus, the therapeutic relationship plays a fundamental role in PCT. It is defined by a collaborative stance, where therapist and client are partners working for the same objective. Each of the parts has privileged access to a particular kind of knowledge: in the case of the therapist, theoretical and technical knowledge, in the case of the client, knowledge about her life circumstances, values and difficulties. The therapist's role is not to tell the client what is best for her, but to guide her exploration and discovery of solutions that suit her needs. She does so in an invitational mode, where current constructions are to be uncovered and elaborated and new possibilities are to be tried out. The therapist credulously accepts the client's way of seeing the world and promotes reflection on its implications. Techniques are seen as useful tools to be used within this relational context, but not as the essence of the therapeutic work (Chiari & Nuzzo, 2005; Kelly, 1969a; Neimeyer, 1995; Winter and Watson, 1999).

Implicative dilemmas

"All change is an act of creation. Each one of us knows that when we decide to give up some piece of behavior, we have created a new 'me'" (Fransella & Dalton, 1990, p. 80). In this sense, reconstruction may be particularly difficult when the aspects the client wants to change are correlated with positive and central aspects of her identity. In that case, abandoning the problem also means leaving behind an important part of who the person is, or the risk of becoming someone she dislikes. The notion of implicative dilemmas (Feixas, Saúl, & Avila-Espada, 2009; Hinkle, 1965; Ryle, 1979; Tschudi, 1977) defines this kind of problematic implication between two or more constructs of different values to the self. Feixas's team (Feixas, Saúl & Sánchez, 2000;

Feixas & Saúl, 2000) has come up with an operational definition and a method for the identification of implicative dilemmas, based on the repertory grid technique (Fransella, Bell & Bannister, 2004; Kelly, 1955). Asking the clients to rate the present and ideal self, along with other elements, in a number of their personal constructs, one can identify in which aspects the person is satisfied with herself and in which ones she is not. The former are named congruent constructs and the latter discrepant constructs. The analysis of the repertory grid with the Gridcor v. 4.0 informatics application (Feixas & Cornejo, 2002) provides, among other data, the correlations between all constructs and the eventual implicative dilemmas, that is, pairs of congruent and discrepant constructs where the desired pole of the latter is significantly correlated with the undesirable pole of the former (see figure 1 for a graphic representation of a dilemma).

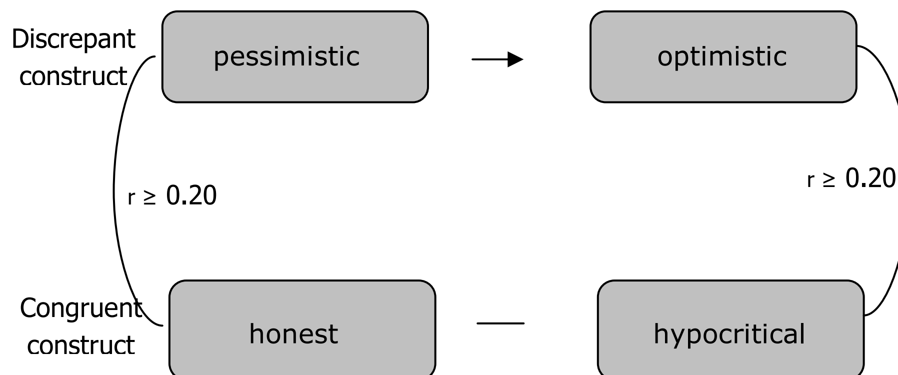

Figure 1. Graphic representation of an implicative dilemma.

Although implicative dilemmas are a relatively common structure, studies (Feixas, Saúl, & Ávila-Espada, 2009; Saúl, 2005) have shown that they are significantly more prevalent in clinical than in non-clinical population, and that they tend to be resolved by the effect of psychotherapy. Personal construct therapy for implicative dilemmas (PCTID) was developed by Senra, Feixas and Fernandes (2007; also Senra, Feixas & Ribeiro, 2010) as a direct approach to the resolution of implicative dilemmas.

Results from its first applications (Senra & Ribeiro, 2010a; b) suggest its efficacy in resolving client's dilemmas and symptoms as well as its consistency with personal constructivist principles.

Change process research

"Much of what takes place in the interview room is a matter of an occasional apt remark, a flash of insight, a choice of a word, a well-timed silence" (Kelly, 1955, vol.2, p. 373). Kelly's point of view seems to be shared by a growing number of researchers, as observed in the movement noticed in the last three decades of psychotherapy research toward the intensive study of clinically significant episodes within the therapeutic session. Since Rice and Greenberg's (1984) proposal, the study of change events has gained importance and different methods have been developed for such analysis (e.g., Elliott, 1984; Elliott et al., 1994; Greenberg, 2007; Stiles et al, 1990). The general objective of this kind of research is to "identify the active ingredients of change and explain the mechanisms that lead to this change" (Greenberg, 1986, p.7). It is a discovery-oriented approach using complex designs, aiming at a rich account of the episodes and the development of explanation models or micro-theories of the phenomena in study (Elliott, 2010; Greenberg, 1999).

In this paper we seek to uncover what factors characterize reconstruction episodes occurring in personal construct therapy for implicative dilemmas. Assuming a credulous approach (Kelly, 1955), we chose to focus in episodes considered important by the clients.

Method

Participants

Clients. The events analysed were obtained from six cases following personal construct therapy for implicative dilemmas (Senra, Feixas & Fernandes, 2007). All clients were female, with ages between 20 and 32. They came to therapy at our university's clinic with anxious and/or depressive symptoms and their therapeutic processes consisted in 12 to 20 sessions of PCTID. Some of the cases continued in therapy after completing the treatment program. Four of these clients' therapeutic processes produced significant decrease in symptoms as measured through OQ45 (Lambert & Burlingame, 1996).

Therapists. Four female therapists with ages between 25 and 30 and with two to six years of clinical experience worked with these clients. They received training and supervision from the authors, concerning the therapeutic manual in use. The first author was also one of the therapists, receiving supervision from the second author.

Researchers

The first author is a PhD student and psychotherapist, with a constructivist approach. She asked for the participants' informed consent for research and conducted most of the BSR and change interviews with the other therapists and their clients. She also took part in all the analyses. The second author, a senior researcher and psychotherapist, and also with a constructivist background, audited the analyses.

Apart from the authors, the study benefited from the collaboration of several other people: Three other PhD students interviewed the first author's clients and took part in the episodes' analysis (two of them were also involved as therapists); all therapists also participated in the intensive analysis of the episodes selected from their cases; in addition, a master's student transcribed part of the episodes from the session's videos and joined the analysts' team.

Although they received training in PCTID and used that therapeutic model with their cases included within this study, the therapists' and analysts' theoretical affiliations were constructivist (4), integrative (1) and cognitive-behavioral (2).

The treatment

Personal construct therapy for implicative dilemmas (PCTID, Senra, Feixas & Fernandes, 2007; Senra, Feixas & Ribeiro, 2010) is a manualized intervention program focused on the elaboration of the clients' dilemmas and organized in five phases: assessment, reframing the problem as a dilemma, dilemma elaboration, alternative enactment and termination. It is planned for 16 sessions, although it recommends a flexible use, respecting each client's rhythm.

Measures

Implicative dilemmas. The Repertory Grid (Fransella et al., 2004; Kelly, 1955) was used in its interpersonal form and analysed with Gridcor v.4.0 software application (Feixas & Cornejo, 2002), which detects the presence of implicative dilemmas in the sample of the subject's constructions system examined. The client's personal constructs were elicited through the dyadic method at the beginning of therapy. Clients re-rated the same grid in two assessment moments during therapy and at the end of the process, thus monitoring the dilemmas' evolution.

Significant events. Helpful Aspects of Therapy (HAT; Llewelyn, 1988; Portuguese version by Sales et al., 2007) was completed by clients at the end of every session, indicating the events they found most important in their therapy. Clients gave an indication of the event's length, location within the session, and rated their importance in a 5-point Likert scale, varying from 1 (*not important*) to 5 (*extremely important*).

Participant's experience of events. Brief Structured Recall (BSR; Elliot & Shapiro, 1988) was conducted with the clients at three assessment moments (after phase 2, 3 and at the end of treatment), so that they identified the beginning and end of the events reported in the sessions' HAT form and described their experience of the event and its impact. These interviews were later done with the therapists, showing them the session excerpts identified by the clients and asking about their point of view on the event's relevance and impact, as well as their therapeutic intentions and their experience during the episode.

Working alliance. The Working Alliance Inventory (WAI; Horvath, 1994; Horvath & Greenberg, 1989) was used in client and therapist versions at the two intermediate assessment moments defined in the research protocol, and at the end of treatment. We used the Portuguese adaptation by Machado & Horvath (1999), which presents good reliability indicators. To have an indication of the quality of the therapeutic alliance, we considered the mean values of the clients' and therapists' responses for the total score.

Symptoms. The clients answered to the Outcome Questionnaire (OQ45; Lambert & Burlingame, 1996; Portuguese version by Machado & Fassnacht, in preparation) at the beginning of each session, providing a session-to-session monitoring of their level of distress.

Clients' perspective on their therapeutic change. At the end of their treatment, clients answered to a Change Interview (Elliott, 1999; Portuguese version by Sales et al, 2007), where they expressed their perception of the therapeutic process, the changes achieved and their causes.

Therapists' perspective on clients' change. Therapists were also interviewed at the end of the protocol about the therapeutic process and their clients' changes.

Procedure

The first author met with the clients in their first therapeutic sessions in order to explain the research procedures and ask for their informed consent for participation (appendix A). Therapeutic sessions were videotaped and interviews were recorded in audio.

Events selection. From a total of 190 helpful events identified by 13 clients participating in PCTID[6], we limited our attention to those which happened in a therapy segment of dilemma resolution, that is, after an implicative dilemma was detected (in the first repertory grid rating, usually in session 3) and before it was found to have disappeared. Thus, episodes from client's who did not attain dilemma resolution were excluded from this study, as were those identified before the first grid was completed and after the dilemma had disappeared (in one of the subsequent ratings). This criterion gave us a sample of 39 events.

In order to focus our attention in the most important events identified by the clients, we followed to restrict our sample to events rated as 4 (*very important*) or higher in the HAT form, coming to 18 events.

Next, the two authors independently selected the events which description in the HAT form was compatible with the PCP's notion of reconstruction, i.e., when it suggested that the client had questioned some of her theories, generating new,

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[6] Although 30 clients signed an informed consent form for participating in research within our project, only 13 got past the first two phases of treatment, i.e., assessment and reframing the problem as a dilemma. As the treatment prescribes that clients and therapists should make a decision about the suitability of PCTID for the case in phase two, we only consider the cases that passed this point.

alternative forms of making sense of the world. In other words, when a client realized things were not the way she thought and therefore created new hypotheses about those things.

Finally, events lasting more than 30 minutes were excluded from the sample, as we considered them to be too unspecific, making reference to the relevance of the session as a whole more than identifying a particular helpful episode. Even so, our final sample was composed of longer events than seen in previous studies (e.g., Elliott, 1984; Elliott et al., 1994; Viklund, Holmqvist, & Nelson, 2010).

The final sample of nine helpful events analysed in this study is displayed in table 1.

Data preparation. The selected events were included in a slightly larger interaction episode (Elliott, 1984), including approximately two minutes before and after the segment of therapy identified by the client, in order to provide the most immediate context and impact of the event. Those episodes were then transcribed by a master's student and checked by the first author. Client and therapist's BSR interviews concerning the selected events were transcribed by the first author.

Comprehensive process analysis. Each one of the selected events was analysed through Comprehensive Process Analysis (CPA; Elliott, 1984; Elliott et al. 1994), a discovery-oriented methodology designed to systematically and intensively examine significant change events in psychotherapy. Since the method varies slightly between studies, we borrowed the version described by Elliott et al. (1994). The understanding of the event was pursued through three major questions: (a) What contextual factors or conditions brought to the event? (b) What aspects of the therapeutic interaction caused the reported reconstruction? (c) What impact did the event cause on the client and the

Table 1. Important events selected for analysis.

Event	Client	Session	Event Description (in HAT form)	Event importance (0 a 5)	Duration (min)
1	A	4	Today I consider all session special and important. I had the opportunity of talking much about what really afects me, what I want to fight. There was much dialogue and expression of feelings, etc. The most relevant moment was the one when I could talk about the method of solving my problems, which are really not mine, but other people's, I could see that I probably ask too much of myself to find solutions for problems that are not mine after all.	4	16
2	B	6	To decide that I'm going to fight for Paul. That if in a short period of time he comes back to me I'll put my pride aside, I'll do everything for our relationship to work. Otherwise, I'll accept reality and try to overcome all this in the best possible way. It was important as I could understand that it is important to admit my suffering to the people that matter to me. Only this way they can help me, and only this way I can overcome this situation without feeling guilty or inferior.	4	7
3	C	5	Identifying sources of change. To direct therapy to focus what I consider my "weaknesses"	4	1
4	D	4	Remembering my childhood, school, how much it was important, how I used to overcome difficulties and now. I think it helped and motivated me to face other people without fear that I'm not able to take the right attitude, without hurting me or others.	4,5	4
5	D	6	Staying calm and trying to solve problems without getting upset so easily. Feeling more fulfilled.	4	10
6	D	8	Leaving selfishness behind. Being happier.	4	10
7	E	5	The fact of realizing that I'm less tolerant with the people I love the most and I'm most sure that I'm not going to lose. To clarify why I have certain behaviours.	4	4
8	E	9	When the therapist started describing in detail my life history and how it influenced my current attitudes. It was important because in a way it made me see the justification for my behaviour. In addition, it made me value myself.	4	11
9	F	7	Searching for the reason why I say I'm not motivated to attain my goals: the fear of not succeeding, in spite of the effort invested. The fear of failing and feeling that the effort was not enough and that in a way it as all thrown away. It was important to help me understand what could be behind some attitudes and behaviours I have, and what I could do to change my way of acting in face of some situations.	5	21

therapeutic process? (c) Thus, there are three main domains to be considered in CPA: (a) context, (b) key response and (c) effects.

Context includes four levels of conditions that could lead to an important therapeutic event: the immediate, i.e., episode context, refers to the themes in discussion or the contents expressed immediately before the key response. Session context includes the interactions that took place before the particular episode in analysis, therapeutic tasks completed or relationship issues present in the session. Pre-session context considers relevant occurrences taking place since the beginning of therapy, including therapeutic work as well as extra-therapy events. Finally, the client's and therapist's background is considered, comprising for example life history, current life circumstances, personal characteristics, therapist's theoretic affiliation and training.

The key response refers to the core of the event, the aspect identified by the client when she signalled the event. It is decomposed in four sub-domains: what kind of action was the key-response, the content of that action, in what style it was carried out and its quality, i.e., how skilful or effective it was.

The event's effects are analysed in three different levels. Immediate effects refer to what happened immediately after the events, describing the participants' next actions. Delayed effects are the consequences of the event observed later in the session on in other sessions. The event's clinical significance topic is intended to find the event's importance to the client's therapeutic process and improvement.

The analysis of each case was independently performed by three judges: the case's therapist, the main researcher and the master's student collaborator. When the case's therapist was the main researcher, the team was completed by the case's interviewer. All analyses were done independently by each judge and then discussed in

group in order to achieve a consensus. We tried to create an equalitarian and collaborative discussion climate, made sure that all versions were presented and exchanged ideas until all analysts agreed with the event's explanation.

In order to get familiarized with the methodology to use, the judges read an article describing CPA (Elliott et al., 1994) before the analyses. At the beginning of each group's first meeting, the first author briefly presented the methodology and doubts were discussed when necessary. The judges were then provided with several sources of information on the event: A summary of the client's description and case progress was read and the case's therapist completed it with some information she considered relevant to the task. The event's description in the HAT form was also presented and the event was situated within the session and the therapeutic process. The event's transcript from the session and the client's and therapist's BSR interviews transcripts concerning the event were also given to the judges, who then watched the video of the session containing the event. The event was fully presented to the group and the rest of the session was available for the judges to play back or forward as they found necessary in order to retrieve information about the event's context or impact.

As a first step for the event analyses, the judges independently indentified what segment of the episode they considered to constitute the key response within the event, which could be the whole segment signalled by the client, part of it or even two different portions of the episode. A consensus on the key-response identification was achieved next.

Second, each judge independently analyzed the episode using the CPA frame. The key-response was the first domain to be addressed, followed by the event's effects, and finally the context, from the most immediate to the most general. This sequence of

analysis allows understanding the core of the event before making judgments about what consequences it might have had or what contextual factors might help explain it. The judges described each sub-domain respecting some fundamental criteria: each statement must be grounded in the data, not redundant with other statements in the same sub-domain and relevant to the comprehension of the event, i.e., help answer the above presented questions. In addition, all the available information had to be considered, including possible discrepancies between the different sources of information.

Finally, the team discussed the individual responses and achieved a consensus version of the episode's explanation, respecting the same sequence of analysis and the same criteria. As a result, we obtained an explanation of each event, organized in the form of a table, covering what it consisted in, how it affected the client and therapy and what factors contributed to its emergence. The results were then reorganised for presentation in chronological order, from context to key-response to impact, as to create a logic narrative of the event.

Cross-analysis of events. In order to attain an integrated vision of reconstruction episodes taking place in PCTID, we compared the results from each of our nine events. Thus, all the judges who participated in CPA got together with the goal of identifying the common features among the nine reconstruction events. We took the results of each case's CPA for each sub-domain as units of analysis: Each analyst independently categorized the data from all nine episodes, one sub-domain at a time, obtaining a set of descriptive categories within each sub-domain. Each unit could be coded into more than one category when appropriate. Afterwards, the whole team decided on a consensus version of the categories and on which units belonged within each one (Appendix D). On a second phase, the judges individually derived more

general and conceptual categories from the first ones, working on a consensus set of abstracted categories afterwards.

Finally, categories were hierarchically organized according to the degree to which they applied to our sample of events. For each sub-domain, themes were regarded as *general* when they occurred in all of the nine events. Themes present in five to eight events were considered *typical;* Categories present in three or four events were labelled *variant* and those applying to only one or two events were called rare. Although variant categories are displayed in table 3, they are not included in the final model of reconstruction events in personal construct therapy for implicative dilemmas, and neither are rare categories (Elliott, 1989).

Each step of the analytic process was audited by the second author.

Results

Analysis of a reconstruction event

In order to illustrate the events we found in our sample, the analysis done in each of the events, and the type of results found, we present hereafter one of the nine events and its analysis. The complete set of nine events and their individual analysis's results can be found in appendix C. For practical reasons, we selected one of the shortest episodes in the sample; within that criterion, Episode 2 stood out for its easily perceived relation with the client's dilemma and relevance in the therapeutic process.

The client was a 20 year-old female university student, who came to therapy with difficulties in controlling her impulses, guilt and interpersonal problems. According to her therapist, the client's life history was marked by overprotection: she had been a "spoiled child", used to always getting what she wanted. In addition, her

mother was seen as emotionally dependant on her father, as she tolerated his infidelity over the years. She presented a dilemma which prevented her from changing in a discrepant construct from “despairs easily” to “persuasive”, due to this construct’s association with the congruent construct “needs affection – cold”. For this client, people who needed affection, as she did, tended to despair; while those in control of themselves and their relationships were usually cold, which she constructed negatively. Hence, as she was not a cold person, but one who needed affection, she felt it was impossible to change her impulsive behaviour. This dilemma was identified in session 3 and was no longer present when reassessed after session 8, nor in the following assessment moments.

By the end of therapy, the therapist found that the client had gained self knowledge, become less impulsive, learned to manage her emotions and become more calm, confident and capable of being alone. According to her report in the Change Interview, the client considered therapy helpful, especially talking about the problems and getting in contact with her emotions as she talked, which motivated to make some changes. She also mentioned the importance of understanding and “breaking down” the problem, and the impact of an extra-therapy event – restarting a previous romantic relationship. The client’s WAI showed high scores in all assessment moments; the therapist’s scores were initially high but slightly decreased in the following assessment moments, presenting slightly lower values than the client’s.

In the sixth session’s HAT form, the client identified the following important event:

> To decide that I’m going to fight for Paul. That if in a short period of time he comes back to me I’ll put my pride aside, I’ll do everything for our

relationship to work. Otherwise, I'll accept reality and try to overcome all this in the best possible way.

It was important as I could understand that it is important to admit my suffering to the people that matter to me. Only this way they can help me, and only this way I can overcome this situation without feeling guilty or inferior.

The event was rated as *very important* (4) by the client and lasted approximately seven minutes. The transcript of the event is presented in table 2.

In the Brief Structured Recall, the client commented:

The day before I'd had a conversation with my ex-boyfriend… where he told me he had another girlfriend. .… I was very anguished… I had cried all night, and all.

I was very upset because of what had happened and I was afraid there would be a real separation. And I wasn't ready for that, I didn't know how I would bare it. It was fear and the feeling that I was alone, fighting for something that probably wouldn't favour me.… It was fear, uncertainty and loneliness…

It was important to help clarify things… because there were some things that didn't make sense… Then to realize that probably what I wanted wouldn't be exactly what would happen, that is, to consider another possibility… And then also feeling that … maybe I wasn't so lonely anymore… I had some support from someone I could tell exactly how I was feeling and who was there supporting me.

When I came out of the session… [I felt] relief, as if [the suffering] diminished a little. And then, courage, more strength to think things will work out. That one way or another, it will eventually be over. And that we just have to know how to wait… The most important idea is that we cannot control everything ….we don't control some things and we have to learn how to deal with that…

The next week I went to talk with him.

The therapist explained her point of view on the event as follows:

My intention was to clarify, to give her the panorama of things… I felt it as important, I needed to tell her that, even if it was in a more pedagogical or clarifying way, not so much the partnership, but talking as someone who's seeing it in a more clear way from the outside.

[As the client answered] I think I was frustrated, feeling that my intervention hadn't had much impact. What she was saying sounded to me as avoiding the subject, as story-telling, rather than reacting to what I had said.

I think I might have transmitted her some security and some clarity about how things can possibly be solved… I think she understood it was important for things to be clear and to resolve them. [Later] she changed her attitude with Paul. She's not [anymore] willing to get involved with him until he leaves his girlfriend.

Table 2. Transcript of the reconstruction event (episode 2).

C1	I told him: I am, I was willing to conquer him back. I was willing to do whatever it took. But if he doesn't want it…
T1	Mhm-mhm
C2	I can't fight that!
T2*	Sure, but you can try to conquer him! What I mean is: I don't know, as I told you before, if this is the best moment indeed to, to restart this re-… this relationship
C3	Relationship.
T3	Because I think you are both very confused, and it could go badly! But it could also go well, nobody knows, and neither do I, what are in fact the real feelings and whether things can go well or not. What I think is important is for things to be clear. And if you think this is not the best moment, then it's important to make a separation. Right? And that separation doesn't have to mean getting nothing. It could, right now, because it's difficult for you, but you don't have to stop being his friend or having contact with him. But if you think it's too difficult for now to manage that, because things get confused, than maybe it would be better…
C4	He, he said: "Uh… I could come meet you whenever you want", right? But it doesn't seem fair to me!
T4	That depends on what moves you, right? If what moves you is a friendship or wanting to be together, than there is no problem! If what moves you is some ambivalence and wanting to be together in an intimate way, uh… with an involvement, uh… then yes…
C5	But then why does he want to be with me? To make things clear in his head, I don't know!
T5	Well, that's something you'll have to ask him! And him, he'll have to question himself about that. What I think is important right now is to make things clear. You should think: if this is not the best moment to be together, than you have to make a rupture, because this is a torture and it's better to suffer all at once. And prepare, and being alone for a while, to recover, to understand what you want, right? Because it's curious that you always pursue people you have already dated, right? You don't project yourself to other people, you go toward the security of someone who has already cared for you, or still

	does, isn’t that right? But you could, you could take the adventure of a relationship that you still don’t know and someo-, and other people could care for you. Not just Zach or Paul, right?
C6	Mhm-mhm
T6	So I see this is also a sign of some insecurity, of being stuck in these relationships, because there was no real separation, and that’s not healthy! It’s not, because you’re always very confused and those relationships become… difficult, without boundaries, right? You don’t understand very much what you two want. If it is clear for you, in your mind, that you want to date him, then I think it’s important to tell him: “look, I want to date you, I am admitting that, and if you want I am here for you, I want to try again”, but not giving him this or that, saying “you don’t take her phone calls, that’s not cool, you should take them…”, No. “If you are with me you shouldn’t take them because that is what I want!” Right? After all what’s important is to clarify, make it clear, if you want to fight for him, if you want to be with him, then don’t be afraid to admit it! Right? If you are afraid to admit it, then we have to think why that is. Is it that you’re not available, you don’t want… Because this becomes very painful, you two continuing in this… this kind of things that no one quite understands, you end up getting hurt, because now you give…
C7	Then you take…**
T7	Then you take… right? So it is important for you to understand what you want and not thinking… when you have a relationship it’s not everything, right? It’s not giving everything… but when you break up you don’t have to lose everything either… When you break up with a boyfriend you don’t have to lose everything, right, you can even be friends, but it seems important to me to have some emotional stability and some certainty of what you want so that some ambiguous things do not happen.
C8	But, for example, this week, what bothered me the most was: my mother, my mother told me: you don’t have to worry because what is ours comes to us. And… if he likes you, this relationship of his won’t work out. But it’s not like that, things are not like that. That’s what I told her. What happens to me… for example, I want to be with him, I have hat need everyday. I did everything to be able to just see him. I had that need to be with him, and already did that before, right? For example, I know that in the morning, between x and y hours, he’s at the café; so in the morning, between x and y hours, I was there too!

Note. * Beginning of the event as identified by the client.

** end of the event as identified by the client.

Event analysis. The context for the occurrence of this event was characterized by the client's *background*, concretely her family's history. As the therapist explained to the team, she had been a "spoiled child", who always got whatever she wanted, and her mother was emotionally dependant on her father, maintaining a problematic marriage over the years. Since the beginning of therapy (*pre-session context*), a strong therapeutic alliance had been established with the therapist, as shown by the WAI scores. In previous sessions, the client had expressed her will to get back with her ex-boyfriend, which the therapist considered to be prejudicial to her and was worried about, she shared with the analysis team. In addition, an event had occurred in the intersession period that gave origin to this event: "the day before I'd had a conversation with my ex-boyfriend… where he told me he had another girlfriend…. I had cried all night", the client said in BSR interview.

The client came to the *session* focusing on the pre-session event, that is, the conversation with her ex-boyfriend. She described that meeting, expressing anguish and reporting some contradictory behaviour on her part in the relationship with the ex-boyfriend, as the analysts could observe in the session video. The *episodic context* was identical to that of the session, i.e., no changes in the themes discussed or the participant's stances were identified.

The key-response of this episode was led by the therapist, and was classified as consisting in clarification (e.g., T5, in the event transcript "What I think is important right now is to make things clear. You should think: if this is not the best moment to be together, than you have to make a rupture"), interpretation (e.g., T5 "you go toward the security of someone who has already cared for you") and confrontation (T2 "Sure, but you can try to conquer him!") (*action*), about the client's relational dynamics with her

ex-boyfriend (*content*). Concretely, she approached the ambiguity of the client's messages to her ex-boyfriend (T6: "saying: *you don't take her phone calls, that's not cool, you should take them…*"), the client's tendency to go back to her ex-boyfriends (T5: "it's curious that you always pursue people you have already dated, right?"), the risks involved in the relationship (T3 "I think you are both very confused, and it could go badly!") and the need for the client to make a decision (T5 "What I think is important right now is to make things clear"). The therapist's *style* was considered to be expositive, empathic and protective. In terms of *quality*, the judges considered the intervention was important as the confrontation allowed for the activation of the client's emotions and promoted her reflection, being a good example of what she described in her Change Interview. In addition, they considered that the therapist's insistence in the theme aided to the client's reflection.

Effects: Looking at the *immediate consequences*, we observed that the client got in contact with the emotions caused by the idea of loss, concretely "fear, uncertainty and loneliness", as she admitted in the BSR interview. Next, she took the decision to "fight" for her ex-boyfriend, as she reported in her HAT form, and "escaped" from the negative experiences by turning to the description of a conversation with her mother – "But, for example, this week, what bothered me the most was my mother (C8, in the transcription of the event)".Also the therapist's experience, according to her BSR interview, was in the same sense: "What she was saying sounded to me as a avoiding the subject, as story-telling, rather than reacting to what I had said". In addition, the client expressed difficulties in putting the therapist's advice to practice, i.e., not despairing: "I want to be with him, I have that need everyday. I would do everything to be able to just see him" (C8, in the transcript).

The event had the *later impact* of providing some clarification to the client, who felt relieved and supported, as she stated in her recall interview: "feeling that … maybe I wasn't so lonely anymore… I had some support". She also reported achieving an increased sense of balance and hope in the future, with a stronger belief in the resolution of her problems: "courage, more strength to think things will work out". The therapist also perceived that type of impact, as shown in her words: "I think I might have transmitted her some security and some clarity about how things can possibly be solved". The client also accepted that she could not control everything and took the initiative to restart the relationship with her ex-boyfriend, as she reports in her BSR interview: "The next week I went to talk with him".

In terms of *clinical significance*, the judges pointed to the relevance of the client accepting uncontrollability, i.e., that she could not always get everything she wanted, as suggested by her background and her statement in the BSR interview: "The most important idea is that we cannot control everything". We also highlighted the client's accepting to be upfront with her ex-boyfriend, showing her vulnerability and risking rejection. In this sense, her therapist commented in her BSR: "I think she understood it was important for things to be clear and to resolve them"; the client's BSR report confirmed that she did go and talk to him about her feelings. Quantitatively, the symptom assessment through OQ45 suggested that a crisis was resolved, as there had been a peak in distress before session six, going back to the previous values at the next session.

A tentative model of dilemma reconstruction

Our explanation of reconstruction events taking place in the phase of personal construct therapy for implicative dilemmas where each client's dilemma achieved

resolution takes in consideration the general and typical categories derived from the cross-analysis of nine therapeutic events of reconstruction, using the CPA frame. Variant categories are included in the presentation of results in tables 3 to 5.

Context. We observed that the client's difficulties, either in the present or in the past, were always an important *background* factor conditioning the reconstruction event. The client's personal and interpersonal functioning, therapist's professional attitudes and the use of personal construct therapy for implicative dilemmas were typical influential elements at the background level.

The therapeutic work done in previous sessions and recent difficulties experienced by the client typically created the *pre-session* conditions for the emergence of the events. Within the *session*, the conducting of a PCTID task or managing the session were the typical determinants of the onset and progress of the reconstruction event. The typical event occurred during an *episode* of therapeutic work focused on the

Table 3. Results of the cross-analysis: Context

Sub-domain		Category	Definition	Example
Background	General	Problems/ difficulties in client's history and current life situation	Difficulties experienced by clients, whether in their present of past life, are considered to influence the event	4.1.5. Family history: mother was victim of violence from father; parents separated; client is oldest child – probably related to her tendency to and take responsibility for other people's problems
	Typical	Client's characteristics (personal and interpersonal functioning)	Client's personal or interpersonal functioning is thought to condition the event	4.1.6. Expansive conversation style: many examples and much detail
		Therapist's professional behaviour or attitudes	Therapist's professional behaviour, skills or affiliations are considered determinant of the events unfolding	4.3.2. Therapist's intention of discovery/ understanding
		Therapeutic model	The use of PCTID is considered to determine the event	4.6.1. The therapeutic model prescribed the task
	Variant			
Pre-session	General			
	Typical	Previous therapeutic work	Work done in previous created the conditions for the event	3.5.1. Initial assessment and returning its results to the client
		Difficulties experienced by the client	Difficulties experienced by the client before the session were relevant to the event	3.2.2. Client had cried all night
	Variant	Therapist's experience of the process	Therapist's opinion or difficulties influenced her stance in the event	3.4.2. Therapist felt some difficulty dealing with client's dispersing style
Session	General			
	Typical	Task or session management	Therapist's conducting of tasks of	2.5.1. Session's task: explanation of the

			management of therapeutic session created the conditions for the event	dilemma through the exploration of the constructs involved and people related to them
	Variant	Therapist's variables	Therapist's experience or stance in the session influenced the episode	2.5.2. Therapist's manner: understanding, open and exploring
		Work on the client's problems	The episode happened while working on difficulties expressed by the client	2.9.1. Client shared a difficulty experienced during the week: she lacks motivation to study and does not understand why
		Exploration of intersession events	The episode rose from the exploration of intersession events	2.2.1. Client was centred in a pre-session event: a conversation with her ex-boyfriend
Episode	General			
	Typical	Work on the client's problems	The episode was triggered by work on the client's problems	1.1.2. Client talks about how her boyfriend's problems affect her
		Task	The episode was triggered by the PCTID task being applied	1.3.1. After the *laddering* task, the therapist makes a summary
	Variant			

Note: Units of analysis are numbered with the code 1.2.3., where 1= sub-domain; 2= episode; 3= unit.

Table 4. Results of the cross-analysis: Key-response

Sub-domain		**Category**	**Definition**	**Example**
Action	General	Therapist clarifies and integrates	The key intervention is a clarification or integration done by the therapist	5.3.1. Summarizing the task and its major conclusions
	Typical	Therapist reframes or interprets	The key intervention is a reframing or interpretation done by the therapist	5.8.3. Interpretation
		Therapist explores or questions	The key intervention consists in the therapist making questions or exploring some theme	5.7.2. Exploring meanings and consequences
	Variant			
Content	General			
	Typical	Client's difficulties	The key intervention was focused on client's difficulties	6.7.1. Client's iritability
	Variant	PCTID work	The key intervention was focused on the PCTID work being conducted	6.5.3. The two sides of the dilemma as two options
Style	General			
	Typical	Therapist is directive or expositive	The therapist's style during the key-response is expositive or directive	7.6.2. Directive
		Therapist is empathic or tentative	The therapist's style during the key-response is empathic or tentative	7.4.1. Therapist is empathic and exploratory
	Variant			
Quality	General	Efficacy of response: technique	The key intervention was marked by an effective use of technique	8.3.1. It allowed the client to organize ideas and clarify the dimensions under focus
	Typical	Therapist is sensitive to the client	The key intervention was delivered in a sensitive way	8.4.3. Therapist was attuned with the client's state
	Variant			

Note: Units of analysis are numbered with the code 1.2.3., where 1= sub-domain; 2= episode; 3= unit.

Table 5. Results of the cross-analysis: Effects.

Sub-domain		Category	Definition	Example
Immediate consequences	General			
	Typical	Client agrees	Immediately after the key intervention, the client agrees with the therapist	9.3.1. Client agrees
		Client elaborates	Immediately after the key intervention, the client elaborates on it	9.5.2. Client reflects and expands, making a connection to previous experiences
	Variant	Client avoids	Immediately after the key intervention, the client avoids it	9.1.1. Client avoids: denies the content of key-response and goes on talking about previous theme
		Client experiences/acts	Immediately after the key intervention, the client experiences emotions or takes action	9.2.1. Client gets in contact with emotions related to loss – fear, uncertainty, loneliness
		Therapist persists on the intervention	Immediately after the key intervention, the client persists on the intervention	9.1.3. Therapist goes back to the intervention
Later impact	General			
	Typical	Personal and interpersonal changes	Later on the session or after the session, the client changed at a personal or interpersonal level	10.8.8. Change in behaviour: priority to personal needs and wishes
		Changing constructions	Later on the session or after the session, the client replaced some personal constructions with new possibilities	10.4.1. New vision about the reported experience: admitting the experienced difficulties and rejection; elaborating new forms of responding

	Variant	Strengthening of therapeutic work	As a consequence of the event, the therapeutic work was enhanced	10.9.3. Client feels more motivated
Clinical significance	General		The episode was clinically significant because:	
	Typical	Problem reduction	It caused reduction of the client's symptoms	11.4.3. Reduction of symptoms (OQ45)
		Proneness to action	The client became more willing to take action	11.6.4. Bigger sense of agency
		Generating alternatives	The client created alternative ways of seeing the world or living	11.6.3. Elaboration of an alternative stance with others
		Integrates experience	The client integrated her experience	11.5.1. Client integrates her experience, giving sense to her problems
	Variant	Strengthening of therapeutic relationship	The therapeutic relationship was reinforced	11.9.1. strengthening of he therapeutic relationship due to the therapist's responsiveness to the problematic episode the client brought

Note: Units of analysis are numbered with the code 1.2.3., where 1= sub-domain; 2= episode; 3= unit

client’s problems or in carrying out one of the PCTID tasks, such as reframing the problem as a dilemma, laddering or historic reconstruction of the dilemma.

Key-response. The relevant categories of key-response referred to *actions* carried out by the therapists. In all events, the key-response contained a clarification or integration done by the therapist. In most of the cases, they also offered some interpretation and/ or exploration of the client’s difficulties, which were the typical *content* of the intervention. Most therapists used an empathic, tentative *style*, but were also somewhat directive and interpretive. The response’s *quality* was always judged effective in the use of technique, and usually sensitive to the client, i.e., effective in the maintenance of a good therapeutic relationship.

Effects. The event’s immediate consequences were marked by two typical themes: immediately after the key-response, clients typically agreed with their therapists’ observations and elaborated on them. Later impact was found to take the typical form of personal or interpersonal changes, changing some of the client’s constructions and strengthening the therapeutic work. Most events were considered clinically significant as they promoted symptom reduction, as observed in the OQ45 values of the next session and in clients’ self-report. Moreover, episodes were typically marked by the client generating alternatives, integrating the different aspects of her experience and becoming more prone to action. Positive effects on the therapeutic process were also considered significant.

Figure 2 shows a schematic representation of this model.

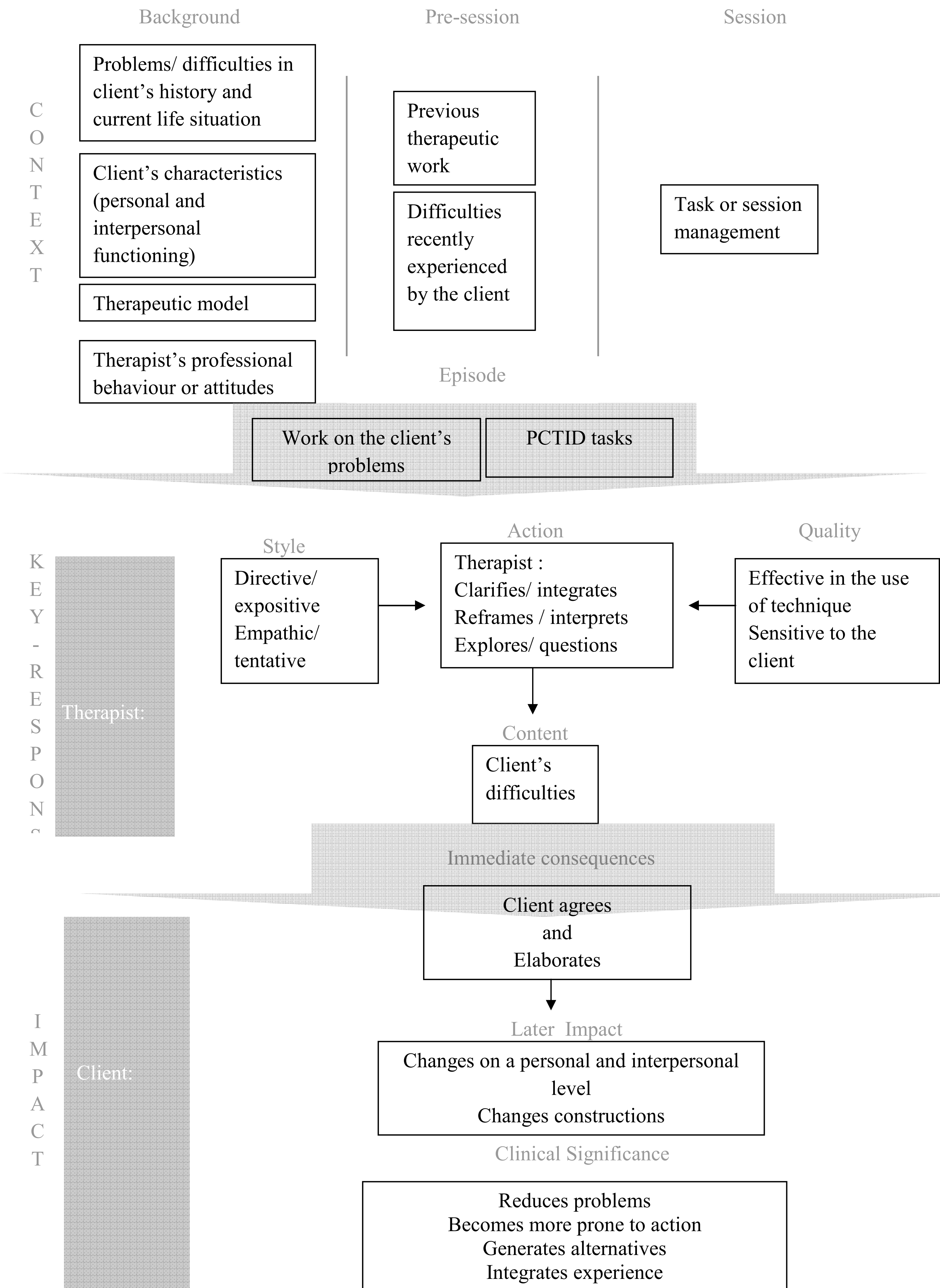

Figure 2. Change model of reconstruction events in PCTID

Discussion

The goal of this study was to understand the reconstruction episodes that take place in personal construct therapy for implicative dilemmas. Through the presentation of a detailed individual event analysis and a comprehensive look at a set of nine reconstruction episodes, we contributed to the comprehension of such events, including their typical onset, progress and consequences. According to our theoretical presuppositions, dilemmas are resolved through reconstruction of the meanings that are causing the impasse or of their relationships with other dimensions in the system. Thus, by understanding how reconstruction in PCTID happens at a micro-analytic level, we increase our comprehension of how the dilemmas are resolved.

Dilemma reconstruction

The analysis of an episode of reconstruction intends to give the reader a deeper understanding of the episodes found in this study, allow for the demonstration of the method of analysis and display in a detailed way the type of intermediate results that gave origin to the final model built for the sample of nine events. The specific episode presented is not the most illustrative of the treatment program in use, as it does not show the application of any of the therapeutic techniques prescribed by the treatment model, but rather of a discussion about a problematic episode in the client's life. Additionally, it does not exactly represent the invitational, tentative style recommended in PCT. On the contrary, it is maybe the most illustrative of the therapists' expositive/directive style typically identified by the judges in this study, as it displays a long intervention by the therapist, giving her an outlook of her problems and the possible ways to deal with them. Nevertheless, it is a good example of the relevance of a particular, client-

identified, significant event in the elaboration of the dilemma in focus along the therapeutic process. In fact, the themes of needing affection and acting in desperate ways that gave form to the client's dilemma are easily visible in the therapeutic segment transcribed.

The results of this episode do represent fairly well the model of reconstruction events found for the sample of nine episodes: They suggest that the client's dilemma was activated by the therapist's intervention, as she confronted her with her desperate behaviour and suggested that there were other, more helpful ways of pursuing her need for affection. That activation caused negative emotions and some immediate resistance, leading the client to change the theme of conversation, until finally expressing her difficulties in acting in a different way. However, the later impact shows that the client accepted the therapist's interpretation (that she could be persuasive, that is, in control, while seeking the affection she needed) as a new tentative construction, which she used to try out a new version of herself: more balanced, accepting uncontrollability and actively looking for what she needs. This change was accompanied by a decrease in symptoms at the next session. Although the dilemma's resolution was only observed two sessions later, it is plausible that it actually changed in this episode.

With the cross-analysis of a sample of events we got closer to understanding how dilemmas are resolved in PCTID, whether it happens in the very event we analyse or as the result of a series of reconstructions that allow the discarding of the dilemmatic structure through progressive invalidations and building of new possibilities, validated until they are accepted with some confidence. As in episode 2, reconstruction happened in most events following the therapist expressing her vision of the client's problems, which was accepted by the client as a new hypothesis and used to experiment new elaborations. Although exploration was also an important type of action, it was most

commonly the therapist shedding light into the client's problems (through clarification, integration or interpretation) that promoted reconstruction. Technical and relational skills were pointed by judges as being well achieved in the therapists' interventions. This suggests that PCTID achieved the desired therapeutic performance for a constructivist therapy, where technique is important, but only within the context of a good therapeutic relationship (Chiari & Nuzzo, 2005; Kelly, 1969a, b; Neimeyer, 1995). On the other hand, the model's prescribed techniques played an essential role in eliciting the reconstruction events, weighing in favour of the view that technique and case conceptualization matter, and that the quality of the therapeutic relationship constitutes a necessary condition for therapeutic change (Rogers, 1957), but is not all there is to it (Silberschatz, 2007). As Horvath and Greenberg (1994) put it, technique and relationship are "interdependent and catalytic to each other" (p.2), rather than two separate mechanisms of therapeutic change.

The client-identified important events which fit the criteria for inclusion in this study gave origin to significant changes, both at intra-psychic (integration, generation of alternatives) and behavioural levels (reduction of problems, proneness to action), advocating for the relevance of understanding the processes taking place in these episodes.

Relation with TCP

Although PCP has been widely studied and many of its assumption confirmed (Walker & Winter, 2007), we do not know of previous studies using the significant event approach in PCT. Nevertheless, this research model's assumptions are coherent with this therapeutic approach, and in particular with the model for the treatment of implicative dilemmas, as it is considered to apply especially well to therapies that are

“task focused and centred in the client as active change agent” (Elliott, 2010, p. 131). This study adds to the verification of the theoretical concept of reconstruction, at a moment-to-moment level of analysis, as most of our interpretations make sense in light of PCP’s view of psychotherapy and reconstruction.

An example of consistency of our results with PCP is seen in the types of action found in this study. The relevance of interpretation as a key response is congruent with Kelly’s (1955) view, as he defended the importance of that kind of therapeutic intervention, always delivered in a hypothetic, tentative way. They are also consistent with the results of previous research on PCT process, which found a greater use of exploration, interpretation and confrontation in PCP, when compared to cognitive therapies (Winter & Watson, 1999). In Fay Fransella’s terms (cited in Winter & Watson, 1999, p. 17), PCP therapists “ask questions rather than make statements; and use interpretation more as a way of checking out their own construing or as a means of helping the client elaborate his or her construing”.

As a consequence of the therapists’ interventions, clients typically accepted the new construction hypotheses offered to them and started to elaborate them, i.e., they tried out new anticipations based on these new possibilities of meaning. This represents in itself a restart of the construing movement, as new cycles are set in motion. Conversely, the impact of the reconstruction was the client’s getting back to a healthy functioning, that is, effectively testing new constructions and creating new meaning (Cormack, 2005), thus unfolding a chain of changes, visible at the individual as well as interpersonal level and enhancing the subsequent therapeutic work. At a more general level, clients generated alternatives and became more prone to action, a result quite harmonious with the notion of reconstruction itself: The person creates a new meaning and is to some extent willing to act on this novelty (Kelly, 1970).

Not so congruent with the theory was the use of a directive or expositive style by the therapists. In fact, constructivist therapy is usually “more exploratory than directive” (Neimeyer, 1993, p. 224). Nonetheless, this is understandable when all events contained clarification or integration, typically focused on the client’s experience of difficulty: The therapist performing this type of action could easily be seen as expositive. Directive style probably refers to the therapists conducting a predetermined therapeutic technique, such as laddering, which required them to guide their clients to the completion of the task. As seen before, that was the case in most events.

The verification of PCT’s presuppositions in the explanatory model of the events analysed also contributes to the validation of the personal construct therapy for implicative dilemmas treatment manual, as we showed that it creates significant episodes of reconstruction which are consistent with the theory it is based on. That is, the suggestion of the presence of reconstruction in the client’s HAT form was confirmed by the intensive analysis of the episodes, as they were explained in a theoretically compatible way. It should be reminded that this explanation was not based on the theoretical assumptions, but was derived from the data using a frame of analysis (CPA) that is not related to PCP.

In addition, we found that most episodes of dilemma reconstruction occurring in personal construct therapy for implicative dilemmas were marked by the work on the clients’ difficulties within the application of PCTID’s techniques. This suggests that this work had impact in clients and set the scene for most of the reconstruction episodes. In the same sense, the treatment model showed to be a relevant background factor in these events, as it determined the type of techniques carried out.

Relation with other studies

Despite its consistency with PCP, the model built for reconstruction events shares some features with other models constructed through comprehensive process analysis. For instance, in Elliott et al.'s (1994) study of insight events, client's difficulties were also a relevant theme at the background context level, and the experience of recent difficulties characterizes the pre-session context of the event. The key-response is always an interpretation, whereas in our work that is a typical intervention. The therapist's style is described as firm and persistent, which has some similarity with our directive/expositive manner. In both studies the therapists were judged to use the treatment model effectively and the immediate consequences consisted in the client's agreeing with the therapist. Also in Elliott's earlier work with CPA (1984) some results coincide, although the method used was less similar to the one we applied here. In that case, insight events were also marked by a context of difficulty and the action was generally an interpretation. Also in that study clients tended to agree and later experience newness and alliance with the therapist, features that are also present in our findings. The unfolding increase of exploration and self-help and the friendly working state reported relate to our observations of proneness to action and strengthening of therapeutic relationship. These commonalities suggest that significant episodes of insight and reconstruction could have more in common than differences; maybe those concepts are not so distinct in practical terms, but only slightly different ways of describing human change. In fact, when a person "arrives at a new understanding or awareness of self" (Elliott, 1984, p.257), we could also say her previous theories were "revised in the light of the unfolding sequence of events" (Kelly, 1955, p. 51).

Some of the findings in this study are also consistent with factors previously established in process-outcome research as ingredients of psychotherapeutic change.

Concretely, the relevance of the therapists' and clients' characteristics, found at the background sub-domain in this study, has been clearly demonstrated by psychotherapy research and the quality of the therapeutic relationship, mostly visible in our model in the key-response's style and quality, has been shown to be one of the strongest predictors of client's improvement. Focusing therapy on the clients' problems, by client and therapist and the use of interpretation have also found to relate to positive therapeutic outcome (Horvath, 1994; Lambert & Barley, 2002; Norcross, 2002; Orlinsky, Grawe, & Parks 1994).

However, some interventions stand out in our results that have not found to be important by the majority of studies. Namely, therapist's exploration is present in most of our reconstruction events, while clarification and integration appear in all of them, raising the hypothesis that these are specific characteristics of reconstruction events occurring in PCTID. While exploration is an important feature of PCT, as discussed above, and thus its specific relevance in this therapy is easily understandable, further research would be useful to assess the role of clarification and integration in PCT, reconstruction, and implicative dilemmas.

Limitations

The procedure of reconstruction event selection used tried to access episodes of dilemma resolution. However, we have no way of verifying with absolute certainty that we have achieved that goal. In the time interval where dilemma resolution occurred, there were a series of therapeutic sessions, and several weeks of life. A number of important therapeutic events were usually identified within that time, and for some clients more than one were considered reconstruction events, and analysed in our study. It is possible that each client's dilemma was solved in that specific moment, or that the

event studied is only one in a series of moments that contributed to its resolution. It is even possible that some of them were important for other reasons, revised other constructions and did not directly contribute to the resolution of the client's dilemma. Either way, what we can affirm with some confidence is that the episodes analysed were moments of reconstruction, that is, moments when something changed in the client's view of the world and new possibilities were considered. Even when the events were not directly related to the dilemma, they certainly represented the type of healthy movement expected as clients improve.

The judges who participated in this study were therapists with different theoretical affiliations, within the broader process-oriented range. Most of them had received training in the personal construct therapy for implicative dilemmas manual, including its theoretical foundation in PCP and its fundamental assumptions. However, their familiarity with PCP was not comprehensive, and consequently the language used while analyzing the data was not the same used in PCP literature. An approximation to PCP terms was attempted in the discussion in order to clarify the relations between the findings and the theory.

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CONCLUSION

This project was built around its first product: the Personal Construct Therapy for Implicative Dilemmas manual. Although not completely original, this model was elaborated, defined and structured from the original draft by Feixas and Saúl (2000) into a concrete intervention protocol. It defines not only the phases of therapy, but also the sequence of techniques to be used and their detailed description. Examples adapted from a real case are also provided, allowing the reader an easier and more accurate application of the treatment.

This first step in the project allowed us to study the process of therapeutic dilemma resolution in a much more rigorous and systematic way. It also allowed us to train the therapists who participated in our project and monitor the therapeutic processes in order to verify treatment adherence.

The case of Caroline, presented in Chapter two, showed us that PCTID could be a helpful treatment for real clients presenting implicative dilemmas. It also found that personal construct theory applied to that case in many aspects. For example, the therapeutic relationship and the client's active role in the process were fundamental elements of her process, allowing her to develop an increased self-knowledge and to create new possibilities of construing. Although she went back to healthy levels of functioning early on the treatment, dilemma elaboration was the phase of therapy causing more improvement. The client's experience of her change process was clearly close to the theoretical assumptions of the treatment manual used in her therapy.

This case also advanced an extension to the theory, namely explaining how Caroline's dilemma was solved. That happened through the client's temporary separation of her view of herself from that of others, so that she could make her desired movement along the discrepant construct, which thus became congruent. After experimenting in the element self only, the

association between the constructs was reduced, allowing the constructs of the dilemma to function independently for all elements. Caroline's view of herself could then come back close to that of others, her construction system tightened and her original psychological confusion was overcome.

The replication of Caroline's case in a clinical series corroborated most of the findings from the first case and added some new insights into the explanation of change. Hence, we found that PCTID was a helpful treatment for most of the clients, causing significant changes, with especial relevance to the dilemma elaboration phase, but also alternative enactment. Moreover, we verified that symptoms decrease and increase of self-esteem in these clients depended on an effective resolution of the implicative dilemma in work, where the discrepant construct becomes congruent, i.e., the clients achieve their desired position. Other movements can cause apparent resolution, but the dilemmas tend to reappear, other dilemmas rise and symptoms are not overcome. That real resolution occurs through the elimination or surmounting of the blockage that had kept it from changing, which happens through a temporary suspension of the client's judgement about the self, the ideal, or the relations between self and others in her construct system. That suspension creates the opportunity for alternative forms of construction to be elaborated and for the client's problems to be overcome.

Our last chapter makes a zoom into the process of dilemma resolution, by examining client-identified episodes of reconstruction, at a micro-analytic level. It shows that the tasks prescribed by the personal construct therapy for implicative dilemmas manual set the immediate context to most of the reconstruction events, which were precipitated by the therapists' exposition of their point of view on the client's problems, in the form of a clarification, interpretation or integration, performed with high technical and relational skills. This intervention was accepted by the clients as an alternative way of seeing their reality,

which they adopted for further elaboration and experimentation. The events resulted in important intra-psychic changes, such as integration and creation of alternatives, as well as behavioural transformations, as the reduction of problems and client's increased action.

As a whole, this work contributed to psychotherapeutic practice with a detailed, user-friendly manual for the approach of clients presenting implicative dilemmas, which showed positive signs of efficacy in its application to eight cases in naturalistic conditions. Larger scale, quantitative comparative studies are required to establish PCTID's effects in an unequivocal way. The results found here might serve as an incentive for the investment in such research.

Conversely, as Elliott (2010) argued, causal research designs, either we are talking about single-case studies or randomized clinical trials, need to be complemented by explanatory approaches: it is not enough to prove that there is a causal relationship between therapy and client change, but it is necessary to explain what that relationship is or how the effect works.

Like any other piece of knowledge, personal construct psychology is subject to the process of confirmation or disconfirmation. In more than 50 years since the publishing of Kelly's magnum opus (1955), a body of research has validated, defined and expanded the theory (Walker & Winter, 2007). This project too contributed to the elaboration of the theory, by defining its application to the specific field of dilemma resolution. It created an explanation of the process of dilemma resolution along the therapeutic process as well as in specific events of reconstruction. The two levels of analysis complemented each other, providing a deeper understanding of the process of dilemma resolution. An integration of the two change models is presented in figure 1.

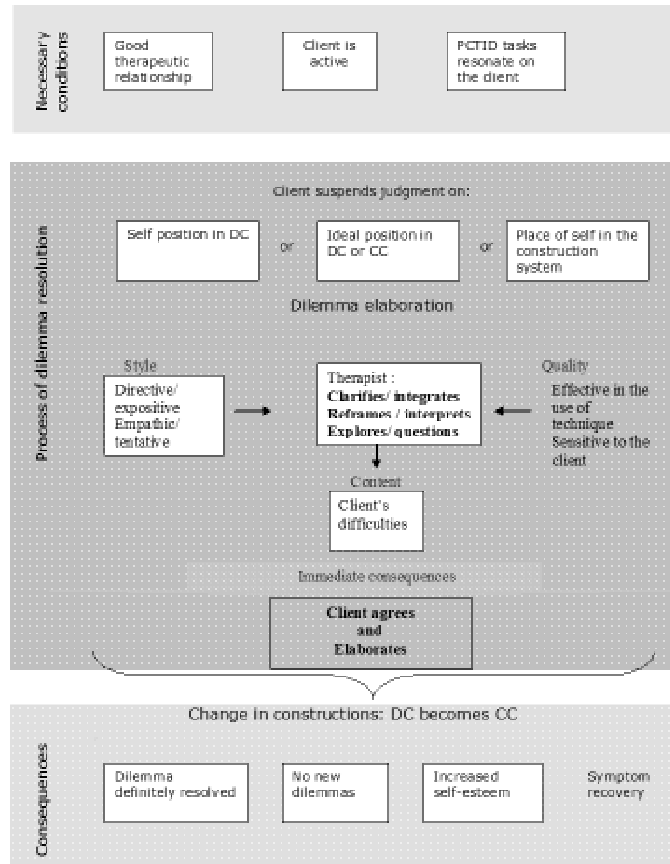

Figure 1. An integrated model of dilemma resolution

We confirmed the theoretical assumption that a good therapeutic relationship and an actively engaged client were necessary conditions for change in personal construct therapy (Kelly, 1969; G.J. Neimeyer, 1995), as in psychotherapy in general (Castonguay, Constantino, & Holtforth, 2006; Horvath, 1994b; Lambert & Barley, 2002; Luborsky, 1994; Tryon & Winograd, 2002). We found that a suspension of judgment was necessary for clients to benefit from the dilemma elaboration tasks proposed by PCTID. Congruently with Kelly's (1955; Fransella & Dalton 1990) view, a hypothetic, *as if*, stance is needed to elaborate new constructions before we can put them to use and replace the old ones. Until then, the previous constructions are kept, although temporarily put on hold.

In that situation, the therapists' exposition of their view of the client's problems promoted the client's consideration of different ways of seeing things, their elaboration and experimentation, leading to change in their behaviour and construing. These changes were reflected in the resolution of the client's dilemmas and their achievement of their desired personal changes, with decreases in symptoms and increase in self-esteem.

In addition, we found that dilemma resolution is sometimes only apparent, that is, dilemmatic relations can be reorganized as they are worked on but not achieve a real resolution. Effective resolution is signalled by the change of the discrepant construct into a congruent one.

Future directions

Case-based research and significant events analysis methods used in this work were useful tools to test our therapeutic model and to understand the mechanisms of its functioning. However, quantitative efficacy studies are required to confirm our model's usefulness for the treatment of clients with implicative dilemmas and psychological distress. Other kinds of therapy have shown positive effects in clients with dilemmas (Saúl, 2005). Thus, it is necessary to determine whether PCTID has advantages over therapy in general or other specific therapies in the quality of the therapeutic relationships established, in the reduction of client's symptoms and resolution of implicative dilemmas.

The processes we found to be involved in dilemma resolution could be confirmed by replication of our work and further explored through the use of other intensive research designs. For instance, the discovery of apparent resolution of implicative dilemmas needs further research to be confirmed, and can open new questions for future inquiry: Is apparent resolution a step towards effective resolution, or a movement of a different nature? Are

different processes involved in the creation of apparent and real dilemma resolution? What client's, therapist's or therapeutic conditions are responsible for this failed movement?

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