THE THERAPEUTIC COLLABORATION IN DROPOUT CASES OF NARRATIVE THERAPY: AN EXPLORATORY STUDY

LA COLABORACIÓN TERAPÉUTICA EN CASOS DE ABANDONO EN TERAPIA NARRATIVA: UN ESTUDIO EXPLORATORIO

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Abstract

With this study, we aimed to describe the interaction within the therapeutic dyads involved in dropout cases of narrative therapy, once the quality of interaction in therapy appears to constitute a critical factor in clients' decisions regarding its discontinuation. Seven dropout cases of narrative therapy, which were conducted by the same therapist, were analysed using the Therapeutic Collaboration Coding System. The coding procedure required two trained and independent judges along with an auditing process. Overall, the findings demonstrated that independent of the clients' responses, the therapist tended to increase the challenging interventions and decrease the supporting interventions over time. In turn, the clients oscillated between having experiences of safety and experiences of intolerable risk. The results will be discussed in terms of their theoretical and empirical relevance in relation to clinical implications.

Keywords: *Dropout, therapeutic collaboration, process research, narrative therapy.*

Resumen

Con este estudio se ha pretendido describir la interacción entre díadas terapéuticas en casos de abandono en terapia narrativa, una vez que la calidad de la interacción terapéutica parece ser un factor crítico en las decisiones de los clientes para abandonar sus procesos. Siete casos de abandono en terapia narrativa, acompañados por el mismo terapeuta, fueron analizados utilizando el Sistema de Codificación de la Colaboración Terapéutica. El procedimiento ha incluido la codificación de todas las sesiones de los casos por dos jueces independientes con formación sobre el sistema, así como su posterior auditoría. En general, los resultados mostraron que, independiente de las respuestas de los clientes, el terapeuta ha tendido a aumentar sus intervenciones de desafío y a reducir las de apoyo, a lo largo del tiempo. A su vez, los clientes oscilaron en presentar experiencias de seguridad y experiencias de riesgo intolerable. Los resultados serán debatidos de acuerdo con su relevancia teórica y empírica y sus implicaciones clínicas.

Palabras clave: Abandono, colaboración terapéutica, investigación de proceso, terapia narrativa.

Introduction

The premature discontinuation of psychotherapy is one of the most common problems in clinical practice, with negative consequences not only for the direct interveners, i.e., the therapists (e.g., Swift & Greenberg, 2012) and the clients (e. g., Knox et al., 2011), but also for the society in general because of the economic and time loss they represent concerning to prior investment (e.g., Jung, Serralta, Nunes, & Eizirik, 2013). The most recent meta-analysis on psychotherapy dropout (Cooper & Conklin, 2015) found a dropout rate of approximately 20%, meaning that one out of five clients of psychotherapy do abandon it prematurely, most of them before achieving their goals and experiencing a significant relief from their symptoms.

There are several definitions of dropout in psychotherapy taking into account different criteria to establish the phenomena, such as the number of sessions attended and the therapist's judgement, for instance (e.g., Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Benetti & Cunha, 2008; Corning, Malofeeva, & Bucchianeri, 2007; Huang, Hill, & Gelso, 2013; Sales, 2003). However, in agreement with Jung and collaborators (2013), in this study we have decided to define dropout based on the unilateral initiative of the client to abandon or prematurely terminate the therapy, after at least one therapeutic session, without the knowledge or the agreement of the therapist. By assuming this definition, we expect to emphasize the non-accomplishment of the therapeutic goals previously established for the therapeutic process, as well as to highlight the break in the collaborative involvement between the therapeutic dyad. Notice that the quality of interaction appears to be a critical factor in client's decisions regarding the discontinuation of therapy (Barrett et al., 2008; Corning et al., 2007; Roos & Werbart, 2013). In fact, the collaborative involvement between the participants on the therapeutic dyad has been considered the core dimension of the therapeutic alliance, which has consistently been associated with the efficacy of psychotherapy, independently of the therapeutic approach in question (e.g., Horvath, 2013) – this being also true for dropouts.

Influenced by the concept of "meaning validation" (Kelly, 1955), Ribeiro (2009) suggested that the collaboration between the therapist and the client should be understood as a meaningful co-construction process, once it entails a process of mutual validation of both participants' experiences and the meanings unfolded in the context of the therapeutic conversation. Later, Ribeiro, Ribeiro, Gonçalves, Horvath, and Stiles (2013) proposed that the therapist facilitates change when intervening within a Therapeutic Zone of Proximal Development (TZPD; Leiman & Stiles, 2001), which is defined by the distance between the client's actual and potential developmental levels. According to this TZPD conceptualization, it is in the aim of the collaborative involvement between the therapeutic dyad that the client is more capable to reach his or her potential level of development.

As Kelly (1955) pointed out, "seeing the client's construction system from the vantage point of a psychologist (…) permits the clinician to join with the client in

a true role relationship and, together with him, make progress which client cannot accomplish alone" (pp. 799–800). In this sense, framing and responding to the client's needs in a developmental perspective not only fosters therapeutic collaboration but also promotes client's change.

In this process, the therapeutic dyad moves from understanding and empathically negotiating the client's actual difficulties to emphasizing the client's potential abilities, thus pushing him or her to reconstruct new meanings. Therefore, from a narrative viewpoint, we might argue that the client might evolve from a mal-adaptive perspective that is painful for him or her to a more adaptive perspective that fosters change and promotes his or her well-being, through the emergence of innovations (Gonçalves, Matos, & Santos, 2009; White & Epston, 1990).

Consequently, change occurs through the use, on the therapist's side, of strategies that enable the client's progress from his or her actual developmental level to his or her potential developmental level (Ribeiro et al., 2013). If the therapist intervenes within the client's TZPD, the client is more likely to experience a sense of safety when facing supporting interventions or a sense of tolerable risk when facing challenging interventions; thus, both interventions are validated and the proposal made by the therapist is accepted. In contrast, if the therapist intervenes out of the TZPD, the client is more likely to invalidate his or her interventions and subsequently refuse to accept or even consider his or her proposal. This outcome would be more expected if the therapist overly challenges, working above the upper limit of the TZPD, thus leading to an experience of intolerable risk on the client's part; it may also occur if the therapist works below the lower limit of the TZPD, which leads to an experience of disinterest or annoyance on the client's part because of the redundancy or unsuitability of his or her interventions. Finally, when the therapist works at the limits of the TZPD, the client is more likely to experience a sense of ambivalence and subsequently oscillate between the proposal made by the therapist and his or her own perspective, thereby moving towards safety or moving towards risk.

Present study: Goals and questions

In the current study, our aim was to analyse the interactive micro-processes that underlaid the development of the therapeutic collaboration over the course of seven dropout cases of narrative therapy. We focused on two main questions: 1) How did the clients respond to each therapist's intervention?; and 2) ow did the therapist respond to each clients' response? With the first question, we aimed to track each type of therapist's intervention and the subsequent experiences of the clients, that were interpreted by their responses, as conceptualized by the Therapeutic Collaboration Coding System (TCCS; Ribeiro et al., 2013); and, with the second question, we aimed to track each type of clients' experience and the subsequent interventions of the therapist.

Method
Participants

Seven therapeutic dyads participated in the study. They were selected from a database of dropout cases based on the criteria that their therapeutic processes ended prematurely with no significant clinical change on the clients' side as evaluated by the Outcome Questionnaire - 45.2 (OQ-45.2; Lambert & Burlingame, 1996; Portuguese version of Machado & Fassnacht, 2014).

The clients were treated in a university clinical centre and were all diagnosed with major depression. At the intake session, the clinicians administered the Structured Clinical Interviews for DSM-IV-TR I (First, Spitzer, Gibbon, & Williams, 2002) and II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) as part of the assessment protocol. There were no situations of comorbidity and the clients' Global Functioning Assessment (GFA) was, on average, 61.43 ($SD = 8.14$). Clients' age ranged from 19 to 43 years old, with a mean age of 29.29 years ($SD = 10.14$); six clients were female; and, three of the clients were taking medication at the beginning of the therapy. Finally, it is important to consider that the clients attended a varied number of sessions, which ranged from one to ten ($M = 4.71$; $SD = 3.59$).

The therapist was a male therapist, with approximately five years of clinical experience and, at that moment, completing his PhD. He had received previous training in narrative therapy and weekly supervision from a senior therapist while conducting the cases.

Considering all the cases that the therapist was responsible for, including the cases selected for this study, the therapist attended a total of 34 cases of narrative therapy, from which 26.47% were successful completers, 38.26% were unsuccessful completers, 5.88% were successful dropouts, and 29.41% were unsuccessful dropouts. Despite the different outcomes, previous case studies using the TCCS (e.g., Ferreira, Pinto, Ribeiro, Pereira, & Pinheiro, 2015; Ribeiro et al., 2014, 2016a) consistently demonstrate that this therapist tended to intervene according to challenging strategies since the beginning of the therapy.

Therapy: The treatment consisted of weekly sessions of narrative therapy based on the principles of White and Epston (1990). According to the specific manual used in the project from which the cases under study were selected, the main interventions included: a) the deconstruction of the problematic self-narrative through the use of strategies of externalization; b) the reconstruction of an alternative self-narrative through the identification of unique outcomes; and c) the consolidation of the emergent changes through social validation and strategies of metaphorization, which attempted to make more visible the way unique outcomes occurred (see Lopes, Gonçalves, Fassnacht, Machado, & Sousa, 2013, for a detailed description of the therapy guidelines).

Researchers: The first author –a PhD candidate of Applied/Clinical Psychology at the time of the coding– and a colleague from the same research team – who is a MD clinical psychologist, coded both the clinical cases. The last author was the

auditor of the coding procedure

Measures

   Working Alliance Inventory: The WAI (Horvath & Greenberg, 1989; Portuguese version by Machado & Horvath, 1999) consists of a self-report measure that comprises 36 items, which can be rated using a seven point Likert scale. It is designed to assess the quality of the therapeutic alliance between the therapist and the client, and it presents substantial evidence for validity and reliability, as well as good internal consistency, even in its Portuguese version.

   In the present study, this instrument was used only in its client's version following each attended session. To obtain the indication of the therapeutic alliance's quality, we considered the mean value for each item.

   Thus, the overall quality of the therapeutic alliance was considered moderately high ($M = 5.65$; $SD = .38$) according to the clients' ratings following each session they attended, as well as for the three subscales of the WAI (agreement on tasks: $M = 5.66$; $SD = .69$; bond: $M = 5.56$; $SD = .48$; and agreement on goals: $M = 5.09$; $SD = .98$).

   Outcome Questionnaire - 45.2: The OQ-45.2 (Lambert & Burlingame, 1996; Portuguese version by Machado & Fassnacht, 2014) consists of a self-report measure that comprises 45 items designed to assess the client's symptomatology, interpersonal functioning, and social role performance. It presents substantial evidence for validity and reliability, as well as good internal consistency.

   In the present study, this instrument was used to assess the presence of clinically significant symptomatology in clients at the moment of the intake and at every four sessions. It enabled us to confirm the absence of significant therapeutic gains until the final assessment of the clients' symptomatology, depending on the number of sessions of the different therapeutic processes. In three cases, the final assessment was obtained at the last session; in two cases, it was obtained at the pre-dropout session, and in the remaining two cases, it was obtained two sessions prior to the interruption of the therapy. The absence of significant therapeutic gains on the clients was identified through the calculation of a Reliable Change Index (RCI) of 15 points and a cutoff of 62 points ($M_{\text{at the intake}} = 90.43$; $SD_{\text{at the intake}} = 13.03$; $M_{\text{at the last evaluation}} = 85.50$; $SD_{\text{at the last evaluation}} = 7.50$).

   Furthermore, the Interpersonal Relations Subscale of the OQ-45.2 (OQ-45.2 IR) was specifically considered in this study to evaluate the presence of significant interpersonal problems in clients' lives from the initiation of the therapy until its termination. For determination of the presence of significant interpersonal difficulties in clients' lives, the OQ-45.2 IR's score must be above 14 points, and the RCI must be of 8 points or more.

   According to OQ-45.2 IR, the clients of this study presented significant interpersonal difficulties, such as loneliness and conflicts with others, namely, with family members, friends and lovers, from the first ($M = 20.71$; $SD = 6.34$) to the last ($M = 22.50$; $SD = 1.50$) evaluations.

Therapeutic Collaboration Coding System: The TCCS (Ribeiro et al., 2013) was used to analyse the development of the therapeutic collaboration. It consists of a transcript-based method, in which the basic unit of analysis is the speaking turn. The therapist and clients' speaking turns were coded in the context of the other's speaking turn (considering the immediate context) and of all previous therapist-client therapeutic exchanges during the considered session (considering the overall context).

This coding system enables the identification of different types of therapist interventions and client responses. Regarding the therapist's interventions, it is possible to identify several sub-categories of supporting and challenging categories; and, concerning the client's responses, it is possible to identify several sub-categories of validation, invalidation and ambivalence categories (Table 1).

Table 1

Sub-categories of the therapist's intervention markers and of the client's response markers

Therapist's intervention markers		
Supporting sub-categories		Challenging sub-categories
Confirmation		Interpretation
Reflection		Confrontation
Summarization		Change of level of analysis
Specification of information		Invitation to adopt a new perspective
Open questioning		Invitation to explore hypothetical scenarios
Demonstration of interest or attention		Invitation to put a new action in practice
Minimal encouragement		Debate regarding client's beliefs
		Emphasizing innovation
		Tracking change evidence
Client's response markers		
Validation sub-categories	Invalidation sub-categories	Ambivalence sub-categories
Confirming	Expressing confusion	Moving towards risk
Providing information	Focusing or persisting on the dominant mal-adaptive self-narrative	Moving towards safety
Extending		
Reformulating one's perspective	Defending one's perspective and/or disagreeing with therapist's intervention	
Clarifying	Denying progress	
	Self-criticism and/or hopelessness	
	Lack of involvement in response	
	Shifting topic	
	Topic or focus disconnection	
	Non-meaningful storytelling and/or focusing on others' reactions	
	Sarcastic answer	

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

Procedure

All therapy processes (N = 33 sessions) were videotaped with the permission of the university clinical centre and with the consent of the participants. All sessions were fully transcribed by the first author.

Both judges, the first and the third authors, were previously trained on the TCCS during approximately three months. The training finished when both judges achieved a good reliability, that is, an agreement percentage of at least 80% (Almeida & Freire, 2000).

According to the coding procedure of the TCCS, the first step was to read all the transcripts of each case sequentially to list each client's problems or difficulties. This step was performed independently by each of judges, and then they met to discuss and consensually define the clients' dominant problematic self-narrative indicators, as well as their potential alternative/adaptive self-narrative indicators.

Next, the judges independently coded each session and, subsequently, they met with each other to identify and discuss potential discrepancies in coding. To achieve a consensual version of the coding, the judges presented and explained their perspectives on the specific unit of analysis, considering the immediate and global contexts. Finally, the consensual versions were submitted to an auditing process to improve their accuracy. Both judges coded 100.00% of the wholly sessions, which means 4756 therapeutic exchanges. The percentage of agreement for the independent coding was 92.66% for the therapist's interventions and 88.21% for the clients' responses. The auditing procedure was conducted on 40.61% of all the sessions (n = 13 sessions).

Statistical analysis

To examine the seven dropout cases under study, we have chosen a statistical analysis involving empirical calculations of proportions in order to understand the progression of the therapist's interventions and of the clients' responses. There was no statistical model assumption.

In the first stage, the empirical proportions were calculated for each type of therapist's intervention and client's response in the overall interventions and responses, respectively, at each session, throughout therapy. The averages for all cases were subsequently calculated. The plots of the individual progressions of these proportions demonstrate that the cases have similar profiles.

The proportions of each type of therapist's intervention and clients' response were then calculated at each session, throughout therapy, depending on the previous type of response and intervention, respectively. Thus, the proportions were based on a subset of the previous speaking turn. Using these proportions of interest, it was possible to understand the sequence of the therapist's intervention, clients' response and therapist's intervention again.

Results

Overall proportions of the therapist's interventions and clients' responses.

The results for the overall therapist's interventions are presented in Figure 1, in which the *y* axis represents the proportion of occurrence of the overall therapist's interventions and the *x* axis represents the sessions over time. The three lines in the figure represent the three potential therapist's interventions.
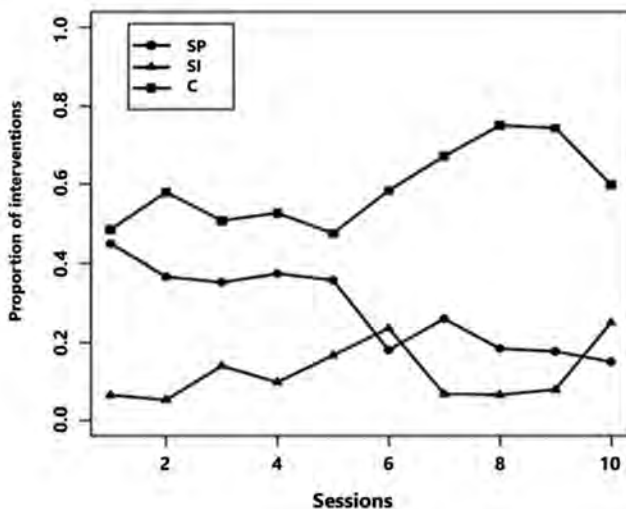

Figure 1. Overall proportion of the therapist's different interventions.
SP: Supporting Problem; SI: Supporting Innovation; C: Challenging.

Once the therapeutic processes under analysis included a different number of sessions, an analysis of the individual profiles of the cases was performed to confirm the overall pattern of the therapist's different interventions. Figure 2 shows that the therapist tended to intervene in the same way in all the cases under study, privileging challenging interventions over time (Figure 2(c)) compared with the other two types of interventions (Figures 2(a) and 2(b)).
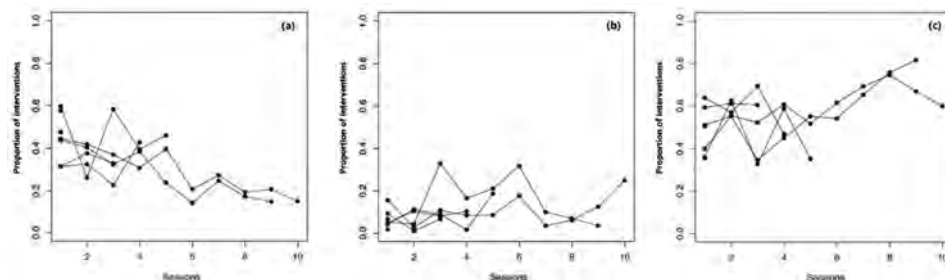

Figure 2. Individual profiles of the therapist's different interventions.
(a) Supporting Problem; (b) Supporting Innovation; (c) Challenging.

The results for the overall clients' responses are presented in Figure 3, in which the *y* axis represents the proportion of occurrence of the overall clients' responses and the *x* axis represents the therapeutic sessions over time. The six lines in the figure represent the six potential responses of the clients.
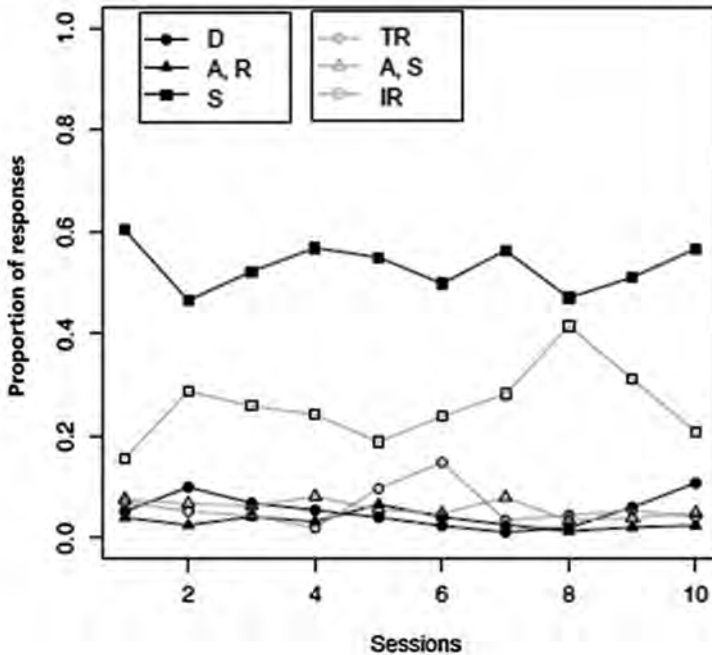

Figure 3. Overall proportion of the clients' different responses.
D: Disinterest; A, R: Ambivalence towards Risk; S: Safety; TR: Tolerable Risk; A, S: Ambivalence towards Safety; IR: Intolerable Risk.

As shown in the Figure 3, safety responses were the most frequent over time, with the intolerable risk responses identified as the second most frequent; the other responses remained relatively stable and similar between them. An analysis of the individual profiles of the cases was performed to confirm the overall pattern of the clients' different responses over time. Figure 4 shows that the clients tended to respond the same way over time, i.e., the safety responses were the most frequent (Figure 4(c)), being followed by responses of intolerable risk (Figure 4(f)).
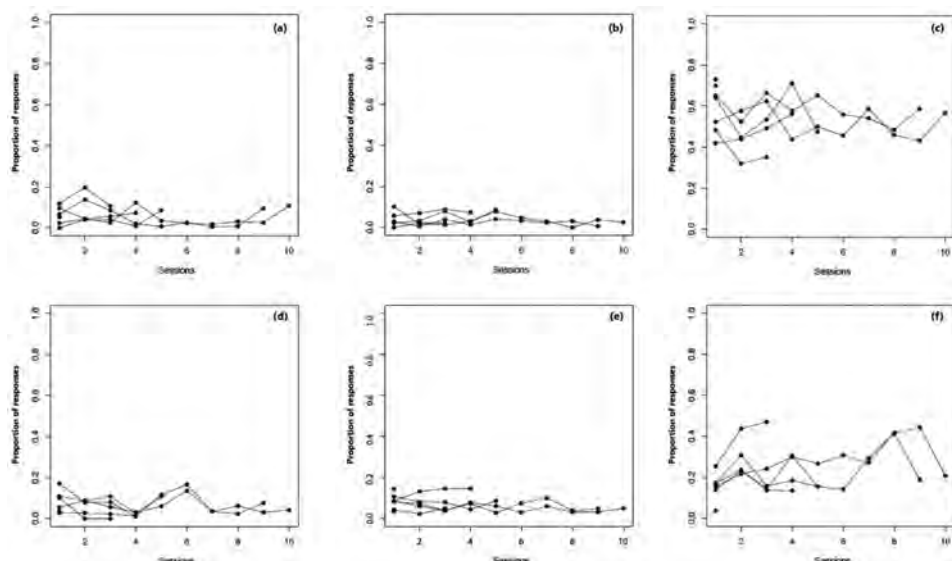
Figure 4. Individual profiles of the clients' different responses.
(a) Disinterest; (b) Ambivalence towards Risk; (c) Safety; (d) Tolerable Risk; (e) Ambivalence towards Safety; (f) Intolerable Risk.

How did the clients respond to each therapist's intervention?

Figure 5 shows that followed by a supporting problem (Figure 5(a)) or a supporting innovation (Figure 5(b)) intervention by the therapist, the clients tended to respond according to an experience of safety more frequently over time. However, following a therapist's challenging intervention (Figure 5(c)), the clients tended to oscillate between responses of safety and responses of intolerable risk over time.
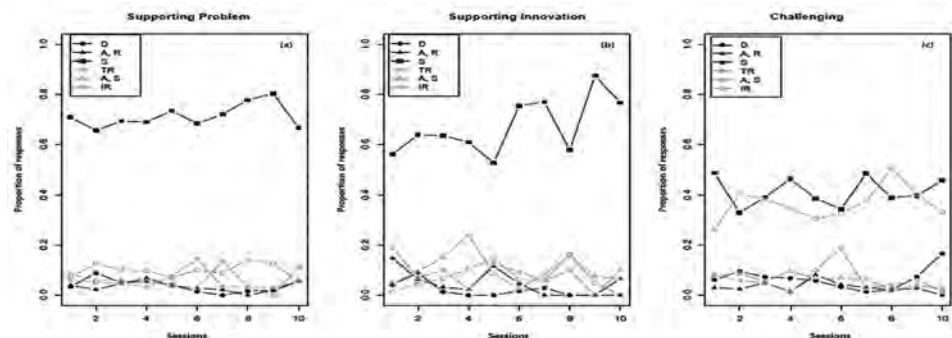

Figure 5. Proportion of the clients' different responses following each type of therapist's intervention.

How did the therapist respond to each clients' responses?

Figure 6 reveals that following clients' responses of disinterest (Figure 6(a)), the most frequent intervention by the therapist was a challenging intervention, with the exception of the eighth session in which the supporting innovation interventions were the most frequent. With barely significant exceptions, the prominence of challenging interventions over time was also true, followed by all other types of clients' responses: ambivalence moving towards risk (Figure 6(b)), safety (Figure 6(c)), tolerable risk (Figure 6(d)), ambivalence moving towards safety (Figure 6(e)), and intolerable risk (Figure 6(f)).
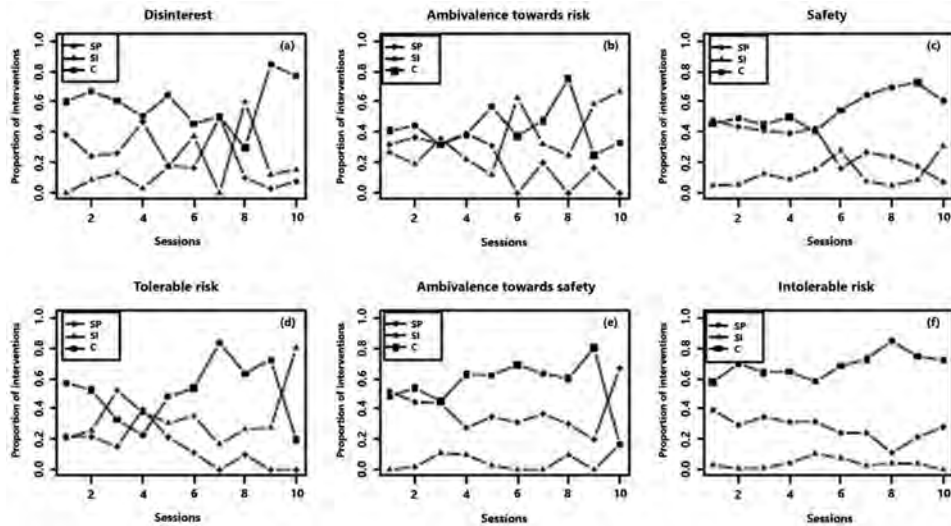

Figure 6. Proportion of the therapist's different interventions following each type of clients' response.

Discussion

In this study, we aimed to characterize the therapeutic collaboration over the therapeutic processes of dropout cases, thus considering both therapist's and clients' contributions. Consistent with the definition of dropout adopted, we analysed dropout cases with a different number of sessions, and we did not distinguish them in terms of, for example, non-engagers or engagers, prior/early dropouts or later dropouts (e.g., Huang et al., 2013; Sales, 2003). Along with the fact that the great majority of the research on psychotherapy dropouts emphasizes the absence of significant improvement from dropout clients in terms of their symptomatology (e.g., Baekeland & Lundwall, 1975; Cahill et al., 2003), the individual profiles of the cases of our study also provided evidence to follow either a general pattern of the therapist's interventions and the clients' responses, justifying our decision. Notice that, similarly to our findings, although Huang and colleagues

(2013) started by distinguishing between non-engagers and engagers, they were not actually able to identify differences in terms of the therapists' verbal response modes between the two types of dropouts over time.

The results regarding the first research question, i.e., "How did the clients respond to each therapist's intervention?", indicate, on average, that the clients' responses of safety were the most prevalent in the sequence of therapist's supporting interventions. However, following the therapist's challenging interventions, the clients' responses of safety have decreased over time, whereas their responses of intolerable risk have increased.

Considering the therapist exhibited a tendency to increase his challenging interventions throughout therapy, these results suggest that the therapy became increasingly risky for the clients. Indeed, the individual profiles indicate that the clients' intolerable risk responses tended to increase prior to the clients' drop out, which suggests an increase in the threatening experiences, whether they had dropped out in the early sessions or had continued for more sessions.

The increase of non-collaborative exchanges over time, i.e., involving clients' disinterest or intolerable risk responses, would suggest difficulties in the alliance formation or in repairing alliance ruptures, which would have led to a significant increment on the clients' discomfort regarding the therapy, during or after the early sessions. This idea appears to be consistent with findings suggesting that the formation of the therapeutic alliance is more difficult and poor in dropout cases (Barrett et al., 2008; Corning et al., 2007). Accordingly, in a study that compared the quality of the therapeutic alliance in cases with different types of therapeutic outcomes, Coutinho, Ribeiro, Sousa, and Safran (2013) concluded that clients who dropped out from therapy exhibited a decreasing tendency on the WAI scores and an increasing tendency in alliance ruptures immediately before they left therapy.

However, in this study, although we expected that the increase in the clients' threatening experiences would negatively influence the evaluation of the alliance at the end of each session, on average that evaluation remained moderately high. Despite the exploratory nature of the present study and the number of cases studied, we believe that different factors may help to understand these results within these specific cases. First, we can suppose that the clients' invalidations of the therapist's proposals did not indicate that the clients and the therapist disagreed on the therapy global goals or tasks, as evaluated at the end of each session by the WAI, but that they were critical signs of the clients' difficulties to involve themselves in the proposed goals and tasks, as well as in progressing further. Thus, the insistence of the therapist in challenging the clients' perspectives following their intolerable risk responses may have suggested to the clients that the therapy, although relevant, was too difficult.

If the dyad is not able to negotiate this type of mutual and momentarily invalidations, it can miss the opportunity to re-establish the collaboration. Non-collaboration is akin to other phenomena referred by other authors as alliance

ruptures (e.g., Coutinho, Ribeiro, Hill, & Safran, 2011; Coutinho, Ribeiro, & Safran, 2009; Eubanks-Carter, Mitchell, Muran, & Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Safran & Muran, 2000), which may prevent the client from engaging in therapy if not properly addressed or repaired (Huang et al., 2013). In this case, for instance, the favourable alliance evaluation at the end of the sessions can reflect the existence of withdrawal alliance ruptures, especially in cases where the clients were deferent with the therapist or were interested in protecting their relationship, similar to what happens with some clients with a preoccupied interpersonal style (Bachelor, Laverdière, Gamache, & Bordeleau, 2007) or with an anaclitic type of depression (Blatt, Shahar, & Zuroff, 2002). Thus, we may suppose that the interpersonal problems presented by the clients in the current study, as revealed by the high scores on the OQ-45.2 IR, may be related to an insecure and preoccupied interpersonal style, which may have contributed to their favourable evaluation of the alliance (Eames & Roth, 2000). These results are also congruent with research on alliance ruptures, which has demonstrated that the occurrence of moment-to-moment breaks on the alliance are not always identified by the clients in their post-session evaluation of the alliance ruptures or reflected in their alliance scores (Coutinho et al., 2013; Eubanks-Carter et al., 2010).

Regarding the dyads' interactions considering the clients' TZPD, the proportion of occurrence of the clients' different experiences in response to the therapist's different interventions also indicates that the clients tended to keep working close to their actual level of development even when the therapist tried to push them to the potential level. The large proportion of safety responses of the clients following therapist's supporting interventions and their rare tolerable risk responses suggest that it was difficult for them to move forward and experience change. This interpretation is sustained by the high proportion of intolerable risk responses following the therapist's challenging interventions, which indicates the dyads were working beyond the clients' TZPD.

From the point of view of the conceptualization of the therapeutic collaboration adopted in this study (Ribeiro et al., 2013), we hypothesize that different interpretations can be made from the results regarding the way the clients' responded more frequently to the different types of the therapist's interventions. The oscillation between the clients' responses, which indicated safety or intolerable risk, suggests some difficulty to move towards their potential level of change, regardless of whether they had dropped out early or not. We can suppose that these clients were not ready to change when they sought help (or were instructed to seek for help; e.g., Baekeland & Lundwall, 1975); thus, they did not demonstrate a real commitment to the therapy and were unwilling to consider alternatives for their lives. In this case, similar to what Brogan, Prochaska, and Prochaska (1999) identified in about 40% of the cases that dropped out early from therapy in their study, it is possible that in our study, the clients were also blocked in a pre-contemplation stage of change (Prochaska, & Norcross, 2002); thus, they experienced

intolerable risk when invited to consider new and more adaptive perspectives regarding their lives because of their incapacity to not only recognize their problems but also to reflect on and defocus from them.

Supposing, however, that the clients were motivated to engage in their therapeutic processes, another interpretation might consider the exigencies of the therapy and the clients' resources and abilities to face them. Notice, once more, that even following the therapist's challenging interventions, the clients tended to oscillate between feeling safe and threatened, which may indicate some openness to accept the therapist's challenges, but also a great difficulty to move beyond their actual level of development. From a constructivist and narrative perspective of change, although the therapist's interventions are tailored to the changes desired by the clients, we may understand the clients' invalidation of them as a self-protective action. Although the clients might have wished to decrease their experience of suffering and might have wanted to change with the help of the therapist, it is possible that they were blocked in the process of collaboration if they were anticipating change as having undesirable implications in their self-meanings or narrative structure. This would be consistent with studies that focused on impasses and blocks of change (Feixas et al., 2013; Ferreira et al., 2015; Gabalda & Stiles, 2009; Ribeiro et al., 2014, 2016a, 2016b; Stiles, Gabalda, & Ribeiro, 2016), which suggest that self-conflicts regarding the experience of change may be involved in an increasing non-collaborative interaction and, subsequently, in dropout cases of therapy.

When considering the results related to the second research question, i.e., "How did the therapist respond to each clients' response?", we determined that the challenging interventions on the part of the therapist increased over time, while the frequency of the supporting problem interventions decreased. In general, the therapist responded to the clients' different experiences exactly the same way. Contrary to what could have been expected, the therapist did not seem to have been responsive to the moment-to-moment clients' needs, being unaware of the clients' signs of anxiety and threat (intolerable risk responses), or failing to consider them. These results suggest that the therapist became more rigid in his challenging interventions, working beyond the clients' TZPD. Interestingly, this finding is also congruent with the idea that unbalanced and too many challenging interventions by the therapist can provoke great anxiety in clients, which, in turn, can contribute to their dropout from therapy (Gabalda & Stiles, 2009; Ribeiro et al., 2013).

Based on the hypothesis previously discussed, we suppose that these clients could have likely benefited more from the therapy, especially in the first sessions, if the therapist had intervened more according to supporting strategies, specifically after the clients' responses of intolerable risk; thus, this approach would have re-established the collaboration, making them feel safe and consolidating their relationship (Roos & Werbart, 2013), and ultimately contributing to their maintenance in their processes. It appears that in these dropout cases, the therapist insisted on

pushing the clients to their potential level of development, thereby pressuring them to change. However, the clients' felt a great level of risk that moved the interaction of the dyad to out of their TZPD, which may have contributed to the clients' dropout from the therapy. This finding is consistent with the study of Lippe, Monsen, Rønnestad, and Eilertsen (2008), which suggests that, especially in successful cases, the therapist and the client might have followed each other, as in a dance, while this harmony decreased over time in dropout cases. Therefore, it appears that the therapist and the clients of the analysed cases failed to coordinate and adjust their actions in a moment-to-moment basis; they became involved in an escalation of non-collaborative therapeutic dialogue, which then compromised the quality of their interaction, which, as we referred at the beginning of this chapter, is assumed to represent a critical factor in clients' decisions regarding the discontinuation of therapy (Corning et al., 2007).

The present study has some limitations such as the number of cases analysed and the fact that the same therapist conducted them all. We conducted this study in an exploratory and theory-building perspective, selecting typical cases of the dropout phenomena and, thus, the implications driven from this study must be cautious in terms of their interpretation and generalization. However, we believe this study provides some new and useful hypothesis of the study regarding the therapeutic interaction and the respective dyads' experience likely associated to the phenomenon of dropping out. Specifically, we anticipate that the therapist's persistence in a certain intervention or, on the other hand, his preoccupation in addressing the client's experience by adapting his intervention closer to the client's development level, as well as the way it pursues both paths, might contribute to the client's maintenance in therapy or, on the opposite, to his or her dropout from it. Of course, to test these hypotheses it would require studying a representative sample of dropout cases in different therapy approaches and with distinct therapists.

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