Universidade do Minho
Escola de Psicologia

Raquel Carvalho de Queiroz Ryttinger

Contribuição da colaboração terapêutica para a mudança ao longo da terapia em diferentes diagnósticos e abordagens psicoterapêuticas

outubro de 2022

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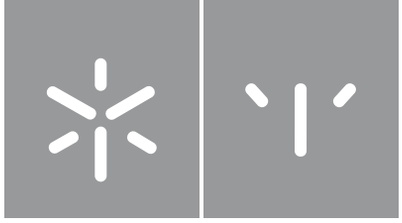

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Tese de Doutoramento
Doutoramento em Psicologia Aplicada
Psicoterapia e Psicopatologia

Trabalho efetuado sob a orientação das
Professoras Doutoras Eugénia Ribeiro e Fernanda Serralta

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DIREITOS DE AUTOR E CONDIÇÕES DE UTILIZAÇÃO DO TRABALHO POR TERCEIROS

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DECLARAÇÃO DE INTEGRIDADE

Declaro ter atuado com integridade na elaboração do presente trabalho académico e confirmo que não recorri à prática de plágio nem a qualquer forma de utilização indevida ou falsificação de informações ou resultados em nenhuma das etapas conducente à sua elaboração.

Mais declaro que conheço e que respeitei o Código de Conduta Ética da Universidade do Minho.

Universidade do Minho, 19 de outubro de 2022

Raquel Carvalho de Queiroz Ryttinger

CONTRIBUIÇÃO DA COLABORAÇÃO TERAPÊUTICA PARA A MUDANÇA AO LONGO DA TERAPIA EM DIFERENTES DIAGNÓSTICOS E ABORDAGENS PSICOTERAPÊUTICAS

Resumo

Os estudos da presente tese foram fundamentados no pressuposto de que a qualidade da colaboração terapêutica é de suma importância para a construção de um relacionamento interpessoal significativo e para a mudança do cliente. Nesse contexto e norteados pelo modelo de assimilação de Stiles et al. (1990) e pelo modelo de colaboração terapêutica de Ribeiro et al. (2013), analisámos todo o processo terapêutico de casos com diferentes resultados, seguidos em Terapia Cognitivo Comportamental (TCC) e Psicodinâmica por recurso metodológico a Escala de Assimilação de Experiências Problemáticas (EAEP) e ao Sistema de Codificação da Colaboração Terapêutica (SCCT).

No primeiro estudo comparativo, analisámos como as interações terapêuticas estavam associadas à mudança das clientes, com diagnóstico de depressão e tratadas a partir da Terapia Cognitivo Comportamental. O caso de sucesso alcançou níveis de mudanças mais altos. O aumento das interações terapêuticas com respostas de ambivalência no caso de insucesso é um resultado inovador, sugerindo uma dificuldade da cliente em manter os ganhos terapêuticos das primeiras sessões e uma resistência à mudança.

No segundo estudo, caracterizamos o padrão da colaboração terapêutica e a mudança, em um caso de desistência da Terapia Psicodinâmica para perturbação de personalidade borderline. O cliente não apresentou mudança e a díade trabalhou dentro da zona de conforto do cliente. Isto sugere que permanecer mais de 80% das interações numa zona focada no problema parece não favorecer o avanço para a mudança.

No terceiro estudo identificamos as interações terapêuticas que caracterizaram os avanços e os retrocessos tanto no processo de mudança quanto, especificamente, em momentos de *insights* em um caso de sucesso, com diagnóstico de depressão e seguido em Terapia Psicodinâmica. Verificámos um irregular progresso na assimilação de experiências problemáticas, um trabalho colaborativo e intervenções da terapeuta sintonizadas com as necessidades e capacidades da cliente. Os resultados encontrados são consistentes com os modelos norteadores do estudo e sugerem que o desenvolvimento de uma colaboração terapêutica suficientemente boa parece ter suportado a mudança da cliente.

Palavras-chave: assimilação de experiências problemáticas, colaboração terapêutica, depressão, estudo de caso, perturbação de personalidade borderline

CONTRIBUTION OF THERAPEUTIC COLLABORATION TO CHANGE THROUGH THERAPY IN DIFFERENT DIAGNOSES AND THERAPEUTIC APPROACHES

Abstract

The studies of this thesis assumed that the quality of therapeutic collaboration has major importance for the construction of a meaningful interpersonal relationship and the client's change. In this context and guided by the assimilation model of Stiles et al. (1990) and the therapeutic collaboration model by Ribeiro et al. (2013), we analyzed the entire therapeutic process of cases with different results, followed by Cognitive Behavioral Therapy (CBT) and Psychodynamic Therapy, and using the Assimilation of Problematic Experiences Scale (APES) and the Therapeutic Collaboration Coding System (TCCS).

In the first comparative study, we analyzed how therapeutic interactions were associated with clients' change, diagnosed with depression, and treated by Cognitive Behavioral Therapy. The successful case reached higher levels of change. The increase in therapeutic interactions with ambivalence responses in the case of poor outcome case is new, suggesting a client's difficulty in maintaining the therapeutic gains of the first sessions and resistance to change.

In the second study, we characterized the pattern of therapeutic collaboration and the change in a case of dropout for borderline personality disorder by Psychodynamic Therapy. The client did not show change and the dyad worked within the client's comfort zone. This suggests that focusing more than 80% of interactions in a zone focused on the problem does not seem to foment progress toward change.

In the third study, we identified the therapeutic interactions that characterized the advances and setbacks both in the process of change, and specifically, in moments of insight in a good outcome case, with a diagnosis of depression and followed by Psychodynamic Therapy. We observed irregular progress in the assimilation of problematic experiences, collaborative work, and therapist's interventions attuned to the client's needs and abilities. The results found are consistent with the study's guiding models and suggest that the development of a good enough therapeutic collaboration seems to have supported the client's change.

Keywords: assimilation of problematic experiences, borderline personality disorder, case study, depression, therapeutic collaboration

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INTRODUÇÃO

Introdução

A presente tese, composta por três estudos, foi realizada sob a orientação científica das Professoras Doutoras Eugénia Ribeiro e Fernanda Serralta, entre Fevereiro de 2018 e Setembro de 2022 no âmbito do Grupo de Investigação em Relação Terapêutica (GIRT) da Universidade do Minho, Portugal. Esta introdução visa disponibilizar um enquadramento geral dos referidos estudos, tanto do ponto de vista teórico quanto do ponto de vista metodológico.

A nível teórico será apresentada uma revisão da literatura focada no estado da arte acerca da mudança do cliente e sua relação com a colaboração terapêutica. A Escala de Assimilação de Experiências Problemáticas (EAEP; Stiles et al., 1990) e o Sistema de Codificação da Colaboração Terapêutica (SCCT; Ribeiro et al., 2013) serão posteriormente enquadrados metodologicamente. Por fim, serão apresentados os três estudos que compõem esta tese, a fim de identificar as questões de investigação que os nortearam, bem como clarificar a sua relevância face a estudos semelhantes.

Enquadramento teórico

A mudança em psicoterapia

A mudança do cliente em psicoterapia é o foco de todas as abordagens teóricas que orientam a prática da psicoterapia. Identificar os fatores que promovem a mudança tanto no contexto investigativo quanto na prática pode facilitar a escolha de estratégias terapêuticas (Kazdin, 2009). Para que esse objetivo seja alcançado e para uma maior compreensão acerca do processo de mudança terapêutica, faz-se necessária a articulação entre aspectos teóricos, práticos e metodológicos.

Nas últimas décadas, houve um grande progresso na investigação em psicoterapia focada na construção de teorias (i.e., *Theory Building*; Stiles, 2007) e de manuais terapêuticos que orientam a prática dos psicoterapeutas (Corrêa, 2016). No entanto, considerando a complexidade do processo terapêutico, observar e compreender a dinâmica da experiência singular do cliente, bem como o seu processo de mudança, constitui um desafio para a pesquisa em psicoterapia. Assim, é essencial mais investigações acerca dos fatores que promovem a mudança, bem como maior partilha dos resultados destas pesquisas com clínicos (Duarte et al., 2019).

O foco da investigação sobre o processo terapêutico consiste em compreender o que acontece na e ao longo das sessões (por parte do cliente, do terapeuta e da interação entre a díade) que facilita a

mudança (Hardy & Llewelyn, 2015). Carl Rogers (1957) foi o precursor das investigações acerca dos fatores que promovem o sucesso terapêutico. De acordo com esse teórico, empatia, congruência e positividade são aspectos importantes na relação terapêutica que possibilitam a mudança do cliente. Esses aspectos facilitadores têm sido associados a diferentes abordagens teóricas e diferentes diagnósticos, bem como têm sido o foco de diversas pesquisas (McAleavey & Castonguay, 2015).

No entanto, pouco se sabe acerca dos processos pelos quais ocorre a mudança em psicoterapia (Kazdin, 2009). A investigação focada no processo terapêutico (*process research*) e no processo de mudança terapêutica (*change process research*) tentam atenuar essa fragilidade, enquanto a investigação focada nos resultados terapêuticos (*outcome research*) busca responder a questão da eficácia em psicoterapia utilizando medidas de resultado. Além de basear-se numa perspetiva experimental, a investigação focada nos resultados (*outcome research*) estuda em que medida os clientes mudam ao longo da terapia (Elliott et al., 2001), ou seja, a influência da terapia no resultado clínico (Hardy & Llewelyn, 2015), bem como destaca a importância do uso de manuais e da técnica (Sousa, 2006).

A investigação acerca do processo terapêutico (*process research*) busca identificar os mecanismos que promovem a mudança, ou seja, o que (i.e., *what*) ocorre nas sessões (Elliott et al., 2001). Além de enfatizar a importância da relação entre o terapeuta e cliente ao longo da terapia (Sousa, 2006), este tipo de investigação visa compreender os padrões de relacionamento e as experiências significativas do cliente (Serralta et al., 2007).

A investigação acerca do processo de mudança terapêutica (*change process research*) vai além dos estudos focados nos resultados ou no processo terapêutico e analisa como (i.e., *how*) e porquê (i.e., *why*) ocorre a mudança . Ou seja, é o estudo acerca dos processos que geram mudança, incluindo o seu percurso temporal (Elliott et al., 2001). De acordo com Elliott (2010), há diversas estratégias para a investigação acerca do processo de mudança como, por exemplo, pedir ao cliente para descrever os aspectos úteis da terapia que ajudaram-o/a a mudar (i.e., *helpful factors design*) e analisar microanaliticamente a influência das intervenções do terapeuta e das respostas do cliente no seu processo de mudança (i.e., *the sequential process design*; Elliott, 2010).

Em concordância com Elliott et al. (2001) e Elliott (2010) sobre a investigação do processo de mudança terapêutica, os estudos desenvolvidos no contexto desta tese enquandram-se no modelo de assimilação (Stiles et al., 1990). Ao construir um entendimento acerca do desenvolvimento sequencial do processo de mudança e sobre como os clientes progridem ou não na terapia, pesquisadores podem fornecer ferramentas conceituais para os psicólogos monitorarem o progresso terapêutico nas sessões (Stiles, 2006).

A mudança em psicoterapia parece ser explicada por fatores comuns e específicos (McAleavey & Castonguay, 2014). Rosenzweig (1936), baseado nas suas observações de que todas as terapias apresentam resultados terapêuticos similares, introduziu a noção de que fatores comuns estão presentes em diferentes tipos de psicoterapia, ou seja, não estão restritos a uma abordagem terapêutica (e.g., aliança terapêutica; Cuijpers et al., 2019). O modelo dos fatores comuns mais conhecido foi desenvolvido por Jerome Frank (1961) no qual ele aponta, por exemplo, uma relação entre o terapeuta e o cliente que promova a confiança, procedimentos que fomentem a participação ativa da díade e que sejam estruturados na crença da eficácia do tratamento (e.g., estabelecer objetivos), um racional teórico que dê credibilidade ao processo terapêutico e um contexto de cura (Cuijpers et al., 2019). Nessa perspetiva, a colaboração terapêutica tem sido descrita como um processo terapêutico panteórico no qual terapeuta e cliente trabalham ativamente, de forma produtiva dentro de um relacionamento interpessoal significativo (e.g., Bordin, 1979; Hatcher, 1999; Kazantis & Kellis, 2012; Ribeiro et al., 2013; Tyron et al., 2019).

Já os fatores específicos fazem parte de um tipo de psicoterapia, mas são ausentes ou incomuns em outros (e.g., *insight*; McAleavey & Castonguay, 2014). Contudo, estudar fatores comuns e específicos isolados, apesar de legítimo, é arbitrário. Compreender como esses fatores interagem é fundamental para ampliar o nosso entendimento acerca da mudança em psicoterapia em diferentes abordagens e entre elas, bem como aperfeiçoar o modo como a psicoterapia é praticada (McAleavey & Castonguay, 2015).

A mudança segundo o Modelo de Assimilação

O modelo de assimilação (Stiles et al., 1990) é um dos modelos organizadores dos três estudos incluídos nesta tese. Este modelo propõe uma compreensão transteórica, transversal e integrativa das mudanças psicológicas ao longo do processo terapêutico. Ele visa compreender como ocorrem as mudanças sintomatológicas e psicológicas ao longo da psicoterapia, uma vez que este processo é composto por diversos estádios ou níveis (i.e., de 0 à 7) que, ao serem ultrapassados, levam o cliente a integrar as suas experiências problemáticas, também conhecidas como o motivo da procura por tratamento (Basto, 2018; Stiles, 2006). Definido como um modelo integrativo por estar fundamentado em diversas abordagens terapêuticas, como cognitivo comportamentais, psicodinâmicas e experienciais, assim como pela psicologia do desenvolvimento, o modelo de assimilação abrange, na sua

conceptualização sobre mudança, os processos emocionais, comportamentais e cognitivos do cliente (Stiles et al., 1990).

Para que mudanças (e.g., sintomática e narrativa) ocorram de forma significativa, é necessário que haja um processo de assimilação das experiências sentidas como problemáticas pelo cliente, de forma a serem integradas num esquema. O conceito de esquema é fundamental na primeira versão do modelo, tendo sido desenvolvido a partir da sua definição nas teorias cognitivas e nas teorias desenvolvimentais (Rumelhart & Norman, 1978). No contexto das teorias cognitivas, um esquema não diz respeito apenas a uma construção abstrata, mas a uma estrutura cognitiva na qual estão inseridas as experiências do indivíduo que, por consequência, influenciam a forma como ele percebe e atua no mundo. Quando essas experiências não se adequam ao esquema disponível, elas passam a gerar sofrimento e são consideradas como problemáticas. Ou seja, ao serem trazidas à consciência, elas são percebidas como sentimentos e memórias dolorosas, ameaçadoras e destrutivas (Stiles et al., 1990; Stiles, 2001). Diante do intenso sofrimento psíquico que pode ser gerado por esse processo, o indivíduo tende a evitar entrar em contato com essas experiências – o que pode acarretar o surgimento de diversas perturbações psicológicas (Stiles et al., 1990).

Baseado nos pressupostos da teoria do desenvolvimento cognitivo de Piaget (1970), o conceito de assimilação corresponde à consciencialização e integração de uma nova experiência no esquema. Assim, de acordo com os princípios desenvolvimentais do modelo de assimilação, essas experiências precisam ser trazidas à consciência, compreendidas e assimiladas para que o indivíduo possa restabelecer o seu sentido de coerência interna, bem como para que ele possa utilizá-las como recursos em futuras situações. Para que isso ocorra, esse esquema rígido pode ser modificado através da acomodação e da assimilação de experiências problemáticas que podem ocorrer ao longo do processo terapêutico, independentemente da abordagem terapêutica que o orienta (Honos-Webb & Stiles, 1998; Ribeiro et al., 2016; Stiles, 2002).

A fim de alcançar a assimilação de experiências problemáticas, a díade terapêutica necessita realizar um trabalho colaborativo para compreender os pensamentos, as emoções e comportamentos dissociativos do cliente de forma a torná-los coerentes com o seu esquema pré-existente. Simultaneamente, ocorre o processo de acomodação que diz respeito às modificações tanto na forma como o cliente percebe a sua experiência imediata, quanto no seu esquema previamente estruturado (Stiles et al., 1990). Nesse contexto colaborativo, a experiência problemática é compreendida e integrada, gerando uma diminuição no sofrimento psíquico e, como consequência, o retorno do cliente a um funcionamento adaptativo.

Na atual versão do modelo de assimilação, os seus autores incluíram o conceito de *self* que, metaforicamente, é definido como sendo constituído por uma comunidade de vozes. Desse modo, o *self* é composto por traços (i.e., vozes) de experiências prévias (Stiles, 2011). Quando temos uma nova experiência, essas vozes interagem entre si e podem surgir como recursos que facilitam a adaptação do sujeito a novos cenários (Honos-Webb & Stiles, 1998; Stiles, 2001, 2011; Stiles et al., 2004). De acordo com esta versão do modelo, as vozes podem ser dominantes e não dominantes ou problemáticas.

As vozes dominantes, também conhecidas como traços de experiências que o indivíduo teve ao longo do seu desenvolvimento, interagem entre si de forma a organizarem-se em uma estrutura denominada de comunidade de vozes (Caro Gabalda & Stiles, 2018; Honos-Webb et al., 1999; Stiles, 2001, 2011). Elas são os nossos habituais sentimentos, pensamentos e emoções e encontram-se intrinsicamente conectadas, de forma a tornarem-se um recurso que pode possibilitar que as futuras experiências sejam vivenciadas de forma mais saudável e adaptativa (Basto, 2018; Caro Gabalda & Stiles, 2018; Honos-Webb & Stiles, 1998; Stiles, 2001, 2002).

No entanto, esse processo de assimilação pode não ocorrer de forma linear quando surgem experiências consideradas problemáticas. Essas vozes problemáticas surgem em situações complexas e ameaçam a estabilidade da estrutura da comunidade de vozes por serem incompatíveis com as experiências previamente vividas (Honos-Webb & Stiles, 1998; Pérez-Ruiz & Caro Gabalda, 2016). Tal incongruência pode gerar um conflito quando, numa comunidade de vozes rígida, a voz problemática tenta sobressair e a comunidade de vozes dominantes, com o propósito de manter o equilíbrio, tenta ignorá-la ou suprimí-la (Caro Gabalda & Stiles, 2018; Stiles et al., 2004). Quando estes confrontos ocorrem de forma recorrente, eles desorganizam a coesão da comunidade de vozes e podem gerar alguma perturbação psicológica como, por exemplo, a depressão (Caro Gabalda & Stiles, 2016, 2020; Honos-Webb & Stiles, 1998; Stiles et al., 1990; Stiles, 2001, 2011; Stiles et al., 2004).

Como dito anteriormente, o sofrimento psicológico gerado pelo conflito da comunidade de vozes tentando evitar ou rejeitar as experiências problemáticas pode ser amenizado através do processo terapêutico (Honos-Webb & Stiles, 2002). Para fomentar a mudança, a psicoterapia deve promover a comunicação entre as vozes dominantes e problemáticas e, consequentemente, a criação de pontes de significado (Stiles, 2011). As pontes de significado são entendidas como imagens, palavras, signos, histórias que tenham um significado similar para ambas as vozes (Stiles, 2011). Essas pontes permitem a comunicação entre as vozes, a assimilação de experiências problemáticas na comunidade de vozes e é usada como recurso em situações semelhantes (Brinegar et al., 2006). Teoricamente, a construção de pontes de significado fundamenta a assimilação de experiências problemáticas e, consequentemente,

geram uma melhoria do cliente em psicoterapia (Stiles, 2011). Em outras palavras, o diálogo entre as vozes dominantes e problemáticas, a construção de pontes de significados e as mudanças geradas ocorrem ao longo do processo terapêutico (Caro Gabalda & Stiles, 2018).

Assim, quando há uma compreensão, assimilação e integração das experiências problemáticas no *self*, elas passam a ser utilizadas como recursos para futuras situações, logo entende-se que houve uma mudança clínica e que o processo terapêutico foi bem-sucedido (Stiles & Osatuke, 2000; Stiles et al., 2004; Stiles, 2011). Isso ocorre uma vez que, para este modelo, o objetivo do terapeuta é facilitar ao cliente o reconhecimento e a compreensão das suas vozes dominantes e problemáticas, de forma que ele possa explorá-las sob diferentes perspetivas (Caro Gabalda & Stiles, 2018).

A Aliança e a Colaboração Terapêutica

Dentre os aspectos fundamentais para promover a mudança terapêutica, Stiles et al. (1986) destacam a aliança terapêutica (AT) e o envolvimento mútuo da díade ao longo do processo terapêutico; as atitudes e habilidades do terapeuta, independente da abordagem teórica; e os fatores do cliente (e.g., expectativas, motivação e participação na exploração de seu sofrimento psíquico). A observação desses aspectos é fundamental para a compreensão da interação terapêutica e para identificação de padrões maladaptativos do cliente (e.g., comportamentos, crenças e sentimentos; Hardy & Llewelyn, 2015).

Bordin (1979) propôs uma definição de aliança terapêutica transteórica e fundamentada no envolvimento colaborativo entre a díade. Para o autor, a aliança é constituída por três componentes interdependentes: vínculo entre terapeuta e cliente, acordo em relação aos objetivos e acordo em relação as tarefas. Especificamente no desenvolvimento do vínculo há compreensão, respeito e confiança mútuos. No que concerne aos objetivos, há um acordo entre a díade acerca das metas de trabalho que o cliente deverá alcançar ao longo das sessões. Em relação as tarefas, há um acordo entre o terapeuta e o cliente sobre as atividades que serão realizadas e que permitam a concretização dos objetivos previamente acordados.

Com efeito, a aliança terapêutica tem sido considerada um preditor robusto, importante e consistente dos resultados terapêuticos, independentemente da abordagem terapêutica e do diagnóstico (Del Re et al., 2021; Flückiger et al., 2018). Além disso, dentre os aspectos mais investigados sobre os processos relacionais em psicoterapia, a aliança terapêutica é a que tem despertado maior interesse (Norcross, 2010). Assim, por ser um fenômeno intrínseco e transversal a todas as correntes teóricas, a

aliança representa a qualidade da colaboração e interação entre a díade (Bordin, 1979). Em outras palavras, ela é um esforço da díade que visa a mudança do cliente em psicoterapia.

Estudos apontam que a aliança terapêutica está associada a resultados terapêuticos positivos e a diminuição da desistência em terapia (Horvath et al., 2011; Spencer et al., 2019). Tais resultados suportam a importância da colaboração terapêutica, uma vez que dois dos três componentes da aliança enfatizam a habilidade do cliente e do terapeuta em trabalharem juntos (i.e., o acordo sobre os objetivos e sobre as tarefas; Bordin, 1979). Diante desse cenário, a habilidade do terapeuta em desenvolver uma boa aliança terapêutica pode ser treinada a fim de contribuir para um bom resultado terapêutico (Pieta & Gomes, 2017). Se o terapeuta e o cliente concordam com os objetivos da terapia e contribuem mutuamente para alcançá-los, eles trabalham de forma colaborativa. Dito isto, faz-se necessário salientar que flutuações nos níveis de colaboração, gerando rupturas da aliança terapêutica, são frequentes (Eubanks et al., 2015). No entanto, quando tais rupturas não são reparadas, elas podem levar à desistência do processo terapêutico (Safran et al., 2011).

A colaboração terapêutica tem sido considerada o ponto central da aliança terapêutica (Bordin, 1979). Além disso, ela tem sido descrita como um processo terapêutico panteórico no qual terapeuta e cliente trabalham ativamente, de forma produtiva dentro de um relacionamento interpessoal significativo (e.g., Bordin, 1979; Hatcher, 1999; Kazantis & Kellis, 2012; Ribeiro et al., 2013; Spencer et al., 2019; Tyron et al., 2019).

De acordo com Hatcher & Barends (2006), a aliança é entendida como a qualidade e a força da relação colaborativa entre o terapeuta e o cliente. Além de influenciar o desenvolvimento do processo terapêutico (Botella & Corbela, 2003), a colaboração é apontada como um importante e transteórico aspecto da psicoterapia (Norcross, 2010). Com base em estudos meta-analíticos, a *Taks force* da American Psychological Association (APA) para relacionamentos terapêuticos baseados em evidências considerou a colaboração terapêutica um elemento relacional útil (Norcross & Lambert, 2018). Além disso, pesquisas sobre colaboração terapêutica mostram associações positivas entre o consenso acerca do objetivo e o resultado da terapia (Tyron et al., 2018, 2019).

Para melhor compreender os processos colaborativos, estudos microanalítcos focados na interação terapêutica têm sido incentivados. Nessa perspetiva, Ribeiro et al. (2013) salientam a importância de investigar, momento-a-momento, o desenvolvimento da colaboração terapêutica e suas contribuições para a mudança do cliente.

A investigação em psicoterapia busca evidências teóricas e empíricas sobre como a colaboração terapêutica está relacionada com a mudança e a não mudança do cliente. No entanto, apesar do

crescente número de estudos focados nos microprocessos terapêuticos, diversas questões ainda não foram clarificadas, especialmente no que diz respeito aos contributos do terapeuta, cliente e da díade que, de alguma forma, promovem a mudança (Hardy & Llewelyn, 2015). Assim, compreender como a colaboração terapêutica influencia a mudança do cliente em psicoterapia pode ajudar os terapeutas a desenvolver estratégias terapêuticas mais pertinentes, fundamentadas, com baixos prejuízos para o cliente (Menezes et al., 2007; Serralta et al., 2016). Em outras palavras, entender como ocorre a mudança do cliente em psicoterapia pode ajudar-nos a aprimorar os fatores que facilitam a mudança, bem como inseri-los na formação dos psicoterapeutas (Zilcha-Mano, 2019).

Modelo de Colaboração Terapêutica

Um dos modelos que orientou os estudos da presente tese foi o modelo de colaboração terapêutica (Ribeiro et al., 2013), que enfatiza a importância de analisar a colaboração terapêutica, enquanto dimensão central da aliança. Esses microprocessos interativos, que influenciam o desenvolvimento da aliança, estão associados à mudança ao longo do processo terapêutico (Ribeiro et al., 2013).

O modelo de colaboração integra o conceito de zona de desenvolvimento proximal terapêutica (ZDPT; Leiman & Stiles, 2001), que foi influenciado pela teoria de Vygotsky sobre o desenvolvimento cognitivo da criança. A ZDPT pode ser entendida como a distância entre a zona de desenvolvimento atual do cliente (limite inferior da ZDPT) e a zona de desenvolvimento potencial (limite superior da ZDPT), que pode ser alcançado com a ajuda do terapeuta (Leiman & Stiles, 2001; Ribeiro et al., 2013).

A colaboração terapêutica é então entendida como um processo desenvolvimental de construção de significados. Isso significa que o terapeuta deve oscilar entre compreender empaticamente os problemas do cliente, realçar as potenciais habilidades e estimular a reconstrução de significados. Assim, ao delimitar e responder às necessidades do cliente a partir de uma perspetiva desenvolvimental, o terapeuta favorece a colaboração terapêutica e a mudança do cliente (Ribeiro, 2009).

A capacidade do cliente em lidar e resolver os seus problemas ou enfrentar os desafios da vida, no início da terapia, define a sua zona de desenvolvimento atual. Um cliente depressivo pode pedir ajuda terapêutica por causa da dificuldade em acreditar em si mesmo e de confiar nos outros, com um recorrente impacto negativo nos seus relacionamentos. Por exemplo, o cliente pode dizer: "É muito difícil acreditar em mim mesmo, então frequentemente eu me afasto das pessoas. E isso me deixa triste e solitário". A zona de desenvolvimento potencial pode ser descrita como as mudanças do cliente que

podem ser alcançadas em colaboração com o terapeuta. Por exemplo, o cliente pode dizer: "Eu estava sempre estressado, tentando agradar todo mundo, e não percebia o quanto isso me adoecia". Assim, a zona de desenvolvimento potencial progressivamente se torna zona de desenvolvimento atual através da interação colaborativa entre a díade (Ribeiro et al., 2013).

Estudos que utilizaram o modelo de colaboração terapêutica (Ribeiro et al., 2013) mostraram que tanto nos casos de sucesso como nos de insucesso as interações da díade tendem a ocorrer dentro da ZDPT do cliente. No entanto, quando comparados com os casos de sucesso, os casos de insucesso tiveram proporções maiores e crescentes de interações terapêuticas fora da ZDPT. Esses estudos também mostraram que as intervenções de desafio tendem a aumentar ao longo do processo terapêutico em casos de sucesso, insucesso e desistência. Nos casos de sucesso, cada vez mais os clientes responderam às intervenções de desafio com risco tolerável, sugerindo que houve uma mudança. Por outro lado, respostas de segurança e risco intolerável foram observadas mais frequentemente na fase final em casos de insucesso e desistência terapêutica (Cardoso et al., 2019; Ferreira et al., 2015; Pinto et al., 2018; Ribeiro et al., 2016, 2019).

Assimilação de experiências problemáticas, mudança sintomática e intervenções terapêuticas

Nesta seccção abordaremos a relação entre a mudança narrativa (i.e., modelo de assimilação), a mudança sintomática e a colaboração terapêutica como uma dimensão da qualidade da relação. Além disso, será destacada a mudança sintomática e a transversalidade do processo de assimilação de experiências problemáticas em diferentes diagnósticos e abordagens terapêuticas.

O estudo de Detert et al. (2006) sugere que há uma relação entre a progressiva assimilação de experiências problemáticas do cliente e a gradativa diminuição dos sintomas clínicos, sobretudo quando o cliente compreende a sua experiência problemática.

Em um recente estudo comparativo, Basto et al. (2021) investigaram como o padrão flutuante (i.e., progressos e retrocessos) da assimilação de experiências problemáticas está relacionado com as mudanças nos sintomas ao longo das sessões. Foram analisados dois casos de depressão com diferentes resultados terapêuticos (i.e., sucesso e insucesso) e tratados a partir da Terapia Focada nas Emoções. Este estudo de caso, baseado na abordagem *Theory-Building* (Stiles, 2009), mostrou que no caso de sucesso houve uma evolução para estádios da assimilação de nível superior, as flutuações aumentaram e, sobretudo na última fase do processo terapêutico, a intensidade dos sintomas diminuiu. No caso de

insucesso, os estádios da assimilação e as flutuações foram pouco alteradas ao longo do processo terapêutico. Os autores concluíram que são necessários outros estudos que observem se os padrões flutuantes em casos de sucesso e de insucesso se replicam ou se surgem novos padrões.

Concomitantemente com o estudo de Basto et al. (2021), diversos estudos ressaltam a importância da assimilação de experiências problemáticas para a mudança sintomática do cliente (Brinegar et al., 2008; Caro Gabalda et al., 2016; Knobloch et al., 2001; Mendes et al., 2016; Ribeiro et al., 2016). Especificamente, estudos empíricos sugerem que a assimilação de experiências problemáticas no *self* e a mudança sintomática é transversal a diferentes diagnósticos: depressão (Barbosa et al., 2016; Basto et al., 2017, 2018a, 2018b, 2021; Brinegar et al., 2008; Caro Gabalda & Stiles, 2020, 2022; Detert et al., 2006; Field et al., 1994; Honos-Webb & Stiles, 1998; Honos-Webb et al., 1999, 2003; Mendes et al., 2016; Meystre et al., 2015, 2017; Mosher et al., 2008; Osatuke et al., 2007, 2011a; Ribeiro et al., 2016; Stiles et al., 2006); esquizofrenia (Osatuke et al., 2011b; Vañó et al., 2020); hipocondria (Stiles et al., 2016); transtornos de ansiedade (Caro Gabalda, 2006b; Caro Gabalda & Stiles, 2013; Gonçalves et al., 2014; Penttinen et al., 2017; Stiles et al., 1992); transtorno de personalidade borderline (Kramer et al., 2016; Osatuke & Stiles, 2006); transtorno de personalidade dissociativa (Humphreys et al., 2005).

Diferentes estudos empíricos também demonstram a relação entre a assimilação de experiências problemáticas e a mudança sintomática em diferentes abordagens, reforçando a sua natureza transteórica: Terapia Cognitiva Comportamental (Basto et al., 2017; Osatuke et al., 2007, 2011a); Terapia Psicodinâmica (Field et al., 1994; Heaton et al., 1998; Knobloch et al., 2001; Meystre et al., 2014, 2015, 2017; Varvin & Stiles, 1999); Terapia Focada nas Emoções (Barbosa et al., 2016; Basto et al., 2018a, 2018b, 2021; Brinegar et al., 2008; Mendes et al., 2016; Ribeiro et al., 2016); Terapia Linguística de Avaliação (Caro Gabalda, 2006a, 2006b; Caro Gabalda & Coscollá, 2012; Caro Gabalda & Stiles, 2009, 2013, 2019a, 2019b, 2020, 2022; Gonçalves et al., 2014; Stiles et al., 2016); Terapia Centrada no Cliente (Mosher et al., 2008).

A generalidade dos estudos previamente citados suportam o pressuposto de que a assimilação de experiências problemáticas está associada à mudança sintomática do cliente. Além disso, eles convergem na premissa de que, nos casos de sucesso, há um progresso nos estádios de assimilação (e.g., compreensão/*insight*) e uma diminuição dos sintomas (Detert et al., 2006). Sobre esse processo de assimilação, Stiles et al. (1990) sugeriram que uma boa relação terapêutica está relacionada ao progresso do cliente e à eficácia do processo terapêutico. Os resultados de diferentes estudos suportam a importância das intervenções do terapeuta estarem sintonizadas com as necessidades e capacidades

emergentes do cliente para essa mudança (Caro Gabalda et al., 2016; Caro Gabalda & Stiles, 2019b; Meystre et al., 2014, 2015; Ribeiro et al., 2016).

Contudo, parece haver a necessidade de mais estudos empíricos micro-analíticos que suportem a relação entre as intervenções do terapeuta, as respostas do cliente e a assimilação de experiências problemáticas ao longo do processo terapêutico. O insuficiente número de estudos que foquem nesses fatores pode ser justificada pela morosidade do processo de codificação (Detert et al., 2006), tanto da assimilação de experiências problemáticas quanto da colaboração terapêutica, uma vez que ele requer a observação minunciosa das sessões, a identificação das vozes problemáticas e dominantes/problema e inovação, a codificação das sessões e o acordo entre os codificadores.

Ribeiro et al. (2016) tentaram contribuir para reduzir essa lacuna através da análise da colaboração terapêutica (i.e., intervenções do terapeuta e respostas do cliente) e da assimilação de experiências problemáticas em um estudo comparativo com diagnóstico de depressão e tratados a partir da Terapia Focada nas Emoções. Com o objetivo de analisar a relação entre o processo colaborativo e os avanços na escala de assimilação de experiências problemáticas, foram analisadas cinco sessões de cada caso. Os resultados encontrados são consistentes com a premissa de que os casos de sucesso tendem a alcançar estádios de assimilação mais elevados, enquanto os de insucesso permanecem nos estádios mais baixos. Adcionalmente, os autores observaram que, quando ocorrem em clima de segurança, as intervenções de desafio podem promover mudanças no cliente.

A partir da perspetiva psicodinâmica, Meystre et al. (2014) analisaram intervenções terapêuticas que podem promover a assimilação de experiências problemáticas ao longo do processo terapêutico de uma cliente com sintomas de ansiedade. Os autores observaram que intervenções que tinham por objetivo encorajar, clarificar ou facilitar a comunicação entre a díade foram úteis em diferentes estádios da assimilação. Além disso, a intepretação dos afetos e comportamentos da cliente, tanto no passado quanto no presente, foram associadas a uma compreensão/*insight* sobre a experiência problemática (Meystre et al., 2014).

Por fim, com o intuito de expandir os resultados acerca das intervenções terapêuticas que facilitaram a assimilação de experiências problemáticas na abordagem psicodinâmica, Meystre et al. (2015) analisaram casos de sucesso e insucesso com diagnóstico de depressão. Os autores observaram que intervenções de confronto facilitaram a elaboração de *insight* . No entanto, os dados do estudo não foram suficientes para observar quais as intervenções terapêuticas facilitaram a assimilação de experiências em estádios mais elevados.

Compreender a função da assimilação de experiências problemáticas na mudança do cliente ao longo do processo terapêutico pode ser útil para a formação dos terapeutas, bem como para a prática clínica destes. Segundo Basto (2018), se outros estudos confirmarem a relação entre a assimilação de experiências problemáticas e a diminuição dos sintomas do cliente, será fundamental treinar terapeutas que possam identificar o nível de assimilação do cliente para, a partir dessa compreensão, ajustar as intervenções às necessidades e habilidades emergentes. Além disso, estudar as interações terapêuticas associadas aos estádios da assimilação, bem como as suas flutuações pode ser um contributo fundamental para a prática clinica.

A ampliação da formação dos terapeutas poderia promover meios para detecção do estádio do cliente e para a escolha de intervenções específicas em cada momento. Além disso, poderia promover a integração dessas experiências e, consequentemente, contribuir para uma mudança clínica teoricamente sustentada e eficaz.

Enquadramento metodológico

Escala de Assimilação de Experiências Problemáticas (EAEP)

Como contributo, tanto para pesquisadores quanto para clínicos, e baseados no modelo de assimilação, Stiles et al. (1990; Stiles, 1999) propuseram uma escala que identifica os estádios de assimilação de experiências problemáticas ao longo da terapia.

Denominada de Escala de Assimilação de Experiências Problemáticas (EAEP; Tabela 1; Stiles et al., 1991; Stiles & Osatuke, 2000; Stiles, 2002), esta escala permite um novo olhar sobre as transformações que, no contexto da terapia, ocorrem intra sessões. Ela visa compreender o importante processo de criação de pontes de significados, assimilação e, sobretudo, da mudança do cliente (Stiles, 2006).

Especificamente, com a sua utilização pretende-se, num primeiro momento, identificar as vozes problemáticas e como elas surgiram. Posteriormente, procura-se entender como elas estão conectadas com as vozes dominantes a fim de promover a integração e o progresso no processo psicoterapêutico (Caro Gabalda & Stiles, 2018). Segundo Stiles & Osatuke (2000), para que esse processo de assimilação ocorra, o cliente atravessa etapas emocionais expectáveis (i.e., estádios ou níveis) que vão desde um completo evitamento da experiência problemática (i.e., estádio 0), passa por uma conscientização dolorosa até uma completa integração desta (i.e., estádio 7).

Tabela 1

Escala de Assimilação de Experiências Problemáticas (EAEP)

Estádio	Descrição
0. Evitamento	O conteúdo não está formado; o cliente não está consciente do problema. O desconforto pode ser mínimo, refletindo o evitamento bem sucedido.
1. Pensamentos indesejáveis	O conteúdo é pensamentos desconfortáveis. O cliente prefere não pensar neles; os tópicos são sugeridos pelo terapeuta ou por circunstâncias externas. A emoção é frequentemente mais saliente do que o conteúdo e envolve fortes pensamentos negativos – ansiedade, medo, raiva e tristeza.
2. Consciência vaga/ Emergência	O cliente reconhece a experiência problemática e descreve pensamentos desconfortáveis associados, mas não consegue formular o problema claramente. A emoção inclui dor psicológica aguda ou pânico associado a pensamentos e experiências.
3. Colocação do problema/ Clarificação	O conteúdo inclui a colocação clara de um problema – algo que pode ser trabalhado. A emoção é negativa, mas pode ser gerida. Não há pânico.
4. Compreensão/ Insight	A experiência problemática é colocada em forma de esquema, formulada, compreendida com estabelecimento de ligações claras. A emoção pode ser mista, com reconhecimentos desagradáveis, mas também com curiosidade e por vezes com agradável surpresa.
5. Aplicação/ Elaboração	A compreensão é utilizada para se trabalhar um problema; existem esforços específicos para a resolução do problema. O cliente pode descrever a consideração de alternativas ou a seleção sistemática de percursos de ação. O tom emocional é positivo, trabalhar e otimista.
6. Solução do problema	O cliente atinge a solução para um problema específico. A emoção é positiva, o cliente está satisfeito, orgulhoso da sua realização. Á medida que o problema diminui, a emoção torna-se mais neutral.
7. Domínio	O cliente usa de forma bem sucedida as soluções em novas situações; esta generalização é, em grande medida, automática e não saliente. A emoção é neutra (ou seja, já não se trata de algo acerca do qual sentir excitação).

Nota. Tabela retirada de: Retrocessos no contexto de terapia linguística de avaliação, Caro Gabalda & Stiles (2009).

Descrita em uma sequência de oito estádios, essa escala analisa longitudinalmente as interações entre as vozes dominantes e problemáticas, bem como a sua assimilação no *self*. Os estádios de

assimilação iniciais são caracterizados por emoções predominantemente negativas e evitamento das experiências problemáticas. No estádio 0, denominado como 'Evitamento', o cliente ainda não tem consciência acerca do problema que o levou à terapia. No estádio 1, 'Pensamentos indesejáveis', há uma intensa emoção negativa e desconforto ao ser confrontado com suas experiências problemáticas (Stiles et al., 1990). Por esse motivo, o cliente evita pensar no assunto, que apenas surge por estimulação do terapeuta.

No estádio 2, 'Consciência vaga/ Emergência', inconscientemente o cliente começa a disponibilizar alguma atenção à sua experiência problemática. Observam-se as primeiras mudanças na forma como o indivíduo entende a sua problemática, uma vez que ele começa a descrevê-la, apesar do intenso desconforto gerado (Stiles et al., 1990). Ao longo da terapia, a partir do momento que o cliente começa a focar intencionalmente na sua experiência problemática, ele passa a ter ideias mais claras acerca da sua voz problemática (Stiles et al., 1990), mas não o suficiente para ser compreendida ou resolvida (Stiles et al., 2004). Diante da intensa emoção negativa, característica desse estádio, o cliente sente-se pior do que nos estádios anteriores. No entanto, ele não consegue compreender o porquê desse sentimento (Stiles et al., 2004).

No estádio 3 – 'Colocação do problema/ Clarificação', apesar de ainda haver conteúdo emocional negativo, este estádio é mais brando do que os anteriores e o cliente já consegue regulá-lo. A voz problemática passa a ser reconhecida e começa a se comunicar com a comunidade de vozes (Stiles et al., 2004). O cliente passa a descrever com maior clareza os seus objetivos, problemas e tarefas (Stiles et al., 1990).

No estádio seguinte, 'Compreensão/ *Insight*' (estádio 4), o cliente articula e compreende a sua experiência problemática (Caro Gabalda & Stiles, 2009), de forma a dar início ao processo de integração desta na comunidade de vozes. Neste momento, *insights* acerca da problemática começam a surgir e, como consequência dessas descobertas, o cliente pode apresentar tanto emoções positivas quanto negativas (Basto, 2018). Diante da progressiva integração das vozes problemáticas no *self*, essas compreensões começam a ser aplicadas em alternativas para a resolução do problema com o intuito de gerar mudanças. A emoção apresentada é predominantemente positiva no estádio 5, denominado de 'Aplicação/ Elaboração' (Basto, 2018; Caro Gabalda & Stiles, 2009).

No sexto estádio de assimilação, 'Solução do problema', o cliente consegue solucionar a problemática geradora de conflitos que o levou a procurar terapia. Por fim, no estádio 7 – 'Domínio', a experiência previamente evitada torna-se um recurso para que o indivíduo possa utilizá-lo em novas circunstâncias (Caro Gabalda & Stiles, 2009). Isso ocorre uma vez que houve uma completa integração

da voz problemática na comunidade de vozes, de forma a fazer parte da constituição do indivíduo e do seu funcionamento saudável.

Baseados nessa escala, estudos apontam que independente da abordagem e da problemática apresentada, os clientes tendem a passar pelas mesmas etapas ao longo de um processo terapêutico para alcançarem uma mudança. O que vai determinar esse percurso é o estádio de assimilação em que os clientes se encontram no início do processo terapêutico (Pérez-Ruiz & Caro Gabalda, 2016; Stiles, 2001, 2002).

De acordo com Stiles (2002), todos os movimentos apresentados na EAEP, de estádios mais baixos para mais elevados, são considerados progressos. Estudos apontam que o estádio 4 – Compreensão e *Insight* – da Escala de Assimilação de Experiências Problemáticas é o ponto crucial que distingue os resultados terapêuticos de sucesso e insucesso (Basto et al., 2021; Caro Gabalda, 2006a; Detert et al., 2006; Ribeiro et al., 2016). Este estádio é caraterizado tanto pela articulação entre as vozes problemáticas e dominantes, quanto pela construção de uma ponte de significado (Stiles, 2006).

Em um estudo realizado por Detert et al. (2006), foram encontradas associações entre estádios mais elevados na escala de assimilação, diminuição da severidade dos sintomas apresentados pelo cliente no início da psicoterapia e bons resultados terapêuticos. Além disso, dentre os casos de insucesso analisados, não foram encontradas passagens em que atingissem o estádio 4. Diante desse contexto, nos casos de insucesso, os clientes permanecem nos estádios mais baixos e, nos casos de sucesso, os clientes alcançam, no mínimo, o estádio 4 (Detert et al., 2006; Ribeiro et al., 2016).

Processo de análise da assimilação de experiências problemáticas. Apesar de não haver uma regra a ser seguida para a análise do processo de assimilação, Stiles & Osatuke (2000) sugerem que algumas etapas podem ser úteis para que esta seja realizada de forma mais rigorosa e fidedigna possível. Para isso, todos os materiais referentes ao cliente são úteis: vídeos e/ou transcrições do processo terapêutico completo, questionários, notas do terapeuta durante as sessões, entrevistas de *follow-up*, entre outros.

De posse de todos os recursos disponíveis, torna-se necessário que os investigadores estejam familiarizados com o caso que será estudado. Esse processo, descrito como o mais árduo, requer uma intensiva e exaustiva leitura do caso. Após a detalhada análise das transcrições de forma individual, os pesquisadores envolvidos devem reunir-se a fim de discutir as problemáticas eminentes (Stiles & Osatuke, 2000).

Concluída a primeira etapa, a seleção da experiência problemática, também entendida como tema, fica evidente. Para Stiles et al. (1991), o tema diz respeito ao que surgiu e foi trabalhado ao longo de todo o processo terapêutico. Especificamente, ele pode ser entendido como crenças ou sentimentos que o cliente tem perante um objeto – seja ele uma pessoa e/ou evento. O investigador deverá selecionar nas transcrições das sessões as passagens centrais na terapia que serão analisadas tendo como base o modelo de assimilação, bem como identificar as vozes dominantes e problemáticas (Caro Gabalda & Stiles, 2018).

Nesse sentido, uma passagem é definida como uma ou algumas frases que expressam experiências em diferentes dimensões (Caro Gabalda & Stiles, 2018) como, por exemplo, "eu me sinto revoltada, sufocada. Eu não suporto ficar em casa. Eu tenho vontade de sair andando e não voltar mais". A extração dessas passagens é realizada a partir do tema escolhido na etapa anterior, de forma a traçar e comparar o processo de assimilação ao longo da terapia. Para que essas passagens de interesse, entendidas como as frases que expressam experiências problemáticas, possam ser facilmente encontradas nas etapas seguintes, os autores sugerem a tomada de notas referentes ao tema a ser analisado e as suas respectivas localizações (Caro Gabalda & Stiles, 2018; Stiles & Osatuke, 2000).

Por fim, a última etapa é caracterizada pelo uso da Escala de Assimilação de Experiências Problemáticas (EAEP) para as codificações das passagens extraídas na etapa anterior, bem como pela elaboração teórica fundamentada na evolução da experiência problemática do cliente. Stiles & Osatuke (2000) referem que há a possibilidade de se realizar tal investigação utilizando apenas algumas sessões de psicoterapia.

Salienta-se que todo esse processo é realizado de forma independente pelos juízes. Mas, ao término de cada etapa, torna-se necessária a discussão e cálculo do acordo entre as codificações. Sobre este assunto, um estudo realizado por Caro Gabalda & Coscollá Iranzo (2012) aponta que o valor *kappa* de .636 no acordo entre juízes nas codificações do processo de assimilação é considerado bom e Basto et al. (2018b) referem que os codificadores estão aptos para codificar quando atingem o nível de confiabilidade de ICC ≥ .60.

Já em um estudo realizado por Detert et al. (2006), os níveis de confiabilidade encontrados foram consideravelmente abaixo dos obtidos ao longo do treino com a EAEP. Para tanto, foram calculados os acordos entre dois dos quatro codificadores para dois casos. Em um dos casos, eles obtiveram um ICC .22 e, no outro, um ICC .36. Ao incluírem todas as codificações, eles alcançaram um ICC .54 para os quatro codificadores. O baixo nível de confiabilidade entre os juízes é salientado como uma limitação deste estudo. Ao tentar compreender esses resultados, os autores atribuiram-nos aos baixos estádios de

assimilação encontrados nos casos de insucesso – predominantemente entre os estádios 2 e 3 da EAEP, uma vez que, nos casos utilizados para o treino nesse modelo, os juízes encontraram estádios de assimilação mais altos.

Sistema de Codificação da Colaboração Terapêutica (SCCT)

Tendo como ponto de partida o modelo de colaboração terapêutica (Ribeiro et al., 2013), para ser bem-sucedido nas suas intervenções, o terapeuta precisa identificar o nível de desenvolvimento em que o cliente se encontra ao pedir ajuda.

Influenciados pelo conceito da ZDPT (Leiman & Stiles, 2001) e de forma a operacionalizar o modelo de colaboração terapêutica, Ribeiro et al. (2013) desenvolveram o Sistema de Codificação da Colaboração Terapêutica (SCCT; Tabelas 2 à 4) para analisar as interações da díade momento-a-momento, bem como proporcionar uma fiável avaliação do trabalho desenvolvido ao longo da terapia.

Tabela 2

Episódios colaborativos resultantes do Sistema de Codificação da Colaboração Terapêutica (SCCT)

Intervenções do terapeuta		Respostas do cliente				
		Validação		Ambivalência	Invalidação	
		Segurança	Risco Tolerável	Ambivalência	Desinteresse	Risco Intolerável
	Suporte no Problema	Suporte no Problema - Segurança	Suporte no Problema - Risco Tolerável	Suporte no Problema - Ambivalência	Suporte no Problema - Desinteresse	Suporte no Problema - Risco Intolerável
	Suporte na Inovação	Suporte na Inovação - Segurança	Suporte na Inovação - Risco Tolerável	Suporte na Inovação - Ambivalência	Suporte na Inovação - Desinteresse	Suporte na Inovação - Risco Intolerável
	Desafio	Desafio - Segurança	Desafio - Risco Tolerável	Desafio - Ambivalência	Desafio - Desinteresse	Desafio - Risco Intolerável
		Dentro da ZDPT do cliente		No limite da ZDPT do cliente	Fora da ZDPT do cliente	

Nota. Adaptado de: How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system, Ribeiro et al. (2013) – adaptado com permissão.

De acordo com a proposta do modelo de colaboração terapêutica (Ribeiro et al., 2013), os terapeutas trabalham dentro da ZDPT do cliente para promover mudanças através do suporte ou do desafio das perspetivas do cliente (Tabela 3). As intervenções de suporte indicam que o terapeuta está atuando próximo da zona de desenvolvimento atual do cliente. Com essas intervenções, o terapeuta procura compreender de forma empática e explorar a perspetiva dominante do cliente (i.e., suporte no problema ou suporte da perspetiva problemática) ou a perspetiva inovadora emergente (i.e., suporte na inovação), proporcionando dessa forma uma experiência de segurança e conforto. A perspetiva inovadora integra progressivamente uma ampla gama de experiências do cliente que eram difíceis de significar. Nas

intervenções de desafio, além de compreender e rever as questões problemáticas trazidas pelo cliente, o terapeuta convida o cliente a considerar novas perspetivas sobre suas próprias experiências, aproximando-o da sua zona de desenvolvimento potencial (Ribeiro et al., 2013).

Tabela 3

Categorias e subcategorias da intervenção do terapeuta

	Suporte
Reflexão	O terapeuta reflete o conteúdo, significado ou sentimentos expressos (mais ou menos abertamente) no discurso/comportamento prévio do cliente. Ele/ela pode repetir as palavras do cliente e/ou usar suas próprias palavras, desde que não adicione nenhum significado novo. As reflexões do terapeuta podem ser afirmativas (e.g., paráfrases, repetições, conclusões) ou interrogativas (geralmente para confirmar se ele/ela entendeu corretamente o que o cliente estava tentando transmitir).
Sumarização	O terapeuta sintetiza o discurso do cliente, fazendo uso das palavras do cliente ou das suas próprias palavras, sem acrescentar informação nova. Pode implicar um pedido de feedback implícito ou explítico.
Questionamento	O terapeuta explora a experiência do cliente através de perguntas. Essas perguntas podem ser abertas, permitindo que o cliente elabore sua resposta de várias maneiras; ou pode ser fechada, para obter informações mais factuais ou concretas.
Demonstração de interesse e/ou atenção	O terapeuta demonstra abertamente seu interesse e/ou atenção no discurso e/ou experiência do cliente.
	Desafio
Interpretação	O terapeuta propõe uma nova perspetiva, usando suas próprias palavras, mas mantendo um senso de continuidade em relação ao discurso e/ou experiência do cliente.
Confrontação	O terapeuta questiona a perspetiva do cliente ou propõe-lhe uma nova. Há uma clara descontinuidade entre a intervenção/perspetiva do terapeuta e o discurso/experiência do cliente. Os confrontos também podem ser codificados sempre que o terapeuta explicitamente faz o contraste entre as perspetivas problemáticas e inovadoras do cliente, a fim de destacar tal contraste ou ambivalência do cliente.
Convite a adotar uma nova ação	O terapeuta convida o cliente a agir de forma diferente, seja dentro da sessão (e.g., convidando o cliente a metaforicamente dar um nome ao seu problema, como na terapia narrativa) ou fora da sessão (e.g., convidando o cliente a praticar na vida real, como na terapia cognitivo-comportamental).
Convite a explorar um cenário hipotético	O terapeuta convida o cliente a considerar diferentes possibilidades cognitivas, emocionais e/ou comportamentais em relação à maneira como ele compreende e experiencia o mundo. Isso pode ser entregue de uma forma mais diretiva ou provisória.
Mudança de nível de análise	O terapeuta convida o cliente a mudar o nível de análise da sua experiência, de um nível mais descritivo para um mais abstrato, ou vice-versa.

Enfatizar a novidade/ Reforçar	O terapeuta enfatiza as mudanças do cliente ou convida o cliente a elaborar sobre seus problemas ou mudanças emergentes.
Procura de evidências para a mudança	O terapeuta questiona o cliente no sentido de explorar indicadores de mudança.

Nota. Adaptado de: How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system, Ribeiro et al. (2013) – adaptado com permissão.

As respostas do cliente, categorizadas como validação, invalidação e ambivalência (Tabela 4), são interpretadas como indicando a localização da intervenção terapêutica em relação à sua ZDPT. As respostas de validação são um indicador de atuação do terapeuta dentro da ZDPT do cliente. O cliente aceita, mais ou menos explicitamente, a proposta do terapeuta de compreender ou desafiar a sua perspetiva habitual. Essas respostas indicam a competência do terapeuta em perceber as necessidades e a prontidão do cliente para mudar (Ribeiro et al., 2013).

Quando há uma invalidação, o cliente rejeita, mais ou menos explicitamente, a proposta de compreender ou desafiar a sua perspetiva habitual. A intervenção é percebida como irrelevante ou desinteressante para o seu nível de mudança. Note-se que, se a intervenção for além do limite superior da ZDPT através de desafios demasiado exigentes, o cliente pode experienciar risco intolerável e apresentar uma postura defensiva. Por outro lado, se a intervenção for abaixo do limite inferior da ZDPT e o terapeuta fizer intervenções redundantes ou pouco relevantes, o cliente pode responder com desinteresse. Já nas respostas de ambivalência, observa-se indicadores de validação e invalidação sugerindo que as intervenções ocorrem nos limites da ZDPT do cliente (Ribeiro et al., 2013).

O modelo de colaboração terapêutica propõe que as respostas do cliente exprimem sua experiência em relação à proposta do terapeuta. Especificamente, essa experiência pode ser de desinteresse (aquém da ZDPT), segurança e risco tolerável (dentro da ZDPT), ambivalência (no limite da ZDPT) ou risco intolerável (para além da ZDPT; Ribeiro et al., 2013). Deste modo, este modelo salienta a importância de uma interação responsiva, colaborativa e diádica para gradualmente mover o cliente da zona de desenvolvimento atual para a potencial.

Tabela 4

Categorias e subcategorias da resposta do cliente

	Validação
Confirma	O cliente concorda e/ou aceita a intervenção do terapeuta, com firmeza e sem deferência, sem maiores elaborações.
Fornece informação	O cliente fornece novas informações em resposta à intervenção do terapeuta sem, no entanto, avançar em sua ZDPT.
Elabora	O cliente responde à intervenção do terapeuta, fornecendo informação nova com indicadores de mudança. O cliente avança em sua ZDPT.
Reformula a sua perspetiva usual	O cliente responde à intervenção do terapeuta, não só fornecendo nova informação com indicadores de mudança, mas mostrando reconhecê-los por oposição à sua perspetiva inicial.
	Invalidação
Expressa confusão	O cliente mostra-se hesitante e responde de forma confusa, sem ser capaz de se posicionar; ou, expressa, de forma aberta, a sua incapacidade para responder à intervenção do terapeuta.
Discorda com a intervenção do terapeuta / Defende a sua perspetiva habitual	O cliente discorda mais ou menos abertamente da intervenção do terapeuta. O cliente discorda abertamente com a intervenção do terapeuta, de uma forma combativa e/ou até irónica; ou, o cliente defende os seus pensamentos, sentimentos ou comportamento mal adaptativos, contra-argumentando com o terapeuta.
Ausência de envolvimento na resposta	O cliente dá uma resposta mínima pouco clara ou ambígua face ao esforço do terapeuta para explorar e/ou compreender a sua experiência.
Desconexão de tópico	O cliente responde tangencialmente à intervenção do terapeuta, mudando de assunto ou focando em um tópico anterior, sendo excessivamente descritivo e detalhado ou elaborando questões circunstanciais e irrelevantes.

Nota. Adaptado de: How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system, Ribeiro et al. (2013) – adaptado com permissão.

Processo de codificação com o Sistema de Codificação da Colaboração Terapêutica (SCCT). A codificação com o SCCT exige um profundo conhecimento do caso, de modo a identificar o problema (perspetiva problemática) e a possível inovação (perspetiva inovadora) específica de cada caso, tendo por base a formulação de caso desenvolvida e negociada nas primeiras sessões. Nesse sentido, é importante que os codificadores tenham acesso a transcrições, vídeos ou áudios para a definição da ZDPT do cliente. Salienta-se que, durante todo o processo de codificação, os dois codificadores e o auditor

devem estar alheios ao resultado terapêutico do caso analisado. Os codificadores definem a perspetiva problemática do cliente e suas potenciais mudanças, definindo assim como a ZDPT do cliente vai sendo especificada para cada sessão. Posteriormente, deve eliminar as passagens que não são foco de atenção terapêutica (e.g., um toque de telefone e conversação a seu propósito), codificar as intervenções do terapeuta, as respostas do cliente e categorizar as interações terapêuticas. Assim, as unidades de análise do SCCT são cada par de fala: intervenção do terapeuta e a resposta do cliente, tendo como contexto imediato a interação anterior e o contexto da sessão (Ribeiro et al., 2013).

O processo de codificação deve ser realizado por pelo menos dois codificadores, de forma independente. Ao término da codificação de cada sessão, os codificadores devem calcular a percentagem de acordo, reunir-se a fim de discutir os desacordos e, resolvê-los através de negociação consensual. Por fim, torna-se necessária uma auditoria para compreender as divergências, fazer alterações nas codificações, caso necessário, e afinar a perceção dos codificadores para a sessão seguinte. Quando os codificadores atingem um acordo de pelo menos 80%, em 30% do total de sessões a serem analisadas, há a possibilidade de um codificador dar continuidade às codificações das sessões restantes de forma independente (Ribeiro et al., 2013).

Finalmente salienta-se que o SCCT foi validado a partir da análise indutiva de 60 sessões, sendo 32 seguidas da Terapia Narrativa e 28 sessões seguidas de Terapia Cognitivo Comportamental, totalizando 6680 interações terapêuticas. Também foi utilizado o critério de qualidade e confiabilidade de percentagens de acordo acima de 80% (Almeida & Freire, 2000). O SCCT mostrou confiabilidade boa e aceitável, com valores médios de *Kappa de Cohen* de 0,92 para as intervenções do terapeuta e 0,93 para as respostas do cliente, e um percentual de concordância para ambas as ações terapêuticas superior a 80% (Ribeiro et al., 2013).

Clarificação do uso dos termos: experiência problemática e perspetiva problemática

Dado que nesta tese utilizamos dois sistemas de codificação em que o termo problemática tem significados distintos, torna-se necessário clarificar os termos e o seu uso de acordo com o modelo de assimilação (Stiles et al., 1990) e o modelo de colaboração terapêutica (Ribeiro et al., 2013).

Os termos problema e problemática pressupõem uma perspetiva a partir da qual uma entidade ou evento é considerado problemático. O modelo de assimilação (Stiles et al., 1990) assume a perspetiva do cliente. Da perspetiva do *self*, as experiências (do passado ou presente) são problemáticas quando são dolorosas, inaceitáveis ou incompatíveis com o *self*. O modelo de colaboração terapêutica (Ribeiro et

al., 2013) assume a perspetiva do terapeuta. Dessa perspetiva, o problema emerge de um esquema rígido que falha em significar algumas experiências importantes e em acomodar experiências novas, gerando sofrimento.

Tendo em atenção as especificidades do modelo de assimilação e do modelo de colaboração terapêutica relativamente ao uso do termo problema ou perspetiva problemática, nesta tese usámos consistentemente a experiência problemática ou a voz problemática para nos referirmos à experiência ameaçadora para o *self* do cliente, e a perspetiva problemática para nos referir ao esquema que não consegue acomodar a nova experiência, que não é familiar.

Theory building case study

Nesta tese, que inclui três estudos, usámos a metodologia de estudo de caso numa lógica *Theory Building*, uma vez que se constituem como oportunidades para comparar detalhadas observações clínicas de processos terapêuticos com a teoria (Meystre et al., 2014).

De acordo com Stiles (2007), a psicoterapia é um espaço privilegiado que apresenta os mais diversos fenômenos humanos que a teoria procura entender. A fim de compreender como ocorre a mudança do cliente momento-a-momento, a análise da prática clínica e sua consequente publicação científica pode explicar diversos fenômenos. Assim, as formulações e construções teóricas advindas da interação entre a teoria e a prática permitem a ampliação e elaboração de uma teoria. Partindo desse pressuposto, entende-se que uma teoria é flexível e está em constante transformação, modificando-se e aperfeiçoando-se de forma a integrar e acomodar as novas observações encontradas (Stiles, 2007). É nesse processo, realizado a partir de observações empíricas e bem fundamentadas teoricamente, que surge a *Theory Building*.

De forma geral, o estudo de caso pode ser entendido como a base para uma investigação, ou seja, através da coleta de dados pode-se identificar a relevância do tema para futuras pesquisas com outros métodos. Pode ainda ser entendido como uma análise aprofundada do caso, através do rastreio e análise do padrão de comportamento do sujeito ao longo do tempo, considerando o contexto em que está inserido (Yin, 2012). Embora essa profunda compreensão acerca do caso seja importante no ínicio do estudo de caso *Theory Building*, esse não é o objetivo deste método (Stiles, 2009). Os estudos de caso *Theory Building* têm por objetivo construir uma explicação teórica coerente, geral, precisa e realista (Stiles, 2009). Esse método verifica como as observações acerca do fenómeno investigado se relacionam

com a teoria (Stiles, 2015). Os estudos de caso formulados a partir da abordagem de *Theory Building*, quando têm suas observações descritas de forma detalhada e sistematizada, permitem confirmar e/ou modificar uma compreensão teórica existente (Caro Gabalda & Stiles, 2018). Assim, quando os resultados encontrados corroboram com a literatura, aumenta-se a credibilidade da teoria; quando não, surge uma oportunidade para ajustá-la, reelaborá-la e ampliá-la (Stiles, 2009).

Apesar de não descrever um roteiro a ser seguido para a *Theory Building* no contexto de estudos de caso clínicos, Stiles (2007) forneceu sugestões úteis para essa tarefa. O ponto de partida é o amplo conhecimento da teoria que irá permear a investigação, o que inclui, da parte do investigador, o conhecimento dos fundamentos teóricos, do contexto em que está inserida, das pesquisas anteriores e capacidade para enquadrar o caso clínico a ser analisado.

Não obstante, o caso clínico em análise também precisa ser dotado de todas as informações disponíveis, tanto no que diz respeito ao cliente, como ao terapeuta e ao que foi construído pela díade ao longo do processo terapêutico. Nesse sentido, transcrições das sessões, dados pessoais de ambos os elementos da díade terapêutica, avaliações de processo e de resultado realizadas a cada sessão e no término do processo terapêutico, avaliações e entrevistas de *follow up*, entre outras informações são de suma importância para ilustrar, enquadrar e validar os resultados encontrados. Após a recolha de todo o material disponível acerca do caso a ser estudado, o investigador deve selecionar o aspecto que pretende aprofundar e, então, relacionar com a teoria de base.

Ao compreender esses princípios fundamentais para um bom e articulado estudo de caso, observa-se que o modelo de assimilação de experiências problemáticas foi construído sob a perspetiva da *Theory Building* (Stiles, 2007). Esse modelo, operacionalizado através da Escala de Assimilação de Experiências Problemáticas (EAEP), apresenta os diversos estádios de assimilação que o cliente percorre para alcançar um bom resultado terapêutico (Stiles, 2006). Esta proposta teórica foi sendo modificada e aperfeiçoada com base em observações e estudos empíricos realizados em diversos casos clínicos, no contexto dos quais foram identificadas as mudanças necessárias para o refinamento da teoria (Caro Gabalda & Stiles, 2018; Pérez-Ruiz & Caro Gabalda, 2016). Assim, observa-se que tanto o modelo teórico de assimilação como a Escala de Assimilação de Experiências Problemáticas (EAEP) possibilitam uma compreensão acerca do processo psicoterapêutico, bem como as mudanças psicológicas que decorrem deste.

Fundamentados no modelo de assimilação (Stiles et al., 1990) e na *Theory Building case studies*, Caro Gabalda & Stiles (2022) investigaram as intervenções do terapeuta após o retrocesso do cliente no processo de assimilação. Os resultados encontrados foram consistentes com a perspetiva de retrocessos

como mudança de vertentes de um problema, bem como sugerem elaborações na teoria. De acordo com os autores, se a díade mantém uma boa relação terapêutica, os terapeutas de abordagem diretiva (e.g., Terapia Linguística de Avaliação) tendem a adaptar suas intervenções após o retrocesso para seguir a vertente escolhida.

Já Pinto et al. (2018) conduziram um estudo a a partir da perspetiva do modelo de colaboração terapêutica (Ribeiro et al., 2013) e da *Theory Building*. Este teve por objetivo descrever a colaboração terapêutica em casos de desistência da Terapia Narrativa. Segundo os autores, o estudo apresenta hipóteses interessantes acerca do fenômeno investigado. Isto é, a insistência do terapeuta em determinada intervenção ou a sua precupação em focá-la na experiência do cliente podem contribuir para a permanência ou desistência do cliente no processo terapêutico.

Em consonância com Caro Gabalda & Stiles (2018), acreditamos que os estudos de casos *Theory Building* podem produzir observações clinicamente significativas que confirmam ou sugerem alternativas para se modificar compreensões teóricas prévias. Assim, entendemos que o estudo de caso *Theory Building* adiciona incrementos de confiança a uma teoria geral. Nessa lógica, nos três estudos da presente tese, investigamos como os casos suportavam o modelo de assimilação (Stiles et al., 1990) e modelo de colaboração terapêutica (Ribeiro et al., 2013), bem como investigamos fenómenos inesperados que poderiam sinalizar a necessidade de elaborarmos nosso entendimento teórico.

State Space Grids (SSG)

No segundo estudo desta tese, analisámos o padrão de colaboração terapêutica ao longo das sessões em um caso de desistência, com o diagnóstico de borderline e através do *State Space Grids* (*SSG*; Lewis et al., 2004). Esse método visa estudar duas ou mais séries de dados sincronizados, que é uma forma de caracterizar os padrões de comportamento em tempo real (e.g., colaboração terapêutica; Hollenstein, 2007). Esses dados sincronizados, que compõem um sistema dinâmico com um número finito de estados possíveis, é denominado de *State Space* e, quando estabilizam em 80% da sua extensão, são designados de atractores (Hollenstein, 2007). Os atractores são representados pelas células do *SSG* que possuem uma maior probabilidade de ocorrência da dinâmica do sistema, comparando com as demais.

Esses sistemas dinâmicos são guiados por um princípio de auto-organização, baseados nas variáveis de tempo e mudança, e a partir das interações entre os seus elementos (e.g., Hollenstein, 2013; Lewis, 2000). Assim, entende-se que a mudança do cliente surge da interação com o terapeuta, uma vez

que as acções de um e outro influenciam-se mutuamente. Tal definição parece compatível com o modelo de colaboração terapêutica, tal como definido por Ribeiro et al. (2013), que é entendido como o esforço mútuo entre terapeuta e cliente, destacando o caráter bidirecional e recíproco dessa relação. Ou seja, a colaboração terapêutica e a mudança do cliente são dinâmicas.

Para responder um dos objetivos do segundo estudo desta tese, consideramos as intervenções do terapeuta e as respostas do cliente como duas séries de dados sincronizados, uma vez que a combinação interativa entre essas séries reflete o trabalho da díade relativamente à ZDPT do cliente (Ribeiro et al., 2013). Ao todo, 15 células, que correspondem aos 15 episódios interativos do SCCT (Ribeiro et al., 2013), compõem a grelha gerada através do *Software GridWare* (Version 1.1.; Lamey et al., 2004). Para identificar os atractores da grelha utilizamos o método *winnowing* (Lewis et al., 1999), que é um procedimento quantitativo baseado na duração cumulativa de uma célula (i.e., interações terapêuticas). Todos os 15 episódios interativos encontravam-se no início do procedimento *winnowing* e, um a um, excluímos os episódios com menor duração que contribuíam para a heterogeneidade da interação. Este procedimento foi repetido até que os episódios interativos fossem considerados homogêneos, destacando as células restantes, ou seja, os atractores.

Apresentação dos estudos

De forma a aprofundar a compreensão sobre como as interações terapêuticas e a mudança do cliente se desenvolveram ao longo do processo terapêutico, nos estudos incluídos nesta tese, foram utilizados o modelo de assimilação (Stiles et al., 1990) e o modelo de colaboração (Ribeiro et al., 2013). Ambos os modelos oferecem um enquadramento conceptual em que a mudança terapêutica é facilitada pelo uso de estratégias (i.e., intervenções terapêuticas) que ajudam o cliente a mover-se na sua zona de desenvolvimento proximal terapêutica, do nível de desenvolvimento atual para o nível de desenvolvimento potencial.

Posto isto, o primeiro estudo desta tese teve por objetivo analisar a relação entre interações terapêuticas (não) colaborativas e o progresso da assimilação de experiências problemáticas em dois casos contrastantes de depressão maior e tratados a partir da terapia cognitivo comportamental. Para atingir o objetivo deste estudo comparativo, utilizámos a Escala de Assimilação de Experiências Problemáticas (EAEP) para avaliar o progresso terapêutico e o Sistema de Codificação da Colaboração Terapêutica (SCCT) para observar e caracterizar o trabalho colaborativo da díade. Para efetuar a referida análise, selecionámos as interações terapêuticas do SCCT que correspondem às passagens da EAEP.

Em seguida, testamos a diferença média na distribuição de interações terapêuticas (não) colaborativas específicas entre os estádios mais baixos e mais altos da EAEP. Todas as análises foram realizadas utilizando o *Software R*.

O segundo estudo teve por objetivo explorar as interações terapêuticas ao longo o processo psicoterapêutico à luz da colaboração terapêutica e sua relação com a mudança do cliente, diagnosticado com perturbação de personalidade borderline e tratado a partir da abordagem psicodinâmica. Especificamente, procurámos caracterizar a baixa assimilação de experiências problemáticas do cliente e os padrões de colaboração terapêutica ao longo das sessões. Para atingir o objetivo deste estudo de caso de desistência terapêutica, utilizamos o Sistema de Codificação da Colaboração Terapêutica (SCCT) para observar e caracterizar o trabalho colaborativo da díade e a Escala de Assimilação de Experiências Problemáticas (EAEP) para avaliar o progresso terapêutico. Utilizámos método do *State Space Grids* (*SSG*) para descrever a colaboração terapêutica e utilizámos o *Software R* para analisar de forma descritiva a mudança do cliente.

O terceiro estudo teve por objetivo identificar quais as interações terapêuticas que caracterizaram os avanços e retrocessos ao longo do processo terapêutico em um caso de sucesso, diagnosticado com depressão e tratado a partir da abordagem psicodinâmica. Além disso, estávamos interessados em compreender os mesmos fenômenos (i.e., avanços e retrocessos) especificamente no que diz respeito ao *insight* (estádio 4 da EAEP). Para atingir o objetivo deste estudo de caso, utilizámos o Sistema de Codificação da Colaboração Terapêutica (SCCT) para observar e caracterizar o trabalho colaborativo da díade e a Escala de Assimilação de Experiências Problemáticas (EAEP) para avaliar o progresso terapêutico. Realizámos uma análise descritiva para responder às questões de investigação.

Em síntese, os três estudos incluídos nesta tese permitiram-nos compreender o processo de mudança do cliente através de uma perspetiva colaborativa, da observação das singularidades e contextos de cada caso, das sutilezas clínicas, das relações e progressão não lineares. Por outro lado, a especificidade de cada um dos estudos resultou de diferentes diagnósticos (i.e., depressão e perturbação de personalidade borderline), abordagens terapêuticas (i.e., terapia cognitivo comportamental e terapia psicodinâmica) e resultados (i.e., sucesso, insucesso e desistência). Os estudos incluidos nesta tese também permitiram a ampliação do uso do SCCT em casos de perturbação de personalidade borderline e em casos seguidos da abordagem psicodinâmica.

ESTUDO I -

IS THE QUALITY OF THERAPEUTIC COLLABORATION ASSOCIATED WITH THE ASSIMILATION OF PROBLEMATIC EXPERIENCES PROGRESS? A COMPARISON OF TWO CASES

IS THE QUALITY OF THERAPEUTIC COLLABORATION ASSOCIATED WITH THE ASSIMILATION OF PROBLEMATIC EXPERIENCES PROGRESS? A COMPARISON OF TWO CASES[1]

Abstract

Objective: How are collaborative interactions associated with clients' progress in therapy? This study addressed this question, by assessing the quality of therapeutic collaboration and comparing it passage by passage with the clients' assimilation of problematic experiences in two cases of major depression treated with Cognitive Behavioral Therapy (CBT), one recovered and one improved-but-not-recovered. Method: We used the Therapeutic Collaboration Coding System (TCCS) to code collaborative work and the Assimilation of Problematic Experiences Scale (APES) to rate clients' progress. In both cases, we tested the sample mean difference in the distribution of specific collaborative therapeutic exchanges between lower and higher APES levels. Results: Both cases progressed on the APES, but in contrast with Annie (Improved-but-not-recovered), Kate (Recovered) achieved higher levels of change in the last sessions. In addition, we found significant differences in the types of collaborative therapeutic exchanges associated with lower and higher APES levels. Conclusion: Our finding that ambivalent therapeutic exchanges distinguished the recovered from the not recovered cases highlighted a source of difficulties in facilitating therapeutic change in the context of CBT. In addition, these cases suggested that the theoretically-posited relations between collaborative therapeutic exchanges closer to the lower or upper limit of clients' therapeutic zone of proximal development and lower or higher APES levels, respectively.

Resumo

Objetivo: Como as interações colaborativas estão associadas ao progresso dos clientes na terapia? Este estudo abordou essa questão, avaliando a qualidade da colaboração terapêutica e comparando-a, momento-a-momento, com a assimilação de experiências problemáticas em dois casos de depressão maior, um recuperado e outro melhorado, mas não recuperado, tratados a partir da Terapia Cognitivo Comportamental (TCC). Método: Usamos o Sistema de Codificação da Colaboração Terapêutica (SCCT) para codificar o trabalho colaborativo e a Escala de Assimilação de Experiências Problemáticas (EAEP) para avaliar o progresso dos clientes. Em ambos os casos, testamos a diferença média da amostra na

[1] This study is under review with the following authors: Ryttinger, R., Stiles, W. B., Serralta, F., Silva, V., Cardoso, C., Ferreira, A., Basto, I., Sousa, I. & Ribeiro, E.

distribuição de interações terapêuticas colaborativas, específicas entre os níveis mais baixos e mais altos da EAEP. Resultados: Ambos os casos progrediram na EAEP, mas em contraste com Annie (Melhorou mas não recuperou), Kate (Recuperou) obteve níveis mais elevados de mudança nas últimas sessões. Além disso, encontramos diferenças significativas nos tipos de interações terapêuticas colaborativas associadas a níveis mais baixos e mais altos da EAEP. Conclusão: Observamos que as interações terapêuticas com respostas de ambivalência distinguiram o caso recuperado do não recuperado, salientando dificuldades para se facilitar a mudança terapêutica no contexto da TCC. Além disso, esses casos mostraram as relações, teoricamente postuladas, entre as interações terapêuticas colaborativas mais próximas do limite inferior ou superior da zona de desenvolvimento proximal terapêutica das clientes e níveis inferiores ou superiores da EAEP, respetivamente.

Introduction

Therapeutic collaboration has been described as a pantheoretical therapeutic process in which therapist and client actively work together within a significant interpersonal relationship and mutually contribute to accomplishing therapy goals (e.g., Bordin, 1979; Ribeiro et al., 2013; Tryon & Winograd, 2011). Research on therapeutic collaboration and meta-analysis findings has shown positive associations of therapy goal consensus, assessed by goals subscales of alliance measures, with therapy outcome (e.g., Tryon et al., 2019).

Understanding how collaboration and treatment progress are related to each other may help therapists adjust their interventions to promote therapeutic change. In the present study, we assessed this relation in a recovered case and an improved-but-not-recovered case of Cognitive Behavior Therapy (CBT) for major depression. We used the therapeutic collaboration model (Ribeiro et al., 2013) to describe both dyads' therapeutic collaboration patterns, and we used the assimilation model (Stiles et al., 1990; Stiles, 2001, 2011) to describe the clients' change process.

A key concept in both models is the therapeutic zone of proximal development (TZPD). This concept was used by Leiman and Stiles (2001) to describe the working zone for a problem within a broad continuum of assimilation. Ribeiro et al. (2013) also made use of this concept to frame the concept of therapeutic collaboration and to describe its relation with the client's change. Both models propose that therapeutic change in a problem occurs within the limits of its TZPD. As clients improve, the working zone advances up the continuum; that is, the upper limit of TZPD increases. In the following sections, we

describe the main ideas of each model.

The Assimilation Model

The assimilation model is an integrative theory of psychological change (Stiles et al., 1990; Stiles, 2001, 2011). It describes the self, metaphorically, as a community of interlinked voices, in which the voices are composed of the traces of previous life experiences (e.g., Stiles et al., 2004; Stiles, 2011). For instance, based on his previous experiences, a man might develop a competent self, saying: "I'm a competent person; usually I do my job successfully." When a new experience resembles aspects of his previous (successful) experiences, those voices are reactivated and can emerge as resources (relevant knowledge and skills) to help him adapt confidently to the new situation (Honos-Webb & Stiles, 1998; Stiles, 2001, 2011; Stiles et al., 2004).

Normally, the dominant community of voices tends to integrate new experiences smoothly. However, some experiences are incompatible or in conflict with the self and are warded off or avoided. Events that address the voices of such experiences generate suffering and damage relationships by reactivating the conflict (Detert et al., 2006; Stiles et al., 1990, 2004). For example, the man referred above who fails to get an expected promotion can feel like a fraud or feel confused because he has little experience of failures. He might say: "It's strange, I feel like I'm not me." This experience is not easily assimilated by the dominant community of voices and may become problematic for the self. The traces of unassimilated experiences can constitute problematic voices (Caro Gabalda & Stiles, 2016, 2020; Honos-Webb & Stiles, 1998; Stiles et al., 1990, 2004; Stiles, 2001, 2011).

In successful therapy, clients can assimilate problematic experiences into the self. To assess the assimilation process, researchers developed the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991; Stiles & Osatuke, 2000). The APES describes a sequence of eight levels of assimilation, marked by affective and cognitive properties, which describe changes in the relation of problematic experiences to the self during good outcome therapy. Clients may enter treatment with problems at any level, and any movement from a lower to a higher level reflects therapeutic progress (Brinegar et al., 2006; Stiles, 2001).

In successful treatments, problematic experiences seem to pass through the same sequence of APES levels, despite differences in psychotherapy approaches and clinical disorders (Honos-Webb & Stiles, 1998; Ribeiro et al., 2016). There is evidence that in good outcome cases, clients tend to reach higher APES levels than in poor outcome cases (e.g., Basto et al., 2018; Detert et al., 2006; Stiles et al.,

1991; Stiles, 2006). In a comparative study of treatment for mild depression, Detert et al. (2006) showed that conventionally-defined good outcome cases tended to achieve at least APES level 4 (i.e., understanding/ insight), whereas in poor outcome cases, problematic experiences remained at lower levels (see also Basto et al., 2018). Further evidence linking assimilation with good process and outcome has come from studies of clients in psychodynamic therapy (Meystre et al., 2014, 2015), emotion-focused therapy (Cunha et al., 2012; Ribeiro et al., 2016), cognitive therapy (Caro Gabalda et al., 2016; Caro Gabalda & Stiles, 2019, 2020) and cognitive behavior therapy (Coelho, 2021).

Therapeutic Collaboration Model

The therapeutic collaboration model (Ribeiro et al., 2013) describes therapeutic collaboration as the therapist's and client's joint effort to work within the client's TZPD (following Leiman & Stiles, 2001). The TZPD is defined as the distance between the client's actual developmental level (i.e., their current ability to work on life's problems, which is usually rigid at the beginning of therapy) and the potential developmental level that can be accomplished with the therapists' help (i.e., the changes that are accomplished through collaborative work) (Ribeiro et al., 2013, 2021).

The actual and potential levels that frame a problem's TZPD are not known in advance, and they change during therapy. So, ascertaining them is a joint project undertaken though negotiation between the therapist and client at the beginning and throughout the therapy. Based on the principle of push where it moves, therapists continuously evaluate the clients' TZPD, taking into account the client's responses of validation (acceptance) and invalidation (rejection) after their interventions (Ribeiro et al., 2013). As clients progress, the TZPD shifts up the developmental (change) continuum, which can be assessed with the APES. Progressively, what was closer to the potential level (unfamiliar/upper limit of the clients' TZPD) becomes a new actual level (familiar/lower limit of clients' TZPD).

Therapists can help clients progress in their TZPD by selectively supporting or challenging clients' perspectives (Ribeiro et al., 2013). In supporting interventions, the therapist acts closer to the clients' actual developmental level seeking to understand and explore either their clients' usual perspective (called supporting problem or supporting problematic perspective) or the innovative, emergent perspective (called supporting innovation). The innovation is thus a perspective or schema that integrates –or at least tries to integrate– a wider range of the clients' experiences in a more flexible way. In challenging interventions, therapists offer new perspectives on their clients' usual problematic or innovative experiences, pushing them closer to their potential developmental level (Ribeiro et al., 2013).

The clients' immediate responses to the therapists' interventions are interpreted as an indication of where the dyad is working regarding their TZPD (Ribeiro et al., 2013). If the client validates the therapist's interventions, for example, by accepting or elaborating them, that means that the dyad is working collaboratively within the client's TZPD. Validation responses are interpreted as an indicator of the therapist's responsiveness to the client's needs of being understood, when they follow supporting interventions, or to going further, when they follow challenging interventions (Ribeiro et al., 2021). If the client invalidates the therapist's interventions, for example, by rejecting them or defending their perspective, that means that the dyad is working non-collaboratively, outside the TZPD. If the client's responses oscillate between validating and invalidating the therapist's intervention within the same speaking turn, that means that the dyad is working at the limit of the TZPD. The client's responses define a continuum of experience regarding the therapist's proposal, from disinterest (below the TZPD) to safety and tolerable risk (within the TZPD, closer to the lower and upper limit, respectively), to ambivalence (at the limits of TZPD), and finally to intolerable risk (above the TZPD) (Ribeiro et al., 2013).

The Therapeutic Collaboration Coding System (TCCS) was developed to analyze the moment-by-moment dyad's therapeutic collaboration (Ribeiro et al., 2013). Research using TCCS has shown that both good and poor outcome cases tended to work within the clients' TZPD most of the time. However, when compared with good outcome cases, the poor outcome cases had increasing proportions of therapeutic exchanges outside the client's TZPD, particularly in the final phases of therapy (Cardoso et al., 2019; Ferreira et al., 2015; Ribeiro et al., 2016, 2019). In good outcome cases, clients increasingly responded to challenging interventions as tolerable risk, suggesting that the client's experiences had progressed along their TZPD (e.g., Ferreira et al., 2015; Ribeiro et al., 2016, 2019); theoretically, challenging interventions followed by responses of tolerable risk characterize work closer to the upper limit of the client's TZPD. In contrast, in poor outcome and dropout cases, intolerable risk responses following challenging interventions increased across therapy (Cardoso et al., 2019; Ferreira et al., 2015; Pinto et al., 2018; Ribeiro et al., 2019).

In general, case studies using the TCCS have supported the theoretical proposal that in successful therapies the therapeutic dyad works preferentially within the client's TZPD, and increasingly advance closer to the upper limit of the client's TZPD (Ferreira et al., 2015; Ribeiro et al., 2016, 2019). In other words, the progress means that the whole TZPD moves up, both the actual level and the potential level increase. One of them used the TCCS to characterize therapeutic collaboration during the assimilation process (Ribeiro et al., 2016). This study compared two cases of Emotion-Focused Therapy and found that, in contrast with the poor outcome case, the good outcome case made excellent progress through

the APES and that the proportion of therapeutic exchanges of challenging-tolerable risk sequences increased, indicating work closer the client's TZPD potential developmental level on the TCCS. In the present study, we extended this line of research to Cognitive Behavior Therapy.

Purpose of the Current Study

The therapeutic collaboration model and the assimilation model share the theoretical principles that client's change occurs within the client's TZPD and that as clients make progress their problems' potential developmental levels advance higher on the developmental continuum (i.e., the APES). In addition, the therapeutic collaboration model suggests that the therapist can help clients' change if they join them working together within the client's TZPD. The current study aimed to analyze the relation between therapeutic exchanges within or outside of the TZPD, as coded using the TCCS, and clients' assimilation progress, as rated using the APES.

To do this, we investigated the relation between the quality of therapeutic collaboration and clients' APES levels in two cases of major depression treated with CBT. One client was considered as recovered and the other as improved-but-not-recovered. This was a systematic theory-building case study (Stiles, 2017); such studies can yield clinically meaningful observations that confirm or suggest ways to modify previous theoretical understandings (Caro Gabalda & Stiles, 2018). Thus, in addition to assessing support for the models, we aimed to keep our minds open to possible novelties or unexpected findings, which might signal a need for us to elaborate our theoretical understanding.

We addressed three questions: 1) What was the trajectory of therapeutic collaboration across sessions in each case? 2) How did the assimilation of problematic experiences develop in each case? 3) How were the different types of therapeutic exchanges, collaborative and not collaborative, related to lower and higher levels of assimilation? We expected that challenging interventions would be more accepted after the client had reached higher APES levels, specifically, above APES 3, the level at which the client can state the problem so verbal problem-solving can begin (Brinegar et al., 2006; Caro Gabalda & Stiles, 2018; Stiles, 2011).

To address the first question, we assessed the proportions of the main types of therapeutic exchanges across sessions. We expected to observe different trajectories in each case. In contrast with the non-recovered case, we expected to find increasing proportions of therapeutic exchanges involving challenging interventions followed by responses of tolerable risk and decreasing trajectories involving the client's responses of intolerable risk in the recovered case.

To address the second question, we tracked changes in APES levels across sessions in both cases. We expected to observe the recovered case to achieve at least APES 4, whereas the improved-but-not-recovered case remained at lower levels through the final phase of therapy.

To address the third question, for each case, we compared the proportions of each type of therapeutic exchange in interactions coded as lower APES levels with the proportions in interactions coded as higher APES levels. We hypothesized that the therapeutic exchange of Challenging-Tolerable risk would be relatively more common in exchanges at higher APES levels, and the therapeutic exchange of Supporting problem and Challenging-Intolerable risk would be relatively more common in exchanges at lower APES levels.

Method

Participants

Clients

Both cases were diagnosed with Major Depression Disorder (DSM-IV-TR; American Psychiatric Association, 2002). The diagnosis was based on an intake interview where the Structured Clinical Interview Diagnosis-I (SCID-I) and Beck Depression Inventory-II (BDI-II) were administered. This interview was done by the main researcher of the CoIPsi project from which these cases were selected. The CoIPsi project is a major investigation of therapist-client collaboration in psychotherapy.

Annie (a pseudonym) was a Portuguese, Caucasian female, 32 years old, single, with a bachelor's degree. She was a successful company manager. She lived with her parents. Annie remembers that, throughout her childhood, she felt responsible for her brother (seven years younger than Annie) while their parents were at work. This caregiver role expanded in her adult life to also concern colleagues and friends. She never had time to enjoy herself and felt as if she was "living the others' lives". Other people and her job were always first, and her personal life was in second place. Early in therapy, she mentioned that receiving attention felt like a strange experience, almost threatening. She had difficulty talking about love relationships and tended to deny feelings of love. Her difficulties in allowing herself to be cared for and receiving attention, particularly from men, were the main problem addressed in therapy. Her initial request was for help to balance her personal, emotional, and professional life.

Kate (a pseudonym) was a Brazilian, Caucasian female, 29 years old, single, and a Ph.D. student.

Kate lived alone. She was the oldest of three children. Her parents divorced when she was 19 years old. Kate described herself as picky and ambitious, aiming to build a family (husband and children) and expecting a successful career, but anxious about failure in both life aims. She asked for psychotherapeutic help after an intimate relationship break. She was suffering from apathy/sadness, having difficulty accepting that she had been betrayed by her boyfriend. They were colleagues, and she reported difficulties working in the same place. She presented as confused and intolerant regarding her feeling sad and vulnerable; this experience challenged her self-perception as a strong and independent woman. She asked for help to manage the experience of loss and regain her life goals.

Therapist and treatment

The same therapist treated both clients, a 49-years old female Ph.D. clinical psychologist with 22 years of clinical experience practicing CBT. Treatment was based on the individual brief CBT approach (Leahy et al., 2012). Typical strategies included cognitive and behavioral self-observation, behavior activation, cognitive restructuring, and relapse prevention. Treatment was based on cognitive-behavior principles and strategies, though it did not follow a manualized protocol. The therapist selected and adjusted CBT strategies according to the each client's problems, problem maintenance mechanisms, and the consensual therapy goals. The therapeutic adherence was monitored in weekly clinical team meetings, which provided peer supervision regarding each case.

After the clinical assessment (at the intake session), the therapist and client discussed the case's formulation and treatment goals. Both cases received 16 one-hour sessions occurring weekly (with a few exceptions), plus two follow-up sessions (one month and two months after the last treatment session).

APES raters and TCCS coders

One pair of judges rated APES levels in both cases: a Ph.D. student and a researcher with a master's degree in clinical psychology. An additional judge, who had training and prior extensive experience in APES research, audited their ratings. A different pair of judges did TCCS coding in both cases; both had master's degrees in clinical psychology. A Ph.D. student member of the therapeutic collaboration research team, who had training and experience in coding several cases using the TCCS, was the auditor in both cases. All judges were unaware of the case's outcome. They were trained to code with APES (Stiles et al., 1990) or TCCS (Ribeiro et al., 2013), respectively, as described in the Procedure section.

Measures

Outcome Questionnaire-45.2 (Lambert et al., 1996; Portuguese version by Machado & Fassnacht, 2014): The OQ-45.2 is a widely used self-report questionnaire to evaluate therapy outcomes. There are 45 items, scored from 0 to 4, which measure the client's current psychological distress, interpersonal functioning, social performance, and clinical symptoms. Total scores can range from 0 to 180. The Portuguese version has a Reliable Change Index of 15 points, with a clinical cutoff score of 62 points, and good internal consistency and reliability (Cronbach's alpha was between .60 and .92 and Test-Retest reliability was between .41 and .80).

The Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1990): The APES distinguishes eight levels, ranging from level 0 (Warded off) to level 7 (Mastery), which describe the changing relation of a target problematic experience to the self. Usually, researchers choose just one or a few problematic themes to investigate, one(s) that appear repeatedly and are central to the case (Caro Gabalda & Stiles, 2018). A theme is understood as all passages that refer to a target problematic experience.

Therapeutic Collaboration Coding System (TCCS; Ribeiro et al., 2013): The TCCS is an observational and transcript-based coding system developed to analyze therapeutic collaboration moment-by-moment. It takes each pair of adjacent speaking turns as the unit of analysis, contextualized on the immediately preceding therapeutic exchange. In a first step, judges code the therapist's interventions as supporting problem, supporting innovation, or challenging and clients' responses as validation, invalidation, and ambivalence. More specifically:

> **Therapist interventions.** When supporting (reflecting, questioning, summarizing, or demonstrating interest), the therapist is coded as supporting either (a) the client's usual perspective (supporting problem) or (b) innovative emergent perspectives (supporting innovation), depending on the client's current focus. When challenging (interpretating, confronting, inviting the client to a new action), the therapist proposes an alternative to the client's usual perspective or tries to extend the innovative one, pushing the client closer to her potential developmental level within the TZPD.
>
> **Client responses and experiences.** The client's validation, invalidation, or ambivalence responses indicate the therapist's intervention's appropriateness and the level of comfort or risk they elicit. If the client validates the therapist's proposal by confirming or giving information, this

is coded as an experience of safety. If the client elaborates on the therapist's proposal, this is coded as an experience of tolerable risk. If the client invalidates the therapist's proposal by expressing a lack of involvement and suggesting that the therapist is being redundant, the response is coded as an experience of disinterest. If the client invalidates the therapist's proposal by expressing confusion, rejecting it, disagreeing with the therapist, or defending the usual perspective, the response is coded as an experience of intolerable risk. If a client validates and invalidates the therapist's proposal in the same speaking turn, this is coded as an experience of ambivalence.

Therapeutic Exchanges. The intersection of three categories of therapist interventions and five categories of client response/experiences defines 15 types of therapeutic exchange.

It is important to note that the Therapeutic Collaboration Model (Ribeiro et al., 2013) and the Assimilation Model (Stiles et al., 1990) consider the concept of problem and problematic in distinct but complementary ways. The assimilation model (Stiles et al., 1990) takes the perspective of the client's dominant self. It means that experiences (past or present) are problematic when they are painful, unacceptable, or incompatible with their usual self. On the other hand, the therapeutic collaboration model (Ribeiro et al., 2013) takes the perspective of the therapist. From his/her perspective, the problem is the client's usual self-narrative, a schema that rigidly fails to accommodate some important (i.e., innovative) experiences.

We have not resolved the issue in this article, but we have tried to consistently use problematic experience or problematic voice to refer to the intruding experience and problematic perspective or problematic narrative to refer to the schema that fails to accommodate it. We ask readers to keep this different usage in mind.

Procedure

Two cases were selected from the dataset of the CoIPsi Project, which had been approved by the institutional ethical committee (CA_CIPsi-072012). The dataset of 26 clients included 21 completer cases and 5 dropouts. Both therapist and clients signed informed consent, in which they agreed with the project procedures and gave permission to use their data in publications. Using the TCCS and the APES, we analyzed sessions for which the video records were available, which included 13 sessions in Annie's case (Improved-but-not-recovered) and 15 sessions in Kate's case (Recovered). Although 16 sessions were

delivered to both cases, due to recording problems, we did not analyze a few sessions (i.e., sessions 10, 14, and 15 in Annie's case and session 12 in Kate's case). We did not analyze the follow-up sessions. The OQ-45.2 was administered before the first and the last session of the treatment and the follow-up sessions.

Case selection

The cases of Annie and Kate were selected to meet the following criteria, 1) a primary diagnosis of depression based on the SCID-I, 2) the same therapist, 3) treatment conducted with a CBT approach, 4) availability of recorded sessions, and 5) contrasting outcomes at the end of therapy. Outcomes were evaluated as meeting or not meeting criteria for reliable and clinically significant improvement (RCSI; Jacobson & Truax, 1991) observed on the OQ-45.2 from intake to the last session. Achieving reliable change required a pre-post difference of at least 15 points on the OQ-45.2; clinically significant improvement required a decrease from above to below the clinical cutoff score of 62 (see Jacobson & Truax, 1991, for formulas). A recovered classification required meeting both RCSI criteria.

At the end of therapy, Annie was classified as improved-but-not-recovered (InR). Her pre-therapy OQ-45.2 score was 107, dropping to 81 at therapy termination. This was a decrease of more than 15 points, but still in the clinical range. At the follow-up sessions, she dropped to an OQ-45.2 score of 77.

At the end of therapy, Kate was classified as recovered (R). Her pre-therapy OQ-45.2 score was 119, dropping to 34 at therapy termination (below the clinical range). At the follow-up sessions, her OQ-45.2 score dropped to 30.

TCCS coding

Annie and Kate's cases were transcribed and coded following the TCCS procedure described by Ribeiro et al. (2013). Two pairs of trained and reliable judges read all sessions of both cases. Based on the first two sessions, the judges consensually decided on the problems to consider in coding. In addition, considering the dyad's negotiated therapy goals, they identified the client's potential changes (innovations). Table 5 shows the problems and innovations identified by judges at the beginning of TCCS coding for each case.

The two TCCS judges independently coded 30% of all sessions of each case (4 entire sessions in Annie's case and 4 entire sessions in Kate's case) according to the TCCS. In Annie's case, judges agreed on 80.7% of the therapists' interventions codes and 86.5% of the client's responses codes. In Kate's case, the judges agreed on 86.4% of the therapist's interventions codes and 85.5% of the client's responses

codes. Disagreements were resolved by discussion to consensus between coders and the auditor. Next, one of the judges of each pair coded all the remaining entire sessions (9 sessions in Annie's case and 11 sessions in Kate's case), and finally, a third trained TCCS judge audited the final codes. The auditor's role was to try to understand the coders' disagreements and doubts in coding and moderate a discussion and a negotiation of consensus on the most appropriate codes. In the case of Annie, the judges coded 1,328 therapeutic exchanges, of which 603 were analyzed (because they were also rated with the APES; see below). In the case of Kate, the judges coded 2,476 therapeutic exchanges, of which 1,192 were analyzed.

Table 5

Problems and Innovations in the cases of Annie and Kate, with examples from session dialogue

Cases	Problems	Innovation
Annie	Difficulty in intimate and close relationships (CI: "*I tend to deny*") Difficulty in accepting attention from others (T: "*Take care of others is something that you know how to do well. It's almost difficult not to take care!*" CI: "*Yes, it's impossible. It's intrinsic to me*") Conflictual interactions with her boss (CI: "*Maybe I'm the one who denies that there's more than a professional relationship here [...] and this is creating such instability*") Difficulty in managing and delegating work tasks (CI: "*I dedicated much time to other people and my company and I didn't live my life*")	To be comfortable with closer relationships (CI: "*Above all, I also like the person [boss], not exactly the professional side. I gained this awareness. The person is important. He fills up a piece of me, which is empty. He gives color to that piece*") To be comfortable with being cared for by others (CI: *"The fact is that I'm not prepared to [...] have this affection*". T: "*To be taken care by others*") To be able to solve conflicts with the boss (T: "*What you did was to relativize what he was dramatizing. It seems that his behavior changed because you also had an attitude of no dramatizing the situation*") To balance her personal and professional life (CI: "*Apart this moment that I have here, I don't have more moments to think about me [...] to understand what's happening in my life and what's making me lose my balance and stability emotional*") To be available to new life scenarios beyond work (T: "*You were demanding this need to stop, to have your own life, a personal life, to diversify the spaces in of her life. The feeling that I have is that you are appropriating more of this, as a goal*")

Kate	Apathy/sadness/anger (CI: "*I left here really angry. But when I went to bed, I already felt unfortunate, sad*") Difficulty accepting the end of her intimate relationship (CI: "*How is that possible? After all, he still does that. How can there be such a person? A heartless person. He hasn't soul*") Loss of interest in usually pleasurable experiences (CI: "*I have tried to read, but I'm not interested*") Difficulty in managing professional work with her ex-boyfriend (CI: "*I'm not in the mood to work. It makes me feel bad. And sometimes he (ex-boyfriend) goes by, once I'm still in the laboratory, sometimes he goes by, and then I ask, 'What is he doing here? Why hasn't he disappeared from the earth yet?'*") The feeling of being stagnated in life (CI: "*My life isn't moving forward*")	To reactivate her interest in usual activities or to be involved in new ones (CI: "*I want to overcome this sadness, anxiety. I want to deal with all this. I want to be what I used to be*") To activate her social network and create opportunities to meet new people (T: "*Trusting someone again means that you will have to be available to meet new people, to be with new people'*") To regulate her emotions and behaviors in the work context with her ex-boyfriend (T: *"Do you think it's possible, once he's there [at lab], you don't focus on him, not be looking at him all the time?*" CI: "*Not yet, but that's what I want*")

APES rating

APES rating followed the procedure described in previous studies (e.g., Basto et al., 2018, 2021). Training consisted of reading and discussing journal articles and the rating manual, followed by practice on cases not included in the current study. The two APES judges' ratings of the practice cases were compared to assess the reliability. Discrepancies were discussed with an experienced judge and resolved by discussion to consensus. The judges were considered reliable when they reached interrater reliability of ICC [2,1] ≥ .60 (Shrout & Fleiss, 1979).

The APES judges first read all the sessions of both Annie and Kate's cases. They were unaware of the cases' outcome and the TCCS coding. Based on clinical relevance and prevalence, the judges consensually chose the theme that stood out as the main problem in each case.

In Annie's case, the judges distinguished interpersonal functioning as the theme. They described her dominant voice as needing to take care of others, to be strong and independent (Therapist: "To take care of others is something that you know how to do well. It's almost difficult not to take care of! Annie: Yes, it's impossible. In my case, it's impossible [...] it's intrinsic to me"). The judges described the problematic voice as having difficulty in close relationships (Annie: "He's a person who likes to touch. And sometimes I don't react very well"), inflexible attitude, and often feeling undervalued (Annie: "Daily, I almost feel as if I have been received an incompetence's certificate [...] I feel that people are using me to reach something [...] there isn't reward, there isn't gratefulness").

In Kate's case, the judges identified difficulties in her relationship with her ex-boyfriend as the main theme. They characterized Kate's dominant voice as the desire to be perfect, strong, and independent (Kate: "I'm feeling that my life should move forward [...] This means to succeed at work, to have a stable partner because soon I'm going to be 30 years old"). As it was challenging to achieve all these goals at the same time, Kate felt she was failing. The problematic voice that emerged was described as vulnerability manifested in the fear of being a failure and anger of being abandoned (Kate: "I'm afraid not to meet somebody and to continue single, an old maid").

Next, the judges extracted all passages dealing with these themes. In the case of Annie, they analyzed 268 passages, including 93 passages in the initial phase (first four sessions), 114 in the middle phase (sessions between 5 and 11), and 61 in the final phase (from session 12 to the end of therapy). In the case of Kate, they analyzed 413 passages, including 145 passages in the initial phase (first four sessions), 208 in the middle phase (sessions between 5 and 11), and 60 in the final phase (from session 13 to the end of therapy). The judges rated them independently and showed good reliability: ICC [2,1] = .76 in Annie's case and ICC [2,1] = .83 in Kate's case. Disagreements in voice characterizations, selected passages, and ratings were resolved by discussion to consensus between the judges (Hill et al., 2005). A third experienced and trained APES judge participated in these discussions.

Data analysis

We analyzed therapeutic collaboration and APES progress in passages dealing with the clients' main themes, both of which involved maladaptive interpersonal functioning (an interpersonal rupture in the case of Kate, and difficulty engaging in interpersonal relationships in the case of Annie).

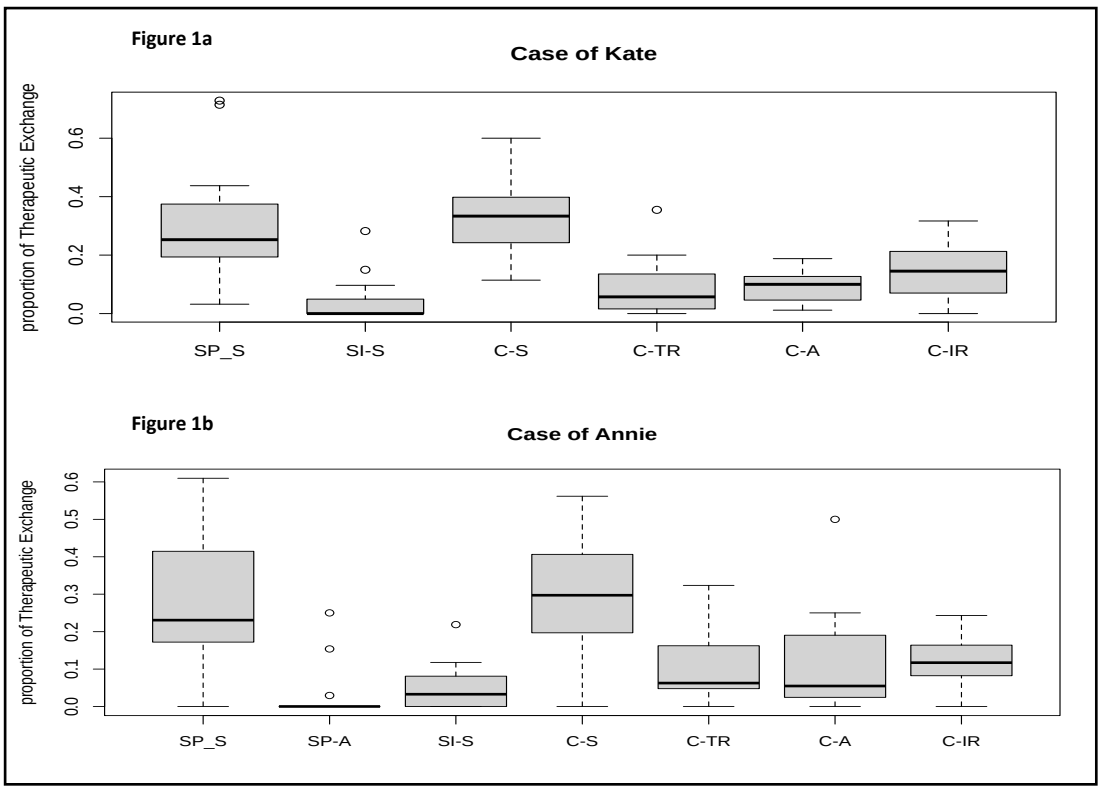
For analyzing our results, we used only those TCCS-coded passages that corresponded to the APES-rated passages (e.g., Table 6). For our exploratory analyses, we considered only those types of TCCS therapeutic exchanges that individually accounted for at least 10% of the exchanges (out of 15 different types of exchanges). These included seven of the 15 types of therapeutic exchanges in the case of Kate (Table 7a) and six of the 15 types in the case of Annie (Table 7b and Figure 1).

To address our first research question, we plotted, for each case, the trajectory across sessions of the proportion of each included type of therapeutic exchange. To compare these trajectories, we calculated the difference between the proportions of therapeutic exchanges in the last and first sessions. To address the second question, we plotted the APES ratings of the included passages for each case, and we performed an exploratory analysis to describe the clients' changes across sessions. To address the third question, we compared the distribution of the proportion of each type of therapeutic exchange,

within the same case, for interactions coded as APES less or equal to 3 and interactions coded as APES greater than 3. The distributions were compared using *t*-test for differences in the sample means. All the analyses were performed using *Software R*.

Figure 1

Proportions of therapeutic exchanges in Kate and Annie's case



Note. SP-S (Supporting problem-Safety); SP-A (Supporting problem-Ambivalence); SI-S (Supporting innovation-Safety); C-S (Challenging-Safety); C-TR (Challenging-Tolerable risk); C-A (Challenging-Ambivalence); C-IR (Challenging-Intolerable risk).

Results

What was the therapeutic exchanges across sessions in each case?

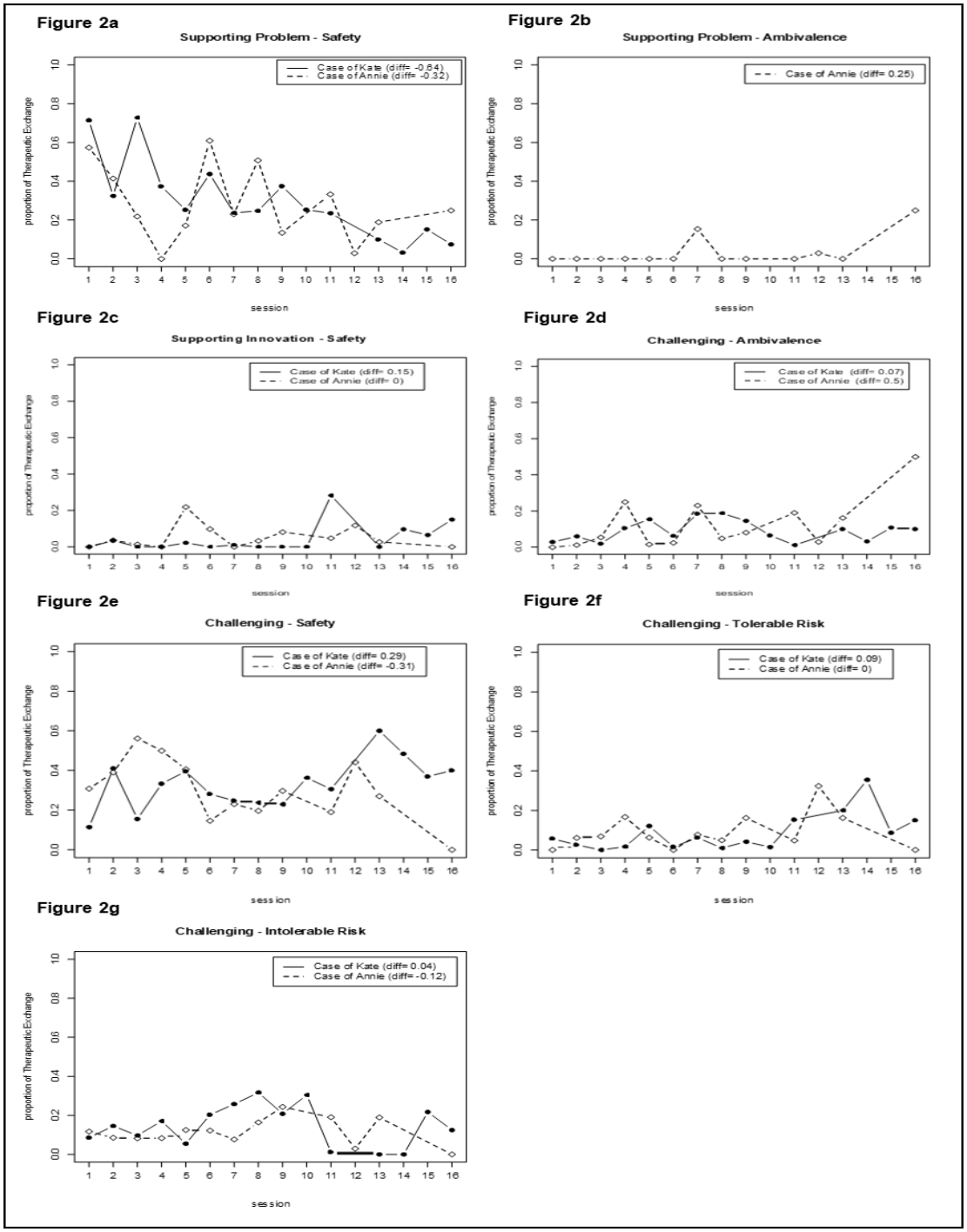
Figure 2a to Figure 2g plots the trajectories of each type of therapeutic exchange used for 10% or more of the exchanges in each case. The difference between the proportions in the last and first sessions is presented in the figures for each case. Note that throughout the Results, "session" refers to

the included (i.e., TCCS-coded, and APES-rated) exchanges within each session, not all of the session dialogue.

In Annie's case, there was an increase in the proportion of Challenging-Ambivalence in the last session (that is a therapeutic exchange at the limit of client's TZPD), which was not observed in Kate's case (Figure 2d). Supporting problem-Ambivalence also increased in Annie's last session, but this type of exchange did not meet the 10% criterion in Kate's case (Figure 2b). In the case of Kate, there was a greater decrease in Supporting problem-Safety (Figure 2a) and a slightly greater increase in Supporting innovation-Safety (Figure 2c). Challenging-Safety exchanges decreased for Annie and increased for Kate (Figure 2e).

Figure 2

Comparative therapeutic exchanges trajectories in Kate and Annie's case



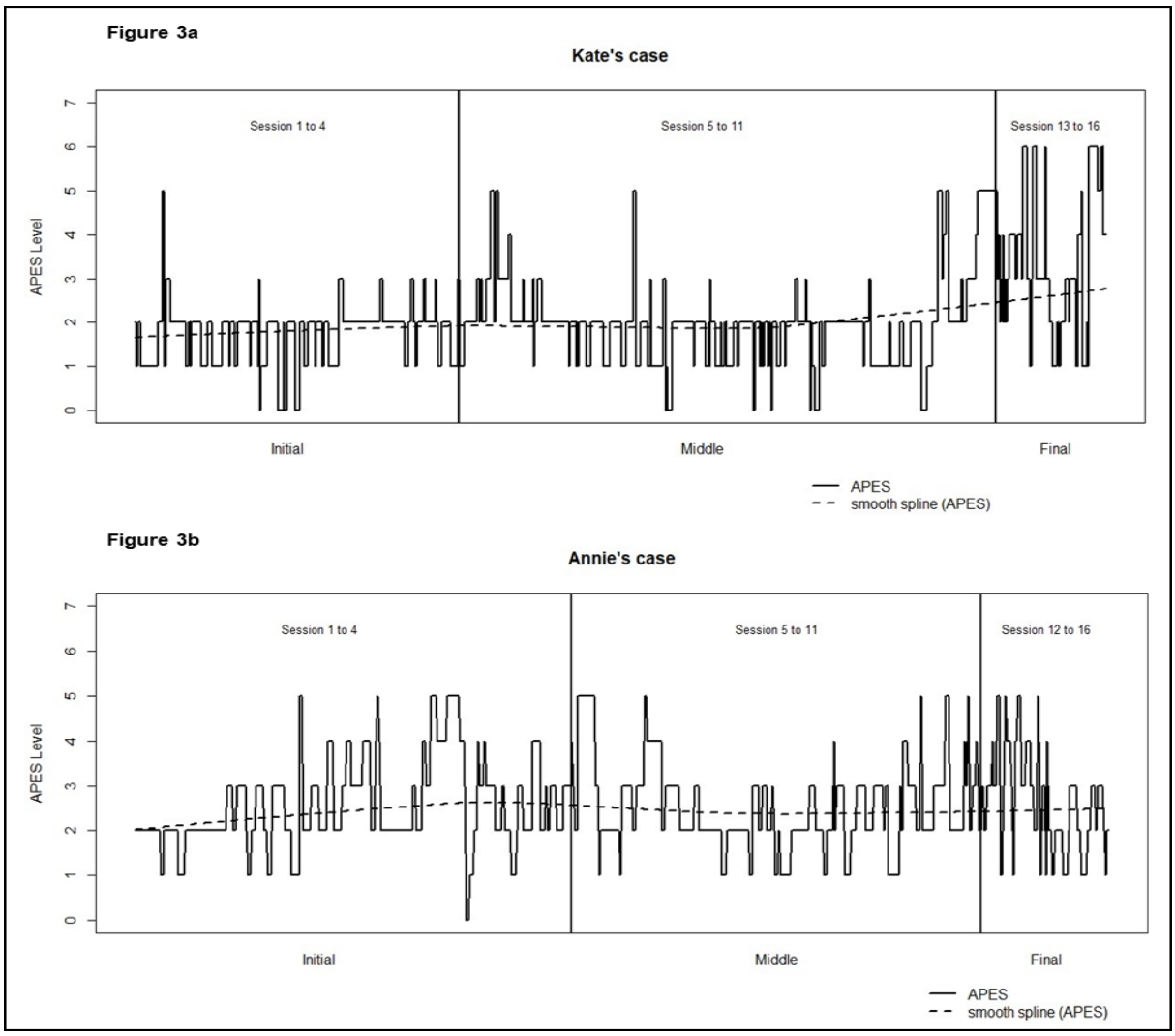
How did the assimilation of problematic experiences develop in each case?

As shown in Figure 3, Kate (Figure 3a) achieved higher APES levels than did Annie (Figure 3b), and levels higher than APES 4, usually associated with a good outcome (Detert et al., 2006), were reached

in her later sessions. The very irregular pattern of APES levels from passage to passage, observed in both cases, is characteristic of assimilation progress (Caro Gabalda & Stiles, 2018, 2020).

Figure 3

Assimilation of Problematic Experiences (APES) per session in Kate and Annie's case



Note. APES 0 (Warded off), APES 1 (Unwanted thoughts), APES 2 (Vague awareness/Emergence), APES 3 (Problem statement/Clarification), APES 4 (Understanding/Insight), APES 5 (Application/Working through), APES 6 (Problem solution), APES 7 (Mastery).

How were the different types of therapeutic exchanges related to lower and higher levels of assimilation?

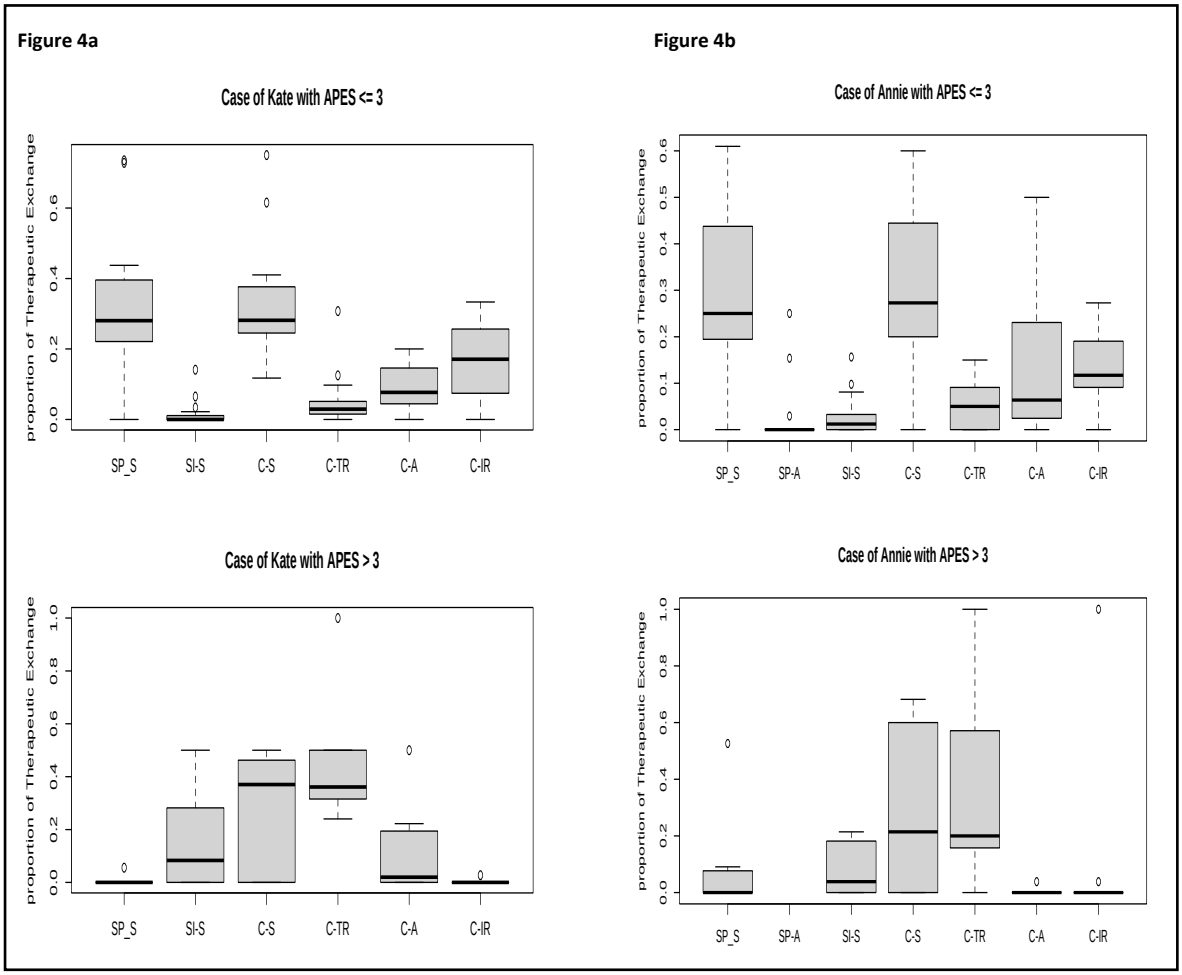
For each of the two cases, we compared the proportions of therapeutic exchanges with APES

ratings lower than or equal to level 3 versus exchanges with APES ratings higher than level 3. In the case of Kate, the *t*-test for the differences between the means of these two sets of proportions (for APES <=3 vs. APES >3), showed that there was a significant difference for the following therapeutic exchanges: Supporting problem-Safety ($p < 0.001$), Challenging-Tolerable risk ($p = 0.002$), and Challenging-Intolerable risk ($p < 0.001$). The differences for Supporting innovation-Safety, Challenging-Safety, and Challenging-Ambivalence were not significant. Passages with APES <=3 had relatively more therapeutic exchanges coded as Supporting problem-Safety, Challenging-Ambivalence, and Challenging-Intolerable risk, whereas the passages with APES >3 had more therapeutic exchanges coded as Supporting innovation-Safety, Challenging-Safety, and Challenging-Tolerable risk (Figure 4a). Thus, our hypothesis that challenging interventions would be more accepted at the higher APES levels than at the lower APES levels was supported for the recovered case.

In the case of Annie, the *t*-test for the differences between the mean proportions of exchanges rated as APES <=3 versus APES >3 showed that there was a significant difference for exchanges coded as Supporting problem-Safety ($p = 0.010$), Challenging-Tolerable risk ($p = 0.026$), and Challenging-Ambivalence ($p = 0.008$). There were no significant differences for exchanges coded as Supporting innovation-Safety, Challenging-Safety, and Challenging-Intolerable risk ($p = 0.298$; $p = 0.801$, and $p = 0.878$, respectively). Passages rated as APES <= 3 were characterized by more therapeutic exchanges of Supporting problem-Safety, Supporting problem-Ambivalence, Challenging-Ambivalence, and Challenging-Intolerable risk, whereas passages rated as APES > 3 were characterized by more therapeutic exchanges of Challenging-Tolerable risk (Figure 4b). Therefore, our hypothesis regarding the link between types of therapeutic exchanges and APES levels was also confirmed for the improved-but-not-recovered case, except for the exchange of Challenging-Intolerable risk.

Figure 4

Characterization of therapeutic exchanges (TCCS) in lower and higher levels of assimilation (APES) in Kate and Annie's



Note. SP-S (Supporting problem – Safety); SP-A (Supporting problem – Ambivalence); SI-S (Supporting innovation – Safety); C-S (Challenging – Safety); C- TR (Challenging – Tolerable risk); C-A (Challenging – Ambivalence); C-IR (Challenging – Intolerable risk).

Table 6

Example of therapeutic exchanges corresponding to the APES passages in the case of Kate at session 16

Therapist-Client	Speaking-turn	Therapeutic exchanges and APES coding
Therapist	Regarding your work, you talked a lot about it. How was it this week?	(Supporting problem)
Kate	It's going well. I had the meeting last week and it went well.	(Tolerable risk; APES 6 – Problem solution)
Therapist	Is it?	(Supporting innovation)
Kate	Yeah. It went well, we are going to continue what we were doing [...] Let's see if there is enough data to publish.	(Safety; APES 6 – Problem solution)
Therapist	Hm-hm. OK. How do you feel about it?	(Supporting innovation)
Kate	Fine!	(Safety; APES 6 – Problem solution)
Therapist	Excited?	(Supporting innovation)
Kate	Yeah. I feel really good!	(Safety; APES 6 – Problem solution)
Therapist	Good!	(Supporting innovation)
Kate	I feel really good!	(Safety; APES 6 – Problem solution)
Therapist	How does you feel about this? Because this meeting came from you, didn't it?	(Challenging)
Kate	Yes.	(Safety; APES 6 – Problem solution)
Therapist	How did you fell after the meeting and this result?	(Challenging)
Kate	I felt proud. I have the reins of the situation in my hands.	(Tolerable risk; APES 6 – Problem solution)
Therapist	Hm-hm. This idea is a [...] A controlling in some way, what is going on in your life is something that is being important.	(Challenging)
Kate	Yeah.	(Safety; APES 6 – Problem solution)
Therapist	Hm-hm. Which is giving you energy and pride.	(Challenging)
Kate	Yes, it is. Exactly that, energy and pride at the same time.	(Safety; APES 6 – Problem solution)

Table 7a

Therapeutic exchanges (TCCS) per session in the case of Kate

Therapeutic-exchanges in the case of Kate	Sessions														
	1	2	3	4	5	6	7	8	9	10	11	13	14	15	16
Supporting Problem - Safety	65,79	30,40	69,44	35,94	23,47	42,42	22,55	23,15	35,29	24,82	21,51	9,09	3,13	14,29	7,14
Supporting Problem - Tolerable Risk	0,00	1,60	0,00	0,00	2,04	0,00	1,96	0,00	0,00	0,00	2,15	0,00	0,00	2,04	4,76
Supporting Problem - Ambivalence	2,63	0,00	1,85	0,00	1,02	0,00	1,96	1,85	1,96	0,71	1,08	0,00	0,00	2,04	0,00
Supporting Problem - Disinterest	0,00	0,80	0,00	1,56	1,02	1,52	0,00	0,00	0,00	0,00	1,08	0,00	0,00	0,00	0,00
Supporting Problem - Intolerable Risk	2,63	0,00	2,78	0,00	0,00	0,00	0,00	1,85	3,92	0,71	1,08	0,00	0,00	2,04	0,00
Supporting Innovation - Safety	0,00	3,20	0,00	0,00	2,04	0,00	0,98	0,00	0,00	0,00	25,81	0,00	9,38	6,12	14,29
Supporting Innovation - Tolerable Risk	2,63	0,00	0,00	0,00	1,02	0,00	0,00	0,93	0,00	0,00	1,08	0,00	3,13	0,00	0,00
Supporting Innovation - Ambivalence	0,00	1,60	0,00	0,00	1,02	0,00	0,00	0,93	0,00	0,00	0,00	0,00	0,00	0,00	0,00
Supporting Innovation - Disinterest	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	1,08	0,00	0,00	0,00	0,00
Supporting Innovation - Intolerable Risk	0,00	0,00	0,00	0,78	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00
Challenging - Safety	10,53	38,40	14,81	32,03	36,73	27,27	23,53	22,22	21,57	35,46	27,96	54,55	46,88	34,69	38,10
Challenging - Tolerable Risk	5,26	2,40	0,00	1,56	11,22	1,52	5,88	0,93	3,92	1,42	13,98	18,18	34,38	8,16	14,29
Challenging - Ambivalence	2,63	5,60	1,85	10,16	14,29	6,06	17,65	17,59	13,73	6,38	1,08	9,09	3,13	10,20	9,52
Challenging - Disinterest	0,00	2,40	0,00	1,56	1,02	1,52	0,98	0,93	0,00	0,71	1,08	9,09	0,00	0,00	0,00
Challenging - Intolerable Risk	7,89	13,60	9,26	16,41	5,10	19,70	24,51	29,63	19,61	29,79	1,08	0,00	0,00	20,41	11,90
Total	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00

Table 8b

Therapeutic exchanges (TCCS) per session in the case of Annie

Therapeutic-exchanges in the case of Annie	Sessions												
	1	2	3	4	5	6	7	8	9	11	12	13	16
Supporting Problem - Safety	55,67	40,96	20,78	0,00	16,67	55,56	21,43	48,44	12,82	28,00	2,78	17,95	25,00
Supporting Problem - Tolerable Risk	0,00	0,00	3,90	7,14	0,00	6,67	0,00	0,00	0,00	0,00	2,78	0,00	0,00
Supporting Problem - Ambivalence	0,00	0,00	0,00	0,00	0,00	0,00	14,29	0,00	0,00	0,00	2,78	0,00	25,00
Supporting Problem - Disinterest	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	2,56	0,00	0,00	0,00	0,00
Supporting Problem - Intolerable Risk	2,06	0,00	1,30	0,00	1,52	0,00	7,14	1,56	2,56	0,00	0,00	2,56	0,00
Supporting Innovation - Safety	0,00	3,61	1,30	0,00	21,21	8,89	0,00	3,13	7,69	4,00	11,11	2,56	0,00
Supporting Innovation - Tolerable Risk	0,00	0,00	0,00	7,14	0,00	2,22	0,00	0,00	0,00	4,00	2,78	2,56	0,00
Supporting Innovation - Ambivalence	0,00	0,00	0,00	0,00	0,00	0,00	0,00	3,13	0,00	8,00	0,00	0,00	0,00
Supporting Innovation - Disinterest	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00
Supporting Innovation - Intolerable Risk	0,00	0,00	0,00	0,00	1,52	0,00	0,00	0,00	0,00	4,00	0,00	0,00	0,00
Challenging - Safety	29,90	38,55	53,25	42,86	39,39	13,33	21,43	18,75	28,21	16,00	41,67	25,64	0,00
Challenging - Tolerable Risk	0,00	6,02	6,49	14,29	6,06	0,00	7,14	4,69	15,38	4,00	30,56	15,38	0,00
Challenging - Ambivalence	0,00	1,20	5,19	21,43	1,52	2,22	21,43	4,69	7,69	16,00	2,78	15,38	50,00
Challenging - Disinterest	1,03	1,20	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00	0,00
Challenging - Intolerable Risk	11,34	8,43	7,79	7,14	12,12	11,11	7,14	15,63	23,08	16,00	2,78	17,95	0,00
Total	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00	100,00

Discussion

Our observations in this comparative case study showed some differences in the patterns of therapeutic exchanges between the two clients, Kate, who met RCSI criteria for recovery, and Annie, who was improved-but-not-recovered.

Specifically, exchanges involving therapists' interventions focused on innovations (changes) tended to increase in Kate's case. In general, these results were consistent with therapeutic collaboration theory and with findings in other comparative TCCS case studies involving different therapy approaches (e.g., Ferreira et al., 2015; Ribeiro et al., 2016, 2021). In the case of Annie, we observed different trajectories of therapist interventions and client's responses in the last sessions when comparing with the poor outcome cases in previous studies. Namely, we found a decrease in the therapeutic exchanges of Supporting problem-Safety and an increase in the therapeutic exchanges involving ambivalent responses. This is regardless of the therapist's challenging or supporting the client's perspective. Comparing with the case study in emotion-focused therapy by Ribeiro et al. (2016), it is interesting to note that there were more consistent results regarding the good outcome case than with the poor outcome case. Although the focus of the dyad works on the client's problems was prevalent in both poor outcome cases, the therapeutic exchanges involving ambivalent responses were rare in the poor outcome case in EFT.

Therapeutic exchanges involving the client's response of ambivalence seem important for understanding therapeutic collaboration in the case of Annie, where exchanges of Supporting problem-Ambivalence emerged and exchanges of Challenging-Ambivalence increased across therapy. Compared with previous comparative cases studies, the increase of Supporting problem-Ambivalence was new. Annie's ambivalent responses (an oscillation between accept and reject the therapist proposals) may have created an opportunity for the therapist check her actual resources and assess her TZPD. Insofar as Annie met criteria for reliable improvement (albeit short of clinically significant), Annie was not a poor outcome case. Although Annie's ambivalence could have reflected a lack of psychological resources for responding to the therapist's proposals, another possible interpretation is that the therapist's attempts to understand Annie's problems (supporting her perspective) were inaccurate or inadequate, so it was followed by an ambivalent response.

Theoretically, whether the resolution of ambivalent therapeutic exchanges situates the

dyad work closer the upper limit of client's TZPD or closer the lower limit of client's TZPD would indicate the clients' actual resources or needs. This was not analyzed in the current study, but it is a hypothesis worthy of future study.

Our finding that Kate achieved APES levels higher than level 4 later in therapy (Figure 3a) was consistent with assimilation theory and with previous results for good outcome cases (e.g., Basto et al., 2018; Detert et al., 2006; Ribeiro et al., 2016). Annie's achieving APES 4 early in therapy but not later (Figure 3b) is more unusual, though taken by themselves, the lower APES levels in the final phase was consistent with other poor outcome cases (e.g., Basto et al., 2018; Caro Gabalda, 2006; Mendes et al., 2006).

Our results confirmed the main hypothesis that, compared with the therapeutic exchanges used at lower APES levels (APES <=3), exchanges used at higher APES levels (APES > 3) were more likely to be closer to the upper limit of the client's TZPD (Challenging-Tolerable risk) and less likely to be outside the clients' TZPD. The results also confirmed the theoretical expectation that interventions focused on the client's usual perspective followed by client acceptance (i.e., Supporting problem-Safety) were relatively more likely in passages coded as lower APES levels (APES <=3) in both cases. That is, results from both cases offer support for our linking of the therapeutic collaboration model with the assimilation model.

Other observations can help explain what distinguished the case of Kate and the case of Annie. First, the passages rated as higher APES levels in the case of Kate seem to be characterized by comfortable therapeutic exchanges in which the therapist's interventions were focused on innovation, either challenging Kate's usual perspective or supporting her emergent innovation. This pattern did not emerge in the case of Annie.

For Annie, the therapeutic exchanges at the limit of Annie's TZPD, eliciting ambivalence, seemed to be relevant to understanding why her assimilation did not progress consistently. Annie's passages rated at lower APES levels were frequently characterized by therapeutic exchanges of Supporting problem-Ambivalence and Challenging-Ambivalence. This evidence of Annie's resistance to the therapist's proposals, together with the increasing trajectories of these ambivalent therapeutic exchanges (Figure 2d), converges with results of other studies using the TCCS in poor and dropout cases, where ambivalence-eliciting exchanges at the upper limit of the client's TZPD increased at the end of therapy (e.g., Pinto et al., 2018; Ribeiro, A. et al., 2016). It seems that Annie's engagement in therapy was difficult, which suggests resistance to change (Engle & Arkowitz, 2006).

Consistently with research showing that progress in APES is not linear (e.g., Caro Gabalda & Stiles, 2018, 2020), we speculate that Annie's ambivalence about her therapist's interventions may help explain her difficulties in making progress, manifested perhaps in her APES fluctuation pattern (Figure 3a). Theoretically, whether ambivalent therapeutic exchanges (namely Challenging-Ambivalence) precede or follow the therapeutic exchanges of Challenging-Tolerable risk, suggests different therapist responsiveness qualities. Investigating such differences would require an interactional sequential design, which is beyond the scope of the present study but may offer fruitful possibilities for future work.

Limitations and Future directions

Of course, we cannot generalize the results of these or any specific cases. However, the therapeutic collaboration and assimilation theories provide a good deal of generality. To the extent that these case studies support the theory, our results add a small increment of confidence to these already-general theories. In addition, case studies can help enrich an understanding of the within-therapy processes in a contextualized way.

Our study compared a recovered case (Kate) with an improved case (Annie), which offered less of a contrast than the more typical comparison of good and poor outcome cases. Perhaps a sharper contrast in outcomes would have yielded clearer differences in the therapeutic collaboration trajectories and APES progress between cases. However, it might not have highlighted the role of the ambivalent therapeutic exchanges that helped elucidate the therapeutic process in Annie's case.

Mindful that our interpretations are very tentative, we suggest that the observed associations of therapeutic exchanges and the APES levels might inform therapists about how to adjust their interventions to clients' experiences and needs, indicating when challenging the client's perspective and supporting the emergent innovation is most likely to promote progress in the assimilation of problematic experiences in CBT. Although the assimilation model and therapeutic collaboration model are considered transtheoretical, different patterns of association of these variables may emerge in good and poor outcome cases of other therapy approaches, such as less directive or more client-centered approaches. To support and expand our results, we suggest repeating this comparative case study with a poor outcome (rather than an improved) case and with different disorders, and therapeutic approaches.

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ESTUDO II -

THERAPEUTIC COLLABORATION IN A COMFORT ZONE: A NON-IMPROVED BORDERLINE PATIENT PSYCHOTHERAPY CASE STUDY

THERAPEUTIC COLLABORATION IN A COMFORT ZONE: A NON-IMPROVED BORDERLINE PATIENT PSYCHOTHERAPY CASE STUDY[2]

Abstract

Introduction: The quality of dyad interaction seems crucial to the client's decision to dropout of psychotherapy. Aim: To characterize the client's lack of change and the patterns of therapeutic collaboration in a dropout of Psychodynamic Therapy for Borderline Personality Disorder (BPD). Method: We used the Therapeutic Collaboration Coding System (TCCS) to assess collaborative work and the Assimilation of Problematic Experiences Scale (APES) to rate client change. The *Software GridWare* was used to characterize patterns of therapeutic collaboration and the *Software R* to describe the client's change. Results: The dyad worked in a comfort zone for the client, with the therapist supporting the client's problematic perspective and the client responding with safety. The APES results showed that the client did not change, remaining in control through avoidance of thinking and discussing his problematic experience. Discussion: Our results challenge the potential impact of the therapists' interventions on BPD clients' comfort zone, suggesting that too much focus on their Therapeutic Zone of Proximal Development's actual level might not be productive.

Resumo

Introdução: A qualidade da interação da díade parece crucial para a decisão do cliente de abandonar a psicoterapia. Objetivo: Caracterizar a não mudança do cliente e os padrões de colaboração terapêutica em um caso de desistência da Terapia Psicodinâmica para perturbação de personalidade borderline. Método: Utilizamos o Sistema de Codificação da Colaboração Terapêutica (SCCT) para avaliar o trabalho colaborativo e a Escala de Assimilação de Experiências Problemáticas (EAEP) para avaliar a mudança do cliente. O *Software GridWare* foi utilizado para caracterizar os padrões de colaboração terapêutica e o *Software R* para descrever a mudança do cliente. Resultados: A díade trabalhou em uma zona de conforto para o cliente, com a terapeuta apoiando a perspetiva problemática e o cliente respondendo com segurança. Os resultados da EAEP mostraram que o cliente não mudou, permanecendo no controle, evitando pensar e discutir sobre sua experiência problemática. Discussão: Nossos resultados desafiam o potencial impacto das intervenções dos terapeutas na zona de conforto dos clientes com perturbação de personalidade borderline, sugerindo que demasiado foco no nível de desenvolvimento atual pode não

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ser produtivo.

Introduction

Psychotherapy dropout is a widespread problem with several negative impacts on clients, therapists, and society. Meta-analysis has shown that one in five clients discontinued psychotherapy (Swift & Greenberg, 2012; Swift et al., 2017). Higher dropout rates are associated with personality disorders (Swift & Greenberg, 2012), loss of motivation (Iliakis et al., 2021), and poor quality of therapeutic relationships (Janeiro et al., 2018). Dropout rates among clients with personality disorders are between 25% to 29.9% (Iliakis et al., 2021), and a study undergoing psychodynamic day treatment with borderlines clients found 36% (Pec et al., 2021), despite psychodynamic psychotherapy being a successful approach to borderline symptoms (Cristea et al., 2017).

In the current study, dropout is defined as a premature and unilaterally discontinuation after the client begins the psychotherapy, before recovering from their suffering, and without the agreement of the therapist (Swift et al., 2017). This definition highlights a non-collaborative dyad work and emphasizes the quality of therapeutic collaboration as an important element of the therapeutic process (Pinto et al., 2018).

Borderline Personality Disorder, interpersonal relationship, and dropout

Borderline Personality Disorder (BPD) is a severe psychiatric disorder characterized by impulsivity, difficulties in emotional regulation, disturbed interpersonal relationships, intensive anger, chronic feelings of emptiness, troubled attachment (Bo et al., 2017; Folmo et al., 2019; Miller et al., 2021) and may have low motivation to change (Coccaro et al., 2005). The affective instability, and the lack of self-integration, observed through a poor and contradictory perception of themselves and others, are factors that increase the difficulties in the therapeutic relationship and emphatic experiences of the therapist (Dotta et al., 2020).

It is noteworthy that the therapist being emotionally attuned and considering the client's responses are advantageous therapeutic strategies with BPD clients regardless of the psychotherapeutic approach (Goodman et al., 2014). In a dropout BPD case treated with psychodynamic therapy, Campezatto et al. (2017) pointed out that the interventions focused on the reflection of affective experience did not facilitate the client's change, possibly because the therapist failed to challenge her. In another study examining the interaction between factors that could hinder or foster the psychotherapeutic

process for clients with a BPD, Folmo et al. (2019) found that a deep engagement with a client's maladaptive patterns is challenging to dyad and requires careful management. However, this confrontation can be imperative in treatment with BPD. In this line, sessions in which the therapists took the clients out of their comfort zone, explored maladaptive patterns, and challenged more, were better rated regarding trust.

Therapeutic Collaboration and change in psychotherapy

To understand the interactive microprocesses (i.e., therapists' interventions and clients' responses) which contribute to client's change, Ribeiro et al. (2013) conceived the therapeutic collaboration model as the joint efforts between the dyad, highlighting the bidirectional and reciprocal nature. In addition, the authors stated that collaboration and change in psychotherapy are dynamic, taking into account the Therapeutic Zone of Proximal Development (TZPD; Leiman & Stiles, 2001). The TZPD is understood as the distance between the client's actual developmental level and the potential developmental level that can be achieved in interaction with the therapist. The client's change arises in this interaction with the therapist that, according to Dynamic Systems (DS) theory (e.g., Hollenstein, 2013; Lewis, 2000), is composed of a dynamic system guided by principles such self-organization and based on variables of time and change.

Since the client's needs and skills are contextualized in his/her TZPD, the therapist recognizes moments of felt risk and opportunities to move forward by challenging (Ribeiro et al., 2016), encouraging the client's building of new meanings and promoting opportunities for his/her change. According to Stiles et al. (2004), psychotherapy change involves the gradual development and assimilation of the problematic experiences (i.e., experiences that generate psychological pain) into the client's self through responsive therapist's interventions (i.e., attuned to the client's TZPD). The client's new understanding becomes part of self and transforms problematic experiences into a resource for future life experiences (Basto et al., 2021).

Purpose of the Current Study

The current study extended the previous understanding of the psychotherapeutic process of Charles (Dotta et al., 2020), a dropout borderline personality disorder case treated with Psychodynamic Therapy. Our overriding aim was to understand the dropout outcome considering the assimilation and

therapeutic collaboration models, seeking to characterize the client's lack of assimilation of problematic experiences and the patterns of therapeutic collaboration in the therapeutic process. Thus, raising some hypotheses about variables that may have contributed to the client's dropout.

Method

Participants

Client

Charles was a Brazilian, male, 30 years old, single, and with a high school degree. He had an older sister and was born when his parents were already divorced. He described himself as impulsive, with difficulties of emotional regulation, disturbed interpersonal relationships, and difficulties in accepting the end of a romantic relationship – which was permeated by a psychological dependency. After 5 months of breaking up and at the beginning of the therapeutic process, they still lived together trying to continue as best friends. His dependent traces were continuously fed by his ex-girlfriend. All these issues were increasingly intertwined, and the client tended to reproduce the impulsive and aggressive functioning he used to have throughout the relationship. Charles often arrived late at sessions and changed the topic of discussions.

Therapist and treatment

The therapist was a 32-years old, female, clinical psychologist in psychodynamic therapy. Treatment was open-ended and psychodynamic-oriented. This approach is based on psychoanalytic principles and methods, but briefer and with lower session frequency. The core feature is the exploration of the unconscious aspects of the self as they appear in the therapeutic relationship (Shedler, 2010). Charles missed nine sessions and only one agreed with the therapist. From the fourth session on, his therapeutic process was intercalated by absences. He received 15 sessions and dropout, however, the central theme related to his ex-girlfriend was worked on only until session 12. After that, the dyad mainly talked about financial issues and how Charles could pay for the psychotherapy debts.

Measures

Outcome Questionnaire-45.2 (Lambert et al., 1996; Brazilian version by Silva et al., 2016): The OQ-45.2 is a self-report questionnaire to follow the client's development during therapy. The scale has 45 items, scored from 0 to 4, measure the client's current psychological distress, interpersonal functioning, social performance, and clinical symptoms. Total scores range from 0 to 180. The Brazilian version shows good internal consistency (Cronbach's alpha .94). The OQ-45.2 was administered at sessions 1, 4, 8, and 12. Charles's onset OQ-45.2 score was 48. It increased to 70 in session 12.

Shedler-Westen Assessment Procedure (SWAP-200; Shedler & Westen, 1998): It is a Q-sort composed of 200 items that measure the cognitive, relationship and, affective aspects of a client with a personality disorder. Scores T>60 mean a personality disorder and T>55 mean traces of personality disorder. A score of T=50 suggests an average level of functioning related to a sample of clients with DSM-IV Axis II diagnoses. It shows alpha coefficients in the 0.90s, indicating high internal consistency. The Brazilian version (Wellausen, 2014) shows satisfactory items reliability (above .70) and broad agreement among the experts (.73). The items' adjustments and clinical validity for Borderline Disorder were considered satisfactory, although for some other diagnoses they were below expected. Charles's score was 61.7 for BPD and 57.6 for Histrionic traces.

Therapeutic Collaboration Coding System (TCCS; Ribeiro et al., 2013): It is an observational and transcript-based coding system developed to micro analyze therapeutic collaboration, as conceptualized by the therapeutic collaboration model (Ribeiro et al., 2013). It takes each pair of adjacent speaking turns as the unit of analysis contextualized on the immediately preceding therapeutic exchange. The therapist's interventions are coded as supporting (problem or innovation) or challenging. The client's responses (validation, invalidation, or ambivalence) indicate the acceptance or not of the therapist's intervention. Based on the specific indicators of the client's responses they are interpreted as signalizing different the client's experiences. Combining the three categories of the therapist's interventions and five categories of the client's response-experiences, TCCS yields 15 types of Therapeutic Exchanges. The TCCS validation study has shown good reliability, with Cohen's kappa values between .84 and .98 for therapist interventions and between .91 and .95 for client responses.

Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1990): It is a rating scale, composed of eight levels, ranging from level 0 (Warded off) to level 7 (Mastery). It describes the changing relation of the problematic experience to the self from the perspective of assimilation theory. The theme rated is understood as all passages that indicate the problems addressed in psychotherapy, and it can

be defined using a common label. It occurs repeatedly in sessions and represents a remarkable expression of a specific problem. Generally, researchers choose one or a few themes to investigate the client's assimilation process (Caro Gabalda & Stiles, 2018).

Procedure

The therapist and client signed informed consent, agreeing with the project procedures, and giving permission to use their data in publications.

Case selection

Charles was selected to meet three criteria: 1) a diagnosis of borderline personality disorder, 2) no symptoms changes, according to OQ-45.2, and 3) dropout outcome. The diagnosis was evaluated considering the therapist's clinical experience observed on Shedler-Westen Assessment Procedure – SWAP-200 (Shedler & Westen, 1998). The client was diagnosed with borderline personality disorder with histrionic traces. Moreover, psychopathy and emotional dysregulation were his most notorious pathological features.

APES raters and TCCS coders

Two judges rated APES levels: a Ph.D. student and a Ph.D. in clinical psychology. Another judge with prior experience in APES research audited their ratings. The same Ph.D. student and a different Ph.D. in clinical psychology did the TCCS coding. The last author was the auditor. All judges were trained to code with APES (Stiles et al., 1990) or TCCS (Ribeiro et al., 2013).

TCCS coding

Charles's case was transcribed and coded following the TCCS procedure described by Ribeiro et al. (2013). Based on a careful read of sessions transcripts, a pair of trained judges discussed the client's problems (i.e., themes of his problematic perspective), and the innovations (i.e., potential changes that would be more functional and adaptive in comparison to his problematic perspective) to consider in coding (Table 8). Then they independently coded the entire sessions. The judges showed good inter reliability: 92.3% of the therapist's interventions and

96.9% of the client's responses. Disagreements on coding were resolved by discussion to consensus and a third trained TCCS judge audited the final codes. In total, 222 therapeutic exchanges were coded.

Table 9

Problems and Innovations in the case of Charles with examples from session dialogue

Problems	**Innovations**
Difficulty in accepting the end of the relationship (Cl: *"It was a huge shock to me. I never could imagine that this could happen. I spent two weeks feeling bad [...] I'm still in love with her"*)	To understand and reframe the end of the relationship (Cl: *"I'm looking for the courage to keep on my life and she does the same [...] I would like to continue with her, but I have to accept that it isn't possible in the next years"*)
Emotional dependency (Cl: *"Soon I'll find a pretty and nice girl. Then I'll fall in love with her. I think that's a dependency [...] I have this defect: I see a girl and suddenly I'm in love"*)	To be comfortable being alone (Cl: *"I miss having someone with me. I don't know, I'm still too confused. The only way to understand this is to get away from her"*)
Conflictual interactions with his ex-girlfriend (Cl: "*I called her a tramp [...] I was really angry"*)	To understand the current relationship with his ex-girlfriend (Tr: *"We need to think together if the fact of you both still living together isn't too mixed [...] You need to impose this on yourself. Otherwise, you'll be attacking her all the time"*)

APES rating

APES rating followed the procedure described in previous studies (e.g., Basto et al., 2021). The judges were considered reliable when they achieved interrater reliability of ICC [2,1] ≥ .60 (Shrout & Fleiss, 1979) in training. First, judges read all session transcripts, and then independently identified the recurring issues (i.e., theme), the client's dominant and problematic[3] voices. Based on the clinical salience and by consensual agreement, the judges selected excerpts where the interpersonal relationship with his ex-girlfriend was observable and then independently rated with the APES (e.g., Figure 5). They distinguished 165 passages and disagreements in the client's voices characterizations, selected passages, and ratings were resolved by discussion to consensus. The interrater reliability was ICC [2,1] .57, which was significantly lower than that achieved in the training ratings.

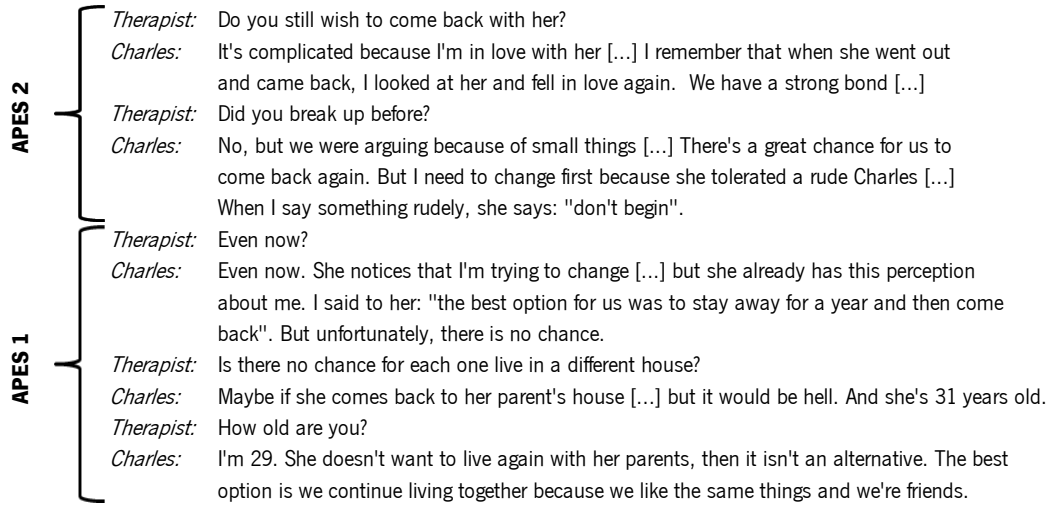
Charles's dominant voice was labeled as "need to have control" regarding his ex-

[3] Note that APES and TCCS use the concept of problematic and problem in different but complementary ways. The APES considers the perspective of the client's dominant self to characterize problematic voices. In contrast, the TCCS takes the therapist's perspective.

girlfriend's life. This control seemed to reflect a feeling of vulnerability expressed through impulsivity patterns in interpersonal relationships. The problematic voice, "fear of being rejected and abandoned" represented experiences related to Charles's need to be protected and loved by his ex-girlfriend (Charles: "*She said she wanted to be with both: me and her current boyfriend [...] 'Okay. If you want, you can stay with both' [...] Maybe I miss someone with me. I don't know. I'm too confused*").

Figure 5

Example of therapist-client exchanges associated with APES in coded transcripts in Charles's case



Data analysis

We used the *State Space Grid* (*SSG*; Lewis et al., 2004) to describe the therapeutic collaboration in passages dealing with the theme of interpersonal functioning. This method aims to study two or more series of synchronized data, which compose a dynamic system with a finite number of possible states, called State Space. The frequent states that have stabilized and are expected are called attractors (Hollenstein, 2007).

This dynamic system is a helpful way to characterize patterns of behavior (e.g., therapeutic collaboration) in real-time. "Clinicians using this technique could use attractor analysis to identify these problematic attractors [...] over the course of treatment, measure the dissolution of that attractor in lieu of other, less problematic ones (Hollenstein, 2007, p. 390).

In the current study, we used two series of data: the therapist's interventions and the client's

responses as two series of categorical data. The result of the combination of both series means the interactive space of the dyad work regarding the client's TZPD, following the therapeutic collaboration model (Ribeiro et al., 2013). In each grid, there are 15 cells, which means the 15 therapeutic exchanges of TCCS. These grids were developed using the *Software GridWare* (*Version 1.1.*; Lamey et al., 2004), in which therapist interventions and client's responses define the axes *y* and *x*, respectively, according to their duration (i.e., measured considering the count of the number of words) moment-by-moment. The attractors are the therapeutic exchanges that explain 80% of each psychotherapy session. To identify the attractors, we used a method of winnowing (Lewis et al., 1999), a quantitative procedure based on the cumulative cell duration (i.e., therapeutic exchanges). We started with all therapeutic exchanges that occurred in each session and excluded those with the lowest duration that contributed to the heterogeneity, one by one. This procedure was repeated until was considered homogeneous and the remaining cell was composed of the attractor. For the same passages rated with the APES, we performed a descriptive analysis using the statistical *Software R* (R Core Team, 2021).

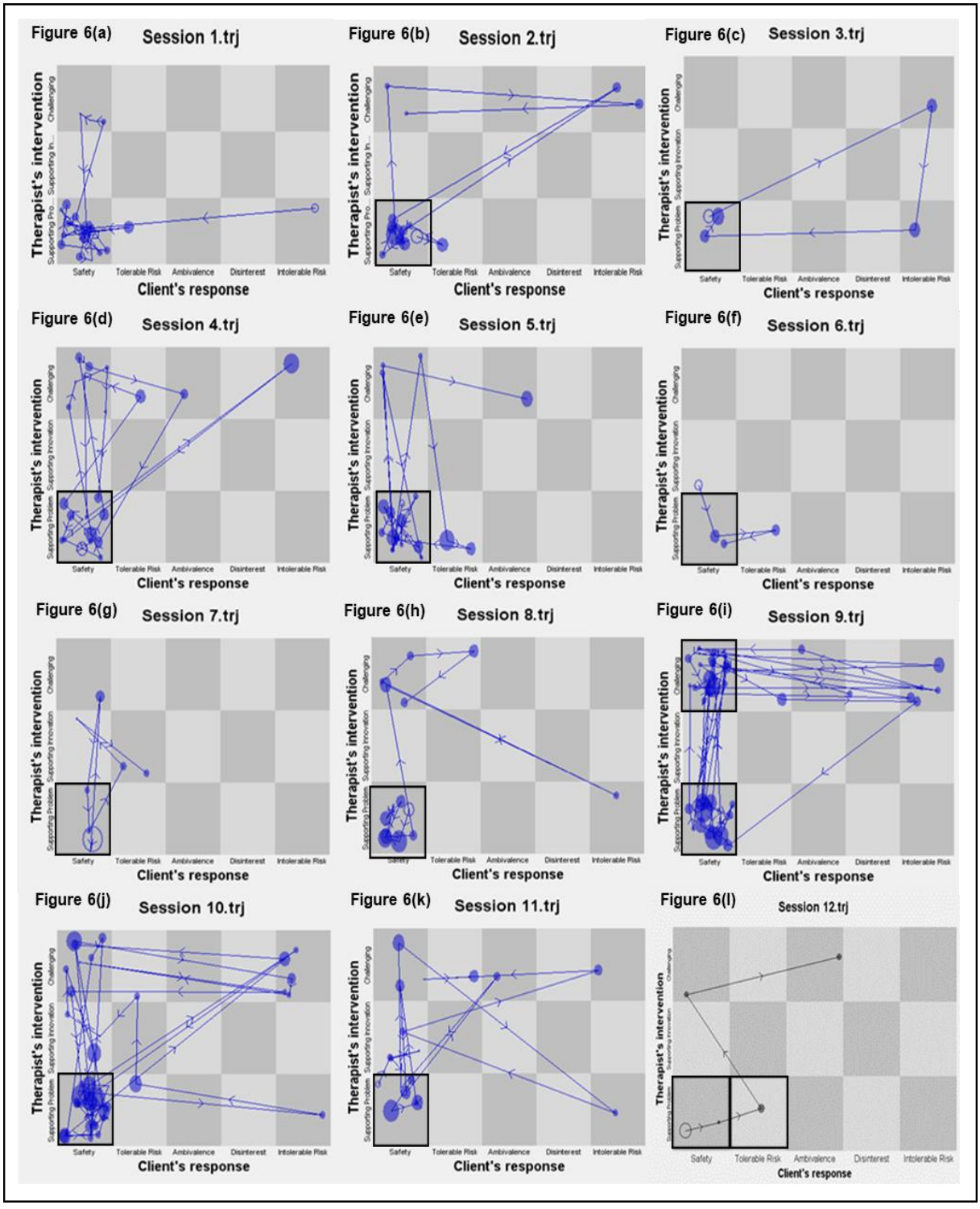
Results

What was the pattern of the therapeutic collaboration throughout the therapy process?

The dyad worked mainly within the client's TZPD actual level (Figure 6). Three different types of attractors were identified. The attractor Challenging – Safety was identified in session 9, and the Supporting problem – Tolerable risk in session 12. In the other sessions, we observed only one attractor: Supporting problem – Safety.

Figure 6

SSGs of therapeutic exchanges (TCCS) per session in Charles's case



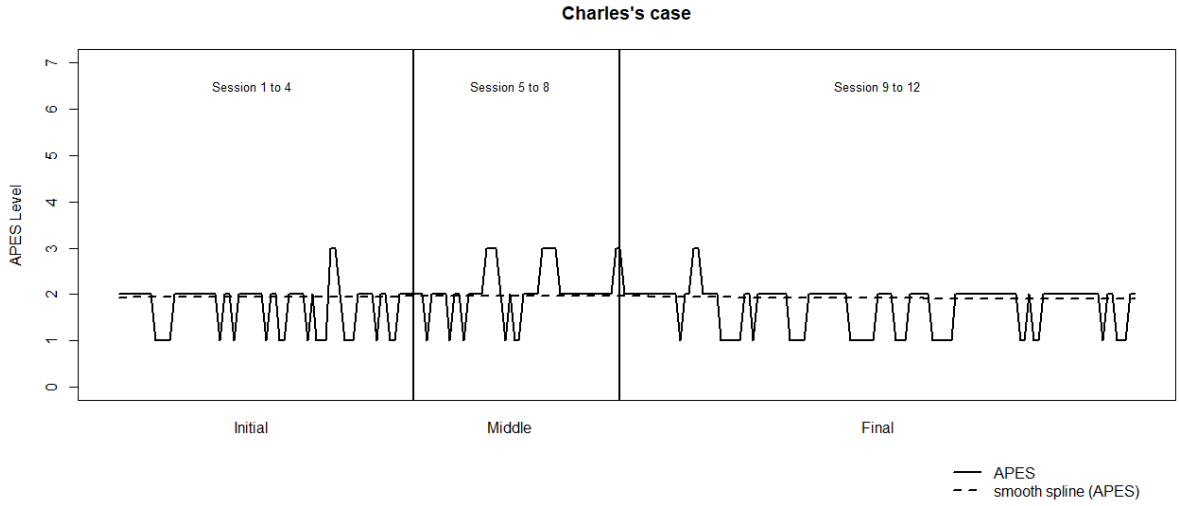
Note. In the figure, an empty circle refers to the first interactive episode in the session (i.e., SP-IR in the first session). The remaining circles with padding refer to more salient interactive episodes along with the session and the size is greater as long it has lasted. The arrows interconnect the circles, and it shows the direction between an episode and the following.

How was the development of the Assimilation of Problematic Experiences?

Charles's assimilation level oscillated between APES 1 (i.e., Unwanted thoughts) and 2 (i.e., Vague awareness/Emergence) across therapy. In rare sessions, he achieved APES 3 (i.e., Problem statement/Clarification), but he did not exceed this level (Figure 7). The sessions are mostly about Charles feeling guilt by the end of the relationship "*I did everything wrong*" and saying that he would like to change his behavior to conquer back his ex-girlfriend. Occasionally he reached APES 3 and expressed his desire to leave the apartment he shared with his ex-girlfriend: "*I don't want to stay there anymore [...] the distance will be a challenge, but it is necessary to go on*".

Figure 7

Assimilation of Problematic Experiences (APES) per session in Charles's case



Discussion

The present case study aimed to understand the dropout outcome by taking the vantage point of the therapeutic collaboration and the assimilation models. Specifically, we sought to characterize the client's lack of assimilation of problematic experiences and the patterns of therapeutic collaboration in psychotherapy.

The lack of assimilation of problematic experience results shows that Charles maintained low APES levels (i.e., APES 1 and 2) over the sessions. Charles seemed not ready to change, nor engaged in therapy tasks, and presented difficulties exploring his problems. Congruent results

were found in a dropout case study by Caro Gabalda (2006) since the client lasted at APES levels 2 and 3 and had difficulties assimilating the problematic experience. As a consequence of this poor assimilation, the author observed a therapeutic failure and no significant clinical changes.

Our observations of Charles trying to stay in control through avoidance of thinking, discussing his problematic experience, and feeling worse are consistent with previous studies (e.g., Caro Gabalda, 2006; Honos-Webb & Stiles, 1998) which show that once the client's assimilation remains at lower levels, the dominant voices continue in the control. In addition, Detert et al. (2006) study pointed out that all the good outcome cases achieved APES 4 and none of the poor outcome cases did.

The more painful the symptom, the less the problematic experience is assimilated (Caro Gabalda, 2006). Osatuke and Stiles's (2006, p. 302) study on BPD and assimilation highlighted that "unassimilated parts are large and structurally complex, so emerging problematic voices bring much potential conflict and anticipated pain [...] this may motivate a greater use of avoidance (rather than engagement) in dealing with problematic voices by such clients and their therapists". For this reason, Meystre et al. (2015) suggest that at the lowest APES levels (0-2), the therapist's interventions may be focused to help the client to gain awareness about their problematic experience.

Following the analysis using the *SSG* (Lewis et al., 2004), we noted that the dyad mainly worked within Charles' TZPD, as exemplified by the main attractor Supporting problem – Safety. Based on the direct observation of Figure 6, this therapeutic exchange seemed to have had a longer duration than the others, which was later proven through the method of winnowing. Charles was not able to move forward from his actual TZPD to reach the levels compatible with expected changes, as confirmed by the lack of attractors with Tolerable risk responses. The findings regarding the therapeutic collaboration, obtained by *SSG*, also corroborate Charles's lack of symptomatology changes obtained in OQ-45.2.

The attractor Challenging – Safety was identified in session 9. In this session, Charles arrived agitated because his ex-girlfriend published on social media that she was dating and because her current boyfriend threatened Charles, who was trying to reconquer her. Charles was mad, feeling guilty about the end of the relationship and justifying why his ex-girlfriend needed him. The therapist promoted comfort in Charles (i.e., Supporting problem – Safety) and encouraged him to consider new alternatives (i.e., Challenging). Charles' responses oscillated between validating (i.e., Safety) and invalidating (i.e., Intolerable risk) the therapist's proposals

indicating that, in this session, the dyad worked within and outside Charles' TZPD, as observed in the quadrant Challenging – Intolerable risk.

A high concentration of dyads' interaction in Charles's actual level of development (i.e., Supporting problem – Safety) suggests some difficulties in the therapeutic dyad's progress toward the client's potential level of change. However, it is interesting to note that in previous dropout case studies with depressive clients an increase in challenging interventions, and intolerable risk and disinterest responses seemed to be a feature of this outcome (Ferreira et al., 2015; Pinto et al., 2018). This could suggest that the development of patterns of therapeutic collaboration may be different in borderline and depressive dropout clients, which can be grounded on different ways of therapist's interventions meets these client's needs or by client's different levels of readiness or expectation to change.

We agree with Campezatto et al. (2016) alert that with BPD clients the potential of the therapist's support and emphatic attitudes "to promote change cannot be overestimated" (p. 497). Since therapists are attuned to the client's emerging needs (i.e., the client's level of assimilation regarding problematic voice; Meystre et al., 2015), they should gradually increase on challenges to facilitate the client's assimilation along the psychotherapeutic process (Ribeiro et al., 2016).

Our results are likely to be related to Folmo et al. (2019) findings in a borderline study regarding adherence and therapists' competence. In the lowest-rated sessions, therapists were less able to challenge, retreated to over supportive attitude, and became progressively careful, while the client was increasingly unmotivated. In the high-rated sessions, the client increasingly worked and accepted the challenging interventions. It suggests the importance of the therapist to confront the client's problematic perspective, challenge more, and take clients out of their comfort zone for a good outcome.

According to Pinto et al. (2018), clients dropout when they were unwilling to look at different points of view about their lives and did not manifest an authentic engagement in the therapeutic process. In this regard, is noteworthy that Charles missed sessions without agreement with the therapist. Therefore, a clinical implication of our findings is the importance of therapists to observe warning signs of low client engagement. Beyond that, they suggest that focusing on therapeutic collaboration and challenging interventions, although it could temporarily disestablish the dyad work (e.g., intolerable risk), may improve the effectiveness of psychotherapy and decrease the dropout rates with BPD clients.

Limitations and Future directions

The current study has some important caveats. First, despite the described observations resembling results from other studies, it is a single case, and generalizations are only theoretical. Replication is needed. Another limitation is the relatively poor reliability of APES ratings in this case. The study is mainly descriptive, and the interpretation of results requires caution until more robust analyzes support them.

We underline that this study's contributions outweigh its limitations. This first study using the TCCS and BPD in psychodynamic therapy provides an understanding of how therapeutic collaboration could be related to the changes (or lack of changes) with these clients. For the assimilation model, a good outcome case is linked to the client's advance over different APES levels. Showing a lack of progress through the levels, Charles's case indirectly supports this statement. We also highlight this study adds new knowledge of the dyad variables that could contribute to BPD dropout, and it will enable therapists to recognize these aspects in similar scenarios. Future studies may be fruitful to conduct research with a large number of BPD cases, different psychological approaches, and outcomes.

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ESTUDO III - THERAPEUTIC EXCHANGES THAT CHARACTERIZE THE ADVANCES AND SETBACKS IN THE ASSIMILATION OF PROBLEMATIC EXPERIENCES IN PSYCHODYNAMIC THERAPY OF DEPRESSION

THERAPEUTIC EXCHANGES THAT CHARACTERIZE THE ADVANCES AND SETBACKS IN THE ASSIMILATION OF PROBLEMATIC EXPERIENCES IN PSYCHODYNAMIC THERAPY OF DEPRESSION

Abstract

Introduction: Psychodynamic therapies emphasize insight as the main mechanism leading to change. The process of change is not linear, and the insight depends on therapeutic collaboration since it occurs in dyad joint efforts to explore the client's dysfunctional patterns. Aim: To identify which therapeutic exchanges, contextualized in collaborative work, characterized both the advances and the setbacks in the process of change in psychodynamic therapy with a depressive client for a good outcome case. In addition, we aimed to investigate the same phenomena specifically regarding insight. Method: We used the Therapeutic Collaboration Coding System (TCCS) to assess collaborative work, the Assimilation of Problematic Experiences Scale (APES) to rate client change and performed a descriptive analysis in 11 sessions. Results: The client showed the usual irregular progress of assimilation and an excellent improvement along with the APES. The dyad worked collaboratively, and the therapist's interventions were attuned to the client's assimilation level. Conclusion: This study provides support for the conceptual premise that the client's assimilation of problematic experiences could not be developed without a good enough and attuned therapeutic collaboration.

Resumo

Introdução: As terapias psicodinâmicas enfatizam o *insight* como o principal mecanismo que leva à mudança. O processo de mudança não é linear e o *insight* depende da colaboração terapêutica, uma vez que esta é uma realização conjunta da díade para explorar os padrões disfuncionais do cliente. Objetivo: Identificar quais as interações terapêuticas, contextualizadas no trabalho colaborativo, que caracterizaram tanto os avanços quanto os retrocessos no processo de mudança em um caso de sucesso, com diagnóstico de depressão e seguido em terapia psicodinâmica. Além disso, investigámos os mesmos fenômenos ocorridos em torno do *insight*. Método: Utilizamos o Sistema de Codificação da Colaboração Terapêutica (SCCT) para avaliar o trabalho colaborativo, a Escala de Assimilação de Experiências Problemáticas (EAEP) para avaliar a mudança da cliente e realizamos uma análise descritiva em 11 sessões. Resultados: A cliente apresentou o habitual irregular progresso e uma excelente melhora baseada na EAEP. A díade trabalhou de forma colaborativa e as intervenções da terapeuta foram

sintonizadas com o nível de assimilação da cliente. Conclusão: Este estudo fornece suporte para a premissa conceitual de que a assimilação de experiências problemáticas pela cliente não poderia ser desenvolvida sem uma colaboração terapêutica suficientemente boa e sintonizada com as habilidades e necessidades da cliente.

Introduction

Several studies have demonstrated the efficacy of individual psychodynamic therapy for depressive disorders (Abbass & Driessen, 2010; Cuijpers et al., 2008; Driessen et al., 2010; Leichsenring & Steinert, 2019). There is also evidence that the effects of this therapy are substantial at termination and can be increased in follow-up sessions (Abbass et al., 2009, 2014; Leichsenring & Steinert, 2019). Çitak et al. (2021) observed that clients with depression and anxiety achieved a significant improvement after a short-term psychodynamic therapy once they decreased self-destructive behaviors and did not attempt suicide. These finds were observed in 94% of clients who did not achieve a good response with previous treatments. Considering this, understanding how the dyad interacts in the context of the client's changes is an important issue for research, clinical practice, and theory.

Psychodynamic therapy address what is subjective and singular in the client's suffering (Dunker & Kyrillos Neto, 2011). More than changing the maladaptive patterns, it seeks to increase autonomy, resilience, and skills to tolerate different scenarios (Gabbard, 2016). Furthermore, it is expected for the client to have self-continuity and become subject to his/her history (Bastos, 2014). To reach this, the therapist helps the client to understand the meaning of his/her behavior using expressive strategies (e.g., challenging intervention) (Santeiro, 2005). Levy (2015, p. 268 - 269) writes that "insight is a deep understanding about psychic life [...] it occurs during a long process of elaboration, which consists of overcoming resistances and culminate in desired psychic changes [...] to make conscious the unconscious".

Traditionally, psychodynamic therapies emphasize insight as the main mechanism leading to change (Jones, 2000; Lacewing, 2014). Later, relational analysts assumed the insight depends on therapeutic collaboration since it occurs in dyad joint efforts to explore the client's dysfunctional patterns (Messer & McWilliams, 2007). Therefore, a contemporary theory of action within this approach considers that the understanding of one's dynamics, affective states, and mental processes (i.e., insight) cannot exist without some essential factors related to dyad interaction (e.g., empathy and therapeutic alliance). In other words, therapeutic relationship, and insight work together to achieve the therapy target and can

only artificially be dissociated (Jones, 2000; Serralta et al., 2016). There is some evidence indicating that therapeutic relationship mediates the effects of insight in psychodynamic therapies (Lacewing, 2014).

Messer and McWilliams (2007) conceive insight both as a sign that a change has happened and as an outcome of successful psychotherapy. In a review of mechanisms of change in psychodynamic therapy, Leichsenring et al. (2018) found that insight was significantly linked to outcome in five of six studies. "The development of a new understanding about oneself is a central feature that is generally pursued as it is viewed as leading to improvements in symptoms and life functioning" (Meystre et al., 2017, p. 134).

The assimilation model (Stiles et al., 1990), a theory about psychological change focused on understanding how the client assimilates the painful experiences into the self, has assumed an integrative perspective on insight (Stiles, 2002). Based on this theory, insight is a middle stage in the client's continuous developmental process in therapy (Stiles & Brinegar, 2007). As stated by Stiles et al. (1990), this model can provide the dyad a sense of progress, due to the small scale of change conceptualized (i.e., Assimilation of Problematic Experiences Scale – APES), and it can be applied by any approach. Then, "a strong relationship is required to hold the client's attention on problematic material (Rice, 1983), a prerequisite for assimilation. Conversely, progress along the assimilation continuum strengthens the therapeutic relationship" (Luborsky, 1984, as cited in Stiles et al., 1990, p. 419). However, despite the therapeutic relationship being imperative for psychotherapy, it remains unclear its role in the client's change (Vilkin et al., 2022).

The Assimilation Model

The assimilation model describes psychological change occurring in psychotherapies across different theoretical orientations (Stiles et al., 1990). This theory provides a descriptive and qualitative method to analyze how the clients assimilate problematic experiences into self (i.e., community of voices; Meystre et al., 2015), which is composed of traces (i.e., voices) of a person's previous experiences (Stiles et al., 1990; Stiles, 2011). When we have a new experience, these voices interact with each other and can emerge as resources to facilitate the person's adaptation to the new scenarios (Honos-Webb & Stiles, 1998; Stiles, 2001, 2011; Stiles et al., 2004). The voice is activated when the person's current experience resembles past ones (Detert et al., 2006; Stiles, 2011) and our self uses these voices as resources to understand the new experience (Caro Gabalda, 2006).

This model proposes that there are dominant voices and nondominant or problematic voices. Dominant voices are organized as a self-community and perform people's habitual ways of thinking, behaving, and feeling (Honos-Webb & Stiles, 1998; Stiles, 2001, 2002). Problematic voices are described as traces of experiences that jeopardize the cohesion of the community of voices, generating psychological pain when it emerges in the client's consciousness (Caro Gabalda & Stiles, 2016, 2020; Honos-Webb & Stiles, 1998; Stiles, 2001, 2011; Stiles et al., 2004). The failure to integrate the problematic experiences in the community of voices can cause psychopathological disorders, for instance, depression (Stiles et al., 1990).

The psychological suffering caused by the conflict of the community of voices trying to reject or avoid problematic experiences can be softened by psychotherapy (Honos-Webb & Stiles, 2002). The psychotherapeutic process promotes the communication between problematic and dominant voices and, as consequence, the building of meaning bridges (Stiles, 2011). Meaning bridges are words, signs, images, phrases, theories, gestures, story that have similar understandings to both voices. Beyond connecting the voices, the meaning bridges allow them to communicate and engage with each other in joint action. The problematic experience is smoothly assimilated and integrated into the community and can serve as a resource in future and similar situations of daily life (Brinegar et al., 2006).

The assimilation of problematic experiences can be understood as a developmental process that can be assessed by the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991; Stiles & Osatuke, 2000; Stiles, 2002). It is a continuum with eight levels that track themes across sessions and describe the change of problematic experiences regarding self. Clients may begin the psychotherapeutic process at any level and all development from a lower to a higher level can be considered an improvement (Brinegar et al., 2006; Stiles, 2001). According to Detert et al. (2006) study, good outcome cases tend to reach at least level 4 (i.e., Understanding/ Insight), while in poor outcome cases, the clients tend to remain at lower levels.

Several empirical research has shown that the assimilation of problematic experiences indicates that the paths taken by the client in therapy can be composed of setbacks to lower assimilation levels. Despite that, these switches may promote broader gains, since they can concern strands of the problem that has not been yet well assimilated (Caro Gabalda & Stiles, 2013, 2018, 2020, 2022; Caro Gabalda et al., 2016; Mendes et al., 2016; Ribeiro et al., 2016).

Therapists' interventions and assimilation into Psychodynamic therapy

Theoretically, if the client's progress in psychotherapy could be facilitated by the therapist's interventions regarding the client's current APES level, the interventions could promote progress to the next level. However, to date, few studies have been found grounded on the assimilation model and psychodynamic therapy that focused on the therapist's interventions (Meystre et al., 2014, 2015).

Meystre et al. (2014) investigated the therapist's interventions that may promote the client's assimilation along the therapeutic process. For that, they analyzed 34 sessions transcripts of a client with bouts of weeping and diffuse anxiety. The authors found that the client's unfocused feelings demanded a clear therapist's interventions, thus the Explicit guidance was responsive to the lowest APES levels (e.g., APES 1 and 2). When the dyad worked on the problem, guidance and advice interventions seemed applicable to APES 1, 2, 5, and 6. Confrontation was appropriate for APES 2 and 3. Interpretation interventions, that aim to associate the client's behaviors and affections, with past and present moments, were responsive at APES 4 (i.e., insight; Meystre et al., 2014).

In light of brief psychodynamic psychotherapy and using the same measurements of the previous research (i.e., APES and the Comprehensive Psychotherapeutic Interventions Rating Scale - CPIRS), Meystre et al. (2015, p. 486) aimed to "complete a discovery-oriented phase task analysis and build an empirical model of how therapists may facilitate clients' assimilation process in a psychodynamic" and expand their understanding of therapists' interventions for clients' assimilation of problematic experiences. They selected three good and three poor outcome cases suffering from depression. Interventions such Create a harmonious relationship, Draw direct attention to unacceptable feelings and Confront the client with their avoidance seemed to promote the assimilation of problematic experiences on many levels. As stated by the assimilation model, the authors also observed that confronting interventions facilitated clients to elaborate an insight. However, the authors concluded that the study had not enough data concerning the higher APES levels to relate to the therapist's interventions (Meystre et al., 2015).

Psychodynamic therapy works on an interpretative-supportive continuum (Leichsenring et al., 2015). Interpreting interventions (as well as clarifying and confronting interventions) raise the client's insight regarding repetitive conflicts maintaining their problems. In addition, supporting interventions intend to enhance the client's skills that are not available due to intense suffering or that have not been developed enough. Then the therapist will use more interpretative or supportive interventions based on the client's needs, bearing in mind the client's assimilation level, for instance.

According to Levy (2015), when the psychotherapist, through interpretation intervention offers a new and specific meaning to client's problem, he/she opens up new possibilities for the client to experience and elaborate on his/her affections. The elaboration effort consists in the therapist following the client's advances and setbacks, providing new understandings and insights about problems and experiences.

Collaborative interactions to insight

A collaborative relationship is understood as the therapist and client working together to achieve psychotherapy's goals (e.g., Tyron & Winograd, 2011). In psychodynamic therapy, a robust collaborative relationship makes it possible for clients to explore their relational patterns (Wiseman et al., 2012). Psychodynamic relational models presume that psychic structure, anxiety, and defenses are not independent of relationships; on the contrary, relationships are the main motivation for behavior. Therefore, within this model, the client and therapist must work together to explore their relationship, as well as other significant interpersonal interactions of the client (Lemma et al., 2018). Otherwise, clients won't be available for new insights that could occur from the dyad collaborative work (Spencer et al., 2019). Thus, we argue that therapeutic collaboration, as the dyad working together to attain a goal, is a core aspect of the relationship that needs to be examined for insight and change.

Considering the complexity of the therapeutic process, isolating common (e.g., relationship) and specific (e.g., insight, interpretation) factors to study, although legitimate, is arbitrary. Understanding how both factors interact in effective therapies is crucial to extend our comprehension of the mechanisms of therapeutic changes in different approaches and between them (McAleavey & Castonguay, 2015).

In agreement with Ribeiro et al. (2013), the current study conceptualized therapeutic collaboration as interactive microprocesses which contribute to the client's changes along the psychotherapeutic process. This model is based on the concept of TZPD (Therapeutic Zone of Proximal Development; Leiman & Stiles, 2001), which can be understood as the distance between the client's actual and potential developmental level. The actual developmental level is described as the moment when the client sought therapy and their ability to deal with the problems. The potential developmental level is described as the client's changes, which can be reached in collaboration with the therapist. The client's potential level progressively develops into their actual level through a collaborative interaction between therapist and client (Ribeiro et al., 2013).

The collaboration model (Ribeiro et al., 2013) offers a coding system (Therapeutic Collaboration Coding System, TCCS) to analyze and track the dyad interaction in therapy moment-by-moment. When supporting, the therapist aims to understand the client's problem as well to promote a safe experience (i.e., supporting problem) or the innovative emergent perspective (i.e., supporting innovation). The therapist's challenging interventions expect to encourage the client's change and promote an alternative perspective (Ribeiro et al., 2013). When therapists are attuned to clients' emerging requirements, they will adjust their interventions considering that.

Departing from the client's responses, if it is validated, the dyad is working collaboratively, within TZPD, and through the experience of safety or tolerable risk. If the client invalidates, the dyad is not working collaboratively, it occurs outside TZPD, and the client shows intolerable risk or disinterest. If the client validates and invalidates the therapist's proposal at the same time, the dyad is working at the client's TZPD limits, and the client experience ambivalence (Ribeiro et al., 2013). According to Ribeiro et al. (2016), therapeutic collaboration concerns the therapist being responsive in recognizing when the client felt risk and when they are ready to move forward by challenging.

For Zonzi et al. (2014), the TZPD can be understood in analogy with the Winnicott's concept of ability to play, which means an ability to assume a flexible attitude regarding a problem and to consider potential alternatives to solve it. He also highlights the value of the therapist's interpretations occurring within the shared playing area, since if it occurs outside the area where therapist and client play together, resistance can emerge. Then if the client has no ability to play, the therapist's interpretations are not useful (Zonzi et al., 2014). Following Winnicott's theory, the client's response within TZPD could be understood as the client playing, manifested by his/her skill to creatively elaborate the therapist's interventions and to develop his/her self-understanding. The client's responses outside TZPD could be understood as the client's difficulties playing, manifested by confused responses and not elaborating on the problem (Zonzi et al., 2014).

Bearing this in mind, Zonzi et al. (2014) analyzed the zone of proximal development in a depression case followed by psychodynamic therapy. As result, the authors observed that the client did not change throughout the sessions and that she seemed had not ability to play with the therapist. This theory-building case study suggests that "seeing the therapeutic ZPD as a playing zone within which the client can move around in creative ways emphasizes the close relationship between the content accessible to the clients and the quality of the therapist interventions. When the zone is too narrow, there is no place to play, and therapeutic progress is slow and difficult" (p. 459).

Purpose of the Current Study

The present study extended the research developed by Ribeiro et al. (2016), Meystre et al. (2015), and the previous understanding of the psychotherapeutic process of Ellen (Serralta et al., 2016; Yoshida et al., 2009), a depression case study treated with Psychodynamic therapy. The innovation consists of the examination of this psychodynamic therapy process from different perspectives: the transtheoretical change proposed by the assimilation model and the therapeutic collaboration model. The case studies with transtheoretical models can potentially help to understand what is specific and what is shared by different approaches in therapy. Thus, we aimed to identify which therapeutic exchanges characterized the client's advances and setbacks in the entire psychodynamic psychotherapy, assessed using the TCCS and the APES, respectively. In addition, we were interested in understanding the same phenomena specifically regarding the insight (i.e., APES 4), taking into account the psychotherapeutic phases. In psychodynamic therapy, the goal in the initial phase is to build a therapeutic alliance and treatment goals. In the middle phase, the goal is to understand client's maladaptive patterns and to promote insight; in the final phase, the goal is to identify client's changes and to elaborate the end of therapy (Luz, 2015).

We addressed the following questions: 1) How did the assimilation of problematic experiences develop across phases?; 2) How did the therapeutic collaboration develop across phases?; 3) What sorts of therapeutic exchanges characterized Ellen's advances and setbacks?; 4) What sorts of therapeutic exchanges characterized Ellen's advances and setbacks regarding insight?

In the first research question, once the client is a good outcome case, we expect that she achieves at least the APES 4 (i.e., understanding/ insight of the problematic experience). Regarding the second question, we expect to observe an increase in challenging and supporting innovation interventions along with sessions with tolerable risk responses and a decrease in Supporting problem – Intolerable risk exchanges. In the third question, we expect to observe client's responses of validation (i.e., accepting the intervention) were associated with APES advances. We also anticipate some invalidation (i.e., rejection) responses were associated with APES setback. Finally, we expected that therapeutic exchanges associated with advances toward APES 4 involved therapeutic interventions of interpretation.

Method

Participants

Ellen's case was drawn from the project Elaboration and application of prototypes to evaluate the ideal process versus the real process of brief psychotherapies: a study on the process of change in brief

psychodynamic psychotherapy, which had been approved by the ethical committee at the University of Vale do Rio dos Sinos, São Leopoldo, Brazil; number 11/133. The psychotherapeutic process was held in a University's Psychology Clinical Center. Ellen's psychotherapeutic process had 11 sessions and two follow-up sessions (three and six months later). All sessions were recorded by audio and video and then transcribed.

Client

Ellen, 48 years old, was divorced and had three married sons (29, 28, and 25 years old). She was forwarded to psychotherapy by her psychiatrist. She did household chores since she was a child. Her mother was sick, and her father was an alcoholic. When Ellen was 18 years old, she was pregnant and got married. Her husband was also an alcoholic and problems regarding this abuse increased over the years. The conflicts between the couple increased after the birth of their third child; when she started to work and gain a higher salary than her husband. After several conflicts, they divorced and she moved to live with her mother, who was sick. When Ellen's mother died, she presented severe depression. A few months before the client begins the therapy, her ex-husband had a stroke and, as consequence, he was semi-paralyzed and had difficulties speaking. Ellen found again a childhood friend and they started a love relationship. She tended to feel like a prisoner of her obligations and complained that could not live her life, since she had to care for her ex-husband.

Therapist and treatment

The therapist was a female, a Ph.D. clinical psychologist, with 33 years of clinical experience practicing psychoanalytic psychotherapy. Treatment was based on brief Psychodynamic therapy (Yoshida & Enéas, 2004). It was focused on the reason why the client asked for help, which was related to a maladaptive pattern of relationship. This treatment highlights that the quality of therapeutic alliance and the client's motivation to change are deeply related and contribute to a good outcome. There was a greater therapist's activity and efforts to identify the client's maladaptive pattern and, considering that, to guide their interventions and goals of the psychotherapeutic process (Yoshida, 2012).

APES raters and TCCS coders

One pair of judges rated APES levels: a Ph.D. student and a psychologist with a master's degree in clinical psychology. Another judge, who had training and prior experience in APES research, audited their ratings. The same Ph.D. student and a different Ph.D. in clinical psychology did the TCCS coding.

Another judge with extensive experience in TCCS research audited their coding. All judges had previous training and practice to code with APES (Stiles et al., 1990) or TCCS (Ribeiro et al., 2013), as described in the Procedure section.

Measures

Beck Depression Inventory (BDI; Beck & Steer, 1993): It is a widely self-report questionnaire that evaluates the intensity of depressive symptoms. It has 21 items that can be scored from 0 to 3 points, and total scores can range from 0 to 63. Scores from 0-11 mean minimum intensity of depression, 12 to 19 is light, 20 to 35 is moderate and 36 to 63 scores mean the presence of severe depressive symptoms. The Brazilian Portuguese version (Cunha, 2001) has internal consistency ranging from .79 to .91; and from .80 to .91 in a one-week test-retest reliability. The cutoff for this population is 12 points. Ellen's trial BDI score was 33 and decreased to 14 in the final phase.

Toronto Alexithymia Scale (TAS; Taylor et al., 1985): It is a self-reported questionnaire that measures the intensity of alexithymia. It is a five-point Likert scale composed of 26 items. The total scores can range from 26 to 130. The total scores ≥ of 74 scores mean that the client is alexithymic, and scores ≤ of 62 mean that the client is not alexithymic. The Brazilian Portuguese version has Cronbach's $\alpha = .71$ (Yoshida, 2000). Ellen's TAS score in the initial phase was 70 and its dropout to 64 in the final phase of the psychotherapeutic process.

Emotional Adjustment/Neuroticism Factorial Scale (EFN; Hutz & Nunes, 2001): It is a psychometric test that evaluates the client's emotional maladjustments. It is composed of four fields that integrate the Neuroticism personality, such as vulnerability, depression, anxiety, and maladjustment psychosocial. It is a seven-point Likert scale composed of 82 items. It has an internal consistency of .87 in test-retest reliability (Yoshida, 2007). Ellen's score for F1 (Psychosis) was 0.9 in the initial phase and its dropout to 0.1; F2 (Obsessive-compulsive) was 0.8 in the initial phase and its dropout to 0.4; F3 (Somatization) was 1.40 in the initial phase and its dropout to 1.1; F4 (Anxiety) was 1.2 in the initial phase and its dropout to 0.6 at the final phase of psychotherapy.

Symptom Assessment Scale-40 (EAS-40; Laloni, 2001): Adapted from the Symptom Checklist-90-R (SCL-90-R; Derogatis, 1994) for the Brazilian population, it is a self-reported questionnaire that measures psychopathological symptoms in four dimensions: psychoticism, obsessiveness-compulsivity, anxiety, somatization. It is a three-point Likert scale composed of 40 items. It has a good internal consistency ranging from Cronbach's $\alpha = .73$ to .88. Ellen's EAS-40 was 1.08 in the initial phase and its dropout to

0.55 in the final phase.

Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1990): It is a rating scale that could be applied to interviews, session conversations, or other material. It is composed of eight levels: level 0 (Warded off), level 1 (Unwanted thoughts), level 2 (Vague awareness/Emergence), level 3 (Problem statement/ Clarification), level 4 (Understanding/ Insight), level 5 (Application/ Working through), level 6 (Problem solution) and level 7 (Mastery). This scale describes the current level of assimilation of the problematic experience, from the perspective of assimilation theory (Stiles et al., 1990).

Therapeutic Collaboration Coding System (TCCS; Ribeiro et al., 2013): It is an observational and transcript-based coding system developed to micro-analyze therapeutic collaboration. This coding system takes each pair of therapist's interventions and client's responses as the unit of analysis contextualized on the immediately preceding therapeutic exchange. Each therapist's interventions can be coded as supporting (problem or innovation) or challenging. Each client's responses indicate the therapist's intervention's pertinence, and the client's experiences and can be coded as validation (safety or tolerable risk), invalidation (disinterest or intolerable risk), or ambivalence. Combining the three categories of the therapist's interventions and five categories of the client's responses, TCCS yields 15 types of therapeutic exchanges. TCCS has shown good and acceptable reliability, with mean Cohen's Kappa values of .92 for therapist's interventions and .93 for client's responses, and a percentage of agreement for both therapeutic actions higher than 80% (Ribeiro et al., 2013, 2021).

Procedure

For the current study, we selected one case from a short-term psychodynamic therapy dataset, which included 3 clients. Two of them showed reliable change and clinical improvement (one had a diagnosis of major depression and the other had anxiety).

The therapist and client signed an informed consent form, in which they agreed to participate in the study and gave permission to use their data in publications. We analyzed the entire psychotherapeutic process, which means 11 sessions.

Case selection

Ellen was selected to meet three criteria: 1) a diagnosis of major depression; 2) short-term psychodynamic therapy and 3) a good outcome as evaluated using the measures described above and considering reliable and clinical improvement (RCSI; Jacobson & Truax, 1991). The other cases in the

dataset were long-term psychodynamic therapy and online psychodynamic therapy. After the psychotherapeutic process, Ellen showed a clinically significant improvement in her depressive symptoms, despite had not achieved recovery. In the follow-up session, six months later, she achieved the functional level. The alexithymic symptoms and general symptomatology showed a significant and reliable improvement, both at the end of therapy and in the two follow-ups. Considering the EAS-40 subscales, it was observed that, at the beginning of therapy, Ellen showed scores compatible with the functional population in psychoticism and obsessiveness/compulsiveness. However, in the somatization and anxiety dimensions, her scores were considered dysfunctional. In the end, Ellen showed clinically significant improvement in all dimensions, except for somatization. Regarding emotional adjustment/neuroticism, at the beginning of therapy, Ellen showed scores above the cut-off points in vulnerability, instability/anxiety, and depression dimensions. In the end, she moved to a functional level in vulnerability and depression dimensions but maintained a high level of instability/anxiety. Concerning the maladjustment/ emotional dimension, at the beginning of therapy, it already was within of expected the for non-clinical population and it remained at the end of therapy and during the two follow-ups. In that sense, it was a good outcome case, even though Ellen had not changed in a functional level in depression (BDI), somatization (EAS-40), and instability/ anxiety (EFN) at the end of therapy (Serralta et al., 2016).

TCCS coding

Ellen's case was coded following the TCCS procedure described by Ribeiro et al. (2013). A pair of trained judges discussed the client's dominant perspective and decided on the problems and expected innovation to consider in coding (Table 9). The judges showed good agreement: 95.29% of the therapist's interventions and 99.67% of the client's responses. Disagreements on coding were resolved by discussion to consensus and a third trained TCCS judge audited the final codes. It was coded 616 therapeutic exchanges.

Table 10

Problems and Innovations in the case of Ellen with examples from session dialogue

Problems	Innovations
Excessive concern about others (CI: "*Everybody is married but I can't step forward without being stuck*")	To allow herself to be helped (CI: "*I won't be upset. Because I was always upsetting myself to please everyone*")
Feeling of revolt for assuming the position of caregiver (CI.: "*I feel revolted because I want to live, but I can't [...] I feel revolted, suffocated*")	To all herself to live (CI: *"I want, I need to live my life*")

Difficulties in delegating responsibilities and tasks (CI: "*I tend to take all the responsibilities. I know this*")	To share the responsibility for caring for her ex-husband with others (CI: "*It's everything organized. My son is giving a shower to his father again. I said: 'Yes, this is how it should be. If you don't come, your father will be two, three days without taking a shower*")
Feeling guilt about her ex-husband's situation (CI: "*I see my ex-husband's situation and I penalize myself*")	To be more flexible, and vulnerable (T: "*Psychologically, emotionally, you aren't feeling like a slave of your ex-husband anymore*")

APES rating

APES rating followed the procedure described in previous studies (Basto et al., 2016, 2018a, 2018b, 2021). Both judges had previous experience in APES rating and were considered reliable, once in previous studies they achieved interrater reliability of ICC [2,1] ≥ .60 (Shrout & Fleiss, 1979).

To assimilation analysis of Ellen's case, all sessions were read several times and the judges consensually chose the theme that stood out during the sessions. According to Caro Gabalda & Stiles (2018), the theme appears repeatedly and points out the problems addressed in the psychotherapeutic process. It represents a remarkable expression of a specific problem. The judges independently identified the main recurrent issues and the dominant and problematic voices. Then they selected excerpts from the transcripts where the main theme was observable and independently applied the APES level in those excerpts. They distinguished 187 passages. Disagreements in voice characterizations, selected passages, and ratings were resolved by discussion to consensus between the judges (Hill et al., 2005). The interrater reliability was ICC [2,1] .94.

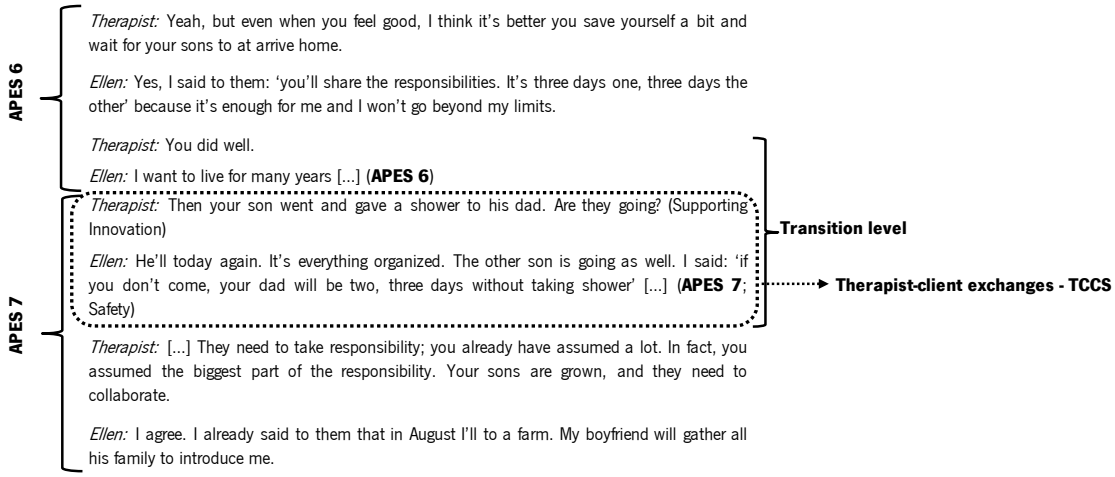
Ellen's dominant voice was identified as "I need to have the control, I must be perfect" and the problematic voice was characterized as "fear of failing" (Ellen: "*I'm feeling revolted because I want to live, but I can't [...] I feel revolted, suffocated [...] I prefer to harm myself [...] I get sick, I hurt myself but I want everybody living well*").

Data analysis

We followed the coding procedure and reliability assessment as stated in the TCCS coding and APES rating. To address our research questions, we performed a descriptive analysis. Concerning the third research question, we considered 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 8. Nested in this analysis we focused on the preceded APES 4 advances.

Figure 8

Example of therapist-client associated with APES transitions in the coded transcripts in Ellen's case



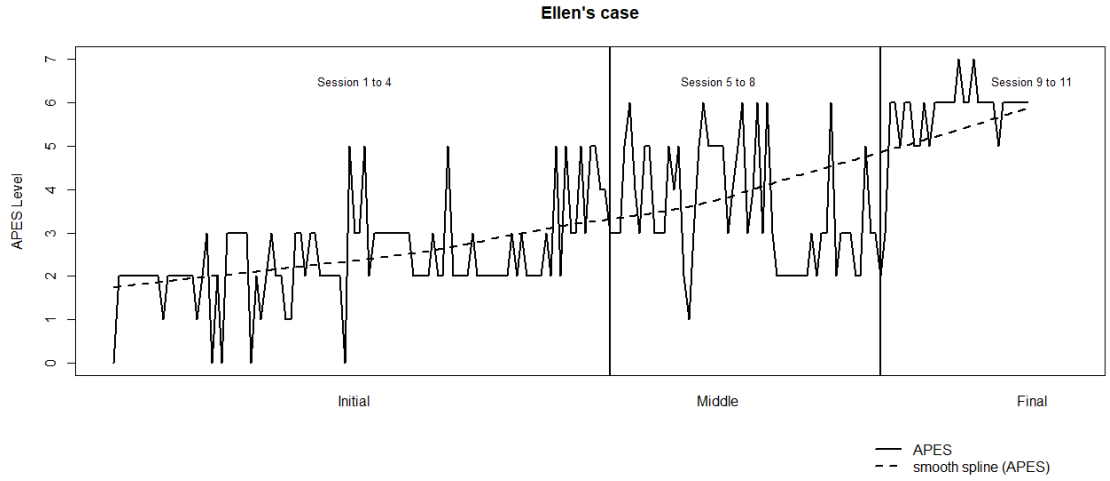
Results

How did the assimilation of problematic experiences develop across phases?

In the assimilation progress (Figure 9), we observed that in the early sessions, APES levels 2 and 3 were the most frequent. However, APES 4 and 5 began to appear during the initial phase. It is important to highlight that APES 4 (n=11) showed 27,27% in the initial phase, 72,73% in the middle phase and it didn't show in the final phase. From session 5 to the final phase of the psychotherapeutic process, Ellen achieved higher levels (e.g., APES 5, 6, and 7). It is noticed, in the sessions, that Ellen decreased her distressing thoughts and strong negative feelings (e.g., anger, fear, sadness), her bias toward blaming others for her problems, and began to show an optimistic affective tone, to achieve solutions for her problems and be proud of her accomplishments.

Figure 9

Assimilation of Problematic Experiences (APES) per session in Ellen's case



In session 6, Ellen noticed the changes that she was achieving in therapy (e.g., accepted getting married, delegated tasks regarding her ex-husband to her sons) and that since she didn't want to create conflicts with her sons, she took all the responsibilities and developed depression, high blood pressure, for instance. "I'm putting it into practice [what is talked about in sessions]".

Example of APES 4 and 5 at session 6

Therapist: As we talk, you take it, you reflect it, you apply it.

Ellen: Wow, when I get out of here, my head is [thinking a lot]. I already told you that my head doesn't stop thinking [...] but I think about many things. [...] I get out of here, I keep thinking about everything we talked about, everything you said to me. I keep thinking, thinking, thinking, thinking. The next day I'm going to do something, then I think: "ops, Ellen [remember that; don't do this]!" (APES 4 – Understanding / Insight)

Therapist: You can stop.

Ellen: These days I was at home saying: "the psychologist said that I should do like that". Everyone was at home and looked at me: "which psychologist?" Then I said: "ah, the professor". (APES 4 – Understanding / Insight)

Therapist: Now I'm the professor.

Ellen: "She said that I have to act like this, and you know that she is right" [she said to her sons]. Then I think: "wait, Ellen. You need to change. That is how to do it". (APES 4 – Understanding / Insight)

Therapist: You got a psychologist.

Ellen: Then my youngest son said: "that's nice, mom!" He thought that the attitude I had was cool. Before I was doing the wrong thing to make them [her sons] happy. (APES 5 – Application / Working through)

Therapist: You can stop [doing the things just to make them happy].

Ellen: [She said to her sons] "My psychologist said that it must be like this. I'm not going to please anyone". My son said "Wow, mom. How nice!" he was amazed by that. (APES 5 – Application / Working through)

How did the therapeutic collaboration develop across phases?

Table 10 shows the types of therapeutic exchanges across therapy phases. In the initial phase, there was a balance between supporting problem and challenging interventions followed by responses within (i.e., Safety) and above (i.e., Intolerable risk) Ellen's TZPD. In the middle phase, the dyad worked mainly within Ellen's actual TZPD (i.e., Supporting problem – Safety). In the final phase, the dyad increased work in Ellen's potential TZPD (i.e., Supporting innovation – Safety, Challenging – Tolerable risk) and decreased work above TZPD (i.e., Challenging – Intolerable risk). In the following vignettes, we observed how the dyad progressed along psychotherapy phases, moving from outside to actual Ellen's TZPD in the initial and middle phases to her potential TZPD in the final phase.

Table 11

Therapeutic exchanges (%) across therapy phases

Therapist-client exchanges	Therapy phase		
	Initial	Middle	Final
Supporting Problem - Safety	51,50	42,57	16,25
Supporting Problem - Tolerable Risk	0,90	1,98	7,50
Supporting Problem - Ambivalence	0,30	0,50	0,00
Supporting Problem - Disinterest	0,60	0,00	0,00
Supporting Problem - Intolerable Risk	0,60	0,99	0,00
Supporting Innovation - Safety	3,89	20,79	31,25
Supporting Innovation - Tolerable Risk	0,00	4,46	8,75
Supporting Innovation - Ambivalence	0,60	0,50	0,00
Supporting Innovation - Disinterest	0,00	0,00	0,00
Supporting Innovation - Intolerable Risk	0,30	0,00	0,00
Challenging - Safety	20,66	14,36	22,50
Challenging - Tolerable Risk	0,90	3,47	11,25

Challenging - Ambivalence	2,99	1,49	0,00
Challenging - Disinterest	0,30	0,00	0,00
Challenging - Intolerable Risk	16,47	8,91	2,50
Total	100,00	100,00	100,00

Note. The initial phase included sessions 1 to 4; the middle phase included sessions 5 to 8; the final phase included 9 to 11.

Example of Supporting problem – Safety at session 2

Therapist: How are you? (Supporting problem)

Ellen: Today I'm not feeling well. (Safety)

Therapist: No? (Supporting problem)

Ellen: No. I got up at three in the morning, I went to bed at 1 a.m. and woke up at 3 a.m. I couldn't sleep and couldn't lie down. Then I got up and walked through the house. When it was 5 a.m., the man [her ex-husband] asked me to make candy for him. And today I'm agitated and I'm going to stay in the hospital tomorrow. (Safety)

Therapist: Why are you going to stay in the hospital? (Supporting problem)

Ellen: Because of my diabetes. (Safety)

Therapist: It isn't good? (Supporting problem)

Ellen: No, I'm not feeling well. These last three days I haven't felt good. (Safety)

Therapist: What do you feel? (Supporting problem)

Ellen: Wow, I feel [...] Today I told Dr. M. that it seems that there is a river, especially at night, it seems that there is a river running inside my body [...] My hands and my feet tingled. (Safety)

Example of Challenging – Intolerable risk at session 2

Therapist: Ellen, the worst thing that can happen to a human is to develop self-pity. (Challenging)

Ellen: But I don't feel sorry for myself, I was revolted. (Intolerable risk)

Therapist: But the revolt is a way to put ourselves as an underdog. (Challenging)

Ellen: I still can't agree. I keep seeing myself as revolted. (Intolerable risk)

Example of Challenging – Tolerable risk at session 4

Therapist: You said, "me and my rigid principles", didn't you? The world already changed but I keep my immutable principles. (Challenging)

Ellen: Yes, that's it. The world is spinning, and I think I'm stuck in time. I think that I'm stuck on a lot of things, such as time, principle, and morality. (Tolerable risk)

Example of Supporting innovation – Safety at session 8

Therapist: As I said, no one changes from one day to the next day: 'Now I won't have problems anymore and there aren't'. We must refurbish the brain to sleep in another way, right? (Supporting innovation)

Ellen: But I was even happy, right?! (Safety)

Therapist: Yes, that's good. So, I'm also glad to hear this. (Supporting innovation)

Ellen: I'm. I wish I had a video camera. (Safety)

Therapist: To record it, right? (Supporting innovation)

Ellen: Yes, to record it. (Safety)

Therapist: To show: 'did you see how I sleep?' (Supporting innovation)

Ellen: Yes, it's hard for me to sleep. What I've been going through in the last year and a half; having insomnia, and not sleeping. I was desperate. As long as we can stay in bed, it still works. But I already couldn't stay in the house, neither on the sofa nor even sitting. I was already starting to walk through the house, through the backyard, and outside. (Safety)

Therapist: And if you start to walk, then you don't sleep at all. What will happen? Certainly, you won't sleep. Will you be sleepwalking? (Supporting innovation)

Ellen: And I take a lot of medicine. The next step is to stop taking all these medicines. (Safety)

What sorts of therapeutic exchanges characterized Ellen's advances and setbacks?

Table 11 shows the types of therapeutic exchanges that accounted for 5% or more of the exchanges. In the initial and middle phases, Ellen's advances were mainly characterized by Supporting problem – Safety and Challenging – Safety exchanges. In the middle phase, increased Supporting innovation interventions followed by Safety and Tolerable risk responses. In the final phase, Supporting innovation – Safety, and Supporting innovation – Tolerable risk exchanges characterized Ellen's advances. Regarding setbacks in the initial phase, they were mainly characterized by therapeutic exchanges above the client's TZPD (i.e., Challenging – Intolerable risk). In the middle, they were above and within the client's TZPD (e.g., Challenging – Intolerable risk and Supporting problem – Safety, respectively). In the final phase, they oscillated between the actual and potential client's TZPD (e.g., Supporting problem – Tolerable risk, Challenging – Safety, and Challenging – Tolerable risk).

Table 12

Therapist-client exchanges preceding assimilation advances and setbacks across the therapy phase

	Therapist-client exchanges	Therapy phase		
		Initial	Middle	Final
Advances	Supporting Problem - Safety	50,00	35,00	0,00
	Supporting Problem - Tolerable Risk	0,00	5,00	0,00
	Supporting Problem - Intolerable Risk	0,00	5,00	0,00
	Supporting Innovation - Safety	0,00	10,00	60,00
	Supporting Innovation - Tolerable Risk	0,00	10,00	40,00
	Supporting Innovation - Ambivalence	4,55	0,00	0,00
	Challenging - Safety	27,27	20,00	0,00
	Challenging - Tolerable Risk	4,55	5,00	0,00
	Challenging - Ambivalence	4,55	5,00	0,00
	Challenging - Intolerable Risk	9,09	5,00	0,00
	Total	100,00	100,00	100,00
Setbacks	Supporting Problem - Safety	27,27	31,25	0,00
	Supporting Problem - Tolerable Risk	4,55	0,00	20,00
	Supporting Innovation - Safety	4,55	12,50	40,00
	Supporting Innovation - Ambivalence	0,00	6,25	0,00
	Challenging - Safety	13,64	25,00	20,00
	Challenging - Tolerable Risk	4,55	0,00	20,00
	Challenging - Ambivalence	4,55	0,00	0,00
	Challenging - Intolerable Risk	40,91	25,00	0,00
	Total	100,00	100,00	100,00

Note. The initial phase included sessions 1 to 4; the middle phase included sessions 5 to 8; the final phase included 9 to 11.

What sorts of therapeutic exchanges characterized Ellen's advances and setbacks regarding insight?

Regarding advances to APES 4, we observed two therapeutic exchanges (i.e., Challenging – Safety and Supporting problem – Safety, both occurred at session 6). Regarding setbacks to APES 4, we observed three therapeutic exchanges (i.e., Challenging – Tolerable risk at session 4, Supporting innovation – Safety at session 5, and Supporting innovation – Ambivalence at session 5).

Example of advance regarding APES 4 at session 6

Therapist: I'll always remember you saying: 'I think I need to stay here [in therapy] for six years. (Challenging)

Ellen: But I think I need six years. (APES 3 – Problem statement / Clarification; Intolerable risk)

Therapist: No, you're already facing your issues. As I said, we'll keep working until the last week of June. (Challenging)

Ellen: Already?! (APES 3 – Problem statement / Clarification; Intolerable risk)

Therapist: Yeah, we still have one more month [of psychotherapy]. Then start our vacation [the university] and we book a time for August or September, to check how things are going. I think that you're improving. The client's change in psychotherapy depends on these conversations, but it depends on how you apply it in daily life, right?! (Challenging)

Ellen: Yeah. (APES 3 – Problem statement / Clarification; Safety)

Therapist: As we talk, you take it, you reflect it, you apply it. (Challenging)

Ellen: Wow, when I get out of here, my head is [thinking a lot]. I already told you that my head doesn't stop thinking [...] but I think about many things. [...] I get out of here, I keep thinking about everything we talked about, everything you said to me. I keep thinking, thinking, thinking, thinking. The next day I'm going to do something, then I think: "ops, Ellen [remember that; don't do this]!" (APES 4 – Understanding / Insight; Safety)

Example of setback regarding APES 4 at session 5

Therapist: Yes, but these issues are being solved. (Supporting problem)

Ellen: For certain issues, I'm radical. I know that I'm harming myself, feeling suffocated. But not today. Today I'm even better, I'm lighter. (APES 3 – Problem statement / Clarification; Tolerable risk)

Therapist: Humm... (Supporting Problem)

Ellen: I'm already considering coming back to my painting course. So, it cheers me up. (APES 5 – Application / Working through; Safety)

Therapist: You must remember that you have someone helping you during the day. Then if you couldn't go to church on Saturday, you can go out to another place at least. (Supporting innovation)

Ellen: Go out on the weekends. (APES 5 – Application/Working through; Safety)

Therapist: Yeah. At least you have this chance in the week. (Supporting innovation)

Ellen: Yeah. (APES 5 – Application/Working through; Safety)

Therapist: Yeah. It gives you some relief. (Supporting innovation)

Ellen: Exactly. (APES 5 – Application/Working through; Safety)

Therapist: It gives you some balance. (Supporting innovation)

Ellen: Yes, because I have to go out. I must get out. I can't be stuck [indoors]. (APES 5 – Application/Working through; Safety)

Therapist: To stay twenty-four hours available to a sick person [...] The caregiver gets sicker than the sick person. Then those who take care of a patient 24h per day, become sick. It's obvious. So, you must find some balance, which you're already finding. You're doing it quickly since today is our fifth session. Those who see you before and today, notice that you aren't the same person. (Supporting innovation)

Ellen: It's how I used to say. I had to talk. I hadn't one to talk with. Now even my brother is talking more with me. I think he looked at my face and realized my drama. (APES 4 – Understanding / Insight; Safety)

Therapist: No, it's because you're more available. (Supporting innovation)

Ellen: Yes. (APES 4 – Understanding / Insight; Safety)

Discussion

In the current study, we analyzed the entire short-term psychodynamic therapy for a depressive client. Our observations were consistent with the therapeutic collaboration model (Ribeiro et al., 2013) and the assimilation model (Stiles et al., 1990) concerning a good outcome case regardless of the theoretical orientation of the therapist. It was also consistent with the development of a good outcome case treated following psychodynamic psychotherapy. Since the client's problem and resistance are mitigated, it creates temporary setbacks (Luz, 2015), highlighting that the process of change is not linear (Caro Gabalda, 2006; Mendes et al., 2016).

We observed that Ellen made an excellent improvement in assimilating her previously painful and problematic experiences into the self. She developed from APES 0 (i.e., Warded off) in the first sessions to APES 6 and 7 (i.e., Problem solution and Mastery, respectively) in the final phase. More specifically, she reached APES 4 (i.e., Understanding/ Insight) at the end of the third session (initial phase) and mostly in the middle phase. It suggests that her psychotherapeutic process promoted the communication and joint between the client's dominant and problematic voices, smooth integration of problematic experience, becoming a resource (Brinegar et al., 2006), and leading to a decrease in the impact on Ellen's life (i.e., depressive symptoms).

These results match those observed in earlier studies in which good outcome cases achieved APES 4 or higher with different therapy approaches (Basto et al., 2018a; Detert et al., 2006; Meystre et al., 2017; Ribeiro et al., 2016; Ryttinger et al., 2022). Some good outcome case studies also have shown that, even in the initial phase, the client can reach APES 4 in a few passages (Basto et al., 2021; Mendes

et al., 2016; Ribeiro et al., 2016). If the client's increased skills to reach insight in the middle phase of psychodynamic therapy is a sign of a good development of the therapeutic process (Luz, 2015). In addition, the assimilation of problematic experiences is not finished at APES 4, "but may go on toward concrete application of the problem and integration into the self" (Meystre et al. 2017, p. 14), as observed in Ellen's case. It occurs since insight is a mechanism of change in psychodynamic therapy (Crits-Christoph et al., 2013; Leichsenring et al., 2018, 2019), it fosters recovery in symptoms and enhances life functioning (Meystre et al., 2017). However, the insight does not occur spontaneously by the client (Meystre et al., 2015, 2017). For that to happen, it is required to have a collaborative therapeutic relationship and the therapist's interventions must be attuned to the client's skills and requirements (Leiman & Stiles, 2001), as observed in the vignettes of Ellen's advances and setbacks regarding APES 4.

In regard to APES 4, we observed that it was a rare event (i.e., n=11). According to Meystre et al. (2017), the client's insight may be understood as peaks of assimilation. As observed in their study, Ellen's case also suggests that even though insight occurred a few times along the psychotherapeutic process, "they may have a significant impact by leading the client to some reflection and elaboration outside psychotherapy. Insight events were rare but probably helpful under certain circumstances" (Meystre et al., 2017, p. 12). Insights are elaborated and help the elaboration of unconscious fantasies, through the creation of new meanings, transformation, and expansion of the client's mind. Namely, the therapist's interpretation of the client's unconscious patterns and insight facilitates the elaboration and opens up new possibilities for the client to experience his/her affections (Levy, 2015). This development supports the psychodynamic studies which suggest "that gains in insight require a lengthy therapeutic treatment in order to bring about their effects" (Lacewing, 2014, p. 162). Luz (2015) added that the psychotherapy continues after the last session since many questions keep elaborating in the client's mind.

In addition, the assimilation model suggests building a meaning bridge, which means the communication between problematic and dominant voices, is facilitated by a psychotherapeutic process (Stiles, 2011). A possible explanation for our results might be that Ellen built a meaning bridge when she understood why her problematic (i.e., fear of failing) and dominant (i.e., need to have control and be perfect) voices were problematic. In the following example from session 8, Ellen understood her problematic experiences, built a meaning bridge, and was proud of her accomplishment: "*Let me tell you how I'm looking at my current situation. When I arrived here, he was my biggest problem [...] My ex-husband. He suffocated me. I used to feel suffocated because I couldn't take a step forward. But it wasn't*

his fault, it was all my fault because I tended to take all responsibilities to myself. But not anymore. Nowadays I can go out and I share the responsibilities with my sons" (APES 6 – Problem solution).

Regarding the advances in the initial phase, they were mostly by supporting problem and challenging interventions often followed by safety responses (50% and 27,27%, respectively). In the final phase, Supporting innovation – Safety and Supporting innovation – Tolerable risk (60% and 40%, respectively) fostered the client's advances. Specifically, regarding advances to APES 4, we observed Supporting problem and Challenging interventions followed by safety responses. These results are in line with previous studies (Meystre et al., 2014, 2015; Caro Gabalda et al., 2014; Ribeiro et al., 2016) indicating that interpretation and confrontation (subcategories of challenging interventions in TCCS; see Ribeiro et al., 2013), facilitated the client's advances, for instance, to elaborate insight (APES 4). Besides this, the aforementioned expressive interventions (i.e., interpretation and confrontation) are insight promoters and intend to bring to the client's conscious what is unconscious (Gabbard, 2016).

Concerning setbacks, they occurred mostly in the client's potential TZPD (e.g., Supporting innovation – Safety and Challenging – Tolerable risk).. However, this result has not previously been described by Ribeiro et al. (2016), which found mainly challenging interventions preceding setbacks in the good outcome case. A possible explanation for this might be that in Ellen's case the dyad was mostly working collaboratively in her potential TZPD in the final phase (i.e., APES 5, 6, and 7). According to Luz (2015), it is common for clients to present setbacks in the final phase to avoid the end of the psychotherapy. Beyond that, in between insight and side effects on the client's symptoms of depression, there is a time for elaboration (Meystre et al., 2017). The elaboration work will consist of the therapist following the client in advances and setbacks, providing insight and an understanding of these movements and their role. This elaboration process, which consists in overcoming resistance, ends up in psychological changes (Levy, 2015).

According to Caro Gabalda & Stiles (2013), it is unavoidable setbacks to develop along psychotherapy. The client's TZPD reformulates the limits moment-by-moment, which means that "what seemed safe at one moment may become risky in the next" (Ribeiro et al., 2013, p. 300). The previous setback explanation proposed by the therapeutic collaboration model (Ribeiro et al., 2013) follows Caro Gabalda et al. (2016, p. 9) statement, in which setbacks may be explained by the fact that since the client reach "the top of the current problem strand's TZPD, then further therapist challenging tends to lead to an invalidation, or rejection, of therapist proposals, that is, to a setback" (Caro Gabalda et al., 2016, p. 9).

It seems that the dyad mainly worked within Ellen's TZPD across sessions. In the initial phase, the dyad worked mainly within (i.e., actual TZPD) and above the client's TZPD, with the therapist balancing her interventions between supporting and challenging the client's maladaptive perspective. Supporting interventions were followed by Ellen's validation in a climate of comfort (i.e., safety); whereas in challenging interventions, the client oscillated between feeling it as safe and as an intolerable risk. According to Luz (2015), the focus in the initial phase of psychodynamic therapy is to understand the client's problems and, mainly to build a therapeutic alliance. During this phase, there are also therapists' interpretations to try to access the client's resistance to treatment since deep interpretations can increase the client's anxiety, unnecessary to his/her development in therapy.

In the middle phase, the dyad worked mainly within the client's actual TZPD, followed by increased work in the potential TZPD (i.e., Supporting innovation's interventions and Tolerable risk's responses). It suggests that the therapist was attuned to Ellen's problem and that she felt more encouraged to talk about her sufferings. As long as the client feels comfortable talking, the therapist can identify in which moments can interpret the conflict underlying the reports. If these conflicts are well addressed, it is expected client's insights and a decrease in symptoms (Luz, 2015). This emphasizes that the therapist must move and be flexible to adjust the interventions considering the client's needs at a given moment of the psychotherapeutic process (Gabbard, 2016).

In the final phase, the dyad moved and worked mostly in Ellen's potential TZPD, with the therapist pushing the client toward change. There is an increase in Supporting innovation and Challenging interventions and in Tolerable risk' responses, suggesting a growing tolerance for novelty. At the same time, there is a decrease in Supporting problem interventions and Intolerable risk responses. In agreement with Luz (2015), regardless of the client's problem which led to treatment, it is important that the client is better able to deal with reality. In this phase, the therapist should identify the client's changes achieved during therapy, identify issues that still deserve some attention, and talk about the end of psychotherapy. "It is a stage of 'balance' and elaboration of the separation" (Luz, 2015, p. 261).

These results are consistent with the short-term psychodynamic therapy and therapeutic collaboration model (Ribeiro et al., 2013). The oscillation between therapeutic exchanges within and outside in the initial phase evolves into a balance between the actual and potential level (client's emerging change) within TZPD. Then it developed to a higher level of change and balance within Ellen's TZPD, with more safety or tolerable risk responses.

In accordance with the present results, previous studies have demonstrated that an oscillation between supporting the client's usual perspective and promoting an alternative and innovative perspective

may facilitate the client's change (Ribeiro et al., 2016). In the initial phase, the therapist must facilitate a safe experience (i.e., actual level), since it concerns the client's ability to deal with the problems when they sought therapy. However, the therapist often works outside the client's TZPD in this phase "challenging the client's usual perspective, leading to revisions that incorporate the initially problematic experience, albeit producing some sense of anxiety or risk" (Stiles et al., 2016, p. 268). For this reason, it is important the therapist recognizes the client's experience (e.g., intolerable risk responses) and adjusts the interventions taking into account the client's needs. It may foster the reestablishment of therapeutic collaboration and improve the confidence between therapist and client.

In this safe environment, the client can express their problematic voice which disrupts the community of voices, "characterized as being too rigid and excluding the assimilation of problematic experiences. This disruption facilitates the development of a meaning bridge" (Caro Gabalda et al., 2014, p. 17). Based on that, it can thus be suggested that the dyad worked collaboratively along with the psychotherapeutic process since the therapeutic collaboration can be understood as the therapist being responsive when the client felt risk and when they are ready to move forward by challenging (Ribeiro et al., 2016).

In summary, our results showed that insight is not an isolated activity but must be followed by elaboration; psychotherapy is not a linear process, but it is characterized by advances and setbacks, as a sawtooth pattern; and the adjustment of the therapist's interventions to the client's level seems to be essential, as well as his/her sensitivity to challenge accordingly to client's needs and skills. This combination of findings provides some support for the conceptual premise that the client's changes (i.e., assimilation of problematic experiences) could not be developed without a suitable therapeutic collaboration, which sets the client for Insight.

Limitations and Future directions

This study has some limitations. Firstly, since it included only one case, replication is needed to observe if it will occur the same patterns of development or if it will emerge new ones. Secondly, our interpretations represent a descriptive and specific reconstruction of Ellen's psychotherapeutic process, achieved by APES and TCCS as a conceptual tool, which allowed us to observe dynamics patterns (e.g., advances and setbacks). Different patterns could be found using other tools or using more robust analyzes.

Although the limitation, we underline that a major strength of this case study was that each piece of information observed (e.g., assimilation, advances, setbacks), provided from different viewpoints (e.g., therapist's interventions, client's responses) enable a full picture of the importance of insight in Ellen's assimilation of problematic experiences. Moreover, intensive study of a good outcome case contributes to theorizing about the client's process of change, generating reflections and hypotheses which can guide the therapist's practice and further studies.

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CONCLUSÃO

Conclusão

O objetivo geral da presente tese foi compreender como a colaboração terapêutica facilita a mudança do cliente ao longo do processo psicoterapêutico. Desenvolvido numa perspetiva micro analítica da colaboração e da mudança em psicoterapia, este estudo foi fundamentado a partir do modelo de assimilação (Stiles et al., 1990) e do modelo de colaboração (Ribeiro et al., 2013).

Os estudos da presente tese foram estruturados a partir da investigação descritiva e da lógica *Theory Building* (Stiles, 2007). A natureza descritiva focou na observação de padrões de interação entre as díades que foram importantes para a mudança do cliente ao longo do processo terapêutico. Nesse sentido, além da profundidade e riqueza do fenômeno de investigação proporcionadas pela minuciosa análise observacional, as nossas interpretações foram baseadas nos dados descritivos e quantitativos, bem como no consenso entre diferentes pares de juízes. À semelhança de Stiles (2005), considerámos que cada novo estudo elabora ou acrescenta algo à teoria, que este é um processo contínuo e em expansão para novas áreas. É nesse cenário, associado à natureza descritiva e de *Theory Building*, que os estudos desta tese visaram contribuir para a consolidação de ambos os modelos.

Diversos autores (e.g., Corrêa, 2016; Lepper & Mergenthaler, 2007; Ribeiro et al., 2013) salientam a importância de analisar, momento-a-momento, os fatores envolvidos na colaboração terapêutica para a mudança do cliente. Assim, ao fundamentarmos nossos estudos na investigação acerca do processo de mudança terapêutica, tal como proposto por Elliott (2010), realçamos a "influência imediata e direta das intervenções do terapeuta nos processos do cliente, da própria sessão, e também o efeito que as ações do cliente têm na forma como o terapeuta processa e planeia as suas atividades" (p.128). Assim, uma compreensão acerca das micro mudanças no cliente pode resultar em sugestões para a prática do terapeuta em contextos semelhantes (Levitt et al., 2006).

De forma a abranger diferentes cenários, optamos por analisar casos clínicos de diferentes diagnósticos (i.e., perturbação de personalidade borderline e depressão), abordagens (i.e., terapia cognitivo comportamental e psicodinâmica) e resultados terapêuticos (i.e., sucesso, insucesso e desistência). A metodologia de estudo de caso, numa perspetiva de *Theory Building*, foi escolhida por permitir uma profunda exploração e descrição dos fenómenos estudados (Yin, 2012) que, ao corroborar com o modelo de assimilação (Stiles et al., 1990) e de colaboração terapêutica (Ribeiro et al., 2013), poderia confirmar e/ou modificar essas conceptualizações teóricas (Stiles, 2009).

Consideramos que investigar estudos de caso de modo intensivo contribui para a teorização sobre o processo de mudança, gerando reflexões e hipóteses que podem orientar a prática e novos

estudos. Tal como referido por Caro Gabalda (2006a), também acreditamos ser fundamental estudar o processo terapêutico em casos de resultado negativo (i.e., desistência e insucesso), uma vez que este permite a observação do processo terapêutico, a identificação de variáveis, desenvolvimento de interpretações fundamentadas e validação e/ou elaboração da teoria. Posto isso, justificamos a nossa escolha com o facto de existirem poucos estudos que articulam a assimilação de experiências problemáticas à colaboração terapêutica (i.e., Ribeiro et al., 2016) e à escassez de estudos de casos clínicos com perturbação de personalidade borderline ou de abordagem psicodinâmica fundamentados no contexto da colaboração terapêutica (Ribeiro et al., 2013).

Nesse contexto, alguns fatores influenciam a escassez de estudos de casos clínicos completos contextualizados nos modelos norteadores desta tese. Para Kazdin (2009), o estudo do processo de mudança do cliente é complexo e árduo uma vez que diversos aspetos podem influenciar o resultado terapêutico. Nesse sentido, observar, analisar e compreender a experiência singular do cliente, seu processo de mudança e a dinâmica da terapia constitui um desafio para a pesquisa em psicoterapia (Duarte et al., 2019).

Outra justificativa atribuída à referida escassez decorre da morosidade do processo de codificação em ambos os sistemas adotados. Tanto a Escala de Assimilação de Experiências Problemáticas (EAEP; Stiles et al., 1990) quanto o Sistema de Codificação da Colaboração Terapêutica (SCCT; Ribeiro et al., 2013) demandam a observação das sessões, microanálises baseadas nas transcrições, codificação, discussão e um bom acordo por dois juízes (cf. os respetivos sistemas) e auditoria das codificações. A título de ilustração, no primeiro estudo foram analisados dois casos completos, com um total de 28 sessões, 681 passagens (i.e., uma ou algumas frases que expressam experiências problemáticas; EAEP) e 1.795 interações terapêuticas (i.e., intervenção do terapeuta e resposta do cliente; SCCT). No segundo estudo de caso foram analisadas 12 sessões, 165 passagens e 222 interações terapêuticas. No terceiro estudo de caso, foram analisadas 11 sessões, 187 passagens e 616 interações terapêuticas. Tais casos totalizaram a análise de 1.033 passagens e de 2.633 interações terapêuticas.

Dito isto, o primeiro estudo desta tese teve por objetivo analisar a relação entre as interações terapêuticas (não) colaborativas e o progresso da assimilação de experiências problemáticas em dois casos contrastantes de depressão maior e tratados a partir da Terapia Cognitivo Comportamental. Nossos resultados demonstraram que, no caso de sucesso (i.e., Kate), houve um aumento gradativo de intervenções focadas nas mudanças alcançadas pela cliente (i.e., Suporte na inovação). Estes resultados

estão de acordo com estudos fundamentados no modelo de colaboração (e.g., Ferreira et al., 2015; Ribeiro et al., 2021).

No que concerne aos resultados encontrados no caso de insucesso, importa notar que o aumento das interações de Suporte no problema – Ambivalência é inédito. Uma hipótese aponta que as tentativas da terapeuta em compreender os problemas de Annie foram inadequadas, gerando respostas de ambivalência. Outra hipótese é de que a resistência da cliente para a mudança pode ter ocorrido diante da falta de recursos para validar as intervenções terapêuticas, considerando a tentativa da terapeuta de compreender a perspetiva atual da cliente.

Os resultados do primeiro estudo fornecem informações interessantes sobre como os terapeutas podem ajustar suas intervenções às necessidades e experiências do cliente, através do desafio à perspetiva do cliente e do suporte das inovações emergentes, de forma a promover progressos na assimilação de experiências problemáticas.

O segundo estudo de caso partiu do pressuposto de que a qualidade da interação entre terapeuta e cliente é fundamental para a decisão do cliente em continuar ou desistir do processo terapêutico. Bem como da importância de se estudar casos com resultados negativos para se construir conhecimentos confiáveis e treinar terapeutas em situações semelhantes. Especificamente, a literatura aponta que a desistência terapêutica está atrelada a transtornos de personalidade (Swift & Greenberg, 2012) e a baixa qualidade da relação terapêutica (Janeiro et al., 2018). E a abordagem psicodinâmica contemporânea valoriza a flexibilidade do terapeuta, bem como realça a influência mútua entre o terapeuta e o cliente (Dotta et al., 2018).

Diante desse contexto, pareceu-nos importante verificar a colaboração terapêutica e a assimilação de experiências problemáticas em um caso de transtorno de personalidade borderline, de desistência e enquadrado na psicoterapia psicodinâmica. Esse estudo, pioneiro do Sistema de Codificação da Colaboração Terapêutica a ser aplicado em um caso de perturbação borderline e na abordagem psicodinâmica, foi analisado através do método *State Space Grids* (*SSGs*; Lewis et al., 2004), fruto da Teoria dos Sistemas Dinâmicos (e.g., Hollenstein, 2013; Lewis, 2000). Tanto a Teoria dos Sistemas Dinâmicos quanto o modelo de colaboração (Ribeiro et al., 2013) entendem que a interação entre o terapeuta e cliente é bidirecional e dinâmica. Assim, a mudança do cliente surge nessa interação que é composta por um sistema dinâmico, guiado por princípios como a auto-organização e baseado em variáveis de tempo e mudança.

Quando observamos as interações terapêuticas, nossos dados apontam para uma concentração de interações dentro da zona de desenvolvimento atual do cliente, ou seja, em uma zona de segurança

e conforto expressa através da interação terapêutica do tipo Suporte no problema – Segurança. Nossa hipótese é de que algumas dificuldades da díade em progredir para a zona potencial do cliente podem ter sido tanto por parte da terapeuta, que não percebeu oportunidades para facilitar uma mudança no cliente, através do desafio da sua perspetiva problemática; quanto por parte de Charles, que não estava preparado para a mudança. Essa estagnação foi confirmada através da falta de mudança sintomatológica (i.e., OQ-45.2) e da não observação de atractores com respostas de Risco tolerável (i.e., *SSGs*).

Tendo em consideração o caso Charles e o caso de insucesso do primeiro estudo (i.e., Annie), observamos que houve uma prevalência das intervenções de suporte no problema, sobretudo na fase final. No entanto, essas intervenções são expectáveis na fase inicial, quando objetiva-se compreender o problema do cliente, aceder às suas resistências e construir uma aliança terapêutica (Luz, 2015). No que concerne às respostas de ambos os clientes, esperávamos encontrar sobretudo respostas de risco intolerável, conforme estudos prévios de insucesso e desistência terapêutica (Cardoso et al., 2019; Ferreira, et al., 2015; Pinto et al., 2018; Ribeiro et al., 2019). Conforme dito anteriormente, as respostas de Charles foram maioritariamente de segurança e respostas de ambivalência foram identificadas apenas no caso Annie. Isso pode sugerir que, além da resistência para a mudança, especificamente Annie precisaria de mais sessões para consolidar seus ganhos terapêuticos. É importante destacar ainda que, nesta comparação, trata-se de clientes com diferentes diagnósticos e abordagens terapêuticas. Assim, quer numa lógica de replicação teórica e/ou replicação empírica, parece-nos importante considerar tanto a variável diagnóstico (e.g., perturbação de personalidade borderline) quanto abordagem teórica (e.g., psicoterapia psicodinâmica, terapia cognitivo comportamental).

Charles procurou a psicoterapia por iniciativa própria, compartilhou a necessidade de ajuda e, teoricamente, aceitou o acordo terapêutico (i.e., vínculo entre a díade, acordo nos objetivos e nas tarefas; Bordin, 1979). No entanto, o não cumprimento desse acordo acerca das tarefas foi observado nos frequentes atrasos e faltas o que, consequentemente, não permitiu a concretização dos objetivos previamente acordados. Nota-se ainda, ao longo das sessões, a ausência de discussão acerca desses comportamentos não verbais do cliente, que pode culminar em dificuldades na interação e em uma maior resistência (e.g., mudança de tópicos). No que concerne as contribuições da terapeuta nas ruturas da aliança no caso Charles, Dotta et al. (2020) sugerem que esta não estava sintonizada com as habilidades e, sobretudo necessidades do cliente. Sendo assim expressas através das ruturas de evitamento.

Nesse sentido, os resultados do nosso segundo estudo levam-nos a hipotetizar que talvez fosse importante a terapeuta ter desafiado a perspetiva problemática de Charles, tirando-o da zona de conforto,

mesmo que isso levasse à uma instabilidade temporária no trabalho da díade (e.g., respostas de risco intolerável). Bem como observar os sinais de pouco envolvimento do cliente (e.g., faltar muitas sessões sem acordo prévio com a terapeuta) e investir no aumento progressivo da aliança terapêutica para um bom resultado terapêutico.

No terceiro estudo desta tese, propusemo-nos a identificar as interações terapêuticas que caracterizaram os avanços e retrocessos em um caso de depressão tratado a partir da abordagem psicodinâmica. Tal qual destacado por diversos estudos (Caro Gabalda, 2006a; Caro Gabalda & Stiles, 2018, 2020; Mendes et al., 2016), partilhamos da ideia de que o processo de mudança não é linear. Para tanto, recorremos ao Sistema de Codificação da Colaboração Terapêutica (Ribeiro et al., 2013), buscando expandir os estudos de abordagens narrativa, cognitivo comportamental e focada nas emoções a abordagens psicodinâmicas, bem como relacionando-o a mudança da cliente (i.e., EAEP; Stiles et al., 1990).

Efetivamente, os resultados encontrados no terceiro estudo parecem consistentes com o modelo de colaboração terapêutica (Ribeiro et al., 2013) e o modelo de assimilação (Stiles et al., 1990), uma vez que se verificou um trabalho colaborativo, o progresso na assimilação de experiências problemáticas, o alcance do estádio 4 e a diminuição dos sintomas. Estes resultados sugerem a importância de as intervenções terapêuticas estarem sintonizadas com as habilidades e demandas da cliente.

Na fase inicial do processo terapêutico, é possível identificar oscilações nas intervenções de suporte no problema e de desafio tanto nos casos Annie e Kate (ambas do primeiro estudo) quanto no caso Ellen (do terceiro estudo). Contudo, é apenas nos casos de sucesso (i.e., Kate e Ellen) que observamos um aumento progressivo nas intervenções focadas na inovação ou no desafio da perspetiva usual das clientes; intervenções estas codificadas com estádios mais altos da EAEP (i.e., ≥4).

Comparando o caso Ellen com o também caso de sucesso do primeiro estudo (i.e., Kate), observamos que, ao alcançarem o estádio 4, ambas apresentaram redução no sofrimento, alívio dos sintomas e novas possibilidades de viver. Essa perspetiva sobre um caso de sucesso é congruente com estudos prévios, que ressaltam que o cliente deve atingir, pelo menos, o estádio 4 na EAEP (Basto et al., 2018; Detert et al., 2006; Meystre et al., 2017; Ribeiro et al., 2016). É importante destacar que, enquanto Ellen alcançou esse estádio no final da fase inicial, Kate alcançou mais tarde (i.e., sessão 11).

Compartilhando da mesma abordagem terapêutica, mas diferentemente do segundo estudo (i.e., caso Charles), Ellen pareceu-nos mais motivada para com o processo terapêutico, bem como para a consequente mudança. Relembre-se que esse desejo de mudar era verbalizado desde as primeiras sessões. Na segunda sessão, por exemplo, ela percebe que é responsável pelas suas próprias escolhas:

"Eu puxo tudo para mim, a culpa é minha, eu reconheço [...] eu quero viver, eu estou tendo a necessidade de viver a minha vida, eu estou sentindo isso". Mais adiante, na quinta sessão, ela completa: "Acho que estou recuperando a minha vida, a minha vontade de viver". Efetivamente, o reconhecimento das suas dificuldades, o pedido de ajuda, a execução das propostas da terapeuta e a consequente perceção das mudanças corrobora com o progresso do trabalho terapêutico da díade; que se moveu da zona de desenvolvimento atual na fase intermédia para a zona de desenvolvimento potencial na fase final.

As interações terapêuticas (i.e., Suporte na inovação – Segurança) encontradas nos retrocessos da fase final do caso Ellen parecem-nos interessantes, uma vez que o estudo de Ribeiro et al. (2016) observou intervenções de desafio nos retrocessos do caso de sucesso. Um aspeto a ser considerado no nosso estudo é que, nessa fase, a díade trabalhou maioritariamente na zona de desenvolvimento potencial da cliente, sugerindo que Ellen estava elaborando sua problemática, bem como apresentando mudanças psicológicas (i.e., estádios 5, 6 e 7). Nesse contexto, em linha com a perspetiva psicodinâmica e com Levy (2015), acreditamos que o trabalho de elaboração consiste no acompanhamento do terapeuta para com o cliente nos seus avanços e retrocessos, de forma a tentar compreender o significado desses movimentos.

Esse trabalho de elaboração fica evidente na fase final do processo terapêutico de Ellen, onde observamos diversas mudanças. Por exemplo, ela manteve a postura de compartilhar a responsabilidade do ex-marido com os filhos, decidiu que iria morar com o noivo, começou a dormir melhor e manteve o novo funcionamento de cuidar mais dela mesma (e.g., a terapeuta diz: "Das suas mudanças, talvez a autossuficiência seja uma das maiores").

Ao analisar o processo de assimilação de experiências problemáticas e a colaboração terapêutica em diferentes casos clínicos, observamos que os resultados encontrados são consistentes entre si bem como com estudos prévios que utilizaram a EAEP (e.g., Basto et al., 2018; Caro Gabalda, 2006a; Caro Gabalda et al., 2014, 2016; Caro Gabalda & Stiles, 2018, 2020; Detert et al., 2006; Honos-Webb & Stiles, 1998; Meystre et al., 2014, 2015, 2017; Stiles et al., 1990) e o SCCT (e.g., Corrêa, 2016; Ferreira et al., 2015; Pinto, et al., 2018; Ribeiro, A. et al., 2016; Ribeiro et al., 2013, 2016, 2019, 2021).

Em suma, os resultados encontrados nos três estudos apresentaram um padrão de assimilação de experiências problemáticas irregular, conforme descrito em estudos prévios. Eles também confirmaram a expectativa teórica de que intervenções focadas na perspetiva usual do cliente, seguidas de respostas de segurança (i.e., Suporte no problema – Segurança) foram mais plausíveis em passagens codificadas com estádios mais baixos da EAEP. Já as intervenções focadas na inovação ou no desafio da

perspetiva atual do cliente foram codificadas com estádios mais altos da EAEP. Baseado nisso, nossos resultados suportam a relação entre o modelo de assimilação e o modelo de colaboração terapêutica.

De forma geral, os estudos da presente tese reforçam a confiança tanto no modelo de assimilação (Stiles et al., 1990) e EAEP, quanto no modelo de colaboração terapêutica (Ribeiro et al., 2013) e SCCT. Especificamente, essa tese permitiu 1) Analisar o padrão da colaboração terapêutica ao longo do processo terapêutico; 2) Observar o desenvolvimento da assimilação de experiências problemáticas; 3) Clarificar como os tipos de interações terapêuticas (não) colaborativas estão relacionadas com baixos e elevados estádios de assimilação; 4) Descrever as interações terapêuticas que caracterizam avanços e retrocessos; e 5) Identificar as interações terapêuticas que caracterizam avanços e retrocessos em relação ao *insight*.

Importa notar que acreditamos que os estudos que compõem esta tese contribuem para uma prática clínica, baseada em evidências, sobre os processos de mudança do cliente. Tais resultados também sugerem alternativas sobre as quais o terapeuta pode ajustar suas intervenções às experiências e necessidades do cliente, bem como identificar variáveis, em cenários similares. Podemos pensar que, quando ocorre num clima de segurança, desafiar a perspetiva usual do cliente e suportar as inovações emergentes podem ser práticas consideradas produtivas para o seu processo de mudança.

Entretanto, algumas limitações precisam ser relatadas. De maneira geral, os resultados são consistentes com estudos prévios. Estas observações, encontradas a partir do estudo de caso *Theory Building*, podem suscitar a investigação com outros *designs* confirmatórios e com base em amostras. E, como dito anteriormente, faz-se necessário salientar a morosidade no processo de codificação da colaboração terapêutica e da assimilação de experiências problemáticas, bem como a necessidade de um acordo entre os juízes para que tais dados sejam considerados válidos.

No que concerne ao primeiro estudo, reconhecemos que a falta da gravação de algumas sessões, bem como a escolha de um caso de insucesso atípico podem ter influenciado os resultados encontrados. Assim, se tivéssemos escolhido um típico caso de insucesso provavelmente teríamos encontrado diferenças significativas, tanto no percurso da colaboração terapêutica quanto no processo de mudança das clientes. No segundo estudo, destacamos o relativo baixo acordo entre os juízes e no terceiro destacamos que, por se tratar de um estudo descritivo, faz-se necessária a replicação deste e a utilização de análises mais robustas.

Apesar das limitações, bem como das potencialidades encontradas nesta tese, reforçamos a necessidade de futuros estudos descritivos a fim de ampliar o entendimento acerca da colaboração terapêutica como facilitador na mudança do cliente ao longo do processo terapêutico. Para tanto, deve-

se considerar diferentes variáveis como, por exemplo, casos típicos de insucesso, sucesso e desistência, diferentes diagnósticos, diferentes abordagens terapêuticas e maiores amostras. Assim, a análise de díades terapêuticas nesses diferentes cenários permitirá a expansão, elaboração e refinamento do modelo de assimilação (Stiles et al., 1990) e do modelo de colaboração (Ribeiro et al., 2013).

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