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

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

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

Introduction

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

Ambivalence and the Return to the Problem Marker

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

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

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

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

The Resolution of Ambivalence

Based on the assumption that ambivalence is a major issue in psychotherapeutic change that must be resolved so that significant gains can be attained (Miller & Rollnick, 2002). Gonçalves and Ribeiro (2011) carried out an intensive qualitative exploration on how ambivalence can be resolved, from the perspective of IMs. This study made it clear that

there are at least two different processes by which ambivalence can be overcome: (1) dominance of the innovative position and consequent inhibition of the problematic position, and (2) the negotiation between both positions. In the dominance process, the innovative position strives to regulate the problematic position by affirming the innovative's position authority, in a process which apparently implies a role reversal: the previously dominated position now seems to be the dominating one. In the negotiation process, the conflicting positions seem to be considerately communicating with one another, promoting a dynamic flow between opposites, rather than the dominance of one of them.

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

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

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

Method

Client

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

Therapy

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

Therapist

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

Measures

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

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

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

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

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

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

Construction of Markers of Resolution. It is important to clarify that in this study, we are essentially concerned with the *process* of ambivalence resolution during psychotherapy. This means that we are not only looking for the final resolution of ambivalence (i.e., how the positions end up relating by the end of treatment) but also trying to understand how this process evolves along treatment. Therefore, we are mainly concerned with what we might term *micro-resolutions*, that is, moments when there is an *agentic and determined* resolution of ambivalence, even if this is a momentary one. This temporary nature of micro-resolutions means that the specific

subject of ambivalence that is resolved in one session could be raised again in the next session, or even in the same one but they are nonetheless resolutions of ambivalence in a specific moment. We speculate that it is the repetition of these micro-resolutions along treatment that will allow for the understanding of the overall process of resolution.

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

Table 1. Markers of resolution.

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

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

Preliminary Validation of the ARCS. The ARCS was constructed, refined and validated through a thorough analysis of 90 sessions of 6 EFT cases belonging to Greenberg and Watson's (1998) study. Of the six clients in this sample, four were

women and two were men (age range = 27–63 years, $M = 45.50$ years, $SD = 13.78$). Clients completed an average of 17.50 ($SD = 1.87$) sessions. Five of the clients were married and one was divorced. All the clients were Caucasian.

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

Procedure

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

Results

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

Table 2. Markers of dominance and negotiation.

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

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

| Problematic self-position	New self-position
Difficulty defining own desires and opinions	Clearly defining own desires and opinions
Excessive need to be validated by others	Self-validation
Excessive need to "cater to others"	Desire to satisfy own needs
Fear of rejection	Self-acceptance
Disinvestment in social relationships	Investment in social relationships
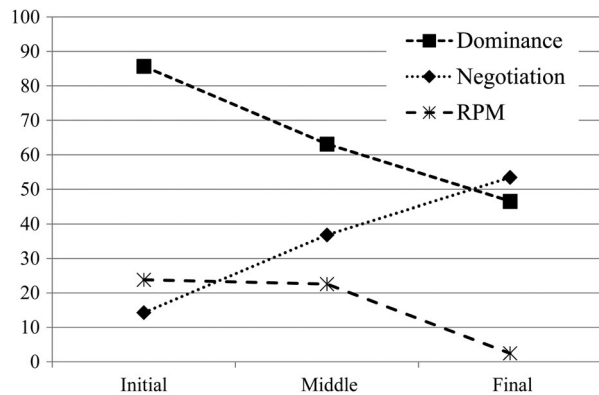
Figure 1. Mean percentage of IMs with RPM, dominance and negotiation for the initial (1st to 3rd session), the middle (8th to 10th session) and the final (16th to 18th session) sessions of treatment.

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

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

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

Initial Phase of Treatment (Sessions 1–3)

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

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

Sarah:	I started to feel bad about that but then I thought: "This is a fun person, he makes me laugh, he is full of stories, this is what I want,

this is what I need, this is one of the highlights of the day. Just go in there. Who cares what everybody else says?" [**IM**]

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

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

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

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

Sarah:	*It's not up to me. Yeah, and not to worry about it anymore.*
Therapist:	*Hm.*
Sarah:	*It's just that there's nothing to think about, say about. Just cut it right there.*
Therapist:	*Somehow all those shoulds and this and that … you were able to just stop those this time.*
Sarah:	*Yeah, yeah.*
Therapist:	*Uh huh. Just be sure that this is what I want and I'm entitled …*
Sarah:	*Exactly. This is my life, I'm entitled to this, and I don't have to track down people, hunt down people, to make sure they get their things.*

Middle Phase of Treatment (Sessions 8–10)

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

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

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

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

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

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

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

Final Phase of Treatment (Sessions 16–18)

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

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

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

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

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

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

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

Therapist: Hm.

Sarah: And not to hold it against other people.

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

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

Discussion

This was a theory-building case study (Stiles, 2009). The theory we are building is our account of how clients overcome ambivalence in psychotherapy. Theory-building case studies can make use of rich clinical material to assess and improve theories. As suggested by Stiles, whereas statistical hypothesis-testing compares observations on many cases with one theoretically derived statement, theory-building case studies compare many observations on one case with many theoretically derived statements (Campbell, 1979). Nonetheless, it should be stressed that all the explanatory hypothesis we raise in order to understand this study's results should be taken into consideration with caution as they stem from a single case study. Despite this, intensive analysis of Sarah's case with the ARCS allowed some interesting insights into the client's process of ambivalence resolution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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