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Ribeiro, E., **Cunha, C.,** Teixeira, A. S., Stiles, W. B., Pires, N., Santos, B., ... & Salgado, J. (2016). Therapeutic collaboration and the assimilation of problematic experiences in emotion-focused therapy for depression: Comparison of two cases. Psychotherapy Research, 26(6), 665-680.

Title: Therapeutic collaboration and the assimilation of problematic experiences in emotion-focused therapy for depression: Comparison of two cases.

Abstract

Aims: The Assimilation model argues that therapists should work responsively within the client's therapeutic zone of proximal development (TZPD). This study analyzed the association between the collaborative processes assessed by the Therapeutic Collaboration Coding System (TCCS) and advances in assimilation, as assessed by the Assimilation of Problematic Experiences Scale (APES).

Method: Sessions 1, 4, 8, 12, and 16 of two contrasting cases, Julia and Afonso (pseudonyms), drawn from a clinical trial of 16-sessions emotion-focused therapy (EFT) for depression, were coded according to the APES and the TCCS. Julia met criteria for reliable and clinically significant improvement, whereas Afonso did not.

Results: As expected, Julia advanced farther along the APES than did Afonso. Both therapists worked mainly within their client's TZPD. However, Julia's therapist used a balance of supporting and challenging interventions, whereas Afonso's therapist used mainly supporting interventions. Setbacks were common in both cases.

Conclusion: This study supports the theoretical expectation that EFT therapists work mainly within their client's TZPD. Therapeutic exchanges involving challenging interventions may foster client change if they occur in an overall climate of safety.

Keywords: Therapeutic collaboration; Assimilation of problematic experiences

Title: Therapeutic collaboration and the assimilation of problematic experiences in emotion-focused therapy for depression: Comparison of two cases.

The often-replicated finding that the strength of the therapeutic alliance predicts client change (Lambert, 2015; Muran, Barber, 2010) begs the question of which therapist interventions, under what circumstances, help clients improve. Norcross and Lambert (2011) noted that what therapists do to implement a specific therapeutic approach has been mostly studied separately from interpersonal or relational behaviors. Our research seeks to understand therapeutic collaboration, that is, how the members of therapeutic dyads behave toward each other. It builds on previous studies of therapist interventions within the assimilation model (Caro-Gabalda, Stiles, & Pérez Ruiz, 2015; Meystre, Kramer, Despland & Stiles, 2013; Meystre, Pascual-Leone, Roten & Despland, 2015), which have shown that useful therapist interventions are closely attuned with clients' emerging needs and capacities. Our study investigated how therapists' interventions, contextualized in collaborative therapist-client exchanges, were related to progress in the assimilation of problematic experiences in emotion-focused therapy (EFT) for two depressed clients selected for their contrasting degrees of improvement on standard symptom intensity measures.

The assimilation of problematic experiences in psychotherapy

The assimilation model is a theory of psychological change that sees the self as a cohesive structure comprising the accumulated ideas, experiences and self-perceptions that are accepted and owned by the person and provide the person's sense of organization, continuity and identity (Stiles, 2002, 2011; Stiles et al., 1990). This self-organization can be described metaphorically as a "community of voices" (Brinegar,

Salvi, Stiles, & Greenberg, 2006; Honos-Webb & Stiles, 1998; Stiles, Honos-Webb, & Lani, 1999). The voice metaphor emphasizes the active, agentic quality of internal traces of people's experiences. The tasks of daily life address the community and the relevant members emerge to speak and act, bringing past experience to bear on current tasks. We call these representatives of the community *dominant voices*.

Problems arise when important experiences cannot be expressed, when some voices cannot engage in dialogue within the self, being avoided or dismissed because they are dissonant within the self (Caro-Gabalda, 2008; Honos-Webb & Stiles, 1998; Osatuke & Stiles, 2006; Stiles, 1999). Examples of such problematic experiences include painful memories, unattended needs, and impulses that are sensed as distressing, threatening, or ego dystonic (Stiles et al., 1990). When such problematic experiences are addressed by current context, they too may seek to emerge to speak and act; we call them *nondominant voices*. When nondominant voices begin to emerge, they quickly encounter dominant voices, and this encounter causes negative affect and psychological avoidance, as dominant voices push the nondominant voices out of awareness to maintain self-coherence and personal integrity (Stiles, et al., 1992, 2004, 2006).

According to the assimilation model, psychotherapeutic improvement involves a gradual process of acknowledging, understanding and integrating such problematic experiences, changing them from distressing problems to valuable personal resources (Osatuke et al., 2011). Through therapeutic work, a productive dialogue between nondominant and dominant voices becomes possible, so that voices originally regarded as problematic can establish connections with the rest of the self (Osatuke & Stiles, 2006).

Intensive case studies have led to the construction and elaboration of the Assimilation of Problematic Experiences Scale (APES; Stiles, 1999, 2002; Stiles et al.,

1992; see Table 1). The APES describes a sequence of eight levels or stages of assimilation through which problematic experiences pass as they become increasingly assimilated into the self. These levels or stages represent anchor points in the change process, which is regarded as a continuum (Stiles, 2002; Osatuke & Stiles, 2006). Any advance in the APES (i.e. a movement from a lower to a higher level) can be considered as therapeutic progress (Brinegar, et al., 2006; Stiles, 2002). Previous case studies have suggested that clients tend to pass through the same stages despite different clinical problems and therapeutic approaches (see Stiles, 2002). Identifying a problem's APES stage may suggest ways to facilitate advancing to the next stage. Clients' main problematic experiences tend to reach at least APES level 4 in good outcome cases, whereas the problematic experiences tend to remain at lower APES levels in poor outcome cases (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006).

Previous research and clinical experience have shown that APES progress is rarely smooth but instead is characterized by frequent setbacks (e.g. Caro-Gabalda, 2006; Caro-Gabalda, Stiles, & Pérez Ruiz, 2015; Honos-Webb et al., 1999; Osatuke et al., 2005). However, most setbacks represent task-appropriate switches to a related but less-assimilated strand of the problem, a normal and potentially productive part of the therapeutic process (Caro-Gabalda & Stiles 2009, 2013; Caro-Gabalda, Stiles, & Pérez Ruiz, 2015; Mendes et al., 2015).

Therapeutic collaboration processes in psychotherapy

We understand therapeutic collaboration as a joint effort to maintain the therapeutic focus within the limits of the client's therapeutic zone of proximal development (TZPD; Leiman & Stiles, 2001; E. Ribeiro, A. P. Ribeiro, Gonçalves, Horvath, & Stiles, 2013). The concept of TZPD extends the concept of Zone of

Proximal Development, proposed by Vygotsky (1978) to describe children's development along an intellectual continuum, to represent clients' development along a therapeutic continuum. The assimilation model provides a framework to understand client change as a developmental process, and the APES provides a description of a therapeutic continuum. The TZPD "can be understood as the segment of the APES continuum within which the client can proceed from [their current APES] level to the next with the therapist's assistance" (Leiman & Stiles, 2001, p. 315). It ranges from the problem's actual (current) developmental level (lower limit) to its potential developmental level (upper limit). At a given time, the client's actual APES level for a problem is limited by the suffering and blocking of experiences, but with the therapist's help, the client can reach the problem's potential level (i.e., the current upper limit of the TZPD).

Theoretically, in successful therapy, the TZPD shifts up the APES (Leiman & Stiles, 2001). Through collaborative and responsive dyadic interaction, the potential level gradually becomes the client's actual level, and what was previously unattainable becomes achievable and familiar (E. Ribeiro et. al., 2013). At the same time, the potential level rises too, making more advanced work possible.

To study this process, E. Ribeiro and co-authors (2013) developed the Therapeutic Collaboration Coding System (TCCS). The TCCS assesses how the therapist's interventions respond to the client's expressions and whether or not the client's actions affirm the therapist's proposals. From these observations, we can infer whether the dyad is working within or outside the client's current TZPD.

Note that the APES and the TCCS use the terms *problem and problematic* in different, though complementary ways. The APES characterizes nondominant voices as problematic because they are problematic from the perspective of the client's usual,

dominant self. In contrast, the TCCS characterizes the client's usual self-narrative as problematic because it fails to accommodate those painful experiences, which are understood as innovative voices (A. Ribeiro et al., 2014; E. Ribeiro et al., 2013). To try to avoid confusion in this paper, we use the terms *problematic experience* for the nondominant, innovative voices and *problematic narrative* for the usual self-narrative, or dominant voices).

The TCCS distinguishes which of the client's voices is speaking (dominant or nondominant voice) and proposes two main categories of therapist interventions: supporting or challenging. When supporting, the therapist intervenes closer to the client's actual level: i) supporting the problematic narrative if the previous client expression was by a dominant voice or ii) supporting innovation if the previous client expression was by a nondominant voice. For example, suppose a depressed client feeling insecurity about social interactions says: "I can't understand what happens when I am with them… I really don't like that situation, I am confused…". An intervention supporting the problematic narrative might be: "It's hard not to understand … it seems like something is wrong with you…". If this client is able to express some feelings (advance in her TZPD/ progress in the APES) saying: " I have been feeling really sad and left out…", an intervention supporting the innovation might be: " Yes…, I understand… Can you tell me a little more about what exactly makes you so sad?"

When challenging, the therapist intervenes closer to the client's potential level within the TZPD by proposing an alternative perspective on the client's problematic narrative or focusing on the problematic experience (the innovation). For example, if the client says: "I become sad when I cannot say anything interesting. I try but I can't…", a challenging intervention might be: " It seems there's a part of you that wants to engage with others, and another part that stops you and discourages you from that".

Thus, therapeutic collaboration involves being responsive to clients' evolving needs and capacities, which includes recognizing moments of felt risk and opportunities to move forward by challenging the client's perspective. The TCCS uses the client´s immediate response to the therapist's interventions to infer the accuracy of therapist's responsiveness. Consider, for example, alternative client responses to the challenging intervention illustrated above. If the client's response is affirmative, like: "Yes…, maybe you are right…, I never thought about that… but it makes sense!", the TCCS scores it as validation for the therapist intervention, which is interpreted as the dyad working within the client's TZPD. However, if the client's response is defensive or confused, like: "I don't know… you know… I really try, but…, you know, I can´t…", the TCCS scores it as invalidation of the therapist intervention, which is interpreted as the dyad working outside the client's TZPD.

Theoretically, therapists can foster or reestablish collaboration by balancing their actions of supporting and challenging in response to the clients' changing requirements, continually working within a zone in which clients feel safe but also willing to explore their emergent innovative narratives (i.e. problematic experiences). Too much support for the problematic narrative risks losing opportunities to change and try out new perspectives; too much challenge risks creating excessive anxiety and promoting setbacks. Previous TCCS case studies, with a total of six clients representing a range of outcomes, included two cases of narrative therapy (Ferreira, Ribeiro, Pinto, Pereira, & Pinheiro, 2015), three cases of cognitive-constructivist therapy (A.P. Ribeiro, et al., 2014; Ribeiro, Silveira, Senra, Azevedo, & Ferreira, 2015) and one case of person-centered therapy (E., Ribeiro, et al., 2014). All sessions of each case (ranging from 8 to 20 sessions) were analyzed using the TCCS. This included a total of 6215 coded therapeutic exchanges (6215 therapist interventions and 6215 client's responses (range

541-1640 exchanges). Descriptive analyses included the proportions of therapist interventions, client's responses, and therapeutic exchanges--separately for each session and aggregated across each treatment. These studies have supported the theoretical suggestion that therapy is most likely to be effective if the dyad works preferentially within the TZPD. Across these therapeutic approaches, successful cases have had a higher proportion of therapeutic exchanges within the client's TZPD and a lower proportion of therapeutic exchanges outside the client's TZPD than have unsuccessful cases. Working within the client's TZPD has characterized the successful cases despite large differences in technique among these approaches: for example, the narrative and cognitive-constructivist therapists used relatively more challenging interventions whereas the person centered therapists used relatively more interventions of supporting the problematic narrative (usual self) or the emergent innovation (problematic experience).

Purpose of the Present Study

This study extended the examination of therapeutic collaboration using the TCCS to emotion-focused therapy (EFT). EFT is an experiential approach that integrates the person-centred relationship stance with marker-driven emotional activation tasks drawn from gestalt and focusing oriented psychotherapy (e.g. Greenberg, 2006). We also aimed to link therapeutic interaction, as assessed using the TCCS, with client change microprocesses as assessed using the APES.

We studied two cases of EFT with depressed clients, one who met criteria for recovery, and one who did not meet these criteria. We aimed to address two questions: 1) How did assimilation and therapeutic collaboration evolve in the two cases? 2) What sorts of therapeutic exchanges preceded assimilation advances and setbacks? To address the first question, we examined changes in the APES and the TCCS across initial,

middle and final phases of the two treatments. To address the second question, we analyzed which types of TCCS exchanges were associated with the transitions in the APES: advances (i.e. increases, from a lower to a higher APES level) and setbacks (i.e. decreases, from a higher to a lower APES level), seeking to elaborate our understanding of how therapists may or may not facilitate assimilation.

Method

Participants

Clients. The cases of Julia and Afonso (pseudonyms) were drawn from the EFT condition of the Instituto Universitário da Maia (ISMAI) Depression study (Salgado, 2008), a randomized clinical trial conducted in Portugal comparing EFT with cognitive-behavioral therapy. Julia and Afonso each received 16 sessions of EFT. From these, we selected the 5 sessions that had been assessed with outcome measures (see Procedure section later) for our analyses: sessions 1, 4, 8, 12 and 16.

Julia was a Caucasian female, 30 years old, single and unemployed, who was diagnosed with Major Depressive Disorder, mild. Her identified problems included feeling rejected and neglected by her dysfunctional family, insecurity, and inadequacy. She made substantial gains in treatment and met the criteria proposed by Jacobson and Truax (1991) for reliable and clinically significant improvement (RCSI) on standard outcome measures, as described later.

Afonso was a Caucasian male, 24 years old, single and a full-time university student, who was initially diagnosed with Major Depressive Disorder, moderate. His identified problems were his difficulties in accessing emotional experiences, inability to understand his feelings, and social performance anxiety issues. Although he showed a little improvement on standard outcome measures, he did not meet RCSI criteria.

Therapists. Julia's therapist was a male PhD-level clinical psychologist with 20 years of clinical experience and 5 years of experience with EFT. Afonso's therapist was a female PhD-level clinical psychologist with 9 years of clinical experience and 2 years of experience with EFT. They both participated in a 24-week training in EFT (within the ISMAI Depression study; Salgado, 2008) using the manual for the York 1 Depression study (Greenberg, Rice, & Elliott, 1993), and received weekly supervision throughout the therapeutic processes.

Treatment. Emotion-focused therapy (EFT – Greenberg, 2006; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006), formerly known as process-experiential psychotherapy (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg & Watson, 1998), is a treatment approach that integrates the client-centred therapy relationship conditions with process-directive experiential interventions meant to facilitate enduring, emotional change. Therapist-provided relationship conditions such as empathic attunement, unconditional positive regard, congruence, and presence provide a safe therapeutic environment (Greenberg, 2006; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006), while emotional change is facilitated through process-directive experiential interventions that are guided by markers (e.g., self-critical splits point to two-chair dialogue; unfinished business point to empty-chair work, among others; Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2006; Greenberg & Watson, 2006; Greenberg, Rice, & Elliott, 1993). In a study using the Experiential Therapy Adherence Measure (cf. Goldman, 1991; Greenberg & Watson, 1998) to study therapist adherence to the treatment manual in the EFT condition of the ISMAI Depression study, Monteiro (2014) and Nogueira, et al. (2012) found that therapists in the EFT condition showed typical and congruent global EFT skills 67% of the time. Specific EFT tasks (such as two-chair dialogue, empty-chair work or evocative

unfolding) appeared in 59.5% of the sample of sessions analyzed. Given these results, the authors concluded that these therapists exhibited a majority of essential and unique EFT behaviors, showing adequate therapist adherence and adequate treatment integrity according to the guidelines proposed by Perepletchikova (2011) and Perepletchikova and Kazdin (2005).

Outcome measures

Outcome Questionnaire - 45.2 (OQ-45.2; Lambert et al., 1996, Portuguese version by Machado & Fassnacht, 2014). The OQ-45.2 is 45-item self-report measure designed to assess the client's general clinical symptoms, interpersonal functioning, and social role performance. There is substantial evidence for its validity and reliability, as well as good internal consistency (Machado & Fassnacht, 2014).

Beck Depression Inventory – II (BDI-II; Beck, Steer & Brown, 1996, Portuguese version by Campos & Gonçalves, 2011). The BDI-II is 21-item self-report measure designed to measure severity of depression, with substantial evidence for its validity, reliability and internal consistency (Campos & Gonçalves, 2011).

Process Measures

Assimilation of Problematic Experiences Scale. As summarized in Table 1, the APES (Stiles, 2002; Stiles et al., 1992) describes the evolution of the relation of a problematic experience (nondominant voice) to the self (dominant community) using a sequence of eight stages, numbered 0 to 7, ranging from dissociation (i.e. the client is not aware of the problem; the nondominant voice is muted or dissociated) to complete integration (i.e. the client automatically generates solutions; nondominant voices are fully integrated and no longer a problem, serving as resources in new situations).

Although the APES is theoretically a continuum, we rated only discrete stages in this study.

Therapeutic Collaboration Coding System – TCCS. The TCCS is a transcript-based method developed to analyze the therapeutic collaboration at a moment-by-moment level (Ribeiro et al., 2013). Each therapist-client adjacency pair (consecutive speaking turns) is evaluated in the context of the client's immediately preceding turn and more broadly the previous interaction during the session.

The TCCS distinguishes two global categories of therapist interventions, supporting and challenging. Supporting interventions are further classified as focused on the problematic narrative or on the emergent innovation (i.e., nondominant voice), depending on where the client's previous speaking turn was focused. Examples of supporting subcategories include reflections, open questioning, and summarizing; examples of challenging subcategories include interpretations, confrontations, focusing on emotions, invitation to adopt a different perspective, and focusing awareness on emotional experience. Client's responses are divided into three global categories: validation, invalidation, and ambivalence. The client can validate the intervention by, for example, confirming or giving information, which is interpreted as indicating an experience of safety and thus as well within the TZPD. Alternatively, the client may respond by elaborating an innovation (problematic experience expression), extending the therapist proposal, or reformulating their perspective, which is interpreted as indicating an experience of tolerable risk and thus as near the upper limit of the TZPD. Client responses that invalidate the intervention, for example by expressing confusion, defending their perspective, or persisting with the problematic self-narrative, are interpreted as indicating an experience of intolerable risk, above the upper limit of the TZPD. Client responses that deny progress, express a lack of involvement, or shift the

topic are interpreted as indicating disinterest and thus below the lower limit of the TZPD.

The ambivalent code means that, in the same speaking turn, the client oscillated between validating and invalidating the therapist's proposal. This is interpreted as working at the limit of the TZPD. These responses are further subdivided as ambivalence toward safety or ambivalence toward risk, depending on the last focus of the client's speaking turn (problematic narrative or emergent innovation, respectively). For more detail about TCCS coding see Ribeiro et al. (2013).

The intersection of therapist interventions and client responses yields 18 types of therapist-client exchanges (Table 2): 6 collaborative exchanges (i.e., occurring within the TZPD), 6 ambivalent exchanges (i.e. occurring at the limit of the TZPD), and another 6 coded as non-collaborative (i.e. outside of the TZPD) (Ribeiro et. al, 2013).

The TCCS has shown good reliability in previous studies, with mean Cohen's kappa values of .92 for the three categories of therapist interventions (based on N=3,234 utterances) and .93 for the six sub-categories client's responses (based on N=3,234 utterances) (Ribeiro, et al., 2013; A.P. Ribeiro, et al., 2014).

Procedure

Phase 1: Recruitment of participants and selection of cases. Clients for the ISMAI Depression study (Salgado, 2008) were recruited from the community through local media, social media and newspaper advertisements. In face-to-face meetings, researchers provided detailed information, gathered informed consent and ascertained eligibility. Like all clients accepted for this trial, Julia and Afonso met diagnostic criteria for major depression according to the DSM–IV–TR (APA, 2000), established through an initial assessment with the Structured Clinical Interview for DSM-IV

(Spitzer, Williams, Gibbon, & First, 1995). After assessment, both cases were randomly assigned to the EFT treatment condition of the trial, receiving 16 sessions of EFT. Depressive and general clinical symptoms were routinely monitored with the BDI-II and OQ-45.2 during the pre-treatment assessment and immediately before sessions 1, 4, 8, 12 and 16. Several previous studies have used cases drawn from the ISMAI Depression study (Barbosa, et al., 2016; Basto, Salgado, Stiles, & Rijo, 2016; Basto, et al., 2016); however none has previously focused on these two cases of Julia and Afonso specifically.

Clients were assessed according to RCSI criteria (Jacobson & Truax, 1991) based on pre-post change on the Portuguese versions of the BDI-II (Campos & Gonçalves, 2011) and on the OQ-45.2 (Seggar, Lambert, & Hansen, 2002; Machado & Fassnacht, 2014). Julia and Afonso were selected from among cases that met or failed to meet RSCI criteria, respectively. Julia met RSCI criteria, dropping from 19 to 2 points on the BDI-II; and from 82 to 59 points on the OQ45.2. Afonso failed to meet RCSI criteria; he showed little change on these outcome measures, dropping from 23 to 16 points on the BDI-II; and from 83 to 80 points on the OQ45.2.

All sessions from the two cases were transcribed by undergraduate students who had been trained on standard transcription guidelines for psychotherapy sessions (Mergenthaler & Stinson, 1992). Sessions were transcribed in Portuguese, with names and identifying details omitted or changed. The examples presented later were translated into English for this article by the authors.

Phase 2: APES Rating. APES ratings of Julia's and Afonso's sessions were drawn from a previous study by Basto, Salgado, Stiles, and Rijo (2016). In the Basto et al. (2016), study, the APES was applied to the cases by separate teams of two trained judges (in each case, a PhD student working with a Masters student in clinical

psychology). All judges were blind to the outcome status of their case and the purposes of this study. APES rating followed the procedural steps described by Stiles and Angus (2001): 2.1) Training in the APES; 2.2) Identification of problematic themes, selection of text, and characterization of dominant and non-dominant voices; 2.3) Rating of excerpts according to the APES; 2.4) Reliability assessment.

2.1) Training in the APES. Training consisted of reading and discussing rating manuals and journal articles on the assimilation model followed by practice in APES rating, after which discrepancies were discussed with an experienced judge. Training lasted until judges reached a satisfactory inter-rater reliability with the more experienced judge (ICC [2,1] ≥ .60; cf. Shrout & Fleiss, 1979). Training lasted for an average of 4 months.

2.2) Identification of problematic themes, selection of text, and characterization of dominant and non-dominant voices. First, the judges read all sessions, identified recurring issues, and independently, designated the problematic themes. At a subsequent meeting, they discussed these designations and arrived at a consensual judgment regarding the case's most clinically relevant and salient themes (high proportion of time spent in therapeutic sessions). Second, judges independently excerpted all text representing the consensually identified themes and also identified and described the non-dominant (problematic) and dominant voices represented in this text. Discrepancies in excepts and voice characterizations were resolved through consensual discussion (see Hill et al., 2005).

*2.3) Rating of excerpts according to the APES***.** At this stage, judges independently rated all of the excerpts according to the APES (Table 1), identifying passages and rating APES levels. Following Honos-Webb, Stiles, and Greenberg (2003), an APES passage was defined as a segment of text in which a topic is

introduced/elaborated and specific assimilation markers appear (allowing judges to assign an APES level; see Honos-Webb, Lani & Stiles, 1999; Honos-Webb et al., 2003). Disagreements were resolved through consensual discussion (Hill et al., 2005).

2.4) Reliability assessment. Interrater reliability, calculated before consensus discussions, was high (mean ICC [2,1] = .93 for the sample of cases studied by Basto, Salgado et al., 2016, and mean ICC [2,1] = .97 for the two cases focused on here).

Phase 3: TCCS Coding. TCCS coding was applied to the entirety of the five sessions of each client. Sessions 1 and 4 were used to represent the initial phase of therapy, sessions 8 and 12 to represent the middle phase of therapy, and session 16 to represent the final phase of therapy. Sessions 1, 4, 8, 12 and 16 were chosen because they were the ones where a periodic assessment was conducted (using the BDI-II and OQ-45.2), following the protocol of the ISMAI trial. TCCS coding was applied following the procedural steps described by Ribeiro et al. (2013; 2014): 3.1) Training on TCCS; 3.2) Identification of the problematic narrative and innovation; 3.3) Coding of each therapist-client adjacency pair (therapist speaking turn followed by client turn) with the TCCS; 3.4) Reliability assessment.

3.1) Training on TCCS. Two trained judges, a male PhD student and a female masters-level clinical psychologist (this paper's fourth and fifth authors), used the TCCS to code the therapeutic collaboration in the selected sessions from each case. All judges were blind to the outcome status of the cases. Their training included applying the TCCS to sessions of several different therapy approaches, including EFT sessions. They were considered reliable in coding with the TCCS when they achieved agreement of Cohen's Kappa ≥ .75.

3.2) Identification of the problematic narrative and innovation. Judges began coding for this study by identifying and characterizing the problematic narrative and the

innovation in the two cases. Judges were involved in a meticulous reading of the first session and discussion to reach a consensual definition of the client's current experience/perspective. Judges listed the problems that characterized the client's problematic narrative and identified possible potential gains of the therapy process (such as the expression or integration of the problematic experience, for example – cf. Gonçalves, Matos & Santos, 2009).

The judges agreed that Julia's problematic narrative was characterized by feelings of rejection, insecurity and inadequacy (e.g. resentment toward childhood, avoidance and rationalization of her past experiences). For example, in session 1, Julia said: "(..) I don't like to talk about feelings (laughing) I admit. (…) I think… yes, here I go again to rationalize … I have never been educated to do that, to display emotions… you know, in our family (laughing) I have a certain aversion...". Julia's emergent innovation was characterized by expressions of her involvement in new activities, being able to speak about past and painful experiences, and accepting her own fragility. For example, innovation was coded when she expressed or elaborated on feelings of sadness or weakness.

Judges agreed that Afonso's problematic narrative was characterized by expressions of tension, feelings of being suffocated or stuck, responsible and pressed in relation to family issues; difficulties in expressing and feeling emotions along with difficulties in accepting his parent's relationship and conflicts. For example in session 1, as an expression of being blocked, Afonso said: "(…) yes, … other relationships…, exactly, ah… and I did that block and then… you know…I will hardly cry." Afonso's main innovation was coded when he expressed or elaborated on his feelings, did not adhere to the role of conciliator in the family, and became more sociable. For example, the innovation was coded when he accepted crying or expressed his feelings and

concerns.

This step of identification of the problematic narrative and innovation is necessary to allow coding of therapeutic interventions and client's responses (which allow to categorize types of therapeutic exchanges according to the TCCS, on the step below).

3.*3) Coding of each therapist-client adjacency pair with the TCCS*. Taking into account these characterizations of the clients' experiences (i.e. problematic narrative and innovation for Julia and Afonso), the judges coded each therapist-client adjacency pair for therapist's interventions and client's responses. The intersection of the therapist's interventions and client's responses generates the 18 types of therapist-clients exchanges, presented in Table 2.

3.4) Reliability assessment. In the coding of these cases, the two judges exhibited an average kappa of .88 for the therapist interventions (based on N= 678) and .76 for the client responses (based on N= 678 adjacency pairs), which indicates acceptable agreement (Hill & Lambert, 2004). Disagreements on coding were consensually resolved by the judges in subsequent discussions. A third trained TCCS judge participated in these discussions and audited their work. This audited, consensual version of the TCCS codes was used for our analysis.

Phase 4: Data analysis. Following the coding and reliability assessment described in phases 2 and 3, we performed descriptive statistical analysis of each case to address the research questions. To address the second question, we specifically looked at the TCCS codes that preceded APES advances (i.e. movement from a lower to a higher level) and setbacks (i.e. movement from a higher to a lower level), as illustrated in Figure 1.

Results

Assimilation and Therapeutic collaboration across therapy phases in the two cases

Julia's APES levels tended to advance across treatment (see Figure 2 and Table 3). Afonso's APES levels began lower (APES 0) and remained more stable across treatment than Julia's; though they increased somewhat, he had no ratings higher than 3 (see Figure 2). In contrast, Julia's APES levels began higher (APES 1) and reached higher levels (APES 6). In both cases setbacks appeared at all APES levels; most were decreases of just one APES level (see Figure 2).

Table 4 shows the distribution of therapeutic exchanges in each of the three therapy phases for the two cases. We classified the therapeutic exchanges based on the intersection of specific therapist interventions with the client's responses (as shown in Table 2). A relatively small number of types of therapeutic exchanges accounted for most of the coded exchanges in both cases: in the case of Julia, only five categories (out of 18) accounted for more than 5% of the exchanges (supporting problematic narrative–safety, supporting innovation–safety, challenging–safety, challenging–tolerable risk, and challenging–intolerable risk). In the case of Afonso, only four categories accounted for more than 5% of the exchanges (supporting problematic narrative–safety, supporting innovation–safety, challenging–safety, and challenging–intolerable risk).

Notice that in Julia's case there was a balance of supporting problematic narrative–safety and challenging-safety exchanges, whereas in Afonso's case supporting problematic narrative-safety was substantially higher than challenging-safety (Table 4). Indeed, in the case of Afonso, supporting problematic narrative–safety was the most prevalent therapeutic exchange in all three phases. By contrast, challenging–safety was the most prevalent therapeutic exchange in the middle and final phases of Julia's therapy (Table 4).

Therapeutic exchanges preceding APES advances and setbacks

Interestingly, within each of the cases, the distributions of therapeutic exchanges preceding APES advances and setbacks were similar, although there was a sharp difference between cases. Table 5 shows the therapeutic exchanges that preceded 10% or more of these transitions. As the table shows, supporting problematic narrative–safety and challenging–safety preceded a majority of APES advances and APES setbacks in both cases. In Julia's case, the proportions of these exchanges were similar to each other both for advances (27.0% to 22.2%, respectively) and setbacks (33.3% to 26.7%, respectively). In Afonso's case, however, supporting problematic narrative–safety was substantially more common preceding both advances (43.7% to 23.4%, respectively) and setbacks (43.5% to 17.7%, respectively). Indeed, all of the therapeutic exchanges involving therapist challenging preceded APES transitions less frequently in Afonso's case than in Julia's (Table 5).

Discussion

Julia made excellent APES progress on her main problem (feeling rejected, insecure and inadequate); she advanced from APES 1 and 2 during the initial phase (avoiding thinking and feeling about difficult experiences) to APES 5 and 6 in the final phase (becoming able to accept and cope with these feelings). In contrast, Afonso made much slower progress; he began the therapy mainly showing an avoidance of symptoms (APES 0 and 1) and managed only to articulate his problem (APES 3) by the final phase (see Figure 2). Setbacks were common in both cases and did not seem an obstacle to progress in the assimilation of problematic experiences, which is consistent with previous case studies (cf. Caro-Gabalda & Stiles, 2013).

The correspondence of APES progress with degree of improvement on standard measures (e.g. BDI-II, OQ-45) in the cases of Julia and Afonso is also consistent with results of previous assimilation studies (e.g., Mendes et al., 2015; see Stiles, 2002). Like other unimproved cases, reported in the assimilation literature, (e.g. George, a poor-outcome case studied by Honos-Webb et al., 1998), Afonso showed modest improvement on the APES (see Figure 2) but minimal change on standard outcome measures. An important point here is that self-report inventories like the BDI-II and OQ-45 assess distress, but the assimilation model suggests that distress is not a monotonic function of assimilation. Theoretically, across the range of APES 0 to APES 2, distress may increase (Stiles et al., 2004), while the sharpest rate of decrease occurs at a substantially higher level, across the range of APES 3 to APES 5. That is, it may be that Afonso's progress (advancing his problem from suppressed to clearly stated) was not well represented by these standard outcome measures.

Basto, Pinheiro et al. (2016) examined how symptom intensity, assimilation and emotional valence evolved across cognitive-behavioral therapy for depression in a good-outcome case and likewise found results consistent with the theoretical expectations. The contrast between Julia and Afonso is also consistent with the observation that conventionally-assessed recovered cases tend to reach APES 4 and above, whereas conventionally-assessed unrecovered cases do not (Basto, Salgado, et al., 2016; Detert et al., 2006).

Both of these therapists seemed to have worked mainly within their client's TZPD. Most of Julia's and Afonso’s responses in all phases indicated validation of their therapists' interventions, signalling feelings of safety more than tolerable risk (see Table 4). Safety responses occurred mainly following the supporting interventions, which suggests that the therapists usually intervened closer to their clients’ actual

developmental level than to their potential level. This is appropriate for EFT (cf. Greenberg, 2006; Greenberg, Rice, & Elliott, 1993) and has been found in previous TCCS studies on humanistic/experiential therapies (E. Ribeiro et al, 2014). In humanistic approaches, clients are presumed to be motivated to actualize (change for the better) on their own, and therapists may be less likely to push limits than in more directive therapies.

Although supporting the problematic narrative-safety was the most frequent type of therapeutic exchanges in both cases (Table 4), there were indications in the differential frequencies of exchanges that the therapists were being appropriately responsive to the clients' different emergent needs and capacities (Stiles, Honos-Webb, & Surko, 1998). For example, challenging-safety exchanges were relatively frequent in Julia's case, suggesting that her therapist felt it was appropriate to engage relatively more in challenging, actively pushing her potential TZPD level, while she responded with openness. In contrast Afonso's stronger prevalence of supporting narrative problematic – safety suggests that his therapist tended to maintain the therapeutic conversation near his actual TZPD level.

In Julia's case, there was a balance between supporting and challenging interventions, with a progressive increase in interventions closer to the client's potential developmental level (challenging-tolerable risk). The therapist used challenging interventions to progressively engage with innovation (Table 4). Complementarily, Julia had a progressive decrease in intolerable risk responses and an increase in tolerable risk responses. This could indicate a growing tolerance for innovation as therapy progressed (middle to final phases). In contrast, the therapeutic exchanges in Afonso's case were more stable across phases of his treatment. Our findings thus underline the importance of appropriate therapist responsiveness (Stiles et al., 1998), creating a balance between

supporting and challenging interventions that respond to each individual client's emerging needs and capacities.

The intersections between therapeutic collaboration and APES transitions, shown in Table 5, suggest that therapeutic exchanges involving challenging interventions (challenging-intolerable risk, challenging-safety and challenging-tolerable risk) preceded most of the transitions in the APES (advances or setbacks) in the case of Julia, whereas in the case of Afonso, exchanges involving supporting interventions most frequently preceded the APES advances or setbacks.

Overall, the contrasts between Julia's and Afonso's cases suggest that progress in therapy is characterized by moving into areas of unfamiliarity and an increased exposure to risk. This process involves therapists paying attention to the client's reactions to challenges and hence depends on the client's readiness or propensity to change (Table 4). Theoretically, exposure to risk must be sensitively monitored within the therapeutic collaboration to remain within the TZPD. This appeared important in these cases of EFT, but it is presumably also important across other psychotherapy models. With this view and mindful of our observations in the case of Julia, we suggest that facilitating change in psychotherapy requires a balance between supporting the usual, familiar narrative and increasing innovation and risk at the right moment (namely through challenging interventions that increase experiential awareness in EFT; e.g. Cunha et al., 2012, and Pascual-Leone & Greenberg, 2007). Similarly, in the integrative model to facilitate corrective experiences proposed by Constantino, et al. (2012), therapeutic goals in the initial phase of the therapeutic relationship are guided by the need to develop security through confirming client expectations and stepping into the client's usual frame of reference (i.e. working low in the TZPD and facilitating client safety). However, in the working stage, therapists must focus on challenge and

disengagement from the initial expectations and on strategies to enlarge the boundaries of TZPD, facilitating clients' assimilation of problematic experiences and increasing their tolerance to risk). Our results seemed consistent with this theoretical pattern and with the previous findings of studies using the TCCS as well (e.g. A.P. Ribeiro et al, 2014; E. Ribeiro et al 2013; 2014).

Consistently with previous assimilation model studies of therapist interventions (Caro-Gabalda, et al., 2015; Meystre, et al., 2013; Meystre, et al., 2015), this study showed how the therapist interventions seemed to be responsive to these two client's emergent needs and capacities, facilitating the assimilation of their problematic experiences, by taking into account their current TZPD. The therapists' choices of whether to support or challenge seem to reflect each client's emergent needs. In the case of Julia, the therapist's challenging interventions progressively increased as she progressed through the APES sequence, pushing her potential TZPD in a way that was comfortable for her, as demonstrated by her safety and tolerable risk responses. In the case of Afonso, the therapist did less challenging, working closer to the client's actual developmental level, perhaps because his TZPD was relatively narrow (cf Zonzi et al. 2014). This choice was validated by the client's response of safety. This contrast between the cases suggests the possibility that a therapist's responsive attention to the current problem's TZPD could help yield the appropriate balance between supportive interventions focused on the usual, familiar narrative and challenging interventions, used at the proper moments to increase innovation and expand client developmental possibilities.

Limitations and future directions

The value of intensive case studies, such as the ones presented here, lies in the detail with which they can conform to and elaborate the theory in which they are based (Stiles, 2009, 2015). Our observations on these two cases of EFT cannot be generalized independently of assimilation and therapeutic collaboration theories. For example, the differences between Julia and Afonso's cases (e.g., the therapists' responsive differential use of challenging) were theoretically sensible and thus supportive, but, in isolation from the theory, these differences would not support generalization to other recovered and unrecovered clients. Just to start with, Julia and Afonso differed in many ways besides their BDI-II and OQ-45.2 scores; for example, one was male and the other female; one struggled with self-acceptance (Julia) and the other struggled to understand and express his own feelings (Afonso). Likewise, each case had a different therapist, and their stylistic differences may have had effects on the coded processes. Future research would benefit from investigating a greater variety of clients and therapists. Even though each therapy case is uniquely rich and unrepeatable, repeated demonstrations of change mechanisms would help to consolidate the theory of how psychotherapy works and strengthen confidence in the assimilation model and the collaboration model.

Other limitations included the analysis's restriction to only five sessions of each client, limiting our view of the contrast between treatment phases. Another is the TCCS's focus on adjacency pairs--speaking turns that are immediately adjacent. Studying longer sequences, though very difficult practically, would permit detection of more complex patterns, such as validation or invalidation occurring two or more speaking turns after an intervention. As always, longer sequences, more cases, and a wider sample of diagnoses and treatment approaches are to be encouraged (cf. Ferreira et al., 2015; Mendes et al., 2015; A. Ribeiro et al. 2015).

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Table 1. Assimilation of Problematic Experiences Scale

Level	Description
Level 0 - Suppression / dissociation	The client is not aware of the problem; the problematic "voice" is silent or dissociated. Affect may be minimal, reflecting an effective avoidance. Alternatively, the problem may appear as somatic symptoms, impulses or interrupting the experience.
Level 1 - Unwanted thoughts / avoidance	The client prefers not to think about the experience. The problematic "voices" emerge in response to interventions by the therapist or to external circumstances and are suppressed or avoided. Affect is negative and intense but episodic and diffuse; the connection to the content can be vague and undefined.
Level 2 - Vague Awareness	The client is aware of the problematic experience but cannot formulate the problem clearly. The problematic "voice" emerges consciously. Affect encompasses the acute psychological malaise or panic associated with the problematic material.
Level 3 - Formulation of the problem	The content includes a clear definition of a problem - something that can be worked. The opposite "voices" are differentiated and can speak about one another. Affect is negative but manageable, with no panic.
Level 4 – Insight	The problematic experience is formulated and understood in some way. The "voices" come to an understanding with each other (meaning bridge). Affect can be mixed, with some nice recognition but also some unpleasant surprises.
Level 5 - Application / working through	Understanding is used to work on a problem. The "voices" work together towards obstacles of daily life. The affective tone is positive, with satisfaction.
Level 6 – Problem Resolution	Past problematic experiences became a resource, used to solve problems. The "voices" can be used flexibly. Affect is positive, with satisfaction.
Level 7 – Mastery	Affect is positive or neutral (i.e. it is no longer something notable). The client automatically generates solutions; "voices" are fully integrated, serving as new situations resources.