

Gonçalves, M. M., Ribeiro, A. P., Rosa, C., Silva, J., Braga, C., Magalhães, C. & Oliveira, J. T. (Forthcoming, May 2018). Innovation and ambivalence: A narrative-dialogical perspective on therapeutic change. In A. Konopka, H. J. M. Hermans, & M. M. Gonçalves, (Eds.), *Handbook of dialogical self theory and psychotherapy: Bridging psychotherapeutic and cultural traditions*. Oxford: Routledge.

Innovation and ambivalence: A narrative-dialogical perspective on therapeutic change

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Abstract

Change is indisputably one of the main goals of psychotherapeutic work. From a dialogical perspective, psychotherapeutic change entails a transformation in the transactional and communicative relationships established in the client's "inner society of I-positions". In the present chapter, we summarize the main findings of our narrative-dialogical research program on the processes of change in psychotherapy, privileging three related processes: the emergence of innovation, the occurrence of ambivalence (i.e., rejection of innovation), and

ambivalence resolution (i.e., back to innovation again). The systematic empirical study of these processes has been made possible by their operationalization and subsequent development of three process-oriented coding systems, respectively: the Innovative Moments Coding System, the Ambivalence Coding System, and the Ambivalence Resolution Coding System. Additionally, the theoretical and clinical implications of this empirical line of research is discussed and illustrated.

Innovative moments and therapeutic change

Over a decade ago (Matos & Gonçalves, 2004), departing from the narrative therapy concept of *unique outcomes* (White & Epston, 1990), we operationalized the concept of Innovative Moments (IMs) as instants during the therapeutic conversation in which exceptions to the maladaptive framework of meaning emerge. The concept of the dialogical self as a “dynamic multiplicity of relatively autonomous I-positions” (Hermans, 2001, p.174) offered a privileged background for the initial innovative moments’ conceptualization and for the theoretical model of change that we have been developing from that moment on. The narrative and other communicative outputs (e.g., signs of tension in the session) observed in psychotherapeutic conversation are the result of different I-positions voicing their own perspectives (see also Stiles, 2002, 2011; Stiles et al., 1990 for a model with similar features). A client’s statement in therapy such as “I am not sure whether I will be able to do things differently” may be voicing an internal I-position (“I as an unable and incompetent person”), and external I-positions of others (e.g., “my mother always told me that I was worthless”). The interactions between these I-positions constitute the dialogical processes underpinning what

can be observed in psychotherapy (e.g., complete or incomplete narratives, brief emotional reactions). Moreover, the arrangement between specific internal and external I-positions provides the content and structure for the client's self-narrative or, as we have most recently designated it, the client's framework of meaning. Recapturing Wittgenstein's (1922) famous dictum, "The limits of my Language mean the limit of my world" (5.6), this framework of meaning establishes the limits of the client's world, i.e., what is possible, what is conceivable, what is plausible, how interpretations emerge, the favorite outcomes, etc. Thus, it is easily conceivable that whenever some I-positions are systematically silenced and overshadowed by the dominant ones, this framework may become too narrow or inflexible, leaning towards the monological pole of the continuum between dialogical and monological relationships (Gonçalves & Guilfoyle, 2006; Hermans & Hermans-Konopka, 2010). Thus, in the case of a monologized self-system, an innovative moment could be conceived as an expression of an alternative I-position that challenges the dominant and problematic framework of meaning, potentially expanding the limits of the client's inner world. These alternative I-positions may be previous silenced ones or new I-positions emerging from new experiences (see the concept of corrective experience in psychotherapy, Castonguay & Hill, 2012). For example, let us take the fictional example of John, a client whose maladaptive framework of meaning is centered on the need to be superior to others in order to avoid being in a fragile interpersonal position, and target of imagined humiliation. This position may become problematic as it leads John to constantly monitor his power relationship with others, searching for signs of anxiety and vulnerability in the self. This pattern is typical of clients suffering from social anxiety. An alternative experience would occur if John was able to express what he sees as a vulnerable self

(often highly exaggerating what this vulnerability is), without feeling attacked or humiliated by significant others. The consistent expression of alternative I-positions throughout treatment (e.g., “I as a person who accepts my flaws”, “my friends as trustworthy”) might create a new dialogical tension between I-positions, promoting a more democratic self, with an increased flexibility (see Hermans, Konopka, Oosterwegel, & Zomer, 2016 on the democratic organization of the self). Thus, as illustrated through John’s example, as innovative moments are expanded and elaborated, they stimulate I-positions’ centrifugal movement towards flexibility and change, setting the stage for the construction of a more adaptive framework of meaning and a more open, resourceful and flexible self.

Tracking the Narrative Innovation

The Innovative Moments Coding System (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) is a methodological tool that allows the identification of innovative moments in the clients’ discourse throughout psychotherapy. Although the development of this coding system was inspired on the narrative therapy tradition (White & Epston, 1990), its application has not been restricted to this therapeutic model. Besides Narrative Therapy (e.g., Gonçalves, Ribeiro, Silva, Mendes, & Sousa, 2016), this methodology has been reliably applied to Client-Centered Therapy (Gonçalves, et al., 2012), Emotion-Focused Therapy (Mendes et al., 2010), Constructivist Therapy (Alves, Fernández-Navarro, Batista, Ribeiro, Sousa, & Gonçalves, 2014), Cognitive Behavioral Therapy (Gonçalves, Silva et al., 2016), and more recently to Psychodynamic Brief Therapy (Nasim et al., 2017). Beyond psychotherapy, this method has been applied to the study of spontaneous change in daily life (Meira, Salgado, Sousa, Ribeiro & Gonçalves, in press), vocational counseling (Cardoso, Gonçalves, Duarte, Silva, & Alves, 2016),

group counseling of underachieving university students (Esposito, 2016), and more recently to the deradicalization process in terrorism (da Silva, Silva, Fernández-Navarro, Rosa, & Gonçalves, 2017).

Through the empirical studies on psychotherapy, conducted mainly with depression samples, but also complicated grief or victims of intimate violence samples, the coding system has been reformulated and updated to encompass the idiographic nature of psychotherapeutic processes. We categorized seven different types of innovative moments (e.g., actions, cognitive products; for a further description of the coding system's specificities of please see Gonçalves, Ribeiro, Mendes, et al., 2017) but recently, and more relevant to this chapter, we have proposed a categorization of these diversity of types into three groups, according to their main developmental function towards change: Level 1 innovative moments, in which exceptions are characterized by the creation of distance from the maladaptive framework of meaning; Level 2 innovative moments centered on the elaboration and expansion of the change process, and; Level 3 corresponding to meta-positions. While Level 1 innovative moments involve actions, cognitive or emotional occurrences in which the maladaptive framework is challenged, Level 2 innovative moments involve behavioral, cognitive or emotional changes, in which change is elaborated and expanded, most of the times assuming two main forms: description of a contrast between a previous problematic position and a more adjusted one, termed contrasting self (CS) (e.g., before I did X, now I do Z); and/or the description, from an agentic position, of the process that allowed this change to unfold, which we termed transformation process (TP) (e.g., I'm more clear about my needs and this allows me to do X), (Fernández-Navarro, Ribeiro, & Gonçalves, 2016). Level 3 innovative moments correspond to meta-positions in which the

two components described above (contrast and transformation process) emerge in articulation. This articulation usually takes the following form: “before I felt/saw/behaved (or some other form) X, now I feel/see/behave (or some other form) Y, and this was possible because I start realizing/doing/thinking (or some other form) Z”. Where X was the problematic I-position, Y is the newer adaptive I-position (i.e., contrast), and Z is the proactive process that allowed the contrast to occur (i.e., transformation process) (see also Gonçalves & Ribeiro, 2012, in which level 3 innovative moments were termed reconceptualization).

Dialogically, Level 1 innovative moments could be perceived as a centrifugal movement towards flexibility and change, while Level 2 and 3 innovative moments could represent a centripetal movement of change construction (see Hermans & Hermans-Konopka, 2010 on centripetal and centrifugal movements, or centering and decentering).

As we have stated, this three-level categorization was constructed from a bottom-up approach, grounded on the empirical data collected over more than one decade of innovative moments research. Interestingly, though, the developmental function towards change implied by each level is in close consonance with the theoretical conceptualization of adult development proposed almost thirty years ago by Freeman and Robinson (1990). These authors assumed that development in adults takes place not by a pre-fixation of ends (as it occurs in traditional developmental theories), but through the revision and construction of new ends. From a dialogical perspective, this means a disruption in the previous equilibrium of I-positions (the previous end), and the emergence of a new temporary equilibrium (the new end). Moreover, Freeman and Robinson, proposed that this creation of a new end occurs along

four stages of change (described next) that are strikingly congruent with what we have found at an empirical level.

(1) Recognition, that is, “some semblance of a disjunction or contradiction between what exists and what is posited as representing a more ideal state” (p. 64). This is a necessary condition for development, and also for psychotherapeutic change. When the client is aware of the need to change, this notion is present from the onset of therapy. In fact, in the absence of this recognition, it is very difficult to actively involve the client, a condition that overlaps with what Prochaska and DiClemente (1982) have termed pre-contemplation stage, that is, a stage in which the client does not even consider the possibility of change.

(2) Distanciation, that is, “some ‘removal’ from one’s current existential situation” (p. 64-65). In our model, this is akin to Level 1 innovative moments, that is, events in which new understandings of the problem emerge, prompting the client to express new feelings and intentions, or to develop new actions. A tension is created here between a former problematic arrangement of I-positions, and an alternative and more adaptive one. But this tension has no form yet, and an alternative framework of meaning is still far from having a distinct structure.

(3) Articulation is “a movement wherein the aforementioned tension [present in the former stage] is given some measure of form ... one comes to identify the difference between the new and the old. One’s narrative and, by extension, one’s self is being reconstructed here” (p. 65). At this stage, which is clearly related to Level 2 innovative moments, the dialogical relationships are being reappraised, and new or formerly silent I-

positions now have more power, creating the possibility of a new framework of meaning to emerge.

(4) Appropriation is “the process of ‘taking in’ newly constructed ends by incorporating them into the fabric of subjectivity” (p. 66). This is an extension of the previous stage, in which the unfamiliar becomes integrated and in a sense, automatic. While Articulation may be prompted by the emergence of Level 3 innovative moments, for Appropriation to take place, it will probably be necessary for Level 2 innovative moments to keep repeating themselves along therapy, facilitating the transformation of the unfamiliar into the familiar until this centripetal movement culminates into a new and consolidated version of the self-system. In order to consolidate this appropriation, meta-positions are needed, connecting what has changed (contrast) with how this change has been developing (transformation process) (see Gonçalves & Ribeiro, 2012 on the functions of meta-positions and reconceptualization, or level 3 innovative moments).

From a dialectical perspective, if the maladaptive framework of meaning is A, Level 1 innovative moments are *non-A* (the step that allows access to the vast field of possibilities beyond A), Level 2 and 3 innovative moments are B (the definition of a new framework of meaning). If we retrieve the example of John, an example of a Level 1 innovative moment could be his expression throughout therapy of something like: “Yesterday I finally got the courage to tell my sister what I thought”. This specific action shows a behavioral movement towards change. John could also state that “Now I realize that I observe myself all the time, and that I avoid to express myself freely. I’m getting tired of that”. This also would be a Level 1 innovative moment (in the form of a cognitive product) and clearly expresses what we termed a protest

against the problematic framework of meaning. Level 2 would represent expanding the centrifugal movement of Level 1 and the setting in motion of a new centripetal movement. Level 2 innovative moments could emerge as a contrast or as transformation process. For instance, John could state “Lately I’ve been feeling different, not so worried about what others think of me”. As clients perform and author their change process, they will be able to reestablish both the sense of coherence (centripetal movement) and the self system’s permeability to innovation (centrifugal movement), two crucial building blocks of a new and more resourceful framework of meaning, which leads to level 3 innovative moments. An example of this in John’s case could be the following example: “Now I feel capable of fighting my own battles and stand up for what I believe, nota mere reflection of what I fantasized others thought of me anymore” (in which we have both components, contrast and process). This is a representation of the already ongoing flow of change, but it is not a mere byproduct of that; it is also a performance of change, *giving shape to a new end*, to use Freeman and Robinson’s (1990) term referred above. Despite this differentiation, it should be underlined that the three levels represent a clear disruption regarding the maladaptive framework of meaning that brought the client to therapy, becoming opportunities for new (or previously silenced) I-positions to emerge.

The body of empirical data gathered so far allowed us to reach two main conclusions concerning innovative moments and therapeutic change. The first one derives from correlational studies (e.g., Gonçalves et al., 2012; Matos et al., 2009; Mendes et al., 2010) and refers to the assumption that clinical recovery is associated with a higher presence of innovative moments, namely Levels 2 and 3. The second one results from longitudinal studies

(e.g., Gonçalves, Ribeiro, Silva et al., 2016; Gonçalves, Silva, et al., 2016) pointing to the hypothesis that innovative moments precede change in symptoms. In these studies, Level 2 and 3 (and not Level 1) emerged as predictors of symptomatic improvement, thus reinforcing the crucial importance of this type of innovation in the process of change.

Nevertheless, the process of change is hardly a smooth one. Innovations imply a kind of “peek experience” which represents a challenge to the usual (even if problematic) framework of meaning. Next we will address a possible and rather typical counter reaction to the challenge imposed by innovative moments, the process of ambivalence.

Ambivalence and therapeutic stability

As suggested in the previous section, the clinical relevance of innovative moments resides in their potential to lead off a process of increased innovation in the self, reaching a point in which an alternative framework of meaning is constructed (Level 2) and consolidated (Level 3). However, change is a challenging process and clients often get trapped in a loop between striving for innovation and dialogue within the self-system and pulling back towards monologue and conservatism (Hermans, 2003). We termed these instances as ambivalence markers and empirically operationalized them as moments in which clients elaborate an innovative moment (e.g., I was finally able to do X) and, immediately after it, they attenuate, devalue or refuse its meaning (e.g., but it probably will not make any difference) (Gonçalves, Ribeiro, Stiles et al., 2011). An example of an ambivalence marker in John’s case would be: “Yesterday I finally got the courage to tell my sister what I thought (Level 1 innovative moment). However, I have not been able to do that with anyone else, I guess I am still the good old passive person that I have always been (ambivalence marker)”.

Dialogically, this process is characterized by a cyclical movement between two opposing I-positions: one representing a centrifugal movement, led by a non-dominant and innovative I-position, and another one representing a centripetal movement, led by a dominant I-position that organizes the client's problematic framework of meaning. This process reflects the client's need for change, his or her ability to create distance from the maladaptive framework of meaning (centrifugal movement), but also his or her urge to maintain self coherence that was, until that point, organized around the maladaptive but familiar framework of meaning (centripetal movement), thus preventing him/her to expand this distance by giving shape to a new framework of meaning. In Freeman and Robinson (1990) terms, Distanciation is occurring, but Articulation is paralyzed. Consistently, according to Hermans and Hermans-Konopka (2010) the overshadowing prevalence of one of these movements puts the client at risk of rigidity and stagnation. Thus, the significant presence of ambivalence markers is a clear indicator of clients' current difficulty to promote change; and their persistent emergence throughout the therapeutic process might be perceived as a red-flag regarding the course of therapy, potentially compromising the therapeutic outcome if left unattended and unresolved (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2014).

Ambivalence can be the result of a diversity of processes. Three common possibilities will be suggested here, but it is essential for the therapist to make sense of ambivalence in each specific case to effectively deal with it (see Miller & Rollnick, 2002). The first possibility refers to the presence of a dilemma in which we have I-positions claiming that the maladaptive pattern is negative, but also I-positions seeing this pattern as an advantage. Several therapists have addressed this phenomenon of a dilemmatic internal organization (Ecker & Huley, 1996; Feixas

& Montesano, 2014). For instance, a person who is in a grieving process can face the “It’s not ok to be ok” dilemma. One I-position holds that the person should be able to be well again, to enjoy life, even in the absence of the lost person; while another I-position affirms that it would be preferable to suffer and stay connected with a lost loved one through the suffering (Alves et al., 2016; Neimeyer, 2006).

The second possible scenario involves the cluster of problematic I-positions being so fused with the client’s identity that he or she may feel that it is better to stay the same, keeping his or her sense of stability, than promoting a change that is perceived as potentially chaotic and unpredictable. This is probably the case when problematic I-positions have been dominant for a long period and have emerged as a response to very disruptive environments (e.g., personality disorders and chronic depression, see Dimaggio, 2006; Dimaggio, this book).

Finally, the problematic internal I-positions could be highly valued by some relevant external I-positions (my wife, my mother), making it difficult for the client to find social validation (Frank & Frank, 1991) in the change process. The dilemma here is not entirely internal since change could be perceived as a betrayal of significant others. Early parental abuse could be a good example. The person, as an adult, may wish to be assertive toward an abusive parent (that does not recognize or even trivializes the past abuse) but simultaneously be afraid of further damaging the fragile ties that sustain this relationship. Here we have a triad of positions that keep the system in a problematic stability: two internal (one favoring change, another favoring stability), and a very powerful external position supporting stability (in this case the abusive parent).

Ambivalence markers have been tracked in several clinical samples with the Ambivalence Coding System (Gonçalves, Ribeiro, Stiles, et al., 2011). The body of empirical data resulting from the application of this coding system (Gonçalves, Ribeiro, Stiles, et al., 2011) led us to two main conclusions: (1) the presence of ambivalence markers is lower in successful psychotherapy, suggesting that these clients' motivation to change is high; or (2) presents a consistent decreasing tendency, suggesting that the ambivalence was high at the onset but resolved along treatment (Alves et al., 2016; Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro, Gonçalves, Silva, Brás, & Sousa, 2015; Ribeiro et al., 2014).

One final remark on the possible meaning of absence of ambivalence at the onset of therapy. We speculate that ambivalence may be low as the dialogical self-system is already flexible enough for the client to mostly consider the advantages of change (the first stage proposed by Robinson & Freeman, 1990, previously described); but low levels of ambivalence may also mean that the system is so rigid that the client is not even able to consider change and all centrifugal movements are boycotted. In this last case, ambivalence is absent because there is not enough tension between opposed I-positions, and the system is leaning towards the monological end. How ambivalence can come to be resolved in psychotherapy is the topic of the next section.

Innovative moments as opportunities for ambivalence resolution

The study of the processes of ambivalence resolution assumes theoretical and clinical importance as ambivalence constitutes a frequent process in psychotherapy, and one that must be addressed and resolved for sustained change to take place (Miller & Rollnick, 2002). The Ambivalence Resolution Coding System (Braga, Oliveira, Ribeiro, & Gonçalves, 2016) was

developed in order to allow the empirical exploration of the dialogical processes involved in ambivalence resolution. Studies with this coding system (Braga et al., 2016; Braga et al., 2018) have proposed that ambivalence can be overcome through, at least, two distinct processes: (1) the dominance of the innovative I-position and consequent inhibition of the problematic I-position, and (2) the negotiation and engagement in joint action between both I-positions (for a similar distinction see Nir, 2012), resulting in a new position (see Hermans & Konopka, 2010, Konopka & Hermans, this book on the concept on third position).

In the dominance process, the innovative I-position struggles to control the problematic I-position by mimicking the strategy of its rival, that is, by affirming the innovative position's power in an authoritarian way. Coming back to John's case, a dominance type of ambivalence resolution could be: *I do not care what people think about me anymore, what I do with my life is totally up to me!* In an effort to overcome the problematic I-position's power, the innovative I-position severely imposes its control, upholding its authority.

In the negotiation process, the conflicting I-positions seem to be respectfully communicating with one another, promoting a dynamic flow between opposites, rather than the dominance of one of them (Braga et al., 2016). An example of the negotiation process in John's case could be: *Of course, what other people think of me is important, mainly the people that have a significant role in my life; but I don't need to be approved by every person in the world.* The negotiation process implies that both I-positions contribute to the meaning making process, establishing a dialogical relationship that is substantially different from the previous confrontational one; they now seem to be collaborating to resolve the conflict (e.g., *What they think is important to me, but that does not mean I must live by what they say.*).

The assimilation model (Stiles et al., 1990; Stiles, 2002) suggests that in successful psychotherapy the non-congruent position is progressively integrated in the community of voices through the eight levels of the Assimilation of Problematic Experiences Scale (APES). Successful cases often reach a level in which a *meaning bridge* emerges (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006), that is, a common language between the problematic I-positions and the innovative I-positions, allowing the negotiation processes to take place. Congruently with the assimilation model, in the innovative moments' model, level 3 innovative moments have been more closely associated with successful cases. Thus, Level 3 innovative moments are a form of insight in which a meaning bridge is established between the problematic I-position and the innovative I-position.

We assume that ambivalence is resolved through the cumulative process of repetitive *momentary resolutions*, that is, moments when there is an agentic and determined resolution of ambivalence, even if it is a momentary one (Braga et al., 2016). Empirical studies (Braga et al., 2016; Braga et al., 2018) revealed that both dominance and negotiation processes of ambivalence resolution can be found in different psychotherapeutic approaches and no significant differences have been found between the different models in terms of these processes' evolution (Braga et al., 2018). However, distinct paths have been observed for successful and unsuccessful psychotherapy cases. In recovered cases the dominance process tends to be less frequent and negotiation gradually increases as treatment evolves. In unsuccessful psychotherapy, this apparent gradual shift between dominance and negotiation does not seem to happen; dominance is frequently used from the beginning to the end of treatment, and negotiation is scarce at any stage of therapy. These results are theoretically

coherent with theories that have been proposing an increasing integration of opposing elements of the self along the therapeutic process (e.g., the assimilation model, Emotion-focused therapy).

Practical Implications: How can IMs inform clinical practice?

The several studies described above have demonstrated important differences between recovered and unsuccessful cases in terms of the production of narrative innovation, levels of ambivalence experienced by clients throughout treatment, as well as the strategies used by these clients to resolve ambivalence. The main question that emerges at this moment is: in what way can this knowledge serve to inform therapists in their clinical practice?

We believe that the line of empirical research we have been developing allowed for some important insights into the dialogical-narrative processes involved in psychotherapeutic change, regardless of the therapeutic modality. In order to clarify the possible contribution that this line of research can offer, we use the example of Mary (a pseudonymous), a young 32-year-old married woman who comes to therapy referring herself as “dumber than all other people” and “cognitively limited”. Her maladaptive framework of meaning was informed mostly by these dominant I-positions which led Mary to avoid several tasks in her work, avoid asking for help, and constantly agreeing with others’ opinion. Also, she frequently compared her performance with others’ performance, criticizing herself for being slower and for making many mistakes.

Throughout therapy, she presented some centrifugal movements towards flexibility, as other suppressed I-positions emerged. Two examples of this movement were the following:

“Yesterday I called a colleague for help with the computer programme and he had the same

doubt” or “This week I was able to feel differently when I had to present my work, I felt some competency” (two Level 1 innovative moments). However, these movements were constantly inhibited by the dominant I-position, consolidating further the problematic framework of meaning: “He didn’t know how to solve the problem because his work functions are different from mine. He is not supposed to know that but I am, I should have known”; “although everyone can have some doubts, these doubts aren’t even similar to the ones I have, so ridiculous and so frequent!”. The previous examples are instances of ambivalence markers, neutralizing previous IMs. The inner tension between these forces was very clear when the client was talking about her final project for her Master’s degree: “I was able to present my project in the meeting but no one made questions. It was easy. However, if they had asked any questions I think I would not have been able to answer, I would have blocked. I am not so clever as they think.”

Mary’s case represents a typical example of an unsuccessful case, where Level 1 innovative moments dominate as the only form of innovation, being frequently aborted by ambivalence markers, while Level 2 and 3 are almost absent. In this kind of psychotherapeutic processes if therapists are able to be attentive and acknowledge these processes they may attune themselves to the client needs, which in this case implies the promotion of Level 2 innovative moments. Of course, deciding when a therapist may try to promote Level 2 innovative moments is a matter of timing. The therapist may think that elaborating and understanding further the maladaptive framework of meaning is necessary before prompting more and more complex innovation. Promoting Level 2 innovative moments, is possible if the therapist tries to elicit contrasts and transformation processes components. Contrasts may be elicited around the theme “what is better/different than before?” or “what were the main

changes in therapy?"; while transformation processes are related to the question(s) of "how did you achieve those changes?" or "what helped you getting to where you are now?". So, returning to the case of Mary, her therapist's first effort could be centered on promoting these components. For instance, when the client said: *"I was able to present my project in the meeting but no one made questions. It was easy. However, if they had asked any questions I think I would not have been able to answer, I would have blocked. I am not so clever as they think."*; the therapist could have asked Mary to recall the episode in detail, in order to avoid generalized memories that would disrupt the recalling (see the role of generalized autobiographic memories in depression, Boritz, Angus, Monete, & Hollis-Walker, 2008). During the recalling, the therapist could be attentive to any difference in her feelings, actions or thoughts compared to other times, searching for the possibility of prompting innovative moments. Another possibility would be to elicit connections between the way she felt in this situation with other Level 1 innovative moments described before: *"Remember when you felt competent presenting your work last week? Was there any similarity between the two episodes?* If similarities emerged the therapist may further ask *"How do you think you managed to do this?"*, trying to elicit the process component, thus prompting a Level 2 innovative moment.

After the emergence of level 2 innovative moments, therapists may try to connect contrasts with transformation processes, promoting level 3 innovative moments. Along these lines, therapists might be more effective if they asked questions that invite the client to relate a particular contrast ("now I feel that I can do X") with a specific transformation process ("I was able to do X, because now I Y").

The second point to keep in mind is the promotion of ambivalence resolution. The process mostly used by Mary to resolve her inner tension was dominance: *“From now on I’m going to stop worrying about others’ opinions about my work”*. As referred previously, in order to resolve ambivalence, I-positions need to communicate with one another promoting the integration of the non-congruent position. This integration is akin to what Hermans and Konopka (2010) described as a promoter position. Considering this knowledge, the therapist should be able to early identify the presence of ambivalence, promoting the understanding of each one of the I-positions that are in conflict and constantly validate both of them in order to clarify their existence to the client and decrease the emergence of resistance to change (Oliveira, Gonçalves, Braga, & Ribeiro, 2016). Integrating elements from different approaches to ambivalence resolution (e.g., Engle & Arkowitz, 2006; Lewis & Osborn, 2004; Sato, Hidaka, & Fukuda, 2009), including well-established techniques such as Two-Chair Work (Greenberg, Rice, & Elliott, 1993; Perls, Hefferline, & Goodman, 1951), Oliveira and colleagues (2016) have suggested ten steps (see table 1) that may guide therapists in conceptualizing their clients’ ambivalence.

Until the present time, our research program has allowed the clarification of several processes associated with clinical change and stagnation throughout psychotherapy. Currently, we recognize it is crucial to deal with the challenge of transposing this empirical data to the daily clinical practice. Lambert (2001) has argued that pre-post evaluations of therapy are a kind of post-mortem evaluation, as they are not useful for the current client. Although our research is not about outcomes but about psychotherapy processes, we still need to avoid only offering “post-mortem” explanations for what is going on in therapy. Thus, we expect that the

previous lines of application could soon inform the therapeutic practice, feeding back to new research, and so forth.

The therapeutic process can be seen as an opportunity to reconstruct a dialogical space that allows all relevant I-positions to be audible, to reestablish a productive communication between them and to reorganize their dynamics in an adaptive way. The dialogical interaction between the I-positions is the best way to protect the multiplicity of meanings and to allow the person to remain the co-author of their own process of change. However, innovative methods and therapeutic strategies are needed to access, understand and change the complex processual dynamics that occur in the self-system. In this sense, we have suggested some therapeutic guidelines resulting from our current effort of transposing our research program empirical data to clinical practice. Although the effectiveness of these intervention guidelines is still to be tested, we assume that task as an important and prioritized line of future research.

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Table 1

Guidelines to conceptualize client's ambivalence in psychotherapy

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1. Define and gather information about the client's problematic self-narrative;
 2. Define an alternative, more adaptive, self-narrative;
 3. Identify movements towards change;
 4. Identify movements away from change;
 5. Conceptualize these oscillatory movements as a dialogue between voices;
 6. Present both identified voices to the client (towards and away from change);
 7. Isolate each voice and explore them separately;
 8. Express validation regarding each voice;
 9. When present, identify the processes used by the client to overcome ambivalence;
 10. Promote the dialogue between the identified voices.
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Note. Adapted from "How to deal with Ambivalence in Psychotherapy: A Conceptual Model for Case Formulation" by J. T. Oliveira, M. M. Gonçalves, C. Braga, & A. P. Ribeiro, 2016, *Revista de Psicoterapia*, 27(104), p. 134.