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Ambivalence in grief therapy: The interplay between change and self-stability

Daniela Alves[a], Pablo Fernández-Navarro[a], António P. Ribeiro[a], Eugénia Ribeiro[a], Inês Sousa[b] and Miguel M. Gonçalves[a]

[a]School of Psychology, University of Minho, Braga, Portugal; [b]Department of Mathematics, University of Minho, Braga, Portugal

ABSTRACT

This article explores the role of ambivalence in grief therapy within a narrative framework. From this perspective, change starts with the occurrence of innovative moments, which can be nullified by reaffirmation of the problematic self-narrative as a sign of ambivalence. This study analyzed ambivalence in six complicated grief cases using the "Return to the Problem Coding System." Markers of ambivalence emerged in all cases, with a decreasing profile in cases with greater symptomatic improvement, suggesting an association between clinical change and ambivalence evolution in therapy. Addressing ambivalence may bring to light important aspects of client's self-reconstruction after a major loss.

In this study we analyzed how ambivalence progressed throughout grief therapy among six cases with different clinical outcomes. The framework of analysis was established according to the innovative moments (IMs) model of change (Gonçalves, Matos, & Santos, 2009), which is based on the narrative perspective (Sarbin, 1986) that highlights humans' capacity to organize the diversity of life experiences into coherent self-narratives (Angus & McLeod, 2004; Bruner, 1990; Polkinghorne, 1988; White & Epston, 1990). Some experiences, however, may disrupt this sense of coherence and self-stability. As Neimeyer, Prigerson, and Davies (2002) pointed out, "The loss of an intimate attachment relationship through death poses profound challenges to our adaptation as living beings" (p. 238). Although the majority of individuals are able to adaptively integrate the experience of loss (Bonanno, 2004), 10% to 15% evidence a response of complicated grief characterized by prolonged grieving, chronic, and persistent separation distress, trouble accepting the reality of the loss, and difficulty in reorganizing life without the deceased (Prigerson & Jacobs, 2001; Prigerson et al., 1995; Shear, Simon, et al., 2011).

But how do clients progress from the maintenance of a problematic story of loss toward a new and more flexible one? Gonçalves and colleagues (Gonçalves, Matos, et al., 2009; Gonçalves et al., 2010) proposed that narrative transformation in psychotherapy occurs through the emergence and expansion of *IMs*, which are moments in the therapeutic conversation in which the client invests in a different way of thinking, feeling and behaving. As they pointed out, "as change starts to develop, IMs necessarily occur, as new voices come to the foreground and the formerly dominant ones are pushed to the background" (Gonçalves & Ribeiro, 2012, p. 83). From this perspective, problematic self-narratives are implicit rules that organize the self and constrain the person's experience, which fail to acknowledge important parts of the person's life (Dimaggio, 2006) and bias clients toward negative episodes (Gonçalves & Machado, 1999). IMs are the exceptions to these rules.

To study the emergence of IMs, Gonçalves and collaborators (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) constructed the innovative moments coding system (IMCS), which defines five types of IMs: action, reflection, protest, reconceptualization, and performing change (see Table 1). Two studies using the IMCS in constructivist grief therapy supported the feasibility and reliability of the IMCS in studying psychotherapeutic change in bereavement (Alves, Fernández-Navarro, Baptista, et al., 2014; Alves, Mendes, Gonçalves, & Neimeyer, 2012). Such findings are especially congruent with a meaning reconstruction perspective on grief therapy, highlighting the major role of meaning oriented forms of innovation (reflection and reconceptualization IMs) in the change process (Neimeyer, 2006a; Neimeyer & Sands, 2011).

IMs: Change and ambivalence

Along with their change potential, IMs may also instigate tension followed by a movement of self-protection

CONTACT Miguel M. Gonçalves mgoncalves@psi.uminho.pt School of Psychology, University of Minho, Campus de Gualtar, 4710-057 Braga, Portugal.

Table 1. Innovative moments with examples (problematic self-narrative: complicated grief).

	Contents	Examples
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control; • Searching for information about the problem(s).	C: Yesterday I woke up feeling very sad about her loss, but instead of staying in my bed crying all day, I took a ride to the city, visited the church to ask God to help me organize my life.
Reflection	Subtype I. Creating distance from the problem(s) • Comprehension: Reconsidering causes of problem(s) and/or awareness of its/their effects; • Formulation of new problem(s); • Adaptive self-instructions and thoughts; • Intention to fight demands of problems, references of self-worth and/or feelings of well-being.	C: I want to live my life in a different way, trying to remember the things my daughter taught me. I'm sure she would say to me "keep going mom, you're on the right track".
	Subtype II. Centered on the change • Therapeutic process: Reflecting about the therapeutic process; • Change process: Considering the process and strategies; implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions: References to new/emergent identity versions in face of the problem(s).	C: Our sessions are helping me to accept this situation (the daughter's loss) in a more peaceful way because now I know that I have the strength to do this.
Protest	Subtype I. Criticizing the problem(s) • Repositioning oneself towards the problem(s). Subtype II. Emergence of new positions • Positions of assertiveness and empowerment;	C I'm tired of not having the right to cry and talk about my feelings and my sadness in front of others! It has to change!! C: I will not wear black clothes everyday just to show others that's I'm grieving! Not anymore! Now I don't care, I wear what I want and no one has to do with it!
Reconceptualization	Reconceptualization always involves two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	C: Let's think, for example, about the Mayan pyramids I climbed a few years ago. At the beginning I was stuck at the middle of the pyramid … However, then I realized that I couldn't be on that position forever, so I found a more stable spot … and started to get down slowly. Here (in therapy) it was the same, I didn't know how to address her loss and I learned gradually how to accept and (…) how to "go down" slowly into the ground (…) For example I started to give much more value to spiritual rather than physical things, and even if I lost a really beautiful daughter (physically), her actions and the way she helped persons were even much more beautiful (…) She's present in a different way.
Performing Chang	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource in new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	C: Now I can feel her presence in my life in a different way, not in her house, in her clothes, or even at the cemetery. Now I feel her presence in my thoughts, in my new life, and I know that she is protecting me, and all my decisions to organize my life count with her strength. In the last week I started to plant new flowers on my backyard. I'm investing in "life" again, seeing these flowers growing everyday because of me. She (the daughter) would be very proud of me!

used by clients to manage the anxiety brought by the emergence of new, although uncertain and unfamiliar meanings in their lives (Engle & Arkowitz, 2008; Engle & Holiman, 2002; Ribeiro & Gonçalves, 2010). Thus, recent research within the IMs model has shown that in both poor-outcome cases (Santos, Gonçalves, & Matos, 2010) and the initial and middle phases of good-outcome cases (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro & Gonçalves, 2011), clients often devalue the potential for change present in IMs by re-emphasizing the problematic self-narrative's dominance through the elaboration of return to the problem markers (RPMs). This return to the problem after the elaboration of an IM is a clear sign of ambivalence toward change Gonçalves, Ribeiro, Stiles, et al. (2011). To track signs of ambivalence in psychotherapy, Gonçalves, Ribeiro, Santos, Gonçalves, and Conde (2009) developed the Return to the Problem Coding System (RPCS). In the RPCS, every IM is coded regarding the presence or absence of a subsequent return to the problem marker (RPM).

In a recent study (Alves, Fernández-Navarro, Ribeiro, Ribeiro, & Gonçalves, 2014) findings suggested that the emergence of ambivalence in grief therapy could be linked with clients' perception of improvement as a betrayal of their commitment to the deceased, thus producing RPMs as a movement of self-protection away from the anxiety or guilt generated by that interpretation. To illustrate this movement, let's consider an example of an IM followed by a RPM in a complicated grief case[1] of a mother who was reflecting on the way she felt on the first anniversary of the death of her son (which she predicted to be a very painful day): "Unexpectedly, I felt so good during my anniversary [IM] that I even felt angry with myself (RPM)." In this example, the client started to elaborate a more positive and less painful experience but immediately attenuated the potential for change involved in that experience by reinforcing the problematic self-narrative. When the meaning of this anger was explored, the client and the therapist ended up reflecting on the cultural and social expectations of grieving, and the client shared another experience that sustained the way she felt: "One doctor, in the hospital, said to me, 'Aren't you ashamed of disrespecting your son's memory like this, just 1 year after his death?' just by seeing me wearing colorful clothes instead of the 'expected' full-black." It may be particularly difficult, for some grievers, to safely invest in a less painful grieving experience in a culture where pain and sorrow are expected (Hagman, 2001). Thus, they may feel obliged to explicitly manifest their sadness and sorrow to others and to themselves as a way to comply with the expected grieving performance (Alves, 2013). Likewise, other theorists have noted and illustrated the occurrence of reassertion of the problematic or symptomatic narrative in grief therapy as a means of preserving coherence with core meanings that militate against change (Ecker, 2012; Neimeyer, Burke, Mackay, & Stringer, 2010).

[1]This clinical vignette was gathered from a complicated grief case that was collected during the therapist's training process, previous to the sample collection.

The present study

This study explores the emergence and evolution of ambivalence during treatment, by tracking RPMs in a sample of six complicated grief clients—previously analyzed with the IMCS (Alves, Fernández-Navarro, Baptista, et al., 2014). Clients' symptomatic change was assessed with the Inventory of Complicated Grief (Prigerson et al., 1995) and the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The clinical intervention was organized according to the constructivist meaning reconstruction approach (Neimeyer, 2001, 2006a) and was performed by a psychotherapist trained in this therapeutic modality.

The main research questions were:

1. Are RPMs (ambivalence) a common phenomenon in this sample?
2. Is the proportion of RPM (ambivalence) associated with the degree of symptomatic improvement?

In general, we anticipate that all cases will present RPMs, associated with a response of self-protection (Engle & Holiman, 2002) after the elaboration of IMs. We also anticipate that the probability of IMs containing RPMs will decrease more in cases with greater symptomatic improvement than in cases with lower symptomatic improvement.

Method

The data used in this study were drawn from the study of IMs in constructivist grief therapy conducted by Alves, Fernández-Navarro, Baptista, et al. (2014). A total of 83 sessions (all sessions of the six cases) were examined using the RPCS for the present study. From these six cases, a sample of 3,293 IMs (corresponding to 22.9% of the text from the transcripts of the entire sample) was analyzed for the presence of RPMs. The methodology and procedures are described below.

Clients were recruited from a research program investigating narrative change in psychotherapy. Each client was followed weekly in individual constructivist grief therapy following the meaning reconstruction

approach proposed by Neimeyer (2001, 2006a, 2012a). The intervention protocol was shared with the client at the pretherapy assessment meeting and followed the guidelines of a clinical trial, which proposed 15 sessions of treatment (clients could be referred for further treatment after the 15 sessions, if necessary). All sessions were videorecorded and transcribed. All clients gave permission for their materials to be used for the study. The ethics committee of the local hospital (the institution referring clients for treatment) also approved this protocol. A total of six clients participated in the study, all of them suffering from complicated grief (Prigerson et al., 1995).

All clients were Caucasian women aged 20–62 years ($M = 42$ years, $SD = 18.63$) who completed an average of 13.83 sessions ($SD = 0.98$). At the pretherapy assessment meeting, clients presented with the following circumstances of loss: loss of a grandmother to stroke 3 years prior to therapy (Case 1); loss of a boyfriend to cancer 2 years prior to therapy (Case 2); loss of a husband to cancer 2 years prior to therapy (Case 3); loss of a daughter to cancer 2 years prior to therapy (Case 4); loss of a son to cancer 3 years prior to therapy, loss of a husband who was fatally injured by an automobile 6 months prior to therapy (Case 5); and loss of a mother to stroke 1 year prior to therapy (Case 6).

Therapist and therapy

The psychotherapist for all six cases (Daniela Alves) was a 28-year-old doctoral student with 4 years of prior clinical experience as a psychotherapist and 2 years of training in constructivist grief therapy. A skilled psychotherapist (Eugénia Ribeiro) with 18 years of experience in constructivist psychotherapy supervised the entire therapy (including the training process) to ensure adherence to the constructivist model, by reviewing and discussing, every 2 weeks, all sessions with the various clients.

The constructivist intervention was grounded in the meaning reconstruction approach proposed by Neimeyer (2001, 2006a, 2012a) and was initiated with the exploration of each client's story of loss, inviting her to share important memories, episodes, and details related to the deceased and to the grieving experience (Neimeyer, 2012a). The "Meaning Reconstruction Interview" (Neimeyer, 2006a, pp. 166–169) was one of the central techniques used in this initial phase. The intervention did not follow a manualized structure and was designed according to the meaning reconstruction approach that promotes client self-reconstruction through investment in alternative, more adaptive meanings of loss (Neimeyer, 2001, 2006a; Neimeyer, Burke, Mackay, & Stringer, 2010). Several narrative-constructivist techniques were used, such as "narrative retelling" (Neimeyer, Burke, Mackay, & Stringer, 2010, p.76; Neimeyer, 2012a), "imaginal conversations with the deceased" (Shear, Boelen, & Neimeyer, 2011, p.149), and "correspondence with the deceased" (Neimeyer, 2012b).

Researchers

Two independent judges, both doctoral students in clinical psychology with previous experience in IM and RPM coding, coded the RPMs in this sample. Judge 1 coded the RPMs of all 6 cases (corresponding to a total of 83 sessions) and Judge 2 coded the RPMs in three cases, for purposes of reliability.

Measures

Assessment measures

The Structured Clinical Interviews for DSM-IV-TR, Axis I (SCID-I; First, Spitzer, Gibbons, & Williams, 2002) and Axis II (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997) are based in *DSM-IV-TR* diagnostic criteria and allow for the assessment of clients' disorders on Axis I (mood, psychotic, and anxiety disorders) and Axis II (personality disorders), respectively. Interrater reliability ranged from .83 to .85 for the SCID-I (Del-Ben et al., 2001) and .63 for the SCID-II (Weertman, Arntz, Dreessen, van Velzen, & Vertommen, 2003).

Outcome measures

The Inventory of Complicated Grief (ICG; Prigerson et al., 1995) is a 19-item questionnaire that assesses the severity of grief symptoms. The items are rated on a 5-point Likert scale, with total scores ranging from 0 to 76. A score above 25, after at least 6 months after loss, suggests complicated grief (Prigerson et al., 1995). The instrument has good internal consistency (.94; Prigerson et al., 1995). We used the Portuguese adaptation by Frade, Rocha, Sousa, & Pacheco (2009), which also has good internal consistency (.91). The cut-off score for the Portuguese population was 30 (Sousa & Rocha, 2011). The internal consistency of the ICG in the present study was .84.

The BDI-II is a 21-item questionnaire that assesses the severity of depressive symptomatology. The items (e.g., self-dislike, pessimism) are rated on a 4-point Likert scale, with total scores ranging from 0 to 63. The instrument shows high internal consistency (.91; Steer, Brown, Beck, & Sanderson, 2001). We used the Portuguese adaptation by Coelho, Martins, & Barros

(2002), with a cutoff of 14.29 and a Reliable Change Index (RCI, Jacobson & Truax, 1991) of 8.46. as proposed by Seggar, Lambert, and Hansen (2002). The internal consistency of the BDI-II in the present study was .71. The BDI-II was used given the relationship between grief distress and depressive symptomatology (Bonanno & Mancini, 2006).

Process measures

The RPCS is a qualitative coding system that analyzes the re-emergence of the problematic self-narrative through elaboration of RPMs occurring immediately after the emergence of an IM. Previous studies using the RPCS (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro, Mendes, et al., 2014) have reported reliable agreement between judges on RPM coding, with Cohen's *k* ranging from .88 and .93.

Procedures

Assessment measures

To assess co-morbidity with other diagnoses that could be as relevant as complicated grief, all clients were evaluated with the SCID-I (First et al., 2002) and SCID-II (First et al., 1997) in the pretherapy assessment meeting. Three psychologists who worked at the university clinic conducted the SCID-I and II assessment: two performed, individually, the SCID-I and SCID-II interviews with two different cases and the third psychologist—the one who conducted the intervention with all clients—performed the SCID-I and II with the other four cases. This distribution was associated with the availability of trained psychologists to collaborate with the project in different periods. There were no clients excluded from the clinical protocol after this initial assessment.

Outcome measures

Both the ICG and the BDI-II were then administered every fourth session as well as in the final session and at the 6-month follow-up meeting. The analysis of pre- to postsymptomatic change was based on the ICG (Prigerson et al., 1995; Portuguese version by Frade, Rocha, Sousa, & Pacheco, 2009) and the BDI-II (Beck et al., 1996; Portuguese version by Coelho, Martins, & Barros, 2002).

Process measures

In this study a total number of 3,293 IMs were analyzed using the RPCS. As previously stated, two judges were involved in the coding process. Judge 1 analyzed all sessions of this sample to code the emergence of RPMs after each IM. The coding of 3 cases by Judges 1 and 2 involved two successive steps: (a) independent coding and (b) resolution of disagreements by consensus. Reliability between Judges 1 and 2, as assessed by Cohen's *k*, was .80. Both judges were unaware of the clinical outcome of the cases.

Results

Besides experiencing complicated grief, five clients also experienced comorbid major depression as defined by the *DSM-IV* (American Psychological Association, 1994). Clients' pre, post, and follow-up ICG and BDI-II scores are presented in Table 2.

Considering the established cut-off score of 30 for the ICG (Sousa & Rocha, 2011), four cases (Cases 1, 2, 3, and 4) decreased their complicated grief symptoms from pre- to postphase of the treatment, moving from nonnormative to the normative population: their final ICG scores were lower than 30 at the end of the treatment and continued to decrease from termination to follow-up. In contrast, two cases (Cases 5 and 6) maintained scores higher than 30 in the ICG by the end of treatment, remaining in the nonnormative population through the 6 month follow-up period (see Table 2). Considering the BDI-II cutoff score of 14.29 (Coelho et al., 2002) and the Reliable Change Index (Jacobson & Truax, 1991) of 8.46, Cases 1, 4, and 6 were considered "recovered" at the end of the treatment as well as in the follow-up phase and Cases 3 and 5 were considered "improved but not recovered" at the end of treatment (although Case 3 was considered recovered

Table 2. Cases' Inventory of Complicated Grief (ICG) and Beck Depression Inventory II (BDI-II) pre–post and follow-up (FU) scores and total percentages of return to the problem markers (RPMs).

Case	Pre ICG	Post ICG	FU ICG	Improvement pre-post-ICG cut-off score 30	Pre BDI-II	Post BDI-II	FU BDI-II	Improvement pre-post BDI-II cut-off score 14.29	Total % of RPMs
1	42	11	4	31 nonnormative to normative	26	8	8	18 recovered	19.2%
2	39	25	9	14 nonnormative to normative	14	13	2	1 -	18.9%
3	61	28	19	33 nonnormative to normative to normative	24	18	12	6 improved but not recovered	7.1%
4	58	21	20	37 nonnormative to normative	23	12	10	11 recovered	12.2%
5	55	42	41	13 nonnormative to nonnormative	35	15	15	20 improved but not recovered	30.4%
6	51	36	32	15 nonnormative to nonnormative	33	13	14	20 recovered	12.2%

at follow-up). Case 2, in contrast, only changed 1 point from pre- to posttreatment phase in the BDI-II (14 to 13). Thus, all cases had reliably improved their depressive symptoms, except Case 2, who remained in the normative range (see Table 2).

All analyses of RPM emergence presented below considered the percentage of IMs with RPMs (frequency of IMs with RPMs/total frequency of IMs × 100).

1. Are RPMs (ambivalence) a common phenomenon in this sample?
   A total of 718 RPMs were found for the entire sample, meaning that 21.8% of the 3,293 IMs were nullified. Previous studies in other samples have reported overall percentages of RPMs between 20 and 40% (e.g., Ribeiro, Mendes, et al., 2014).
   As we anticipated, every case presented IMs with RPMs. The case with the highest percentage of RPMs was case 5 (30.4%) and the case with lowest percentage of RPMs was case 3 (7.1%).
2. Is the proportion of RPM (ambivalence) associated with the degree of symptomatic improvement?

The data of this study were modeled using a Generalized Linear Model (GLM; McCullagh & Nelder, 1989) to explore the probabilities of RPMs occurring among cases with differing symptomatic improvement throughout the sessions. Using the GLM, a regression model of the probabilities was described as a linear function of the explanatory variables; outcomes varied between 0 and 1 (McCullagh & Nelder, 1989). Significance levels were established at $\alpha = .05$. This method of analysis allowed all sessions to be included in the model, which is an advantage over more traditional regression analyses. The proportion of RPMs was considered the response variable. The variables time (number of sessions, one to 14), improvement in grief symptomatology (ICG pretherapy–ICG posttherapy), improvement in depressive symptomatology (BDI-II pretherapy–BDI-II posttherapy), and interaction between time and symptomatic improvement (in both ICG and BDI-II) were considered as explanatory variables.

The results for RPM probabilities in overall IMs, considering clinical change in complicated grief (ICG), are illustrated in Figure 1.

The GLM analysis for RPM probabilities in the overall IMs showed that the variable "symptomatic improvement" in ICG had no significant effect on RPM production ($p = .807$). In contrast, the variables time ($p = .012$) and interaction between time and symptomatic improvement in ICG ($p < .0001$) both had significant effects in the overall probability of RPM occurrence. That is, at baseline, cases with different clinical outcomes in ICG did not differ significantly in terms of the production of RPMs. However, as therapy progressed, cases with differing

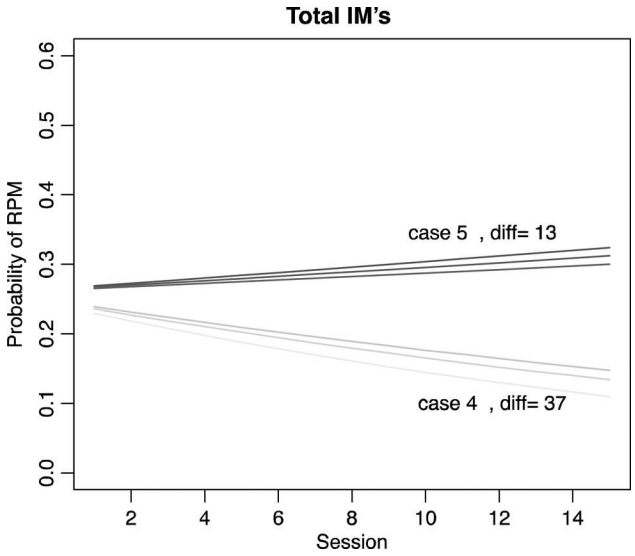

Figure 1. Probabilities of return to the problem markers (RPMs) in overall innovative moments (IMs). The Y-axis depicts the probability of an RPM occurrence, and the X-axis depicts the evolution of therapy (session number) over time. Only the cases with extreme pre–post differences in the Inventory of Complicated Grief (Cases 4 and 5) are labeled in the figure. The grey color gradient represents the degree of differences, with the lighter grey being the greater pre- to postdifference in the ICG (37 points) and the darker grey being the lower difference (13 points). The other grey lines appearing between these extremes represent the four remaining cases.

symptomatic improvements became significantly different in terms of RPM production. More specifically, as presented in Figure 1, cases with greater change (illustrated by the lighter grey lines) experienced larger reductions in RPM production throughout the sessions (progressing from approximately 24% to approximately 11%, considering the first and last sessions of Case 4, the case with the highest improvement in grief symptomatology). Cases with lower symptomatic change (illustrated by darker lines in Figure 1) experienced increased RPM production from the beginning to the end of therapy (progressing from 27% to 32% if we consider the first and last sessions of Case 5, the case with the lowest symptomatic improvement in grief). An effect size of $R^2 = .50$ was found for this model.

The inclusion of the symptomatic improvement in depression as an explanatory variable in the GLM model showed similar results to those found with the ICG. More specifically, a significant impact of the variables time ($p = .001$) and interaction between time and symptomatic improvement ($p = .032$) occurred. That is, cases with greater symptomatic change in the BDI-II also experienced significantly larger reductions in RPMs across the sessions than did cases with lower symptomatic change.

Discussion

In line with previous research using the RPCS (Gonçalves, Ribeiro, et al., 2009; Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro, Mendes, et al., 2014; Ribeiro, Sousa, Brás, & Gonçalves, in press), this study allowed us to analyze how RPMs may be associated with change in psychotherapy. In general, the results of this study show that RPMs can be reliably identified in grief therapy using the RPCS. The analysis of 83 sessions using this coding system revealed that all cases presented RPMs. This result appears to be consistent with the assumptions of several authors who suggest that ambivalence may be a normal aspect of the change process (Mahoney, 2003; Messer, 2002; Neimeyer, 1995), which is probably associated with clients' self-protection regarding the anxiety of changing familiar ways of experiencing the world to new, unfamiliar ways (Engle & Holiman, 2002). In grief therapy this transformation process may be especially challenging as it involves the construction of a new "space" for the deceased as the person allows him/herself to say goodbye and to reconstruct a new life without the physical presence of that person.

As presented in Table 2, the percentages of RPMs in this sample range from 7.1 (Case 3) to 30.4% (Case 5). We speculate that low ambivalence may occur both in cases that are highly prepared to change, as well as cases that may not be considering change at all. Pervasive high ambivalence, in turn, may be associated with low readiness for change (Prochaska & DiClemente, 1982), bringing our attention to client's timing of loss integration. For example, the case with highest ambivalence (Case 5) was facing a double loss (loss of son and husband) and was also the case with lowest clinical improvement in ICG. This suggests that this client is in a different timing of her grief recovery when compared to other cases, as in Case 3, the one with the least ambivalence, who is facing the loss of a husband that occurred 2 years ago. This hypothesis is congruent with the results of Field and Friedrichs (2004), who found that widows who were grieving for longer than 2 years reported greater comfort in the postmortem relationship with the deceased when compared to widows whose husbands died more recently.

Thus, the timing of change may be important to understand the progression of ambivalence in grief therapy. Its emergence may reflect clients' ongoing negotiation between the former and the emergent story of loss, by balancing the desire to change and the necessity to revisit the former grieving reaction as a way to validate their commitment to their lost loved ones. By being aware of these processes and the ways clients negotiate them in therapy, the therapist may be better prepared to propose different interventions that do not disregard client priorities and expectations (Alves, Fernández-Navarro, Ribeiro et al., 2014; Rando, 2012).

This study also showed that cases with different symptomatic improvement (both in the ICG and BDI-II) showed different trajectories of RPM occurrence throughout the sessions, which is consistent with recent research using the RPCS (Ribeiro, Mendes, et al., 2014; Ribeiro et al., in press). Cases with lower symptomatic change (both in the ICG as well as in the BDI-II) also increased the elaboration of RPMs throughout treatment, whereas cases with higher symptomatic change showed the opposite trajectory: In these cases RPM probabilities decreased as therapy progressed. Probably, these results highlight, once again, the differences between cases regarding their "timing" to reintegrate problems into a new self-narrative. As suggested above, it is possible that cases with lower symptom improvement may need more time to give meaning to the uncertainty of change and to reintegrate unfamiliar experiences into a new self-narrative with lower levels of anxiety. Until this occurs, these clients may continue to elaborate RPMs to protect themselves from the challenges of self-transformation.

We consider that therapist performance may also influence the way clients negotiate ambivalence in therapy. According to Ribeiro, Ribeiro, et al. (2014), RPMs are more prone to emerge among less supportive and excessively challenging interventions that exceed the client's *Therapeutic Zone of Proximal Development*. As a consequence, clients tend to dismiss the therapeutic intervention and move toward a response of self-protection. Or as pointed out by Neimeyer (2012c), "pursuing something too soon, before the client's growing edge is receptive to it, will produce resistance at worst or intellectual or behavioral compliance at best, and pursuing it too late will halt the client's forward momentum and redundantly reaffirm what is already clearly enough grasped or accomplished" (p. 7).

Limitations and future research

The small sample size and the fact that all clients were Caucasian women, assessed only with two self-reported measures, are central limitations of this study. Further research using a larger sample of complicated grief cases is needed. Future studies should also include different therapists in order to control the effects of this specific therapist. Also, the fact that the therapist was the lead researcher of this study (as it was part of her PhD project) is another methodological limitation that may have

had impact in the way the results were discussed and interpreted.

Further information about this type of ambivalence in grief therapy could be gathered from the exploration of cultural and social expectations about the grieving response. As pointed out by Neimeyer, "grief is as much a social as individual process, and more attention is needed into how social groups can support or impede the adaptation of their members" (2006b, p. 184). For instance, it may be difficult to live a less painful experience of grief in a cultural context that is still modulated by traditional views of grief entailing pain and sorrow as the "expected" reactions while emotions such as pleasure or happiness may be seen as abnormal or unexpected (Hagman, 2001), somehow perceived as a "lack of commitment" to the experience of grief itself (Alves, 2013).

Future research with the RPCS should also address the therapist's involvement in the emergence of RPM's, considering different clinical samples and therapeutic modalities. It could also include the analysis of the length RPMs (and not just their frequency), as a way of searching for the differential impact of RPMs in the progression of change.

Even in light of these limitations, however, we hope that the present study suggests the feasibility of reliably and empirically identifying the occurrence of episodes of ambivalence in grief therapy, as well as their relation to outcome assessed in symptomatic terms. Further research on such process-outcome links could refine the practice of bereavement interventions for those clients who suffer a prolonged struggle to adapt to a life story disrupted by profound loss.

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