THE RESOLUTION OF CLIENT CONFRONTATION CHALLENGES

IN EXPLORATORY PSYCHOTHERAPY:

DEVELOPING THE NEW PARADIGM IN PSYCHOTHERAPY RESEARCH

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Summary

'How are Client Confrontation Challenges to the therapeutic relationship in Exploratory therapy best addressed?' was the question explored here. Given the significance of the therapeutic relationship in Exploratory therapy (a Psychodynamic Interpersonal therapy), Confrontation Challenges are significant, 'make or break', moments. Depending on the effectiveness with which they are addressed, Confrontation Challenges may significantly threaten or significantly promote therapeutic change.

The question was explored within the new Change Process Paradigm in psychotherapy research. Therapeutic change is conceptualised as a fluid, continuous, heterogeneous process; outcomes are achieved cumulatively, during and between sessions and after therapy. With this reconceptualisation of relations between process and outcome, the new paradigm aims to inform micro-level, moment-to moment, psychotherapeutic decision-making and theory-development.

The new paradigm's Significant Change Events strategy and its Task Analysis method were used to explore the question. Thus Client Confrontation Challenges were recast as affective tasks 'calling for' resolution; Challenge Resolution Events are Significant Change Events in Exploratory therapy. The researcher's 'best guess' at how resolution may proceed (expressed in a Rational Model) was revised by iterative and cumulative comparison with detailed, descriptions of more and less effective resolution performances observed (in the Empirical Analysis) in therapy practice. The Rational Empirical Comparison resulted in a Revised Model of effective Confrontation Challenge Resolution; this represented the task analytic answer.

Effective Challenge Resolution was interpreted as process of 'Going with but containing the Challenge' and thereafter managing two interdependent subprocesses, Negotiation and Exploration. This substantive contribution was discussed in relation to clinical thinking and to previous empirical work. The task analytic approach and the Change Process Paradigm were developed by enhancing the triangulation of psychotherapeutic theory and practice with the research approach.

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Introduction to the Thesis

The influence of psychotherapy research on practice has been disappointing. Making this statement in 1994 is not a new or radical revelation. Published in 1984, Morris Parloff's paper, "Psychotherapy Research and its Incredible Credibility Crisis" was probably more disturbing to the field of psychotherapy research.

Efforts to narrow the gap between research and practice were, however, not abandoned. The gap was recognised as credible. Researchers' (and funders') persistent adherence to traditional designs, and the values and conceptualisations of psychotherapeutic phenomena implicit in these, were the focus of much criticism. Questions addressed by research were design-led and answers provided by research were design-limited. Moreover the designs were 'unresponsive' to the phenomena; they tried to fit the square peg of the positivistic, scientific paradigm and medical metaphor into the round hole of psychotherapeutic phenomena. In particular, the traditional designs do not address micro-level, processual questions; 'when I'm faced with x, then what do I do, how should I be?' This particular limitation of traditional designs is consequential for both psychotherapy practice and theory: Moment-to-moment, clinical decision-making is not informed by traditional psychotherapy research and the kind of theoretical propositions Gendlin requested back in 1967, "If the patient at the moment does so and so, then I find it helpful to do so and so", have not been forthcoming.

However, there is a new paradigm in psychotherapy research. Rice and Greenberg's (1984) Events Paradigm and Greenberg's (1986) Change Process Paradigm responded to the limitations outlined and proposed a mutually informative and responsive relationship between psychotherapy practice, theory and research. Significant Change Events are proposed as the unit of analysis. Significant Change Events are selected for intensive analysis in the belief that they encapsulate processes of change that are key in the particular therapy and that they can thus facilitate exponential therapeutic change. The present work employs this events-based strategy to explore a question that was suggested by clinical phenomena and which is considered to be both theoretically grounded and clinically significant.

The new paradigm's promise to reduce the research-practice gap lies in its empirical methods being representative of and responsive to psychotherapeutic practice and in-therapy phenomena. Put simply, the research methods aim to systematise clinical methods and skills. What do these statements say about practically implementing the new paradigm? Firstly, psychotherapeutic theory, practice and the research method are triangulated; each closely informs the other. Secondly, this triangulation persists throughout the research. Psychotherapeutic theory, for example, is not put to one side while the 'important work' of the empirical work and its analysis are carried out, only to be reintroduced in discussion of results. The continuous integration of the theory and practice of the particular therapy being investigated is most explicit in Task Analysis, the Events Paradigm method used here. The task analytic approach was used and developed in this exploration of the research question.

The research question explored is 'How are Client Confrontation Challenges to the therapeutic relationship best addressed in Exploratory therapy?' Real or transferential in origin, these are significant, 'make or break' moments in PI therapy; in a client making a Confrontation Challenge the therapeutic relationship is immediately destabilised. The consequences of the destabilisation remain to be seen. That is, successfully addressed, a Confrontation Challenge can afford substantial therapeutic gains on key interpersonal issues and strengthen the working alliance; however, unsuccessfully addressed or not addressed a Confrontation Challenge can undermine any potential for change. Clearly a processual answer is required to the question 'how best to address Confrontation Challenges?'

The point of the Introduction is to highlight to the reader both the substantive and methodological foci of the present work. Whilst the Introduction is weighted more to the methodological than the substantive issues covered in the following chapters, the thesis chapters follow the temporal sequence of the activities undertaken. Two goals are achieved; firstly, the research question is explored and secondly, the Change Process Paradigm and its task analytic approach is implemented and developed. In conclusion, in this thesis, as in Exploratory therapy, the 'how' is at least as important as the 'what'.

Chapter One

1.1 Introduction

1.1.1 Outline

The Research Question investigated in this thesis was,

> How are Client Confrontation Challenges to the therapeutic relationship in Sheffield's Psychodynamic Interpersonal therapy ('Exploratory') best responded to by client and therapist?

Chapter One presents the rationale for this question. Essentially it is argued that, as a function of their significance to the therapeutic relationship, Client Confrontation Challenges are highly consequential for the progress and outcomes of Psychodynamic Interpersonal (PI) therapies; that is, Client Confrontation Challenges may 'make or break' the therapeutic relationship: In PI therapies the therapeutic relationship is the medium for, *a* prerequisite to and *the* vehicle of therapeutic change. Therefore, Challenges to this therapeutic relationship, Confrontation Challenges, hold dramatic implications for therapeutic change. Depending on how effectively Confrontation Challenges are addressed, therapeutic change may be exponentially promoted (their 'make' quality) or hindered (their 'break' quality). How to address to Clients' Confrontation Challenges such that they are 'makeworthy' rather than 'breakworthy' of the therapeutic relationship and so of therapeutic change? This was the Question investigated here.

This outlines Chapter One's argument for the Research Question investigated in the thesis. Prior to detailing this argument, the therapy to which the Question was applied (Exploratory therapy) and Client Confrontation Challenges will be introduced.

1.1.2 A comment on Exploratory therapy

The Question was asked of the Psychodynamic Interpersonal (PI) therapy called 'Exploratory' therapy (Shapiro and Firth, 1987), which was adapted from Hobson's (1985) 'Conversational Model' for the Sheffield Psychotherapy Projects (Shapiro et al, 1993, B&C). Modifications provided for (a) Exploratory therapy being time-limited (3, 8 or 16 sessions) and (b) for including in its interpersonal focus clients' work relations in addition to more personal and familial relations. Exploratory therapy is cast in terms that are peculiar to Hobson's (1985) original formulation. These express his (a) rejection of certain psychoanalytic notions (mechanistic, causal explanations; reification of unconscious drives and psychic structures) and (b) his conviction that the 'how' of the client-therapist interaction is more important than the 'what'. Whilst Exploratory's terms are peculiar, it's conceptualisation and practice are not. There are substantial conceptual and practical parallels between Exploratory and short-term (PI) therapies that use more traditional, psychodynamic terms (for example, Strupp and

Binder's (1984) Time Limited Dynamic Psychotherapy). For example, whilst Strupp and Binder write of psychodynamic interpretations and Hobson writes of Explanatory Hypotheses, what they say about them is the same; they are neither the ultimate therapeutic technique nor the ultimate goal of therapy and they should be expansive rather than definitive. Rather than risk these parallels being obscured by Exploratory's terms it was decided that they should be made evident. More familiar short-term PI terms will be referred to in the conceptualisation of the Research Question (in Chapters One and Two) and Exploratory therapy will be referred to in relation to the Question's empirical investigation (in Chapters Five through Ten). This strategy serves to make explicit the context in which the present work will be discussed.

1.1.3 An introduction to Client Confrontation Challenges in Exploratory therapy

To orient the reader to the phenomena that were named Confrontation Challenges in Exploratory therapy, this is a brief introduction to their occurence in Exploratory sessions.

A woman in her mid thirties, a helping professional, began her sixth (of eight) sessions with an older, male, clinician by saying in a clipped, hurt and angry tone,

> "I thought you were giving me an alternative, I really did. And that's how I took it and then, and then I felt you then afterwards accused me, and I felt it was an accustation, of taking the wrong alternative".

A woman in her early thirties, a social studies tutor, began her second (of eight) with an older, male clinician, by saying with studied, controlled fury,

> "Yes well, the more I thought about it, I was quite angry with you...for the way I felt, what felt like you set me up and then you told me off".

These were moments in Exploratory therapy that came to be called Client Confrontation Challenges. They were moments when as a listener, in the split second the Challenge was made, one would gulp an 'uh oh', think 'this is it, this is it ... she's taking it on, therapist, therapy, ... this could end in tears' and then, nervously, you'd carry on listening; what transpired?, did it end 'in tears' or 'happily ever after'? Listening as an outsider to a session of Exploratory therapy, a client making a Confrontation Challenge may be experienced in this way.

1.1.4 Confrontation Challenges in terms not specific to Exploratory therapy

1.1.3 described how a listener external to the therapeutic situation may experience the phenomena that, in terms congruent with Exploratory therapy, were named Confrontation Challenges. How would other writers and other therapists name the same phenomena? A brief answer to this question is provided in order to further orient the reader to the Research Question's Confrontation Challenges. Bordin (1979, 1980, 1994) would call Confrontation Challenges 'alliance ruptures'; Safran et al

(1990, 1993, 1994) would call them 'extreme cases of alliance rupture'; Pinsof (1994) would call them 'alliance tears'; Kohut (1984) would call them 'manageable transference failures'; Horowitz, Rosenbaum and Wilner (1988) would call them 'role relationship dilemmas' and Strupp and Binder (1994) would call them 'critical points'. (Implicit here, these writers' understandings of the origins and significance of Challenges will be referred to later in this chapter; see below).

1.1.5 Chapter Structure

How are Client Confrontation Challenges to the therapeutic relationship in Sheffield's Psychodynamic Interpersonal therapy ('Exploratory') best responded to by client and therapist?

How will Chapter One present the rationale for this Question? Evident from the above, understanding Confrontation Challenges in PI therapies is important only in so far as the therapeutic relationship is important in these therapies. But what is the therapeutic relationship and how is it effective of therapeutic change? 1.2 discusses PI theories' definitions of the therapeutic relationship. 1.3 then explains how, according to these theories, the therapeutic relationship functions therapeutically. The theoretical importance of the therapeutic relationship is summarised in 1.4. From the therapeutic relationship, 1.5 and 1.6 shift the focus on to Client Confrontation Challenges to that relationship. Informed by the preceding explanation, the origins of Confrontation Challenges are set out in 1.5 and their significance in clinical practice made explicit in 1.6; the Chapter's rationale for the Research Question is thus concluded.

1.2 Definitions of the therapeutic relationship in PI theory

1.2.1 Introduction

What is the therapeutic relationship, according to PI theory? Beginning with Zetzel (1956), psychodynamic theorists have written of the therapeutic relationship as the therapeutic alliance. Currently, however, there is no consensual definition of the therapeutic alliance (Henry, Strupp, Schacht and Gaston, 1994). The points at which definitions diverge reflect debates concerning the working and affective aspects of the relationship (Gaston, 1990); these are reviewed in 1.2.2. Reviewers' attempts to consensualise an alliance definition are presented in 1.2.3. In 1.2.4 the definitional difficulties are explained and the explanation illustrated. They are explained in terms of the nature of the therapeutic relationship itself; as a significant relationship its 'real' and 'as if' qualities are inherent and continuously shifting. These statements about the nature of the therapeutic relationship are illustrated using the Model of the Therapeutic Relationship in Strupp and Binder's (1984) Time Limited Dynamic Psychotherapy (1.2.4)

1.2.2 Historical debates surrounding the definition of the therapeutic alliance

The therapeutic alliance was first defined by Elizabeth Zetzel (1956), as " a working relationship between patient and analyst" (1956, 1970, IN FOREMAN AND MARMOR), who considered it essential to the effectiveness of any therapeutic intervention. In his extensive review of the alliance, Greenson (1967) first used the 'working alliance', but used it interchangeably with the therapeutic alliance. The working alliance was the relatively "neutralised", "rational" "part of the patient's relationship to the analyst" which provided for the patient's co-operation with the analyst (Greenson, 1967, p. 47). This was composed of both the patient's affectionate feelings toward the analyst and the patient's capacity to work in therapy. He argued that this rational, working alliance should be differentiated (in principle and by the analyst in practice) from the 'internal misperceptions' the patient had of the analyst in their "transference" relationship (Greenson, 1967, p. 47).

To what extent does the distinction between the 'rational', working, alliance and the transference relationship exist and can it be maintained? This question has been the source of considerable theoretical and clinical debate (Frieswyk et al, 1984; Gutheil and Havens, 1979, in Foreman and Marmor, 1985) which will be summarised. Greenson's (1967) views represent one end of the spectrum of opinion. For him the two facets of the relationship were distingushable; the 'rational' 'allied' relationship provided for the patient's cooperative work with the analyst and it was this 'working alliance' which permitted a patient even "in the throes of intense eroticised or hostile feelings towards the therapist" (Gaston, 1990, p. 144) to maintain an effective working relationship with the analyst. In contrast, from the opposite end of the spectrum of opinion, Brenner (1979), for example, maintained that the rational and transference relationships were indistinguishable; that the alliance was merely a facet of the transference which pervades the entire relationship between the patient and therapist; the concept of the alliance was for him rendered meaningless. Alongside these polarised views others have, for example, discussed the extent to which the alliance is *colored by* transference (Langs, 1976) or is a *special form of* transference (Sandler, 1973).

1.2.3 Attempts to consensualise a definition of the therapeutic alliance

This debate is reflected in the lack of a consensual definition of the therapeutic alliance. Recent reviewers (eg Gaston, 1990; Hartley, 1985; Horvath and Symonds, 1991) seeking to tease out the consensualised alliance aspects themselves achieved limited consensus:

"Although there are variations among alliance definitions provided by investigators there appears to be general consensus on the central ideas that (a) the working alliance captures the collaborative element of the client-therapist relationship and (b) it takes account of both therapist's and client's capacities to negotiate a contract appropriate to the breadth and depth of the therapy" (Horvath and Symonds, 1991, p. 139).

"... a consensus seems to be evolving that the therapeutic alliance has two components: the real relationship and the working alliance. The real relationship refers to the mutual human response of the patient and therapist to each other, including undistorted perceptions and authentic liking, trust and respect for each other, which exist along with the inequalities inherent in the therapy situation. The working alliance depends upon and reflects the ability of the dyadic partners to work toward the alleviation of the problems experienced by the patient" (Hartley, 1985).

"Within the dynamic and client-centred frameworks, three alliance dimensions have been offered: (a) the therapeutic alliance, or the patient's affective relationship to the therapist; (b) the working alliance, or patient's capacity to purposefully work in therapy and (c) the therapist's empathic understanding and involvement. ...a fourth alliance dimension has been proposed, that is, the patient-therapist agreement on the goals and tasks of treatment" (Gaston, 1991, p. 3).

All three consensus-statements include a 'working alliance' (indeed Horvath and Symonds refer only to this) but whether this is a patient and/or therapist capacity varied. For Horvath and Symonds and for Hartley this reflected both the client's and the therapist's capacities to working together purposefully. However for Gaston the working alliance reflected only the client's capacity to work purposefully in therapy; she separates this from the therapist's empathic understanding and involvement.

What place was given to the transference relationship in these consensus statements? Hartley wrote of the therapeutic alliance's two *undistorted* components; the real, affective relationship, and the collaborative, working alliance. Distinguished from these, by implication, is a distorted, affective, transferential relationship. In contrast, Gaston viewed the therapeutic alliance as an affective relationship and distinguished this from a second, working alliance, component. Implicit in Gaston's therapeutic alliance presumably were both transferential and nontransferential affective aspects. As stated, Horvath and Symonds's consensus-statement gives no place, explicit or implicit, to a transferential relationship. The place of the transferential relationship among reviewers' consensus statements was unclear.

All three statements referred to the goal-directedness of therapeutic work which, in particular, characterises brief dynamic psychotherapies (Koss and Butcher, 1986): For Horvath and Symonds a contract is negotiated by both participants; for Hartley patient and therapist work together towards the goal of alleviating the patient's problems and for Gaston client and therapist agree therapeutic tasks and goals and then work purposefully together to meet these.

The above evidenced there being no unanimously accepted definition of the therapeutic alliance and reviewers' differences reflecting wider and longstanding debates in the psychodynamic literature (see 1.2.2 above).

1.2.4 An explanation for the definitional difficulties

The evident difficulties in delimiting distinctions between the real and transference relationships, and so in defining the alliance, are to be expected; this statement is explained and illustrated here. They should be expected for two reasons; firstly,

> "*All relationships have both real and transferential qualities* in that they are, at least in part, determined by our prior interpersonal experiences" (Waterhouse and Strupp, 1984, p. 81; my italics)

and secondly, these qualities will wax and wane, attain prominence and recede, in the course of therapeutic work (eg Gelso and Carter, 1985; Weiner, 1975). The Model of the Therapeutic Relationship in Strupp and Binder's (1984) Time Limited Dynamic Psychotherapy (TLDP) will be used to expand and illustrate this explanation.

For Strupp and Binder the therapeutic relationship, like any other significant relationship, has 'real' and 'as if' qualities and these qualities continuously oscillate. In their terms the 'real' relationship qualities reflect the "valid adult-adult relationship of the present", and the 'as if', transferential relationship qualities represent the "anachronistic child-parent relationship of the past"; this is the tendency to relate to a significant person in the present "as if he or she were a personification from the past" (p. 38).

What does the continuous oscillation of these 'real' and 'as if' qualities mean for the therapeutic relationship? It means that patient and therapist are both reciprocally influenced by different and interdependent 'real' and 'as if' perspectives on their relationship. The patient holds three different and interdependent perspectives on the therapeutic relationship; the therapist holds four: The patient's are (1) a flexible, 'adult' perspective, (2) a rigid, predetermined 'as if' perspective and (3) the 'action' component of the predetermined perspective which 'pulls' the therapist to conform to the learned pattern. The therapist is influenced by the following four perspectives: (1) "a caring, reasonable, and dispassionate attitude, as well as a professional stance"; (2) his or her "personal style, which has a complex impact on the patient" and is "often experienced as 'positive' or 'negative'"; (3) the constant pull "into reactions that conform to the roles designated by the patient's maladaptive interpersonal scenarios" and (4) "strictly personal meanings which have their origins in his or her own unresolved neurotic conflicts" (p. 142).

Each participant is constantly influenced by their respective perspectives; the influence of each of these continuously shifts and so has a shifting influence on the other participant. The patient constantly experiences, understands and relates to the therapist as "both a significant person in the present as well as a personification of past relationships". Strupp and Binder refer to these as 'parts' of the therapeutic relationship; the 'real', adult part and her/his 'as if' part. It falls to the therapist to constantly monitor and address both parts. It is the real, adult part, the "observing ego", that collaborates with the therapist, forms a therapeutic alliance and "in other respects desires better adjustments to reality" (Strupp and Binder, 1984, p. 38-39).

The organisation of and variations in clients' and therapists' perceptions, expectations and intentions over the course of therapy were captured by Horowitz, Marmar and Krupnick et al's (1985) typology of role relationship models. Role relationship models are combinations of a self schema, a schema for at least one other person and a script of transactions between them that are used to organise expectations and intentions as they arise during therapy (Horowitz, 1991). Thus the meaning of any interpersonal transaction is determined both by perception of the situation and by the dominant role relationship model from an enduring repertoire of schemas. They suggested that therapy's interpersonal transactions can be characterised by three types of role relationship models, the influence of which varies over the course of therapy: the therapeutic alliance, the transference relationship and social alliance.

The therapeutic alliance designates the relationship pattern in which both participants hold the shared goal of progressively understanding and resolving the patient's difficulties. Derived from wishes and fears based on earlier experiences, transference relationship models are composed of various negative and positive intentions and expectations which are unconsciously transposed into the therapeutic situation. The social alliance (Horowitz, 1979) is a model of the relationship that might take place were the participants to meet in 'ordinary life'.

How in general does the influence of the three types of role relationship vary over the course of therapy? All three role relationship models derive from "elements from the repertoire of schematic forms carried into the situation by the patient and the therapist" (Horowitz and Marmar, 1985), therefore some kind of 'transference' is involved in the formation of all three and this is influential in their variation over the course of therapy: The therapeutic alliance is formed from the availiable elements that most resemble the realistic possibilities within the ground rules of dynamic therapy. When the social alliance deflects from these by substituting aims and scripts of courtship, friendship, games for the aims of therapy, then the therapeutic alliance is resisted. In the experiencing and interpreting of the transference relationship's set ideas and emotions

that are congruent with past rather than current realities, the therapeutic alliance is deepened; that is,

"it loses some of the properties transferred from preexisting role relationship models imposed upon the situation, and schematises the new transactional properties found in the growing mutuality and intimacy of the actual therapeutic give-and-take" (Horowitz and Marmar, 1985, p.).

1.3 The therapeutic functioning of the relationship.

1.3.1 Introduction

How does the relationship function therapeutically? The Introduction to this chapter said that the relationship is both *a* prerequisite for and *the* vehicle of therapeutic change (Frieswyk et al, 1986; my italics). This section will explain the therapeutic functioningof the relationship and also this statement.

The explanation will be cast in terms of recent developments in the conceptualisation of the relationship's functioning, developments which have been closely associated with the burgeoning of short-term dynamic therapies. With their upper limit of 25 or fewer sessions (Koss and Shiang, 1994), shorter term dynamic therapies have required that sessions are more focussed and aimed at limited psychogenetic understanding (Koss and Butcher, 1986, p. 629). Developments in the conceptualisation of the real and transferential relationships (and their implementation in practice) have enabled these requirements to be met. It should be stressed here that TLDP (Strupp and Binder, 1984) and Exploratory therapy (Shapiro and Firth, 1987) incorporate these recent developments.

The recognition of the fundamentally interpersonal, dynamic nature of the therapeutic situation (the first development, reported in 1.3.2) provides the medium for therapeutic change and makes clear the currently popular term, 'Psychodynamic Interpersonal therapies'. The increasing importance attached to the active collaborative aspect of the therapeutic relationship (the second development, reported in 1.3.3), is a prerequisite for the working alliance which is in itself one of the prerequisites for therapeutic change. The increasing use of the transference in the here-and-now of the therapeutic relationship (the third development reported in 1.3.4), is the vehicle for therapeutic change in PI therapies.

1.3.2 The recognition of the interpersonal therapeutic situation

The first development in the conceptualisation of the real relationship is the increasing recognition of the fundamentally interpersonal, relational aspect of the therapeutic situation (eg Safran, 1993). Thinking by interpersonal theorists (eg Anchin and

Kiesler, 1982) and social constructivists (eg Hoffman, 1991; Mahoney, 1991) have been influential in this development.

Interpersonal psychotherapy, from the work of Harry Stack Sullivan (1953), has substantially influenced efforts toward psychotherapy integration (Hartley, 1985). Interpersonal psychotherapy focuses on transactions in a two person system in which both therapist and patient are active participants (Cashdan, 1973); Anchin and Kiesler, 1982). These ideas have been assimilated into both psychoanalytic thinking (see Eagle (1984); Greenberg and Mitchell, (1983) and short-term dynamic therapies; only the latter will be illustrated. Strupp and Binder (1984), for example, translated the traditional psychoanalytic concept of transference as follows:

The patient's enactment of an anachronistic, conflictual relationship predisposition. ... our translation ..into interpersonal terms emphasises not only the patient's readiness to perceive the therapist in terms of his or her salient predisposition, but equally important, it encompasses the behaviour by which the patient unconsciously attempts to manipulate the therapist into reciprocally enacting the role of the object in the patient's scenario (Strupp and Binder, 1984, p. 35, my italics)."

The second influence has been the increasing recognition of psychotherapy as an 'emergent phenomenon' and an 'interactive process' (Docherty, 1985) in which both therapist and client are active in constructing and reconstructing the meaning of their dialogue and their situation (eg Hoffman, 1991; Mahoney, 1991). This constructivist perspective challenges notions that have long been implicit in psychotherapy and psychotherapy research: the notion that the therapist's techniques are therapeutically all powerful (Strupp and Binder, 1986),

"the significance of the procedure is not in the application of a disembodied technique but *how* the procedure becomes integrated into the ongoing *interpersonal* context of the particular dyad. ... The complexity and subtlety of psychotherapeutic processes cannot be reduced to a set of disembodied techniques because techniques *gain their meaning and, in turn their effectiveness, from the particular interaction* of the individuals involved" (Strupp and Binder, 1986, p. 33, my italics);

the notion that the therapist's behaviour determines the success of the intervention and the notion that an intervention 'delivered' as prescribed accurately reflects what is 'absorbed' by the patient (Docherty, 1985).

What is the significance of this more interpersonal, dyadic and constructivist thinking for practice? The current interpersonal transactions between client and therapist are used explicitly and deliberately as the "medium of change" (Strupp and Binder, 1984, p.35)

"Whatever the patient learns in psychotherapy, whatever conduces to therapeutic change, is acquired exclusively in and through the dynamics of the therapeutic

learning. In other words, therapeutic learning is experiential learning" (Strupp and Binder, 1984, p. 35).

Therapeutic understandings are first and foremost informed by the contemporary transactions; the here-and-now is critical in brief, dynamic psychotherapy (Strupp and Binder, 1984). In contrast with archaeological explorations of childhood experiences (Gill, 1982; Sarvis, Dewees and Johnson, 1958), the contemporary client -therapist transactions vividly and concretely evidence the patient's experience and perceptions of the relationship and therapist's involvement in the same. Henry and Strupp (1994) argued that ongoing attention to these transactions might increase patient involvement, strengthen weak alliances and extend the range of patients benefiting from - particularly short-term - psychotherapy. In short the dynamic, emergent, interpersonal transaction is conceptualised as the medium for change in PI therapies (Henry and Strupp, 1994; Pinsof, 1994).

1.3.3 The importance of active collaboration

Within this interpersonal medium of change, the client's active collaboration on therapeutic tasks has increasingly been recognised as "a major therapeutic force" (Waterhouse and Strupp, 1984, p. 80; Horvath and Greenberg, 1994); this is the second recent development. Waterhouse and Strupp (1984), for example, considered that "the principal task of dynamic psychotherapy" (p. 80) was for the client to form a collaborative working alliance with the therapist's efforts. This is achieved by the client's 'rational, observing ego' allying and identifying with the therapist's analysis of the transference and their mutual agreement to work together.

Luborsky's (1976, 1984) work defining and operationalising the alliance significantly influenced this developement (Docherty, 1985; Frieswyk et al, 1986). From the psychoanalytic tradition he distilled two types of Helping Alliance, in an attempt to clearly separate the *patient's actual collaboration* with the therapist from the *patient's experience* of being helped by the therapist. The patient's actual collaboration, the Type II alliance, was defined by patient and therapist "working together in a joint struggle against what is impeding the patient":

"(1) the patient experiences working together with the therapist in a joint or team effort, (2) the patient shares with the therapist similar conceptions about the sources of the problems, (3) the patient demonstrates qualities that are similar to those of the therapist, especially those connected with his ability to use the tools for understanding" (Luborsky, 1984, p. 80)

Following Luborsky, Marmor, Horowitz, Weiss and Marziali (1986) considered that

"Only when the therapist and patient become collaborative partners in taking up the tasks of treatment (the working alliance) does the therapy achieve it's aims" (Marmor, Horowitz, Weiss and Marziali,1986, p. 368).

The Menninger Group went one step further in proposing that the "patient's collaboration in the tasks of psychotherapy" (Frieswyk et al, 1986, p. 32) was *definitive* of the alliance. In common with Waterhouse and Strupp (1984), they were stressing what the working alliance required of the *patient* and they were differentiating this from both the therapist's technical contributions and the patient's affective experience, in particular the patient's transference.

What is necessary for this realistic and active collaboration, a prerequisite for effective dynamic psychotherapy? This question will be briefly considered here. Foreman and Marmor (1985) provided a brief answer; for them the realistic collaborative relationship is "based on mutual respect, liking, trust and commitment to the work of treatment" (p. 922). To be more specific, what is required firstly of the client and secondly of the therapist? Strupp and Binder's TLDP will be used to represent answers to these specific questions. The mature functioning of the patient's ego is held to be the most important determinant of the client's capacity to form a collaborative, working alliance (Dickes, 1975; Greenson, 1967; Zetzel, 1956). The patient's ego functioning provides two major selection criteria for brief psychodynamic work (Horowitz et al, 1984; Malan, 1976); the patient's interpersonal functioning(in particular their capacity for stable object relationships):

"sufficient capacity for relating to others as separate individuals so that identifiable relationship predispositions, no matter how painful and conflict-ridden, can be enacted in the therapy relationship and then examined" (Strupp and Binder, 1984, p. 57-58);

and the patient's defensiveness towards her/his problems

"In brief psychotherapy, patients should ideally be motivated and able to discuss central problems early in treatment. ..More resistant patients are less likely to commit to treatment and to engage in an open, active collaboration with the therapist" (Gaston et al, 1988, p. 484).

The patient's ability to "develop a measure of trust" (Strupp and Binder, 1984, p. 33) is essential to their formation of the working alliance:

"When this important precondition is met, the possibility for collaboration in the joint endeavour of psychotherapy has been created. It means that the patient can look upon the therapist as an ally in his or her struggles and that the therapist has an ally in the patient who, within limits determined by apprehensions present in any of his or her relationships, will endeavour to collaborate by providing honest, unedited accounts of experiences (particularly if they evoke painful affects) (Strupp and Binder, 1984, p. 33).

These selection criteria aim to ensure that the patient is able to meet the ground rules of psychodynamic therapy; the demands imposed by the ground rules vary with intervention type (Bordin, 1975). Assuming that the patient is able to meet the ground rules' demands and that patient and therapist have, early on, agreed the goals and tasks of therapy, the strength of the collaborative, working alliance formed will then depend on the 'difficulty' of the therapy-specific goals and tasks (for example, the extensiveness and depth of the goals, the compatibility of the treatment's demands with the patient's emotional capabilities (Gelso and Carter, 1985)).

How does the therapist's nontechnical behaviour facilitate the development of the working alliance? Strupp and Binder provide a succinct answer:

"first, assiduously avoids engaging in activities that have the effect of perpetuating the difficulties that have resulted in the patient's interpersonal difficulties, and, second, actively promotes experiences in constructive living" (Strupp and Binder, 1984, p. 36).

That requires further specification. The therapist should maintain 'a free floating responsiveness' (Sandler and Sandler, 1978) to the patient's unconscious efforts to pull the therapist into her/his scenarios; this (a) prevents the therapist being drawn into reciprocal, wish-fulfilling behaviour at the same time as (b) allowing the therapist "empathic involvement" (p. 36) with the patient and (c) providing information about the patient's relationship predispositions. In addition to this and to actively promote the patient's' experiences in living, the patient must be enabled to trust the therapist and trust that the therapist "in a fundamental sense, has the patients best interest at heart" (p. 36). The therapist's attitude must consistently reflect

"interest, respect, a desire not to hurt (even when provoked), a suspension of criticism and moral judgement and a genuine commitment to help (within the limits set by the therapeutic role and by being human)" (p. 41).

These then are the requirements in client and therapist forming the active, realistic, collaborative alliance which is a prerequisite of PI work; in their absence

"it is predictable that a good outcome - certainly in time-limited psychotherapy - is seriously in question (Strupp, 1980a, 1980b, 1980c, 1980d) (Strupp and Binder, 1984, p. 36).

In summary, 1.3.3 has shown that the client's active collaboration with the therapist has recently been recognised as a prerequisite for effective PI therapy. What is required of client and therapist in forming this working alliance has been outlined. Whilst the client's realistic and active collaboration is *necessary*, it is not however *sufficient* for therapeutic change. How the relationship functions as the 'vehicle of

change' is explained in 1.3.4's presentation of the third recent development in the conceptualisation of the relationship's therapeutic functioning.

1.3.4 The use of the transference in the here-and-now

"The crucial change agent common to [short-term psychodynamic psychotherapies] was an intensive emphasis on interpretation and working through of the transference relationship" (Bauer and Mills, 1979).

Gill (1982) used the expression the "analysis of the transference in the here-and-now" to describe the use of current transactions to identify and examine the patient's enactments of anachronistic, self defeating, interpersonal behaviours. He argued

"what primarily convinces the patient that his transference is indeed transference is the detailed examination of the transference in the analytic situation rather than the recovery of memories of the past" (Gill, 1982, p.123).

Compared with genetic transference interpretations, the affective salience of here-and-now transference interpretation reduces the possibility of the transference being intellectualised by the client. This contrasts with earlier psychodynamic thinking and practice, in which technical interventions were geared to maximise the development of the transference neurosis (eg Greenson, 1967), as they had been in classical analytic technique (Freud, 1912a). This here-and-now approach to transference analysis is the third of the recent developments in psychodynamic thinking and practice to concern the therapeutic relationship.

Strupp and Binder (1984) cast transference in their dyadic, interpersonal framework, and wrote of their identification, understanding and modification of the transference enactments as the "keys" to therapeutic change; the enactment of the patient's relationship predispositions and "characteristic patterns of relatedness" (p. xiii) with the therapist are at one and the same time an expression of the patient's interpersonal difficulties and an opportunity for understanding and relearning through the therapeutic alliance.

Their emergence facilitated by the "manifest and apparent inequality and inequity of the therapeutic relationship" (Blatt and Erlich, 1982, p. 88), these characteristic patterns of relatedness are re-enacted with the therapist in the following way: patterned like structured role relationships, internal object relationships assign roles and images to the self, to others and to self-other transactions (Allen, 1977; Sandler and Sandler, 1978). Associated with self-other transactions are feelings, wishes, thoughts and expectations which characterise the internal object relationship. Since experiences become meaningful when associated with strong affect, an enduring internal object has a strong affective component; this is the "motive force" (p. 35) for

the re-enactment of the internal object relationship in significant, current relationships and is particularly strong when the individual's security is threatened:

"In that event the object relationship enacted in the present becomes defensively distorted in order to protect the patient from the feared vulnerability resulting from fantasies or yearnings for primitive forms of intimacy (such as total possession of or engulfment by the love object). The patient will resist awareness of these fantasies because of the painful affects (loss of self-esteem) associated with them" (Strupp and Binder, 1984, p. 34).

Thus the patient will tend to re-enact the structured role relationships rigidly, interpret events and unconsciously seek to draw from the therapist behaviours consistent with the role assigned to the object in the patient's enduring scenario:

"One changes as one lives through affectively painful but engrained interpersonal scenarios, and as the therapeutic relationship gives them outcomes different from those expected, anticipated, feared and sometimes hoped for" (Strupp and Binder, 1984, p. 35).

Thus the here-and-now identification and working through of the transference enactments is the "key" to therapeutic change in short-term PI therapies and thus the therapeutic relationship is 'the vehicle of change':

"The transference repetition, motivated mostly by the patient's need to defend himself and resist change, also sets up an in vivo situation in which the therapist can make a difference to the patient's life because he has become part of it" (Schlesinger, 1982, p. 29).

As for the therapeutic or working alliance, it is both required for the analysis of the transference enactment (see 1.3.2) and is strengthened by it:

"The therapeutic alliance will be reinforced as both participants arrive at a better understanding of the patient's recurrent need to reenact with the therapist those interpersonal patterns that, in one way or another, are related to the core of the disturbance" (Strupp and Binder, 1984, p. 140).

1.4 Summary

The chapter is presenting the rationale for the research question, which concerns Client Confrontation Challenges *to the therapeutic relationship* in PI therapies. Sections 1.2 and 1.3 have explained the importance of the therapeutic relationship. 1.2 considered definitions of the relationship and 1.3 considered how the relationship functions therapeutically in these therapies.

The therapeutic relationship has 'real' and 'as if, transferential' qualities which continuously oscillate during PI therapy. Whilst definitions of the relationship's

components vary, all can be represented in three role relationship models: a therapeutic alliance, a transference relationship and a social alliance. Increasingly influential in PI theory and practice are the transactive, interpersonal system in which the relationship emerges; the client's active, realistic collaboration with therapist in the therapeutic alliance and systematic attention to here-and-now transference enactments. The interpersonal system is the *medium* in which change can be effected; the client's collaboration is a *prerequisite* for and the here-and-now identification and working through of transference enactments is the *vehicle* by which change is effected.

The focus will now shift to *Client Confrontation Challenges* to the therapeutic relationship. The origins of Clients Confrontation Challenges to the therapeutic relationship are outlined in 1.5 and their significance in clinical practice are made explicit in 1.6.

1.5 The Origins of Client Confrontation Challenges

1.5.1 Introduction

If, as stated above, the relationship functions therapeutically, Challenges to the relationship are clearly significant for potential therapeutic change. Where do the Clients' Confrontation Challenges originate? Essentially, as all relationships are assumed to have both transferential and real qualities, so Challenges to the relationship in PI therapies are assumed to have both real and transferential qualities. To illustrate, both these qualities were evidenced in the most common impasses reported by Klagsburn and Brown (1984):

"(1) the therapist's misperception of the presenting problem or the patient's dynamics; (2) the problem of pacing, of being out of phase with the patient; (3) dealing with a patient's acting out behaviour; (4) the difficulties induced by transference and countertransference; (5) the difficulty of making an alliance with severely disturbed patients" (Klagsburn and Brown, 1984, p. 256).

Real and transferential origins to Confrontation Challenges identified in the theoretical and practical literatures are presented below. For coherence with the explanation of the relationship's therapeutic functioning, transferential origins will be considered (1.5.2) prior to their real origins (1.5.3)

1.5.2 Negative transferential Challenge origins

Negative transferences can orginate Client Confrontation Challenges. In Strupp and Binder's (1984, p. 38) terms here-and-now transference presents both the "key" and an "obstacle" to therapeutic change. This is so because transferences, resistances and patients' characteristic ways of relating are rigid, pre-established dispositions to interpretation and action that have been learned as means of maintaining

interpersonal security. Reluctances, hesitations and fears all have an inherent potential to "reach the proportion of" a resistance in therapy (Blatt and Erlich, 1982, p.71) and

"Transference is in and of itself a form of resistance because it reflects the reluctance or inability to relinquish well-established deeply ingrained, repetitive modes of adaptation in favour of attempting new, alternative and more mature modes" (Blatt and Erlich, 1982, p.73).

How is resistance cast in PI therapies? Resistance is a dynamic, process phenomenon (Schafer, 1983) which is "constantly operative in ways that do not usually call attention to its presence" (Schlesinger, 1982). Resistance is a fundamentally interpersonal phenomenon, directed by unconsciously held convictions about oneself in relation to others (Strupp and Binder, 1984) and is located within the dyadic system and therapeutic situation (not simply within the patient; Gill, 1979; Langs, 1973). Resistance is inevitable; PI therapies identify and re-work established ways of relating and resistances are established, self protective modes of relatedness. Thus in all therapies there is a 'fundamental resistance to change' (Blatt and Erlich, 1982). Resistance can also manifest itself in any behaviour; trivial or overt (Schlesinger, 1982; Strupp and Binder, 1984):

"Obvious examples are a patient's prolonged silence, refusal to talk about what the therapist wants to hear, coming late or not at all. But these flagrant 'misbehaviours', although they certainly involve resistance, are not the most common forms of resistance or even the most important ones" (Schlesinger, 1982, p. 26).

The less 'obtrusive' (Glover, 1955) or 'acute' (Fenichel, 1945) resistances occur within apparent compliance with the therapeutic ground rules (Sandler, Dare and Holder, 1973). Resistances are obstacles in the sense that they limit the patient's collaboration in the working alliance (Strupp and Binder, 1984), the patient's authentic relatedness (Safran, 1993) and the full enactment of patient's transference (Schafer, 1983). In short, resistances limit the extent to which the relationship can function therapeutically. However the 'paradox' (Schlesinger, 1982) of resistance is that it guides the therapist, "indicating where he can profitably concentrate his efforts" (Basch, 1982, p. 4):

""Although the resisting patient may be attempting to thwart us, to withold information, to deny cooperation, or more subtly to avoid collaborating in the therapeutic task, the resisting patient is also conveying a good deal of information and in the larger sense is fully cooperating in the treatment. Since our major premise is that the patient does not fully know what the problem is, cannot remember but is forced to repeat, the behaviour we call resistance is part of that repetition and is his way of communicating with the therapist through reenactment. Rather than being dismayed by resistance, the therapist might well welcome it" (Schlesinger, 1982, p.27).

Therefore identifying and working with the patient's resistance constitutes the primary focus for therapeutic work (Strupp and Binder, 1984). If successful, this work concommitantly increases the patient's trust in the therapist and strengthens the working alliance (Blatt and Erlich, 1982), which will help in the resolution of further resistances (Strean, 1985).

"Resistance is manifested as a disruption of the work of therapy, and yet at the same time the task of therapy is the resolution of the forces that create these disruptions" (Blatt and Erlich, 1982, p. 70).

What, firstly, is transference resistance and secondly how important is it? Blatt and Erlich systematised the manifestations of resistance by proposing three "overlapping, interdependent and interrelated levels" (p. 74) of resistance: episodic resistance, transference resistance and fundamental resistance to change. Transference resistance is expressed in a variety of specific forms (these are established ways of relating) and thus has a continuity over time both outside and throughout the analysis:

"Transference resistance involves a repetitive reenactment of earlier modes of interpersonal relations. The patient is unaware of the repetitive nature of his interpersonal relationships and of the availability of alternative modes of relating within the therapeutic relationship. Transference resistances are the expression of well-established, primary modes of relatedness that have their antecedents in primary relationships in the past and that are expressed in minor and major form in many subsequent relationships" (Blatt and Erlich, 1982, p.73).

The analysis of transference resistance is the major arena for work and the major goal for interpretive work in TLDP (Strupp and Binder, 1984). Its centrality derives from its here-and-now expression of the structured role relationships PI therapies seek to understand and work with to enhance the client's interpersonal relatedness. Transference resistance thus requires attention. Particular attention is required by the most pervasive of these, resistances to the *awareness* of the transference (in contrast to resistances to the *resolution* of the transference) (Basch, 1982; Strupp and Binder, 1984).

The systematic examination of resistances to the awareness of transference is rare in clinical practice (Gill, 1979); there are two reasons for this. Firstly, the occurence of here-and-now transference enactments are "frequently not in focus" (Strupp and Binder, 1984, p. 161); that is, they are rare in their occurence, never mind their examination. Secondly, the occurence of what Gill (1979, 1980) called 'disguised allusions to the transference' are more common; these include, for example, patients' narratives about experiences outside therapy or apparently insignificant comments about the therapist or the therapeutic situation. On the basis that resistance is

fundamentally interpersonal, "the transference is always and inevitably an interweaving of a contribution from the patient and the actual situation (Gill, 1979, p. 2) and thus the narrative or the insignificant comment may be a symbolic commentary on the relationship with the therapist. Such symbolic communications may not be recognised as such and transferences not recognised:

"Patients tend to avoid recognising that they experience and react to the therapeutic relationship in any way other than an uncomplicated, professional fashion. ... In addition, the specific constellation of affects, attitudes and behaviour characterising a particular transference enactment tends to be experienced as the only reality of the moment and therefore it is not questioned" (Strupp and Binder, 1984, p. 186).

Thus comments of no or little consequence for the therapeutic relationship "may be less threatening to the patient" (Strupp and Binder, 1984, p. 161) and to the therapist. Strupp and Binder (1984) and Gill (1979) counsel strongly against responding in kind (superficially) to these comments and argue strongly for their systematic consideration as 'disguised allusions'. They argue that responding superficially may enable patients to avoid or trivialise unsettling feelings in the therapeutic relationship and whilst therapeutic improvements may still be made these may constitute 'false solutions' (Malan, 1976a) or 'misalliance cures' (Langs, 1976) which are costly in time limited therapies (Strupp and Binder, 1984). Instead, if disguised allusions are to be identified the contemporary transactions between client and therapist must be examined - this examination Strupp and Binder considered the first technical goal of TLDP.

Given the importance of transference resistance, what are the consequences of either not attending to or attending unsuccessfully to transference resistances?
When the therapeutic alliance is resisted and its stability threatened 'critical points' (Strupp and Binder, 1984) can be reached. The destabilising transference resistances can be imposed by either the transference relationship or the social alliance (Horowitz and Marmar, 1985); that is by the transference relationship imposing rigid, past not present-congruent role relationships or the social alliance disturbing the roles and ground rules prescribed by the therapeutic alliance. Patients' 'dilemmas, snags and traps' possibly arising in brief therapies are: a distance/closeness dilemma; a controlled/controlling dilemma; a must/won't dilemma; a forced choice dilemma; a trap in which a problematic role relationship can only be reversed with the unacceptable consequence of only being in either position, and an anxiety-producing snag involving a wish to enact some transaction with either a parent or a sexual partner (Ryle,1979). The destabilisation of the therapeutic alliance occurs as the transference enactment becomes affectively compelling to the patient and their rational, collaborative engagement in therapy recedes:

"The internal needs to have powerful needs gratified in the therapeutic relationship may be more compelling than to tolerate the pain of nonfulfillment which is the price that must be paid for gaining insight into a neurotic constellation" (Strupp and Binder, 1984, p. 155).

This destabilisation can be compounded by the therapist's "capacities and limitations, sensititivities and insensitivities, astuteness and blind spots"; that is, by the therapist's countertransferential reactions which can also occur at the episodic, transferential and fundamental levels (Blatt and Erlich, 1982; Henry and Strupp, 1994). Blatt and Erlich concretise the different forms that this compounding of the therapeutic alliance's destablisation can take. When the therapist's resistance is episodic and the therapist is unresponsive or unaware of issues being brought up (directly or indirectly) by the patient, the patients' issues can become episodic resistances that, at least immediately, are difficult to resolve. When the therapist's resistance is transferential and the therapist's object-related issues are 'blinding', 'horns can become locked' and "psychotherapies can come to a standstill or stalemate" (p. 77).

What are the implications for progress in therapy of the destabilisation occuring at these critical points? On the one hand, if unaddressed or unsuccessfully addressed, these unresolved conflictual relationship predispositions will continue to limit the patient's relatedness inside and outside of therapy. Hartley (1985) described these implications of negativistic, hostile transferences thus:

"Such feelings, unaddressed, will build to disruptive proportions or go underground, silently eroding the therapeutic relationship and so limiting the amount of progress the patient can make" (Hartley, 1985, p. 539).

Strupp and Binder went further; at the extreme the "therapeutic relationship may be sacrificed as the patient's neurotic structures remain intact" (Strupp and Binder, 1984, p. 155). On the other hand, successfully addressed, awareness of historical bases that underlie repeated, interpersonal experiences is enhanced (Blatt and Erlich, 1982) and change is affected "in the therapeutic relationship and therefore in the patient's personality structure" (Strupp and Binder, 1984, p.182). Strean (1985) described these implications of negativistic hostile transferences thus:

"The first treatment crisis, if accepted as par for the course and taken seriously by both therapist and client, can lead to a deepening of the working relationship" (Strean, 1985, p. 185).

Clearly then, the critical points of transference enactments hold substantial implications for progress in therapy:

"Patients with a history of highly conflicted relationships add stress to the alliance and demand from therapists a capacity to absorb and manage responses which are

ambivalent, confusing and obstructionistic. Probably it is the working through of these treatment relationship conflicts that determines the outcome of therapy" (Marziali, 1984, p. 422).

In summary, negative transference enactments occur rarely but when they do, particularly in short-term therapies, they have significant implications for therapeutic progress. With the goal of PI therapies being to relearn established and currently self defeating ways of relating, if negative transference enactments are successfully addressed they can have potent, positive consequences:

"One of the major early findings in clinical observation of that dynamic interchanges was that transference manifestations ... often created an opportunity for deepened insight and working through of conflicts to points of new decision" (Horowitz and Marmar, 1985).

On the other hand, if negative transference enactments are not addressed or are unsuccessfully addressed, the therapeutic alliance can be destabilised and the patient's engagement in therapy is threatened. This destabilisation can be compounded by the therapist's reactions; a therapeutic stalemate may arise. The unresolved conflictual relationship predispositions expressed in the transference enactment will persist in limiting the patient's authentic relatedness in relationships outside therapy and with the therapist (if s/he remains in therapy).

1.5.3 'Real' Challenge Origins

The therapist and the therapeutic situation were discussed above as objects of patients' 'disguised allusions' (Gill, 1979) to the transference; they may also be sources of nontransferential difficulties experienced by the patient. Ways in which the therapist and the therapeutic situation can originate real, nontransferential, Challenges are reported here.

The PI and psychodynamic literatures' focus on therapists and their "errors" (Strupp and Binder, 1984, p. 192), "failures, mistakes and evasions (sometimes more painfully one's follies)" (Williams in Foreword to Casement, 1985, p.x), to the exclusion of the therapeutic situation as real Challenge sources. Therapist failures is the most commonly used term. Two aspects of these failures should be noted at the outset. Firstly, therapists' failures are to an extent inevitable; at some point "the therapist system will fail the patient system" (Pinsof, 1994, p. 186). The therapist will fail to perform the self-other and self-regulating functions (for example, the mirroring, idealising and twinning forms of transference (Kohut, 1984)) required by clients' preestablished object relations. Secondly, the 'reality' of therapists' failures is often unrecognised or difficult for therapists to recognise (Henry and Strupp, 1994).

"When the patient fails to acknowledge some truth about himself as presented by the therapist, or agrees verbally without any significant shift in his life or in the therapeutic

relationship, it is common to regard this as due to unconscious resistance within the patient. It may be so; but sometimes it can be an indication that there is, in this lack of change, an unconscious cue to the therapist to re-assess his assumptions about the patient, his theory or technique. There may be something the therapist has not yet recognised, or acknowledged, and the therapist can be resistant too" (Casement, 1985).

Therapists' 'misjudgements' of the alliance have recently been thought to be more common than is acknowledged or desirable (Horvath, Gaston and Luborsky, 1993); such misjudgements compound difficulties in recognising therapists' failures.

Bugental (1988) put down all therapeutic failures to one common denominator, the

"hesitation of the therapist to invest as fully, to be as truly present, as the patient needs" (p. 534)

at the base of which were therapists' anxieties and responsibilities. He suggested that this common denominator took three, clearly interrelated, forms: (1) therapist's personal anxieties (which he considered failures of personal responsibility)

"We fail our patients when we hesitate to confront them for fear of their anger, ...when we divert them from emotional outbursts, from transference 'messiness'...We fail them when we refuse to take responsibility for our own neurotic distortions" (Bugental, 1988, p. 534);

(2) therapist's professional anxieties

"for fear of their disappointment in us, or their taking flight..when we let clients believe that there are answers to all life issues if only they will persist in therapy, if only they will rid themselves of neuroses and resistances, if only they will accept our teachings, then we truly fail and betray them" (Bugental, 1988, p. 534);

and (3) therapists' objectification of clients

Each of these three sources of failure will be briefly considered below. But firstly, to facilitate their full appreciaton, it is necessary to state how (in Bugental's terms) the therapist *is* 'truly present'. Strupp and Binder's (1984) TLDP will again be used to illustrate the therapist's stance in PI therapies.

In PI therapies the therapist's attitude should consistently (1) be expectant

"that is, ready not only for observing but also for experiencing and, to some degree, for becoming engaged in the interpersonal scenario enacted by the patient" (Strupp and Binder, 1984, p. 42);

(2) be aware of the possible real and transferential meanings of the patient's contributions, by monitoring answers to these questions,

"What is the patient communicating to me verbally as well as nonverbally? What reciprocal role does he or she assign to me? What does the patient expect me to do? What am I expected to be? What responses is he or she trying to 'pull' from me? What, in broad terms, is the nature of the interpersonal drama in which I am being asked to participate?" (p. 42);

(3) be aware that the experience of the therapeutic transaction is more important than its content,

"What is critical is the shared understanding of the subjective truth of the patient's experience" (Strupp and Binder, 1984, p. 45);

(4) communicate respect for the patient, in particular

"The patient should never have the experience of being treated like an object, a case, the bearer of a disorder...Respect also means steadfast adherence to the professional role" (Strupp and Binder, 1984, p. 45-46); and

(5) communicate empathy, by listening to the patient

"Listening means immersing oneself in the world of another human being; allowing oneself to resonate to the spoken and, more important, unspoken messages; and being aware of one's own feelings, images, fantasies and associations" (Strupp and Binder, 1984, p. 47).

This is the ideal therapeutic stance for the TLDP; therapists' failures detract from this and in so doing can originate client's Challenges. Each of the three forms of failure (the therapist's personal anxieties, professional anxieties and objectification of client) identified above will now be considered in turn.

Bion suggested that "In every consulting room there ought to be two rather frightened people" (Bion, 1974, p. 13). The question here is how can therapist's personal fears and anxieties originate clients Confrontation Challenges? As indicated above, the therapist's 'trial identification' (Greenson, 1967) is part of the therapeutic stance; the therapist "acting in" the patient's transference can however be disruptive and antitherapeutic (Casement, 1990, p. 166; Strupp and Binder, 1984). In the trial indentification with the patient, in PI terms,

"the therapist, for a time and to a limited degree, is recruited into enacting roles assigned to him or her by the patient's preconceived neurotic scenarios" (Strupp and Binder, 1984, p. 149).

This "capacity to be in two places at once", in "the therapist's and the patient's shoes" enables the therapist to discern elements of the patient's object-relating that are being relived by the patient and might otherwise be missed (Casement, 1985, p. 35); this understanding can then guide therapeutic work. Trial identification depends on the therapist "developing a capacity to synthesise these apparently paradoxical ego

states" and on the therapist's 'internal supervisor' which is "an attitude to listening that includes an awareness of the patient's perception of the therapist's reality, and some responses to that reality" (Casement, 1985, p. 71).

This process goes awry when the therapist is unable to 'pull back', or 'retain sufficient separateness' from the interaction to be able to reflect on it rather than 'act in it' (Casement, 1990). In PI terms the therapist's countertransference

"encompasses those therapist actions and reactions (including attitudes and behaviour as well as thoughts, feelings and fantasies) that are evoked by the patient's transference enactments" (Strupp and Binder, 1984, p. 149).

The therapists' own anxieties and object-related issues prevent the therapist from 'working his way out' (Gill and Muslin, 1976; Levenson, 1982) and the therapist responds reciprocally to the patient's transference enactment by, for example, becoming impatient or attacking. The therapist thereby becomes

"an opponent in the battle the patient needs to wage for self-protective reasons" (Strupp and Binder, 1984, p. 188),

and a "recipocal mounting attack", or "persecutory spiral" (Meares and Hobson, 1977, p. 357) results. This is antitherapeutic:

"The analytic 'good object' is not someone better than the original object: it is someone who survives being treated as a 'bad object'. By surviving I mean neither collapsing under that experience nor retaliating because of it" (Casement, 1990, p. 87).

Thus the therapist's personal anxieties, "the therapist's own personality structure and current problems" are an "important factor" in the development of this antitherapeutic situation (Meares and Hobson, 1977, p. 357). The therapist's failure to 'pull back' is, for Bugental, a failure of personal responsibility.

How can the therapists' professional anxieties originate Challenges?
The failures described above are associated with therapists' personal anxieties *within* their professional role as 'expert', 'helper'. Therapists anxieties *about being* in that role may originate clients' Challenges; for example, therapists may be omniscient, controlling, invalidating. Examples of these failures are presented here.

Therapists' anxieties about 'not knowing', particularly during "extended periods during which they may feel ignorant and helpless" (Casement, 1985, p. 3), may result in the therapist attempts to be, in various ways, all-knowing and all-powerful (Bion, 1967a). The therapist may not be respecting of the patient's right and responsibility to make decisions and/or the therapist may "push, promote a course of action, or limit the patient's freedom in other ways" (Strupp and Binder, 1984, p. 45). Meares and Hobson (1977) describe how therapists' omniscience may be intrusive to patients. A highly intuitive therapist, for example, may express accurate understandings of a patient too early in therapy and

"then, at best, the patient is afraid and avoids further exposure; at worst, he or she feels invaded and attacked inside by the 'magical therapist' who can control the hidden self which, now, is no longer his 'own' (Meares and Hobson, 1977, p. 350).

Similarly, they describe how a therapist believing their interventions to be 'insight-giving' may subtly derogate the patient:

"Telling a patient that he is angry or that he wishes to dominate may be a covert way of calling him names. Then..the therapist is confirming what he, the patient feels he is - bad and worthless" (Meares and Hobson, 1977, p. 350).

A therapist "under stress" may be controlling of the patient, for example, by rigidly using techniques with which they are secure (Casement, 1985). The therapist (maybe due to their personal anxieties about, for example, being manipulated or controlled by the patient) may insist on controlling the course of the session or entire therapy. For Casement the controlling therapist leaves the patient feeling impotent. For Pilgrim (1983) the controlling therapist reinforces the patient's feelings of impotence which increases their sense of personal isolation and their indignation at this isolation.

The therapist being controlling is an indirect means by which the patient's experience can be invalidated. Meares and Hobson (1977) discuss others; for example, therapists' search for 'deeper' meanings:

"It may occur when the therapist considers that what his client says does not mean what the latter thinks it does. There is a suggestion that the 'real' meaning lies elsewhere. ...such a quest might be illusory or destructive. At its most extreme it involves the assumption ... that what the patient says means *nothing but something else* - a 'something else' which is regarded as being more fundamental or causative...Thus the therapist behaves as if the patient is communicating in a curious kind of code, which it is the duty of the therapist to break. Under these circumstances the patient finds his words a cage. ...he is imprisoned behind the bars of an explanatory stereotype (Meares and Hobson, 1977, p. 352; italics in original).

The therapists' professional anxieties expressed in the ways illustrated above run counter to the desired therapeutic stance in PI therapies. Using Bugental's term, they are therapist failures that can provide the source for client Challenges.

Whilst evidently a form of patient invalidation, Bugental (1988) viewed objectification as "less acceptable" (p.534) than and therefore worthy of consideration separate from sources of failures presented above. Often discussed in terms of reductionism (eg Pilgrim, 1994; Smail, 1978), treating patients as if they were 'objects' or 'things', not treating patients as 'persons' and, indeed, persons not dissimilar to the therapist is antithetical to Psychodynamic Interpersonal therapy (PI; Barnes, 1983; Strupp and Binder, 1984). Meares and Hosbon (1977) set out their understanding of the effects of objectification. In common with Pilgrim (above) they closely associate objectification and alienation:

"By subtle means the patient is made to feel that he is 'bad', 'ill' and 'abnormal'; and, hence, completely different from the therapist. Such patronising intimations, implying 'It's all your problem which I do not share' induce a sense of alienation" (Meares and Hobson, 1977, p. 350).

The therapeutic situation, with its prescribed roles, rules, tasks and goals, may also be the source of nontransferential difficulties for clients. Whilst PI therapy's 'personal relationship cast in impersonal terms' (Strupp and Binder, 1984), 'equal but asymmetrical relationship' (Meares and Hobson, 1977) is recognised and desired as a (or possibly 'the') means of personal change, it can, at least, be confusing, as the following two examples illustrate:

A patient not being given clear information, or a patient being given "opaque" or "conflicting" messages, regarding the structure of therapy and the demands that will be made therein illustrate what Meares and Hobson describe as an "untenable situation in which he [the patient] is rendered helpless, not knowing how to respond or to express himself" (Meares and Hobson, 1977, p. 355);

"The patient who sits under the eye of the therapist without a notion of what he is doing, or of what is likely to happen, will feel unnerved, frightened and even under attack. This situation is rare in pure form. Nevertheless, in a lesser degree, it seems to be exceedingly common" (Meares and Hobson, 1977, p. 355).

This second example of how real Challenges can orginate from the therapeutic situation could be included as one of the paradoxes of psychotherapy (Casement, 1985, p. 2). As the personal/impersonal, equal/asymmetrical descriptions above indicate, as well as being an explicitly helping relationship, the therapeutic relationship is recognisably 'different from' other relationships. One of the expectations clients can hold, and can be encouraged to hold, of this relationship is that they will not

experience the same norms, values and associated judgements as they do in their individual and communal relationships outside therapy. There is a (post-Rogerian) societal belief that a relationship with a therapist will be uniquely accepting and expansive, such that clients can more freely, that is, without the therapist's direction or coercion, explore 'all their options'. However,

"Psychotherapy happens within the context of an institution (with or without walls) and the institution happens within the context of a society. It follows that, in psychotherapy, the political themes of institution and society, their power structures, are immanent. Therapists and clients swim in political waters" (Bannister, 1983, p. 139).

Thus, the therapeutic relationship (by therapist and client) is not and cannot be divorced from the class, gender, race, etc dynamics of the society in which it takes place. These dynamics can be 'real' sources of Client's Challenges.

1.6 Additional practical significance: Challenge difficulty

The theoretical and practical significance of Confrontation Challenges has above been explained in terms of their challenging the *modus operandi* of PI therapies. Additional practical significance lies in Confrontation Challenges being 'difficult' (Davis, Elliott, Davis et al, 1987; Horowitz and Marmar, 1985); they are difficult in the following respects:

1.6.1 Challenging therapists and the therapeutic situation is difficult for clients

Given the therapist's power base within the therapeutic situation, for most clients confronting therapists is difficult and anxiety provoking. (Casement, 1985; Shapiro, 1994).

1.6.2 Challenges are rare and 'make or break'

As indicated above, in spite of therapists' inevitable failures, clients' full transference enactments are rare. Therefore whilst therapists might have an abstract understanding of the unfolding process, they might have little practical knowledge or experience of dealing with the 'critical points' reached in transference enactment. For Henry and Strupp (1994) such a situation highlights the difference between "inert knowledge" and "knowledge in action"; a difference they recommend can only be overcome by "fundamental training in the perception of moment-to-moment interpersonal process" (p. 68).

1.6.3 Challenges express negative affect

Clients' expressing strong negative (or positive) feelings toward the therapist:

"The client is expressing strong positive or negative feelings toward the therapist in an intensely personal relationship indicative of emotional bonding, confrontation, encounter, clash, or transference" (Mahrer, Dessaulles, Nadler et al, 1987, p. 8),

as in a Confrontation Challenge, are considered 'good moments' in psychotherapy; these are moments of "welcomed and desirable client movement, progress, improvement, process or change" (Mahrer, 1985; Mahrer, Dessaulles, Nadler et al, 1987, p. 7). Managing clients' hostility, attacks and confrontations is however a common difficulty for therapists (Davis, Elliott, Davis et al, 1987), as is managing the "usual human response" to these client expressions (Strupp and Binder, 1984). At the least, these moments can be experienced as frustrating the therapists' efforts to establish the desired relationship (Horowitz and Marmar, 1985). Compounding this, of the continuous 'transference tests' set the therapist (Weiss, Sampson et al 1987), it is patients' anger and hostility (not their 'seductive behaviours') which 'pull' most for countertransference reactions (Strupp and Binder, 1984):

"We believe that the anger surrounding the emergence of unfulfilled needs into consciousness poses one of the most difficult problems for many therapists. If the patient succeeds in evoking anger from the therapist, he or she may feel that they are "closer", which in turn evokes anxiety" (Strupp and Binder, 1984, p. 154).

1.6.4 Challenges bring into immediate focus the therapeutic relationship

Establishing and managing the therapeutic relationship is no mean feat in itself (Strupp, Butler and Rosser, 1988; Hobson, 1985). Challenges have the effect of destabilising the established relationship and this disruption is anxiety-provoking in itself. However, Challenges also (a) focus attention on and, given their make or break quality, (b) require that attention is focussed on the here-and-now of the therapeutic relationship; this can be anxiety provoking for both therapist and client (Casement, 1985; Jilton, Batchelder, Muran, Gorman, Safran, Wallner, Samstage and Winston, 1994: York SPR).

1.7 Summary and Conclusions

Chapter One has presented the theoretical and practical arguments for the Research Question, 'How are Client Confrontation Challenges to the therapeutic relationship in Sheffield's Psychodynamic Interpersonal therapy best responded to by client and therapist?'

Chapter Two will review the theoretical and practical answers to this question.

Chapter Two

2.1 Introduction

Chapter One presented the theoretical and practical rationale for the Research Question,

How are Client Confrontation Challenges to the therapeutic relationship
in Sheffield's Psychodynamic Interpersonal therapy
best addressed by client and therapist?

Chapter Two puts together an empirically-grounded response to this question. As a 'state of the art' answer to the Research Question, this integration of relevant research findings will contextualise the empirical findings from the present work.

Prior to examining the literatures it might be expedient to remind the reader of how Confrontation Challenges were characterised at the close of the previous chapter. Challenges are critical points in short-term PI therapies: whether the Challenge is the full enactment of a negative transference or is, in that moment, expressing the client's reaction to her/his objectification (for example), the Challenge disrupts the previously established status quo in the working alliance. In the moment the Challenge is made the working alliance is destabilised. The client's affectively and negatively charged Challenge has become 'the central issue' (Bloom, 1992). In addition the Challenge is central to change; it has a make or break quality for the relationship and the therapy. It is axiomatic to change in PI therapies that the Challenge's transferential origins are examined (Bauer and Kobos, 1984). But making a break in the alliance into a significant part of the change experience takes more than restoring the alliance (Bordin, 1994). Thus oriented to the characteristics of Confrontation Challenges, the next section (2.2) considers how in clinical theory and practice these Challenges are best addressed.

2.2 Empirical answer to the Research Question

2.2.1 Introduction

According to the empirical literature, how are Client Confrontation Challenges best addressed? Alliance research can be said to have begun some twenty years ago (eg Doherty, 1985), under the influence of (1) Bordin's (1975) and Luborsky's (1976) early conceptual work that suggested the pantheoretic utility of the alliance construct and (2) serendipitous findings (eg Kernberg, Burstein, Coyne, Appelbaum, Horwitz and Voth (1972) suggesting the significance to outcome of the therapeutic relationship (Waterhouse and Strupp, 1984)). Research into the therapist activities addressing tears, strains and otherwise poor alliances has been said to have begun five years ago (Horvath and Greenberg, 1994; at a Society for Psychotherapy Research Conference Panel (Safran, 1989)). The twenty years' alliance research has been the subject of recent,

'position statement'-style reviews (Gaston, 1990; Horvath and Symonds, 1991; Horvath and Greenberg, 1994). Bordin (1975, 1979) began; what was his 1994 evaluation of empirical work relevant to understanding how Challenges are best addressed?

"The strain aspect of alliance theory has been little researched" (Bordin, 1994, p.19);

and he cited three studies (Lansford, 1986; Foreman and Marmar, 1985; Safran, Crocker, McMain and Munay, 1990). Bordin's was something, but not much, of an underestimate; Foreman and Marmar's work has recently been replicated (Kivlighan and Schmitz, 1992) and Safran and colleagues have recently completed the initial empirical stages of the research programme they began in 1990 (Safran, Muran and Samstag, 1994). All five publications will duly be considered here.

First however some general statements regarding the twenty years' worth of empirical investigations are required to contextualise this review. The contextualisation will be presented in terms of alliance research's repeated findings (to indicate 'what's been done and found', 2.3.2) and researchers' repeated recommendations for future research (to indicate 'what's not been done', 2.3.3). Thereafter research exploring relations between client hostility and outcome will be reported (2.3.4); this hostility-outcome relationship has been shown to be equivocal and dependent on therapists' contributions. The stage thus set, empirical work informing the question how best to address Confrontation Challenges will be reviewed.

Bordin was accurate in his assessment that little empirical work has focussed on alliance ruptures and repair. However, his inclusion of Foreman and Marmar's (1985) study indicates a confusion, or a distinction not made, in the empirical literature. Foreman and Marmar and others have investigated poor alliances early in therapy. Interest in poor early alliances stems from the mixed empirical findings concerning the variability of the alliance over the course of therapy. (On the one hand ratings of the alliance early in therapy consistently predict final outcomes to suggest that the fate of therapy may therein be sealed; on the other hand ratings indicate variabilities in the alliance over the course of therapy.) But poor alliances are neither synonymous with, nor necessarily productive of alliance ruptures. Similarly poor alliances are not necessarily constituted by client hostility. Research into each may, however, inform the question regarding how to address Confrontation Challenges. Therefore, therapists' contributions to the continuation or otherwise of poor alliances are considered in 2.3.5. Therapist activities relating to patient

hostility are considered in 2.3.6. And, last but not least, Lansford's (1986) and Safran et al's (1990, 1994) investigations of alliance ruptures are presented in 2.3.7. The closing statement (2.3.7) brings together these researches to consider how they inform the question, how best to address Confrontation Challenges?

2.2.2 Alliance research's repeated findings

The repeated findings regarding the alliance are reported here. Intentionally general statements are made. From initial macro-level considerations, such as how the alliance relates to outcome, the statements increasingly reflect more micro-level considerations, such as differences between the variations in early and mid -phase alliances. No design details or considerations are reported here; they are discussed in Chapter Three. These statements aim to overview what alliance researchers have 'done and found':

- A positive alliance is positively related to good outcomes (Doherty, 1985; Frieswyk et al, 1986; Hartley, 1985; Waterhouse and Strupp, 1984). This is the most consistent finding of psychotherapy process-outcome research to date (Goldfried, Greenberg, Marmar, 1990; Orlinsky, Grawe and Parks, 1994).

- This consistent positive alliance-outcome association is not affected by the type of therapy, the length of therapy or the timing of the alliance measurement (see Horvath and Symonds, 1991, for a review)

- There is a "substantial lack of unanimity" regarding how the alliance operates and what and how client and therapist contributions to the alliance effect outcomes (Horvath and Symonds, 1991, p. 147; Gaston, 1990).

- Client contributions to the alliance have been consistently found to be more influential than the therapist's in the alliance-outcome association (Freiswyk et al, 1985; Hartley, 1985; Horowitz, Marmar, Weiss, DeWitt and Rosenbaum, 1984; Marziali, 1984)

- There is consistent empirical support for psychodynamic theory's distinctions between the affective and working alliances (Gomes-Schwartz, 1978; Hartley and Strupp, 1982; Marmar, Gaston, Gallagher and Thompson, 1989a) but that regarding a separate task and goal agreement is mixed (Marmar, Weiss and Gaston, 1989b; Horvath and Greenberg, 1989).

- The therapist's positive contribution (including therapist's empathic understanding) to the alliance has repeatedly been shown to be distinct from the positive contribution of the patient (Gomes-Schwartz, 1978; Hartley and Strupp, 1982; Marmar et al, 1989a, 1989b, Marziali, 1984).

- Patient hostility is distinguished from
  (a) other patient negative contributions to the alliance and
  (b) the therapeutic and working alliance (Gomes-Schwartz, 1978; Hartley and Strupp,

1983; Marmar et al, 1989a, 1989b). This has been understood to indicate patient hostility deriving from a different, transferential source (eg Gaston, 1990).

- Of negative *therapist* contributions, items reflecting the therapist's hostility toward the patient have been grouped separately from the therapist's understanding and involvement (Marmar et al, 1989a, 1989b).

- Alliance quality or 'strength' as early as the third session in brief therapy predicts outcome (Hartley and Strupp, 1983; Horvath and Greenberg, 1986, 1989; Morgan, Luborsky, Crits-Christoph, Curtis and Solomon, 1982; O'Malley, Suh and Strupp, 1983). Overall alliance scores peak at about the 25% of therapy, with high and low outcome cases being maximally differentiated at this point (Hartley and Strupp, 1983; DeRubeis and Feely, 1991).

- Early alliance development is influenced by
  (a) expressed hostility (Gomes-Schwartz, 1978; Marziali, Marmar and Krupnick, 1981; Strupp, 1980a, 1980b, 1980c, 1980d);
  (b) quality of current relationships (Gomes Schwartz, 1978; Moras and Strupp, 1982; Piper, DeCarufel and Szkrumelack, 1985);
  (c) quality of past relationships (Horowitz, Marmar, Weiss and Rosenbaum 1984; Lehrke, 1977)

- Early alliance quality was proposed to be related to premature termination (Bordin, 1979); findings are equivocal (Hartley and Strupp, 1983; Kokotovic and Tracey, 1990; Ryan, 1973).

- Alliance variation beyond the early sessions has attracted less research interest. Horvath (1986) found relatively large middle phase variations, which he attributed to breaks and repairs in the alliance. The successful Penn Project clients' alliances and Vanderbilt I clients were characterised by (a) constantly positive Type II alliances and (b) increasingly positive Type I alliances (Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen and O'Briend, 1980; Hartley and Strupp (1982).

2.2.3 Alliance researchers' repeated recommendations

Alliance researchers' recommendations for 'future research' are reported here. The aim of reporting these is to indicate researchers' views of what the bulk of alliance research 'has not done but should do'. In the literature overviewed above, two substantive recommendations have been made repeatedly. (Methodological recommendations are addressed in the next chapter). Research should take account of the

- multifaceted dynamic interaction to which both the patient and therapist contribute" (Hartley, 1985; Waterhouse and Strupp, 1984), in particular the immediate moment to moment effects of therapist's technical activities (Kivlighan, 1990; Windholz and Silberschatz, 1988) in order to progress our understanding of the 'alliance-intervention' relationship.

- the variabilities, waxing and waning, in alliance qualities over the course of therapy (Bordin, 1975; 1979; 1980; Gelso and Carter, 1985), in particular influence of technical activities during early sessions (Horvath and Greenberg, 1994).

Put together, these recommendations to take into account the dynamic transaction and alliance variabilities and its sources are testimony to there being relatively little research impacting on the question of how best to address Challenges. However, as indicated in the Introduction (2.3.1) five publications report empirical work directly relevant to the Challenge aspect of the question and others report work which is relevant to the alliance aspect of the question. These are reviewed below and conclusions drawn.

2.2.4 Client Hostility and Outcome

This section concerns the relationship between patients' expressed hostility and outcome. As stated, patient hostility has repeatedly been distinguished from other patient negative contributions to the alliance and patient's contributions to the working alliance. Hostility thus taken to indicate patients' negative transference, its "unique relationship" with outcome has been speculated (Gaston, 1990). What does the empirical literature reveal about its relation with outcome?

Research data indicate that clients expressing hostility *can* be positively associated with their benefiting from therapy: For example, Mintz et al's (1971) factor analytic investigation of the relations between process dimensions and outcome indicated that patients who were able to verbalise hostile feelings ("particularly in the context of high health and low distress", p. 116) tended to benefit more from treatment than those who did not express these feelings. The hostile-competitive, supportive-interpretive and passive-resistant quadrants of Leary's (1957) interpersonal diagnosis schema were explicitly taken to reflect client transference behaviours in Crowder's (1972) study of the emotional (as opposed to the content) meaning of clients' behaviour in early, middle and late phases of therapy. 25 clients' were classified as successful or unsuccessful (by their pre-post ratings of change). Successful clients were differentiated from unsuccessful clients by being more hostile-competitive and less passive-resistant early in therapy.

The data are however equivocal. Research data indicate that clients expressing hostility *can* be negatively or not positively associated with their benefiting from therapy: Mueller's (1969) "important but underaddressed monograph" (Gelso and Carter, 1985) first

examined therapist behaviours with clients' negative transferences. Therapists' behaviours were consistently illustrative of countertransference reactions. Similarly the therapies of hostile, resistant patients in Strupp's (1980a, 1980b, 1980c, 1980d) series of four case comparisons were characterised by alliance formation being difficult; therapists' reactions evidencing countertransference and patients not benefiting from therapy. In all Vanderbilt I cases (Suh, Strupp and Samples O 'Malley, 1986), Strupp and Binder (1984) "failed to find a single instance in which a patient's hostility and negativism were successfully confronted and resolved" (p.300), but found the therapist's reactions expressing coldness, distancing and other forms of rejection, and concluded

"as therapists we have not adequately faced up to the negative reactions engendered in us...therapist's negative responses to patients were far more common and far more intractable than has been generally recognised" (Strupp and Binder, 1984, p. 300).

Thus, to understand the differential outcomes associated with client expressions of hostility, Strupp's four case comparisons indicated the need to consider therapists' contributions to the therapeutic process. Research focussing on aspects of therapists' responses to patients' hostility/transference (2.3.5) and initially poor alliances (2.3.6) is presented below.

2.2.5 Patient Hostility, Therapist Behaviour and Outcome

How have therapists' behaviours been found to influence the relationship between patient hostility and outcome? Strupp and his co-workers can be considered 'ahead of the field' in their continuing investigation of these cases and in their multi-method approach; their work will now be summarised (Suh, Strupp and Samples O'Malley, 1986; Henry and Strupp, 1994). (Chapter Three will discuss research design and methods in depth; it suffices here to note their multi-method approach). Henry, Schacht and Strupp (1986, 1990) undertook intimate analyses of in-session process. They used Benjamin's (1974, 1982) Structural Analysis of Social Behaviour (SASB) to closely analyse the interpersonal process taking place in the third session of four 'good outcome' cases and four 'poor outcome' dyads. Poor outcome dyads were characterised by

- patients showing significantly more hostile separation (walling off and avoiding) and significantly less friendly autonomy (open disclosure and expression of positive affect)

- therapists showing significantly more hostile control (belittling and blaming) and significantly less affiliative control (helping, teaching and protecting)

- a higher incidence of negatively complementary exchanges; these are reciprocal, hostile or controlling interchanges

- significantly more complex interpersonal process; ie conveying contradictory interpersonal process (eg accepting *and* rejecting).

High change and low change dyads were thereby differentiated in their early interpersonal process. In the low change dyads 19% of the patient's and 20% of the therapist's communications were considered hostile (compared with 0% and 1% in the high-change dyads). In the low-change dyads the reciprocal, hostile and/or controlling complementarity between patient and therapist was striking . Henry, Schacht and Strupp concluded that relatively high levels of subtle therapist hostility, complex communications and negative complimentarity marked countertherapeutic interpersonal process (for them a measure of a poor working alliance).

These same countertherapeutic interpersonal behaviour patterns have recently been observed in dyads of prematurely terminated dynamic psychotherapy (Hildenbrand (1994). In addition, over the course of the sessions prior to premature termination, Hildenbrand observed (a) increases in both the hostile negative complementarity cycle (which had been seen in the first session) and the complexity of communications, and (b) in no case of the interpersonal initiative being hostile was attention directed to the therapeutic relationship. Henry et al's and Hildenbrand's work present a graphic picture of occasions in which patient and therapist 'fight fire with fire'.

Horowitz, Marmar, Weiss, DeWitt and Rosenbaum (1984) examined the interactions between therapists' actions, patients' dispositions (motivation and developmental level), alliance and outcome in 12-session psychodynamic therapy for people suffering grief-related, post-traumatic and adjustment difficulties. When patients were poorly motivated, particular therapist actions were not associated with increases in alliance strength; therapists maintaining a consistently positive attitude was associated with alliance strengthening. However, with highly motivated patients, examining negative transferences (with exploratory, uncovering interventions) was associated with increases in alliance strength.

2.2.6 Poor Alliances, Therapist Behaviours and Outcome

What therapist behaviours are associated with patients with poor prognosis obtaining better than expected outcomes? This was one of the question addressed by Suh and O'Malley's (1982) 'prognosis failure' study. Disappointed with their results of their earlier work (O'Malley, Suh and Strupp,

1983), Suh and O'Malley (1982) abandoned the process-outcome strategy of elucidating overall relationships between alliance and outcome for an entire sample and used a 'prognosis failure' strategy to identify cases with significant discrepancies between their expected outcome and eventual outcome in order to assess the differential therapist contributions associated with these discrepancies.

In the Vanderbilt projects, alliance quality is assessed by the Patient Involvement subscale, measuring Patient Participation and Patient Hostility, of the Vanderbilt Psychotherapy Process Scale (VPPS; Suh, Strupp and Samples O'Malley, 1986). O'Malley, Suh and Strupp, (1983) had found that Patient Participation increased over the first three sessions of therapy and that this pattern of process contributions was positively correlated with outcomes. Suh and O'Malley (1982) used Patient Participation as a Prognostic Index to group sixteen of the dyads from the earlier study along two dimensions; 'prognosis for change' and eventual outcome. Thus four groups were identified; High Prognosis-High Outcome; High Prognosis-Low Outcome; Low Prognosis-High Outcome and Low Prognosis-Low Outcome. Changes in - Negative Therapist Attitude, Therapist Warmth, Therapist Exploration, Patient Participation observed during the first three sessions were rated as 'positive', 'negative' or 'null' and Negative Therapist Attitude in the First Session was rated as 'present' or 'absent'.

Striking differences in (a) the patterns of therapist behaviour were observed between the two groups of dyads whose outcomes were different than predicted (the Low Prognosis-High Outcome and High Prognosis-Low Outcome groups) and again more differences between (b) the two groups of dyads whose outcomes were as predicted (High-Prognosis-High Outcome and Low-Prognosis-Low Outcome) cases. The patterns of therapist behaviour in these dyads were summarised as follows:

<u>Therapist behaviour in groups achieving outcomes that were not predicted</u>

- Low Prognosis-High Outcome

Half the cases starting out with Low Prognoses (four out of eight) obtained High Outcomes and these were attributed to positive changes (increases) in Therapist Warmth

and Therapist Exploration and in Patient Participation (in three of the four cases) which was initially low in all four cases.

- High Prognosis-Low Outcome

A smaller proportion, two out of seven of the cases considered to have High Prognoses at the end of the first session obtained Low Outcomes. These poorer-than-expected outcomes were attributed to initially high levels of Negative Therapist Attitude which subsequently increased with concommitant decreases in Therapist Warmth and Therapist Exploration.

Therapist behaviour in groups achieving expected outcomes

- High Prognosis-High Outcome

Those cases that obtained the expected High Outcomes were characterised by initially positive Therapist Attitude and by increases in Therapist Warmth and Exploration across the sessions.

- Low Prognosis-Low Outcome

By contrast, the cases obtaining the expected Low Outcomes were characterised by initially Negative Therapist Attitude and decreases in Therapist Warmth over the three sessions.

In its reliance on informal assessments of broad therapist factors in fifteen minute segments of three sessions, Suh and O'Malley's (1983) analysis was relatively coarse-grained. Nonetheless they were satisfied that the results pointed out the therapist behaviours that influenced the expected outcomes in these clinical cases. In short, in dyads in which poor prognoses were achieved, therapists' behaviour indicated initially negative attitude and decreasing warmth over the sessions. By contrast, in poor prognosis dyads which achieved better than expected outcomes, therapists' behaviour indicated increasing exploration and warmth over the sessions.

Foreman and Marmar's (1985) study is the most cited in discussions of ruptures and their repair and as such will be reported in some detail here. The question they addressed was similar to that investigated by Suh and O'Malley. Two alliance-outcome groups were identified; an 'improved alliance' group characterised by initially problematic alliances but ultimately good outcomes and an 'unimproved alliance group' characterised by initially poor alliances and poor ultimate outcomes. The question they addressed was, What therapist actions differentiate the two, improved and unimproved alliance groups?

Six women clients were selected from the sample of bereaved for their high negative alliance contributions. The clients' negative alliance contributions in the second session of therapy (Horowitz et al, 1984) were independently assessed using the California

Therapeutic Alliance Scale (CTAS; Marmar et al, 1986). Three clients went on to obtain lower ratings of these negative alliance contributions and either good or excellent ratings of their outcomes (according to assessments of symptomatology and social functioning made by the patient, therapist and external assessor). The remaining three clients continued to obtain high ratings of their negative alliance contributions and poor ratings of outcome. Therapists' collaboration and alliance ratings were comparable.

What therapist actions were examined? Seven therapist actions considered to be (a) differentially present and (b) clinically effective in addressing alliance difficulties were identified for investigation. The list of actions was informed by the theoretical and empirical literatures; clinical reviews of other cases with problematic alliances; pre-and post-therapy evaluations and session-process notes; videotapes of sessions that preceded hours marked by improvements in the ratings of the patient's negative alliance contributions. These were the therapist actions examined:

- actions addressing the patient-therapist relationship
- actions addressing patient-other relationships (the patient's past or current relationship with anyone other than the therapist)
- interpretations of the patient's defense, or anxiety or underlying impulse
- interpreting the defence used by the patient to ward off problematic feelings; eg 'You change topics just when you begin to express feelings about me' (p. 924)
- interpretations of the problematic feelings themselves; eg 'You seem uncomfortable with me today' (p. 924);
- actions addressing problematic relationship patterns repeated by the patient; either the patient had a problematic powerful self-image as a strong and hurtful person in relation to a weak and vulnerable other, or the patient had a problematic vulnerable self-image as a weak and injured person in relation to a powerful and hurtful other (p. 924)
- a 'triangle of punishment' organising three interrelated elements - a problematic powerful image, the associated guilt and the expectation or need for punishment.

Their observations of these actions in the two improved and unimproved alliance groups were summarised as follows:

Three therapist action patterns characterising the improved alliance group

- The therapist addressing defences the patient used to deal with feelings in relation to the therapist and in relation to others was the therapist action that most consistently differentiated improved from unimproved alliance cases.

- Therapist actions addressing the triangle of punishment in both the patient-therapist and patient-other relationships also characterised the improved group.

- In the improved alliance cases therapists addressed and linked *both* (a) the patient's problematic feelings in relation to the therapist and (b) defences against these problematic feelings.

Contrasting therapist action patterns in the unimproved alliance cases

- The therapist focussed on the patient's problematic feelings in other relationships in the face of therapist-directed feelings being explicitly expressed by the patient; this was a pattern in two of the three unimproved alliance cases.

- Therapists addressed either problematic feelings or defences against these feelings; therapists did not address both problematic feelings and defences against them.

They concluded that

"...there are at least some instances in which the alliance scores reflect an increased willlingness and capacity of the patient and therapist to work together. There seem to be therapeutic approaches that can improve an initially poor alliance and ultimately contribute to a better outcome" (Foreman and Marmar, 1985, p. 925).

and that the 'therapeutic approaches' they had observed to do this were consistent with clinical theories (eg Brenner, 1979; Gill, 1982; Langs, 1975).

Foreman and Marmar's explicitly exploratory study (1985) was recognised as an "important starting point" by researchers who have more directly investigated the repair of alliance ruptures (Safran et al, 1990; p. 155); the question addressed was clinically and theoretically meaningful; specific therapist actions (rather than global therapist factors) were examined and the results were derived from observations of moment to moment, in-session process. Its methodological limitations were recognised by the authors and others (Kivlighan and Schmitz, 1992; Safran et al, 1990). The sample size was small and precluded statistical analysis; the coder (Foreman) of therapists' actions was not blind to alliance or outcome status and the reliability and validity of his ratings was not assessed. The authors and Bordin (1994) made more substantive criticisms. Foreman and Marmar (1985) critiqued their not having examined the role of countertransference in therapists' dealing with the initially poor alliances. Bordin's (1994) was a substantive criticism:

Foreman and Marmor (1985) had not distinguished between (a) overcoming difficulties in the formation of alliances and (b) responding to strains in the established alliance once it has been established. Kivlighan and Schmitz (1992), however, undertook a replication study that was not susceptible to the same *methodological* criticisms.

Kivlighan and Schmitz examined associations between alliance quality and dimensions of therapist activity (both rated after each of four sessions) in 15 dyads of Strupp and Binder's (1984) Time Limited Dynamic Psychotherapy; 7 dyads were rated as having continuing poor alliances and 8 were rated as having improved alliances. The alliance was measured using the Working Alliance Inventory (WAI; Horvath and Greenberg, 1989) and therapist activity characterised using Jones (1985) Psychotherapy Process Q-Sort which identifies the following dimensions of activity: supportive/challenging, distant/involved, permissive/controlling, thematic-/concretely-oriented, here-and-now/there-and-then oriented. In the improved alliance dyads, therapist behaviour was rated as more challenging, more thematic and more here-an-now oriented. A substantial caveat must however be added to this report: the external validity of this investigation was limited by the therapists being trainees and the clients being college students.

2.2.7 Addressing ruptures, strains etc and their relation with outcomes

Lansford (1986) was the first to empirically investigate strains; remember strain is

"only one of the terms that might be used to designate the appearance of a significant deviation in the patient's commitment to the working alliance, whether it is with regard to goals, tasks or bonds" (Bordin, 1994, p, 18).

Strains occurring in six cases of Mann's (1973) time limited therapy were rated for the effectiveness of strain repair, patient and therapist repair factors and outcome. Lansford found a positive association between the effectiveness of strain repair and the final outcome measurement; that is, the more effective repairs covaried with the better outcome therapies. In respect of how the strains were repaired, (a) the therapist factor appeared unrelated to both the effectiveness of the repair and final therapeutic outcome; (b) the patient factor (including, for example, the patient's initiative in attending to the strain and the patient's ego strength) was, on the other hand, influential to both.

As stated, Safran et al (1990; 1994) recently investigated the successful resolution of alliance ruptures that are marked by

"a patient statement or behaviour that distances the patient from the therapist or the therapeutic task, and/or their own internal experience. Examples would be intellectualisation, shifting the topic, justification, compliance, or immediate agreement with the therapist's statement without exploration or elaboration" (Safran et al, 1994, p. 231).

Attributable to Withdrawal (Harper and Shapiro, 1989), these ruptures are antithetical to the active, negative and confrontational Confrontation Challenges; thus the results of their investigation will not be reported here but considered in the final Discussion (Chapter Ten) of empirical work into alliance ruptures.

2.3 Empirical guidelines: A closing evaluation

What has the empirical literature told us about how best to address Confrontation Challenges? Hostility has been associated with both good and poor therapeutic outcomes. A reciprocity between patient and therapist hostility has been identified and this has been associated with low change and premature termination. This cycle can be characterised as follows: as the patient separates by expressing hostility so the therapist controls with hostility. This negative complementarity cycle has been seen to occur in concert with increasingly complex, contradictory interpersonal communications.

Consistent findings indicate that early alliance quality (ie within the first three sessions) predicts outcome and that beyond this early phase alliance quality can vary. Some research has examined the influence of therapists' contributions to the improvement of early poor alliances. The following therapist contributions have been seen to be associated with this alliance improvement: the therapist's warmth and exploration; the therapist taking a here-and-now orientation; the therapist addressing the patient's defences, guilt and expectations of punishment in the therapeutic relationship and in relationships outside therapy; the therapist addressing the patient's difficult feelings in the therapeutic relationship and, finally, the therapist linking the patient's difficulties in the therapeutic relationship with her/his defences against these feelings. With specific regard to alliance ruptures, however, clients' repair contributions have been seen to relate more closely than therapists' to the effectiveness of the repair and final therapeutic outcome.

These statements of the researchs' accumulated findings require critical evaluation. Firstly in the research reviewed here, patients' hostility and patients' alliance contributions have been the startpoints and therapists' contributions at these points have been the foci of the investigations. For example the Prognostic Index used by Suh and O'Malley (1982) was Patient Participation; the realisation of Low Prognosis was linked to intially Negative

Attitude and decreases in Warmth on the part of therapists. How is this 'design feature' understood in this thesis? Given the PI perspective, it is not taken to mean that hostility and a low quality alliance are a product of the patient, and their resolution a function of the therapist. Both, like countertherapeutic behaviour patterns, are understood to be a function of the dyadic, transactive communication.

Secondly, and relatedly, Henry, Schacht and Strupp's (1986) and Hildenbrand's (1994) investigations can be distinguished from other research described above: therapists' contributions were embedded in the interpersonal context created with the patient and account was taken of the patient's conjunctive contributions to the therapeutic process.

Thirdly, and relatedly, back to the 'how to' question regarding addressing Challenges. The research reviewed here has provided more of a 'what to do' rather than a 'how to do' answer to the question. That is, the empirically supported statements above are informative of the question 'how best to respond to Challenges?' but they leave a processual gap that can be characterised as follows;

"I know in my second meeting with Jim, a client Suh and O'Malley would identify as Mr Low Prognosis and Hildenbrand would identify as having made hostile initiatives in our first meeting, I would be advised to take a thematic, here and now orientation, to increase my warmth and exploration, and to direct my activities to his difficulties in our relationship and how he defends these, but how? How do I put all this together, how do I put it into operation as I sit in the session with Jim?"

Therefore the processual gap is signified in the empirical investigations presented above; the gap occurs in moment-to-moment decision making at the micro-level of therapeutic practice, as the therapist sits with the client in the session and wonders how to act on, or how to operationalise an integrated understanding of, researchers' findings. The next chapter will consider how a more 'how to' answer to the question 'how best to address Confrontation Challenges?' can be provided.

2.4 Overview and relation with Chapter Three

Chapter Two has presented an empirically based answer to the question of how best to address Confrontation Challenges. The empirical work reviewed was considered to evidence what has been called a processual gap. That is, the research presented above has been more informative of the 'what' than the 'how' of responses to Challenges. Having considered how to achieve a more 'how to' answer to the question 'how best to

address Confrontation Challenges?', Chapter Three presents the approach taken to the present empirical investigation of the question.

Chapter Three

3.1 Introduction

3.1.1 Aim

Chapter Three presents the rationale for the methodological approach taken to addressing the research question (Chapter One). The approach reflects the new paradigm in psychotherapy research; in particular its translation into a Change Events research strategy. Why was a new paradigm needed? Where did it come from? Why adopt it here? What constitutes the new paradigm? How is it different from the 'old' paradigm?; Chapter Three will explain.

Chapter Two identified what was called a 'processual gap' in psychotherapy studies that have informed the question 'how best to address Confrontation Challenges?' The gap is signified by the therapist in the session with the client wondering how to act on, or how to operationalise, an integrated understanding of, researchers' findings. The aim was to derive a conceptual and methodological approach that promised to overcome this gap. The rationale for the approach selected are presented in this chapter.

Horowitz (1982) referred to selecting an empirical paradigm as researchers' "strategic dilemma". In effect Horowitz applied Wertsch's (1991) identification of models and frameworks as "mediating mechanisms" to research paradigms; he argued that paradigms are

"forms of approach that dictate not only the design but the questions asked initially, and especially how questions are asked, answered, re-asked and elaborated in a series of investigations over a number of years" (p. 120).

To introduce this 'strategic dilemma', two questions will be addressed: Why attempt to overcome the processual gap? (3.1.2) How to overcome the processual gap? (3.1.3).

3.1.2 Why overcome the 'processual gap'?

"With virtual unanimity, psychotherapy researchers have argued that (a) psychotherapy research should yield information useful to practising therapists, (b) such research has not done so, and (c) this problem should be remedied" (Morrow-Bradley and Elliott, 1986, p. 188).

Indeed, as well as clinicians not absorbing and using research findings (Butler and Strupp, 1987) researchers have been sceptical of the value of their research to their clinical practice (Shapiro, 1979):

"One researcher (Luborsky) let the cat out of the bag by reporting in a circuitous way that it was the general opinion of most psychotherapy researchers that their own therapy was not influenced by research" (Treacher, 1983, p. 105)

In 1968 Krumboltz conceived the influence of research on practice in terms of 'clinical relevance'; his 'test of relevance' required that research affect what clinicians do in practice (Krumboltz and Mitchell, 1979); this is the most stringent definition of research 'use' (Cohen, Sargent and Sechrest, 1986). Thus the ambition that research should inform practice is longstanding. Similarly the dissatisfaction that the ambition has not been met is not new (Dahl, 1987); remember it was in 1978 that Parloff wrote of psychotherapy research's "incredible credibility crisis" (Parloff, 1982).

3.1.3 How to overcome the processual gap?

The processual gap can be overcome by understanding the sources of disappointment and, from this understanding, identifying necessary modifications.

Russell's (1994) "Reassessing psychotherapy research" was written in recognition of researchers'

"shared sense of dissatisfaction with the methodological tradition in which they were trained and did their early work" (Orlinsky and Russell, 1994, p197):

This tradition is constituted by the group contrast paradigm and the relational paradigm (Horowitz, 1982). In process outcome research, asking 'how does psychotherapy work?, these designs and an associated "methodologism" have dominated the third period in psychotherapy research's development, 1970-1983 (Orlinsky and Russell, 1994). Investigations adopting these paradigms

"have been shown to be seriously flawed, both conceptually and methodologically, but they continue to be conducted and to gain acceptance to their seeming adherence to the methods of science" (Russell, 1994, p. 167).

How do these paradigms originate the processual gaps identified in the previous chapter? They subscribe to 'drug metaphor assumptions' (Stiles and Shapiro,1989; 1992); this metaphor is inconsistent with current understandings of psychotherapeutic process and practice.

3.1.4 Chapter Content

The drug metaphor assumptions (stated in the terms used by Stiles and Shapiro) and their translation into process-outcome measurement strategy are critiqued.
Thereafter, consequences of this dominant paradigm and its attendant drug metaphor assumptions are noted: firstly in terms of its effects on the questions of research;

secondly in terms of its effects on the relationship between research and practice; and thirdly in terms of its effects on the relationship between research and theory.

These limitations provided for a new paradigm in psychotherapy research which reconceptualised the relation between process and outcome; this is the Change Process Research Paradigm (Elliott, 1983; Greenberg, 1994, 1986; Rice and Greenberg, 1984; Greenberg and Pinsof, 1986). The new paradigm is presented, as is its translation into a methodological strategy. These outlines, can be thought of as outlining the principles and the practice of the new paradigm. But firstly, why was a new paradigm needed; 3.2 explains.

3.2 The Drug Metaphor

3.2.1 Introduction

The explanation offered for the processual gap identified in the previous chapter is as follows: The drug metaphor and its translation into traditional, group contrast and relational, paradigms have provided that process-outcome research has not been responsive to certain psychotherapeutic phenomena.

The drug metaphor (Stiles and Shapiro, 1989) has six assumptions; they are

(1) "that process and outcome are readily distinguishable from, and bear a simple cause-effect relationship to one another;

(2) that component names refer to ingredients of consistent content and scope;

(3) that the potentially active ingredients are known and measured or manipulated;

(4) that the active ingredients are contained in the therapist's behaviour, with the patient in a correspondingly passive role;

(5) that the dose effect curve is ascending and linear in the range being examined;

(6) that the best way to demonstrate a psychotherapeutic procedure's efficacy is by controlled clinical trial...and that a process component's efficacy is shown by its correlation with outcome" (Stiles and Shapiro, 1989, p.525).

Psychotherapeutic phenomena to which traditional paradigms have not been responsive include (a) the synergistic relationships between (i) process and outcome and (ii) between client and therapist; (b) the complexity of in-session process; (c) the time course of and location of change and (d) between and within individual client differences; this statement will be supported here.

The drug metaphor has been extensively critiqued elsewhere (Stiles, 1988; Stiles and Shapiro, 1989, 1992; Strupp, 1986; Henry and Strupp, 1986). Limitations of space preclude replication of these critiques. To illustrate the metaphor's limitations, the non-responsiveness of three of its assumptions (1,2, and 3 above) are stated. To indicate the associated methodological limitations, the traditional paradigms (represented in terms of Assumption 6 above) are critiqued. To conclude this critique, the psychotherapeutic phenomena to which the old paradigm is not responsive are further specified. Thereafter the effects of these limitations on research question selection, clinical practice and theory are made explicit.

3.2.2 Assumption 1: Process and outcome are distinct from and causally related to one another

This assumption says that the effects of psychotherapy are (a) conceptually and (b) operationally distinct from the process of psychotherapy, and (c) that psychotherapy process causes psychotherapy outcome.

Traditionally psychotherapy process and process research has concerned *how* change occurs and psychotherapy outcome and outcome research has concerned *what* change occured (Wellman, 1967). In his 1959 review of psychotherapy Luborsky distinguished process from outcome research as follows:

"The studies to be summarised here can be roughly dichotomised into those with principal concern as to *how* the changes took place, therefore focussing on the interchange between the patient and the therapist (ie the process), and those that focus on the end point, to answer the question of *what* change took place (ie the outcome)" (Luborsky, 1959, pp. 320-321).

The *how* and *what* distinction is evident in the definitions used by in the most recent review of process-outcome research conducted by Orlinsky and Howard (1986) . They defined process as "everything that can be observed to occur between, and within, the patient and the therapist during their work together" (pp. 311-312) and outcome as "the consequences of the therapeutic process...with respect to the life and person of the patient [which] must be judged in terms of some particular value standard" (p.312). Stiles and Shapiro (1989) also articulated the second inherent distinction, in which psychotherapy outcome is held to be a causal consequence of psychotherapy process. The dichotomy between process and outcome, first expressed by Kiesler (1971) as the "Process-Outcome Confusion" (p. 45) has been heavily criticised.

- Criticism 1: Outcomes occur during sessions. The process-outcome dichotomy does not recognise in-therapy changes in the client's process and the therapeutic relationship as legitimate outcome. That is, in-session changes in the client's experience of and contributions to the therapeutic situation are not considered valid outcomes of therapy. The implication that changes manifest in the session are somehow clinically inferior to changes manifest after therapy is finished is difficult to support. Changes in the clients' way of relating with the therapist, for example, signify both process and outcome. Changes in the clients' posture are clinically meaningful indications of current affective and relational status. In this respect the process-outcome dichotomy provides a limited understanding of *what* change occurs over the course of therapy.

- Criticism 2: Process and outcomes occur between sessions. The process-outcome dichotomy fails to take account of outcomes that occur between sessions over the course of therapy. That is, with process viewed as occuring during the therapy sessions and outcome viewed as occuring after the therapy sessions, process continuing and changes taking place between sessions during the course of therapy are not taken into account. Following Criticism 1, neither process nor outcome necessarily stop when the client walks out of the therapist's office. Processing of session material, for example, can continue outside the session. Consciously or not, desired or not, the therapist has become a 'significant other' for the client; the therapeutic relationship is reflected on and internalised by clients and this can continue between sessions. In this respect also, the process-outcome dichotomy provides a limited understanding of *what* change occurs over the course of therapy.

- Criticism 3: The shape of change is not captured. The process-outcome dichotomy does not capture the shape of change occuring over the course of therapy. That is, "exclusive reliance" on the assessment of therapy outcome at two time points, before and after therapy, does not reflect the change function of a particular outcome between the two points and so "may obscure or distort meaningful patient improvement" (Kiesler, 1971, p. 46). Meaningful fluctuations in outcome indicators (such as those already mentioned) can occur on a moment to moment basis within sessions, on a session to session basis, between early, middle and late phases of therapy, and can continue after therapy is ended. Thus the process-outcome distinction resulted in a limited understanding of the *how* change occurs over the course of therapy.

- Criticism 4: Process scores are unchanging and unchanged. Process outcome research assumes that scores on a process measure at a particular point in time

(for example, the middle of the eighth of thirty sessions) will be consistently related to scores on an outcome measures taken at a point after the end of therapy (for example, after thirty sessions). It is on this assumption that consistent process-outcome relations are expected.

But can it be expected that no experience either inside or outside therapy occurring between the two measurement points is going to impact on that process score and so "dilute" the resulting process-outcome relationship? Since "few psychotherapeutic experiences seem to be so potent" and "the possibility of other intervening events affecting the outcome at termination is so great" (p.7) Greenberg and Pinsof (1986) criticise this drug metaphor expectation for being "both extremely ambitious and somewhat naive" (p.7).

- Criticism 4: Bidirectionality confounds causality. Stiles and Shapiro (1989) questioned the assumption that process causes outcome. In particular they drew attention to the possibility of process measures being responsive to the progress made up to the timing of that measurement in the course of therapy. That is, process measures may be reflecting changes that have occured in the session or in the therapy to the point of the measurement. Gottman and Markman (1978) pointed to the bidirectionality of process/outcome effects; they suggested that clients who are changing are likely to be more responsive to their therapists, and that those who are not changing will be less responsive. In both cases the process-outcome distinction is blurred and the direction of causation confounded.

3.2.3 Assumption 2: Component ingredients have consistent contents and scope

This assumption embodies a simplistic view of drug functioning, in which a drug's formula and dosage are transportable across administrations, patients and settings. Applied to psychotherapy, the assumption says that (a) the constituents of and (b) the therapeutic actions of ingredients are constant. There are a number of difficulties with this assumption.

- Criticism 1: Process variables do not have consistent form or content. Firstly, process variables do not have what Yeaton and Sechrest (1981) called 'integrity', or the 'purity', of a drug. They do not have consistent content or form within a therapy. Gurman (1973), for example, illustrated the variation in rated levels of therapist empathy, both within sessions and over the course of therapy. Most therapeutic processes vary significantly over time (Klein, Mathieu-Coughlin and Kiesler (1986);

"even if 31% of a psychoanalytic therapist's utterances were reliably coded as

interpretations, each of these utterances may have expressed different content and used different words to do so" (Stiles and Shapiro, 1989, p. 528).

- Criticism 2: Process variations are appropriate and influence outcomes. Variations in the content, form and action of process ingredients are wholly relevant to the moment to moment responsivity required in therapy; their invariance is not appropriate (Stiles, 1988). Stiles defined client requirements as "a process component that promotes a particular positive outcome for a particular client" (Stiles, 1988, p. 28). These requirements include client needs and resources, and vary from moment to moment, session to session, and client to client. A client's requirements for a particular 'process component' (for example asking a depressed client a question about current life situation) are indicated on a moment to moment basis by their responses to the component (for example by the quality of the information they give and the manner in which it is presented). These requirements are responded to on a moment by moment basis in the sessions by the therapist continuously making 'process diagnoses' (Rice and Greenberg, 1984) of areas for exploration, the depth, timing and accuracy of interventions and on a session by session basis in formulations and treatment plans. As the client's resources and requirements are immediately influenced by the therapist's responsiveness, so are the therapist's responses to those of the client. In sum, at the least, it cannot be assumed that these variations will have no effect on the therapeutic actions of the process variables within and across sessions and client-therapist dyads (Stiles and Shapiro, 1989).

- Criticism 3: Meaning is context dependent. A second difficulty with Assumption 2 is that the therapeutic action of a process component varies with its meaning and the meaning which is attributed to the process variable is determined by the context in which it exists (Butler and Strupp, 1986). The same process component in a different context will have a different meaning (Rice and Greenberg, 1984). As a simple example, an interpretation concerning patterns in the client's relationships presented at the end of a first session that has mainly been spent on history taking, may at least be received with surprise, if not annoyance. If the same interpretation were voiced to the same client at the middle of the seventh session, it may be explored willingly and reflectively.

"Psychotherapy is not a medical technology that can be administered to a passive patient...[It] consists of behaviours and vocalisations whose influence depends on the meanings attributed to those behaviours and vocalisations by the participants. These meanings cannot be partialled out from, nor are they independent of, the psychotherapeutic setting. Unlike drugs, where a biological action is readily distinguishable from the symbolic meaning of the treatment, psychotherapeutic techniques have no meaning apart from their interpersonal (social-symbolic) context (Butler and Strupp, 1986, pp. 32-33).

- Criticism 4: There are definitional variations between studies. A final criticism of Assumption 2 is that process variables do not have consistent content or form in different psychotherapy studies. For example, the studies cited by Orlinsky and Howard (1986) that related the process variable 'confrontation' to therapeutic outcomes were defined and operationalised in substantially different ways (Shapiro, Harper, Startup, Reynolds, Bird and Suokas, 1994).

3.2.4 Assumption 3: Potentially active ingredients are known and can be measured

A central aim of clinical trials into drug treatments is to separate the effects produced by biologically "active ingredients" from those produced by inert substances or placebos (Klein and Rabkin, 1984; Critelli and Neumann, 1984). This notion of 'active ingredients' has been adopted in psychotherapy research as a means of reducing and so making more manageable the number and complexity of the psychotherapeutic constituents that might be contributing to outcomes. 'Active ingredients' in this assumption are synonymous with the 'specific' factors of the 'specific/nonspecific debate' which is longstanding in psychotherapy research.

The earliest systematic psychotherapy research dichotomised specific and nonspecific factors thus:

"Specific factors refer to the particular theoretical orientation adopted by the therapist as well as the technical manoeuvres (techniques) based on the theory" (Butler and Strupp, 1986, p. 31).

The assumption goes that the techniques effect therapeutic change and the theory explains the causes of that change. The nonspecific factors are usually elements of the healer-patient relationship that, while not specific to one particular theoretical orientation, may be responsible for therapeutic change. Nonspecific factors have also been equated with the 'placebo effect' (Shapiro and Morris, 1978), referring to the qualities of the therapeutic relationship which influence outcome" (Butler and Strupp, 1986, p. 31). The arguments within the specific/nonspecific debate are these: If the effects of psychotherapy are a function of specific technical factors then, controlling for the nonspecific factors, research should identify which of these 'ingredients' and their theoretical base are uniquely effective. If, on the other hand, the effects of psychotherapy are a function of nonspecific factors then the findings of "no difference" (Butler and Strupp, 1986, p. 31) or "equivalence of outcomes" (Stiles, Shapiro and Elliott, 1986, p.165) between different therapies and their theories are to be expected.

Assumption Three says that *there are* 'specific and active ingredients' in psychotherapy; that these 'ingredients' are *more effective* than other 'ingredients'; that

without these more active 'ingredients' psychotherapy is automatically less effective; that these 'active ingredients' are *known* and that they can be *isolated from* and *measured and manipulated* in relation to other 'ingredients'. This assumption is flawed both in principle and in practice.

- Criticism 1: Active ingredients are not necessarily more active. In principle, these 'ingredients' are *not necessarily* more active than others in effecting change. It is more accurate to say that these active 'ingredients' are therapist practices which have been derived from psychotherapeutic theories. This is insufficient basis for assuming that *these* are the crucially effective 'ingredients' and that other ingredients are automatically less- or in-effective, "analogous to fillers and flavours" (Stiles and Shapiro, 1989, p. 529).

- Criticism 2: Ingredients are functionally interdependent. In practice, separating the therapeutic activity of these 'ingredients' from the activity of other 'ingredients' misrepresents psychotherapeutic phenomena. The process and effectiveness of psychotherapy is a function of much more than the *presence or absence* of these specified, supposedly active ingredients. Expressed in terms of the drug metaphor, all ingredients are *functionally interdependent.* Each 'ingredient' functions at one and the same time in the context created by other 'ingredients', both other 'techniques', and 'the relationship', and these constantly impact on one another. In addition, the effect of each 'ingredient' is *at least* influenced by the 'skillfulness' and 'interpersonal manner' of that therapist's intervention (Schaffer, 1982) and by the way in which it is received by the client. Whilst the notion of specific, therapeutically active ingredients was readily adopted by the field as a means of managing the complexity of psychotherapeutic phenomena, it is sufficiently unrepresentative of these phenomena as to be redundant; instead

> "What is needed is a method of sufficient complexity to adequately reflect the phenomenon it is attempting to assess, one that can tap configurations or patterns in process and that allows the discovery of associations or relations" (Jones, Cumming and Horowitz, 1988, p. 49).

3.2.5 Assumption 6(a): Controlled clinical trials are the best way to examine a treatment's efficacy

The contrast groups approach is psychotherapy research's "most elegant" paradigm in terms of "its acceptance as high quality and rigorous" (Horowitz, 1982, p.120); clients are randomly assigned to different treatment contexts and certain variables systematically altered and results aggregated across clients within the groups.

- Criticism 1: Patients are neither homogeneous nor average. Averaging outcomes across the groups being compared obscures the outcomes of individual group

members. In this way the group comparison design falls foul of Kiesler's (1966) uniformity myth; it effectively assumes that the patient groups are homogeneous. Patients are rarely homogeneous (Kiesler, 1966) . Added to that, a homogeneous patient group according to a diagnostic classification index does not preclude patients' different histories and environmental situations being brought into treatment and influencing each individual's response to treatment, with the effect that some patients will improve and others will not. To summarise, the average response of the group of patients will not reflect the response to treatment of *any* individual client; rather it will reflect the response of a *nonexistent* average client. Therefore it is impossible to infer backward from the group's performance to that of the individual within the group (Chassan, 1979; Barlow, 1981).

- Criticism 2: Generalisation is difficult. An additional consequence of the findings reflecting an average rather than an actual client is that it is difficult to translate and generalise to specific situations in clinical practice (Bergin 1966, Hersen and Barlow, 1976). In the first instance it is not possible to know which patient characteristics are associated with improvement (Chassan, 1967). In the second place it is not possible to identify the extent to which a client presenting for treatment in clinical practice is similar or different to the 'average' client. In the third place, as samples become more homogeneous (to answer Grand Prix-type questions) the complexities of individuals within populations will not be adequately represented and thus it will become more difficult to infer from the reported sample to the individual client with the same diagnosis. Thus as it is impossible to infer backward from the group to the individual within the group (Criticism 1), it is similarly impossible to infer forward to the individual client presenting in clinical practice.

- Criticism 3: Intra-individual variations are lost. A further and considerable limitation of the group comparison design for practice is the way in which variabilities *within* individuals are largely ignored. Measures of change are typically taken at substantial time intervals, such that intra-individual change has usually only been considered on a pre- post- and follow-up basis. A clinician interested in time course of change over and after the period of treatment will not be much enlightened by data derived from the contrast groups paradigm (Hersen and Barlow, 1976, p. 17).

- Criticism 4: Ethical and practical considerations. There are ethical objections to having a no-treatment control group (Hersen and Barlow, 1976). There are practical difficulties in (a) collecting large amounts of data from large numbers of homogeneous patients and in (b) a controlled trial requiring that only the process

ingredients of interest distinguish the two groups being compared (Hersen and Barlow, 1976; Stiles and Shapiro, 1989). The latter not being feasible has led to the adoption of the relational paradigm (Horowitz, 1982).

3.2.6 Assumption 6 (b): Correlations with outcome are the best way to demonstrate a process component's efficacy

According to the correlational design,

"if a process component contributes causally to an outcome, then a greater amount (frequency, percentage, strength, intensity, duration) of that component should lead to a better outcome whereas a lesser amount should lead to a worse outcome. Consequently the process component and the outcome should be positively correlated across clients....Conversely a zero or nonsignificant correlation is taken to indicate that no causal relationship exists" (Stiles, 1988, p. 27).

This design is however not without its limitations, which have been detailed by Stiles (1988) and Stiles and Shapiro (in press).

- Criticism 1: Correlations reveal associative not causal relationships.

Correlations do not reveal a causal relationship between a process variable and an outcome variable. The direction of causation cannot be detected from the correlation and may indeed be attributable to other variables that have not been measured.

- Criticism 2: Responsivity to requirements vs random delivery. When significant process-outcome relations have been discovered it has been assumed that the particular process ingredient is "therapeutically inert" (p. 28); that is, the process component's therapeutic impact is doubtful, weak or inconsistent. Stiles considers this interpretation to be 'misleading' since it overlooks variations in client requirements and therapist responsiveness to those requirements, outlined in 3.2.3 above. The responsiveness of therapist *and* client to client requirements and resources presents the following difficulty for interpreting process-outcome correlations. In so far as therapists are "appropriately responsive" (Stiles, 1988. p. 30) to client requirements, process-outcome correlations underestimate the process-outcome relationship, and is flawed in its assumption that the more of a particular process variable the better. Stiles explained this by presenting first extreme and then more realistic examples:

> "In the extreme, if therapists were perfectly responsive with respect to a process component, and that component were entirely responsible for a particular outcome, then all clients would have the same outcome. ...if therapists were perfectly responsive with respect to the component but outcomes were, more realistically, multiply determined, then the expected process-outcome correlation..would still be zero, despite variation in outcome, insofar as no outcome variance would be accounted for by failure to provide an appropriate level of the process component. Still more realistically, if therapists are appropriately but imperfectly responsive, then the size and direction of the

process-outcome correlation will depend on the relative variance of client requirements for and therapist provision of the component, and the correlation between them. Only if the delivery of the component were unrelated to client requirements would the correlation reflect the underlying causal relationship" (Stiles, 1988, p. 30).

Stiles concluded that "the use of correlations as a criterion of a process's importance is problematic because the implicit assumption of random delivery is absurd" (p. 30).

3.2.7 Summary:

Psychotherapeutic phenomena not captured by traditional paradigms

In introducing the drug metaphor and its translation in group contrast and relational measurement strategies, it was stated that the psychotherapeutic phenomena to which traditional paradigms have not been responsive include (a) the synergistic relationships between (i) process and outcome and (ii) between client and therapist; (b) the complexity of in-session process; (c) the time course of and location of change and (d) between and within individual client differences. The above critique provides for further specification of the phenomena not captured by traditional research paradigms; these are presented in the table below.

Table 1

Psychotherapeutic phenomena not captured by traditional paradigms

Process-Outcome and Client-Therapist Synergies

- Process affects outcome and outcome affects process (cf linear, unidirectional, causal relationship)
- Reflexive and transactive influences of client and therapist

Complexity of in-session process

- Functional interdependence of process constituents (cf isolable, uniquely active ingredients)
- Responsive variations in constituents' form and content
- Context-dependent meaning and therapeutic action of constituents
- Pluri-determination of effect of constituents (cf presence/absence, total amount)

The time course and location of change

- In-session, micro-level, outcomes
- Inter-session outcomes
- Continuation of process between sessions

- Groups of clients are not homogeneous
- Individual clients are not average

3.3 Effects of limitations on questions researched, practice and theory

3.3.1 Introduction

As indicated above (3.1.1) research paradigms influence more than the measurement strategy. This section considers the effects of the traditional paradigms on one particular research activity; identifying questions to be addressed empirically. These effects are translated into implications for therapeutic practice and theory (3.1.2). Question-formulation has been research method- and researcher- and research-driven (Elliott, 1983). The effects? Clinical theories have been neglected and clinical practice and practitioners have been "shortchanged" (Alexander and Luborsky, 1985; Horowitz, 1982, p. 19).

3.3.2 Some influences on the research questions selected

Three influences, considered most relevant here, are noted. Fristly the traditional paradigms influence the questions selected by research *by virtue of* their being traditional designs:

> "There has been a large gap between what researchers do in therapy and what they study in their research (Luborsky, 1972). *This is probably because therapy process research has been guided more by availiable methods than by clinical relevance.* ...The result has been to isolate process research from psychotherapeutic practice, both within the field as a whole and within individual researcher-therapists (Elliott, 1983: p. 48; my italics).

Traditional methods are, in the terms used by Elliott, available; their availability has been influential in the 'strategic dilemma' necessarily faced by researchers (3.1.1.) and thus influential in the research question formulated. A significant second influence has been the "socialisation" of clinical researchers (Horowitz, 1982, p.119); researchers have been socialised to overvalue traditional paradigms with the effect that questions which are not amenable to these are largely dismissed (Horowitz, 1982; Strauss and Hafez, 1981). The overvaluing of the group contrast and relational paradigms has persisted despite (a) recognition of their limitations (Russell, 1994) and (b) recognition that the descriptive paradigm has had the greatest influence on clinical practice (Elliott and Anderson, 1994). A third significant influence has been the 'scienticism' prevailing within and outside the researchers' social system (Koch, 1959). Positivistic, scientific values influence decisions regarding research funding, publication policy and service delivery (Budge, 1983; Parry, 1982; Strupp, 1986); consideration of these influences are influential in identifying research questions.

3.3.3 Effects of question selection on practice

When psychotherapy research questions have been driven by the traditional paradigms, what effect has this had on psychotherapy practice? The questions those paradigms can answer, macro-level questions, have been addressed and macro-level practice has been informed. The questions those paradigms cannot answer, micro-level questions, have not been addressed and micro-level clinical practice has not been addressed (Barlow, 1981; Bergin and Garfield, 1994). Barlow used clinical research which *has* had some influence on practice, research concerning the treatment of phobias and other anxiety-based disorders, to illustrate these statements. He argued that micro level questions are the "major questions of clinicians" and that they ask

"How effective would the specific procedure or strategy be with a specific individual?" (Paul, 1969; Barlow, 1981, p. 150)

Greenberg (1979) characterised micro-level questions in terms of 'when-then' clinical decisions. These are the "process diagnoses" that clinicians make continuously in sessions to inform their choice of strategy or intervention; *when* clinicians recognise recurrent client performances *then*, using their implicit or explicit guidelines, they recognise that the client may be ready for a particular intervention Greenberg (1984, p. 138). Disregarding these micro-level experiences and questions

"not only disqualifies much clinical experience from research but also distances much research from clinical relevance, leaving many clinical problems to be dealt with on the basis of anecdotal experience alone" (Strauss and Hafez, 1981, p. 1593).

3.3.4 Researchers' response to the effects on practice

How to ensure that micro-level therapeutic practice (a) *informs* the questions selected for research in order that it will be (b) *informed by* the research findings? Essentially researchers' answer has been 'go back to the micro level practice'. For research to be of more direct use to practioners, research questions must be asked at the level at which therapeutic decisions are made; that is, at the level of moment-to-moment interchange during the session (Greenberg, 1986; Stiles, 1980).

"The clinician requires information, not only about more molar sources of intrasubject variance which lead to success and failure but also about more molecular in-session changes in subtle psychological processes (Greenberg, 1986, p. 5)"

Statements such as these predated what is now called 'discovery oriented process research' (Gendlin, 1986; Mahrer, 1988). In this approach research questions are 'discovered' by observing the psychotherapeutic phenomena (Gendlin, 1986; Mahrer, 1988). Discovery-oriented process research takes a "a closer look, a look that offers a

good chance to discover something new" (Mahrer, 1988, p. 699). Close observation of ecologically valid data with a 'welcome receptivity to the discoverable' provides 'rich, full blooded descriptions' of the phenomena being observed (Elliott, 1984; Gill, 1979; Mahrer, 1988, p. 699). Descriptions thus derived are more accurate;

"Discovery in the context of measurement involves the construction of new measures by inductive procedures, in which the investigator closely observes phenomena in order to describe them more accurately. ...the investigator devises coding categories based on observation, rather than applying existing predetermined coding schemes in which the coding categories have been rationally devised and represent the operationalisation of a particular view of reality" (Greenberg, 1994, p. 125).

This observation strategy has also been termed 'holistic data exploration' (Gibbs, 1979) and more recently 'exploratory process research' (eg Hill, 1990).

3.3.5 Effects of question selection on theory

Horowitz (1982) argued that in the methodologism surrounding the adherence to traditional designs in recent psychotherapy research, theory has been shortchanged by its reduction to a few variables:

"Theory that is presented in these [research] proposals is usually concerned with a matrix of only two or three variables, not the larger matrix that leads transactively into the human experience of troubled states of mind, problematic interpersonal relationships and impaired work performance" (Horowitz, 1982, p. 119).

To be more precise, the 'few' theoretically coherent variables have become 'a few amongst many' process variables in process-outcome research's "fishing expedition" measurement strategy (Greenberg and Pinsof, 1986, p.9).

Bergin and Garfield (1994) describe the last 25 years of psychotherapy research as "an atheoretical era" (p. 821) and attribute the shortchanging of clinical theory, in part, to the theories themselves. They say the following of "traditionally dominant theories, such as the behavioural, psychoanalytic ...approaches":

"This trend [to asking questions at the micro level] has been dictated partly by ...the failure of macro theories to yield definable practices that are clinically and empirically tenable. Empirical research has speeded up this process, because many of the assumptions of the macro theories simply have not held up to scrutiny or have not been translatable into operations that will bear scrutiny" (Bergin and Garfield, 1994, p. 822).

For example, Luborsky, Barker and Crits Christoph (1990) suggested two evaluations of the availiable empirical support for theory-related propositions of psychodynamic therapy; one was optimistic, "the glass is half full and can be filled even more" and the other pessimistic, "the glass is half empty and cannot be filled much further" (p. 285).

However, Luborsky et al, unlike Bergin and Garfield, consider that this situation is in part attributable to the limitations of the relational paradigm.

3.3.6 Researchers' response to the effects on theory

Essentially, in response to the above, both the theories guiding research and the theory development desired from research have been 'scaled down'; minitheories are used to guide research questions in the effort to develop microtheories of therapeutic practice: researchers (eg Sampson and Weiss, 1986) have begun to address minitheories in their research questions (Bergin and Garfield, 1994); such as, "the therapeutic alliance should have certain characteristics in order to facilitate outcome; cognitive retraining adds to the effect of relaxation in reducing panic responses" (p. 822). Using such minitheories has required (a) the careful and close linking of hypotheses to the clinical theory and (b) precise and theoretically face valid measures of the dependent and independent variables (Greenberg and Pinsof, 1986).

This response echoes the appeal made by Gendlin in 1967 for theoretical propositions in the style "If the patient at the moment does so and so, then I find it helpful to do so and so" (p. 375). More recently Pinsof (1981) defined clinical microtheories as therapy specific, micro therapy theories that specify *what* should occur *when* and the relationship between in-therapy and outside-therapy processes at specific points in therapy (Pinsof, 1981); specific theories can than be integrated into existing macro-theories of human functioning and change (Rice and Greenberg, 1984). Their development entails the identification of the 'microstrategies' (Mahrer, Nifakis, Abhukara and Sterner, 1984) and 'subprocesses' (Gendlin, 1986; Greenberg, 1994) that contribute cumulatively to effecting outcomes. That traditional paradigms have not provided such highly specific, micro-scale theories has severely hinderered progress in psychotherapy research (Greenberg and Pinsof, 1986).

3.3.7 Summary

Section 3.2 explained how traditional research designs are not responsive to psychotherapeutic phenomena. This section (3.3) has (a) considered how this nonresponsiveness has affected the selection of research questions and, as a consequence, clinical practice and theories and has, in combination, (b) reviewed psychotherapy research's responses to these effects. It has been shown that the questions selected for research have been researcher- and research design led. This has had two effects: firstly, macrolevel questions (such as 'Is client confrontation differentially associated with outcome in Exploratory and Prescriptive therapies?') have been addressed and microlevel questions (such as 'How are Client Confrontation Challenges in Exploratory therapy?') have been neglected to thereby limit the impact of research on clinical practice; secondly, research has excessively

reduced macrolevel clinical theories and has not advanced theoretical understanding of therapeutic change. It has been argued that if microlevel research questions are derived by 'taking a closer, discovery-oriented' look at psychotherapeutic phenomena, this will inform the development of specific, clinical microtheories and moment-to-moment, within-session, decision making in clinical practice.

In summary, for research to inform the micro-, moment-to-moment, level of clinical practice it is necessary that research questions are asked at this level. Of course, this is not in itself sufficient to reduce the research-practice or processual gaps (3.1); the paradigms, their methods and their inherent conceptualisations of psychotherapy used to address the questions are also required to be more responsive to psychotherapeutic phenomena. The new paradigm in psychotherapy research, the Change Process Paradigm, was proposed to achieve this and will now be outlined.

3.4 The new paradigm: Change Process Research

3.4.1 Introduction

The 'new paradigm' in psychotherapy research has variously been referred to as "change process research" (Greenberg, 1986), "a new process perspective" (Kiesler, 1986) and a "new style of process research" (Greenberg, 1994). On the basis that the new paradigm reconceptualises the relations between process *and* outcome it will be referred to here as Change Process Research. Earliest reconceptualisations appeared in Elliott's (1983) "Fitting process research to the practitioner" paper and in Rice and Greenberg's (1984) book "Patterns of Change"; the latter marked the beginning of the fourth, "reformulation", phase of psychotherapy research (Orlinsky and Russell, 1994).

3.4.2 The reformulation of the relation between process and outcome

How does the new paradigm reconceptualise the relationship between process and outcome? Outcome is conceived as a fluid and continuous process; all of therapy is considered process and process research encompasses what goes on both inside and outside the spatiotemporal limits of the psychotherapy sessions (Greenberg and Pinsof, 1986).

Outcome is conceived as "a fluid and continuous process that is not 'best measured' at termination or any other single point", such that, "what is defined as a 'process' and an 'outcome' is arbitrary and relative" and "an intervention (a 'process') can have various outcomes ranging from its immediate impact within the session (a 'process-outcome'), to its longer-term impact after the session (a 'little 'o'), to its even longer terms impact after termination (a 'big 'O')" (Greenberg and Pinsof, 1986, p. 7). With the focus on '"proximal" as opposed to "distal" outcomes (Pinsof, 1981, p. 735), the

"likelihood of other events and experiences diluting or negating the process-outcome link" (Greenberg and Pinsof, 1986, p. 7) is reduced. Thus, this conception of psychotherapy process and outcome relations firstly, promises to most directly track change processes and secondly, requires a new research strategy, one that tracks the distal outcomes of these processes by focussing on smaller, clinically meaningful, contextualised 'units', 'chunks' or 'episodes' (Greenberg, 1986). Greenberg and Pinsof (1986) called this variously the 'smaller is better approach' and the 'small chunk research strategy'.

The question currently preoccupying psychotherapy researchers, 'How does psychotherapy work?' (Shapiro, 1991), is reframed by the new paradigm: From the position that

"Therapy is a complex, multivariate process ..Different processes involved in different approaches also account for change. In addition, different processes are important at different times and all the processes combine to produce the final effects. It is the complex integration of processes that we need to investigate and understand" (Greenberg, 1994, p. 116).

The question that psychotherapy research must address is, 'What are the processes of therapeutic change?'.

3.4.3 Derivation of the reformulation

This is a resume of the shifts in thinking that culminated in the new paradigm's reconceptualisation of the relation between process and outcome. Kiesler (1971) was the first to recommend that the process-outcome distinction be abandoned in favour of a more accurate in-therapy/out-of-therapy distinction:

"Perhaps it would be helpful to discard these terms, referring instead to in-therapy (interview) studies and extra-therapy (in situ) investigations" (p. 46).

This new within/outside session distinction was significant in that it allowed within-session variables to be conceptualised as outcomes. However, it's uptake by researchers was slow. Stiles (1980) proposed that the *impact* of sessions during the course of therapy should be distinguished from long-term therapy *outcome*. On the basis that "outcome cannot be assessed until long after any particular intervention and may then reflect the cumulative effect of many, diverse, psychotherapeutic encounters" (p.176-7), he anticipated two stages of inference from session impact data. These were firstly from the in-session psychotherapeutic interaction to the impact, which would be measured immediately after sessions, and secondly, from that post-session impact to the eventual outcome" (Stiles, 1980, p.177).

Similarly, in their generic model of psychotherapy, Orlinsky and Howard (1986, 1987) distinquish post-session outcomes, 'micro-outcomes', from long term, 'macro'-outcomes. According to their conceptualisation, *micro-outcomes* are evidence of the immediate effects of particular therapy sessions made apparent in the daily lives of clients during the course of therapy. They defined micro-outcomes as "subtle but significant steps toward personal transformation" that can, under "favourable circumstances", gradually accumulate over the course of therapy and be "synthesised by the patient to change the habitual, problematic assumptive systems used in dealing with self and others" (p.367); thus macro-outcome became "the net result of an extended series of incremental shortterm changes" (Orlinsky and Howard, 1986, p. 366).

Orlinsky and Howard and Stiles thus recast outcome as a continuously-occuring process. Their thinking challenged, firstly, the myth of outcome homogeneity and secondly, the fundamental assumption of the process-outcome research strategy: the myth of outcome homegeneity (Kiesler, 1966) says that there is a final static therapeutic outcome that is best and definitively measured at the end of therapy or at follow-up, which has come be referred to as 'the Big 'O". For Stiles there would be as many impacts, or 'little 'o's', (for example, "This session was full/empty"), as there are sessions. For Orlinsky and Howard there are would be as many of a particular type of micro-outcome, or little 'o's', (for example, instances of increased choice in an emotional moment) contributing to the macro-outcome as can be defined and identified in the client's everyday situations outside therapy. Secondly their thinking challenged the assumption that process at a particular point in therapy has a constant relationship with the big O, final, outcome; the fundamental assumption of the process-outcome measurement strategy. They had reconceptualised 'process-outcome' as 'the process of outcome'.

Stiles' and Orlinsky and Howards' thinking was in certain respects however, consistent with that implicit in traditional paradigms. For them, intermediate, within-therapy, outcomes (impacts and micro-outcomes, respectively) remained singularly between- rather than within-sessions phenomena. Thus consistent with the traditional paradigms in-session experience was not considered as outcome; process and outcomes were not considered to continue within and between sessions.

By contrast, Greenberg and Pinsof proposed that suboutcomes are evident and should be tracked within sessions, immediately after sessions and between sessions, to the end of treatment and beyond; they viewed the process of therapy as a chain of suboutcomes linked together toward ultimate outcome (Greenberg, 1982, 1986a; Greenberg and Pinsof, 1986; Pinsof, 1980). Thus an intervention (a 'process') can

have various outcomes ranging from its immediate impact within the session (a 'process-outcome'), to its longer term impact after the session (a 'little 'o''), to its even longer term impact after termination (a 'big 'O'')" (Greenberg and Pinsof, 1986, p. 7-8):

"*Therapy is process.* Therapy is the interaction between systems. This interaction is continuous and dynamic outside as well as within the sessions. The distinction between process and outcome is arbitrary and primarily a function of the goals of the observer. Anything that happens within and between the patient systems is part of the therapeutic process" (Pinsof, 1994, p. 176; italics in original)

This conceptualisation abandons the assumption of homogeneous psychotherapeutic process; abandons the fixation with rates and levels of process variables and increases the role of the context of those variables. By searching for what Pinsof (1981) has called 'proximal outcomes', as opposed to process-outcome research's distal outcomes, the new paradigm promises

"an understanding of how each encounter affects (or fails to affect) the client. There can be no long-term effects without short-term effects, even if the short-term effects are covert, requiring incubation to some critical mass before appearing as major life changes" (Stiles, 1986, p. 184).

The long-term goal of understanding how psychotherapy works depends on cumulative understanding of these encounters, their proximal outcomes and their cumulative critical mass (Stiles, 1986).

3.4.4 Putting the paradigm into research practice: Intensive process analysis

To access the change process, new paradigm research requires "a grain of analysis that will more accurately reflect the phenomena under study and will allow a study of change" (Greenberg, 1975, p. 26). This is achieved by methods in which process is intensively analysed (Greenberg, 1991). The two 'intensive process analytic' approaches most well developed to date are Task Analysis (Greenberg, 1984a, 1984b) and Comprehensive Process Analysis (Elliott, 1984). The greater clinical relevance of these methods

"probably derives from the fact that they are all closely related to aspects of the clinical method - that is, they are all more systematic versions of cognitive activities engaged in by good therapists: (1) the analysis of intervention contexts in order to manage the timing of responses; (2) careful attention to the perceptual worlds of self and client; (3) recognition and understanding of significant change moments in
the observation and undertanding of single cases over time; (4) the search for sequential contingencies in therapy and out of it; and (5) integration of all availiable information as part of the search for patterns of individual meaning" (Elliott, 1983, p.51).

Given the initial requirements to be micro- and proximal- (cf macro- and distal-), intensive process analyses are based on "small chunks" of therapy (Greenberg and Pinsof, 1986); these small chunks are therapeutic episodes and Significant Change Events.

"Therapeutic episodes are meaningful units of therapeutic interaction which according to the therapeutic approach being used, are designed to achieve an intermediate goal" (Greenberg, 1986, p. 5). These intermediate sub-goals and tasks are explicitly defined by the therapeutic approach; others may sometimes be implicitly defined by the therapist. Meaningful therapeutic episodes are constituted by the client-therapist interactions that achieve these goals. Change Events are also episodes, meaningful 'whole' units of therapy, but they are differentiated by two, possibly but not necessarily interrelated, features. Firstly they are understood to have a high probability of effecting significant change (Elliott, 1983b, in G,1986) and secondly they are likely to bring into focus theoretical issues concerning the hypothesised processes of change in the particular therapy (Rice and Greenberg, 1984). With their 'make or break' quality and their accessing key processes of change in PI therapy, Confrontation Challenges can be considered Significant Change Events. Rice and Greenberg's (1984) Change Events research strategy will now be outlined.

3.5 The Change Events Research Strategy

3.5.1 Introduction

Dividing therapy into Change Events mirrors clinical practice; the majority of psychotherapists and psychotherapy researchers or theorisers-recognise key, critical, decisive or significantly helpful or harmful events in psychotherapy (Rand, 1979; Standhal and Corsini, 1959).

These key, critical, decisive or significant in-session moments are especially potent examples of Greenberg's (1975; 1984) 'when-then' process diagnoses.

To reiterate (3.3.2), Greenberg (1975) suggested that the practice of experienced clinicians is guided by "implicit or explicit formulations that involve 'when-then' types of behavioural sequences" (p. 20) that function to reduce the complexity of the therapeutic interchange. He locates the 'when' of the sequence in the client and its 'then' in therapist. The 'when' of the 'when-then behavioural sequence' occurs as the client presents

" particular performance patterns recognised by the therapist as a target for therapeutic work" (Greenberg, 1975, p.20),

(for example, a Confrontation Challenge), 'then' the therapist makes a 'process diagnosis' and her/his implicit and explicit understandings of therapy guide therapeutic strategy. The 'when' of Significant Change Events are particularly critical in-therapy moments; the 'pull for' the 'then' will be particularly potent.

3.5.2 Definition and Constituents of Change Events

The 'when', the client's in-therapy behaviour, marks the beginning of an event and suggests a responsive therapeutic procedure to the therapist. The 'then' of the 'when-then' sequence are then the therapist operations that, defined by the type of therapy, characterise and are specifically responsive to that client-provided target.

"A therapeutic event is defined as being constituted by a client 'marker' of an opportunity for change, a series of therapist interventions, an ensuing client performance and, in successful performances, an affective resolution" (Rice and Greenberg, 1984, p. 27).

As indicated, an event has four constituents:

the *patient problem marker*

"a statement or set of statements by the patient that indicates to the therapist that the patient is in a particular problem state at the moment (such as conflict) and is amenable to intervention" (Greenberg, 1986, p. 6);

the *therapist operation*

"the set of interventions made by the therapist to promote problem resolution and is described in an operation manual" (Greenberg, 1986, p. 6);

the *client performance*

"the ongoing client responses to the therapist intervention" (Greenberg, 1984, p. 6);

and, in resolution events, the end of the event is signalled by

an *in-session outcome*

"such as the integration of conflicting tendencies or cognitive reorganisation" (Greenberg, 1984, p. 6).

Thus the 'when-then' sequences capture the process of mutual influence inherent in psychotherapy. Change is then studied in terms of the ensuing client-therapist

transaction; the meaning and structure of which is determined by the understanidng of the client's initial 'when' behaviour (Greenberg (1975).

3.5.3 The questions asked in the research strategy

The Events Paradigm strategy asks the following questions of these potent change events:

(1) What client in-therapy performances, or markers, suggest themselves as problem states requiring and ready for intervention?

(2) What therapist operations are appropriate for these markers? What therapist operations will best facilitate a process of change at this marker?

(3) What client performances following the markers lead to change? What are the aspects of the client performance that seem to carry the change process, and what does the final in-therapy performance or immediate outcome look like?" (Greenberg, 1986, p. 6).

3.5.4 The answers provided by the strategy

In general terms, the answers to these questions amount to a close and detailed description of the process of change in the particular class of event; this represents a substantial advance for psychotherapy research:

"Once we know what interventions were most appropriate for which client states and what resulting client performances led to problem resolution, we would be much closer to describing how change actually takes place in therapy. We would then be able to identify the active ingredients of change and explain the mechanisms that lead to this change" (Greenberg, 1986, p. 7).

There is a tendency in the literature to use 'mechanisms of change' and 'processes of change' interchangeably: a note on mechanisms of change. Rice and Greenberg (1984) are uniquely careful to specify what they mean by "client mechanisms of change" (p. 14). Intensive process analysis methods (eg in "Patterns of Change") provide three levels at which mechanisms may be captured; the level of client *process;* the level of client *operation* and the level of *information-processing operations* (Posner and McLeod, 1982). Client process, the first level, concerns the manifest, observable client performance in the session. (Rice and Greenberg use the example of a manifest verbal output being rated as 'focussed' in terms of "Client Vocal Quality; Rice and Saperia, 1984). Client operations, the second level, involves drawing inferences from the observable process to the internal operations:

"One might infer that the client was engaged in *inner tracking* in order to *symbolise* an inner referent" (Rice and Greenberg, 1984, p. 14; italics in original).

The third, information-processing operations, level is at the greatest level of abstraction from manifest process. These operations refer to elementary cognitive-

affective information processing operations underlying the client operations (eg shifting focus and comparing two symbols (Rice and Greenberg, 1984, p. 14).

On the basis that the level of client internal operations "promises to be the most transferable level of understanding across orientations" (p. 15), Rice and Greenberg suggest the longterm objective of identifying client mechanisms of change at the level of clients internal operations.

3.5.5 The principles underlying the Change Events strategy

Rice and Greenberg (1984) articulate the following as the fundamental principles to be adhered to in undertaking Change Events research:

Principle 1

FOCUS ON RECURRENT AND POTENT CHANGE PHENOMENA

Points at which the client-change is considered to be occuring are "probably the most promising phenomena to select" (p. 19). These are the points in therapy that are most likely to be "crucial to the eventual outcome" (p. 19) and at which "theoretical issues will often come into focus" (p. 19). These instances at which the potential for change is high are assumed to recur throughout a therapy and across therapies and, with this recurrence, to be "similar to each other in some important ways" (p. 19).

"Allthough not exact repetitions of each other, often dealing with quite different specific content, they do have some clearly identifiable structural similarities. They recur sufficiently often within and across clients to permit a systematic focus on their commonality" (Rice and Greenberg, 1984, p. 19).

Principle 2

USE EXPLICIT AND IMPLICIT THEORY TO SELECT AND STUDY THESE PHENOMENA

Explicit theories of therapy and personality change are used, in combination with implicit, clinical knowledge, to inform the selection of these phenomena and to guide their investigation.

Principle 3

USE A RATIONAL EMPIRICAL METHOD

A "rational empirical" approach (Lewin, 1951; Pascual-Leone, 1976; 1978; Pascual-Leone and Sparkman, 1978; Piaget, 1970) is the central strategy in the Events

Paradigm. The empirical aspect, "the primary investigative tool", entails rigorous observation and induction. Throughout this is informed by the "basic rationalist supposition" (p. 20); which says that

"for a person of a given type, there exist invariances in the organisation of his or her inner processes which apply across situations to generate the person's performance" (Rice and Greenberg, 1984, p. 19).

Both these invariances and the performance-demands of the particular class of event are taken account of by incorporating the rational with the empirical analyses:

"One starts with a clinical notion of what is important. This implicit or tacit knowledge is explicated as best one can and an initial model of the phenomenon is constructed on the basis of the regularities perceived across people and across situations of a particular class. ... (this) represents the rational aspect of the analysis. ... The empirical aspect is, however, informed by the clinician's experience as represented in the model. One looks intensively at a series of examples of a particular type of change episode drawn from the same client or from different clients and tries to isolate the essential patterns that form the structure of this kind of episode. An organised series of such empirical trials is made, each one enriching and clarifiying one's understanding of the essential pattern. *The tool of clinical observation and induction is used in a rigorous and addititve fashion.* ...Finally, from the refined descriptions of in-situation performances, models of the person's internal operations are constructed, which are held to apply across different instances of the situation studied and across people of a given type" (Rice and Greenberg, 1984, p. 20; my italics).

7Principle 4

STUDY CHANGE PHENOMENA IN TERMS OF SEQUENCES AND PATTERNS UNFOLDING OVER TIME

On the basis that "a certain kind of change has or has not taken place" (p. 20) in the selected events, the analysis concentrates on "the patterning of behaviour before, during and after the change event" (p. 20). Initial attempts to explain relations between a-contextual, process variables took an associative approach: if c then y. The discovery and identification of the patterning of in-session behaviours promises improved explanation of these relations (Gottman and Markman, 1978; Rice and Greenberg, 1984).

"It is more the occurrence of a particular pattern of variables than their simple presence or frequency of occurrence that indicates the therapeutic significance of what is occurring in therapy" (Greenberg, 1986, p. 7).

Principle 5

DESCRIBE THE COMPLEXITY AND DETAIL OF THE PROCESSES ENGAGED IN BY THE CLIENT THROUGHOUT THE CHANGE EVENT

The analysis depends heavily on description. This description should be as detailed and complex as is consistent with "the reduction of observed behaviours to meaningful and identifiable classes" (p.21).

"Some reduction of complexity must take place. However, the observational categories should be, as far as possible, at a descriptive level rather than at an inferential level" (Rice and Greenberg, 1984, p21).

Principle 6

FOCUS ON THE CLIENT; REGARD THE THERAPIST'S BEHAVIOUR AS PART OF THE CONTEXT OF THE EVENT

Why? Simply, it is the client who changes. Whilst "the whole sequence of transactions before, during and after the change point" is under investigation, "it is the client who changes" (p. 21).

"Preoccupation with the role of the therapist and the theoretical orientation have led investigators to lose sight of the mechanisms of change within the client and yet it is these we need to understand" (Rice and Greenberg, 1984, p.14).

Rice and Greenberg combine this view with their recommendation to investigate client operations to access mechanisms of change:

"Clearly the essential client operations take place in an interactional context in which client operations are shaped by therapist interventions, and their essential nature must be grasped in this context" (Rice and Greenberg, 1984, p. 15).

Beyond this,

"focussing on client behaviour and regarding the therapist behaviour as context for this...is a simplification strategy which enables us to look first at patterns of client behaviour and then to view the therapist as one important source of influence on the client at that point" (Rice and Greenberg, 1984, p. 21).

Principle 7

CONSIDER THE INDIVIDUAL DIFFERENCE VARIABLE MORE AS AN EXPLORATORY VARIABLE THAN AS A CLASSIFICATORY CATEGORY

The approach assumes that the selected change events are similar as performances. Thus the individual difference variable is simply one of the many constructs that may help to explain client performance in these events.

Principle 8

STUDY THE CLIENT PROCESS IN CONTEXT

The clinical meaning of particular behaviour is enhanced by specifying its particular function in a particular context.

Principle 9

BUILD TOWARDS HYPOTHESIS-TESTING AS THE FINAL STEP OF A PROGRAMME OF DISCOVERY AND UNDERSTANDING

Contrasting with traditional paradigms, the Change Events strategy progresses towards the formulation and testing of hypotheses is the endpoint rather than the startpoint:

"Some preliminary evaluation of the therapeutic potency or relevance to change of the client performances to be studied is, of course, called for in the early stages of the research program. ... Elaborate verification studies, however, come at the end of the program, when a deeper understanding of the mechanisms of change affords much greater control over the sources of variance affecting outcome" (Rice and Greenberg, 1984, p. 22).

3.6 Review of the New Paradigm and its 'Promises'

To close, the new paradigm will be overviewed and its potential for psychotherapy research in general and the present empirical work in particular spelt out.

The 'emerging', new process perspective focusses on the processes of client change and the identification and understanding of the processes that operate in concert both inside and outside the therapy sessions which, together, constitute the process of change. These client processes are affected by the therapist's interventions and associated with change during the course of therapy. Most recently Greenberg (1994) has characterised the new style of process research thus:

Greenberg (1994) A new style of process research

FEATURES	CHARACTERISTICS
Studying the change process	Studying the patient/therapist or the interactional process
Studying process in context	Defining therapeutic episodes
Discovery oriented research	Identifying patterns of regularity and constructing measures of phenomena
Causal explanation	Building a mini-theoretical model with causal laws, processes and interactions

What promises does the new paradigm hold?

- "The primary yield of the new paradigm is an understanding of particular classes of change phenomena and the client mechanisms underlying the change" (Rice and Greenberg, 1984, p.22).

- Better understanding of outcome: With the achievement of this specific process-description and operational-understanding of a particular class of change event, the relations between this event and outcomes can more systematically be investigated.

  "Whether the connections are simple or complex, it is apparent ... that understanding the particular change phenomena can move us a step closer to understanding that complex event called outcome" (Rice and Greenberg, 1984, p.23).

- Better understanding of the selection and evaluation of therapist interventions: Understanding the client operations essential for *favourable* change increases our understanding of the criteria on which therapist interventions may be selected and evaluated.

  "We will ask more appropriate questions concerning which therapist interventions facilitate the appearance of the necessary components of a successful client performance" (p. 23).

  The answers to these questions hold obvious implications for therapist training and supervision.

- A deeper understanding of the therapy process: Rice and Greenberg point to a contribution "seldom discussed in relation to research" - "a deeper understanding of the therapy process" (p. 23). Their strategy "stimulates clinical thinking'" by combining the supervision-like, fine-grained analysis and questioning ("thinking theoretically in new ways", p. 23) with repeated checks of these speculations against a series of actual performances.

- Therapy-specific micro-theories: Greenberg and Pinsof (1986) were keen to stress the potential impact of the 'small chunk approach' on the development of psychotherapy theory. As stated, Change Events are selected on the basis of clinical theories specifiying 'what' are the potent change phenomena in the therapy. Subsequent analyses in keeping with the principles outlined above should provide for the development of specific, microtheories about the mechanisms and process of change within the particular therapy .

In short, tracking the processes of proximal change promises to address the processual gap and thus increase the relevance of research to micro-level, clinical decision making.

3.7 Preliminary evaluative comments on New Paradigm research

3.7.1 Introduction

Greenberg's "Change Process Research" paper was published in 1986, two years after Rice and Greenberg's (1984) "Patterns of Change: The intensive analysis of psychotherapy process". Some ten years later the articulation and recommendation (eg Greenberg, 1991, 1994) and commendation (eg Orlinsky and Russell, 1994; Bergin and Garfield, 1994) of the 'new style', change process research is still more common than its implementation in empirical practice. Its rationale and promises have not been questioned; its uptake has been slow and its implementation is time consuming (Safran, Greenberg and Rice, 1988); thus comprehensive evaluation of all the promises outlined above (in 3.6) must wait:

"This approach, seemingly, could produce more interesting results than much of what has been investigated previously. However, how valuable it will be remains to be seen. For example, Greenberg (1986) in discussing recent studies of change episodes in psychotherapy sessions, such as resolution of conflicts and problematic reactions, changes in states of mind and resolution of core conflictual themes, feels this work "shows some promise of helping to isolate processes of change in different types of therapeutic interaction" (p. 6) (Garfield, 1990, p. 277).

Specifically Garfield (1990) was reserving his assessment of new paradigm contributions to the time when studies provided empirical evidence regarding "how such change processes influence the ultimate outcome of therapy" (p. 277). Given that Greenberg (1991) considered his two phase, discovery-verification, programme investigating the resolution of 'unfinished business', in which a large scale group study

"to see if those patients who resolve unfinished business in the course of treatment according to our model show better outcomes than those who do not" (Greenberg, 1991, p.14)

is the final stage would take between 5 to 10 years, Garfield will be waiting for some time. But as Greenberg and others (eg Safran et al, 1988) have argued,

"the field needs to recognise the steps along the way as good science. Hypothesis testing should be the final step in a rigorous programme of discovery and understanding. We shouldn't try to prove something until we are confident of success, otherwise much effort is wasted" (Greenberg, 1991, p. 14).

This being the case, how will the new paradigm usefully be evaluated here? There are empirical indications that the paradigm's rationale is influencing research thinking and interpretation; two examples are cited (3.7.2). There is also an increasing number of published studies and studies which, in Greenberg's terms, are 'steps along the way'. A 1995 Special Issue of the Journal of Consulting and Clinical Psychology will, for example, be given over to theoretical and empirical 'Change Process Research'.

Distinctive lines of new paradigm research are developing; these will be identified (3.7.3). Space precludes substantive discussion of these but consultation of the publications indicated will evidence the "fruitful additions to research findings" required of the new paradigm by Bergin and Garfield, (1994, p. 828) in the latest edition of the psychotherapy researcher's 'Bible', "The Handbook of Psychotherapy and Behaviour Change".

It should be stated here that these and the following observations are general and positive indications of the new paradigm's influence to this point in time. These are counterbalanced in the following chapter by the author's specific criticisms and required modifications to new paradigm rationale and method. Presenting these in the following chapter rather than here was considered more appropriate: the present chapter has introduced the conceptual arguments on which the new paradigm rests. The next chapter considers how to use an Events based method in addressing the question, 'How best to address Confrontation Challenges?' In presenting the criticisms among the more practical, planning decisions detailed in the next chapter, the aim was to make them as accessible as possible to the reader.

3.7.2 The influence of the new paradigm on research thinking and interpretation

Recently published are two empirical estimates of the influence of new versus old style understandings of psychotherapy process (Elliott and Anderson, 1994; Shapiro, Harper, Startup et al, 1994). Both concluded that new paradigm critiques and rationale are influencing research thinking, if not in its design at least its interpretation. Their common conclusions are succinctly represented by the following quotation:

"Our analysis serves mainly to demonstrate the prevalence of simplifying assumptions in the therapy research literature. There seems for us to be a trend for the recent studies to make fewer simplifying assumptions, even while remaining within one of the traditional research paradigms. To our thinking, this indicates the increasing influence of new-paradigm research using task analysis of signficant events methods" (Elliott and Anderson, 1994, p. 101).

Both projects were concerned with the limiting and oversimplistic assumptions underlying traditional research paradigms. In view of process-outcome research's pervasive adherence to an oversimplistic drug metaphor, Shapiro et al's work was stimulated by

"the suspicion that the conclusions reached by Orlinsky and Howard were dependent upon conceptual and methodological limitations both of the research they reviewed and the relatively uncritical approach they took to reviewing it" (Shapiro, Harper, Startup, Reynolds, Bird and Suokas, 1994, p. 2).

Elliott and Anderson's startpoint was similar:

"As therapists, we know that psychotherapy is a complex process. ... However, when we act as therapy researchers, we typically ignore this knowledge, following instead the simplifying assumptions we learned in graduate school as part of our positivistic tradition" (Elliott and Anderson, 1994, p. 65).

Shapiro, Harper, Startup et al applied meta-analytic techniques to 33 process intervention-outcome research studies. Six scales were constructed to determine whether the studies addressed the limiting assumptions Stiles and Shapiro (1989) attributed to process-outcome research's oversimplistic adherence to the drug metaphor. The scales asked whether the studies considered (a) the moderating effect of client variables on the intervention-outcome relation; (b) the process variable having more than two values on the process continuum; (c) anything other than a linear relationship between process and outcome; (d) the influence of variables other than client variables influencing the process-outcome relation; (e) the responsivity of interventions to fluctuating process requirements and (f) outcome-process effects. According to orthodox methodological standards (Cook and Campbell, 1979; Shapiro and Shapiro, 1983), the meta-analysis also evaluated the quality of evidence for the direct effect of the intervention on outcome.

The 33 studies assessed in these terms were collected together in Orlinsky and Howard's (1986) review of process-outcome research. Their review distilled process-outcome research's answer to the question, "What is effectively therapeutic about psychotherapy?" and their answer founded the author's Generic Model of Psychotherapy (Orlinsky and Howard, 1986, 1987; Golden, 1991). The process variables examined in the 33 studies were all interventions which Orlinsky and Howard classified as interpretation, confrontation/feedback, exploration and questioning, support, encouragement, advice, reflection and self disclosure. Two early new paradigm studies, both by Greenberg, had been included in the 33 source studies collected by Orlinsky and Howard (Greenberg and Dompierre, 1981; Greenberg and Rice, 1981).

Elliott and Anderson undertook an "empirical examination of 10 key therapy process-outcome studies" (p. 66) that, in the authors' views, represented traditional approaches to evaluating the effectiveness of a therapeutic process. Following Elliott, Cline and Schulman's (1983) scheme for classifying traditional change process studies, the approaches included were process-outcome paradigm studies, sequential process studies, studies of immediate perceived impact and retrospective perceived effective ingredients. The 10 studies selected to represent these were "well known and well executed for its genre and time" (p. 98).

Limitations of space prevent detailed presentation of both and there is overlap between the two. Shapiro et al's meta-analysis of the 33 intervention-outcome studies (a) included 80% of studies selected by Elliott and Anderson (the remaining two investigations of immediate perceived impact, were not published at the time of Orlinsky and Howard's review) and, (b) paid equal attention to it's 'quality of evidence' and 'drug metaphor' critiques, thus the meta-analysis will be presented in more detail. Uniquely important in Elliott and Anderson's project, however, was their having compared the traditional process-outcome studies with an early new paradigm change process study (Elliott, 1984); the results of this comparison will be discussed in detail.

Shapiro et al's six drug metaphor considerations reported above were rated 0 if no attempt was made to address the issue; 1 if the issue was considered in the text but not in the analysis and 2 if the issue was addressed in data analysis. The reliability with which these ratings were made was hampered by a combination of relatively low quality reporting in the source study reports, variability in methods and approaches, and 'fuzziness' in some of the concepts coded. Weighted kappas ranged from .21 to .65.

Drug metaphor limitation	No of studies taking account of limitation in text/ analysis	...in Analysis	Reliability
Nonlinear relations	3	3	.65
Responsivity	8	2	.60
Outcome-process effects	6	1	.42
Client-intervention moderation	16	13	.30
Nonbinary process continuum	11	11	.21

These data suggested that some of the concerns regarding the oversimplistic adherence to drug metaphor assumptions were being addressed in most of the process-outcome research cited by Orlinsky and Howard. However it was found all the studies made one or more of the assumptions critiqued by Stiles and Shapiro (1989). Similar conclusions were reached by Elliott and Anderson:

"every [simplifying] assumption appeared in at least one of the ten studies... The majority of assumptions (9 out of 14) appeared in at least 60% of the articles. ...Only three articles held 7 (50%) or fewer of the simplifying assumptions" (Elliott and Anderson, 1994, p. 99).

Interestingly, Elliott and Anderson (1994) found that the example of new paradigm research they had selected for comparative purposes, an analysis of four insight events by Elliott (1984), also evidenced two simplifying assumptions. The assumptions in evidence were firstly, that effects associated with a particular process variable are consistent over time and secondly, that no additional or alternate variables operate sufficiently strongly to produce similar correlations between process and outcome. Evidence of these traditional assumptions was attributed to the particular study using an earlier form of comprehensive process analysis

"in which the effects were not tracked through time (stable effects) and inquiry was restricted to a preselected set of variables (closed causal system)" (Elliott and Anderson, 1994, p. 101.

In the view of the present author, of more general importance in understanding this finding are the following: Firstly, the assumptions found by Elliott and Anderson to most sharply delineate new from old paradigm research (equal weighting of process units, vs significant events; uniform relevence of variables, vs specificity; and unidirectionality of causal influences, vs birectionality) were not evident in the new paradigm study. Secondly, Russell's (1994) explanation for evidence of paradigmatic thinking he observed in two new paradigm proposals (Elliott et al, 1987; Stiles, 1987) has to be taken seriously here. Of the pervasiveness of paradigmatic thinking he wrote

"even these critics of tradition are unconsciously bound by it" (Russell, 1994, p. 181).

In conclusion, both Elliott and Anderson's and Shapiro, Harper and Startup et al's recent works have shown that the new paradigm *is influencing* thinking and design in psychotherapy research; and that the pervasiveness of paradigmatic thinking should not to be underestimated.

3.7.3 Indications of distinct and developing lines of new paradigm research

Distinct and developing lines of new paradigm research will be identified and referenced here. As indicated, these are 'pointers to' rather than a 'comprehensive review of' the new paradigm's 'fruitful additions' to the literature to date.

There are two lines of new paradigm research associated with two of the methods included in the first statement of the Events based approach (Rice and Greenberg, 1984): Task Analysis (Greenberg, 1984a, 1984b, Rice and Saperia, 1984) and Comprensive Process Analysis (Elliott, 1984; 1986), which have been further developed through their empirical implementations. The applications of Task Analysis to focussing, evocative unfolding, intrapsychic split, unfinished business, therapists' processing proposals and meaning-creation events in experiential psychotherapies have recently been reviewed (Greenberg, Elliott and Lietaer, 1994). The most recent publication of task analytic research is Safran et al's (1994) task analyses of a type of alliance rupture originally termed Withdrawal Challenges (Harper and Shapiro, 1989). Comprehensive Process Analysis (CPA) is a hermeneutic research method (Packer and Addison, 1989) that subjects important therapeutic events to intensive, mulitdimensional analyses drawing on as many different types and sources (perspectives) of information as possible, including the understandings of clinical observers and clinical participants (Elliott, 1989; Elliott, et al 1983; Labott, Elliott and Eason, 1992). CPA's use of multiple perspectives on a variety of data sources enables contextualised and linked meanings to be made accessible, based on consensual agreement.

There is a line of new paradigm research clearly indicating the new paradigm's reconceptualisation of the change process; these investigations are developed from and have developed Stiles, Elliott and Llewellyn et al's (1990) proposal of an Assimilation Model of clients' internal change processes. The Assimilation proposes a sequence of cognitively and affectively signified states by which psychological change in a particular content domain occurs during successful psychotherapy. The fundamental tenet on which the Model rests is that a problematic experience is assimilated into a schema that is developed in the client-therapist interaction (Stiles et al, 1990). The Model suggests that problematic experiences can be tracked through predictable stages of assimilation; these have been labelled progressively as: warded off, unwanted thoughts, vague awareness, problem statement, understanding or insight, application or working through, problem solution and mastery (Stiles et al, 1990). Qualitative and quantitative case studies using the Assimilation Model to track changes in clients' problematic experiences over the course of therapy have circumvented many of the conceptual and methodological limitations of traditional process-outcome research (Field, Barkham, Shapiro and Stiles, 1994; Stiles, Morrison, Haw et al, 1991; Stiles, Meshot, Anderson and Sloan, 1992). The latest Assimilation Model investigation has, for the first time, incorporated systematic analysis of the therapist's contributions to change in the particular content domain of a single clinical case (Stiles, Shapiro and Harper, in submission).

The fourth line of new paradigm research responds constructively to longstanding calls for methodological plurality and diversity to meet the challenge of the limitations imposed by traditional paradigms (Elliott and Anderson, 1994; Greenberg, 1986b, Hartley, 1985; Horowitz, 1982; Shapiro, Harper, Startup et al, 1994; Stiles, Shapiro and Elliott, 1986). Formal attempts to combine methods (pluralism) are limited but increasing in number (Kazdin,1994). Formalised new paradigm methods have been actively combined both (a) one with one another (eg Shapiro and Elliott, 1992) and (b) with traditional process and outcome measurement strategies (eg Agnew, Harper, Barkham and Shapiro, 1994) to inform change processes in specific clinical cases. This latter strategy in particular is both endorsed by those less than convinced of the new paradigm's promises (see 3.7.1):

"We find ourselves endorsing a kind of pluralism that does not throw out the virtues of the traditional approaches to research, but complements those with a variety of more flexible techniques for getting at the complexity of phenomena we deal with" (Bergin and Garfield, 1994, p. 828);

and also recommended by persistent proponents of the new paradigm in their scheduling and integration of research priorities and activities (Rice and Greenberg, 1984; Greenberg, 1986b; 1991; 1994).

3.8 Summary

The research providing Chapter Two's 'what rather than how' answer followed a traditional, paradigmatic approach; Chapter Three critiqued this approach and presented the new paradigm in psychotherapy research. Traditional, relational and group comparative designs imply a drug metaphor conceptualisation of psychotherapy and are not sensitive to process-outcome and client-therapist synergies, complexities of in-session process, the time course and location of change and between and within individual differences. Inappropriate and over-subscription to this paradigmatic approach has had the effects of limiting the questions researched, of micro-level, moment-to-moment clinical practice not being informed and clinical theories not being developed by psychotherapy research.

The new Change Process Research paradigm promises to address these limitations. Outcome is conceptualised as a heterogeneous and continuous process, including immediate in-session impacts (a process-outcome), post-session impacts (a little 'o') and post-therapy impacts (a big 'O'). Change Process Research is more 'micro'; proximal rather than distal outcomes and clinically meaningful, contextualised units, (episodes, events) are investigated in order that the processes of change can be tracked (and so provide more 'how to' answers). Evident from the rationale set out in Chapter One, Client Confrontation Challenges meet the criteria for selecting

Significant Change Events for study. Confrontation Challenge Resolution Events access a key process of change and can be productive of exponential therapeutic change. Chapter Three selected the new paradigm's Events-based strategy with which to explore the research question.

The Event-based strategy focusses on recurrent and potent change phenomena; uses explicit and implicit theory to select and study these phenomena; uses rational empirical methods; studies change phenomena in terms of sequences and patterns over time; describes the complexity and detail of the processes engaged in by the client throughout the change event; focuses on the client; considers the individual difference variable as an exploratory rather than a classificatory variable; studies the client process in context and builds toward hypothesis testing as the final step in a research programme.

Suggested in the mid-eighties, the influence of the Change Process Paradigm in psychotherapy research to date has been evaluated. Despite relatively low uptake in research practice, the new paradigm has been shown to be developing distinct lines of research; influencing researchers' thinking and, in Greenberg's terms, making significant empirical contributions in moves towards what Garfield has required - evidence regarding how such change processes influence the ultimate outcome of therapy.

Chapter Four

4.1 Introduction

To recap briefly, the question being explored in this thesis is 'How is it best to address Client Confrontation Challenges in Sheffield's PI therapy?' (Chapters One and Two). The previous chapter argued that, in terms of the new paradigm in psychotherapy research, Client Confrontation Challenges are Significant Change Events in PI therapy; they have a 'make or break' quality and they access key mechanisms of change (Chapter Three). The question addressed in the present chapter is, 'How is the new paradigm's Change Events strategy to be used to empirically explore the Research Question?'. As indicated in the thesis's Introduction, this 'how' question is at least as important as the substance of the question being explored.

Task Analysis, one of the methods presented in Rice and Greenberg's (1984) first statement of the Events based approach, was selected to do this. Why? The previous chapter indicated that the new paradigm requires intensive analysis of in-session process and that Task Analysis is an evolving, process analytic method (Greenberg, 1984a, 1984b,1991). Commonly used in information processing research, Task Analysis *describes and analyses* human behaviour in problem-solving tasks (Simon and Newell, 1972; Pascual-Leone. 1973). Applying Task Analysis to psychotherapeutic tasks that signify the opening of Change Events was initially proposed by Greenberg (1975). He argued that client's tasks in psychotherapy can be likened to problem-solving tasks:

"They can be thought of as an overall goal-directed attempt to reach an affective objective in the face of a particular problematic aspect of experience" (Greenberg, 1975, p. 31).

In addition he argued that a peculiarity of clients' tasks in psychotherapy is that they 'call for' resolution; they have subjective "nagging" or "teasing" qualities which indicate their goal-directedness (p. 31). The first phase of a Task Analysis proposes a descriptive model of how 'best' to resolve the particular task. Given that the present study aimed to explore the question 'how to best address Confrontation Challenges in a PI therapy?', Task Analysis seemed to hold substantial potential for informing the research question.

This chapter will develop the use of the task analytic approach in the present work. 4.2 makes general and informal statements about the procedure and features of the Task Analytic approach. 4.3 presents a formal, procedural statement of the method and 4.4 outlines the rationale on which the method is based. 4.5 then states the modifications made to the standard procedure in the present work. These modifications respond to (a) the author's specific criticisms of statements of new paradigm rationale and (b) the specific requirements and constraints of its present

implementation. It will be seen that making these modifications is consistent with the call for the triangulation of research methods, psychotherapeutic theory and phenomena. As such, these modifications are considered to represent significant contributions to the expanding task analytic literature.

4.2 A general introduction to the Task Analytic approach

4.2.1 An informal resume of the Task Analytic procedure

Prior to its detail, this is an informal resume of the Task Analytic procedure: the researcher makes a 'best guess' at how the task might be resolved. S/he then observes instances in which client and therapist are engaged in resolving the task and describes their performances. The 'best guess' and the 'performance descriptions' are then compared. Differences between more and less successfully resolved tasks suggest what 'is best' in their resolution performances and this understanding is proposed as 'Model of Best Resolution Performance'. (More technically, for consistency with what follows: the 'best guess' is termed a Rational Model; the Performance Descriptions result from an Empirical Analysis and the comparison is referred to as the Rational-Empirical Comparison).

4.2.2 Three features of the Task Analytic procedure

Three features of task analysis will be pointed out here. The Task Analytic procedure is intensive, programmatic and time consuming (Safran, Greenberg and Rice, 1988). Firstly, task analytic procedure is intensive; the largest undertaking lies in constructing the performance descriptions of observed resolutions. Secondly, the procedure is programmatic; the first phase is discovery-oriented, entailing intensive analysis of phenomena and the second phase is verification-oriented, entailing testing hypotheses suggested by the model proposed at the close of the first phase. Thirdly, as already indicated, the procedure is time consuming. From his experience of task analysing intrapsychic splits in Gestalt therapy, beginning with his thesis in 1975 and continuing through collaboration with colleagues and students to the verification phase in 1984, Greenberg (1991) recognised that

> "a research program of this sort probably involves 5-10 years of study on one phenomenon" (Greenberg, 1991, p. 14).

These features make it inevitable that the present work is considered a preliminary attempt to undertake the intensive analysis of Confrontation Challenge Resolutions. Thus it was necessary to carefully consider how to implement the procedure in order to maximally explore the question 'how best to resolve Confrontation Challenges?' These considerations were informed by (a) the development of Greenberg's ideas (1975; 1984b; 1991); (b) the different ways in which Task Analysis has been implemented in the psychotherapy research literature (eg Greenberg and Safran,

1987; Rice and Saperia, 1984; Safran et al, 1994) and (c) the guidelines Safran, Greenberg and Rice (1988) put together for evaluating Task Analytic research proposals.

4.3 A methodological statement of the Task Analytic approach

4.3.1 Overview

This overview provides a 'general impression' of what is entailed in practically implementing the Task Analytic approach. This, in combination with the above Introduction to Task Analysis, aims to orient the reader to the formal procedure.

The researcher selects a particular kind of recurring change event for intensive analysis. Then the clinician's best understanding of how resolution might take place is spelt out in a Rational Model; the Model is called Rational because it is from implicit and explicit theories regarding possible task resolution strategies. Instances of task resolution occuring in clinical practice are observed, and the researcher's understanding of these represented by Observed Performance Descriptions. In a series of intensive single case analyses, the 'best guess' of the Rational Model is then compared with the understanding derived from the clinical examples. This comparison is an iterative process, moving back and forth between Rational and Observed actual performances until a model of a 'best' resolution performance is built. This Performance Model proposes the researcher's understanding of Best Task Resolution Performance; the model is then subjected to appropriate verification procedures.

4.3.2 The formal Task Analytic procedure

Task Analysis's discovery oriented phase is undertaken in this thesis. Greenberg (1991) identified the 'formal steps" of a Task Analysis and Safran, Greenberg and Rice (1988) suggested requirements of Task Analytic research proposals. The steps and the requirements associated with the discovery-oriented phase are integrated here to provide a formal statement of the procedure's requirements:

- Explicate the map of the expert clinician

The expert clinician/researcher is able to make explicit the general model of therapy and, from clinical experience, a 'cognitive map' of some of the specific important events in the therapy; this map provides a framework with which to study therapeutic change.

- Select and describe the task and the task environment

The Task Description involves selecting and describing, clearly and completely, the client task to be performed. This is governed by articulated ideas about what incidents are critical to or important in bringing about therapeutic change. The event is chosen

in the belief that understanding the processes involved in the event will illuminate the workings of psychotherapeutic change. Both implicit and explicit theory guide selection of the event. It is important for the investigator to spell out as explicitly as possible the theoretical assumptions guiding the selection in order to explicate the theoretical framework that will influence the study of the event.

The description requires defining the Client Marker and the Stimulus Situation. The Client Marker is the client statement that reflects the problematic reaction and opens the event and the Stimulus Situation is the intervention which appears to provoke that client statement.

Specifying the Task Environment amounts to writing a manual of suitable therapist interventions for facilitating task resolution. The most effective intervention or set of interventions available to the therapist at any one time are specified, as is their function in relation to task resolution.

- Verify the significance of the task

The significance of the task and its resolution to the process of change in the therapy needs to be established; this amounts to an assessment of the potency of the event as Significant for Change.

- Development of a Rational Model of Possible Resolution Performance

The Rational Task Analysis is a mental analysis, or 'thought experiment' performed by the researcher repeatedly, speculating about how the task might be best solved. This provides an initial understanding of problem resolution strategies and components of resolution performances. The aim of this Rational Analysis is to construct a rational map of the essence of task resolution; this then serves as a framework for empirically examining actual task resolution performances. This Rational Analysis is based on the assumption that the demands of the task and the task situation limit the set of performances and performance-components that may be performed by any individual resolver. A valuable strategy is for the researcher to as freely as possible consider, 'What would I do now in this situation?'; 'What options are open?'; 'Which is the most desirable of these?'.

The 'chain of reasoning' on which the Rational Model rests is fully outlined. This outline should be grounded in the relevant theoretical and empirical literatures and articulate the theoretical assumptions on which the Model is based.

- Preliminary Intensive Analysis

Having developed a Rational Model it is then necessary to demonstrate its applicability to the practice of the particular therapy. To do this "a few cases" of task resolution are intensively observed using clinical transcripts (Safran et al, 1988, p. 14). The researcher's assessment of (a) the applicability of the Rational Model and (b) the representativeness of the therapy sampled are stated. This preliminary intensive analysis ensures "a good degree of fit between the preliminary model and the clinical transcript" (Safran et al, 1988, p. 14).

- Empirical Analysis

The Empirical Analysis involves describing actual moment-by-moment performance of individuals engaged in the task. This procedure separates and identifies in sequence each discrete state and diagrams the progression from one state to another. It is important to note that if the assumption on which the Rational Analysis is based is valid then these actual, observed performances can to a large extent be anticipated. The empirical analysis serves to correct any mistakes in the performance description generated in the rational analysis. In addition, any behaviour from the empirical description of the actual performance becomes in and of itself interesting when viewed in the light of the rational analysis, because it automatically confirms, broadens or radically changes the assumptions underlying the thought experiments of the rational analysis. To the extent that the investigator is able to generate a nearly complete set of possible performances in the rational analysis the actual performance used by the client will have been anticipated.

If process measures are selected they should have adequate reliability and at least face validity as measures of the hypothetical constructs being examined; in addition their reliability and construct validity should be assessed. Preliminary development and planned refinement of newly developed coding systems or process measures should be detailed.

- Rational Empirical Comparison

Increasing familarity with observed resolution performances permits the construction, on primarily rational grounds, of more detailed performance descriptions. This is literally a rational-empirical comparison. The comparison is iterative and successive; detailed descriptions of client and therapist behaviours are carried out on a number of events, and a successive reworking of the client performance diagram takes place. Comparing less with more successful resolution performances means that the performance undertaken to 'make good' the unsuccessful resolution is understood. It is only after substantial looping through the rational and empirical analyses that the investigator can have any faith in the performance model and use it in attempts to

predict the performance of a client dealing with a particular type of task (Greenberg, 1991):

"In building a specific model, the investigator is able progressively to correct, expand and make more explicit his or her understanding of the processes involved in generating resolution performances. It is at this stage that the clinician-scientist attempts to conceptualise the mechanisms that enable the process of therapeutic change. The construction of a detailed, specific model of the components of of resolution involving successive repetitions of steps is the long-range goal of the model building effort. In the early stages, the bulk of the effort is directed to the postdictive, inductive steps. In the later stages, the model becomes sufficiently accurate and refined that it can be subjected to testing" (Greenberg, 1992, p. 29).

Depending on the type of Model to be Constructed, this rational-empirical comparison may be considered the final step of the task analysis. Two types of model are possibly constructed from a task analysis of affective tasks and each type "represents an important research thrust" (Greenberg, 1984b, p.142). The detailed description of task performance resulting from the rational-empirical comparison outlined above provides a Performance Model of observable resolution performance. Consistent with Fiske's (1977) call to study 'acts not people', this detailed model of observable resolution performance enhances understanding of 'what occurs in therapy'. To construct the second possible type of model, an Information-Processing Model, the observable performance generated by the rational-empirical comparison is used to construct a model of the covert mental processes underlying task resolution performances. Prominent in the study of cognitive problem-solving performances, this type of model aims to represent the psychological system that would have generated the change performance. This second Information-Processing type of model is the 'ultimate goal' of the task analytic approach and is consistent with that of the Events Paradigm in its specification of the internal operations that consistute client processes of change. The ultimate goal is to construct a specific model that would account for the problem-solving performance.

4.4 The rationale underlying the procedure

4.4.1 Introduction

Presenting Task Analytic research to psychotherapy researchers and psychologists unfamiliar with or unsympathetic to the new paradigm research consistently prompts similar questions concerning the use of the Task Analytic approach within the Events based research strategy. These are 'what do you consider to be a case?', 'how do you know your sample of Events is homogeneous?' and 'how generalisable is your analysis of the Events you've selected for intensive analysis?' These questions will be used to explain the rationale underlying the formal procedure which was specified above. (See Greenberg, 1975, 1984a (Intrapsychic Splits); 1984b (The general approach) for more detailed articulations of these arguments).

4.4.2 What is a case?

A "few cases" are intensively observed in the preliminary intensive analysis required by Safran et al (1988, p.14); in Task Analytic terms, what is a case?

A case is the unit of therapy containing the task which is analysed. On the basis that they are

"broad enough to capture the main themes of the therapy yet narrow enough to enable an in-depth study of the therapy process" (Rennie and Toukmanien, 1992, p. 244-5)

Change Events are the units of the analysis undertaken here. Therefore a case is an event; one Confrontation Resolution Event is a case in the present study.

"It is events not people that we propose as the unit of study in the belief that when different people come to construe a task in a similar fashion, their performances will be similar... for similar task construals there will be a 'general law' governing task resolution" (Greenberg, 1974, p. 166)

4.4.3 How do you know the sample of events is homogeneous?

In terms of the quotation from Greenberg (1974), this question is asking 'How do you know that different people are construing the task in a similar fashion?' In short, the precise, behavioral definition of the Client Marker of the Change Event provides the homogeneity of the event's sample.

The Event Paradigm assumes that therapy participants actively construe and set goals in their situation:

"people in therapy are goal-setting beings who actively construe the task and the situation and act in terms of their goals and construals. Clients will respond differentially to the same interventions depending on how they perceive the situation and in terms of their own goals and intentions" (Rice and Greenberg, 1984, p. 13).

The rationalist assumptions of the Events Paradigm say that clients construing the therapeutic task similarly will perform similarly and it is these performance similarities that permit the discovery of the common regularities of task resolution which can then, through the rational-empirical comparison, be modelled. Thus behavioural similarities 'mark' clients' similar construction of the task.

To reiterate, Client Markers of the event's start can be thought of as the *client's* process diagnosis of the current situation in the session. Markers are concrete, in-session manifestations of the client being in a particular state which requires and is

suitable for intervention (Goldfried, Greenberg and Marmar, 1990; Greenberg, 1991); they are the 'when' of the therapist's 'when-then' process diagnoses.

"They are essentially definitions of the person-situation interaction states in therapy that are problematic and need intervention" (Greenberg, 1991, p. 9).

The Client Marker marks the task to be resolved; therein the Client Marker indicates the occurrence of the Change Event.

Since clients' similar construal of the task and thus the homogeneity of the event's sample lies in the client state signalling the affective task, "Strong definitions and understandings" of the client marker to the task are imperative (Greenberg, 1975). For a Task Analysis the Client Marker must be "a distinctive and reliably identifiable client behaviour or statement (or combination of statements and/or behaviours) indicating the onset of a particular event in therapy" (Greenberg and Pinsof, 1987, p.302). This client marker "being a momentary client state, as opposed to a performance unfolding over time, is most easily captured by describing invariances in samples collected within and across clients" (Greenberg, 1974, p.169).

4.4.4 How generalisable are your analyses of the Events you've selected?

To reiterate, two related criteria govern the selection of events for analysis; firstly they are believed to be significant in effecting change and secondly they are believed to access a change process within the particular therapy. How generalisable are the understandings resulting from analyses of these 'small chunks' of particular therapies?

In Greenberg's (1991) terms, the two Gods that have ruled the world of scientism are the Gods of Random Sampling and Generalisability. New paradigm research calls for careful re-examination of both. Random sampling will be discussed in the following chapter; the God of Generalisability is the concern here. Chapter Three discussed the limited generalisability from traditional, research paradigms. In brief, it was argued that generalising 'forward' to specific clients presenting in clinical practice was not substantially informed by group comparative data; similarly generalising 'backward' to specific clients or dyads within the groups compared was not substantially informed. In response, new paradigm researchers have argued that psychotherapy research be explicitly, more context-specific:

"Instead of making generalisation the ruling consideration in our research, we should instead describe what was controlled and uncontrolled, and move from situation to situation interpreting effects anew in each situation" (Greenberg, 1991, p. 8).

Moreover, Greenberg (1991) noted that this context-specificity is not alien to, but *evidenced by* the 'general laws' that have set the standard for the traditional research

approaches in psychological and psychotherapy research. Referring to the laws of thermodynamics and laws of motion, he wrote,

"No scientist worth his or her salt would drop a billiard ball and ping-pong ball and expect to see them accelerate at the same rate, and neither would disconfirming results in a comparative study on the differential time to impact of ping-pong and billiard balls lead the hypothesis to be refuted" (Greenberg, 1991, p.7).

Thus, rather than 'falling short of' or 'compromising' a scientific standard, the new paradigm's push to develop context-specific understandings and microtheories is considered to be making "a major leap forward in developing a true science of psychotherapy" (Greenberg, 1991, p.7).

Turning back from these arguments to the opening statements regarding Event selection, it will be seen that the understandings obtained by new paradigm analyses are (a) specific to class of Events in the particular therapy and (b) specific to the change process accessed by the Significant Event. Thus the understandings generated by their analyses will generalise to (a) other Events from the same class in the particular therapy and (b) other therapies sharing the same change process. These statements will be further discussed once the empirical work has been presented (see Chapter Ten).

4.4.5 Summary

A question and answer format has been used to spell out ideas that are central to the task analytic approach. The questions, commonly asked by people unfamiliar with or suspicious of new paradigm research, were, 'What is a case?', 'How do you know the sample of events is homogeneous?' and 'How generalisable is the understanding generated by your analysis?' For emphasis and clarity, the central ideas will be restated here.

A case, when N=1, in the Events based strategy is a Significant Change Event. Using the task analytic approach within the Events based strategy, the case can be described as an Event which is signified by the client's task. Since the client's task 'calls for' resolution the Event can be considered a Task Resolution Event. In terms of the question being explored here then, the Events to be task analysed are Confrontation Challenge Resolution Events.

The client's manifest behaviour in the session signifies the task to be resolved; this signifying behaviour is termed a Client Marker of the task and opens the Task Resolution Event. Clients' similar constructions of the task allow for the precise, behavioural definition of the task's Client Marker. Once a Client Marker is precisely

specified and can be reliably identified it is considered to define a 'class' of psychotherapeutic task. This Marker permits a homogeneous sample of Task Resolution Events to be identified. As a distinctive, affectively salient moment in the session, Client Markers are most easily specified by describing commonalities in samples of task-relevant material collected within and between clients.

Clients' similar constructions of the task will provide similarities in their task resolution performances, and these similarities permit the identification of regular patterns and sequencing constituting resolution. Through task analysis's rational empirical comparison these regularities are modelled.

The criteria on which Change Events are selected for analysis and the careful articulation of context, provide for the results of these analyses (a) generalising to new examples of the same Event occurring in the same therapy (eg other Confrontation Challenge Resolution Events in Exploratory therapy), and (b) generalising to other therapies in which the change process accessed by the Change Event has the same or similar theoretical and practical significance (eg other short-term PI therapies actively attending to the here and now transactions between client and therapist).

4.5 Modifications to the task analytic approach and procedure

4.5.1 Introduction

The modifications stated here respond to specific criticisms of new paradigm thinking and specific requirements of using Task Analysis in the present project. The modifications are influential; they determine the *strategy* used to select Events for analysis; the *approach taken in* and *the focus of* this analysis. The modifications represent specific contributions of the present work to the use of Task Analysis in psychotherapy research.

The two criticisms concern, firstly, the inattention paid Events occurring within a single clinical case and secondly, the 'drive to discover' (which is explicit in recommendations for the new paradigm in general and Task Analysis in particular). Required by this particular project was a modification to the focus of the analysis; in contrast with previous Task Analyses, the focus is on the dyad and transactions between client and therapist, rather than the client with the therapist in the background. These will be discussed below; first the criticisms and requirements and then the planned modification will be stated.

4.5.2 Criticism 1: The inattention paid Events within a single clinical case

There are important and substantive arguments for task analysing Events occurring within a single therapy case, particularly early in a research programme. To date

these have not been considered or implemented in psychotherapy research's use of Task Analysis within the Events based strategy. These arguments are presented here.

Greenberg's (1975) recommendation to initially study Events occurring within a single clinical case has not been implemented in the empirical literature. (His argument was practical, as a means of reducing the complexities of the analyses). It has become custom and practice for initial task analytic investigations to concentrate on a handful of task resolution events selected from a number of different clinical cases (eg Greenberg and Safran, 1987; Safran et al, 1994). This custom and practice is not responsive to the new paradigm's reconceptualisation of the processes of change and does not provide the stable task environment required in intial task investigations. These constitute important and substantive arguments for analysing Events occurring within a single clinical case.

If Significant Change Events are selected on the basis that they access clinically and theoretically significant processes of therapeutic change, then the processes of change observed within the Significant Change Events are part and parcel of the mechanisms of change in the particular therapy. The new paradigm conceives therapeutic change as a continuous and cumulative process which is achieved via a series of little 'o's reaching the 'critical mass' (Stiles 1988) of a 'big O'. Accordingly the resolution of psychotherapeutic tasks is an active, unfolding and cumulative process; as with Reitman's (1956) ill-defined problems, solutions emerge from the attempt to resolve the task. From this position, it is at least possible, if not likely, that the solution process unfolds and cumulates both within an event and over the course of a number of events. Each event may provide a 'partial task solution', a little 'o', that as a 'working solution' is sufficient for therapeutic work which is not task-related to proceed. But with only a partial solution to the affective task, the task will recur (Greenberg, 1984) as a second event and again press for further work towards the 'big O' of a complete solution. That is saying that, whilst a task resolution event may be a meaningful and discrete unit of the therapeutic process it may not necessarily provide a finite task solution. The finite task solution (the 'big O') may only be achieved by the cumulative progress of partial task solutions ('little o's) achieved over a number of events, each containing a task resolution attempt.

Weight is added to these arguments by considering the in-therapy experience and meaning of the client states being accessed by the Client Markers. In terms of clinical practice, these

"client in-therapy states; such as experiencing conflict, engaged in transference or in self-critical thoughts, or being in interactional patterns such as pursue/withdraw or attack/defend... the phenomena to understand" (Greenberg, 1991, p.8)

require considerable and persistent attention over the course of a therapy. To consider that their solution will occur within one resolution event is antithetical to the notion of therapeutic 'processes of change'.

These are arguments for psychotherapeutic task resolution being conceived as a process of incomplete task solutions successively and cumulatively approximating to complete resolution over the course of therapy. This process will not be accessed by the custom and practice strategy of studying a few task resolution events each taken from a different clinical case; it will however be captured by studying a series of events sampled from a single clinical case.

Committing to the strategy of analysing events from a single clinical case has an additional advantage; it maintains the stability of the task environment. According to the formal task analytic procedure, the task environment is the repertoire of therapist interventions available for resolving the task. Particularly in initial analyses, Greenberg (1980, 1984) established that the task environment should be consistent; Safran et al (1988) stated this as a requirement of research proposing task analyses. Analysing the resolution performances of only one therapeutic dyad is a means of achieving this.

For these two reasons the strategy of analysing Events from within one clinical case was adopted. Doing so is considered to be responsive to (a) the new paradigm's conceptualisation of the change processes; the (b) nature of psychotherapeutic tasks; and (c) the requirement for a stable task environment.

4.5.3 Criticism 2: Premises underlying the 'drive to discover'

How to approach the Events identified within a single clinical case? This question raises the second criticism. A 'drive to discover' is evident in recommendations for new paradigm research in general, Task Analysis in particular and in other, complementary, suggestions for alternatives to traditional research approaches (eg Rice and Greenberg, 1984; Greenberg, 1991; Mahrer, 1988). The first and second phases of a task analytic approach are, for example, characterised as 'discovery-oriented' and 'verification-oriented' respectively (Greenberg, 1991). The 'drive to discover' can be characterised as "going back to the thing itself" (Elliott and Anderson, 1994, p. 68) "to discover something new" (Mahrer, 1988, p. 699), to uncover "what has actually occurred" (Greenberg, 1991, p. 6). Two criticisms are made of this drive. The first criticism applies to all research attempts to respond to the limitations of traditional

research paradigms. Below it is argued that the 'drive to discover' is not alternative to, but indicative of traditional, paradigmatic thinking. The second criticism applies to the present empirical attempt to do this. Below it is argued that the 'drive to discover' is inconsistent with the fundamental nature of PI therapies which requires narrative explanation. Thus these criticisms detract from the new paradigm's aims of (a) reconceptualising psychotherapy process and psychotherapy research and (b) triangulating research questions and methods with psychotherapeutic theory and practice. These statements and their consequences for the present work are explained below.

The new paradigm reprioritises description and explanation as goals:

"It is not that prediction is an unimportant goal but rather that we need rigorous description and explanation to illuminate prediction" (Greenberg, 1986b, p. 708).

Consistent with this, Task Analysis's Empirical Analysis, which describes and represents moment-by-moment task resolution performance, is "the most complex strategy" undertaken (Greenberg, 1984b, p. 142). Bruner (1986) identified two fundamental approaches to explanation which he termed 'paradigmatic' and 'narrative' approaches. Traditional research paradigms follow the paradigmatic, logico-deductive, demonstrative approach to explanation; the narrative approach is inductive, constructive and hermeneutical. The first criticism being made here is that the premises embedded in the 'drive for discovery' evidence the paradigmatic approach to explanation and therefore are not 'new' or 'alternative'. The embedded premises are illustrated by the following quotation taken from Mahrer's (1988) characterisation of the "welcome receptivity to the discoverable" (p. 699):

"The clinical researcher is to be exceedingly open to what is new in the data, to what is out of the ordinary, different, unexpected, exceptional, surprising, challenging, disconcerting. The researcher must be vigilant to what does not seem to fit, to what is hard to grasp, organise, explain. ... You must scan the data, to be open to cues and leads, try out various patternings, attend to repeated instances, organise and reorganise the data, and go back to the data again and again until you receive the discoverable" (Mahrer, 1988, p. 699)

Embedded in notions of the researcher 'receiving what is actual and in the data' are assumptions of realistic, objective, 'truths' that are intrinsic to the phenomena being observed and that wait to be uncovered by the researcher. These premises are central to the logico-scientific, paradigmatic approach to explanation (Bruner, 1986; Polkinghorne, 1988) that underlies the group constrast and relational paradigms which have not provided the micro-level answers required in clinical decision making. Therefore, in these respects the discovery-oriented emphasis associated with new paradigm research does not present an alternative to traditional research thinking.

This inconsistency is further compounded in the present work; the second criticism of the 'drive to discover' says that it is inconsistent with the fundamental nature of PI therapy and that this negates the new paradigm's emphasis on triangulating research methods with psychotherapeutic theory and practice. In PI therapy (as evident in Chapters One and Two) understandings of experience, personal meanings and reasons are actively, constructively and reflexively negotiated between client and therapist (Rennie, 1992). As the agent of the therapeutic theory, the therapist does not assume to know or impose 'the truth' or 'a reality'. Integral to this transactive, constructive process are clients' and therapists' subjective understandings, their more or less formal theories; these theories influence the process and the participants' reflexive understandings of that process. Changes in clients systems of meaning are fundamental outcomes (Keeney, 1983)

Rather than discovery-orientation's 'paradigmatic' thinking, these fundamentals of PI therapy are consistent with 'narrative' thinking and explanation (Bruner, 1988; Polkinghorne, 1988). The narrative approach assumes that human action expresses regularities, that people have reasons for their actions, that these reasons are contextualised, particularised and constructed from agents' interpretations of their experience (Polkinghorne, 1984; Rennie and Toukmanien, 1992). Thus, the 'narrative' mode of thinking and its emphases on the construction and interpretation of meanings, is more consistent with the fundamentals of PI therapy. New paradigm proponents have consistently argued that if research is to be more informative to practice, then research questions and methods need to be more responsive to clinical theories and microlevel practice (Elliott, 1983; Rice and Greenberg, 1984). Given that fundamentals of PI therapy cohere with the narrative, rather than the paradigmatic, approach, it is the narrative approach that will be taken to the Empirical Analysis here.

This approach is less well developed in the social sciences than in other fields (eg literary criticism, psycholinguistics and discourse analysis, cognitive psychology and psychoanalysis (Edwards and Potter, 1992) and has to a large extent been neglected in psychotherapy research (Luborksy, Barber and Diguer, 1992). In undertaking the Empirical Analysis the aim will be to generate 'fullblooded' descriptive accounts of Challenge Resolution performances (Cronbach, 1975). Bruner (1986) cast these as good, not minimal, stories; good stories are plausible, coherent accounts of events (Robinson and Hapwe (1986). In discourse analysis, for example, storytelling transports individual experience into shared knowledge (Ehlich, 1988; cited by Kachele, 1992). Narrative accounts, stories, are "a construction of what is observed according to some internal logic" (Stiles, 1993, p. 599); the 'internal logic' is the author's. Their construction, through language, entails interpretation; description and

interpretation are not separable (Russell, 1986; 1994). Already implicit, the author of the narrative account is an active research participant (Hollway, 1992). Constructing a narrative account is informed by the author's informal and formal theories, experience and understanding of intersubjective meanings within a society (Atwood and Stolorow, 1984; Taylor, 1979):

"language constructs as it describes, and construction always proceeds from a limited perspective, whether such perspective is rooted in everyday or theoretical languages" (Russell, 1994, p. 173).

The 'trustworthiness' (Guba, 1981) of the author's account is "a matter of the extent to which the hermeneutic researcher can win the consensus of the consumers of the explanation" (Rennie and Toukmanien, 1992, p. 235). Consumers' consent is based on

"(a) the extent to which the researcher can convince consumers that he or she has been evenhanded in the hermeneutic investigation (Giorgi, 1989; Smith, 1989) and (b) the extent to which the explanation is judged by consumers to make sense in the light of their own understandings of the phenomenon in question (Polkinghorne, 1988; Rennie, 1992; Rorty, 1979; Smith and Heshusius, 1986)" (Rennie and Toukmanian, 1992, p.236)

This narrative approach will be taken to the Empirical Analysis; its aims and assumptions are spelt out above. Taking this approach (a) rejects the paradigmatic premises which have been shown to underlie the new paradigm's drive to discover and (b) supports the triangulation of the task analytic method with PI therapy.

4.5.4 Requirement 1: Focus on the therapeutic dyad

With only one exception (Safran et al, 1994), the previous Task Analyses in the psychotherapy research literature have foregrounded the client. Rice and Greenberg (1984) had two reasons for recommending that new paradigm research be focussed on the client; presented in the previous chapter's articulation of the Events based strategy (see 3.5.5, p.30), these will be restated here. Their first reason was that "it is the client who changes" (p. 14) and it is the mechanisms of change within the client that should be illuminated by research. Their second reason was pragmatic, "a simplification strategy"; "looking first at patterns of client behaviour and then to view the therapist as one important source of influence on the client at that point" (p. 21). Understanding clients' performances was clearly to be set in "an interactional context" (p. 15), in which the therapists' contributions "shaped" (p. 15) clients', but the focus of the analyses they were recommending were weighted heavily to clients.

This focus is inappropriate to the dyadic, interpersonal system of PI therapies described earlier (see Chapters One and Two). In PI therapies, the client's change is

the explicit concern of therapy but therapists are also changed by and during therapy; both participants' contributions and change are understood *as a function of* the dyadic and dynamic therapeutic system, of the transactive, mutually influencing communications between client and therapist. The next chapter will present the particular PI therapy to which the task analytic approach is being applied: Exploratory therapy (Shapiro and Firth, 1987). It will be evident that, in common with Henry and Strupp (1994), there is an extent to which Exploratory therapy's interpersonal, dyadic communications are synonymous with the therapeutic relationship. Dyadic and transactive foci are clearly required for analyses of Exploratory session material.

4.5.5 Summary

The Confrontation Challenge Resolution Events will be explored by examining events within a single clinical case (4.5.2). A nonparadigmatic, narrative approach will be taken to their Empirical Analysis (4.5.3). The unit of analysis is the Challenge Resolution Event; the focus of its analysis is the client-therapist dyad (4.5.4).

4.6 Synthesis and Plan

4.6.1 Introduction

'How is the new paradigm's Change Events strategy to be used to empirically explore the Research Question?' was the question that opened this chapter.

From the Change Events strategy, an understanding of Task Analysis and its approach has been developed. The approach has been presented in terms of its method (4.3) and rationale (4.4) and critiqued to suggest modifications (4.6); these are synthesisd here, in the form of a plan of the empirical work presented in the remaining chapters.

4.6.2 The plan

It is clear from the above that the credibility of any task analytic investigation rests on (a) the Rational Model and (b) the Marker signifying the opening of the Change Event. The Rational Model, the researcher's 'best guess' at how task resolution may proceed, must be applicable to task resolutions occuring in clinical practice.

From understandings of the theoretical underpinnings of Exploratory therapy, Chapter Five will develop a Rational Model of possible Challenge Resolution Performance in Exploratory therapy.

Chapter Six will demonstrate the applicability of the Rational Model to resolutions occuring in Exploratory practice.

Secondly, the Marker signifying the opening of the Change Event must be precisely defined and reliably identifiable.

> Chapter Seven describes the development of a system for identifying and classifying Confrontation Challenges in Exploratory therapy and its use by external coders to identify the Challenge Markers occuring in the Exploratory therapy of a clinical case, 'Anita'.

The Rational Model and the Client Marker are the foundations on which task analytic investigations rest. Once the Model has been shown to be applicable to therapeutic practice and a homogeneous sample of Change Events reliably identified, the Events can be Empirically Analysed and systematically Compared with the Rational Model:

> Taking a nonparadigmatic approach, Chapter Eight constructs narrative accounts of the Challenge Resolution performances occuring in Anita's eight sessions of Exploratory therapy.

> Chapter Nine undertakes a Rational Empirical Comparison to revise the Rational Model and propose a Performance Model of Challenge Resolution in Exploratory therapy; this chapter revises the researcher's best guess at possible resolution to propose the researcher's understanding of what was best in the resolution performances in Anita's therapy.

To summarise, this chapter has shown that Task Analysis, a new paradigm research method,

"involves a process of moving from clinical and theoretical expectations to observation and back again until the investigator is satisfied that the phenomena at hand have been described. The model constructed by this method is then subject to appropriate verification procedures, such as relating these performances to outcome. This iterative procedure of comparing actual and possible performances represents a rigorous form of inductive clinical theorising that results in the construction of a model that can be tested by process measurement" (Greenberg, 1986, p. 7).

The first phase of a Task Analysis culminates in a Model of Best Resolution Performance, based on an iterative comparison between a 'best guess' Rational Model of possible task resolution and the researcher's intensive analysis of Resolution Events occuring in clinical practice.

To use the Task Analytic approach in exploring the research question, 'How best to address Confrontation Challenges, the following five stages of empirical work were planned: The first stage develops a Rational Model of *possible* Challenge Resolution Performance; the second stage intensively observes Resolution Performances

occurring in one session of therapy to demonstrate the practical applicability of the Rational Model; the third stage develops a system with which external coders can identify and classify Confrontation Challenges in a single therapy case; the fourth stage describes and represents the Resolution Performances occurring in the single case; the fifth stage iteratively and successively compares these Performance Descriptions with the Rational Model to build a Model of Best Confrontation Challenge Resolution Performance.

Chapter Five

5.1 Introduction

In the previous chapter it was stated that the credibility of any task analytic empirical work rests, in part, on the Rational Model developed in the Rational Analysis. The Rational Model is the researcher's 'best guess' at how the particular task may be resolved in the particular therapy. This 'best guess' is informed by explicit and implicit understandings of the particular therapy and its functioning, both in theory and in practice. The Rational Model is a rational suggestion of the best possible strategy for resolving the particular task; it is crucial to the task analytic approach for the following reason. If the rationally derived Model of Task Resolution can be shown to be applicable to tasks being resolved in clinical practice, the Rational Model becomes a clinically and theoretically valid reference point for the Task Analysis. Then the researcher can be confident in using the Rational Model as a guide in the Empirical Analysis and the Rational Empirical Comparison. This chapter develops a Rational Model of possible Confrontation Challenge Resolution in Exploratory therapy. Chapter Six will next examine the Model's applicability to Challenge Events occurring in Exploratory practice.

The Rational Model is derived from the theory and practice of the particular therapy in question. Developing the Model requires that these are made explicit at the outset (Safran et al,1988): In 5.2 Exploratory therapy (Hobson, 1985; Shapiro and Firth, 1987), the Psychodynamic-Interpersonal therapy practised in the Sheffield Psychotherapy Research Projects, is introduced. Like Strupp and Binder's (1984) TLPD, used to represent time limited PI therapies in Chapters One and Two, the practice of Exploratory therapy is consistently experiential and relationship-oriented; explicit attention is constantly paid to the here and now of the therapeutic relationship and the 'minute particulars' of the conversation between client and therapist are axiomatic to change. Whilst the language of Exploratory therapy is unfamiliar, the conceptual and practical parallels with, for example, TLDP, are evident.

By making explicit the theoretical and practical bases of the therapy 5.2 achieves the first step in performing a Rational Analysis. 5.3 sets out how the Rational Analysis proceeded and 5.4 presents its results. Thus, in Safran et al's (1988) terms, Chapter Five articulates the 'chain of reasoning' on which the Rational Model is based.

5.2 Exploratory Therapy

5.2.1 Introduction

Hobson modelled the process of therapy as a process of Personal Problem Solving; solving problems by living in and through a relationship between persons. In "Forms of Feeling" (1985) he specified both the *general principles* guiding Conversational therapy and, from his view, that "broad theoretical ideas and psychodynamic

formulations are of importance only in so far as they are incarnated in the 'minute particulars' of what we do" (p. 207) and their translation into *practical procedures* -the 'minute particulars' above. In Shapiro and Firth's (1985) manualisation of Exploratory therapy, these were termed *Conversational Strategies*; they are the 'strategies' through which the therapeutic relationship is developed.

To introduce the therapy to which the research question was applied, the general principles and practical procedures will be cited. To orient the reader to the language used in the following chapters, Hobson's language is used throughout. With this context the Conversational Strategies used in Exploratory therapy are presented.

5.2.2 The general principles of Conversational Therapy

This is Hobson's statement of the 'general theory that guides the practice' (Hobson, 1985, p195-6) of Conversational therapy.

- The Conversational Model is designed for the therapy of patients/clients whose problems lie in intimate relationships, in 'knowing' persons as distinct from 'knowing about' people or things. Past deprivations, hurts and failures have resulted in (a) lack of opportunity to learn a langauge in which personal feeling can be expressed, understood and shared; (b) activities used to avoid feared painful situations (especially 'loss of contact' with another person) are reflected in disorders of behaviour.

- The process of therapy is a process of personal problem solving. This means the discovery, exploration and solution of significant problems which are directly enacted, here and now, in the therapeutic conversation. Learning in therapy involves experimentation with ways of knowing and being known within a relationship; it is extended to other life situations.

- A personal conversation, promoted in therapy, involves the differentiation and integration of many forms of language - these forms reflect modes of being with people. The crucial language of 'knowing' is one which expresses, communicates and shares feelings. It involves:

  (a) an apprehension of, and staying with, immediate experiencing;

  (b) a process of discriminating, symbolising and ordering experiences; expecially the creative expression in living symbols (using, for example, figurative language and metaphor);

  (c) 'owning' experiences (thoughts, wishes, feelings - especially in relation to persons) in a movement from passivity to activity, characterised by accepting responsibility for actions and acts which formerly have been disclaimed by means of avoidance activities, usually associated with conflict;

  (d) mutual correction of misunderstandings through the adjustment of ineffective communication and promotion of a dialogue.

(e) learning different ways of of achieving personal 'knowing' especially by dealing with misunderstanding.

- A therapeutic conversation usually progresses by 'steps' in which new insights, new ways of 'seeing', are achieved.

- The ever-present therapeutic purpose is to facilitate growth by removing obstructions. Especially important is the reduction of fear associated with separation, loss and abandonment.

- A central feature of growth is an aspiration towards an ideal state of aloneness-togetherness. This accompanies increased individual awareness in which 'inner' conversations between 'I' and many 'selves' in a society of myself'"

5.2.3 Personal Problem Solving: The process of Exploratory therapy

Personal Problem Solving proceeds as follows:

- A diagnosis is made.
"This is made by the detection, recognition, amplification, exploration and formulation of problems deemed to be significant.
This hypothetical formulation is to some extent based on what is described or 'talked about' (the history; but, of much greater importance, is how the problem is directly revealed and shown in the verbal and non-verbal conversation" (p. 184).

- The problem is actively explored.
"Passivity becomes activity. But sometimes activity serves only to avoid important problems, especially those which are charged with the pain of anxiety and conflict. Avoidance action taken in the past is often repeated, often unprofitably, in the present. The most important fears and conflicts are those connected with separation and loss. On the one hand there is a need for attachment to, and contact with, another significant person; on the other hand there is a need for autonomy and privacy" (p. 185)

"Those twin fears and the conflict between them, can be avoided in diverse ways. The anxiety can be denied or disclaimed. One extreme state can be sought as a flight from the other. ...The basic conflict is one of approach and avoidance. It embodies a wish for, and action towards, personal contact, with a moving away out of fear of intimacy: 'I want to be closer but I daren't'". ...In all conflict there is the opposition of the need for stability and order, and the wish for, and fear of change: a repeated process of organisation, relative disorganisation and re-organisation": (p. 185).

"Exploring a difficult problem demands a capacity to tolerate anxiety and stress, to stand in 'mysteries, uncertainties, doubts'. It means staying with conflict and the acceptance of actions which, hitherto, have been rejected and unadmitted. Psychotherapy requires the maintenance of an optimum level of anxiety, arousal and motivation" (p. 186).

- New possibilities for actions are generated.
"The unfolding lines of growth are often gradual, but my experience suggests that progress in explorative psychotherapy usually occurs in 'steps'. There are epochs: turning points with sudden changes which are often accompanied by insight. ... Our very perception is different: our experience, staled by custom, is

re-ordered in a moment of surprise. ...Moments such as these cannot be contrived. ... We cannot make them come, but perhaps we can prepare the ground. Disciplined practice in the use of figurative language can provide conditions for the genesis of living symbols which can (but might not) be steps in creative thought and in the deepening of personal meetings" (Hobson, 1985, p. 186).

5.2.4 The Conversational Strategies and their rationale

The Conversational Strategies are used to create a relationship "in which the client's interpersonal problems are revealed, explored, understood and modifed by testing out the possible solutions which are generated in the dialogue" (Shapiro and Margison, 1985, p.1). The strategies are implicit in the above; they will be made explicit here:

- The first strategy promotes the mutuality of the therapeutic process

The first person pronouns, 'I' and "we', are used to affirm the aims of both client and therapist being involved in the therapeutic process and of both having responsibility for their actions within that process.

- The second strategy prevents a one-sided relationship "that is inimical to conversation" (Hobson, 1985, p. 196)

Statements and not questions are used. Questions can inhibit and limit both client and therapist in their mutual exploration. Appropriately made statements "are less likely to put the client on the spot, are more open to correction, and provide a starting point from which diverging themes can be developed" (Hobson, 1985, p. 197).

- The third strategy promotes the negotiation of understandings

Tentative statements are used to disclose the therapist's understandings of the client; in Exploratory therapy

"The how of the therapist's talk is crucial" (Hobson, 1985, p. 197)

The tentativeness of the therapist's statements leaves them open to the client's contribution. The client is encouraged to elaborate, modify or correct the understanding expressed by the therapist.

"To be tentative is not to be vague. ...A therapist's statements are definite (ie clearly owned by him). He does his best to be accurate but he does not know which answers are right for the patient. He conveys his wish to be corrected. He hopes for communication which will lead on to dialogue, with an adjustment of misunderstanding" (Hobson, 1985, p. 197).

- The fourth strategy focusses actively on immediate experiences in the here and now

"the essence of exploratory work is that the therapist should respond to the client's current feelings" (Shapiro and Firth, 1985, p. 10).

The client's feelings in the session with the therapist access difficult feelings in relationships with significant others. Actively focussing on these feelings promotes the identification of their precursors and consequences for the client's way of relating and for the relationship. Solutions to the interpersonal problems underlying the difficult experiences can then be sought. The therapist is required to notice the minute particulars and at the same time to listen to the whole of the client's communications. This means maintaining a concentrated attentiveness to cues and patterns of cues and, at the same time, maintaining a relatively unfocussed awareness in order to see these anew.

"The combination of these two attitudes is dfficult to convey, and even more difficult to maintain" (Hobson, 1985, p. 199).

In facilitating the client attending to her/his immediate feelings in the session, the therapist may have to explicitly suggest or direct the client to specific activites ('process advisements').

- The fifth strategy enhances immediate experience in the here and now.

Metaphors are used frequently to make the expression of feeling more immediate, vivid and 'whole'. The therapist aims to convey and encourage a 'symbolical attititude'; words, gestures and dreams are given value. They are not only considered for the message they are communicating; Hobson considers them as 'living symbols'. Fresh insights are created when metaphors are extended; "juxtaposing previously unrelated feelings brings new meaningful wholes and extends understanding" (Shapiro and FIrth, 1985, p. 2-3).

- The sixth strategy promotes the exploration and organisation of feeling through three types of hypothesis; Understanding, Linking and Explanatory.

Expressed in a negotiating manner ('I reckon', 'I guess', 'I wonder') to communicate their openness to modification by the client, they are 'tested', not by simple agreement or disagreement, but by whether they are extended, amplified, or corrected.

<u>Understanding hypotheses</u> focus on the here and now therapeutic relationship: verbal and nonverbal cues are used to make 'informed and empathic guesses' about how the client is feeling here and now in the relationship; these are Understanding Hypotheses. These are more than a simple reflection of feeling. The therapist's own perspective extends the understanding of the client's feelings to facilitate the mutual exploration and understanding of the client's experience.

"Empathy is conveyed in such a way as to call forth a response; to achieve a dialogue with increasing mutual understanding. ... The aim of the hypothesis is to promote a never-ending process" (Hobson, 1985, p. 198);

the never-ending process is the development of a shared language in a personal relationship.

Linking Hypotheses increase the extent and depth of this understanding by linking areas of the patient's experience. They particularly emphasise parallels between the current therapeutic relationship and other relationships. The aim is to make sense of experience by linking together feelings from different situations and, in so doing, to make greater 'wholes' of understanding. Bringing together similar feelings from different situations in this way counters the fragmentation and loss of integration underlying many symptoms. On the basis of recurrent patterns in the client's experience, links are made (a) between events within therapy at different times; perhaps during one interview, perhaps relating what is happening now to previous sessions; and (b) between patterns in the present therapeutic conversation and those in other areas of life. The crux of and immediate impact of linking hypotheses lie in their including the client's feelings and ways of relating in the here and now of the therapeutic relationship:

"If a link is to be made between two external experiences (such as an early experience A and a current outside experience B), then this is best formulated by initial links between A and an experience in the therapy situation, X, and between B and X. Thus, linking hypotheses do not involve extensive 'archaeological', 'futuristic' or 'globe-trotting' expeditions linking external experiences A, B, C, D...Z. If a link cannot be made between one of more of these and the here and now, they are best omitted (although not forgotten, as new links emerge) by the therapist" (Shapiro and Firth, 1985, p. 3).

Explanatory Hypotheses suggest possible reasons underlying the client's difficulties in relationships, both inside and outside therapy. These reasons may or may not be the causes for the distress in relationships. Explanatory Hypotheses are usually based on a considerable amount of information and this information should include the client's responses to previous Understanding and Linking Hypotheses. They are usually related to repeated patterns of behaving and experiencing inside and outside therapy and are responsive to the situation currently being discussed. They correspond closely with the 'because' nature of Interpretations. In Hobson's view the 'because' statement usually concerns fear:

"In its complete form there are three such clauses. The clauses are given at intervals and it is desirable that the patient should make the explanation himself or, at least, make a substantail contribution. For example, 'I shrink back into my overcoat because I am scared of getting too close to you because then you would cruelly reject me'. A

present action is carried out in order to avoid a particular type of relationship which would result in some catastophe. The fear of the catastrophe may or may not be completely outside awareness. In the conversation it may or may not be explicitly linked with past experience." (Hobson, 1985, p. 198).

These hypotheses are conventionally and progressively sequenced in this order (Understanding, Linking, Explanatory) and in this way they achieve the majority of the 'work' in Exploratory therapy. Reflection identifies the feeling which is then explored using Understanding Hypotheses. In the interpretation of the feeling, Linking Hypotheses (providing 'parallel interpretations') precede Explanatory Hypotheses ('causal interpretations'). Following this sequence prevents either

(a) the client not integrating the formulation within the interpretation; via

"premature, intellectualised or insufficiently integrated acceptance of, or acquiescence with" the therapist's formulation. This is unlikely to yield lasting change. The client's agreement is superficial, because it can not be fully owned and used with maximum impact by the client until (s)he has experienced and acknowledged the feeling itself, in the here and now. The 'insight' achieved will be excessively identified with the therapist as expert, and hence not sufficently internalised to outlive the actual contact between client and therapist, or to yield an impact generalisable beyond the expert-client relationship to other personal contexts" (Shapiro and Firth, 1985, p. 6-7);

or (b) the client's rejecting or not understanding the interpretation:

"rejection of or failure to understand the interpretation. If a link or explanation is offered too quickly, the client may simply fail to make the connections required. If situations F and G are linked by the feeling Y evoked in each, then a full appreciation of Y is required before the link can be recognised. If F is offered as an explanation of the feelings associated with G, then these feelings must be appreciated for the client to evaluate the explanation. These are the preconditions for the cognitive processes involved in receiving interpretations. In addition, the absence of prior acknowledgement by the therapist of the client's feelings in the situation under examination may itself trigger negative affect, with the client feeling neglected, rejected, misunderstood, demeaned or manipulated (as a thing or machine whose workings are exposed to the therapist-engineer). ...If the client does not feel understood at the feeling level, the therapist may sometimes be 'right', sometimes 'wrong', but rarely close enough to permeate the client's interpersonal boundaries (the client-centred 'with-ness' is lacking). ...Many clients having experienced objectification in early life and subsequent relationships, the exploratory therapist should seek to disconfirm the expectation that this will recur in the therapeutic relationship. Therefore it is essential to achieve and express empathic understanding of feelings." (Shapiro and Firth, 1985, p. 6-7).

Three important distinctions between Explanatory Hypotheses and more traditional, analytic interpretations should be pointed out. Firstly as stated, they are rooted in observing the here and now feelings of the client in the therapeutic situation. Secondly according to the interpersonal framework of Exploratory therapy, the importance of early experience derives from the lasting impact of the actual early environment experienced by the client. Thirdly, Explanatory Hypotheses are not the

aim of Exploratory therapy; nor are they essential to 'insight'. They help organise and make sense of immediate experience and of 'disclaimed actions'. But still they are in essence suggestions; they are additionally valuable for their promotion of the on-going conversation.

These six Conversational Strategies provide, develop and express the relationship. Therefore they are more than the 'means by which the relationship is achieved', as this quotation from Hobson indicates:

"Undergraduate and postgraduate students are given the hackneyed precept: 'Make a good relationship'. It is usually hastily passed over and nothing is said about how to achieve it. ...I am trying to elaborate vague terms such as 'establishing rapport', using 'a bedside manner', and hoping to elucidate the meaning of so-called non-specific 'factors'. But I am saying far more than that. *The form of a developing conversation often is the diagnosis and also is the treatment.* That is not to say that conversation in itself is the whole or main treatment. It may be." (p. 177; italics in original).

Hobson commits to the view that achieving a 'true voice of feeling' in the development of a personal dialogue in which language, meaning and understanding can be shared requires both 'genuineness' and 'technical accomplishment'.

5.3 The Rational Analysis

5.3.1 The principles of the analysis

Making explicit the theory and practice of the therapy is the first step in performing a Rational Analysis. This permits the second step, a 'thought experiment' (Husserl, 1939/1973) to be performed. This is a creative process, playing with the possibilities of performance, asking questions (What's needed now? What would I do? How is x best achieved from here?); answers are juggled and rejected to construct a rational map (Greenberg, 1984) of the best possible resolution strategy for the particular therapy.

In short, the Rational Analysis is a mental analysis, performed by and made explicit by the researcher speculating about how the task is best resolved:

"This provides an initial understanding of the possible resolution strategies and the components of resolution performances. ... The investigator is conducting a kind of 'thought experiment' (Husserl, 1939/1973) in which possible performances are varied freely in imagination to extract the essential nature of resolution performances and the fundamental strategy underlying these performances" (Greenberg, 1984b, p. 141).

Based on the clinical theory and its translation into practice, the resulting idealised 'rational map' represents a 'best guess' at task resolution and serves as a guiding framework for empirically describing the actual task performance and determining how it compares with the 'best guess'.

These terms may seem somewhat abstract; Greenberg (1984b) highlights two aspects of this procedure that may make it more concrete. Simply put these are the Rational Analysis's similarity with and difference from traditional scientific thinking. Firstly, he notes that the Rational Analysis's generation of idealised possibilities is in *common*, it is "an aspect of all creative scientific thinking" (p. 141). Secondly, he notes a difference; the "approach is clearly not 'induction by abstraction'; rather it is "an intuition of essences" (p. 141). Both approaches are based on 'facts' but in the Rational Analysis aspects of the facts are varied in imagination to 'intuit' their essence. (This contrasts with traditional, 'induction by abstraction' in which the facts are considered and their common character is abstracted).

"To do this we consider a concrete experience, for example, that of a lamp, and then change it in our thought, trying to imagine it as effectively modified in all respects. That which remains constant or invariant throughout these changes is the essence of the phenomena in question" (Greenberg, 1984b, p.141).

Thus the Rational Model is the researcher's best creative integration of everything s/he knows about the essential elements of task resolution performance.

5.3.2 The practice of the analysis

In practice, the Rational Analysis was undertaken by a group of three people; two experienced clinician researchers and the researcher. All were familiar with the principles of Exploratory therapy, the Events Paradigm and Task Analysis; none had previously undertaken task analytic research.

The two scientist-practitioners could be profiled as follows: David Shapiro (DAS) is the most experienced researcher and clinician in the Sheffield Psychotherapy Research Team. He is an experienced Exploratory therapist whose research experience includes Events Paradigm projects (for example, Elliott and Shapiro, 1992; Insight events paper). Robert Elliott (RE) is an experienced researcher and proponent of the Events Paradigm (eg Elliott, 1983) and a practising therapist. His longstanding involvement with the Sheffield Psychotherapy Research Team includes planning of the main and subsidiary research projects. As a process researcher he has developed and applied two Event Paradim methods, Comprehensive Process Analysis and Brief Structured Recall (see, Elliott, 1984; Elliott and Shapiro, 1992). Whilst he is intimately familiar with the theory and practice of Exploratory therapy, his own therapeutic practice is oriented more to the experiential than the psychodynamic tradition. In summary, each had unique and complimentary contributions to make; DAS's appreciation of practising Exploratory therapy and RE's appreciation of implementing Events Paradigm methods.

Prototypical examples of Client Challenges excerpted from session tapes by the researcher were played at the beginning and throughout the meeting, as Greenberg's questions for a Rational Analysis ('What are the possible components that might lead to resolution?'; 'What series of processes is it necessary for the client to go through?'; 'What would I do now in this situation?'; 'Which is the most desirable option?') were presented. The aim was to explore these questions 'as freely as possible'.

Some brief comments on how the analysis proceeded may be illuminating:
It is essential (but effortful) that a sense of the task and its resolution are maintained throughout the 'experiment'. Why? *Making explicit* assumptions and intuitions regarding the path to task resolution can sometimes be excrutiating; losing sight of the task, where the path has come from and its resolution, where the path is leading, can be counterproductive.

Despite the 'free consideration' given to possible resolution strategies, the experiment was not akin to a 'brainstorming' activity in which all suggestions were accepted and recorded. The consideration was highly purposeful, with all suggestions scrutinised in relation to the task and how to achieve its resolution.

A series of questions *emerged* from the experiment; they were asked of each suggestion. These questions served as the group's operationalisation for those suggested by Greenberg (above). For example, the questions put to a suggested therapist activity were:

How would you respond?
In saying that what would you be trying to do?
Are there other things you could do?
What are they?
Which is preferable? and why?
Which is most appropriate at this point?
How would you want the client to respond?
What's the client feeling?
How might the client respond?
How ideally would the client respond?
What would facilitate that ideal response?
What else would be facilitative?'
What is most facilitative now?
Would it be more facilitative
earlier or later?

A Rational Model was constructed, piecemeal fashion, by systematically, repeatedly and explicitly considering these questions. To abstract slightly from the details of this particular experiment, these questions illustrate that the 'mental experiment' is systematic, recursive and empathic. The process of imagining oneself into the dynamics of the task and the therapeutic situation required engagement, vigilance and focussed energy. It should be noted that to engage imaginatively and creatively with the task and its resolution, these questions were considered systematically but not necessarily in the 'linear' sequence presented above. All were considered in relation to each component suggested for the model but not necessarily in the above order. The endpoint was reached when no changes to the model's components or their ordering could be made. The resulting model was recorded and circulated for re-consideration by individual group members but no modifications were required.

5.4 The results of the analysis: A Rational Model of Confrontation Challenge Resolution in Exploratory therapy

5.4.1 A verbal picture of a Confrontation Challenge

Above it was stated that essential throughout the thought experiment is *a sense of* the task; below is a verbal picture to provide the reader with the same - a felt sense of a Confrontation Challenge occuring in Exploratory therapy. The reader can thus approach the results of the experiment, the Rational Model, with a similar sense to those who developed the Model.

A verbal picture of a Confrontation Challenge being made

A Confrontation Challenge being made can feel decisive: It can feel decisive of something different being required. Something different is being sought for but what that something is remains unknown. It is knowable but it is not known in the immediate moment of the Challenge being made.

There can be a sense of everything 'standing still' in the moments the client makes a Confrontation Challenge: There feels to be an active disconnection with what's gone before; a protest against, a rejection of. The client's Challenge can feel like its committing to something different but what's different is unknown. There is no sense of what the future might be but there is a sense that a future is possible. A future is not being rejected but there is a sense of it being uncertain and conditional on what is done, actively, with the Challenge in the following moments.

There may be a sense of something being ended by the Challenge; a limit has been reached. Maybe the client wanting but not getting x; the client getting x and wanting y; the client not supporting, tolerating or complying with an established 'status quo' any longer. The emotional expression of the Challenge can feel like it's stating the need for a commitment to action, different action.

There may be a sense of this being an ultimate or climactic communication for the client. The client may previously have communicated or attempted to communicate what is in the Challenge but the Challenge bringing it into the here and now of the session can provide a sense of 'this is it', 'this is what the previous communications were about'. This is where the make or break feeling of the Challenge lies. Because 'this is it' there may be a 'now or never' quality.

There may also be a sense of the Challenge communicating or accessing something ultimate, or at least, substantial. There may be a sense that something 'big' for the client may be revealed through the Challenge having been made. There may be a sense of something emerging in the Challenge.

There is a sense of the Challenge being urgently directed 'out' or 'at'; actively away from the client. There is a sense in which in doing this the client is moving from the established status quo, somehow outside it, on the other hand the affect that goes with the Challenge may provide for emotional engagement; this is one of the sources of a felt precariousness to Challenges.

There may be a sense of the client not going back from this point; this being something of a last ditch attempt; if this doesn't work for the client then the client will (by various means) absent themselves from the process and its dynamics. This may be felt as the client not going back from this point, back to what was previously established, and going forward only if conditions that need to be discovered are met.

This verbal picture provides a sense of a Confrontation Challenge being made.

Thereafter what is the best strategy?

5.4.2 The Rational Model of Confrontation Challenge Resolution in Exploratory therapy

CLIENT MARKER	A CONFRONTATION CHALLENGE
Stage No	Stage-Description and -Components
I	Acknowledgement of client's feelings associated with Challenge
II	Negotiation of understandings of respective contributions in originating Client's Challenge
	i Therapist invites client's understanding of sources
	ii Client's understanding
	iii Negotiate a shared understanding of contributions, roles & responsibilities
	iv Consensualise negotiated understandings of in-session sources
III	Exploration
	i Exploration of out-of-session sources of Challenge
	ii Exploration, linking and explanation of sources of Challenge in terms of ways of relating and patterns learned in early relationships
IV	Closure
	i Renegotiation of working relationship
	ii Use of challenge resolution to illustrate client's ability to make constructive relationship changes

5.4.3 The 'chain of reasoning' embodied in the Model

The idealised Rational Model proposes Challenge Resolution is a four-stage process; Challenge-Acknowledgement, -Negotiation, -Exploration and -Closure. What is achieved and how in each of these stages? The first two stages, Acknowledge and Negotiate work towards a shared understanding of the in-session origins of the Challenge just presented by the client in the here and now of the session. The third stage Explores similar experiences in situations outside therapy, in the client's past and present relationships, as well as to other experiences in the therapeutic relationship to further understand and suggest possible reasons for the client's Challenge. The final stage Closes the Challenge's resolution by examining its meaning for further therapeutic work and secondly for the client's ability to make changes in significant interpersonal relationships.

The 'chain of reasoning' embodied in these hypothesised stages will be spelt out here by referring both to the Model and the foregoing statements of the principles and practice of Exploratory therapy.

The client's Challenge has Confronted the therapist. As Challenges provide an affectively salient opportunity to the possibility of understanding interpersonal experiences that are recurrently difficult and distressing for the client, the focus is on the client's immediate feelings the session The therapist Acknowledges (Stage I) the Challenge's expression of the client's feelings. This is an explicit and empathic statement of the therapist's engagement with, her/his respect for and understanding of the client's feelings that will also lessen the client's anxiety. The goals are now to firstly understand the in-session origins of the Client's Challenge (through Negotiation, Stage II) and then to understand the links these have with interpersonal situations, current or past, outside therapy (through Exploration, Stage III). The therapist begins the Negotiation by acknowledging the fact of her/him having somehow contributed to the client's difficulty in the session (Stage IIi). In so doing s/he is again (a) accepting the reality of the client's Challenge and associated feelings (not invalidating them), and (b) conveying their mutual responsibility for their interaction (not putting the client on the spot or pathologising the client). The therapist invites the client to share her/his perspective on the in-session feelings and actions and their meanings for the client that led to her/him making the Challenge and the client does so (IIii). This is a specific process-direction to draw forth the client's understanding of the in-session situation that for the client was the stimulus to her/his Challenge. The therapist tentatively providing her/his perspective on the same will begin an exchange (IIiii) of their understandings of what has occurred between them to the Challenge in the session. These perspectives will be framed (initially by the therapist) in terms of their respective therapeutic roles, their respective contributions (including their content and manner) to

the session and to the Challenge. Modelled intially by the therapist (in IIi) and whether or not the actions were initially disclaimed (unwitting) responsibilities for their respective contributions are owned. This exchange and progressive accommodation of perspectives works towards developing an understanding of their interaction that is shared; that is, accepted by both as reflecting their respective contributions and responsibilities. Both this understanding of how each contributed (albeit unwittingly) and its mutual acceptability is made explicit (IIiv).

This understanding of the in-session origins of the Challenge established, it is deepened by therapist and client exploring parallel situations in relationships with significant others outside therapy (IIIi). The understanding of the in-therapy Challenge and its orgins informs and is informed by this exploration (IIIii); the current in-therapy Challenge and Stage I and II, previous in-therapy situations and situations from the client's current and past interpersonal relationships are explored. Similarities and differences in the client's experiences (the precursors), her/his ways of relating as previously adaptive coping strategies and their consequences for the client are explored. Differentiating the client's feelings from their associated actions in this way limits the client's fear of acting out impulses and indicates the possibility of learning alternate ways of relating. These links may suggest possible reasons for the Client's Challenge in the earlier in-session situation or for the Client's learned way of relating in these recurrent and similarly difficult interpersonal situations.

This enhanced understanding is used in the Closure of the resolution process. The understanding of the contributions of client and therapist in the here and now and of the contributions of the client's interpersonal history are used as the bases from which to explicitly negotiate the working relationship and the goals of therapy (IVi). These explicit negotiations concern the 'terms and conditions', the ways in which client and therapist will relate with one another as they work together and concern particular foci for their work that have been identified as they have deepened their understanding of the origins to the Client's Challenge. Resolution ends with the therapist making explicit to the client the generalisable value of their having resolved her/his Challenge (IVii). As the client's Challenge and its resolution has brought constructive change to their working relationship (IVi) so it evidences the client's ability to make similar changes in relationships outside therapy.

5.5 Conclusion

This chapter has described the development of a Rational Model of Confrontation Challenge Resolution in Exploratory therapy; the Model represents the researchers' best guess at the best possible resolution strategy for client and therapist once a Challenge has been made. Informed by understandings of the theory and practice of

Exploratory therapy, which were made explicit, possible Challenge Resolution strategies were experimented with mentally, described above, to develop this Model.

Guessed best was a four-stage strategy; Acknowledgement, Negotiation, Exploration and Closure. Components that may achieve each of these stages were also proposed. It should be pointed out that the sequencing of stages in the Rational Model follows the the general principles for structuring Exploratory work. The Acknowledgement and Negotiation Stages will tend to lower the client's anxiety. The Negotiation Stage having arrived at a "mutually-agreed account of the anxiety-provoking issue" (Shapiro and Firth, 1985, p. 4), the Exploration of the Challenge is achieved by the sequencing of interventions that is standard in Exploratory therapy: reflection, understanding hypothesis (to explore), linking hypothesis (a parallel-interpretation) and explanatory hypothesis (a causal-interpretation).

But how does the researchers' best guess regarding a Challenge Resolution strategy relate to resolution performances occuring in sessions of Exploratory therapy? Chapter Six addresses this question.

Chapter Six

6.1 Introduction

In a Task Analysis, the researcher's confidence in using the Rational Model as a 'rational map' to guide the subsequent Empirical Analysis and Rational Empirical Comparison depends, in part, on the Rational Model being demonstrably applicable to task resolutions being performed in clinical practice. Chapter Six presents a 'Preliminary Intensive Analysis'; this was required by Safran, Greenberg and Rice (1988) to demonstrate the applicability of the Rational Model of Challenge Resolution (developed in Chapter Five). The Confrontation Challenges made by a client, Jane, in the second of her eight sessions of Exploratory therapy within the First Sheffield Psychotherapy Project (SPP1; Shapiro and Firth, 1987) are selected for this preliminary analysis. In order to be confident of the applicability of the Rational Model to therapeutic practice, Chapter Six will also assess the extent to which the therapist's activities observed in resolving Jane's Challenges is representative of Exploratory therapy.

This Preliminary Intensive Analysis was required by Safran et al (1988) in their specification of 'design criteria' for Task Analysis. With one exception (Greenberg and Safran, 1987) this analysis has not been undertaken in published Task Analyses. That is, although verification studies of the intensive Empirical Analysis and the Rational Empirical Comparison have commonly been undertaken; verification of researchers' Rational Analysis have commonly been omitted. For two reasons this a serious limitation of previous Task Analytic implementations. Firstly, in standard procedure (4.2.3), the Empirical Analytic and Rational Empirical Comparative stages following the development of the Rational Model are (a) guided and influenced by the Rational Model and (b) labour intensive and time consuming. Undertaking these stages without having first assessed the 'trustworthiness' (Stiles, 1993) of their guide, the Rational Model, is potentially erroneous. Secondly, consistent with the principles of the Change Events approach (3.5.5), Task Analysis is a Rational Empirical method; the rational and empirical analyses are equally important. Thus, not verifying the results of the rational analysis devalues the rational in relation to the empirical analysis. In sum, if the Rational Model has been carefully grounded in the psychotherapeutic theory and an understanding of its implementation in practice, then the verification of the Rational Model via the Preliminary Intensive Analysis can be expected; undertaking this analysis is nonetheless important.

That the substantive work (the Empirical Analysis and thus the Rational Empirical Comparison) of a Task Analysis depends on the applicability of the Rational Model has been explained. This explanation specifies how the Preliminary Intensive Analysis *relates to* the final Rational Empirical Comparison. How the Preliminary Intensive Analysis *is distinguished from* the Rational Empirical Comparison should

however be spelt out. Both entail examining the Rational Model in relation to session material and are thus potentially confused. There are however three important differences between them: Firstly, their primary focus is different. The Preliminary Analysis focuses on the Rational Model *in relation to* the clinical data; the Rational Empirical Comparison focuses *on the relationship between* the Rational Model and the clinical data. Secondly, different questions are asked during both the Analysis and the Comparison. The question in the Preliminary Analysis is '*confirmatory*'; 'Does the clinical data generally support the Rational Model's 'chain of reasoning' about Challenge Resolution in this therapy?'. The question in the Rational Empirical Comparison is '*revisionist*'; 'How is the Rational Model's 'chain of reasoning' challenged and revised by the clinical data?'. Thirdly, the level of abstraction from the clinical data is different during the Analysis and the Comparison. The Preliminary Intensive Analysis relates the Rational Model of Resolution to session transcript material. The Rational Empirical Comparison compares the Rational Model with the descriptions of resolution performances that are generated by the Empirical Analysis. In short, the Preliminary Intensive Analysis is preliminary to the substantive work of a Task Analysis; unlike the Rational Empirical Comparison, it does not provide a preliminary revision to the Rational Model.

Safran et al (1988) required that the researcher intensively and publicly observe "a few cases" of task resolution in the Preliminary Intensive Analysis. How are these few cases to be selected? As stated the focus of the Preliminary Intensive Analysis is the Rational Model; this has implications for the selection of the clinical data. The Rational Model sets out researchers' 'best guess' at successful task resolution performance. In the Model's development, other possible performances and performance outcomes are experimented with mentally but what is represented in the Model is a best guess at *successful* resolution. Therefore, to examine 'like with like' the events selected from the single clinical case must be successfully resolved. The previous chapter argued that such successful resolution is likely to be the cumulation of many or several, partially successful resolution attempts and that this is a substantive argument for selecting resolution events from a single clinical case. These statements were considered in the selection of the clinical material to be reported here.

One client's Exploratory therapy and three Confrontation Challenges she made in her second (of eight) sessions are reported here. The reasons for their selection and the context in which her therapy took place are presented in 6.2. The three Challenge Resolution Events to be studied intensively are also contextualised (6.3) and then their analysis presented (6.4). The representativeness of the Exploratory therapy practice observed in these analyses is assessed (6.5). To conclude, the

applicability of Chapter Five's Rational Model to these Resolution Events occurring in clinical practice is then assessed (6.6).

6.2 The Selection of a Clinical Case from SPP1

6.2.1 Introduction

This section presents the research project in which the client (Jane) took part, the criteria used in selecting her therapy for analysis here and profiles both Jane and the therapist (DAS).

6.2.2 The First Sheffield Psychotherapy Project (SPP1)

The First Sheffield Psychotherapy Project was a comparative study of two brief psychotherapies administered in crossover Design (Shapiro and Firth, 1987). Each client received eight sessions of the psychodynamic-interpersonal treatment (Exploratory) and eight sessions of a cognitive-behavioural treatment (Prescriptive) in counterbalanced order, with the same therapist throughout.

An assessment battery was administered to each client four times: before treatment began, after the first eight sessions, at termination and again three months later. Among other measures the battery included a structured interview to assess psychological symptoms (the Present State Examination; PSE: Wing, Cooper and Sartorius, 1974) and self-report questionnaires, including the Hopkins Symptom Checklist (SCL-90; Derogatis, Lipman and Covi, 1973) and the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock and Erbaugh, 1961). Client's mean improvement, assessed as change on these measures from pre-treatment to termination was both clinically and statistically significant and this improvement was maintained at three months (Shapiro and Firth, 1987).

6.2.3 The criteria for selecting a clinical case from SPP1

Chapter Four presented substantive arguments for analysing Events from a single clinical case; this strategy (a) reflects the continuous and cumulative process of therapeutic change; (b) allows the possibility that resolution may proceed by a series of solution attempts and (c) maintains a stable 'task environment'. In addition, Greenberg (1975; 1984) has recommended that therapists' memories of their clinical work are invaluable in selecting material for early task analytic work. Random sampling is antithetical to the selection of material early in the Events-based strategy; material is selected on the basis that it is most likely to contain examples of the phenomena of interest (Greenberg, 1991). Prototypical or 'pure' examples of the Events in question are more likely than 'average' examples to be remembered by therapists and memorable cases are more likely to provide prototypical, examples of the Events in question (Greenberg and Harper, 1989). Jane's therapy was

memorable to the most experienced therapist taking part in the First Sheffield Psychotherapy Project (SPP1; Shapiro and Firth, 1987). He remembered it for its process; he *"anticipated difficulties but felt he worked hard and productively with these"*. Profiles of client and therapist will now be presented.

6.2.4 The therapist

The therapist (DAS) was a research clinical psychologist with ten years' post-doctoral research and clinical experience, including extensive work in the specific PI treatment model used. Completion of therapy predated his supervision of the present project by approximately 12 months.

6.2.5 The client: Jane

Her General Practitioner's referral to the Clinic indicated that the client had been experiencing difficulties for the past eighteen months and was taking 1mg Ativan once or twice daily. She was generally tense and experiencing panic under stress and friction at work. Additionally, she was experiencing hypertension and insomnia.

As one of the research requirements, she made the following problem statement (Personal Questionnaire; PQs; Mulhall, 1976) prior to the start of therapy:

'I have difficulties with my boss
I am worried about my health
I am bored
I feel hopeless about the future
I feel tense
I have difficulty showing my feelings
I have difficulties concentrating
I feel lonely
I have problems sleeping
I feel as though I am losing control'

The client was a helping professional in her early thirties. She had a distinctive, stylised way of relating that included rituals (for example, referring to herself only by her surname or as *"one"*). Her conversation had a complex, literary grammatical structure, with embedded clauses and striking, emphatic inversions of words (for example, *"Thinking up with this I will not put"*). She repeatedly made asides (for example, *"Is all this being taped, with me and my foul language?"*) and commented on her contributions to the conversation (for example, *"she said, agressively"*).

The client was randomly allocated to the PI-CB order of therapy. Evaluated by outcome data, her therapy was successful. For example, her BDI score fell from 24

before treatment to 4 after the PI phase of treatment and 3 after the subsequent CB phase, 7 at three month follow-up and 0 at two year follow-up. Her SCL-90 Global Index of Severity fell from 1.23 pre-treatment to 0.79 after the PI phase, 0.31 after the CB phase, 0.54 at three month follow-up and 0.17 at two year follow-up. Outcome data for the PI phase compare quite favourably with the means for the group of 19 clients receiving this treatment first in the crossover (Shapiro and Firth, 1987, Table 1), which fell from 22.0 to 14.2 on the BDI and from 1.46 to 1.08 on the SCL-90, over the PI phase. At two year follow-up she reported having received further behavioural treatment.

Table 6.1

JANE'S PRE- AND POST-TREATMENT SCORES ON OUTCOME MEASURES

	Pre treatment	Mid treatment	End treatment	3 month follow-up	2 year follow-up
BDI	24	4	3	7	0
SCL-GSI	1.23	0.79	0.31	0.54	0.17

6.3 Contextualisation and Selection of Events for Intensive Analysis

6.3.1 Introduction

The author identified Challenge Markers in the first and second but not third of Jane's Exploratory sessions. Three of the Challenges in Session Two were selected for intensive analysis (6.4). This section explains the selection of the three events, gives them a context and indicates the dynamics and themes of Jane's therapy.

6.3.2 Researcher's identification of Challenge Resolution Events

To identify events for intensive observation the researcher reviewed the therapist's case notes for indicators of Challenges. His notes for the second session started *"Began with her anger at me..."*.

Listening to this session tape revealed a series of 18 Confrontation Challenges in this second session, some of which pointed to the occurrence of similar in the previous session. This was confirmed by listening to the first session tape; Confrontation Challenges occurred in Sessions One and Two. However, no Challenges but evidence of Resolution was identified in Session Three.

This suggested that the resolution evidenced in Session Three may have been achieved in Session Two; that is, that Session Two would contain clinical material appropriate for demonstrating the Rational Model of successful Confrontation Challenge Resolution. These statements were confirmed by re-listening to the session tapes and Jane's first three sessions were transcribed (by the author).

The following three subsections provide support for these statements:

- Confrontation Challenge Events occurred in Sessions One and Two but not in Session Three
- There was evidence of their resolution in Session Three.

Note that Jane's Challenges in Session One and client and therapist's evaluations of this session are presented in more detail; they are context to the Resolution Events that are intensively analysed in 6.4.

6.3.3 Session One: Challenges and Session Evaluations

Jane made eight Challenges in Session One. Four of these Challenged the therapist's persistent attention to ways in which her use of language distances her feelings; referring to herself as 'one' or by her surname for example: As Jane 'talked about' feeling lonely not being in a sexual relationship the therapist interjected,

T: And even now again the language, why "one" puts up the front

She responded with controlled but pithy anger;

C: Sorry, that's just me

Confrontation Challenge Five

Towards the close of the session the therapist pointed to the distancing function of her referring to herself by her surname;

T: Well, are you, yes, maybe this makes you feel picked up on or under the microscope but I can't help having a feeling that this is kind of somehow less intimate, less personal

Her seventh Confrontation Challenge followed; its sarcasm and anger was heightened by her whispering,

C: What does that mean?

Confrontation Challenge Seven

Three of Jane's Challenges expressed her difficulties with being in the client role; and this provided for their *"power struggle"*, in the therapist's terms. This dynamic was evident at the opening of the session; Jane responded to the therapist's empathic reference to the assessment and research *"hurdles"* she'd undertaken prior to their meeting thus;

> *C: I feel one should get a prize, I usually get the consolation. Yes it's amazing. As a social scientist I'm absolutely fascinated on the one hand, and as a professional carer on the other it's very thorough*

The therapist understands her difficulty in accepting her role;

> *T: Like my feeling is that you've been driven to some extent by the image, like you come in say as a social scientist...like you're establishing your position as an equal. You're not a client really, part of you is saying you're a social not a client, you're a competent person*

This expression of his understanding was the focus of Jane's final Challenge; asked how she had found their first meeting, she responded in a confrontational manner;

> *C: Well at the beginning you really annoyed me but you were right, saying that I was trying to avoid being in this chair..I wasn't too pleased with the blast of insight but no, other than that. ...It felt like you were telling me off and saying no, come on, you're in this chair.*
> Confrontation Challenge Eight

In this first session they developed a shared understanding of an aspect of Jane's difficulty with her client role; in the therapist's words, *"the therapeutic situation was on the one hand, all too well known (because of her job) and, on the other, was (being in the client role) unknown"*. Her difficulty with the 'unknowns' of the situation was expressed in three Challenges (One, Two and Seven); they expressed uncertainties regarding her part in the session process and the benefit of being in therapy. To illustrate, she made her second Challenge following the therapist's direction to *"move off work and get to talking about more personal things, your personal life"*:

> *C: I sit here with my mind blank thinking (laughs), what does he want me to throw in. Sorry, I'm not playing games*
> Confrontation Challenge Two.

Immediately after the session Jane completed an Helpful Aspects of Therapy form (Llewellyn et al, 1989); she evaluated the first session as 'fairly helpful'. She had found the therapist saying *"there was work we could be doing that would alter my situation"* 'very helpful'. The most 'important aspect' of the session for the client was *"Clarifying important issues and feeding back to me how I came over to the therapist"*.

Between the first and second sessions the therapist sought peer group supervision (which was usually deferred until after the second session) and reviewed the session tape. His notes identified the client's third person language, fast talk and intellectualisation as targets, noting that *"words are a barricade"*. He estimated that, in their first session, he had *"moved too fast"* and *"without empathising"* from picking up her past tense language to her desperation for help. Similarly he felt that he did not *"pick up sufficiently"* on either her nervousness or the effort that it took for her to come to therapy and he described the client *"ticking him off"* for the latter. He questioned whether the client's evaluating his observations in terms of what's *"fair"* was evidence of her competing with him, cautioned that neither were *"facing the inner chaos"* but, in total, felt optimistic about their work together.

In summary, in Session One the therapist repeatedly confronted Jane's defensive, controlled use of language. On four occasions as he did this Jane made Confrontation Challenges. Two Challenges expressed her uncertainties and active struggle with 'being a client'. In reviewing their first meeting, Jane Challenged the way in which the therapist had expressed his understanding of this struggle. Clearly there was work to be done but, after the session, both client and therapist were relatively optimistic.

6.3.4 Session Two Challenges

Jane presented Confrontation Challenges on 18 occasions in the second session; 13 concerned the therapist, 5 the therapy. The first six of these referred exclusively to therapist behaviours in the previous session; they had a there-and-then quality: The Challenges revealed that the client felt that right at the opening of the session, she had been *"set up"* and was then *"taken to task"* by the therapist. Referring to the therapist's interpretation of her identifying herself as a social scientist, she had experienced the therapist telling her she *"wasn't prepared to be a client"*. In addition, she felt rather than *"turn it on her"*, he should have appreciated that her nervousness coming into therapy would lead her to *"respond in ways that I'm familiar with"*. The therapist accepted her Challenges by expressing his similar understanding; his drawing attention to Jane's self-presentation had been experienced as unsympathetic and critical.

A shift occurred with Jane's seventh Challenge; it had a here-and-now immediacy;

> *C: God you pick up every bloody word. It's just one of my phrases*
> Confrontation Challenge Seven

Immediately preceding this Challenge, the therapist had *for the first time in this session* drawn attention to her language use, and he had done this in such a way as

to 'disagree' with what she was saying. This seventh Challenge both epitomised and brought to a climax their struggles to this point; it was the focus of the remainder of the session.

Jane Challenged on 11 more occasions to the end of the session. Space precludes their presentation here. The therapist's link back to *"what's happened today,...what's happened between us"* provided the proximal context for Jane's final Challenge, 18 minutes prior to the end of the session;

> *C: We had a fight*
>
> *T: But at a basic level there's a question was it worth it, like we got into a fight*

was the precursor to the client's final Challenge of the session:

> *C: (Over T) I think it was very necessary because otherwise and that was why I said to you I'm sitting here thinking well shall I go now, cos I thought Christ you know, I cannot go through this each week if this is what it's going to be like. Now it may be my fault but I'm not into it and I'll go. And keep taking the pills or something.*
> Confrontation Challenge Eighteen

6.3.5 Evidence of Challenge Resolution

Jane's seventh Challenge in Session Two both epitomised and brought to a climax the struggles between client and therapist to that point. At the end of this session both expressed their satisfaction that the work done on these struggles subsequent to this point had been fruitful. In testimony to this, the client had moved in her understanding of the dynamics occurring between them; from unnecessary hassles (in Challenge Twelve) to an unnecessary fight (in Challenge Thirteen) to *"we got into a fight...(which) ...was very necessary"* (in Challenge Eighteen). She explained the fight's necessity. It had *"cleared some of the air"*, *"perhaps clarified a few things"* and *"begun to come up with an agenda"*. Its benefits are evidenced in the change in her feelings over the course of the session. Early on she felt herself to have been *"in her corner"*; at the close of the session she reported feeling *"more relaxed, which is pleasant"*. She repeated these sentiments in her Helpful Aspects of Therapy form . She reported *"I began to relax into the relationship"* as the session's most Important Aspect and *"Getting some indication of where we go from here"* as its more Important Event. Helpful Events, which she rated as Very Helpful, were

> *"1 Making links between the public and the private me*
> *2 Clarifiying the communication lines and expressing my anger"*

No Confrontation Challenges were identified in the audiotapes of subsequent sessions. However, the client noted *"I got angry and said what I thought"* as an

Important Event in the fourth session but the session recording failed, preventing transcription of this session.

More importantly, in a parallel situation in Session Three the client did not make a Confrontation Challenge. When the therapist drew attention to the client's intellectual use of language (which in Session Two elicited Challenges) the client accepted this without demur, recognising that this language expressed *"the coping, competent me bit again, yeah, you're right"*.

6.3.6 Summary

Jane made eight Confrontation Challenges in Session One, eighteen in Session Two, and none in Session Three. They expressed struggles between client and therapist; in respect of their roles; the therapist's attending to the client's defensive use of language; the client's concommitant experience of the therapist as critical.
Their resolution seeming to have occurred in Session Two Challenges made during this session were selected for intensive analysis.

6.3.7 Selection of Session Two Events for Intensive Analysis

To reiterate, the intensive analysis aims to positively demonstrate the applicability of the Rational Model to Resolution Events occurring in representative Exploratory therapy. Remembering that this stage is a positive demonstration, not an evaluation, of the Rational Model, the transcript for Session Two was reviewed to identify Events having positive relevance to the Rational Model. Three were selected; Challenges Thirteen, Seventeen and Eighteen. The rationale for these decisions are summarised here:

- Challenges One to Six

These Challenges had a there-and-then quality; they reported Jane's experiences in the previous session. They were not selected for this reason.

- Challenge Seven - *"God you pick up every bloody word"*

In this Challenge, their *"fight"*, in the client's words, began; and continued the *"power struggle"*, in the therapist's words, of the previous session. This marked the start; events being selected for their informing resolution.

- Challenges Eight to Ten

Little or no resolution was evident in these; they had a 'tit for tat' aspect. In each of the three Challenge Markers the client simply reacted against the literal content of the therapist's preceding intervention.

- Challenges Eleven to Thirteen

The immediate session process and their respective contributions were the focus of these three Resolution Events. Jane and the therapist directly discuss their interactions prior to and since Challenge Seven; these Resolution Events were considered relevant to the Negotiation Stage of the Rational Model.

In contrast with Challenges Eleven and Twelve, in Challenge Thirteen Jane explicitly located the start of this *"fight"* in the therapist *"taking her up on the use of the word trog"*, the intervention that immediately preceded Challenge Seven.
It was considered that there may be a quantitative difference in the Negotiation represented in the three Challenges; if some Negotiation had taken place in Events Twelve and Thirteen maybe more and different hypothesised Negotiation activities would be evident in Event Thirteen? Challenge Thirteen was selected for intensive analysis.

- A minute's silence separated Challenges Thirteen and Fourteen.

- Challenges Fourteen to Seventeen

Challenges Fourteen, Fifteen, Sixteen and Seventeen then concerned the client's difficulties regarding the immediately previous process between them; the client feeling that she'd *"dug a hole"* (Fourteen) and their silence (*"are we going to keep quiet for the next 45 minutes"* (Fifteen); *"I just didn't know what the norms were"* (Sixteen). Of these Challenge Seventeen was selected for observation. In this the client most directly related these difficulties in the therapeutic situation to the therapist's activity; this suggested a closer relation with their *"fight"*. In addition the precursors to Challenge Eighteen (see 6.3.5) suggested that Challenge Seventeen may represent the Exploration stage.

- Challenge Eighteen

Challenge Eighteen was selected on the basis that it contained explicit evidence of successful resolution.

6.4 Preliminary Intensive Analysis

6.4.1 Introduction

The three Resolution Events from Jane's second session are intensively analysed here. Transcriptions of the three Resolution Events are presented to demonstrate the applicability of the Rational Model. Thus, the intensive observation can be thought of as transcript-driven and Rational Model focused. Analytic commentaries are embedded within the transcriptions of the three events. These commentaries meet the aims of the analysis: they demonstrate the applicability of the Rational Model to

the session material; they demonstrate the researcher's close observation of Challenge Events occurring in clinical practice and they comment on the representativeness of the excerpts of Exploratory practice.

Complete transcriptions of each of these events will be presented, with each speech unit labelled according to whether spoken by the client (C) or the therapist (T) and numbered to indicate its position within the session (within which there are 324 speech units).

In common with the Rational Model's stages, 'stages' of resolution activity within each of the events are identified in the analysis. Stages are signified by activities seeming to be moving towards a common, microlevel, goal; when the goal shifts a further stage is identified. For example, the researcher identified nine distinct stages in Challenge Thirteen. The therapist's immediate response to the client's Challenge is, in all three Challenges, identified as the first of these stages and titled accordingly; 'Immediate Response'. The remainder of the stages are titled according to the researcher's understanding of the primary goal to which the component activities are directed.

Whenever a consistency between the session material and the Rational Model is observed it is indicated. These indications take the form (Negotiation: IIiii). In order that the reader can refer in parallel to the Intensive Analysis and the Rational Model a duplicate of the Model proposed in Chapter Five (5.4.2) is included in Appendix 1.

Each of the three Resolution Events is examined in turn and the verbal commentary summarised in a table. The present tense is used in the analyses to indicate the active, ongoing engagement with the transcript's 'data' during its analysis.

6.4.2 Applicability of the Rational Model to Challenge Thirteen

Client Marker for Challenge Thirteen

C113: It feels at the moment that we got into an unnecessary fight, which perhaps I started by overreacting when you took me up on the use of the word trog and I think I can't be doing with it if we're going to play, not play, engage in that sort of communication. Which is why I said OK I'll talk in precise English language

In the Challenge Marker the client makes a current Challenge; *"I think I can't be doing with it"* and reports the precursor to a previous Challenge -*"when you took me up on the use of the word trog"* - Challenge Seven. Her description of their process for the first time reflects it's severity; whereas in Challenge Twelve she had referred to their current difficulties as *"unnecessary hassles"*, in Challenge Thirteen she refers to them as an *"unnecessary fight"*. Given Jane's typical use of minimising language this is significant shift.

Components of the Negotiation (II) Stage are also evident in the Client's Challenge Marker. The client provides her understanding of the in-session origins of their *"fight"* (the therapist drawing attention to her use of the word 'trog') (Negotiation: Iii); explicitly takes responsibility (Negotiation: Iiii) for her contribution to this, *"which perhaps I started by overreacting"*; and explains the consequences of both for her behaviour in making Challenge Ten; *"which is why I said I'll talk in precise English language"*.

Stage One: Immediate Response

T114 Which was a very aggressive thing to say

C115 Yes. It was meant to be

The therapist's immediate response to the Client Marker takes up her reference to Challenge Ten and *"precise English language"*. Doing so returns the focus to Jane's words and their influence on the process between them. This, in combination with his negative evaluation of them as aggressive and the sharpness of his tone, leave the client again feeling attacked. As in Challenge Ten when the client said she was *"firing back"* at him (for *"picking up"* her use of *"trogging"* by saying she'll talk in *"precise English language"*), the therapist here is 'firing back' at her. The client confirms the 'aggressiveness' (C115) in her tenth Challenge. In doing this, and unlike the therapist, Jane validates her felt-need to make Challenge Ten. The therapist's Immediate Response here is more invalidating than validating.

The Rational Model is not applicable to this interchange, which is more threatening to than facilitative of the resolution process.

Stage Two: Acknowledgement

T116 Sure, sure

The therapist backtracks; he acknowledges (Acknowledgement: I) the intention behind her *"precise English language"* Challenge. The therapist's acknowledgement is insistent but inexplicit. In contrast to the reasoning behind the Model's Acknowledgement (I), his acknowledgement is to the intentions and not the feelings underlying the tenth Challenge.

C117 You know

Stage Three: Exploration in-session

T118 If you don't like me the way I am, I'm going

C119 Yeah. Bit arrogant of me but yes

T120 Yeah right.

T121 [14] Um. Guess that's important

C122 [6] Well I think so. Sort of central really

T123 Umm

T124 [10] To do with what it means to you to come for help

C125 Yeah

T126 And maybe expressing something which starts with that but goes beyond it to feeling alone and feeling unloved

C127 Umm, yes it's all linked

T128 Umm

The therapist continues to focus on her tenth, rather than the current, Challenge by exploring its meaning (Exploration: IIIii). The therapist's movement from Acknowledging to Exploring is consistent with 'working' in Exploratory therapy but neither the resolution process nor their therapeutic work are advanced here. The style of his exploration is 'closed' rather than open. He presents Jane with his understanding and seeks her evaluation rather than exploration of this. His understanding is painfully accurate for the client; she described similarly insightful but painful contributions in their previous session as the therapist *"looking at it between the eyes"*. The client's engagement is intellectual and her contributions minimal. She simply acknowledges the therapist's understandings; she 'treads water'. In the context of her Challenge and the therapist's Immediate invalidating Response, Jane's lack of engagement suggests that his all-too-accurate understandings are insufficiently supported for her to accept and work with and therefore premature.

<u>Stage Four: Pause</u>

There is a 14 second pause

<u>Stage Five: Negotiation</u>

T129 So when you said it was partly of your own making, the unnecessary hassle, maybe that's saying well it's quite, it's an important thing to look at and maybe if we can understand it a bit better, far from being unnecessary it might help us with some of your problems

The therapist ends their 14-second silence by directing their attention back to the client's experience and understanding of their process this session (T129). He uses Jane's words to describe her experience of *"unnecessary hassle"* and her understanding of this being *"partly of her own making"* in a process direction to Negotiation (II). The direction makes explicit the value of their understanding the

sources of her Challenges for their work together; this is followed by Jane's minimal acknowledgement.

C130 Umm

T131 [4] But of course there are going to be times when I say things that aren't, talking about absolutely correct English, absolutely correct psychotherapy

The therapist follows the direction he's set out; he successfully facilitates Negotiation. Firstly (in T131), he indicates his responsibility in originating her dissatisfactions (Negotiation: IIiii). Again using the client's words (*"absolutely correct English"*) he makes the strongest expression of his responsibility. In her next speaking turn there is relief in Jane's laughter as she affirms his responsibility (C132).

C132 Yes (laughs)

T133 Right

C134 Oh yes

In T133 and C134 his responsibility is consensualised (Negotiation: IIiv).

T135 And er if you feel I'm demanding of you, I guess you're demanding of me too

C136 Yeah

T137 And part of the problem, you know the problem that you're expressing about being in the client's chair is one which, in a way, mirrors one that you're going to create for me, which is that I'm working with someone who knows what it's like to be in my chair

Secondly he expresses his understanding of the dynamics of their working together, which the client affirms (T137; C140); responsibility is implicitly shared (IIiii). Consistent with the Exploratory Model he uses personal, 'I', and then mutual 'we' language to do this.

C138 Umm

T139 So in a way what we're up against is a kind of

C140 (Over T) Which I fear may make me harder on you

T141 Yeah, right, of course

C142 So that's why I say of my own making

The client expresses her understanding of *her* contributions to these dynamics, thereby implicitly accepting responsibility for her role in their relationship (Negotiation: IIiii). Her understanding both confirms and consensualises the therapist's and explains her previous reference to their *"hassles"* being of her *"own making"* (Negotiation: IIii).

This Negotiation was opened by a means different to that hypothesised in the Rational Model. Rather than invite the client to provide her understanding (as hypothesised), the therapist states (T129) the value of their enhanced understanding to their work. This is a statement of what the Negotiation will potentially achieve; it is not a direction to a specific activity. The Rational Model had hypothesised the value of Negotiating Challenge origins as a Closure activity.

Both the Negotiation stage and its components and the dialogue of Exploratory therapy are closely represented in these interchanges. Consistent with the endpoint hypothesised in the Rational Model, they achieve consensualised understandings of their roles and responsibilities for their in-session difficulties. The therapist is more active in the negotiations than the client; her contributions are nonetheless significant to the achievement of consensus.

How this consensus was achieved here evidences consistencies and inconsistencies with the Rational Model: The value of Challenge Resolution was hypothesised to constitute part of the final stage of resolution (Closure); here it represents the opening to their Negotiations. In addition, at this point in the resolution process, it is the value of their negotiations for their work together which is highlighted (not its value to either their relationship or Jane's relationships outside therapy). Here, negotiations were opened by the therapist's process-direction stating what the Negotiation will achieve; this is hypothesised as part of the Closure (IVii) to resolution. In the Model, Negotiations proceed from the therapist's invitation (cf direction) to the client to present her understanding of what in the session has originated her Challenge. The process-direction can be considered less tentative and less open than the invitation.

Consistent with the Rational Model, both therapist and client present their understandings of what has been happening between them during the Challenges of this session and these understandings concern their roles and responsibilities. Consistent with the Exploratory Model but absent from the Rational Model, the therapist first accepts his responsibility for his contributions to their difficulties. The client then does the same. Likewise consistent with Exploratory therapy but not specified in the Model, the therapist uses the client's language in expressing his understandings and accepting his responsibilities.

Stage Six:Renegotiation

T143 Yeah, yeah. But it feels what we're up against is a pretty fundamental issue about how, how we can establish a kind of, a kind of mutually respecting relationship in which we er, in which each of us can be themselves.

C144 Umm

T145 And not hassle, unnecessarily it seems, by the other person making these demands that we somehow be perfect or rather as they want us to be

C146 Umm

The therapist uses their consensualised understanding to extrapolate conditions for their future work (T143; T145). Using the mutual 'we', he expresses his understanding of the ways in which they need to relate with one another in order not to re-experience the difficulties expressed in Jane's Challenges. Jane acknowledges his suggestions.

The therapist Renegotiating (IVi) in this way was proposed in the Rational Model but scheduled differently. It was proposed as one of the components of the final, Closure, stage of resolution. Jane accords with the therapist's suggestions but does not contribute actively to the renegotiation of terms for their relating.

Stage Seven: Linking out to Explore in

T147 And the almoner wants you to be a lady almoner and your mum wanted you to be all sorts of things (Umm) and maybe you feel that I want you to be things too

C148 Yes I haven't worked the latter one out yet but the lady almoner and my mum (Yeah), um,

The therapist uses their consensualised understanding (Stage Five) to explore further the client's experience of their relationship. The therapist links his understanding of the demands they have placed on one another in the session to those placed on the client by her boss and mother; this is Exploration and Explanation (IIIii). This is consistent with the movement from Negotiation (II) to Exploration (III) hypothesised in the Model. The client confirms but does not explore the link.

Stage Eight: Silence

There is a minute's silence

Stage Nine: Here-and-now

T149 [60] Are you still feeling angry?

The therapist (T149) ends the minute's silence by returning to the here-and-now of the therapeutic relationship. This is the therapist's final attempt in this Challenge

event to further associated exploratory work; it is consistent with the Rational Model's Exploration (IIIii) stage.

C150 Um?

T151 Are you still feeling angry?

C152: I'm feeling ten-, very tense now, thinking now, how does one, how do I dig myself out of that hole (laughs)

Were the client's manner confrontational in her response (C152) it would have been identified as a Confrontation Challenge. It is not; her manner is deflated and resigned as she describes herself as *"no longer angry but tense"*.

T153 Out of the hole of

C154 That I feel I've just dug myself into

T155 Can you say a bit more about that, I'm not quite sure what you mean

Client Marker for Challenge Fourteen

C156 Um (C sighs). I'm not feeling angry now (UhHmm). As much as one can that has now been replaced by feeling fairly tense, thinking, right, where do we go from there, I feel as if I've dug a hole

The therapist does not understand the client's response to his here-and-now question. His reflection and request for the client to say more elicit her fourteenth Challenge.

Inconsistent with Exploratory therapy the therapist uses and repeats a direct question to access the client's feelings in the here-and-now. The client makes her fourteenth Challenge; she is feeling lost and tense.

6.4.3 Summary of Rational Model's applicability to Challenge Thirteen

The table below summarises the analysis above. All consistencies observed between the Rational Model of Challenge Resolution and the resolution attempted in practice in addressing Jane's thirteenth Challenge are reported.

Table 6.2

RATIONAL MODEL'S APPLICABILITY TO CHALLENGE THIRTEEN

Stage in Challenge Thirteen		Rational Model Stage & Components
1	Immediate Response	N/A
2	Acknowledgement	I
3	Exploration in session	IIIii
4	Silence	N/A
5	Negotiation	IIiii IIii IIiv IVii
6	Renegotiation	IVi
7	Linking out to explore in	IIIii
8	Silence	N/A
9	Here-and-now exploration	IIIii

In short the resolution performance following Jane's thirteenth Challenge demonstrates the applicability of the Rational Model to Challenges occurring in Exploratory practice; all four stages proposed by the Model were considered to be evident in this session excerpt. Reference to the Rational Model (see 5.4.2 or Appendix 1) indicates that only two of the Model's components were not observed by the researcher. These were the therapist inviting the client to present her understanding of the in-therapy origins of her Challenge (Negotiation: IIi) and client and therapist exploring parallel situations in relationships outside therapy (Exploration: IIIi). More, however, can be said about each of these stages.

The therapist's Immediate Response was not facilitative of resolution and thus did not demonstrate the applicability of the Rational Model of *successful* Challenge resolution. His subsequent backtracking and Acknowledgement of the Challenge were followed, in Stage Three, by Exploration. Whilst oriented more to the 'work' of Exploratory therapy than to addressing Jane's Challenge to the relationship, this Exploration was broadly consistent with the Rational Model.

After the first silence (Stage Four) substantial Negotiation was observed (in Stage Five). This achieved the Negotiation-endpoint proposed by the Rational Model; a degree of shared understanding of the Challenge's origins. The Rational Model proposed that this Negotiation was opened by the therapist's invitation to the client. As indicated, the invitation was not observed. In the view of the researcher the opening was achieved by a component proposed as part of the Closure stage of

resolution; that is, by the therapist making clear the value to therapeutic work of understanding the Challenge's origins.

Also proposed as a component of Resolution's Closure was Renegotiation of the terms of the working relationship. In Challenge Thirteen Renegotiation was considered to be both a component of the Negotiation (in Stage Five) and to be the primary goal of activities in Stage Six.

The seventh stage, Linking Out to Explore In, demonstrated an unsuccessful attempt at the Rational Model's Exploration, Linking and Explanation stage; a link made by the therapist to Jane's experience of her boss, mother and him was confirmed but not explored by the client. The subsequent Exploration, in Stage Eight, this time of Jane's immediate feelings in relation to the therapist, was similarly unsuccessful and predated her next Challenge.

The applicability of the Rational Model received general support from the researcher's analysis of Challenge Thirteen. Acknowledgement, Negotiation and Exploration stages were identified. The proposed components of the Closure stage were also observed but in service of Negotiation and Renegotiation.

How applicable was the Rational Model to the resolution attempt in Challenge Seventeen?

6.4.4 Applicability of the Rational Model to Challenge Seventeen

Client Marker for Challenge Seventeen

C168 I was wondering how long I was going to have to wait before you threw me the lifebelt (Sure)

This is the fourth of four Challenges in which Jane has expressed her difficulties with what has been happening between her and the therapist in this session; that is, with their immediate process. Essentially she indicated that their *"fight"* which began in Challenge Seven left her feeling she had *"dug a hole"* (expressed in Challenge Thirteen, C154, above) and that the minute's silence (Stage Eight, Challenge Thirteen above) left her uncertain and tense about their direction, *"where do we go from here"*. For the first time, in the current Challenge, Jane attributes these difficulties solely to the therapist's in-session behaviour.

Stage One: Immediate Response

T169 Yeah. But it's hard for you to say help.

In his *"Sure"* during the Client's Challenge and in his initial *"Yes"* after the client has finished speaking the therapist is inexplicitly Acknowledging the feelings underlying Jane's Challenge (I). These acknowledgements are clear but do not explicitly address the feelings underlying Jane's Challenge; what follows to an extent does.

In her Challenge, Jane had focused on the therapist's behaviour (him not providing a *"lifebelt"*); he focuses on hers (her not asking for help). His immediate response is most consistent with Negotiation (IIiii); he expresses his understanding of Jane's contribution to her difficulty with his behaviour.

Consistent with the principles of Exploratory therapy, the therapist responds to cues in Jane's language; her *"lifebelt"* becomes his *"help"*. Less consistent is the *"but"* with which he presents his understanding; this sets his understanding as an alternative to, rather than an addition to, the client's.

As hypothesised, these initial contributions are broadly consistent with the Model's Acknowledgement (I) and Negotiation (II) stages.

Stage Two: Exploration in therapy

C170 Yes.

Jane (C170) affirms but does not extend the therapist's understanding.

T171 Umm. Maybe that's some of the trap you're in, that it's hard for you to ask for help.

The therapist continues to explore her Challenge (T171) in terms of its general meaning for the client; again the client agrees but does not engage with the exploration.

C172 Oh yes

T173 You know going back to last time

C174 Yes, oh yes

T175 Um and it sort of, OK you get here and that's been a tremendous struggle and having got here, if we get into a silence, to ask for a lifebelt at that point is asking for help yet again

C176 Yes, yes

T177 As if somehow you need to know what the norms are in order to be able to pass as competent, and you need to be able to be competent because if you're not competent, ahhhh! (Can't hear, Yeah, Yeah). That's very scarey.

C178 Umm

Using Jane's language, the therapist makes concrete and current his exploration. He locates his understanding firstly (T175) in their previous session (in which the client

felt the therapist not recognising the 'tremendous struggle' coming to therapy had been) and secondly (T177) in the content of the previous Challenge ('I didn't know what the norms were'; Challenge Sixteen). The client continues to acknowledge but not to engage actively with his exploration.

T179 But I guess what I feel about that is at some level and this is where, there is where maybe it is frightening for you, you know really deeply terrifying for you, is that that helplessness is something very powerful that you do feel. It's somewhere locked inside actually

C180 Yes, oh yes and like I was saying last week it will sometimes leap out and will (Um) result in panics and tension (Um), whatever, yeah

Following the therapist's explicit recognition (T179) of Jane's difficult feelings about being in therapy she engages and, as the therapist has, she refers to their first meeting.

C181 And I can't help feeling that that's sort of how, you know, talk about the next 45 minutes is like can I, can I get through this without, without going to pieces. Without getting so upset that I can't walk out of the door

C182 Umm

T183 And I guess that's the risk

C184 Oh yes

T185 That's the risk for you, that you're kind of, you know, you're poised to take in a way

C186 Oh yes that's right, that's right

Largely through the therapist's exploratory efforts, in which he uses Jane's language to express his understanding, client and therapist are able to consensualise an enhanced understanding of the origins for the client of her Challenge in particular (Negotiation: IIiv), how this relates to her being in therapy in general and how this relates to the immediate here-and-now of the session.

<u>Stage Three: Silence</u>
There is a 26 second silence

<u>Stage Four: Renegotiation</u>
T187 And I suppose one of the first requirements for that was, is probably to feel that you are accepted here and are not going to feel attacked and criticised. And that when you know, you know that I'm not going to be intimidated or repelled by the mess inside you

C188 Umm

T189 Cos then you really are on your own

C190 (Laughing) Yes, yes

Their understanding of the feelings underlying the client's Challenge consensualised in Stage II above, the therapist explores its implications for the way in which they relate in their work together (T187). This Renegotiation-acitivity was hypothesised in the Closure (IVi) stage of the Model. The therapist makes vivid the consequences of their interactions failing to meet these requirements. He sets the requirements for their future work in the context of a core fear they identified in the first session, Jane feeling alone. Laughing nervously, Jane affirms his projected consequences.

Stage Five: Silence
There is a slience of 46 seconds

Stage Six: Exploration in therapy
T191 And maybe one of the things too is that this is all too kind of stark somehow, this way of talking about it

After a 46 second silence, the therapist continues with his focus on Jane's experience in the sessions (Negotiation, II); he presents an 'informed guess' of a possible difficulty, therapy's *"starkness"*. The terms of this understanding hypothesis are responsive to both Jane's Challenge and their immediately preceding interaction; his reintroduction of Jane's fear was *"stark"*.

C192 Umm. Yes I think that was an initial reaction and one from last week as well but then I also think, well what's the point of beating around the bush, so if it's there it's there (Umm). It's been identified so you know (Umm). It's part of my unnecessary hassle I think, at (Um). Um, so OK yes it might make me wince when two or three succinct lines you sum it up and I'm not being rude to you, you sum it up and I think ouch, yes, but OK, ouch yes

In C192, Jane also Negotiates; she confirms and presents her understanding of this difficulty with their process (Negotiation: IIii). She refers to interactions in both the previous and the current sessions.

T193 You can stand the pain and then what happens? After the ouch?

C194 After the ouch, um, I think as far as I can say anything then yes, and what am I going to do about it?

T195 Umm, Umm, Umm

C196 You know, there's no point in sort of what? After a while the ouches become sort of self-defeating don't they? (Um) So you either learn to live with them or (Um) no-one takes any notice or you do something about it (Um). So I don't think the er, starkness puts me off. Perhaps I'm getting conditioned to some of it by doing that questionnaire every night, no every other night. And there's all those identified things written down. Does focus your mind.

T197 Umm

C198 Being serious you know, it does, to go through all that

Both engage in understanding Jane's experience of the accurate but painful understandings that have contributed to her difficulties in the sessions. In doing this, Jane extends their shared understanding of her Challenges, which the therapist and then she continues (Negotiation, II). Jane relates the starkness of the sessions to the Personal Questionnaires she is required to complete each day in between the sessions.

Stage Seven: Exploration out of therapy: Boss and Mum

T199 Umm. Well I wonder, maybe if we take a different tack and say well let's look at what we were talking about last time at some length about the lady almoner, that's what I named her, she must have a name

The therapist (T199) shifts the focus away from the client 'talking rationally about' (C196) therapy's starkness and her experience of the research requirements associated with being in therapy. He directs the client to explore links between her experiences of her boss and her mother. This is largely consistent with the Model's Exploration (III) stage but the direction to explore is not explicitly set in the context of Jane's Challenge.

C200 (Over T) She is (laughing), she's a lady almoner as opposed to a social worker

T201 Um, and the link with your mum (Um)

C202 Umm

T203 I wonder if that makes sense to you, whether, as if, as if when she's, when she's been in way blackmailing you and controlling you, I wonder whether what you feel is like your mum on the phone

C204 There are certainly um, there are certainly elements yeah. And she's been doing it very well this week but perhaps we'd better not digress but yes (laughing) (Yes, yes). It's been the feelings there, they've been kept alive

Jane (C204) accepts the parallels and confirms the link by recalling a situation with her boss from the week in between the sessions (Exploration: IIIi).

T205 And when you and when you feel angry and frustrated and helpless with her, it's a bit as if it's your mum that was doing it

C206 There's certainly an analogy there (Umm), yeah, and in fact when she did me over this week I was quite interested as to how I reacted cos I was furious and yeah, went back to my office. But it, it was the not being in control bit. And also thinking that I'd been done a great injustice by the wretched woman (laughing) (Umm). Yeah, er,

Consistent with Exploration, the therapist makes explicit and Jane confirms the feeling links between the two relationships with her boss and mother; this is Exploration (III).

Stage Eight: Silence

There is a shorter, 9 second, silence

Stage Nine: Exploration out of therapy: Mum and Boss

C207 And not being able to be honest which I think also one can link with one's mother. Um but as well as being angry I wished I'd confronted her with what she was doing cos she was being excessively devious and I didn't want any truck with that (Umm). Um, and that has certainly sometimes been the spiral one has got into with er mother

In their exploration of parallels, Jane begins (C206, C207) to attends less to her boss and more to her Mum (Exploration: IIIi).

T208 Wishing you could point out what's going on

C209 Yes. Yeah very much so cos you know, it used to get me, to say the least it used to get me (laughing), (Yeah)

T210 And so that's something you've not been able to do with mum, to point out

C211 No because on the occasions when I've, I've tried, um, and it links in with the lack of er, sort of er, feeling and affection bit (Um) that we got onto last week (Umm, Umm). On occasions when I tried she would say oh you're always far too clever

T212 Um, right. Rejection

C213 Put down

T214 Yeah

C215 And so avoided that way (Umm), which after a while one just said, sod it (Umm), I'll just you know (laughs) batton down the ears (Yes), um

T216 So you've not, yes, you've not, you've not been able to repeat that, it's just too painful when she does that

C217 Yes it's both, both very painful and it's, it's the analogy that you were talking about earlier of here, you know, on the side of the swimming baths is the one I'd use and deciding whether to dive in or not

T218 Yeah right, I was, nearly said that, I thought no I won't give you my language (both laugh), I thought I'll wait for yours. Right I was almost, I was almost going to, I was nearly, I was almost going to do this you know

C219 I always do belly flops but yeah (Yes) (both laugh), you know

T220 And that really hurts, in the middle (Yeah) (both laugh), yeah. Right

C221 Um, you know, with her, um, of whether to take that risk but also too, if someone cuts out on you that way, especially if it happens to be your mother with all that emotional agenda around, what can you do. And after a while, um, I've given up trying. You find, you find your middle ground don't you (Um), um and you know how much reality can you take. It's how many layers of the onion (Um), and er, ditto with the boss. Though it still leaves me with great, you know, great feelings of irritation (Um, Um), frustration etcetera, which I would subtitle sludge in one way but it's not very helpful, but it's still there (UhHmm).

Through exploration and linking, and the client's reintroduction of a metaphor from Session One and the therapist's empathic response to the metaphor, they explore Jane's repeated experience of being *"put down"* by her mother. Jane makes explicit

this pattern in her relationship with her mother and then its link with her boss; this is consistent with Exploration (IIIii). The link back to her difficulties being in therapy, expressed as she did in the previous session as *"peeling off layers of an onion"*, is not as explicit but is also consistent with Exploration (IIIii).

In this Exploration, Jane (C217) uses the metaphor for being in therapy which the therapist had introduced in their first session; *"taking the plunge into the swimming pool"*. That is, Jane uses his language to explore her feelings. The therapist's immediate response (T218) to this is to disclose that he had, at the same moment, taken the decision not to present his words but to wait for Jane's. Implicit in this communication is the therapist's responsibility for having *"picked Jane up on her use of the word trog"*; this is a component of the Model's Negotiation (IIIiii) stage.

Consistent with the Exploratory therapy rationale, the metaphor extends their understanding; consistent with the Rational Model, links with relationships outside therapy are Explored (IIIii).

<u>Stage Ten: Linking back to in-session process</u>

T222 Well I wonder how what's happened today ties in with that, what's happened between us

The therapist brings these parallels back to their in-session process (Exploration: IIIi).

C223 [4] Sorry you've got me, please expand (laughing)

T224 (laughing) I'm sorry, yes, I, I

His linking (T222) is obscure to Jane. Both acknowledge (with their laughter) this irony as Jane asks for clarification and the therapist apologises (T224). Jane does not wait for his clarification:

C225 (Over T) We had a fight

T226 Yeah, right, OK

C227 Um, Um

T228 I wanted you to expand, not me (Yeah), because I (OK) want to know how you feel about it

C229 But, right, right. Yeah. A fight which I think has, for me, cleared some of the air and I'm now beginning to feel more relaxed which is pleasant, um, perhaps clarified a few things, and begun to come up with an agenda which at this moment in time I cannot remember because something else came in. Um, sort of at the end of the first silence (Umm) when I was in my corner so it feels as if a variety of things have gone one (UhHmm), um, really

Jane continues (C225) to address the therapist's process-direction by presenting her understanding of their process in the current session. The therapist continues to explain his process-direction (T228).

T230 But at a basic level there's a kind of question was it worth it, like we got into a fight

The therapist responds to the client's description and positive evaluation of their process with an out-of-mode *"but"* followed by a direct question (T230). This is the precursor to the client's final Challenge of the session, which is presented below. Challenge Eighteen and its resolution ends with the session end (at speech unit numbered 234).

The therapist's link back to the therapeutic situation focuses on Jane's understanding of their in-session process; this she expresses as their having a *"fight"*. Understanding Challenges' in-session origins is proposed in the Negotiation stage (II) of the Rational Model. The therapist's response, his request that Jane evaluate their *"fight"*, precedes Jane's final Challenge in the session.

6.4.5 Summary of Rational Model's Applicability to Challenge Seventeen

The table below summarises the analysis above. All consistencies observed between the Rational Model of Challenge Resolution and the resolution attempted in practice in addressing Jane's seventeenth Challenge are reported.

Table 6.3

RATIONAL MODEL'S APPLICABILITY TO CHALLENGE SEVENTEEN

Stage in Challenge Thirteen		Rational Model Stage & Components
1	Immediate Response	I IIiii
2	Exploration in therapy	IIIii IIiv
3	Silence	N/A
4	Renegotiation	IVi
5	Silence	N/A
6	Exploration in therapy	IIIii
7	Exploration out of therapy	IIIi
8	Silence	N/A
9	Exploration out of therapy	IIIi IIIii IIiii
10	Linking back to in-session process	IIIii

The Rational Model's applicability to Challenges observed in clinical practice was generally supported by the intensive analysis of Challenge Seventeen. All stages of

resolution proposed by the Rational Model were represented in the researcher's analysis, with the Exploration stage predominant among the four.

Exploration was considered to proceed from the therapist's Immediate Acknowledgement of the Challenge; the Exploration was responsive to the Challenge. Jane's Challenge had attacked the therapist for not having provided her a "lifebelt" during a minute's silence; the meaning and feelings associated with Jane coming to therapy for "help" is the first focus of Exploration.

The Rational Model proposed Negotiation to follow a client's Challenge and Exploration to follow this Negotiation. Whilst, in Challenge Seventeen, Challenge-related Exploration immediately followed Jane's Challenge, it was accompanied by proposed Negotiation components: Early on, in Stage Two, Exploration was accompanied by a consensualised understanding of the in-therapy origins of Jane's Challenges. Later, in Stage Nine, Exploration was accompanied by the therapist recognising his having contributed to originating her Challenges. Both were proposed as significant steps in Negotiating a consensualised understanding of the contributions of each participant to Challenges.

Consistent with the Rational Model, later in this resolution attempt parallels with relationships outside therapy were explored. Their linking back to explore in-session Challenge origins prompted Jane's final Challenge; how did this add to the Rational Model's applicability demonstrated in Challenges Thirteen and Seventeen?

6.4.6 Applicability of the Rational Model to Challenge Eighteen

Client Marker for Challenge Eighteen

C231 (Over T) I think it was very necessary because otherwise and that was why I said to you I'm sitting here thinking well shall I go now (Umm, Umm), cos I thought Christ you know, I cannot go through this each week if this is what it's going to be like (Of course). Now it may be my fault but I'm not into it (Umm). And I'll go (Umm, Umm). Just keep taking the pills or something

In Jane's final Challenge she makes explicit the severity of her difficulties in the present session; having felt unable to continue with therapy and having wanted to leave the session.

Stage One: Immediate Response

T232 Sure, right.

Throughout Jane's Challenge and immediately afterwards, the therapist's Acknowledges the sentiments she is expressing. Consistent with the Rational Model his Acknowledgements (I) are immediate, emphatic and uncluttered. However, they

do not explicitly respond to the content of and feelings associated with the Challenge; in this sense they are more a simple acceptance than an explicit understanding of the Challenge and its origins.

C233 So I think it was a necessary altercation

In contrast with the therapist's questioning (T230), the client reinforces her positive evaluation of their fight.

Stage Two: Contrasting in-session process with extratherapy pattern

T234 Umm, and expressing something which does reflect quite closely things that happen with you in other relationships. And the options were there. The option of leaving was certainly there. The option of not, of not bothering to mention it was also there but fortunately you didn't pursue that option, you were determined to say something about it I guess. Were you?

The therapist reiterates the links they established between their *"fight"* and Jane's relationships with her boss and mother, and points out positive differences between their in-session process and patterns in these extratherapy relationships. He asks Jane to spell out how she understands her contibutions to these positive differences.

C235 Oh yeah

T236 Like you, you planned when you came in you were gonna say some of this, yeah

C237 I'd certainly planned that when I came in I thought if you'd said to me as you did you know, how did it feel after last week, yes I'd thought of that (Yeah right), and given that some of it was fairly critical (Yeah right). Um (Sure), yeah

T238 And maybe the

C239 (Over T) Not in terms of let's put the boot in on the therapist, but you know (Sure), say what it feels like

T240 Yeah

They establish an understanding of the way Jane has related with the therapist in the session. This builds on the work of Stages Seven and Nine in the previous Challenge (Seventeen), in which differences between the client's way of 'fighting' with the therapist and her way of avoiding similar with her mother were explored. Here, at the therapist's request, the client makes these differences explicit. The client's ability to make constructive relationship changes, proposed in the Closure (IV) of the Rational Model, is implicit.

Stage Three: Silence

There is a seven second silence

Stage Four: Further contrasting in-session process with extratherapy pattern

T241 And in a way the effect of doing that, I mean what you're, you said that you felt it cleared the air and you (Yes) felt more relaxed (Yes). As if you'd been able to say this thing and it it hadn't, things haven't gone terribly wrong

C242 Um yeah, cos well unlike those two examples I gave where you know, you didn't do er certain responses of other people

T243 So I didn't act out like your mother in the end

Client and therapist contrast the consequences of the resolution process in the session with the therapist with the client's extra-therapy pattern with her mother (C242; T241; T243).

C244 No mercifully

T245 Although perhaps I might have done, you might have been scared that I might

C246 Yeah but I think I would have been surprised (laughing)

T247 Sure but that's you with your rational, professional hat on (Um), I think at an emotional level er

C248 (Over T) Yes there is, there is always the

T249 (Over C) The fear that this will happen

C250 Yeah I was gonna say the danger, yeah, yeah

T251 Danger, fear, yeah. I suppose I'm wanting to put it in, really in terms of feelings rather than probabilities, you know (Um). Fear is what you feel, danger is what could happen

C252 Yes, yes

Again, the differences in process and outcomes between the client-therapist relationship and the client-mother relationship are confirmed by both client and therapist; this is consistent with the Closure (IV) stage.

Stage Five:Therapist accepts responsibility for his contributions

T253 And er. Yes, it's quite clear to me now, I think, that er, a lot of the time, last week your, some of your basic feelings were not recognised

C254 Umm

T255 And er, so you had a, you came this week (C laughs) with a legitimate protest

C256 Well

257 [6] I wanted to get over to you, to try and make you understand, yes (Um)

More explicitly and emphatically than previously the therapist validates the reality of the in-session origins to Jane's Challenges. By implication, consistent with the Negotiation stage, he is accepting responsibility for his actions having contributed to

these (Negotiation: IIii). However, in contrast with the Exploratory Model, he does not explicitly 'own' these statements. His language is passive and he does not make personal 'I' statements in respect of these actions.

Stage Six: Confirmation of Challenge-origins indicating a recurrent interpersonal pattern

T258 [4] And it's something to do with the two, well, at least two levels really, at which you present yourself, coming across. You know can I get both messages or am I, am I going to be kind of, am I just going to tune into one

The therapist's contributions to the client's Challenges consensualised (Negotiation: IIiii), the therapist (T258) and client (C260) explore what the Challenges reveal about the origins and maintenance of the client's recurrent interpersonal difficulties (Exploration: IIIi); this move is consistent with that proposed in the Rational Model.

C259 Yeah

T260 And er that's very hard, that must be a recurrent problem, when it comes to meeting people for the first time. What level are they going to take you on

C261 Yes, um, and in the main, I'm going through what people say, they, they take me on the, the competent, confidence (Um, Um) level. Which I think we probably all do to each other, but for me it's turned out to be a bit sort of unfortunate, um

T262 So yeah it seems like the distance is somehow too great, that if they take you on that level then the rest of you is somehow really pushed right out of the picture

C263 Yes, yes, perhaps that is it, 'cos on occasions when I've been with people and might have made a comment or they might have said something to me. Like you know, oh you chair this meeting, that's my usual joy (Um), er know you can do it (Um), you're competent (Um). I might partly in jest but not, say well you know I'd rather not (Um) and they're surprised if the conversation then goes on, if people have heard it and they want to hear it and they'll say well, why not and I might give them some explanation about really you know, a) I loathe it and b) I'm not as confident as that may seem and then you get messages back, oh you always appear to be, whatever (Umm, Um, Um). And um

The client actively engages with the therapist in the exploration of the recurrent interpersonal pattern; this demonstrates Exploration (IIIi). By referring to situations outside therapy she confirms both the pattern and the difficulties it brings her (C261; C263). Both therapist and client express her interpersonal difficulty in terms of the way in which the client's way of presenting herself is perceived by others.

The way in which the therapist frames this exploration is consistent with the Exploratory Model; he relates it to the future of the therapeutic relationship and expresses it in terms of the ways in which they relate together.

Stage Seven: Role of the client's way of relating in the pattern

C264 [4] I don't know how to unlearn the confidence bit and all (Quite) and you know, therefore go about drooping, that is the wrong word but you know what I mean, how much do I undo that (Sure). Therefore how many of the dominoes do you knock down

The client makes explicit her understanding of how her learned way of relating contributes to maintaining the difficult interpersonal pattern (C264).

T265 Quite, quite

C266 And I think I'm quite cornered there

T267 Um absolutely, this is the corner, this is the, that this is a way of being, a way of, I don't know maybe it's been, a way of being recognised and appreciated, is this how it started perhaps. Which has somehow taken, it's somehow taken the wrong turn, it's got too predominant or something

Consistent with further understanding the contributions of both participants in originating the Challenge (Negotiation: IIiii), this discussion is however abstracted from the immediate here-and-now.

Stage Eight: Exploration and Explanation of the pattern's origins

C268 Um yes I think so, in that in a way quite by chance, though you could say that nothing is by chance, um, got involved in fairly public things (Um) and once you're on that particular (Um) conveyor belt, you know, other things come along and you, you taken on board, I take on board, I took on board the behaviour to deal with it (Umm), er

T269 But maybe that goes back to mum in some way, does it, about, the demand to be competent and professional

Client (C268) and then therapist explore the origins of the client's learned way of relating Consistent with the Rational Model, the therapist first (T269) locates this exploration in terms of the dynamics between the client and her mother (IIIi).

C270 Oh yes, and er that I should succeed (Umm), um

T271 And maybe if you were successful enough you'd get some of that love that wasn't forthcoming

C272 I hadn't thought of it that way. Yes I suppose it's a possibility. Or certainly um,

C273 [6] You're meaning if I was successful I would get some

T274 Umm

C275 Agh

T276 You were thinking something different

C277 I was thinking her more calling the tune, er

T278 Sure, she's calling the tune but why do you follow. You follow because you're desparate for that contact, that affection which you said last week were lacking (Yeah) in your family (Yeah). So you struggled to be successful in order somehow, if you give her what she

wants then maybe you'll get what you want, but, but the tragedy is that, that what this has led to has been a way of being which actually in the end prevents you from getting the affection because you are somebody who somehow doesn't need being taken care of, because you're so competent

C279 Oh right on, yes, yes to the latter bit, I'm not

T280 (Over C) So, so, you're not sure of the

C281 I'm not so sure about the former bit now, in that, though I don't deny that perhaps, deep down it was there but by the time I came to leave home (Um) I think I'd given up consciously (Sure, absolutely) um, on the um, the quest for affection bit because we had just sparred and sparred

T282 (Over C) Absolutely but

C283 (Over T) And it was a delight to jump on the train and get away

T284 Absolutely, to escape this scene of frustration (Yeah) but in terms of setting you on the track, setting, maybe setting the kind of, you know the kind of aspirations and goals for yourself as a person that you had, you were set up in the service of one set of needs (Umm), um, er in relation to your mum perhaps and, in a way, what what you're left with is, is that you're st-, almost like, it's almost as if you're programmed, you are in a corner because you are programmed by something which is quite autonomous, it's real, you, it was great to get away from home and you wanted to be competent and that's a part of you now

C285 Um

T286 So there's no sense in which you don't, you know, you asked the question should I give it up, well you don't want to do that because it's important to you

C287 Yes and there are chunks of things that I do that I actually do enjoy (Umm, Um), um

T288 But there's the underlying frustration that, there are other things that, you're, you miss, that you're not getting in your life and somehow the painful paradox is that in some way some of your assets actually prevent you from meeting (Um) some of your needs

C289 Yes

From their Exploration, the therapist states clearly his understanding of the reason for the client adaptively learning the 'competent' way of relating (Exploration: IIIii). He understands it deriving from a condition implicit in her relationship with her mother ; *"if you are successful enough I will love you"* (T271). Similarly he states his understanding of how this learned way of relating currently contributes to maintaining interpersonal difficulties for the client (Exploration: IIIii); *"if you give her what she wants then maybe you'll get what you want but the tragedy is that what this has led to is a way of being which actually in the end prevents you from getting the affection because you are somebody who now doesn't need to be taken care of, because you're so competent"* (T278). Through linking with a current extratherapy situation (the client's employment as a successful and 'competent' 'caring' professional), the client partially and wholly accepts these respective explanations; these activities are consistent with the Exploration stage of the Model (Exploration: IIIii).

Stage Nine: Linking to current situations inside and outside therapy

T290 And that is again, in microcosm happened here today. That you know we've been teetering on the brink of that happening, that, that some of your professional, rational, combatorial kind of assets (Umm), right, were almost reached (C laughs), almost led you to the point (Yeah), you know, of saying enough of this I'm not having this, this isn't good enough (Yes) and somehow to come to terms with, accepting what's, what's here, um and accepting a side of yourself that's bringing you here is really very hard. Cos it seems like it's an either or choice, either you're competent or you're not, um

C291 Yes, yes it's where is the middle ground. Yeah

T292 Somehow the middle is empty

C293 The middle is uncertain, um

C294 [6] In that practically speaking,you might think this is a digression, I'm consciously getting shot of some of the good works, as we shall label it (Um), er. Thinking well, you know, where does it get you if you don't enjoy it (Um, Um) whereas at the time, three or four years ago, I think you're quite right, I did it because I always have done it and that was me (Sure). I don't do that now. I think personally that is quite good (laughs) (Umm)

T295 You're less driven by the requirement all the time to do every possible (Yes)

C296 (Over T) Yes, yes at long last, it might have taken a long time but I think I will do more things to suit me, because I want to do them (Umm), which is meaning (Sure) yes, less of the public good works (Um) and more of um time for me (Umm, Sure). So that's what I'm saying it's not totally empty but it's uncertain, I still haven't got the map yet (Umm, Umm), or the picture

287 [5] Yeah the old protestant ethic was working away for many a year (Um)

Therapist and client explore the meaning of this understanding for the client's current situation (Exploration: IIIi). In common with Stage Six above, the therapist's first focus (T290) is on their situation in the session and the therapy (Closure: IVii;) while the client's is on her work situation.

Stage Ten: Value of therapy and encouragement of client

T288 And somehow it's like, what happens in the middle is like bringing together different bits of you (Yes) and er in a way this is about, that yes you know, you're learning, you're finding, you're frightened of going to pieces if you get in touch those messy feelings inside, but another way of looking at it might be to say that er, it's only by getting in touch with them that you can put yourself together, that you're already in pieces. And you've got, you've actually already working on it with your discarding some of the good works and looking to your needs more (Umm) but there's still a sense in which you come here fragmented, in the sense that you're either competent or you're needy

C289 Yes

T290 And in a way what this is about is helping you to put the two sides together, being able to be both of them at one and the same time, being able to be accepted at both levels

C291 Yes

T292 Which is why I did make the point of saying to you last time to you, that I think you do, your resources are important in this in order to enable you to take the risks and the chances

C293 Umm

T294 That you're not the sort of person who is going to go to pieces just because you get upset

C295 Umm

T296 Because you've got too many resources for that

C297 Yes you're probably right (laughing)

298 [14] But I think they have been given a rather fundamental jolt

T299 By

C300 By my reactions over the last year in terms of the (By the, yes) tension, the panic etcetera, and the implications of that (Umm),and there have been times when

T301 (Over C) When you being to wonder

C302 (Over T) Wondering if er (Sure), you know, this time things really were getting out of synch (Umm)

T303 But in fact you've done the competent thing, you've come for help. You know it's in a way it's an expression of the need but it's also a judgement about what to do

C304 Yes, yes in that the competent bit of me is saying sort of enough is enough (Yes, Umm), up with this I will not put (Umm, Umm)

T305 There's some, there's some fine English for you

C306 Indeed (both laugh), yes (Yes)

T307 Umm.

From their consensualised understanding of the origins and current expressions of the client's difficulty, the therapist encourages the client's efforts to seek alternatives. He identifies her current needs, what therapy can do in respect of these needs and her resources for engaging in therapy. This stage and its activities are not represented in the Rational Model.

<u>Stage Eleven: Closing review of session process, understanding and confirmation of benefits</u>

T308 [8] I guess it's pretty well time for today, is there anything else you want to say

C309 Don't think so

T310 It's a different feeling from last week isn't it

C311 Umm, oh yes, (Um), yes. I think it is. And if I had walked out the door I would have felt terrible when I got the other side (Umm). Ah, you've really blown it there, I would have thought

T312 That's right

C313 Umm

T314 I don't know. I don't actually think you were very near to doing that. That was my feeling

C315 I wasn't sure, a bit of me was

T316 Yeah but

C317 (Over T) But it probably wouldn't have carried my legs (No) which is why I thought (over T), right I'll give him a blast

T318 Yes exactly, that's that's what, it was enough to say, um, but again I mean that's like expressing a thing without having to act on it (Umm). You don't have to hide the feeling but you don't have to act on it either

C319 Yeah, yes, yes

T320 And that's great.

C321 Um

T322 No I mean I think that um, I think I recognise the situation when someone is going to walk out and er, I er, didn't think you were. And again that's partly expressing my sense of some of these things, yes it's interesting, because after last time I felt very, I felt, I felt optimistic. I felt that we could get somewhere (Umm), even though I was very aware of some of these things that we've been talking about today and we. You know that we, where we haven't quite communicated, and where you have some reason to be cross. There was a sense as well of it'll be OK (Umm)

C323 [7] Right

T324 OK

Both therapist and client (T310; C311) indicate the positive benefits for their relationship achieved in the session (Closure: IVi). The resulting constructive relationship changes are nonspecific but there is strong indication that they are felt. Additionally Jane expresses relief that she did not act on her earlier feeling of wanting to leave the session (C311). They (C317; T318) express similar understandings of the process at this point in the session (Negotiation: Iliv). The session ends with the therapist restating his recognition after the first session of their *"struggles"*, of his contributions to them (Negotiation: Iliii) and of his confidence that they would, as they have, achieve their resolution.

6.4.7 Summary of Rational Model's applicability to Challenge Eighteen

The table below summarises the analysis above. All consistencies observed between the Rational Model of Challenge Resolution and the resolution attempted in practice as Jane's final Challenge was responded to are reported.

Table 6.4

RATIONAL MODEL'S APPLICABILITY TO CHALLENGE EIGHTEEN

Stage in Challenge Eighteen		Rational Model Stage & Components
1	Immediate Response	I
2	Contrasting in-session with extratherapy pattern	IVii
3	Silence	N/A
4	Further contrasting in-session process with extratherapy pattern	IVii
5	Therapist accepts responsibility for Challenge contributions	IIiii
6	Confirmation of interpersonal pattern identified	IIIi
7	Role of client's ways of relating	IIiii
8	Exploration and Explanation of the pattern	IIIii
9	Linking to current situations inside and outside therapy	IIIi IVii
10	Value of therapy and encouragement of client	N/A
11	Closing review of session process, understandings and confirmation of benefits	IVi IIiv IIiii

Whilst the Rational Model's Closure stage predominated in this Challenge, all other three stages were also demonstrated. The demonstration of Closure-related activities should be seen in the context of this being the *eighteenth* Challenge in the session and this Challenge being made 18 minutes before the end of the session. One of the eleven stages identified in Challenge Eighteen was not proposed by the Rational Model; Stage Ten was titled 'Value of therapy and encouragement of client'.

Components proposed to close the Negotiation Stage were evident in the researcher's analysis: In Stage Five the therapist accepted responsibility for his having contributed to originating the Challenges; in Stage Seven the contributions made by the client's way of relating were discussed; in Stage Eleven their joint contributions and a consensualised understanding of these were indicated.

Components proposed to close the Exploration Stage were also evident: In Stage Eight Jane's pattern in relating with her mother (which had been identified in Challenge Seventeen) was explored and explained and then, in Stage Nine, was linked to current situations in and outside therapy.

Closure's proposed indication of the constructive relationship changes both achieved and achievable by the client was observed in three Stages; Four, Six and Eleven. Explicitly and concretely, the therapist encouraged Jane to articulate differences between her way of relating with the therapist in the present session and her learned pattern of not confronting her mother.

6.5 The extent to which Exploratory practice is represented

6.5.1 Introduction

To be confident that the Rational Model is applicable to events occurring in clinical practice, the session material on which the assessment of applicability is made must be shown to be representative of the particular therapy. Prior to concluding this analysis therefore, the Exploratory therapy excerpted above has to be shown to be generally representative of Exploratory practice. In the analyses above specific, 'out of mode' aspects of the therapist's behaviour were noted; these observations are supplemented by the following commentary. The commentary is pitched at the strategic level; consistencies and inconsistencies with the Conversational Strategies which embody the principles of Exploratory therapy (see 5.2.4) are noted. The therapist's own assessment of his practice in this session, in the form of his post-session notes, is cited to complement the researcher's observations.

6.5.2 Strategy 1: Promoting mutuality

The strategy of communicating the (a) involvement and (b) responsibility of both therapist and client was observed repeatedly and consistently in analysing the three Challenges. Their joint involvement and its mutuality was, for example, expressed in the following therapist contributions (paraphrased to save space); *"you feel I'm demanding of you, you're demanding of me"* (T135, Challenge Thirteen); *"your difficulty is in being in the client chair, my difficulty is that you know what it is to be in my chair"* (T137, Challenge Thirteen); *"what we're facing is a fundamental issue, how we can establish a mutually respecting relationship"* (T143, Challenge Thirteen). During Negotiation, taking responsibility for contributing to Challenges derives from

the Exploratory's emphasis on actions being owned. Both Jane and the therapist did acknowledge their contributions but the therapist's statements of responsibility were not as explicit as they might be. For example, at the close of the session, in Challenge Eighteen, he says of their previous session, *"a lot of the time, some of your basic feelings were not recognised"*; his use of the passive tense indicates less than fúll ownership of his actions in the first session.

6.5.3 Strategy 2: Statements not questions

On two occasions during the three Challenges the therapist asked direct questions of Jane; the first questioned her immediate experience in the session (*"Are you still feeling angry?"*; T151, Challenge Thirteen) and the second questioned her experience of his accurate but painful insights (*"What happens then? After the ouch?"*; T193, Challenge Seventeen). For Hobson (1985), no matter how they are expressed, direct questions are antithetical to the 'how' of Exploratory therapy; they close rather than open dialogue and they may be experienced as persecutory. The particular directions of these two questions, to the immediacy of the session and the therapeutic relationship, increase the likelihood of their being experienced as persecutory. These two questions were exceptional. More representative of Exploratory therapy were the therapist's accurately empathic statements; for example, *"And maybe this is all too kind of stark"* (T191; Challenge Seventeen); *"You might have been scared that I would act like your mother"*, (T245; Challenge Eighteen) and his owned understandings; for example, *"Well I guess what I feel about that is"* (T179, Challenge Seventeen) and *"I can't help feeling that.."* (T181, Challenge Seventeen).

6.5.4 Strategy 3: Tentative statements to promote negotiation

The therapist's tentativeness expresses her/his openness to negotiating understandings and correcting misunderstandings; these are proposed in the Negotiation Stage of Challenge Resolution that predominated in Challenge Thirteen. The therapist's statements therein were, to a limited extent, tentative and open (for example, *"I guess that's important"* (T121); *"maybe that's expressing something"* (T126)) but there was a sense in which he was *presenting his understanding to* Jane rather than *developing an understanding with* her. In his notes on the session he recognised this; he described the *"completed, nonexploratory"* aspects of work in the session.

6.5.5 Strategy 4: Focus on here-and-now experience

In the material above the first focus is the Challenges; therein attention was paid to Jane's immediate experiencing in the session. The therapist accepted Jane's feelings as she made all three Challenges and attempted exploration from these. However, much of the activity in the material analysed was focused on understanding and exploring the meaning of Jane's Challenges. Throughout this Negotiation and

Exploration, consistent with Exploratory therapy, the therapist articulated his understanding of Jane's feelings in therapy; he wrote, *"I worked to show my acceptance of the feeling, but slowly"*.

6.5.6 Strategy 5: Enhance immediate experiencing

Despite Jane's use of words *"as a barricade"*, the therapist successfully enhanced the salience of Jane's feelings in three ways. Throughout he used vivid, physical, expressive language for feelings Jane intellectualised; for example, *"she's calling the tune but why do you follow? Because you're desperate for that contact, that affection"* (T287, Challenge Eighteen). He extended Jane's *"swimming pool analogy"* to produce a significant shift in their discussion of her feelings in relating with her mother; her *"belly flops"* became his *"hurting in the middle"* (Stage Nine, Challenge Seventeen). On several occasions he insightfully used Jane's language to make evident to her his understanding of her experience and their dynamics; for example, in Stage Two of Challenge Seventeen. All these activities are representative of Exploratory therapy.

6.5.7 Exploration and understanding of feelings

In his session notes the therapist reported *"I'm working too hard, saying too much"*. However, the sequencing and structuring of the material analysed above represents Exploratory principles; Challenge Thirteen was predominated by Negotiation and Challenge Seventeen by Exploration; in Challenge Eighteen the session process was summarised and its achievements highlighted.

6.5.8 Summary

Whilst not 'textbook' the therapy analysed above is considered, in general, representative of Exploratory therapy. Implicit in the specific comments above, and evident in the session transcripts and their analyses, is the focus and pressure presented in Jane's Confrontation Challenges.

6.6 Summary and Conclusions

6.6.1 Summary

Chapter Four made it clear that the credibility of a Task Analysis depends in part on the Rational Model of Task Resolution and its demonstrable applicability task resolutions occurring in clinical practice (see 4.6.2). Safran et al (1988) required that the researcher perform what they called a Preliminary Intensive Analysis of a 'few' task resolutions occurring in sessions which represent the practice of the therapy in question. The researcher closely analyses the relevance of the stages and components proposed by the Rational Model to the activities observed in clinical practice. Chapter Six has analysed the relevance of the Rational Model developed in

Chapter Five to three Challenge events occurring in a single session of a memorable case of SPP1 Exploratory therapy; Jane, a caring professional was in therapy with DAS.

Their first session the therapist described as a *"power struggle"* and Jane felt that she had been *"told off"* for resisting being in the client's chair. In this session the reseacher identified eight Challenge Markers and a further eighteen in Session Two; she identified evidence of their resolution in Sessions Two and Three. The seventh Challenge of the second session brought to a climax and epitomised the client-therapist dynamics to that point in the therapy. Since some resolution could be argued to have been achieved by the end of this session three of the remaining Challenge Events were selected for intensive analysis; Challenges Thirteen, Seventeen and Eighteen. The first two Challenge Events were ended by a subsequent Challenge; the eighteenth Challenge Event terminated as the session ended.

Each of the three Events was intensively analysed in terms of (a) the relevance of the Rational Model and (b) specific, out-of-mode therapist behaviours; distinctive stages of resolution were labelled. A summary table of each analysis specified (a) both the stages identified as the therapist and client responded to her Challenge and (b) the relevant Rational Model stage and/or its components. These analyses will now be integrated and concluded.

6.6.2 Conclusions

The table below integrates the foregoing analyses of the applicability of the Rational Model to Challenges Thirteen, Seventeen and Eighteen made by Jane in her second session of Exploratory therapy.

Table 6.5

THE APPLICABILITY OF THE RATIONAL MODEL IN THREE OF JANE'S CHALLENGES

Rational Model		Challenge13	Challenge17	Challenge18
I	**Acknowledgement**	+	+	+
II	**Negotiation**			
IIi	Invitation			
IIii	Understanding	+		
IIiii	Contributions & responsibilities	+	+	+
IIiv	Consensus	+	+	+
III	**Explore**			
IIIi	Explore parallels		+	+
IIIii	Link & Explain	+	+	+
IV	**Close**			
IVi	Renegotiate	+	+	+
IVii	Constructive value	+		+

The foregoing analysis of the three Challenges provided broad, repeated verification of the applicability of the Rational Model to Exploratory therapy considered sufficiently representative of Exploratory practice. The researcher's close observation of the three Challenges repeatedly identified all stages and all but one of the stage components (invitation to negotiation) proposed by the Rational Model. A stage not proposed by the Rational Model was also identified; this was titled 'Value of therapy and encouragement of the client'.

Two aspects of this analysis and its implications for the Rational Model should be reiterated here. Firstly, the Introduction (6.1) distinguished the Preliminary Intensive Analysis presented here from the concluding stage of a Task Analysis, the Rational Empirical Comparison. Unlike the Rational Empirical Comparison, the intensive analysis does not revise the Rational Model. Thus, the table above (Table 6.5) represents neither (a) the progression, patterning and frequency of activities observed

in the session material, (which is the aim of the Empirical Analysis (Chapter Eight)) nor (b) the researcher's assessment of what, compared with the 'best guess' set out in the Rational Model, is 'best', most facilitative of resolution, in the activities observed in the session material (which is the aim of the Rational Empirical Comparison (Chapter Nine)). Rather, the Table shows that the researcher's detailed and critical analysis of three Challenges made in clinical practice provided general support for the stages and their components proposed in the Rational Model (Chapter Five). Secondly, the Introduction (see 6.1) stressed that (a) this Preliminary Intensive Analysis serves to 'check the Rational Model against' therapy session material and that, (b) the analysis proceeds from the position that general support for the Rational Model is expected in so far as the Rational Model and the 'chain of reasoning' embedded therein have been carefully articulated (Chapter Five). Despite this expectation, this chapter shows that the intensive analysis, entailing close, detailed and critical scrutiny of the session material, is a substantial undertaking. Support for the applicability of the Rational Model may be expectable but demonstrating this via the intensive analysis of session material is a significant achievement in a Task Analysis.

Chapter Four's planning indicated that the preparatory stages of any Task Analysis are required to demonstrate that the Rational Model is applicable to the practice of the particular therapy and that the Task Marker is precisely defined and reliably identifiable. The present chapter has met the first of these requirements; Chapter Seven will deal with the second.

Chapter Seven

7.1 Introduction

The previous three chapters have made clear the dependence of Task Analysis's Empirical Analysis and Rational-Empirical Comparison on two preparatory steps. Chapters Five and Six achieved the first of these; developing and demonstrating the practical applicability of a rationally-derived Rational Model of Challenge Resolution in Exploratory therapy. The present chapter is concerned with the second and final preparatory step; defining and ensuring the reliable identification of in-session, behavioural, Client Markers of the task being investigated.

Chapter Four explained that, in task analytic terms, the Client Marker of a Task is an in-session manifestation of the therapeutic task and the client's readiness to work on the task. In effect, Client Markers are behavioural expressions of the client being in a particular state; for example, experiencing intrapsychic conflict, experiencing transference feelings, engaging in self-critical thoughts. Client Markers are taken to signify the opening of the Significant Change Event under investigation. Identifying Client Markers is crucial in sampling the events that are to be Empirically Analysed (Chapter Eight). Their behavioural manifestation is defined and systematised in order that they can be reliably identified. Once Client Task Markers are reliably identified, Task Markers can be identified in any number of clinical cases of the same therapy and the researcher can be confident that they are have collected an homogeneous sample of the particular class of task. This chapter describes the development of a system for identifying and categorising Client Confrontation Challenge Markers in Exploratory therapy). Chapter Four argued for the task analytic investigation of events occuring within the course of a single therapy case. For the present work then, the coding system was applied by external coders to the sessions of a single therapy case, 'Anita', and Challenge Events reliably identified. As a result of the work to be reported here, the system is availiable for application to any case of Exploratory therapy. Part One describes the development of a system for identifying and categorising Confrontation Challenge Markers. Part Two describes its use by external coders, culminating in their reliable identification of the Challenge Markers in Anita's eight sessions of Exploratory therapy.

By design, Chapter Seven is a practical, step by step report of the activities undertaken in defining and manualising the Challenges. This approach has been taken for two reasons: until recently little has been published concerning 'how to do' process research; acquired 'practical knowlege' has been communicated person to person (Moras and Hill, 1991). Hill's (1991) "All you ever wanted to know about process research but didn't know who to ask" is testimony to this. The second reason is that limitations of space preclude

more process-oriented documentation of the work represented in this Chapter. In recognition of this, the 'want to tell' approach taken in the preceding chapters was exchanged for a 'need to know' approach; 'what does the reader need to know now in order to understand what was done to achieve the above aims?'. Supplimentary material is presented in the Appendices, to which the reader is directed.

Part One

7.2 Aim

Part One presents the steps undertaken in developing a system for identifying and categorising Confrontation Challenge Markers. This was achieved by (a) defining the 'common behavioural denominators' Confrontation Challenges (7.3) and (b) categorising the possible in-therapy origins of these Challenges (7.4).

7.3 Defining the common behavioural denominators of Confrontation Challenges

7.3.1 Overview

Client and therapist therapy evaluations were used to identify 7 cases from the First Sheffield Psychotherapy Projects (SPP1; Shapiro and Firth, 1987) that were believed likely to contain material relevant to defining Challenges; Challenges and 'almost but not quite' Challenges were identified from the session tapes and transcribed; two common denominators were identified. The denominators were; the client's manner being confrontational and the client actively expressing dissatisfaction.

7.3.2 Therapists' evaluations of good and poor process and outcome

Therapists were asked, firstly to assess clinically the 'process and outcomes' of the Exploratory therapy phase in each of the 40 SPP1 cases and secondly to explain their asssessment. Therapists were given lists of the clients they had seen in SPP1; this included clients who had prematurely terminated therapy as well as those completing the contracted eight sessions. Therapists were asked to assign each SPP1 case to one of the following groups,: 'good process-good outcome' cases; 'good process-poor outcome cases'; poor process-good outcome cases' and poor process-poor outcome cases'. These poor/good process/outcome assessments were used as a simple heuristic for accessing clinicians process assessments. It was not assumed that an assessment of 'poor process' indicated the client making Confrontation Challenges in the sessions. It was assumed that assessments of 'poor process' might access therapist's recall of difficulties in the therapeutic relationship which might identify moments in the sessions that would help identify the defining features of Challenge Markers.

7.3.3 Clients' postsession Helpful Aspects of Therapy (HAT) evaluations

Client and therapist's postsession evaluations were reviewed. The clients' session reports selected were the HAT forms (Helpful Aspects of Therapy ; LLewelyn, Elliott, Shapiro, Firth and Hardy 1988) which asked clients helpful, significant and otherwise

important events occurring in the sessions and were completed by SPP1 clients after each Exploratory session.

7.3.4 Therapists' post session case notes

The post session reports selected were case notes completed by therapists after each session. These recorded the following information:

Table 7.1

INFORMATION RECORDED IN THERAPIST'S POST-SESSION NOTES

Client ID	**Therapist ID**	**Date**	**Session No**
Areas	**Not covered**	**Mentioned**	**Major theme**
Self esteem			
Loss			
Disputes			
Deficits			
Investment			
Fear/anxiety &avoidance			

Client behaviour	**worse than at E1**	**same as at E1**	**better than at E1**	**much better at E1/no**
Targets (eg. eye contact, expressive voice, posture, speech rate, avoidance, use of metaphor)	1	2	3	4

Out of mode episodes	**Exploratory Hypotheses**	**Session Outline**

7.3.5 The seven Exploratory cases selected

The table below profiles the seven clients selected for potentially providing Challenge relevant material. Two were seen by the least experienced therapist on the project (GH); five were seen by the principal therapists on the project (DAS and JF). Two were male (C54 and C117). Two (C28 and C117) dropped out of therapy prior to the completion of the contracted eight sessions. Their not being matched did not impact on the aim of positively identifying example Challenges and Challenge-relevant moments in their sessions.

Table 7.2

SPP1 CASES CONTAINING CHALLENGE RELEVANT MATERIAL

ClientNo	Sex	Therapist	Therapist Sex	P/E Order	Complete (C)/ Drop Out (D/O)
28	F	DAS	M	EP	D/O
40	F	JF	F	PE	C
46	F	DAS	M	EP	C
50	F	JF	F	PE	C
54	F	JF	F	EP	C
99	M	JF	F	PE	C
117	M	GH	F	PE	D/O

7.3.6 Integration of therapist and client post session evaluations: An illustration

The integration of the therapist's and client's post session evaluations will be illustrated by reports from two sessions of one case, (client 046 in therapy with DAS). This therapy case was unique among the seven in that the therapist reported 'Disputes' as a theme in all eight sessions; two examples are presented to illustrate the type and content of information obtained from the above procedures.

Session Four

THERAPIST
Work difficulty after last session; fear of abandoning caring persona; compliance to avoid exploration; focus was on wanting acceptance for real self

Disputes	2
Fear anxiety & avoidance	1
Investment	1

CLIENT

Helpful	Pointed out that I was agreeing with everything he said instead of confronting myself
Important	My agreeing with people is a way of not confronting

Session Five

THERAPIST
Anxiety around confronting feminist beliefs; focus on mistrusting men compared with idealising women; feeling inadequate at work

Disputes	2
Fear anxiety & avoidance	1
Investment	1

CLIENT

Helpful	Looking at anger towards mother
Important	My need to patch things up

These were pragmatic attempts to efficiently consider all Exploratory cases in SPP1 for their potential access to examples additional to those propotypical examples presented in the previous chapter. This search aimed to increase the sample of "Markers, exceptions and subtypes" (Greenberg, 1984b) sufficiently that a definition of common behavioural denominators could proceed; the search was not exhaustive.

7.3.7 Identifying Challenges and 'Almost but not quite Challenges': An illustration

Oriented by the above, the researcher listened to sessions of the seven selected clients for Challenge relevant material. If the HAT forms and/or therapist notes had been useful in pointing to a session (eg the client's HAT form reporting 'I got angry with him') the

researcher began by listening to the session in which the recorded event had occured and used this session to direct her to others. If the HAT forms and/or therapist notes had not been useful the researcher listened to the eight sessions in sequence. Questions asked were 'Is this a Client Confrontation Challenge, and why?', 'If this isn't a Challenge why isn't it?". The tapes were listened to repeatedly to consider these questions. Material informing the questions was transcribed.

Most informative to these questions were instances in which the 'felt sense' listening to the session was something like 'I want to say this is a Challenge but I can't', 'this would be a Challenge if...', 'this is almost but not quite a Challenge'. The comparison of these 'almost but not quite a Challenge' instances and 'bingo, a Challenge!' instances was most informative in thinking about the definition. Transcribing both and asking of 'bingo' instances, 'why is this a Challenge?' and asking of 'almost but not quite' instances, 'why is this not a Challenge?', provided for the definition below.

To illustrate, session material from the case presented above will be used to demonstrate the 'almost but not quite' and 'bingo' instances in the session material. Again going to the most likely site first, after Session Six the therapist reported the client in a 'confrontative manner' having been 'angry at the previous session's confrontation'. A transcript excerpt is presented and discussed in terms of their 'almost but' and 'bingo' Challenge qualities.

This is a verbatim transcript of the first fifteen speaking turns in the sixth session. The following transcription conventions should be noted: Speech in a confrontational manner is underlined. A pause of 4 seconds or more is noted in [brackets] and numbered as another speech unit eg C5. $Speech bounded$ thus is spoken at the same time. (Speech bounded) thus is back channel speech.

'BINGO' AND 'ALMOST BUT NOT QUITE CHALLENGES' IN CLIENT NO 46'S SIXTH SESSION

Off microphone, C sighs

T1 The secretary made you late

C2 No I probably made her, I talk too much. We er realised we have daughters at the same school (Um) and we also met in the supermarket last night, so you know. Nobody made me late. Although it always seems to be a rush to get here (Um). Always seems very difficult to get here.

ALMOST BUT NOT QUITE DISSATISFACTION
GETTING TO THERAPY?, BEING IN THERAPY?

T3 More difficult than to get to other things

C4 Yes (Umm). Oh yes. I always have difficulty sort of getting out, catching trains. No not always, sometimes, but this is always, always very hard (Umm)
ALMOST BUT NOT QUITE DISSATISFACTION
GETTING TO THERAPY?, BEING IN THERAPY?

C5 [5] I was also thinking about last week. Um do you remember when, I thought you got quite angry, and or I thought you were angry. And I thought you gave me an alternative. I thought you said we can either talk, carry on talking about this, your what I think was the anti-male bit, or we can talk about your mother (UhHmm). And I chose to talk abut my mother (UhHmm). And afterwards I thought that you were, er there's two things. I thought you were angry, so I thought it was best to talk about my mother and, and the other thing was, that I thought the anger may be destructive and that's what I wasn't here for. Those were the two things that I felt were happening $last week$
ALMOST BUT NOT QUITE DISSATISFACTION
THERAPIST'S BEHAVIOUR IN PREVIOUS SESSION

T6 $The anger$ maybe destructive (Yes I d-), my anger

C7 I think both, I mean, I, I thought we were getting angry with one another (UhHmm, Umm), we seemed to be. Um, I seemed to be repeating mself, what I was saying and you seemed to be saying yes and (Um) or yes but (Um) or
ALMOST BUT NOT QUITE DISSATISFACTION
THERAPIST'S BEHAVIOUR IN PREVIOUS SESSION

T8 And that's something that you kind of recognised as er, maybe something from your own experience about doing a yes and or a yes but

C9 I thought you were giving me an alternative, I really did. And that's how I took it and then, and then I felt you then afterwards accused me, and I felt it was an accusation, of taking the wrong alternative
BINGO CHALLENGE
THERAPIST'S BEHAVIOUR IN PREVIOUS SESSION

T10 Accused you of taking

C11 Yes you said we haven't, I mean it seemed that we hadn't resolved the other bit (Indeed not), we had to, and that um, you were, er, you know you were, you were being nice to me again and, and though this thing wasn't resolved (Umm) but I, I really did see it as a way of, um, diffusing and I thought it was a real (Yes) alternative you were giving me. Maybe it wasn't an alternative, that's, I , I, that's how I (UhHmm), that's how I (UhHmm) $take it to be$
BINGO CHALLENGE
THERAPIST'S BEHAVIOUR IN PREVIOUS SESSION

T12 $Yeah, when you say$ maybe it wasn't an alternative (Yes), you mean that you weren't really being offered the choice or that the two issues were linked anyway

C13 Well, not only were the two, maybe the two issues linked but it wasn't an alternative, it was a choice. I, I took it as a choice., um, shall we do, carry on doing this or shall we get down to the important things (AhHah), um, $that's how$
BINGO CHALLENGE
THERAPIST'S BEHAVIOUR IN PREVIOUS SESSION

T14 $And you$ felt that was loaded, you felt that I knew what was important (Yes) and I was giving you the opportunity of avoiding it, letting yourself off the hook

C15 Or that we weren't, that um, that there was a um, that something was happening um , which I didn't find to be helpful, what was happening. There seemed to be a feeling around that we were going round and round in circles, and I know I was get, I was feeling quite angry and also fed up (Umm). I mean I was feeling very fed up by the end of it
BINGO CHALLENGE
THERAPIST'S BEHAVIOUR IN PREVIOUS SESSION

7.3.8 Abstracting the common denominators: The behavioural definition

To illustrate, how did the material above inform the abstraction of common behavioural denominators of Confrontation Challenges from the session material?

Of the eight client speaking turns presented above, the researcher identified the first 4 as 'almost but not quite Challenges' and the next 4 as 'bingo' Challenges. The most salient difference between the first and second four was the client's manner; in the second 4 her manner was confrontational, in the second it was not. In the terms of the verbal picture above, there was no sense of the client' 'taking on', or 'having a go at' in the first four speaking turns; there was no sense of the client actively directing outwards acute negative feeling. The client's manner being confrontational was in part defining of a Confrontation Challenge being made.

This said, the client's manner being confrontational was considered necessary but not sufficient for defining a Challenge. The Challenges identified in the session material of the seven cases and in the case presented in Chapter Eight were a function of the client's manner having been confrontational *as she expressed dissatisfaction with an aspect of therapy.* In addition it was noted that this content was *not necessarily* different in a 'bingo' Challenge than in an 'almost but not quite' Challenge. For example C5 was identified as an 'almost but not quite' instance in which the client was dissatisfied with the therapist's behaviour in the previous session and C9 was identified as a 'bingo' instance in which the client was also dissatisfied with the therapist's behaviour in the previous session. In C5

the client first described the therapist's behaviour, his being angry and presenting her with an alternative. She then expressed her dissatisfactions with it; his anger led her to comply with his "alternative" and the potential destructiveness of his anger being antithetical to her presence in therapy. In C9 again described the therapist having presented her with an alternative and then expressed dissatisfaction with his subsequent behaviour; his accusation that she had taken the wrong alternative. The content of C5's 'almost' is no more or less Challenging than the content of C9's 'bingo'; the *context* is crucial. The 'bingo, a Challenge' of C9 is a function of the client's manner having been confrontational, but this alone would have been insufficient for it to have been considered a 'bingo' Challenge.

As indicated above, questioning the session material provided by the seven selected cases resulted in a behavioural definition of a Confrontation Challenge. According to this definition a Confrontation Challenge contained two elements: (a) the client's confrontational manner; (b) the client's dissatisfaction with an aspect of the therapist, therapy or research contract. Accordingly a Client Confrontation Challenge in Exploratory therapy was defined as

> **an instance in which the client, in a confrontational manner, expresses dissatisfaction with an aspect of therapy**

7.3.9 Decisions made regarding the definition's common denominators

Two decisions were taken regarding the above definition; these will be noted here. These decisions were made in the light of observations made while listening to session material. Firstly, rather than further operationalise the definition of 'confrontational manner', it was decided to train coders to be sensitive to a client's usual speaking manner in order that they detect variations which, for the particular client, may be considered confrontational. Jane, the client presented in the previous chapter could, for example, have achieved a rating on, for example, Gottschalk's (1979) Hostility Directed Outward scale which measures the intensity of adversely critical, angry, assaultive, asocial impulses and drives towards objects outside oneself. The feelings of destructiveness she expressed with vehemence regarding her boss and the building in which she worked could have been scored on the Covert Thematic Categories of the Hostility Outward scale. Selected above, Client No 28, a client who prematurely terminated SPP1 therapy could however, not have been scored on the same scale, yet her manner was at times considered confrontational. These were occaisions when her manner felt significantly different from the way in which she usually spoke to the same therapist. As a rule, her manner was

much quieter, more hesitant and almost monotonic, compared with Jane's. In the moments when her manner was considered confrontational she expressed extreme irritation in very short, clipped bursts. These were extraordinary and confrontational moments in Client No 28's relationship with the therapist; whereas moments such as these were a matter of course for Jane and the same therapist. Considering the substantial literatures on the appraisal and labelling of emotion and on the use of language in psychotherapy (see for example, Ellsworth and Smith, 1988; Parkinson and Lea,1991; Greenberg and Safran, 1987; Russell, 1987, Zajonc, 1980) it was decided that systematising the individual differences described above was beyond the scope of the present project. This decision was also influenced by the author's confidence that it, if sufficiently sensitive to both the client's manner and the therapeutic process, coders would be able to reliably identify moments in which the particular client's manner was confrontational for her/him. Thus confrontational manner was not further operationalised.

Secondly, it was decided to propose a categorisation of the aspects of therapy with which clients may express dissatisfaction. Undertaking this had two aims; firstly, to make the aspects of therapy toward which clients may express dissatisfaction as concrete and differentiated as possible, and secondly, to allow for the possibility that different resolution performances may be associated with Challenges addressed to different aspects of Exploratory therapy. The development of this categorisation will now be described.

7.4 Categorising In-session origins of Confrontation Challenges

7.4.1 Overview

A general categorisation of 'aspects of therapy' was made from the literature (therapist, purpose and structure of therapy); examples of these classes were identified in the clinical literature; differentiations made among these examples permitted their re-categorisation.

7.4.2 A general categorisation of aspects of therapy

A general categorisation was taken from Hobson's and Strupp and Binder's discussion of disguised allusions to the transference;

For Hobson,

> "A person always means what he says. But he does not always say all that he means, nor always act upon what he says. Nor does he know everything he is saying. And he often says different and sometimes contradictory things at the same time" (Hobson, 1985, p.)

and each person is always saying something in relation to one of the following four aspects of the therapeutic session;

> (i) himself and his life situation; (ii) the other person; (iii) the nature and setting of the interview (its structure, its purpose, the non-human environment)" (p.179)

Strupp and Binder (1984) provide a similar list of the actually occuring aspects of the therapeutic situation which may be the source of clients' transference enactments;

> "conscious or unconscious attitudes and behaviour of the therapist; aspects of the therapeutic arrangements, such as office fixtures, fees, appointment times, and so forth" (Strupp and Binder, 1984, p. 145)

For Hobson and for Strupp and Binder then the client's experience of the therapeutic relationship are communicated by their references to the following aspects: the therapist; the physical environment, the structure and purpose of therapy. These then maybe the *real sources for or transferential objects* of clients' Challenges.

7.4.3 Examples of the general classes

The clinical and empirical literatures were examined to identify concrete, in-session examples of each of these general classes; sources examined were Strean's (1985) reporting of the first treatment crisis; Hobson, (1985) Meares and Hobson, (1977) Schlesinger and Dewald in Wachtel's (1982) writings on resistances in psychodynamic practice; the California Psychotherapy Alliance Scales (CALPAS; Marmar et al, 1986). Illustrative examples are tabulated below.

Table 7.3

ASPECTS OF THERAPY ORIGINATING NEGATIVE CLIENT FEELINGS

Helping Interventions	Associated client feelings
(1) Therapist as Helper	
*therapist's interpretive behaviour is invalidating eg attributing feelings to resistance eg searching for deeper meanings (Meares & Hobson, 1977)	unreality failure
*therapist denies own involvement in the interaction eg neutrality, opaqueness (Meares & Hobson, 1977)	unreality
* client criticises therapist's activity eg therapist intrusive * client wants therapist to be more responsive (Strean, 1985)	frightened of intimacy
(2) Therapist as Person	
* client makes therapist into her/his superego (Strean, 1985)	wary of criticism and rejection by therapist
*client attacks therapist for not being empathic and caring (Strean, 1985)	wanting reassurance praise and approval
* client feeling therapist is irritated, annoyed or disappointed CALPAS	
(3) Purpose of therapy: What therapy does and how it proceeds	
* questions about nature of therapeutic process (Strean, 1985)	anxious at being in therapy
*client disagrees with goals for therapy CALPAS	
*client disappointed by progress of session or therapy CALPAS	

Table 7.3 (cont'd)

ASPECTS OF THERAPY ORIGINATING NEGATIVE CLIENT FEELINGS

(4) Structure: How therapy is set up	
* schedule is inconvenient for client (Greenson, 1967)	disappointment in therapist not being omnipotent
*client tests, defys limits set (Strean, 1985)	rebelliousness masking vulnerabilities
	burdened by time and other demands of therapy CALPAS

The interrelatedness of the aspects of therapy was evident; clients' experience of and fears associated with being in therapy were experienced and attributed to the therapist and the clients' fears and experience of the therapist were attributed to the therapy. Strean (1985), for example, indicated that whilst clients' disappointment in therapists not being all-powerful, all-knowing 'symobiotic mothers' (Stone, 1973) might be expressed directly to the therapist, it is more commonly manifest by the client challenging the structure of the therapy and sessions. However, reviewing the examples from the literature suggested further differentiations among the general classes and these were used to recategorise sources/objects of clients' Challenges.

7.4.4 Differentiations informed by clinical examples

In this subsection the differentiations made among the clinical examples (illustrated above) are reported; the subscript numbers refer the reader to the relevant recategorisation presented in 7.4.5. Evident within the above examples representing the therapist as the helper and a person were (a) the client's experience or understanding of the therapist's activities($_1$ see 7.4.5); (b) the client's experience of 'being in therapy'; (c) the client's role in how therapy proceeds (representing the aspect above called Purpose) (d) the client's experience of actual and potential benefits attributable to the therapist$_2$.

Two aspects of (b) the client's being in therapy were distinguished; (i) the client's experience of being in the therapeutic situation per se$_7$ and (ii) being in the client role$_8$

Two distinctions made among the examples representing the structure of therapy were; (a) being in the client role to the therapist's role as expert helper$_8$; (b) being in the

therapeutic situation[7]. In the Sheffield Psychotherapy Reseach Projects, negotiation of the therapeutic and research contracts is concluded during the pre-therapy assessments. As a consequence, the formal rules of the contracts for therapy and research commitments are 'written' pre-therapy.[3, 4]. This most clearly differentiated the aspect originally called Structure from the confusions evident in the aspect originally called Purpose.

Among the examples found for the structure of therapy two sets of implicit rules, generally not made explicit, 'written out' to clients: These were (a) 'rules' specific to the particular therapy and its prescriptions for tasks assigned the client and the goals achievable via engagement with the tasks[5]; (b) 'rules' generic to being in the client role in any therapy[6]; (c) the applicability of the particular therapy's goals to the client[9]

7.4.5 Recategorisation of objects/sources of dissatisfaction

These differentiations provided for the following recategorisation of the objects/sources of clients' dissatisfactions. Each category is defined and an example provided; these were manualised (See Appendix 2: The Manual for Practice Coding). Their numbering reflects the subscript notation of the differentiations reported above.

Table 7.4

RECATEGORISATION OF OBJECTS/SOURCES OF CLIENT DISSATISFACTION

1	**Therapist Activity** Something the client experiences or understands the therapist having done, said, thought, or felt **eg:** When I knew I was going to be late I worried that you would be angry with me
2	**Therapist Capacity** The client's experience of the actual and/or potential benefits of the therapist as her/his helper **eg:** On the basis of these two sessions I just don't see how you're going to be able to help me with this

3 **Written Rules of Therapy**

The client's experience of the explicit and fixed terms and conditions governing the length of sessions, timing of sessions, number of sessions, participants

eg: I hate it, each time you look at the clock so I know it's time to finish and I'm feeling like I just got here, like we've hardly begun

4 **Research Contract for the Therapy**

The client's experience of the explicit assessment procedures during therapy and their emotional and practical consequences

eg re Brief Structured Recall interviews after sessions:
I go through an hour of this which is hard enough and then I have to go through it again; it's like going back to sleep and havng the same nightmare again

5 **Unwritten Rules of Exploratory Therapy**

The client's experience of the implicit rules that are peculiar to Exploratory therapy; these concern the client's in-session tasks and the goals achievable by the tasks;
for example, exploring links between the client's relationship with the therapist and with signficant others

eg: What does it matter how whether there are what you call links with you, the point is that my partner and I can hardly bear to be in the same room together

6 **Unwritten Rules: General**

The client's experience of the implicit rules that are a function of any professional therapeutic relationship. These can concern the way in which client and therapist roles are translated in practice (for example the client will not know the therapist personally); the session process (for example, the client will not be told how the therapist is wanting her/him to respond) and the session outcomes:

for example, the client will not be told what outcomes the therapist is expecting for the client

eg: I can't stand not knowing where you're trying to get with this, you keep asking me about it but I don't know where you're headed with your questions, what you're trying to achieve

7 **Therapeutic Situation**

The client's experience of being in therapy per se (for example, feeling abnormal, a failure) and being in the client role in particular; for example, feeling vulnerable to, dependent on the therapist

eg: How can I tell it all to you, I don't know what you'll do with what I say

8 **Capacity of Therapy**

The client's experience of the actual or potential capacity of the therapy to be of benefit for her/him

eg: I've been thinking I don't think this is going to be enough for me, that this is going to do what I need

In conclusion, the above categorisation system represents a clinically and theoretically informed attempt to differentiate among the inevitably interrelated objects/sources of clients' dissatisfactions in therapy.

7.5 The role of session context in identifying Challenges

7.5.1 In principle

Many observational coding systems have been designed and used in ways that 'strip' behaviour of context (Mishler, 1979). The call to redress this balance in psychotherapy research and take account of context has been made repeatedly (eg Greenberg, 1986b; Kiesler, 1973; Labott, Elliott, and Eason, 1992; Marmar, 1990), and is of course a fundamental tenet of the Events Paradigm (Rice and Greenberg, 1984; see Chapter Three; 3.4 and 3.5).

7.5.2 In practice

Context is not unidimensional or intrinsic to a phenomenon. In broad sympathy with Stiles (1993), context is discerned, delimited and described by (in this case) the researcher such that it is independent of neither the researchers' and the participants' cultural and personal histories nor of the immediate setting in which it is observed. Meaning of experience and actions are cumulative such that "an exchange contains the meanings of what has already been said" (Paget, 1983, p. 79); " meaning is a matter of relations within a pattern" (Hobson, 1985, p. 67). In the developing pattern and interaction, clients and therapists are active in constructing the meaning of their interaction (Rennie, 1992).

> "A human being, whether therapist or client, is constantly noting, formulating, and modifying what he is doing, while he is doing it. He 'monitors' his own performance and can monitor his monitoring 180"

An observation or statement may have many, context-dependent, meanings (Rommetveit, 1988; Paget, 1983; Rommetveir, 1988).

There are few guides for consideration of these issues in the psychotherapy process research literature (Weiss, Marmar and Horowitz, 1988); they will be discussed further in Chapter Ten. Heatherington (1989) suggested and evaluated three strategies that could be used to take context into account. They were considered for implementation here. The first, using the client's and therapist's understanding of their communications obtained systematically, for example, by Interpersonal Process Recall (Elliott, 1984) conducted after the therapy session, was precluded by the pre-established contracts with clients. The third strategy she suggested was to "first 'get into the heads' of people collectively in order to specify the important types of contexts as they relate to psychotherapy, and to then use that information to take context into account. Greenberg (1986), for example, suggested taking into account the following four levels. This strategy was estimated to be the most expensive in terms of time and money for he following reason. The aim of defining and operationalising the client markers according to the arguments set out here is that they can be reliably identified and thus serve to demonstrate the homogeneity of the events sampled. New style process research that "takes a closer look" (Mahrer, 1988, p.697), reliability requires agreement between a number of perspectives (Hill, 1991). Obtaining data from a number of coders on all four of Greenberg's four levels from a number of coders was considered beyond the scope of the present work; too expensive of time and money. The second was the strategy attempted here;

> "Another solution to the problem is to allow, or rather teach, the coders to make inferences about the meaning of a message. These inferences presumably would be influenced by the various levels of context in which the behaviour was embedded" (Heatherington, 1989, p. 440).

According to Heatherington, if observer's inferences are used in this way it is possible that the reliability of the coding can be assessed, inferences about the unconscious can be made and coding can potentially be completed within a single step. However she noted the following limitations; interrater reliability is (1) "more difficult to achieve than with more purely objective coding systems"; (2) the basis on which the coder's inference of meaning is made cannot be verified; (3) coders must be highly trained and clinically sophisticated if high levels of inference are required and (4) the "unconscious context of the coding cannot be specified/coded" (p. 441). How to implement these recommendations?

- Code whole sessions, from start to finish, in the order in which they take place.

Meaning is cumulative (Paget, 1983, above), therefore any coding decision should take into account the context of the therapy and the session to that point, therefore whole sessions should be coded in their naturally occuring temporal sequence.

- Construct specific guidelines for taking into account the local session context

Meanings can be multiple and context dependent. The content of the client's preceding utterance can, for example, be considered as context for inferring the meaning of the client utterance being coded. The content of the therapist's immediately preceding utterance can, for example, be considered as context for inferring the meaning of the client utterance being coded. Specific guidelines should indicate these possibilities and guide their consideration of them as they undertake the coding tasks.

7.6 Selection of coders

7.6.1 In principle

'How much clinical experience is necessary?', 'how homogenous is the previous training of raters?', 'what is the nature and complexity of the coding task?', 'how much inference from the observable treatment process is required?' are questions that should be addressed in selecting and training of coders (Marmar, 1990). Whilst it is recognised that these and other factors (for example, the number of sessions to be sampled, the rating format, the medium of information on which ratings are based) may influence the validity and reliability of ratings there is, as stated, scant empirical data concerning how (Weiss, Marmar and Horowitz, 1988). Marmar (1990) wrote, with little ambiguity, of his extensive experience selecting and training judges,

> "Perhaps no single task in psychotherapy process research is more arduous than the recruitment and calibration of clinical judges. ... The investigator's resources in terms of both time and funds availiable are often strained and may be disproportionately allocated to this task" (Marmar, 1990, p. 267).

Most process researchers want coders to be (a) "attentive to detail, yet not so compulsive that they cannot make decisions about gray areas" (Hill, 1982, p. 103); (b) "questioning" which "helps to clarify the concepts involved and (c) able to "think within" or "buy into" the coding system as well as being able to reflect on it; (d) dependable; (e) trustworthy and (f) ethical. From her own experience Hill, (1991) recommended hiring more coders than needed (anticipating drop out) and presenting a "trial task" at a selection interview.

7.6.2 In practice

Notices in the University's Psychology Department and discussions with colleagues accessed six people interested in finding out more about the coding work. Three were Master's Clinical Psychology students and three were graduates, two in Psychology, one in Communication Studies. Individual meeting's were arranged to discuss the project and the nature and extent of the investment required. All were interested in the opportunity to learn more about psychotherapy, particularly a dynamic psychotherapy. In all cases, listening to a session tape with the researcher stimulated lively and exacting discussions. Anticipating increasing coursework, all three of the MSc students were anxious of the extensive commitment required but were keen to begin training. Their course requirements prevented all three from completing training; this is stated to suggest that the commitment required of coders is substantial.

The three remaining coders completed training and the coding. None had personal or professional experience of psychotherapy. Two worked within the University but not in the same department as the author. The third coder worked in the same psychotherapy research team as the author with responsibilities for clinical assessments, project management and data analysis; she was not employed in this team at the time the clients were seen in therapy.

7.7 Coding Unit

7.7.1 In principle

What were the coders asked to code? Greenberg (1986) recommended that decisions regarding what of the therapy process should be analysed and how this should be undertaken be "determined in general by the research question being asked" (p. 717). Barkham (1983) argued that intersubjective categorisation systems (eg Hill, 1986; Stiles, 1979) are based on the appropriateness of both the categories comprising the system and the unit of analysis selected for coding. Thus the units analysed should be responsive to the categorisation system which should be responsive to the research question.

Additionally, it is argued here that the units to be coded should, alongside the categorisation system, be responsive to the people who will be coding them; namely, they should maximise the coders' access to the session material. This idea was consistent with Stiles's (1993) recommendation that good practice in qualitative research is facilitated by the researcher "engaging with the material" (p. 604). It is argued here that

this should be considered to apply at least equally (if not more so) to the coders working with the researcher in analysing the material.

How did this argument impact on the unit of analysis chosen here? A "critical dilemma" for process researchers in the selection of a unit of analysis is the choice between 'objectivity' and 'familiarity' (Russell and Staszewski, 1988, p. 196). The 'objectivity' strategy argues for obtaining an objective standpoint on language by developing

"a descriptive metalanguage (eg propositional calculi, deontic logic, etc) that is as free as possible of the ambiguities, inconsistencies, and mulitple meanings, associated with the use of natural language. Natural language discourse can then be described in terms of the purified metalanguage" (Russell and Staszewski, 1988, p. 196).

In contrast, the 'familiarity' strategy advocates the use and explication of the rules that govern everyday language practices;

"Unit identification progresses in consultation with intuitions about where the segmentation of discourse occurs in everyday conversations" (Russell and Staszewski, 1988, p. 197).

Coders, clients, therapists are familiar with conversation and for Hobson, conversation is at the "heart of psychotherapy" (1985, p. 7).

7.7.2 In practice

Accordingly the 'rules' used to guide identification of the speaking turns here were:

- A speaking turn starts when one contributor (client /therapist) takes the floor and ends either when (a) the other contributor (therapist/client) takes the floor or (b) the speaker pauses for four or more seconds. Why four or more seconds? Four seconds was an arbitrary cut off made to reflect the felt significance pauses can acquire in the therapeutic conversation surrounding a Confrontation Challenge.

- Instances in which contributors were 'talking over' or 'talking at' the same time as one another were indicated on the session transcripts; as were laughter and sighs.

7.8 Type of session materials to be used in coding

7.8.1 In principle

Hill (1991) noted that, assuming accuracy and checking by a second person, a transcript of a one hour session can take up to 40 hours to obtain and, in the light of this, suggested that provided the units to be analysed are clearly defined (such as speaking turns) then session tapes could be used in the absence of transcripts.

"The trade off is that some accuracy is forfeited. Listening to a tape recording can be somewhat of a projective test with gaps and inaudibilities conveniently filled in by the listener" (Hill, 1982, p. 14)

It is suggested that two additional and related factors not mentioned by Hill (1982, 1991) but conceivably reducing the reliability of codings made from sessions tapes alone are (a) the importance of context to and (b) the level of inference required in making the coding decisions. Having a transcript permits session material to be reconsidered, thus reducing the amount of material coders are required to retain. Anchoring the decision to be made in material that has already been listened to and allowing recapping of that material to inform the immediate decision can be crucial for both the accuracy of the coding decision and for the confidence of coders. Marmar (1990) supported McDaniel, Stiles and McGaughey's (1981) observation that ratings made from transcripts generally provided higher coefficients of interobserver agreement than those from audiotapes. It was decided to provide coders with session tapes and transcripts.

7.8.2 In practice

All transcription for the present project was undertaken by the researcher. Transcribing conventions were agreed with and checked by an experienced researcher and therapist (DAS). The cost of the 'transcription trade off' noted by Hill was time and the benefit accuracy. Where time permits (or resources do not provide an alternative), there are three additional and important benefits to the research of the researcher undertaking transcribing. Firstly transcribing provides an opportunity early in the research for acquaintance with the session material; transcribing session material encourages a more active engagement than listening to and/or reading material. Secondly the concrete session material stimulates consideration and reconsideration of questions and issues related to the research at the same time as physically progressing the project; this is a particularly valuable opportunity if the research project is time constrained. Thirdly transcribing the session material can inform researchers' (empathic) understanding of how to present the coding task and procedure to coders.

7.9 Selection of session materials

7.9.1 In principle

Chapter One established that Confrontation Challenges occur infrequently in Explorotory therapy but with signficant consequences for the therapy when they do (see 1.5 and 1.6). That they are 'few and far between' has significant consequences for the selection of session material for training coders and coding7; the material is highly restricted. This is an inevitable situation in process research (Mahrer, 1988). To 'work with' this situation, he recommended training two groups of coders to use the same system with replicated data (Mahrer, 1988). With additional coders unavailiable, Hill's (1991) subsequent recommendation that session material is scheduled to minimise coders' recall of the material and their coding answers, was implemented here:

"If no other data are availiable for ratings, then the ratings done for training should be redone at the end. This is because ratings during training vary radically until the rater gets an understanding for the system. Further it takes a while for the rater to get a sense of what the universe of responses is and to anchor which responses are deviant" (Hill 1991, p. 106)

The ultimate aim was to code one client's 8 Exloratory sessions (see 7.12). Material for preliminary coding was taken from the cases listed earlier (see 7.3.5), with that from the single clinical case selected (see 7.12) scheduled as above.

An unanticipated advantage of the session material coming from a limited number of cases is worth noting at this point. Given the amount of information to be retained and considered in making their coding decisions, coders were relieved to have to familiarise themselves with the backgrounds and details of only eight clinical cases.

7.10 Training coders

7.10.1 In principle

Training coders is one of the most time consuming and important aspects of process research (Klein, Mathieu-Coughlan and Kiesler, 1986; Benjamin, 1988) that can also be enjoyable.

Little is written about training coders. Marmar made general (1991) recommendations for (a) the development of detailed manuals with clear examples for both dimensions and levels within dimensions; (b) the use of extensive transcripts or audiotape or videotape vignettes to serve as precalibrated master ratings; (c) extensive discussion to clarify subtleties in the rating process and (d) training to a pre-established criterion of reliability

before initiating the formal rating task (p. 268). More specifically Hill (1991) recommended (a) initial presentation of clear examples, moving on to "grey areas"; (b) extensive opportunity for each coder to think through and articulate their coding decisions; (c) regular opportunities for coders to question of the trainer; (d) individualised feedback and discussion with coders separate from the 'social influence process" of group training sessions. Elliott (1988) spoke of the "care and nurturing" of coders; the importance of this was not underestimated by Hill (1991). She observed that coding can be an unrewarding, boring and isolating task; the trainer engaging and encouraging the coders requires a substantial commitment throughout training and coding. She also noted that the self awareness that can result from coders listening to therapy tapes can be "beneficial". It can also be painful; the trainer providing for and responding sensitively to this situation has not been recognised in the literature.

7.10.2 In practice

All training was undertaken by the researcher. The training sessions described here were undertaken prior to Practice Coding (7.13). Coders undertook seven two and a half to three hour training sessions prior to the Practice Coding; approximately 20 hours group training. Sessions were held weekly and followed a similar format: the aims of and schedule for the session were presented, with rationale; the first half of the session focussed on discussion and the second half on consideration of the same issues in relation to session tapes; future training needs were negotiated with coders.

Following Barkham (1983), the training materials and session contents will be overviewed. The first three sessions had a common objective; to familiarise coders with the rationale and practice of Exploratory therapy. Working in combination with 'Exploratory Therapy: A Phrase Book' (see Appendix 3) and session tapes from the cases selected above (7.3.5) achieved this. The remaining four training sessions progressively acquainted coders with the questions and categorisations in the Practice Coding Manual, their conceptual distinctions and their distinctions in practice, listening to session tapes. Following Hill (1982), coders were given experience of applying the Coding Manual to progressively more ambiguous session material. Clear, hypothetical examples of the coding answers (written by the researcher) were initially presented; then the prototypical Challenges made by Jane (discussed in Chapter Five) and finally less clear session material. Each training session was evaluated. The evaluations fed back to the researcher the coders' experiences of (a) training and (b) the coding tasks and materials; limitations of space preclude further discussion of these evaluations. (Monitoring and

feedback sessions held with coders during the practice and pilot codings and during coding of Anita's eight sessions will be noted as appropriate in Part Two).

7.11 Selecting a reliability index

7.11.1 In principle

"The ultimate criterion to indicate that training is completed is the reliability check" (Hill; 1991, p. 106).

Reviewers of the issues involved in observational measurement agree that reliability includes estimates of the accuracy and stability of measures and the conditions under which the observations are made (eg Johnson and Bolstad, 1973; Medley and Mistzel, 1963; Weick, 1968) but there are no consensualised definitions of accuracy and stability. Indeed, despite its centrality to psychometrics there is no concensualised definition of reliability and this has led to the misuse of statistics assessing reliability (Hollenbeck, 1978). Hollenbeck (1978) reviewed the assumptions and limitations of the reliability statistics availiable for use with nominal data, and along with others (Gamsu, 1986; Hill, 1991; Jackson, 1983; Tinsley and Weiss, 1975), presented Cohen's (1960) kappa as the statistic of choice for establishing interobserver reliability of categorical data. Accordingly, kappa has customarily been used to asess the reliability of ratings of psychotherapy process; for example, in studying verbal response modes (Barkham, 1983; Hill, 1986; Stiles, 1986). The kappa statistic indicates the proportion of agreement between two or more raters after agreements due to chance have been removed; "kappa is percentage agreement corrected for change agreement" (Hill, 1986, p. 141).

There are however circumstances in which using kappa is inappropriate and could lead to misleading results (see Brennan and Prediger, 1981; Harrop, Foulkes and Daniels, 1985; Walters, 1984). In summary the criticisms derive from (a) the way in which kappa calculates change agreement (Maxwell, 1977; Janes, 1979; Walters, 1984) and, more pertinent to the present coding, from (b) the way in which kappa responds to low base rates in the population sampled (Carey and Gottesman, 1978; Grove, Andreason, McDonald-Scott, et al, 1981; Kraemer, 1979). It was primarily the latter, which Carey and Gottesman (1978, p. 1454) called kappa's "base rate problem", that made questionable it's use as the reliability statistic here. Essentially the 'problem' is that kappa values are artificially lowered by low base rates (prevalence) of the phenomenon in question; for example, first-rank symptoms of schizophrenia, instances in which clients confront their therapists. Most attention to the base rate problem has come from researchers assessing the reliability of psychiatric diagnoses in population studies;

"Perhaps the most difficult problem in using the k is that its value varies with sensitivity, specificity and the illness base rate simultaneously" (Spitznagel and Helzer (1985, p. 725)

where, sensitivity is the rate of "true positive diagnoses" (or coding decisions) and specificity the rate of "true negative diagnoses" (or coding decisions; Grove et al, 1981, p 412). Grove et al (1981) used Kraemer's (1979) formulation of the way in which kappa calculates the relations between base rate, sensitivity and specificity-relations to demonstrate the effects of low base rates. When, for example, sensitivity and specificity are both .95 and the base rate is .50 the maximum kappa obtainable is .81. This value compares favourably with Suen and Lee's (1985) suggestion that a kappa of .60 is a lenient criterion (suggested by Gelfand and Hartman, 1975) and a kappa of 0.75 (suggested by Landis and Koch, 1977) is a more stringent criterion. When however, the base rate falls to .10 with the same high, .95, values for sensitivity and specificity, the maximum obtainable kappa value falls to .14.

"If kappa is judged to be of dubious value, the investigator is apparently left without any appopriate way of deciding whether the recorded data are satisfactory" (Harrop, Foulkes and Daniels, 1979, p. 187).

Given the readiness with which kappa is recommended and its suitability in the majority of circumstances, solutions to the base rate problem are few and far between. Hill (1991) recommended continuing to report kappa values but reporting these alongside percentage agreements. But how then to interpret the acceptability of the "artificially low" (p. 98) kappa value or, as Grove et al (1981) explained, the kappa values peculiar to each base rate?

"it is not a single reliability but a whole series of reliabilities, one for each base rate. Generalisations to base rates other than those observed in the reliability study may or may not be valid" (Grove et al, 1981), p. 412).

Also writing of the interpretability of the kappa values lowered by base rates, Harrop, Foulkes and Daniels (1989) noted that statistical tests of significance provide no solution since they are much influenced by sample size. (In the case of the present coding, adding a statistical test would further complicate matters; the large number of speech units in the session influencing the statistical test of signficance and the low number of category instances influencing the kappa statistic). How does the accompanying percentage agreement influence the interpretation of the lowered kappa value? Kappa values and percentage agreements are not well correlated and even in the absence of a low base rate, kappa provides consistently lower estimates of agreement than does

percentage agreement (Whelan, 1974; Suen and Lees, 1985). These are serious flaws to Hill's recommended means of overcoming the base rate problem of the kappa statistic. The kappa statistic was thereby precluded from use in the present study.

7.11.2 In practice

Suggested by Hill (above), percentage agreements are the most frequently used agreement statistic (Hollonbeck, 1978)

$$\text{Percentage agreement} = \frac{\text{Number of agreements}}{\text{Number of agreements + disagreements}} \times 100$$

and percentage agreements of 80% are customarily considered acceptable (Harrop, Foulkes and Daniels, 1989). Percentage agreements may be popular but they also have their limitations. The two most common criticisms of percentage agreements, that they become inflated by chance when there is an imbalance between scored and unscored instances and that they do not take account of change agreement have been addressed (see Harris and Lahey, (1978) for occurrence and nonoccurrence agreement and Hopkins and Hermann, (1977) for chance agreement calculations respectively) but the modifications have not been widely adopted. This is because the modifications suggested "are not easy to evaluate and the range quoted could raise questions in the readers' minds" (Harrop, Foulkes and Daniels, 1979, p. 183).

Harrop, Foulkes and Daniels (1979) applied the most commonly used indices of agreement (overall percentage agreement, occurence and nonoccurence agreement, chance agreement and kappa) to the same data set presented in contingency tables. The different interpretations of this same data revealed by the indices led them to recommend that the contingency tables from which the reliability indices were calculated should be presented. They argued that, in contrast with the reliability indices, these tables (a) showed the number of times observers agreed or disagreed on occurences and nonoccurences, (b) did not contain in built assumptions and were therefore a more precise source of information and (c) did not have to exceed any particular value or index and were therefore more "dogma-free" (p. 188) and concluded

"It is therefore suggested to avoid the conceptual confusion engendered by the use of summary indices of agreement, investigators should present contingency tables showing numbers of agreements and disagreements on occurences and non-occurences of

behaviour. Any mathematical indices presented to support assertions from these primary data should be presented in the contexts of the demands of the investigations. ...Whether we accept or reject these data as evidence of observer agreement must surely depend upon the use we wish to make of them, and upon other features of the investigation. For example, it would be foolhardy to expect observer agreement to be as high for behaviours which require high levels of interference on the part of the observer, such as 'pupil asking awkward questions', as for lower inference questions, like 'pupil talking'" (Harrop, Foulkes and Daniels, 1979, p. 187-8).

In short, despite being the statistic of choice for calculating interobserver agreement, kappa's base rate problem and associated difficulties precluded its use in the present study. Percentage agreements provide a familiar but limited alternative summary statistic. Given that one of the reasons for deciding against the kappa statistic was anticipated difficulties in its interpretation, the modifications to percentage agreements (concerning occurence/nonoccurence and chance agreements mentioned above) were also rejected. Following Harrop, Foulkes and Daniels it was decided to use percentage agreements in combination with the contingency tables used in calculating these agreements. The contingency tables will identify where the agreements and disagreements summarised by the percentage agreement appear in the coding data. Moreover, these tables permit the identification of errors of commision versus omission and will thereby address the third, less common crticism made of percentage agreements (Hartmann, 1974).

Finally, to return to the definition of reliability at the beginning, Hollenbeck (1978) argued that reliability is defined by accuracy *and* stability. This coheres with Carey and Gottesman's (1978) conclusion that "reliability must always be viewed in the context of validity" (p. 1459). Validity refers to the extent to which the ratings accurately reflect the true state of the subject (Hollonbeck, 1978). While reliability is necessary for validity, high reliability is insufficient to guarantee validity (Shrout et al, 1985); indeed Carey and Gottesman (1978) demonstrated how different uses and interpretations of reliability can lead to false impression of validity. In the majority of observational research the 'true state' referred to above cannot be established, validity is usually assessed by comparing the observers' ratings of the subject to the subject's state as determined by a criterion measure or calibration rating (Hill, 1991; Hollonbeck, 1978; Marmar, 1990), In practice these criterion or calibration ratings are usually established by an 'expert' or a previously trained group of raters; here the trainer's ratings of the material given the coders served this purpose.

7.12 Selection of the single clinical case

In the present study the client identified her own Challenges in clinical interview. In the Second Sheffield Psychotherapy Project (SPP2; see Shapiro, Barkham, Rees, et al, 1994; Shapiro, Rees, Barkham et al, in press, for details) all clients are assessed on three occasions after therapy is completed. In an interview (based largely on the Present State Examination (PSE; Wing, Cooper, Sartorius, 1974) Anita told the interviewer (off tape) that her second session had been a decisive, turning point in her therapy. She described how she had been openly angry with the therapist and had thought of leaving. Based on these client reports the researcher listened to her eight sessions and, using the operationalisation of Challenges, positively identified Challenge relevant material.

Examination of Anita's quantitative, outcome data indicated that her therapy was successful. At the intake assessment her scores were representative of the Low Severity of SPP2's depressed clients and her outcome scores met criteria for determining statistically reliable and clinically meaningful change (Jacobson and Truax, 1991). SPP2 (Shapiro, Barkham, Rees, Hardy, Reynolds and Startup, 1994) clients self-rated two core battery measures: the Symptom Checklist-90R (SCL-90R: Derogatis, 1983), a 90-item measure of psychiatric symptomatology; and the Inventory of Interpersonal Problems (IIP: Horowitz, Rosenberg, Baer, Ureno and Villasenor, 1988), a 127-item measure of client interpersonal difficulties. The SPP2 design randomly assigned each client to either 8 or 16 weekly sessions of either PI or cognitive/behavioural therapy. The SCL-90R was administered on three occaisions before therapy; at prescreening, at assessment interview (A1) and immediately prior to the first session. The SCL-90R was subsequently administered two weeks after the eighth session (A2). The IIP was administered at A1 and A2. At intake the client obtained a t-score of 69 on the SCL-90R (group M = 70.90, SD = 7.92) based on non-patient norms, improving to 65 at initial assessment, and 61 immediately prior to her first session. (Note that despite these improvements the client was still in the dysfunctional population prior to the start of therapy). Two weeks after therapy, the SCL-90R t-score dropped to 53 and at three month follow up was 55. The IIP was rated at initial assessment prior to therapy, when the client scored 1.61 (group M = 1.56, SD = .42), which improved to 0.72 post-therapy and 0.67 at three month follow up.

In short, the researcher's impressions of the eight session tapes indicated that her therapy contained Challenge Events and/or Challenge relevant phenomena. That therapy was successful according to SPP2's outcome measures in the SPP2 suggested that resolution performances would be observable in the session material. Anita's eight

sessions of Exploratory therapy were therefore selected for Challenge Marker identification by external coders.

7.13 Summary of Part One

Part One firstly identified two 'common behavioural denominators' that define Confrontation Challenge Markers. These were the client's confrontational manner and the client expressing dissatisfaction with the therapist, therapy or research. This definition was derived from the observation of Challenge relevant material in seven selected SPP1 cases.

This definition was developed into a system that permits users to identify and categorise the Markers. Questions suggested by the above observation of clinical phenomena were considered in relation to the clinical, theoretical and empirical literatures. This suggested (a) the categorisation of ten objects/sources of clients' dissatisfaction (into Therapist Activity; Unwritten Rules of Exploratory therapy; Unwritten Rules of Therapy in General; Therapeutic Situation; Written Rules; Research Contract; Other; General); (b) a general, natural language definition of dissatisfaction as negative sentiment and (c) the equal importance of session content and context in identifying Markers.

Thereafter the methodological decisions necessarily taken in preparation for external coders applying the identification and categorisation system to clinical material: Three external coders were employed. Speaking turns were selected as the unit of analysis. Session transcripts and audiotapes were prepared. Session material for coder training was selected from the clinical cases reviewed. Guidelines for training coders were reviewed. A strategy combining percentage agreements with contingency tables was selected as the means with which to assess the reliability of coders' applying the coding system to clinical material.

Part Two

7.14 Introduction

Part Two outlines users' application of the system, developed in Part One, to Exploratory session material. The related aims were (1) to determine modifications required to Part One's coding system and (2) to have external coders identify and categorise Confrontation Challenge Markers in Anita's Exploratory therapy.

The coding system was applied by the external coders on two occasions prior to their coding of Anita's eight Exploratory sessions.

- The Practice Coding aimed to access modifications required to the "Client Practice Coding Manual" (Appendix 2) and to assess the level of agreement between the coders and the trainer using the system. Percentage agreements fell just beneath the 80% acceptability criterion and consistent confusions were identified among coders. Whilst these confusions were to some extent expected and acceptable, understanding the sources of these confusions provided for revisions to the system.

- The Pilot Coding aimed to assess the effects of these revisions on agreements between coders. Percentage agreements were well above the 80% criterion but these were mainly constituted by coders' nonoccurrence agreements. This can be explained by the session material selected for this coding attempt having provided few positive answers to the questions asked of coders by the coding system. Time constraints and coders' external commitments prevented a second piloting attempt and coding of Anita's eight sessions was undertaken.

- In the Case Coding, levels of agreement were acceptably high (80-100%) and four Challenge Markers were reliably identifed. With the Markers for the four Challenge Events in Anita's sessions reliably identified, the researcher proceeded with Empirical Analyses of the resolution performances observed in each (Chapter Eight).

Part One described the development of a coding system to identify and categorise Confrontation Challenges. The three applications of this coding system are outlined here. As stated, given the amount of detailed information and the limitations of space, the detail of these applications is reserved for the Appendices.

7.15 Practice Coding

7.15.1 Aims

The Practice Coding had two aims; (1) to assess the reliability of coders' decisions and (2) to access modifications required to the Manual for Client Practice Coding. It was named Practice Coding in recognition of this being the coders' first experience of coding session material outside the group training sessions. Presented here is information regarding the session material selected for coding, the coding procedure and a statement of the questions asked of in the Coding Manual. The materials used by coders can be found in Appendix 4: these were the Client Practice Coding Manual; Client Backgrounds; session transcript and tape; Manual Evaluation Sheet and a set of Coding Instructions (which reiterated the Procedure set out in the Coding Manual).

7.15.2 The material selected for coding

There were two requirements of the sessions selected for this practice coding; the requirements and their rationale will be stated. Firstly, the sessions were required to provide coders with clear and positive examples of the session phenomena asked about in the Manual. Whilst coders had each taken part in a total of 20 hours training, this was to be their first experience of making coding decisions without support and discussion with other coders and the trainer. Material providing clear and positive examples was required so as not to compound their nervousness in this situation. Secondly, the sessions selected were required to provide coders with less clear examples of the same in order to identify common confusions and difficult distinctions between the Manual's answers; the rationale being that understanding the source of the coders' difficulties would indicate necessary modifications to the coding manual.

A restrictive number of sessions met these criteria. The two sessions selected by the researcher were the sixth session from Client 46's therapy (presented above in the discussion of Bingo and Almost but not quite Challenges) and Anita's second session, the case selected (above) for full task analytic treatment. The inclusion of Anita's second session at this point met Hill's (1991) recommendation that material used for both training and 'coding proper' be presented as far apart as possible; in this case some twelve months separated the coders first and final exposure to Anita's therapy sessions.

7.15.3 The coding procedure

The Procedure for coders to follow was presented on a separate Coding Instructions sheet and in the Introduction to the Coding Manual. Coders were asked to read the Client Background; listen to the session tape and read the session transcript once

stopping; read the instructions on how to answer the questions asked by the Manual and then, using the tape and transcript answer all the Manual's questions for each client speech unit in the session. Hill's (1991) dictum regarding unitisation of session material, 'don't ask raters to unitise and rate at the same time', was applied to listening to the session. They were asked to listen through to the session tape to familiarise themselves with the client and session material, prior to coding. These procedures aimed to prevent a situation in which coders were making decisions on new material at the same time as retaining it as context for future material. Coders were asked to ask all the Manuals' questions of each speech unit and record their answers to these. This procedure had two aims; firstly, to ensure that all questions and answers were considered and secondly, to ensure equal commitments to negative and positive answers to all the Manual's questions.

7.15.4 The questions asked in the Client Practice Coding Manual

The Manual for Client Practice Coding (Appendix 2) asked coders to answer the following twelve questions, in this order, for each client speech unit:

Q1	Is the client dissatisfied with therapy or reporting having been dissatisfied in therapy or both?
Q2	Is the client dissatisfied with the therapist's activity?
Q3	Is the client dissatisfied with the unwritten rules of Exploratory therapy?
Q4	Is the client dissatisfied with the unwritten rules of therapy in general?
Q5	Is the client dissatisfied with the therapeutic situation?
Q6	Is the client dissatisfied with the written rules?
Q7	Is the client dissatisfied with the research contract?
Q8	Is the client dissatisfied with the therapist's capacity?
Q9	Is the client dissatisfied with the capacity of the therapy?
Q10	Is the client dissatisfied with other specific aspect of therapy?
Q11	Is the client generally dissatisfied with therapy?
Q12	Is the client's manner confrontational?

The aims of the practice coding were (1) to assess the reliability with which coders were solo-coding session material and (2) to access common confusions with the content and

solo-coding session material and (2) to access common confusions with the content and process of coding. The results of the Practice Coding will be summarised in respect of these aims. It should be reiterated that (a) the trainer's coding answers were taken to calibrate the external coders'; (b) only headline statements are presented to economise on space; appropriate reference is made to Appendix tables.

7.15.5 Results regarding Question 1: Is the client dissatisfied?

For each of the dissatisfaction (Question One), confrontational manner (Question Twelve) and the sources/objects questions (Questions Two to Eleven), contingency tables were created and percentage agreements within and across (a) coding pairs and (b) the two sessions were calculated (using the formula presented above).

Table 7.4

PERCENTAGE AGREEMENTS FOR THE DISSATISFACTION QUESTION
(N = 164)

	Tape 1	Tape 2	Overall
Trainer - Coder 1	87	89	88
Trainer - Coder 2	84	82	83
Trainer - Coder 3	86	94	90
Trainer - All coders	81	86	87

Table 7.4 shows that overall agreement for the trainer with all three coders across both sessions was an acceptable 87%. This across-coders' agreement was slightly lower for the first session (81%) than the second (86%). Trainer-Coder coding pair agreements were all above 80% and so acceptable. Agreements between the trainer and Coder 1 were 88% over both sessions, with only 1% variation between Tape One (87%) and Tape Two (89%). Agreements between the trainer and Coder 2 were slightly lower but still above the 80% criterion; their overall percentage agreement was 83% with agreement slightly higher in the first (84%) compared with the second session (82%) coded. Agreements between the trainer and Coder 3 were the highest; with overall agreement reaching 90%; agreement was lower but still acceptable for the first session (86%) than

the second session (94%).

Table 7.5 profiles the distribution of the trainer and coders positively identifying dissatisfaction (that is, answering 'Yes' to Q1) to indicate the accuracy of the Practice Coding.

Table 7.5

PROFILE OF ANSWERS TO THE DISSATISFACTION QUESTION
(N=164 client speech units)

	4 coders			3 coders			2 coders			1 coder			Total
	Tr + 3	N/A	T	Tr + 2	3C	T	Tr + 1	2C	T	Tr	1C	T	
N	11	N/A		9	0		14	0		6	9		49
%	6.7			5.5	0			0		3.7	5.6		
T			11			9			14			15	49
%			6.7			5.5			8.5			9.1	
Cumulative totals			20			34							164
			12.2			20.7			29.8			29.8	

Tr : Trainer

C : Coder

The external coders 'missed', or made 'false negative' decisions for 3.7% (N=6) of the total client speech units and 'false positive' decisions for 5.6% (N=9) of the client speech units in the sessions. False positive identifications of client dissatisfaction were more common than false negative identifications, but still the incidence was low (5.6%).

To add to the information presented above, the contingency table for Practice Coding's Dissatisfaction Question was examined for differences between coding pairs that would reveal possible confusions or difficulties; the results are summarised in Table 7.6.

Table 7.6

DISTRIBUTION OF ANSWERS TO THE DISSATISFACTION QUESTION (Q1)

			Tape 1			Tape 2			Overall		
			Yes	No	Total	Yes	No	Total	Yes	No	Total
Coder No 1											
		Yes	9	10	19	11	10	21	20	20	40
	Trainer	No	0	58	58	0	66	66	0	124	124
		Totals	9	68	77	77	76	87	20	144	164
Coder No 2											
		Yes	7	12	19	5	16	21	12	28	40
	Trainer	No	0	58	58	0	66	66	0	124	124
		Totals	7	70	77	5	82	87	12	152	164
Coder No 3											
		Yes	15	4	19	18	3	21	33	7	40
	Trainer	No	7	57	58	2	64	66	9	115	124
		Totals	22	55	77	20	67	87	42	122	164
Overall											
		Yes	31	26	57	16	29	63	65	55	120
	Trainer	No	7	167	174	2	196	198	9	363	372
		Totals	38	193	231	36	225	261	74	418	492

Neither Coder 1 nor Coder 2 made 'false positive' identifications of client dissatisfaction, whereas Coder 3 made 9 (12%). That is, there were no speech units in either of the Practice Coding tapes for which Coders 1 and 2 answered 'Yes' to the dissatisfaction question when the trainer had answered 'No'. In contrast, there were nine occasions on which Coder 3 answered 'Yes' and the trainer had answered 'No'.

Taken together, these results show that the trainer and Coder 3 achieved highest agreement; against this were Coder 3's false positive identifications of client dissatisfaction. Coders 1 and 2 made no false positive identifications but their agreement with the trainer was lower.

Table 7.7

DISTRIBUTION OF ALL CODERS' ANSWERS TO THE TEN CATEGORY QUESTIONS

	TA	URE	URG	TS	WR	RC	TC	CT	O	G	n/a	Total
TA	39			1					3		26	69
URE		0										
URG		6	0	2							4	12
TS	1	1	2	2							27	27
WR					0							
RC						0						
TC							0					
CT		2		2				1			1	6
O	2	1							0		3	6
G										0		
n/a	3		2	3					1		363	372
Total	45	10	4	10	0	0	0	1	4	0	478	492

n/a : no answer

7.15.6 Q2-11: The Object/Source of the client's dissatisfaction

Table 7.7 totalled answers across coding pairs to the ten questions categorising the source/objects of clients' dissatisfaction; overall percentage agreements were calculated from this data. Overall agreement, across coding pairs and across categories, was an acceptable 82%. Regarding within-category agreements across coding pairs, 74% (N=363) of agreements were nonoccurrence agreements; 8% (N=39) were agreements on the Therapist Activity object/source; 0.4% (N=2) were agreements on Therapeutic Situation and 0.2% (N=1) was agreement on Therapist Capacity.

Table 7.8 presents the percentage agreements for each coding pair; that is, the trainer and each coder separately. Across categories, mean percentage agreements for each coding pair fell just below the 80% acceptability criterion. For the trainer and Coder 1 mean agreement was 77%; for the trainer and Coder 2 this was 76% and for the trainer and Coder 3 this was 71%. However, each coding pair's percentage agreement on the Therapist Activity category was above the 80% criterion; for the trainer and Coder 1, agreement was 82%; for the trainer and Coder 2, agreement was 80% and for the trainer and Coder 3, agreement was 83%.

Table 7.8

PERCENTAGE AGREEMENTS FOR SOURCES/OBJECTS CATEGORY QUESTIONS

	TA	URE	URG	TS	WR	RC	TC	CT	O	G	mean % agreement
Trainer - Coder 1	82	76	76	76	76	76	76	76	76	76	77
Trainer - Coder 2	80	76	76	76	76	76	76	76	76	76	76
Trainer - Coder 3	83	70	70	71	70	70	70	70	70	70	71

Confusions among the category answers are indicated by the entries lying off the diagonal in Table 7.7 above; the confusions and their incidence are summarised in Table 7.9 below.

Table 7.9

BETWEEN-CATEGORY CONFUSIONS IN THE PRACTICE CODING

		Coders' Confusions		
		Object/Source	**No**	**% of trainer's total**
Object/Source	**No of Positive Occurrences Identified by Trainer**			
Therapist Activity	69	None	26	37%
		Other	03	4%
		Therapeutic Situation	01	2%
Therapeutic Situation	27	None	21	78%
		Unwritten Rules of Therapy in General	2	7%
		Unwritten Rules of Exploratory	1	4%
		Therapist Activity	1	4%

Object/Source	No of Positive Occurrences Identified by Trainer
Unwritten Rules of Therapy in General	12
Capacity of Therapy	6
Other	6

Coders' Confusions

Object/Source	No	% of trainer's total
Unwritten Rules of Exploratory	6	50%
None	4	33%
Therapeutic Situation	2	17%
Unwritten Rules of Exploratory	2	33%
Therapeutic Situation	2	33%
None	1	17%
None	3	50%
Therapist Activity	2	33%
Unwritten Rules of Exploratory	1	17%

No instances of the following five objects/sources were identified by the trainer in the two sessions; Unwritten Rules of Exploratory Therapy, Written Rules, Research Contract, Therapist Capacity, and General Dissatisfaction. Of these five categories, the external coders agreed that there were no positive instances of four, Written Rules, Research Contract, Therapist Capacity, and General Dissatisfaction, in the session material. However, coders' positive identification of Unwritten Rules of Exploratory Therapy suggested that confusion may surround this category answer.

The trainer categorised Therapist Activity and Therapeutic Situation in 69 and 27 of the 164 total client speech units in the Practice Coding material. For both these categories,

the coders' most common confusion was to make false negative answers; that is, to answer negatively to all ten object/source questions.

With all the trainer's positive categorisations of the session material, three answers were repeatedly confused; Therapeutic Situation, Unwritten Rules of therapy in General and Unwritten Rules of Exploratory therapy. Of these repeated confusions, the Unwritten Rules of Exploratory, (the occurrence of which had only been identified by the external coders) was confused with all five of objects/sources positively identified by the trainer. The most frequent of the Unwritten Rules of Exploratory confusions occured when the coders positively identified Unwritten Rules of Exploratory and the trainer positively identified Unwritten Rules of therapy in General.

Examination of confusions peculiar to coding pairs (Appendix 5) revealed that Coder 1 consistently confused the Unwritten Rules of Exploratory answer with all but the Therapist Activity answer. When Coder 2 identified Unwritten Rules of Exploratory therapy the trainer identified dissatisfaction with the Therapeutic Situation. Coder 3's confusion over the Unwritten Rules of Exploratory answer was between this and Unwritten Rules of therapy in General; the latter of which she also confused with Therapeutic Situation.

On the one hand these confusions were understandable and acceptable; they embodied the inevitable interrelatedness of therapist and therapy; for example, Therapist Activity being confused with Unwritten Rules and Therapeutic Situation. On the other hand, these confusions required attention; for example, confusions between a 'process' category such as Unwritten Rules of Exploratory therapy and an 'outcome' category, Capacity of Therapy. Revisions were sought (see 7.15.6 below).

7.15.7 Results regarding Question 12: Is the client's manner confrontational?

Table 7.10 presents percentage agreements across and within coding pairs for answers (Yes/No) to this question.

Table 7.10

PERCENTAGE AGREEMENTS FOR CONFRONTATIONAL MANNER QUESTION

(a) Trainer - Coder 1

		Coder 1		
		Yes	No	Total
Trainer	Yes	2	0	2
	No	0	79	79
	Total	2	79	81

(b) Trainer - Coder 2

		Coder 2		
		Yes	No	Total
Trainer	Yes	1	1	2
	No	0	79	79
	Total	1	80	81

(c) Trainer - Coder 3

		Coder 3		
		Yes	No	Total
Trainer	Yes	1	1	2
	No	0	79	79
	Total	1	80	81

(d) Overall

		Coders		
		Yes	No	Total
Trainer	Yes	4	2	6
	No	0	237	237
	Total	4	239	243

Overall agreement between the trainer's and all three coders' answers to the question, 'Is the client's manner confrontational?', across both Practice Coding sessions was 98%. There was no difference in the level of this overall agreement for the separate sessions; 98% for each. Each coding pair's percentage agreement was similarly acceptable: Overall agreement between the trainer and Coder 1 was 99% (99% and 98% for Tape 1 and Tape 2 respectively); overall agreement between the trainer and Coder 2 was 97% (with no difference between the two tapes); overall agreement between the trainer and Coder 3 was 99% (again with no difference between the two practice coding tapes). All agreement levels were clearly acceptable. The contingency table (Table 7.11 below) from which these calculations were made was examined to assess the accuracy of these answers;

Table 7.11

CONFRONTATIONAL MANNER ANSWERS IN PRACTICE CODING

		Tape 1			Tape 2			Overall		
		Yes	No	Total	Yes	No	Total	Yes	No	Total
Coder No 1										
	Yes	2	1	3	1	2	3	3	3	6
Trainer	No	0	74	74	0	84	84	0	158	158
	Totals	2	75	77	1	86	87	3	161	164
Coder No 2										
	Yes	1	2	3	0	3	3	1	5	6
Trainer	No	0	74	74	0	84	84	0	158	158
	Totals	1	76	77	0	87	87	1	163	164
Coder No 3										
	Yes	2	1	3	3	0	3	5	1	6
Trainer	No	0	74	74	1	83	84	1	157	158
	Totals	2	75	77	4	83	87	6	158	124
Overall										
	Yes	5	4	9	4	5	9	9	9	18
Trainer	No	0	222	222	1	251	252	1	473	474
	Totals	5	226	231	5	256	261	10	482	492

Coders 1 and 2 'missed' (gave false negative answers) 3 (50%) and 5 (83%) of the positive instances identified by the trainer, Coder 3 'missed' only 1 (17%) of these. Whilst Coder 3 made 1(17%) false positive answer, Coders 1 and 2 made none. This pattern of results is similar to that obtained for answers to the question regarding client dissatisfaction.

7.15.8 Coders' observations of the results

Group and individual discussions of the results were held to tease out distinctions that were not being made or distinctions that might be made between the answers to the questions asked in the Practice Coding Manual. In the group meeting each Coding Manual question was discussed separately. Coders were asked to brainstorm around the question, 'How do you explain this confusion?'. The trainer recorded the understandings and the distinctions arising from the group discussion. Thereafter, the trainer and each individual coder met separately to discuss their answers made in the Practice Coding. Answers on which they had agreed were used to help understand answers on which they had not agreed; the trainer noted their rationale. These discussions produced the consistent observations which were used to revise the Practice Coding Manual and Procedure. The observations and resultant revisions will be stated.

Observation 1: All three coders had more confidence in their having internalised a sense of the answers to the category questions (Questions 2 to 11) than their answer to the first question regarding client dissatisfaction (Question 1). As intended the category questions made concrete their understanding of the session material. They tended to work out their answer to Questions 2 to 11 and answer Question 1 accordingly. Rather than orient the coders to the coding task, Question 1 was confusing and therefore redundant.

REVISION
Omit the separate question regarding client dissatisfaction;
associate it only with the categorisation of the sources/objects of dissatisfaction
(for example, 'Is the client dissatisfied with the therapist's activity?')

Observation 2: Associated in particular with Coder 1's and Coder 2's lower confidence in answering the first question regarding client dissatisfaction was a tendency to refer more to the content of the client's speech unit than the context. This went against the Coding Procedure, according to which they were asked to give equal consideration to both. This had resulted in Coders 1 and 2 making fewer 'Yes' answers to the Dissatisfaction Question than the trainer.

REVISION
Emphasise that all answers should be informed equally by session content and context.

Observation 3: With the planned inclusion of the dissatisfaction question with each of the objects/sources questions the coders wished the ten objects/sources questions to be asked separately. Recognising that they had 'favourite' answers or answers they were more confident of giving, all three coders considered that retaining the ten objects/sources as separate questions would encourage them to consider alternative answers to the one they first arrived at.

REVISION
Ask coders to separately ask and answer each of the category questions

Observation 4: The coder (Coder 3) who identified dissatisfaction with Therapist Activity on more occasions than the trainer, had a broader understanding of the definition than that presented in the Practice Coding Manual. She understood the definition to include general comments about the therapist (eg 'You make me nervous') as well as specific comments (eg 'When I knew I was going to be late I thought you would be angry').

REVISION
Emphasise that dissatisfaction with the Therapist's Activity is limited to the client's perception or experience of a specific thought, feeling or action of the therapist

Observation 5: Discussions revealed that coders' decisions to answer positively to Unwritten Rules of Exploratory therapy (URE) question (as opposed to the trainer's decisions to give Therapeutic Situation (TS) or Unwritten Rules of therapy in General (URG) as the answers) were determined more by their personal reactions to listening to the Exploratory sessions more than the Manual's specification of the Exploratory Model. Their 'sympathies' lay predominantly with clients and this identification led them to attribute clients' dissatisfactions more immediately to the particular therapy (URE) than to therapies in general (URG) or general aspects of being in the client role (TS). Through considerable discussion it was possible to (a) clarify coders' confusions and uncertainties regarding these categories and (b) to consensualise distinctions which made sense both to the coders and of the categorys' definitions.

REVISION

Distinctions between the commonly (URE, URG, TS) and potentially (TA, TC) confused Object/Source categories were written to accompany each category's Definition in the Coding Manual. This provided coders' constant access to the results of their discussions with the trainer.

Observation 7: In the Practice Coding coders had frequently pencilled in multiple answers to the coding questions in order to maximally represent their decision making and uncertainties in their first coding attempt. At the risk of not fully representing either the coders or the session material, one answer for each speech unit was desired for the Pilot Coding.

REVISION

Revise the Coding Procedure to instruct coders to (a) ask each question of a speech unit in turn and as soon as they answered Yes to one of the 'Is the client dissatisfied with ...' questions (Questions 1-10 in the revised manual) they were to then answer the Confrontation question (Question 11 in the revised manual) and then move on to ask the same questions of the next client speech unit in the session.

7.15.9 Summary

"Is the client currently experiencing or reporting having experienced dissatisfaction with therapy, or both?" was Question 1 in the Client Practice Coding Manual. The level of coders' agreement in answering this question (Yes/No) was acceptable within and across coding pairs but its separation from the sources/objects of dissatisfaction was found to confuse rather than simplyfy the coding task.

Questions 2 through 11 in the Client Practice Coding Manual asked about the sources/objects of clients' dissatisfaction; each question had to answered Yes/No. Across coding pairs, agreements on these questions ranged from 70% to 83%. Satisfactory agreement was only obtained for the Therpaist Activity category; 80-83%. Coders consistently confused the Unwritten Rules of Exploratory therapy answer the most commonly with the Unwritten Rules of therapy in General. Distinctions between confused categories were worked out with the coders and written into the coding manual.

Question 12 in the Client Practice Coding Manual asked 'Is the client's manner confrontational?'; answers were Yes/No. Agreement in answering this question was well above the 80% acceptability criterion both within and across coding pairs (98%-99% for coding pairs) and external coder's false positive answers to this question were less frequent than to the other eleven questions.

There were no meaningful differences in levels of agreement achieved for the two sessions coded in the Practice Coding.

Given the interrelatedness of aspects of therapy process and outcome in practice, some confusion, particularly in the Manual's categorisations of aspects of therapy with which clients may be dissatisfied, was expected. The levels of agreement achieved in the Practice Coding were almost acceptable. However, discussion with coders indicated the redundancy of the separate 'dissatisfaction' question and further distinctions between the sources/objects of dissatisfaction. The Pilot Coding which followed aimed to assess the effects of these revisions on levels of agreement.

7.16 Pilot Coding

7.16.1 Aim

The pilot coding aimed to establish the effects of the revisions arising from the Practice Coding levels of agreement between the trainer and external coders.

7.16.2 The material selected

For coder's ease of access to the material a client with whom the coders were already familiar was selected; Client 46's fifth session. Client 46 Session Six was the first of the session tapes coded in the Practice Coding. In this session she had referred to dissastisfactions experienced in Session Five, such that would provide instances for positive coding decisions to be made by the external coders.

7.16.3 Materials and Coder Preparation

The Manual for Pilot Coding (see Appendix 6) contained the revisions suggested by the results of the Practice Coding. All other materials, the Coding Booklet, Case Background and Evaluation Sheets were the same as those used in the Practice Coding (see Appendix 5). Coders were also given the session tape and unitised transcript. To familiarise coders with the revisions they were asked to read through the Pilot Coding Manual prior to a 'refresher' training session. The training session was discussion, not session tape, driven. Hypothetical examples of client dissatisfaction originated at the outset by the trainer and thereafter by all members of the coding group were discussed in terms of the re-definitions. The Pilot Coding Manual asked the coders to answer the following eleven questions:-

Q1	Is the client dissatisfied with the therapist's activity?
Q2	Is the client dissatisfied with the unwritten rules of Exploratory therapy?
Q3	Is the client dissatisfied with the unwritten rules of therapy in general?
Q4	Is the client dissatisfied with the therapeutic situation?
Q5	Is the client dissatisfied with the written rules?
Q6	Is the client dissatisfied with the research contract?
Q7	Is the client dissatisfied with the therapist's capacity?
Q8	Is the client dissatisfied with the capacity of the therapy?
Q9	Is the client dissatisfied with other specific aspect of therapy?
Q10	Is the client generally dissatisfied with therapy?
Q11	Is the client's manner confrontational?

7.16.4 The coding procedure

The Coding Procedure was presented in the Introduction to the Coding Manual and was the same as that followed in the Practice Coding. Coders were asked to read the Client Background; listen to the session tape and read the session transcript once through without stopping; read the Instructions on how to answer the questions asked by the Manual and then, using the tape and transcript answer the Manual's questions for each client speech unit in the session.

In common with the Practice Coding, coders were instructed to answer Question 11, 'Is the client's manner confrontational?', for each client speech unit in the session. In contrast with their instructions in the Practice Coding, coders were asked to answer Questions 1-10 in the order presented. As soon as they answered "Yes" to one of these ten questions they were asked to answer Question 11 before proceeding to apply the same procedure to the next client speech unit in the session. The Coding Instructions reminded coders that (a) the client dissatisfactions asked about in the questions could be currently experienced or reported dissatisfactions or both and (b) the questions required that equal attention be paid to the session content and context.

7.16.5 Results regarding aspects/sources of dissatisfaction: Questions 1-10

Two of the 81 client speech units in the session were identified by the trainer and all three coders as containing expressions of client dissatisfaction. For both these units, the trainer and two of the coders (Coder 1 and Coder 3) identified the clients' dissatisfaction as being with the Therapeutic Situation; in 99% agreement across coders for that question (Question 4). Coder 2 answered Yes to the 'Other' question for the same two client speech units, resulting in the same level of agreement (99%) across coders.

Neither the trainer nor any of the three coders identified positive instances of the following sources/objects of dissatisfaction in the session material; Therapist Activity, Unwritten Rules of Exploratory, Unwritten Rules of therapy in General, Written Rules, Research Contract, Therapist Capacity, Capacity of Therapy, Other and General Dissatisfaction. Thus the level of agreement for each of these answers, based on the trainer and all of the three coders answering negatively, was 100%.

In general, percentage agreements for the Pilot Coding were higher than in the Practice Coding but no positive instances of the answers which had been confused in the Practice Coding were identified by either the trainer or the coders.

7.16.6 Results regarding Question 11: Is the client's manner confrontational?

For the question asking about the client's confrontational manner, percentage agreements across coders were 99-100%. The trainer identified the client's manner as confrontational in two (of the 81) speech units in the session. Coder 1 did the same; resulting in 100% agreement for the Trainer-Coder 1 pair. Coders 2 and 3 positively identified one of these and another speech unit as containing the client's confrontational manner. Percentage agreement for each of these coders with the trainer was 99%. Overall percentage agreement for the group of trainer and coders was 100%.

7.16.7 Summary and Discussion

Levels of agreement were higher in the Pilot than in the Practice Coding; all reached the 80% acceptability criterion. However, the vast majority of these derived from negative agreements, that is agreements between trainer and coders on the nonoccurrence of the phenomena asked about in the Pilot Coding Manual. It can be argued that the session selected for the Pilot Coding did not permit the effects of the revisions made to the Practice Coding Manual and Procedure to be examined. This said, given the Procedure of answering 'Yes/No' for each of the eleven questions for each speech unit in the session, it should be noted that the material did however permit for the *positive rejection* of the answers commonly confused in the Practice Coding. Time pressure prevented further application of the Pilot Coding Manual to session material selected for its containing more positive instances of the phenomena which had been confused in the Practice Coding. Given the almost acceptable levels of agreement achieved in the Practice Coding it was decided to proceed with coding of Anita's sessions and, thereafter, re-assess levels of agreement among coders.

7.17 Case Coding: Coding Anita's eight sessions

7.17.1 Aims

The aims were to (a) identify Confrontation Challenge Markers in Anita's eight sessions and (b) assess the level of agreement with which trainer and coders achieved this.

7.17.2 Coding procedure

No changes were made to the Coding Manual; the same manual used in the Pilot Coding was used in this Case Coding. The manual asked the eleven questions listed above (7.16.3). Coders were asked to answer Question 11, the confrontation question, for each client speech unit in the session. Coders were asked to answer Questions 1-10 in the order presented. As soon as they answered "Yes" to one of these ten questions they were asked to then answer Question 11 before proceeding to apply the same procedure

client speech unit in the session. The Coding Instructions (see Client Coding Manual, p. in Appendix 6) additionally reminded coders that (a) the client dissatisfactions asked about in the questions could be currently experienced or reported dissatisfactions or both and (b) that the questions required equal attention be paid to the session content and context.

No alterations were made to the Coding Procedure. Coders were instructed to read the Case Background and listen to the session tape and read the transcript once through prior to coding,read the manual's Instructions on how to answer the questions and answer the Manual's questions for each client speech unit in the session. Coding each session was anticipated to take between two and two and a half hours. Coders only coded one therapy session each time they worked. Codings were arranged as close together as possible in order to maximise coders' retention of the therapy material. To maximally contextualise the therapy material, sessions were coded in their temporal sequence.

7.17.3 Coding Materials

Besides the Coding Manual (appearing in Appendix 6) the Coding Materials materials were the same as those used in the Practice Coding (see 7.15); a Coding Booklet, session transcript and tape, an Evaluation Sheet and a Case Background. For consistency with coders' previous coding of Anita's second session (a year previous in the Practice Coding), the same Case Background and trainer's summary of the first session was given to coders.

7.17.4 Support and 'drift' meetings

Meetings were held throughout coders' coding of the eight sessions. The meetings had two purposes; to check 'rater drift' and to check coders' anxieties. A group meeting was held after all coders had completed coding of the second therapy session and the trainer had analysed these results. Thereafter meetings with individual coders were held after the fourth and seventh therapy sessions had been coded. Records of the trainers' and the coders' coding decisions were discussed at each meeting. In addition the coders' questions and concerns about the coding and their views of the sessions were talked through.

17.17.5 Results: Examining levels of agreement

Table 7.11 summarises percentage agreements of all coders (a) across the ten source/object questions (Questions 1 through 10, called 'Cat' to indicate coders' Categorisation of Anita's dissatisfaction) and (b) the question asking about the client's confrontational manner (Question 11) for all eight of Anita's Exploratory sessions.

Table 7.11

PERCENTAGE AGREEMENTS FOR FINAL CODING OF ANITA'S 8 SESSIONS

	Trainer - Coder 1	Trainer - Coder 2	Trainer - Coder 3
Session 1			
CAT	96	95	95
CON	100	99	97
Session 2			
CAT	84	88	92
CON	100	100	100
Session 3			
CAT	99	91	85
CON	100	100	100
Session 4			
CAT	99	100	100
CON	100	100	100
Session 5			
CAT	100	99	99
CON	100	100	100
Session 6			
CAT	98	98	100
CON	100	100	100
Session 7			
CAT	99	100	99
CON	100	100	100
Session 8			
CAT	99	99	99
CON	100	100	100
Overall			
CAT	95	96	97
CON	100	99	100

Across all eight sessions and all ten source/object questions, the level of agreement between the trainer and Coder 1 was 95%; for the trainer and Coder 2 was 96% and for the trainer and Coder 3 was 97%. Across all eight sessions the level of agreement for answers to Question 11, asking about confrontational manner, for the trainer and Coder 1 was 100%, for the trainer and Coder 2 was 99% and for the trainer and Coder 3 was

Table 7.12 presents the contingency table summarising all coders' answers to the ten source/object questions which provided for the agreement calculations and from which the accuracy of answers can be assessed. Of the dissatisfactions positively identified by the trainer, most (4%, N=69) were with the Therapist's Activity. The three coders agreed on 75% of these answers. Coders' disagreement most commonly arose from them answering 'No' to all ten object/source questions (N= 11, 16%) or from them identifying the dissatisfaction as being with the Therapeutic Situation (N=3, 4%).

In contrast with the results of the Practice Coding, neither coders nor trainer identified any positive instances of the client's dissatisfaction with Unwritten Rules of Exploratory therapy and only once was this answer confused with Therapist Capacity. This suggests the revisions concerning this category made after the Practice Coding were effective in reducing confusions.

After Therapist Activity most of the clients' dissatisfactions were with the Unwritten Rules of therapy in General. On no occasions was this confused with Therapist Activity. Most confusions arose from the trainer identifying dissatisfaction with the Unwritten Rules with therapy in General and coders identifying no dissatisfaction. Other confusions were with coders identifying Therapeutic Situation (N=3, 11%) and with Therapist Capacity (N=2, 7%).

Despite good agreements for the Therapeutic Situation, Capacity of Therapy, Other and General dissatisfaction answers, coders missed additional positive instances identified by the trainer. Other confusions with these categories occured only once, twice or not at all. For both the Therapeutic Situation and Other categories as many positive instances were missed (N=5, 42%; N=9; 43% respectively) by the coders as were identified in common with the trainer. For both the Capacity of Therapy and General dissatisfaction categories more instances were missed (N=7,58%; N=10, 66.6% respectively) by the coders as were identified in common with the trainer.

Levels of agreement for the categorisation of dissatisfaction for each of the three coding pairs were acceptable. This statement was further supported by examining the coding answers given by each trainer-Coder pair (Appendix 7); all between-category confusions occured only once or twice in the coding of all eight sessions.

Table 7.12

OVERALL AGREEMENT ACROSS 3 CODING PAIRS FOR ANITA'S 8 SESSIONS:
SUMMARY CONTINGENCY TABLE FOR OBJECTS/SOURCES

Trainer's answers \ Coders' answers	TA	URE	URG	TS	WR	RC	TC	CT	O	G	n/a	Total
TA	52		1	3			1		1		11	69
URE		0										
URG			14	3			2				8	27
TS				5				2			5	12
WR					0							
RC						0						
TC	1	1					4					6
CT							1	4			7	12
O	2								9	1	9	21
G										5	10	15
n/a	3						1	1	3	3	1630	1647
Total	58	1	15	11	0	0	9	7	13	9	1680	1800

n/a : no answer

Table 7.13 presents the summary contingency table for all coders answers to Question 12 to indicate the accuracy of coders' identification of the client's manner being confrontational.

Table 7.13

OVERALL AGREEMENT FOR ALL EIGHT SESSIONS FOR ALL CODERS IN THE CASE CODING: SUMMARY CONTINGENCY TABLE FOR CONFRONTATIONAL MANNER QUESTION

		3 Coders		
		Yes	No	Total
Trainer	Yes	13	2	15
	No	1	1787	1788
	Total	14	1789	1803

Examining these data within coding pairs (see Table 7.14) indicated that for 5 speech units in the eight sessions the trainer and Coder 1 had agreed the client's manner was confrontational; they agreed 100%. Both Coder 2 and Coder 3 agreed with the trainer that the client's manner was confrontational on 4 occaisons in the eight sessions (Coder 2 disagreed once and Coder 3 disagreed twice with the trainer).

Table 7.14

PERCENTAGE AGREEMENTS FOR CONFRONTATIONAL MANNER QUESTION: WITHIN CODING PAIRS

(a) Trainer and Coder 1

		Coder 1		
		Yes	No	Total
Trainer	Yes	5	0	5
	No	0	596	596
	Total	5	596	601

Table 7.14 (cont'd)

(b) Trainer and Coder 2

		Coder 2		
		Yes	No	Total
Trainer	Yes	4	1	5
	No	0	596	596
	Total	4	597	601

(c) Trainer and Coder 3

		Yes	No	Total
Trainer	Yes	4	1	5
	No	1	595	596
	Total	5	596	601

In sum, the levels of agreement between the trainer and the external coders for the categorisation of client dissatisfactions and the identification of instances in which the client's manner was confrontational were acceptable. The revisions made subsequent to the Practice Coding had increased levels of agreement and decreased the incidence of confusions. Acceptable agreement established and remembering that a Confrontation Challenge is

> an instance in which the client, in a confrontational manner, expresses dissatisfaction with an aspect of therapy,

the specific location of coders' answers was examined to identify the Confrontation Challenge Markers reliably identified by the external coders in Anita's therapy.

7.17.6 Results: Identifying Confrontation Challenge Markers

The data providing for the above analyses (taken from the Coding Booklets) were searched to identify Confrontation Challenges in Anita's eight sessions. The trainer and the three coders identified the client's manner as confrontational and positively categorised her dissatisfaction on only four occasions in the eight sessions. All occured

in the second of the eight sessions. All four coders identified the client's manner as confrontational in all four of the client speech units (Units No 71, 119, 138 and 155).

All four units were positively categorised as containing dissatisfactions. All four coders agreed in their categorisation of the dissatisfaction in the third and fourth of these; this is maximum agreement. For the first two of these the trainer and Coder 1 agreed in their categorisation, as did Coder 2 and Coder 3. Whilst this is not maximum agreement the combination of the trainer and one coder and the two other coders agreeing was considered acceptable, for two reasons. Firstly, the categorisation of the first unit by the two coding pairs revealed the expected interrelation of therapist and therapy; Therapist Activity and Therapeutic Situation. Secondly, the two categories which conceptually are the closest in the categorisation system, Unwritten Rules of therapy in General and Therapeutic Situation, were selected by the two pairs of coders for the second unit.

	Categorisation by Trainer & Coder 1	**Categorisation by Coder 2 & Coder 3**
Unit No		
C71	*I feel a little as if I was to say the word black you'd pounce on it and say, 'black, now what does that mean?'. I suppose I'm almost sitting dead still so I don't give you the wrong impression*	
	Therapist Activity	**Therapeutic Situation**
C119	*I would like to think that the sessions that we're going to have will do something for me, will help me if you like, but this role thing is going to be there all the time isn't it. Me doing the role of being a patient or a subject if you like and you as, I hesitate to use the word expert in case you pounce on that but, the fact that you're qualified to deal with people with emotional disturbances, so that perhaps you can help me with mine, perhaps so that I can be aware of the signals that I'm giving out to other people*	
	Unwritten Rules of therapy in General	**Therapeutic Situation**
C138	*Well it would be interesting to know what your weaknesses were because I'm telling you about my weaknesses and you're not necessarily giving off what your weaknesses are*	
	Unwritten Rules of therapy in general	**Unwritten Rules of therapy in general**
C155	*No I'm testing you out in a way that I feel you're testing me out. At one time I would have felt reluctant to almost turn on you and say, well you've been doing that to me all session. I'd just have thought it to myself, but I think if we're going to get anywhere I've got to be honest and say what I think, even if I think you're posing as a psychologist, then I feel I ought to say that*	
	Therapist's Activity	**Therapist's Activity**

7.18 Conclusions

Part One developed a system for identifying and categorising Client Confrontation Challenges according to the object/source of the client's dissatisfaction and prepared for its application by external coders to Exploratory session material. Decisions were made regarding the role of session context; the selection of coders; the unit to be coded; the type of session materials to be used in coding; the selection of session materials; training coders; a suitable reliability index, and the selection of a single clinical case.

Part Two described three applications of the system developed in Part One. After almost acceptable levels of agreement were obtained in the first of these, the Practice Coding (7.15), revisions were made to the system and acceptable levels of agreement obtained in the Case Coding (7.17). That is, this chapter has shown that the Client Confrontation Challenge Coding Manual can be used by external coders to reliably and accurately identify Client Confrontation Challenges in Exploratory therapy.

Part One's definition of Part Two's identification of Client Confrontation Challenge Markers achieves the second and final step in preparing for task analytic investigations of Challenge Resolution Events in Exploratory therapy. This chapter indicates the applicability of the Manual beyond the analysis of the Challenge events in the present work.

The present analysis focusses on Challenge events identified in the single clinical case selected at the close of Part One. Applying the Manual to all eight Exploratory sessions, the external coders together with the trainer considered that Anita made four Confrontation Challenges in her second session. These Challenges and their resolution will be the subject of the next two chapters.

Chapter Eight

8.1 Introduction

The previous three chapters have achieved the preparatory steps in the present task analytic investigation of Confrontation Challenge Resolution. The development of the Rational Model of Challenge Resolution (Chapter Five), the demonstration of its applicability to therapeutic practice (Chapter Six) and the reliable identification of Challenge Markers (Chapter Seven) ground the substantive task analytic steps to be presented in this and the following chapter.

Chapter Seven closed with three external coders having agreed with the author in their identification of four Confrontation Challenges in Anita's therapy. The question addressed in this and the following chapter is, 'How were these Challenges resolved?'. To answer this question, Task Analysis revises the Rational Model of Challenge Resolution in the light of Resolution Performances taking place in clinical practice. Firstly the Resolution Performances taking place in practice, in Anita's therapy,are described in the Empirical Analysis; this is the aim of the present chapter. The following chapter will then revise the Rational Model in the light of these descriptions to propose a Performance Model of Best Resolution Performance to indicate how best the challenges were resolved.

For two reasons, Chapter Four argued for the Empirical Analysis taking a narrative approach (Bruner, 1986; see 4.5.3). Firstly, the narrative approach triangulates the methodological approach with the therapeutic approach which is necessary if research is to inform micro-level therapeutic practice. The narrative approach to understanding and explanation coheres with Exploratory therapy's emphases on the development of meanings and understandings being active, involved and negotiated. Secondly, and in contrast to the discovery-oriented approach popular in new style process research, the narrative approach does not assume an intrinsic, objective reality, that is latent in the data and discoverable by the reseacher. Rather, like the client and therapist participants, the researcher is explicitly cast as active in understanding the situation s/he is observing; all reflexively construct contextualised and particularised understandings of the situation (Rennie, 1992; McNamee and Gergen, 1992). The researcher's narrative account of the situation is a plausible, coherent account of the situation (Robinson and Hapwe, 1986); is constructed according to the author's logic (Stiles, 1993); shows the dialectical relationship between description and analysis (Wolcott, 1990) and is availiable for the consensus of its consumers (Rennie and Toukmanien, 1992).

A preliminary attempt to apply this narrative approach to the Challenge Events in Anita's therapy was undertaken as part of a separate, different project that responded to calls

for methodological pluralism in psychotherapy research (Agnew, Harper, Shapiro and Barkham, 1989; 1994; see 3.7.3). Grounded in the Exploratory therapy rationale, the previous project integrated quantitative, pre-post-therapy and session impact measures with qualitative, in-session analyses to propose an explanation for the continuous and heterogeneous process of change observed in Anita's case. The preliminary narrative accounts and their subsequent Rational Empirical Comparison generated in this mutlimethod project are thoroughly reworked for the present project in Chapters Eight and Nine; Chapter Ten will discuss their respective, substantive and methodological contributions.

Prior to 'writing a story' or 'generating an understanding' of the resolution of Anita's four Challenges, her therapy is set in the context of her personal history; the author's account of this, written for the external coders, is presented in 8.2. Secondly, the session material to be analysed had to be identified; Anita's reports of her dissatisfactions in therapy (identified by the external coders, see 7.17.7) were examined in combination with session transcripts to identify where the client and therapist located the Resolution to the Challenges she made (8.3). Thereafter the researcher's understanding was progressively, iteratively constructed by more and less close observations of the session material. This process is reflected in the presentation of its results. With the reader's access in mind, the researcher's understanding of how Anita's Challenges were resolved is progressively constructed (8.4). To close, observations made during the generation of these narrative accounts are reported (8.5) these observations were informative in the Rational Empirical Comparison (Chapter Nine).

8.2 The context to Anita's therapy: An account of her personal history

Anita, an arts lecturer in her mid forties, was experiencing symptoms of depression and anxiety. In the year prior to the start of therapy, a breakdown had prevented her from working for several months; she had seen a psychologist once and a hypnotherapist three times. She returned to a highly pressurised period at work and this in combination with difficulites in her relationship with her second husband had prompted her to seek help. Also her three children have also recently left home.

On completion of the standard SPP2 assessments (see 7.12), Anita was randomly assigned to eight sessions of Exploratory therapy with DAS, a therapist in his mid forties with 13 years postqualification clinical experience.

Anita's first session was largely taken up with history taking. She characterised her

childhood as painful, including repeated, significant losses. He mother died giving birth to her. When she was seven, her father remarried and she was taken from her paternal grandparents with whom she had lived happily. Her step mother was emotionally and physically abusive and resented Anita when her own daughters had died (the first died soon after birth and the second when she was nineteen years old). Her father was 'an ostrich' and stayed away from their home.

She left when she was sixteen and worked in a shop. At seventeen she married an academic who was 14 years older and whom she described as conceited; they had two daughters. She went to night school and teacher training college. Living with her present husband she likened to having another child. She described both husbands as inadequate. She was emotionally, not sexually, involved with a male colleague who was also married. She hoped that for the first time her needs would be met by this relationship but fear of hurting his wife prevented him from leaving.

8.3 Identifying session material to be analysed

8.3.1 Introduction

The Empirical Analysis generates and represents the researcher's understanding of the resolution performances s/he observes in the session material. Where in Anita's eight sessions were these resolution performances located?

In addition to the four Challenges she made in her second session, coders' reliably identified 22 occaisions in which Anita, in a nonconfrontational manner, stated her dissatisfaction with therapy. In the previous chapter these were called 'Almost but not quite Challenges'. They are distinguished from Confrontation Challenges by the client's manner not being confrontational; this accords them a reported, there and then quality as opposed to the Confrontation Challenge's in the moment, here and now quality.

These nonconfrontational reports of previous dissatisfactions were reviewed in parallel with the session transcripts to identify where she and the therapist located the resolution of her four Challenges. Using Anita's and the therapist's words this review is summarised.

8.3.2 Summary review of reports of previously experienced dissatisfaction

Firstly client and therapist agreed the Challenges in Session Two were resolved; secondly they seem to agree that resolution was achieved during Sessions Two and Three.

That both participants considered the Challenges resolved was most explicit in Session Eight's review of the therapy. In this session they negotiated their understandings of how resolution took place. Anita felt that she had gradually expressed her experience of and feelings towards the Therapist's Activities which had been the source of her dissatisfactions and provoked her Challenges. She felt that her slowly expressing her feelings about his activities took place the week after "things between them had gone wrong"; that is, in Session Three. She agreed with the therapist that his "gradually bringing it out of me" had helped and implied that it helped by "establishing an honesty" between them. The therapist expressed his understanding of their resolution in terms of Anita's learned ways of relating. He attributed their difficulty in Session Two to a well learned pattern (Anita "going silent" rather than openly and positively expressing her feelings) having been accessed in but not fully enacted; she had found an alternative way of relating in Session Three. He referred to this as "a powerful example of that, of finding a new solution".

Reviewing the transcript of that third session provided indications that, there and then, the therapist considered some resolution to have been achieved. He suggested the stalemate they had reached in the second session had been overcome; "we were in some kind of stalemate and we recognised it". His understood this in terms of Anita having related differently in the third session; she was less defensive, she was acknowledging her feelings and was expressing these, along with what she wanted and didn't want from the therapist. These achievements the therapist suggested were important for her ability to make constructive changes in extratherapy situations. Anita, however, was indeed more immediately concerned with situations outside therapy, in particular with her father, in which she experienced feelings similar to those she had experienced with the therapist in the previous session. Thus, whilst she later located resolution as having been achieved in Session Three there was little explicit expression of this in the session.

In Session Four however, Anita's nonconfrontational dissatisfactions did support the understanding that she had expressed in the therapy review, that resolution was achieved in Session Three. Session Four was also the session in which her pattern of withdrawing into silence, the relationship pattern identified through their difficulties in Session Two, was discussed. The focus was on Anita learning to negotiate her feelings and needs in significant relationships (with her husband and son) outside therapy. Anita followed the therapist's suggestion that examining how they had overcome their difficulties in Session Two would be informative: In Session Three they had overcome their difficulties by being

determined to "overcome hurdles" and "deciding to accomodate one another"; "we both decided to make a positive effort".

In Session Six Anita described their second meeting as "a thing of the past"; explicit confirmation of the 'there and then' quality to her nonconfrontationally reporting dissatisfactions experienced in Session Two. Their more detailed discussion of Session Two came from discussing Anita's learned way of 'going silent'. The therapist had "pounced on" and "misinterpreted" actions of which Anita was unaware; she became "wary" and withdrew; she became "horrified" at the thoughts of not being able to communicate with the therapist and not benefitting from therapy. Thus, at the same time as affirming that they had successfully negotiated the enactment of Anita's learned way of going silent, they made concrete its operation.

Identified as the sites of Challenge Resolution, Session Two and Three were analysed.

8.4 Empirical Analysis of Challenges in Session Two and of Session Three

8.4.1 Introduction

Elliott (1983b) observed that inductively analysing complex units of the therapeutic process, even when they are small, produces complex analyses. Shoham-Salomon (1990, p. 302) noted that the danger therein is "losing the forest while examining a tree". The researcher's understanding of both forest and trees is presented here. The researcher's understanding of how Anita's Challenges were resolved is progressively constructed for the reader. The first construction is the simplest; the researcher's *cumulated* understanding of each resolution attempt is characterised in a single sentence (8.4.2). Together these sentences give a simple account of how Anita's Challenges were resolved. Secondly, summary narratives expand this account (8.4.3). The richest account of resolution is then presented in two detailed narratives. Two of the five resolution attempts are selected (8.4.4) and client-therapist transactions are embedded in the researcher's detailed accounts of these (8.4.5 and 8.4.6). (The reader has access to the complete session transcripts (see Appendix 8). This structuring is intended to provide an accessible, cumulative and ultimately coherent narrative account of the session material.

To reiterate, five units are analysed here; the four Challenge Resolution events in Session Two and the entirety of Session Three. Each unit represented a Challenge Resolution attempt. Both client and therapist indicated that resolution had been achieved by the end of the fifth attempt (that is, by the end of the third session). All five Challenge

Resolution attempts will be diagrammatically represented in order that the resolution occuring in the two sessions can be reviewed 'as a whole' (8.4.6).

Characterisation of each resolution attempt in a single sentence
(8.4.2)

Summary narrative of each resolution attempt
(8.4.3)

Detailed narrative of
two resolution attempts
(8.4.5 & 8.4.6)

Diagrammatic overview of all five resolution attempts
(8.4.7)

8.4.2 Characterisation of each resolution attempt in a single sentence

These single sentences are presented at the outset to provide the reader with simple summaries with which to approach the amount and detail of session material in the following narratives. They represent conclusions to the inductive, constructive process described above.

Resolution Attempt One — Session Two, Challenge One

The therapist wanted to work; Anita wanted to tell him how he had contributed to her Challenge.

Resolution Attempt Two — Session Two, Challenge Two

A shared understanding of how therapist's Session One activities contributed to Anita's first Challenge was affirmed; the decks were cleared of Session One

Resolution Attempt Three — Session Two, Challenge Three

The here and now was taken on differently and substantive exploratory work followed; the 'here and now' got to the 'there and then'.

Resolution Attempt Four — Session Two, Challenge Four

At the close of the session there was little exploratory work but client and therapist roles, the rationale of therapy and a focus for work were clarified.

Resolution Attempt Five — Session Three

Attentively and thoroughly the object/sources of dissatisfaction were negotiated and explored; they stopped, looked and listened.

8.4.3 Summary Narratives of each of the Five Resolution Attempts

A summary narrative of each of the five resolution attempts will be presented, following (a) a summary report of the client's opening Challenge and (b) the researcher's characterisation of the resolution attempt.

Challenge One _____, Session Two

Anita: if I say the word black you"ll pounce and say 'black, now what does that mean?'

Characterisation of Resolution Attempt One

The therapist wanted to work; Anita wanted to tell him how he had contributed to her Challenge.

Summary Narrative of Resolution Attempt Observed in Challenge One

How the Therapist's Activity impacted on Anita's feelings in the session was explicit in her Challenge. The therapist prompted her to explore the meaning of these feelings. Anita presented her experience of his activities and their contribution to her Challenge. Referring also to the first session, the therapist set his understanding for these activities in the context of the rationale of the therapy. Anita again expressed her understanding of these contributions and this was explored by the therapist. The therapist linked Anita's feelings in relating with him with feelings she experienced in two recent situations outside therapy. Anita explored these briefly but returned to what was happening between them earlier in the session; she then made her second Challenge.

Challenge Two, Session Two

Anita: this role thing is going to be there all the time, me doing the role of patient or subject and you as the expert.

Characterisation of Resolution Attempt Two

The decks were cleared of the therapist's Session One contributions to the first Challenge; a shared understanding was affirmed.

Summary Narrative of Resolution Attempt Observed in Challenge Two

Anita put her dissatisfaction with the Unwritten Rules of therapy in General in the context of two recent experiences; the therapist's activities in the first session and the feelings which brought her to seek therapy. The therapist put his activities in the first session in the context of the rationale of therapy and Anita affirmed her understanding of the rationale. She did not take up the therapist's link between the latter and what was happening between them in the current session prior to the first Challenge. They explored links between the client's way of relating in another extratherapy situation (introduced by the therapist in Resolution Attempt One) and her way of relating in the current session were explored. Following a link back to the therapeutic relationship, Anita made her third Challenge.

Challenge Three, Session Two

Anita: I'm telling you my weaknesses, you're not giving off yours.

Characterisation of Resolution Attempt Three

The here and now was taken on differently and substantive exploratory work followed; the 'here and now' got to the 'there and then'.

Summary Narrative of Resolution Attempt Observed in Challenge Three

Set in terms of the Unwritten Rules of therapy in General and Exploratory therapy in particular, the therapist presented his understanding of what's been happening between them and makes explicit how they need to relate to work together. Paraphrasing the therapist, Anita confirmed her understanding. At the therapist's suggestion they explored and compared Anita's relationships with men and women. Exploration moved from relations with men and women in general, to her father and stepmother, to the present and her previous therapist, a woman. The therapist linked a

pattern in her relationships with men with her experiences of him prior to her Challenge; Anita made her fourth Challenge.

Challenge Four, Session Two

Anita: I'm testing you in the same way you're testing me.

Characterisation of Resolution Attempt Four

There was little exploratory work at the end of the session but roles, rationale and a focus for work were clarified.

Summary Narrative of Resolution Attempt Observed in Challenge Four

In her Challenge Anita expressed her view how she wanted to be able to work with the therapist. The therapist explored the feelings associated with this view. Therapist and client consensualised their understandings of the place of therapy in Anita's life, their roles in relating with one another and a focus for their work. The client's negative feelings about the outcomes of the present session were followed by therapist's request that Anita expand her understanding of the session. At the close he shared her feelings but indicated the potential value of their session for therapeutic learning.

Session Three

Anita: I've been thinking about it all week, thinking how do you get over that and back to communicating.

Characterisation of Resolution Attempt Five

Attentively and thoroughly the object/sources of dissatisfaction were negotiated and explored; they stopped, looked and listened

Summary Narrative of the Resolution Attempt Observed in Session Three

The therapist then Anita acknowledged their shared negative feelings about Session Two. Anita presented her experience and understanding of her contributions to these. The positive consequences of further understanding the origins of their difficulties were articulated by the therapist. The therapist explored Anita's experience and understanding of his Session Two contributions. Therapist linked these to the pattern in her relationships with men (that was identified in Resolution Attempt Three). Anita explored this pattern in relation to named men and then linked this

back to instances in Session Two with the therapist. In the light of these experiences, the therapist acknowledged the contributions of his activities to her Challenges and presented his understanding of his activities. Further negotiation of the client's dissatisfactions, the therapist's contributions to these, the client's consequent in-session experience and the effects on their relating together followed. The therapist linked this shared understanding of the client's experiences in Session Two with those of her first husband. Exploration of the parallels was followed by further shared understanding of Anita's feelings in Session Two and the therapist's contributions to these. Therapist then client recognised how each had contributed to maintaining these feelings; they agreed these understandings. The therapist presented his understanding of his Session Two activities. Exploration of links with other relationships outside therapy enhanced these shared understandings of Session Two. A parallel situation with Anita's father was explored. Her search for alternative ways of relating with her father was related by the therapist to differences in her style of relating with him in Sessions Two and Three. Anita's way of relating in Session Two had been indicative of her difficulties in relationships outside therapy; she had found alternative ways of relating in the present session and they had negotiated the difficulties of Session Two.

8.4.4 Selection of the Challenge Resolution Attempts for Detailed Narration

Space precludes presentation of the detailed narratives for all five resolution attempts. Two were selected; Challenge Resolution Attempt Three in Session Two and Session Three. These have been (8.4.2) characterised as the resolution attempts in which 'the here and now got to the there and then' (Resolution Attempt Three) and 'they stopped, looked and listened' (Resolution Attempt Five). These were selected on the basis of the researcher's understanding of the movement towards resolution across the five resolution attempts. Significant steps (Hobson, 1985) towards resolution were considered to take place in these two attempts. Steps are "turning points with sudden changes that are often accompanied by insight" (Hobson, 1985, p. 186). This is not saying that movement towards resolution was exclusively observed in these two resolution attempts; rather that moments of exponential movement toward resolution were understood to occur in these resolution attempts. In the narratives the steps will simply be identified. They will be summarised in the closing observations and later discussed in relation to the results of the Rational Empirical Comparison (Chapter Ten).

8.4.5 Detailed Narrative for Resolution Attempt Three in Session Two

This resolution attempt was characterised above (8.4.2) as the "'here and now' providing for the 'there and then'".

Anita and the therapist have been exploring links between her feelings in relation to the therapist and situations at work in which, despite feeling vulnerable she had tried to maintain her "coping person" rather than express her "soft person". These contrasted with her behaviour when she had been off sick, she had been able to express her needs and accept others' help, and with changes Anita had experienced in her relationship with her male superior. The therapist's linking (T137) these statements back to their relationship preceded her third Challenge (C138 below):

T133 & 5 *So you were accepting other people's help...and people were still accepting you and not exploiting you or their power. And you were able to like your superior better once he had acknowledged his weakness.*

T137 *Well I wonder if there's a link here with me. I'm just wondering whether I need to acknowledge my weakness for you.*

Challenge Three

C138 Well it would be interesting to know what your weakness is because I'm telling you about my weaknesses and you're not necessarily giving off what your weaknesses are.

The therapist responded to Anita's Challenge by presenting his understanding of how he had been trying to address the client's issues associated with their roles and sets this in the context of the purpose of the therapeutic relationship:

T139 *Well it's seemed to me as if I've tried to do something about that today, in terms of getting away from being the expert, or knowing it all in advance and having all the power...I've been trying to be open to you and to hear what you're saying and for what happens between us to be something real...Of course we're not equal in this situation, of course what we're doing is focussing on your problems and if I did anything else I'd be cheating you. But I'm trying not to be this severe and superior figure who doesn't acknowledge his own weakness and is therefore unsympathetic to other people. Because clearly that would be counterproductive, I couldn't help you if I was like that.*

At this point, as the client had earlier, the therapist acknowledged that he had in part contributed to the client's difficulties in the sessions (Step1). Whilst he expressed their joint contributions his statement ended by focussing on the client's and her

contributions presenting him with a difficulty.

T140 But I get the feeling that maybe partly because of the way I am and because of what you bring, it is quite hard for me to get out of that role

The therapist returned again to the content of Anita's third Challenge; he presented a more positive construction of their client and therapist roles and indicated how these could provide for their therapeutic work together:

T141 It is true that this is a special situation, that we're not friends, but to me it still seems possible for us to make a kind of contact...where I'm not stuck in this severe role and you're not stuck in a helpless, dependent role. And that if we can do that it will help us make sense of the patterns in your life and your relationships, through what it feels like as we talk

Anita clarified her initial understanding of his different construction of their roles (Step 2). She affirmed her understanding of their "aiming for a kind of no-man's land" and needing to "meet half way" as a blueprint for their relationship.

Anita took up the therapist's recognition that there was something about him which was "triggering" difficult feelings to initiate exploration of her relationships with men (Step 3). Anita compared these with her relationships with women.

T148 ...there's something about me that was actually triggering that

C149 I don't think it's you, I think it's men in general. I think my relationship if you were a woman would be quite different, I would be less suspicious

The discussion became increasingly specific; beginning with these relationships in general, moved to those with her father and her stepmother and ended with those with her therapists, the former of whom was a woman. The therapist identified a repeated experience in Anita's relationships with men, of feeling let down as she became more intimate with them, and linked that back to their present session:

T152 & 3 It's almost as if you don't expect much from women and you're looking for something from men and the pattern is to be repeatedly disappointed, let down. And perhaps that's a part of what's been happening between us, that you're testing and you're looking for a pattern of being let down

Anita responded with her final Confrontation Challenge of the session, in which she again expressed her dissatisfaction with the Therapist's Activity; she experienced him as testing

her and her reacting similarly to this. Thus, client and therapist roles negotiated and clarified in the 'here and now', Anita's relationships in the 'there and then' were explored and a repeated experience in her intimate relationships with men identified in Challenge Resolution Attempt Three.

8.4.6 Detailed Narrative for Resolution Attempt Five: Session Three

Above (8.4.2) this Challenge Resolution Attempt was characterised as "'they stopped, looked and listened'".

The entirety of the third session was spent working on the difficulties between the client and the therapist in Session Two. Anita presented no Confrontation Challenges in this session. Throughout she reported her dissatisfactions in the previous session and expressed two current dissatisfactions (with the physical environment) but at no point was her manner confrontational. The therapist's opening comment recalled them both having felt frustrated at the end of the previous session:

T4 *We were sharing a feeling of frustration at the end last time weren't we?*

which the client acknowledged:

C5 *Yeah. I've thought about it all week. Thinking how do you get over that and back to communicating*

Exploration of the sources of their frustration began immediately. Anita provided her understanding of her part in their frustrations:

C9 *...I think perhaps I was being defensive and trying to establish where I stood in relation to you.*

This was her understanding of what she had done and why in Session Two. This the therapist accepted and pointed to the positive values of their further understanding what happened between them (Step 4); this he presented in terms of their difficulties illuminating a relationship difficulty for the client and illustrating that these difficulties can be resolved.

The client added to her understanding by expressing a continuing dissatisfaction with an Other aspect of therapy; her experience of therapy's physical enivronment:

C11 *I think actually the building is another thing. I don't want to start criticising the building but it feels a bit clinical and it smells clinical, so from that point of view*

you're not relaxed

The therapist acknowledged both this dissatisfaction and the possibility of the environment affecting him similarly but returned to further exploring the client's experience of the previous session, which she reports:

T14 *So you were blaming yourself a bit, or wondering*

C15 *I was wondering, I wasn't totally blaming myself, I was blaming the situation. But I was remembering that I felt myself tightening up, which I do anyway when I'm unsure*

In this articulation of her feelings during the session, Anita did not take all the responsibility for what happened (which the therapist had implied she might have); neither did she attribute any to the therapist, only to "the situation".
Taking the client's description of herself "tightening up" during Session Two, the therapist linked her experience of him in the previous session to parallel situations in the client's significant other relationships with men (Step5). In doing this he initiated a Linking & Exploring - Sharing & Negotiating Understandings cycle which from this point is repeated to the end of the session. The cycle entailed the therapist(a) firstly linking and secondly exploring their difficulties in Session Two with similar instances in her significant relationships with men outside therapy; (b) the client reporting patterns and situations in these extratherapy relationships; (c) the client reporting and exploring specific dissatisfactions with the therapist in the previous session and (d) the therapist providing his understanding of what he was doing in the previous session and informing the client about their roles and his way of working in therapy. Repeating this cycle increased both participants' understandings of their difficulties in Session Two and of the sources of those difficulties. Indeed, the third repitition of this cycle culminated in therapist and client agreeing an understanding of how the second session was difficult for the client.

This third repitition will be reported in detail: The therapist started by looking for links between the client feeling that she "couldn't get through" in Session Two with other relationships outside therapy.

T61 *Yeah I think we both felt frustrated and that feeling of frustration is something you recognise, is something that you've had in other situations in not getting through to people*

The client cited examples of similar feelings with her first husband, which the therapist

explored firstly in relation to her husband and secondly in relation to her experience of him (Step 6); for example:

C62 *And I used to feel very frustrated at not being able to get to the root of any problem we had, because ... silence is an absolute weapon, and that happened over all the time I was married to him...And that was the thing that was never resolved. ...When we were actually splitting up, we tended not to row even then. But discuss things quite clinically and broadly, he wouldn't put all his cards on the table, he wouldn't say exactly what he was thinking, so there was poor communication there*

T63 *And you didn't have a way of dealing with that*

C64 *Well if someone won't answer, you find it difficult forming the next question*

T65 *So was there a sense for you in which I wasn't answering*

The client expanded her understanding of what happened between them:

C66 *You were looking. I thought you were letting me flounder....(C68;) I also felt you thought that I was almost putting on a performance*

The therapist reflected and paraphrased his understanding of the client's experience, recognised its importance for their work together and, for the first time, provided a comprehensive understanding of what he was feeling and trying to do in the previous session (Step7):

T69 *You felt that I felt that you were putting on a performance... You're reporting me, you're seeing me as being quite sort of critical, quite hostile to you...You were feeling that from me, you were sort of feeling sort of distancing disapproval and somehow hostility from me Well I think that tells us a hell of a lot...because that can't be what I was feeling. Because it would be completely against everything I'm doing this for...to react in that, to actually feel hostile. I could feel frustrated and what I was trying to do and maybe even this didn't succeed, this is interesting, I was trying to say at the end, with the frustration, I was trying to share with you and say 'Well, at least we can agree that we've both, we're both dissatisfied with what we've done together here'. That felt to me like it was worth acknowledging that. To say, 'Look, you know, we're frustrated, we're still here and we're gonna try and do better next time'. That was the kind of message that I was wanting to share with you*

The client responded by recognising her part in maintaining their difficulties (C70: *...afterwards I thought, I was very suspicious*...) and providing her further understanding of her dissatisfactions with the therapist:

C70 cont'd: ...To the point of thinking that in a sense you were trying me out. You know that you said that you had other ways of working other than discussing my life story in detail and ...I thought 'Is this one of the ways that we're working, is he trying to provoke a response from me?'. You see, because I don't know your methods...and I thought 'Are you trying to provoke a response from me by saying to me 'You're very suspicious', the thing about looking up there, ...And I felt suddenly you were making quite a lot out of that and I thought everything I said after that you were going to make something of huge magnitude out of it.

C72 ...that's what I meant by the performance, almost as if I was not communicating with you therefore I was putting over an image to you... and I felt at the end of the session last week as if I was total flop...I felt disappointed that you hadn't been able to work with me. I felt as much disappointed for you as I did for me and yet the other half of me was saying, 'Was he trying to provoke me?', you know. I think, we've said already today, I'm told I overanalyse everything. I've got this dreadful habit of analysing myself and analysing other people

Throughout this expression of the client's understanding of his activities, the therapist consistently acknowledged and reflected her feelings and articulated his understanding of these, thereby implicitly recognising his responsibility for the effects of his activities. He also expressed his empathic understanding of how the client's experience of him in the previous session resonates with her difficulties with her first husband.

He then articulated how, as a function of the model of therapy and his way of working, his contributions effectively maintained the client's dissatisfactions with him (Step8):

T73 Analysing yourself so much, and that's somehow in combination with me trying to use observations, and that's what I'm doing, I'm trying to pick up on what's happening between us...that's the way I'm working...but I'm trying to do that in service of helping communication but somehow you're feeling under scrutiny, under attack, potentially perhaps taken advantage of, and all that just feels like more of the same. And the more I did it the worse it was

That the client and therapist had both and together reached a greater level of understanding of the objects/sources and effects of the client's dissatisfactions in the previous session was evident, for example, continuing from the above:

C74 The more uncomfortable I became

T75 That's right...And it's something like ...it becomes impossible for you to say, to put into words what you want, what you feel...You ended up feeling paralysed and confused and attacked and having to retire to lick your wounds

C76 Umm, very isolated, ummm.

From here the same Linking & Exploring - Sharing and Negotiating Cycle was repeated to the end of the session, but with significant differences. In common with the cycle to this point, both therapist and client linked and explored her experience of the therapist in Session Two in relation to parallel relationship difficulties outside therapy, and this formed the context for their discussions of her dissatisfactions in that second session.

The content focus of their conversations however changed; from patterns in the client's experience of relationships with men to her learned ways of relating and expressing her feelings in these relationships. Anita provided this change in the focus (Step9):

C77 *...But what I can't understand is, having felt that (isolated) in so many situations, particularly with men, I'd not realised this before, this difference because I always thought I got on well with men...C79: But what I don't understand is why do I go back for more, why do I knowing that I've had this situation and I've tried to put out feelers towards the other person, whether it be a cuddle or whatever...that hasn't happened so why do I keep on going back for more? Why do I keep perhaps not being discerning about men? Is it the fact that I send out signals that are not saying to the man 'I'm helpless' but in fact 'I'm very independent', you know, doing the reverse of what I want really?*

Her understanding confirmed by the therapist relating his experience of her contradictory messages, the client proceeded to relate in detail a specific situation in which her father did not respond to her desparate need to go and stay with him; her ways of relating her feelings to her father in this situation were explored. For example, she said

C81 *And then to add insult to injury, the next time he rang me, which was about two months later, he said, 'You know the last time you rang you were a bit down' and I said, 'You'll never know how down I was' and said how much he'd hurt me, that 'you couldn't be bothered to find time for me and he said, 'I find it difficult to believe, you've always been so resilient and so hardboiled'...I thought, 'You don't know me very well Dad'. I remember that conversation and that just about sums it up on other occaisions. That's the response I've had and I'm not talking about putting up barriers there, I'm talking about saying, 'Can I come up for the weekend, I need you'.*

Both Anita and the therapist understood that her well-learned and -practised strong, coping style of self-presentation prevented her needs and feelings being recognised:

T82 *..so the thing about saying what you want and saying what you need, somehow people don't actually hear it*

C83 *They don't listen*

T84 *They don't listen...you were saying you were putting out the wrong message, somehow you're putting out messages but some other message is so strong from you that they don't hear the words*

C85 *It gets in the way, yeah. But I mean if that had been a videophone, he'd have seen me sitting on the bottom of my stairs in my house wailing my eyes out, feeling utterly, totally lost.*

And the therapist picked up the clear similarity between her feelings in this situation with her father (lost) and her feelings late in their previous session:

T86 *It feels like there's a message to me ... telling me this story about your dad is telling me ...I haven't really recognised the depths of your pain. That I don't really know how bad it feels.*

The client's response took their conversation away from exploring this parallel situaiton with her father. Whilst she talked at length and sometimes intellectually about her strict religious upbringing and subsequent religious dilemmas the therapist attempted to focus on the emotional meanings that religion and God have held for her. Having established the link between the client's feelings towards God and her father (having felt let down by them both), the therapist returned to their difficulties in the previous session (Step9):

T124 *So it seems to me that there may be something quite important...about the times and places and the people that make you feel angry. And we've talked about, we were sharing a feeling of frustration last week and...you were putting it on yourself, maybe blaming the building, maybe blaming yourself but perhaps also wanting but not quite being able to blame me for that*

C125 *Yeah blaming the expert, in the same way that God wasn't exactly helping...not calling you God by any means but in terms of the expert who should know, he should recognise what I'm, I can't communicate with him for some reason...*

From this point their exploration more specifically concerned Anita's way of relating when she is angry. This was explored firstly in relation to the therapist and secondly in relation to her father. The therapist consistently presented his understanding, to the effect that Anita had difficulty expressing her anger directly.

T131: *...you not expressing anger, frustration, that you were actually quite cross with me and it came out on the (post-session) form and not as we were talking*

Anita acknowledged this but pointed out a positive change; she had been able to articulate her dissatisfaction:

C133 I felt I got a little bit near it when I said I wouldn't have said that to you in the past...Whereas I did tell you how I was feeling as far as I could. But not saying, 'Look I think you're putting me on the spot and just trying me out, and you're making a bloody fool of me'. I didn't say that but I couched it in if you like polite terms. But at one time I wouldn't even have said the polite terms.

The therapist having again linked their difficulties in Session Two with other instances in which she had "not been able to get the message through, like with your dad (T136)", Anita (C137) expressed her difficulty understanding how her way of expressing herself had not been successful (Step10):

T:136 ...there's lots of other situations where you haven't said how you've felt, or where you've said and you've not been able to get the message through, like looking back with you dad, you haven't really had the experience of getting your point across and having someone know how you feel

C137 But I think the thing is, how strong have I got to put the message across

She illustrated this with another situation with her father in which she had felt "neglected and unimportant". Her understanding of the way in which she expressed her hurt and anger to her father and that of the therapist were substantially different:

C137 ...Now I told him, and you can't tell anyone any plainer than that can you, how neglected and how unimportant I'd felt ...and I felt very angry about that. (C139):I was being sympathetic...and so I didn't use a really nasty tone of voice, but I quite calmly told him why...I didn't feel it was revenge, it was just showing him as plainly and as loudly as I could that I wasn't this hard image that he thought I was

T138 And so you gave him what for...(T144:)... it sounds like you're as tough as old nails, you can give as good as you get...(T146:)...it's not quite 'sod you'. It's aggressive defences up...it's that your vulnerability is somehow disguised by kind of , 'Well if you're not interested in me then I'm not interested in you'. It's a kind of reaction, 'If you're going to reject me then I'll reject you'.

Their different understandings are not negotiated. Anita indicated that she felt unable to relate differently with her father and repeated her dilemma (see C137):

C147 But how else can you show that you're hurt

At this point the therapist attempted to illustrate to the client her ability to relate differently,

by effectively contrasting the way in which the client has been with him in this session as they had worked on their difficulties, with the way in which she was relating to him in the previous session.

T150 *Well I think there are other ways of doing things. There's something about what you did today telling me how angry and upset you were inside, when we were being defensive with each other, which is different. Telling me how you felt inside is different from being kind of defensive. Being defensive is what you do when it doesn't feel safe to express what you feel because it's not going to be well-received.*

Despite the therapist's clarifications, Anita expressed confusion both in relation to her father and in relation to their conversations:

C151 *I'm a bit confused by what you've just said. I can't think of any other way I could have told my father that I was hurt...(C155:)...I felt that was the only way I could show him how I felt*

C157 *Would you have preferred me to say, 'Look I mean I'm finding this a waste of time, I feel as if I'm on the spot here. I feel very vulnerable, I don't know what the hell you're doing but I don't like it*

The therapist persisted in emphasising firstly that what happened between them in the previous session indicated difficulties the client has had in other relationships and secondly, that through relating differently it had been possible for them to recognise and address their difficulties:

T158 *...I'm trying for us to understand what was happening and what pattern in your life that tells us about...(T160:)...all I'm saying is that, that is what seems to have been happening and that is expressing a problem you have in relating to people. And indeed what you're suggesting now, you know the alternative of saying 'I'm feeling I'm not getting what I want', ...yes that would have been easier to respond to and if that had happened we probably wouldn't have, you know we were in some kind of stalemate, and we recognised it.*

The session ended with the client acknowledging that in this third session she had related differently and thereby resolved her dissatisfactions with their relationship, but she anticipated greater difficulty doing this with her father, with whom patterns and styles of relating were more firmly established.

They 'stopped', that is the therapist gave and the client followed a clear and positive direction to further understand their difficulties in the previous session. They 'listened',

each to the other's understanding of their activities, feelings and rationale in Session Two, to the point of accepting and acknowledging how both had contributed to the origination and maintenance of their difficulties. They 'looked' closely at parallels in experience and ways of relating between their relationship and Anita's relationships with men outside therapy; this 'looking' informed their 'listening' and the 'listening' informed their 'seeing'.

8.4.7 Broadening out: A diagramatic overview of all five resolution attempts

Greenberg (1984b, 1992) has recommended that the descriptions of resolution performance resulting from the Empirical Analysis be presented as performance diagrams. The five resolution attempts narrated above are presented here as box and arrow plots. The plots represent the temporal sequencing of researcher-identified stages in the five resolution attempts. To facilitate the reader cross referencing the author's analysis, the plots identify transcript unit numbers (eg T74) which link the summary diagrams to both the detailed narratives above and to the full transcripts (in Appendix 10). To end this analysis, the plots provide a final overview of the researcher's understanding of how resolution proceeded in Anita's second and third sessions.

Session Two: Challenge One

"I feel a little as if I was to say the word black you'd pounce on it"

T explores Challenge associated feelings (T74, T76) & C presents understanding of T's Challenge contributions (C79)

T presents understanding of his contributions in S1: rationale of therapy (T81)

C presents her understanding of T's contributions & T explores associated feelings (C86; T87)

T links to & both explore parallel situation outside therapy (T100)

T links back to & explores origins of Challenge (T110) C states joint contributions

T explores C's feelings in relation to him (T112)

|

C's response: **Challenge Two**

Session Two: Challenge Two

"this role thing..patient or subject and you as, I hesitate to use the word expert in case you pounce"

+

C confirms shared understanding of T's S1 contributions
(C122&3)

C links to parallel situation
outside therapy &
(T133)
C&T explore

T links to therapeutic relationship
(T137)
|

Challenge Three

Session Two: Challenge Three

"I'm telling you about my weaknesses and you're not necessarily giving off what your weaknesses are"

T's understanding of
roles, in-session origins,
joint contributions, rationale of therapy
(T139-)
&
C clarifies and affirms understanding of rationale

T suggests in-session origins as focus for exploration
(T148)
&
C & T explore relationships
with men vs women

T links to therapeutic relationship
(T154)
|

Challenge Four

Session Two: Challenge Four

I'm testing you the same as you're testing me...if I think you're posing as a psychologist then I ought to say that"

Explore C's feelings in therapeutic relationship
(T158, C163)

T states (T166) and C negotiates roles (C165);
T states rationale for way of working (T168)
& confirms a focus; men

C evaluates session outcomes
(C171)
& process
(C175, C177)
& T indicates positive consequences for therapy
(T176)

Session Three

"How do we get back from that to communicating?"

C&T acknowledge "frustrations" of S2
T4, C5

T points to positive consequences of their
further understanding origins of Challenges
(T10)

T explores C's experience & understanding of S2
in terms of identified focus; men
(T14, C15)

Cycle 1:
Exploration of extratherapy parallels
providing for Negotiation of S2 Challenges
*see next page

Cycle 2:
S2 way of relating providing for
Exploration of extratherapy parallel: anger with dad
*see next page

Session 3's Two Cycles

Cycle 1:
Exploration of extratherapy parallels
providing for Negotiation

*T links to patterns in relationships with men (T16);
*T&C explore parallel patterns & situations outside therapy;
*T link to S2 Challenges;
*C's understanding of S2 origins
*T's acknowledgement of C's feelings in S2
& of extratherapy links
*T's understanding of his contributions, role & rationale & responsibility
C's understanding of her contributions
*Increasingly shared understanding of mutual contributions
(Cycle x 3
eg T69-C76)

Cycle 2:
S2 way of relating providing for
Exploration of specific extratherapy parallel:
being angry with dad

*C&T explore way of relating in parallel situations-
therapist & dad (C81-)
*T's understanding of S2 informing joint exploration of specific & parallel situation with dad
*Contrasting understandings of situation with dad
*T contrasts C's way of relating in S3 with that in S2 and in situation with dad to illustrate C's alternative way of relating

8.5 Concluding observations

8.5.1 Introduction

To as fully as possible inform the reader of the understanding with which the researcher approached the Rational Empirical Comparison (Chapter Nine), observations made by the researcher in the process of generating the above analyses will be noted. These observations were 'striking' in undertaking the foregoing analyses. Incorporated into the text of the previous section, the observations are highlighted here and will be discussed in relation to the results of the Rational Empirical Comparison (Chapter Ten).

8.5.2 The 'steps' in resolution observed in Challenge Three and Session Three

In Hobson's (1985) terms, the author identified 'steps' of significant movement toward Challenge Resolution during the third resolution attempt in Session Two and in Session Three. Twelve steps were identified in the detailed narrative accounts of the resolution performances observed in these two events (8.4.5 and 8.4.6). The steps will be repeated here; this time in terms of the researcher's understanding of why they were significant.

In Step 1 the therapist acknowledged that he had contributed to Anita's Challenges. In Step 2 Anita articulated and clarified her understanding of client and therapist roles. In Step 3 the therapist's acknowledgement of 'something about him' having 'triggered' Anita's Challenges provided an opening for her to express her understanding of the dynamics of their relationship. In Step 4 the therapist explicitly accepted Anita's Challenges and associated reactions, both as a part of the therapeutic process and as a source of potential benefit. In Step 5 the therapist expressed his understanding of Anita's 'tightening up' in Session Two and the terms of his understanding were supportive. In Step 6 the therapist expressed his understanding of both (a) Anita's experience in relating to her first husband and (b) its possible meaning for her experience of relating with him in the previous session. In Step 7 the therapist presented a comprehensive account of his contributions in the previous session, and the rationale he was following in these actions. In Step 8 the therapist expressed his understanding of how his contributions maintained Anita's discomfort in the previous session. Step 9 repeated Step 6; this time Anita's relationships outside therapy were with God and her father. In Step 10 Anita put into words her difficulty relating in situations paralleling those in their second session.

8.5.3 Tension between Negotiation and Exploration of the Challenge

In Challenge Resolution Attempts One and Two there a tension evident between the client engaging in activities typical of Negotiation and the therapist engaging in typical Exploratory work. In terms of the researcher's 'empathic understanding' (Stiles, 1993),

there was a sense of incompatibility between the two (expressing a a second struggle, or the same struggle expressed differently?); there was a sense that Anita having made her first Challenge, her requirements were not being met by the therapist's Exploratory efforts. More facilitative of Anita's movement toward resolution seemed to be a balance between Negotiation and Exploration that seemed first to occur in Challenge Resolution Attempt Three and again in Session Three. The researcher's understanding these qualities of incompatibility, tension, struggle, her understanding could be paraphrased as, 'this is not what's required'; 'there's something being missed'; 'if this goes on much longer it will make things even worse'.

8.5.4 Tension at the close of Session Two

The researcher also sensed a tension at the close of Session Two, Challenge Resolution Attempt Four. Both client and therapist were expressing frustration with the progress made in the session. The tension seemed to surround, on the one hand, responding to her final Challenge and on the other, closing the session and drawing out its achievements. There was a sense of the 'closing' being premature; perhaps indicative of insufficient resolution having been achieved?

8.5.5 Session Two and Three proceeding at a different 'pace'

A striking difference was observed between Sessions Two and Three in terms of something that at this point in the analysis seemed like 'pace'; Session Three proceeded at a slower 'pace' than did Session Two. Again there was a sense in which the Session Two's faster pace in the second session was incompatible with the client's requirements. The researcher's understanding of the second session could have been paraphrased as 'This is too much too soon', 'Anita's not with the therapist; he's out ahead and she's being left behind'. The question arising from this observation was, 'How is this incompatible 'pace' related to Anita making repeated Challenges?'; 'To what extent are these repeated Challenge a function of the therapist being ahead of the client, of their pacing being incompatible?'.

8.5.6 The common end to the first three Resolution Attempts

A fourth observation concerned the way in which the first three Challenge Resolution Attempts in Session Two ended. All were ended by Anita making her next Challenge. What was striking was that on all three occasions her Challenge was preceded by the therapist refocussing attention on Anita's feelings in relationship with him.

8.5.7 The necessity of Anita's Challenges

The final observation bears on the rationale for the original research question. The therapist commented at the close of the second session and again during Session Eight's review of therapy, 'maybe this had to happen between us, maybe this was necessary'. In so doing he was suggesting more than the research question's 'when they occur Challenges are significant in Exploratory therapy'; he was suggesting that 'it was necessary that the Challenges occured'. Anita neither confirmed or disconformed this understanding of their relationship.

These observations will be picked up in the Discussion (Chapter Ten) of the Rational Empirical Comparison's results. Chapter Nine presents the Rational Empirical Comparison.

Chapter Nine

9.1 Introduction

Chapter Nine concludes the implementation of the task analytic approach in the present work and proposes an answer to Chapter One's research question. The Rational Model of Confrontation Challenge Resolution (developed and applied in Chapters Five and Six) is revised by iteratively and successively comparing it with the narrative and diagrammatic accounts of the five resolution attempts made in Anita's therapy (generated in Chapter Eight). Its revision results in a Performance Model of Best Confrontation Challenge Resolution. Via the Rational Empirical Comparison, the researcher's 'best guess' at Challenge Resolution is revised to propose 'Best Performance' observed in clinical practice. The Model of Best Performance represents the task analytic answer to the Chapter One's Research Question 'How are Confrontation Challenges best resolved?'.

To be clear, the focus of the Rational Empirical Comparison concerns the five Challenge Resolution attempts in Anita's therapy described in the previous chapter. How the Rational Empirical Comparison proceeded is outlined (9.2). Features of the comparison process not previously articulated in the task analytic literature are highlighted. The comparison resulted in revisions to the stages of Challenge Resolution proposed in the Rational Model; these are outlined and located in the previous chapter's narrative accounts (9.3). The comparison also resulted in revisions at the within-stage level; that is, to the components making up the stages of Challenge Resolution. Given their microscopic nature, these are located in selected transcript material (9.4). The revisions are summarised; 9.5 presents the Model of Best Challenge Resolution Performance.

9.2 The Rational Empirical Comparison: The procedure

9.2.1 Introduction

This section sets out how the Rational Empirical Comparison proceeded. Anita made four Confrontation Challenges in her second session. Some progress toward resolution was achieved in that session; both client and therapist considered it completed at the close of the third session. The previous chapter's Empirical Analysis described and represented these five resolution attempts. In the Rational Empirical Comparison each description was compared with the Rational Model. Each comparison informed revisions to the Rational Model. The Rational Model was revised on the basis of the researcher's cumulative understanding of these comparisons.

9.2.2 The iterative nature of the Rational Empirical Comparison

The Rational Empirical Comparisons were iterative and their results cumulative. The iterations were two-fold; considered first was 'how does this description inform the

revision to the Rational Model?' and considered second was, 'how does the revisions resulting from one description inform the revisions arising from the previous comparisons?'. This is saying that in addition to (a) movements back and forth between the Rational Model and each performance description, the comparison entailed (b) movements back and forth between the results of these and the revisions from the same comparisons undertaken for the other four performance descriptions. The cumulative results of each of these two-fold iterations were incorporated into the revisions to the Rational Model. This two-fold nature of the Rational Empirical revisions has not been made explicit in the task analytic literature. It is this two-fold iteration that distinguishes the iterations required in the Rational Empirical Comparison from the iterations between the clinical material and the researcher's understanding in the Empirical Analysis.

9.2.3 The role of the Rational Model

The Rational Model provided a template for approaching the Performance Descriptions. The template was revised by the researcher's cumulative understanding of similarities and differences between the Rational Model and the Performance Descriptions.

The Rational Model provided questions that could be asked systematically in understanding the revisions suggested by the clinical material. For example the questioning regarding the therapist's Acknowledgement (Stage I) of the client's Challenge may proceed thus: 'What is the therapist's immediate response to the Challenge?, what accompanies and follows his Acknowledgement?, what is his response when it isn't an Acknowledgement?, how is it responsive to the Challenge?. For example, whilst the Rational Model suggested it was possible that the Challenge Resolution's positive value to the therapy would be indicated during the final Closure stage (Stage IV), the session material indicated that Positive Value was frequently associated with activities typical of the Negotiation stage (Stage II): Q: At what point in this example of Negotiation is Positive Value indicated? A: Both early and late in Negotiation; Q: What's it accompanied with? A: If it's early it's accompanied by the therapist paraphrasing his understanding of the object/source of the client's dissatisfaction; Q: What's it followed by? A: If it's early this is one common sequence of activities; the client provided her view of the objects/sources, the therapist actively understood and expressed his understanding of these, the therapist presented his rationale for these objects/sources she identified by referring to the rationale of the therapy, the client repeated and expanded on her view of the objects/sources of her dissatisfaction, etc..

9.2.4 The role of the descriptions generated by the Empirical Analysis

The Rational Empirical Comparison is both located in and abstracted from the Performance Descriptions generated by the Empirical Analysis.

The Revised Model only contained resolution activities and their patternings that were observed in the session material. All the activities specified in the Revised Model occurred to some extent, on some occasions, in some patterning during the observed resolution attempts. However, they were not simply 'lifted from' the descriptions of the performances and 'placed in' the Revised Model. Revising the Rational Model is not a simple, linear, mapping process; it is a complex, constructive process based on a cumulative understanding of what's best in the performances. This understanding was built from systematic consideration of questions, such as 'Based on what's observed elsewhere in the resolution attempts, what would have been more facilitative at this point?', 'Would the different patterning of these same activities observed in a previous resolution attempt have been more or less facilitative of resolution here?'. Thus the revisions are both a function of and an abstraction from the narrative accounts of moment to moment resolution performance.

9.3 Revisions to the Rational Model's stages

9.3.1 Introduction

From the Rational Empirical Comparison described, revisions were made to the Rational Model at two levels; at the higher level, the *stages* of resolution were revised and at the lower level, revisions to the *activities* constituting the stages were made. For ease of access, the two levels of revision will be presented separately. Thereafter, revisions at both levels will then be integrated; the Revised Model of Best Resolution Performance will be presented (9.4). In view of the location of these revisions in the previous chapter's analyses of Challenge resolution in Anita's therapy, the revisions are described for a male therapist and a female client. The Revised Model is, however, a proposition regarding Challenge Resolution in Exploratory therapy dyads.

9.3.2 Revisions to the Rational Model at the Stage-level

For ease of comparison, the stage-level revisions incorporated into the Revised Model are presented alongside the Rational Model.

Ideal Model	Revised Model of Best Performance
Confrontation Challenge	Confrontation Challenge
I Acknowledge Challenge	**I Acknowledge Challenge and associated feelings**
II Negotiate shared understanding of in-session origins of Challenge	**II Negotiate in-session origins of Challenge**
III Explore access Challenge provides to Client's interpersonal patterns	**III Explore extra-therapy parallels**
IV Positive consequences of Challenge Resolution	**IV Consensus and Renegotiation**
	V Further Exploration of extratherapy parallels
	VI Positive contributions for therapy and client's potential for constructive relationship change

All the stages suggested in the Rational Model were identified in the five Resolution Attempts. No additional stages were identified. However a different relationship between the Rational Model's suggested stages was proposed in the Revised Model.

The Rational Model (see Chapter Eight) presented a linear and discrete movement between the Negotiation and Exploration Stages (Stages II and III) in the Rational Model. The Rational Model suggested the Negotiation of the in-therapy origins of the client's Challenge preceding the Exploration of parallel situations in relationships outside therapy and in the client's past. That is, with the Challenge to the therapeutic relationship Negotiated, the access provided by the Challenge to the client's repeated interpersonal difficulties could be Explored.

In contrast the Revised Model proposed that neither the Negotiation or the Exploration stages were either (a) completed in a single, discrete efforts or (b) were independent activities. In respect of their not being discrete, Negotiation of the in-therapy origins of the Challenge was proposed to proceed in two stages; the second of these (Stage IV in the Revised Model) made more concrete and specific the shared understanding which had been achieved in the first Negotiation attempt (Stage II of the Revised Model). The two Negotiation attempts resulted in a shared understanding of the moment to moment specifics of the in-therapy activities, experiences and understandings that had contributed to the client making her Challenges.

This represents an advance on the endpoint of the Negotiation Stage suggested by the Rational Model: The understanding of the in-therapy origins is not only shared and consensualised; it is particular in its specification of the client's behaviours, feelings and understandings contributing to the Challenge.

The Revised Model similarly proposed that Exploration of the extratherapy parallels proceeded in two stages: In the first of these, in Stage III of the Revised Model, a general relationship pattern, which specifies the commonalities between the dynamics of the Challenge in the therapeutic relationship and relationships outside therapy, is identified. In the second of the Exploration attempts, in Stage V of the Revised Model, the specific operation of the pattern, within and across particular situations, in a specified relationship are explored. Therefore, in common with the Negotiation attempts of Stages II and IV of the Revised Model, the Exploration attempts in Stages III and V are proposed to become increasingly concrete and focused.

The Revised Model proposed that the Negotiation and Exploration stages of Challenge Resolution are not independent of one another; they are functionally interdependent. Their interdependence can be conceptualised as a 'spiralling' between Negotiation and Exploration, in which each 'twist' of the spiral advances Challenge Resolution, thus:

Negotiation
provides for Exploration
provides for Further Negotiation
provides for Further Exploration

As suggested by the Rational Model, the Revised Model proposed that Challenge Resolution Performance was best opened by acknowledging the client's Challenge and associated feelings and best closed by pointing to the positive contributions made by the Challenge Resolution to the therapeutic relationship in particular and for the client in general.

9.3.3 Location of the Stage-level revisions in the session material

Table X locates the Negotiation-Exploration spiralling the Challenge Resolution observed in Anita's second and third sessions. Each of the five resolution attempts is identified by the single sentence proposed to characterise the particular resolution attempt (8.4.2); the Negotiation-Exploration spiral is abstracted from the diagrammatic representation of the researcher's understanding of how resolution proceeded across all five resolution attempts:

Table

LOCATING NEGOTIATION-EXPLORATION SPIRALLING IN ANITA'S FIVE RESOLUTION ATTEMPTS

Challenge Resolution Attempt One	'Working vs. telling'
T explores in session meaning	
	C presents her understanding of T's contributions
Challenge Resolution Attempt Two	'Clearing decks of Session One'
	T&C Negotiate previous session
Explore out of session parallels	
Challenge Resolution Attempt Three	'Taking on here & now'
	Negotiate roles & rationale in current session
Explore interpersonal pattern	
Challenge Resolution Attempt Four	'Clarifying and closing'
Explore current session experience	
	Negotiate roles, rationale & focus for work
Challenge Resolution Attempt Five	'Stop, look & listen'
Explore in-session experience	
Explore out of session in general	
	Negotiate previous session
Explore out of session in specifics	

The first Negotiation attempt revealed that Anita's Challenge ('If I say black you'll pounce') originated from the therapist's ways of using here-and-now observations to illuminate Anita's experience and way of relating in the session. This Negotiated understanding provided for Exploration of extratherapy parallels; Anita's expectations of her relationships with men had repeatedly been dashed. This provided for Further Negotiation of the specific in-therapy origins of Anita's dissatisfaction. To paraphrase Anita's experience, by the therapist saying that in eight sessions there was no time for her life story, Anita's hopes for their relationship have been undermined and her understanding of how therapy would proceed confused. Further Negotiation of these experiences provided for Further Exploration of a parallel situation in a specific relationship outside therapy; the way in which Anita experienced and related to her father on the repeated occasions when she felt he had not recognised her needs.

9.3.4 Revisions to the Rational Model at the Activity level

Within-stage revisions were made to the Negotiation stage. Three sub-stages to Negotiation activities were proposed by the Revised Model; they were considered Negotiation substages on the basis that they seemed oriented to the same objective, that of understanding the in-therapy origins of Challenges. They were titled 'Recognition and Direction'; 'Negotiation Cycle' and 'Consolidation'. In brief, in the Recognition and Direction substage the Challenge is recognised and the client explicitly directed to Negotiation of its origins; in the Negotiation Cycle, the client's and then the therapist's understanding of these origins are adjusted and finally shared and in the Consolidation substage their consensualised understanding is reiterated and the value of the Challenge as providing a focus for Exploratory work made explicit.

The Revised Model proposed that the three substages were achieved by characteristic activities; these are presented in the table below:

Revisions to Negotiation

Recognition & Direction

T paraphrases understanding of here-and-now feelings

T acknowledges his possible contribution

T indicates positive value of understanding the origins for
(a) relationship
and (b) therapy

T initiates discussion of C's understanding of in-session origins

Negotiation Cycle

T's acknowledgement, paraphrasing, clarification of C's understanding

C's understanding of T's contributions

T's understanding of his contributions
C's understanding of both contributions

Understanding of joint contributions

Consolidation

T summarises consensus and repeats positive value

The Revised Model's Recognition and Direction substage is preparatory to the Negotiation. The therapist's communication being distinct and deliberate in this substage was observed to have the effect of 'halting' the therapeutic process in recognition of the client's Challenge. The Challenge is thoroughly recognised and this recognition communicated to the client by the therapist paraphrasing his understanding of the client's feelings in the here-and-now and explicitly stating the importance of the Challenge to their relationship and their work. The therapist takes the initiative; acknowledging the possibility of his having contributed to the Challenge and opening discussion of the client's understanding of its origins.

The Negotiation Cycle substage has four steps. In the first the client's understanding of the Challenge's origins is prioritised over and above the therapist's. The constituent activities are directed to affirming and understanding, not evaluating, the client's experiences and understanding. As the client's understanding is progressively expanded the therapist affirms both (a) her understanding and (b) his understanding of her understanding. His understanding is most effectively communicated by paraphrasing and clarifying (rather than, for example, reflecting or exploring) her understanding. In the second step the therapist expresses his own understanding of the objects/sources of dissatisfaction identified by the client. His understanding is expressed in explicit and empathic relation to the client's understanding, taking responsibility where appropriate and secondly, in relation to their roles in the therapeutic relationship and the rationale of the therapy. In order to progressively negotiate a shared and mutually acceptable account of the therapist's contributions to the Challenge's origination, cycling between these first two steps is required. In the third step the focus switches from the therapist's to the client's contributions to the Challenge and her responsibility for these, however unwitting, is encouraged. Thereafter the contributions of both participants can be explicitly stated. In the Consolidation Stage their shared understanding, its value for clarifying and negotiating the therapeutic relationship are reiterated by the therapist; as is the direction their Negotiation has provided for their Exploratory work.

9.3.5 Location of the Activity-level revisions in the session material

These Activity-level revisions will be located in the session material by presenting selected transcript excerpts. As stated (9.2.4), revising the Rational Model is not a simple, linear, mapping process. Revisions are not simply lifted from the descriptions of performances and placed in the Revised Model; they are a product of a complex, constructive process. Thus no single example of all the activity-level revisions can be lifted from the session transcripts; they have to be constructed from the five resolution

attempts. However, for ease of cross reference with their descriptions in the previous chapter, these excerpts will, where possible, be selected from Challenges Three and Session Three since complete and detailed narratives of these were presented (8.4.5& 8.4.6). (Selecting material from these is also testimony to the exponential steps toward resolution observed in these resolution attempts). To accompany these transcript excerpts, reference will also be made to additional observations of the same activities occurring at different points in the five resolution attempts (These references indicate their location (C1, C2, C3, C4, S3).

RECOGNITION AND DIRECTION	
T paraphrases understanding of Challenge associated feelings	EgC3*T148...It seemed that you're needing, need to protect yourself from attack* **(C3, C4, S3)**
T acknowledges possible contribution	EgC3*T148...and there's something about me that was triggering that* **(C3, C4, S3)**
T indicates value of negotiation for relationship and (b) work	EgC5*T10...when those things happen it's* (a) *usually telling us something that we can use..I mean, not just telling me, telling us..I think it's something we needed to do. If we didn't do it, there'd be some kind of possibility in the air* **(C4, S3)**
T initiates discussion of origins	EgC5*T14...so you're blaming yourself (for S2 going "badly wrong" (C9)) or wondering* **(C1, C4, S3)**

NEGOTIATION CYCLE	
T's paraphrasing & clarification of understanding of Challenge origins	EgS3*T65...there was a sense for you in* C's *which I wasn't answering?* *C66 ...you were looking,...you were letting me flounder (C68)...I also felt that you thought I was almost putting on a performance* *T69 ...you're seeing me as being quite critical, quite hostile to you, you were feeling sort of distancing disapproval* *C70 ...I was feeling suspicious.. thinking that in a sense you were trying me out..trying to provoke a response from me by saying 'You're very suspicious',* *T73 ...somehow you're feeling under scrutiny, under attack, potentially taken advantage of* *T76 ...you ended up feeling paralysed and confused and attacked and having to retire to lick your wounds* **(C1, C4, S3)**
T's understanding of his contributions	EgS3*T59 You were feeling very, very edgy.. so you were coming with one expectation and then that's suddenly taken away from you [C40 by T saying there wasn't time for C's life story] and you feel exposed and you don't know what's going to happen. And that seems to connect with feelings about men in particular, that you don't quite know what's going to happen then it's dangerous cos there's a lot they can do to hurt you..* **(C1, C3, S3)**
C&T understand contributions	EgC4*C175you were sort of questioning* joint *what I was saying and from then on it seemed as if both of us were defining our roles* EgS3*T73... you analysing yourself so much and somehow in combination with me trying to use observations,..and the more I did it the worse it was* **(C1, C3, C4, S3)**

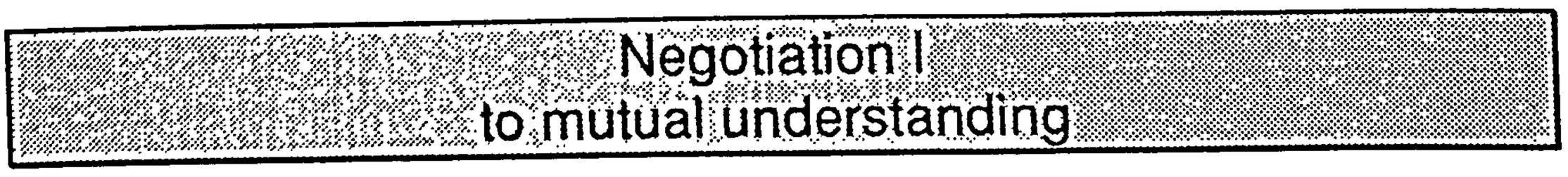
CONSOLIDATION	
T summarises consensus and repeats positive value	EgS3*T59 ...Like you know when you were, when you were looking around you felt uncomfortable. However unusual that is it's something that happened, something that you were doing, something that you were feeling. And it has led us to be able to say quite a lot about you in relation to men and your worst fears about what can happen* **(C4, S3)**

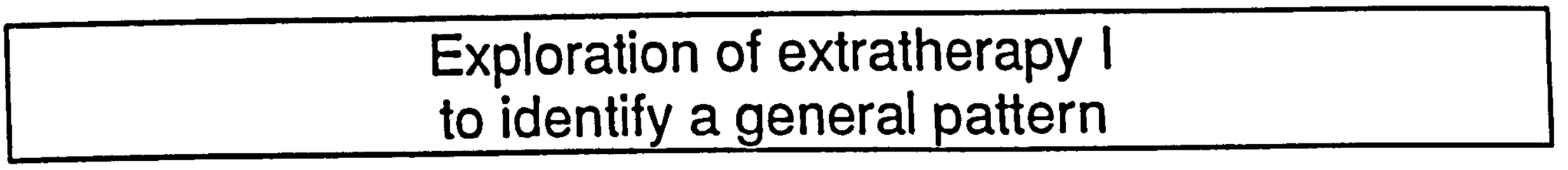
9.4 Summary: The Revised Model of Best Challenge Resolution Performance

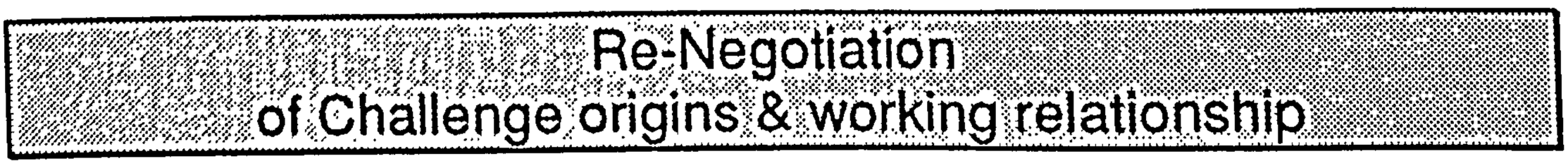
This chapter has described the Rational Empirical Comparison and presented its results. The iterative nature of the Comparison was explained; iterations are made between (a) the Rational Model and the Performance Descriptions and (b) between the revisions suggested by successive comparisons. The researcher's cumulative understanding of these, the content, sequencing and combinations of activities within the observed performances, decides the revisions made to the Rational Model. In this process the Rational Model serves as a template through which to identify performance patterns and their movement or otherwise toward Challenge Resolution. All the resolution activities proposed in the Revised Model are observed to occur, in some form, on some occasions, in some combination during the resolution performances. Their proposed configuration represents the researcher's cumulative understanding of 'what and how' is facilitative of resolution in the clinical practice sampled.

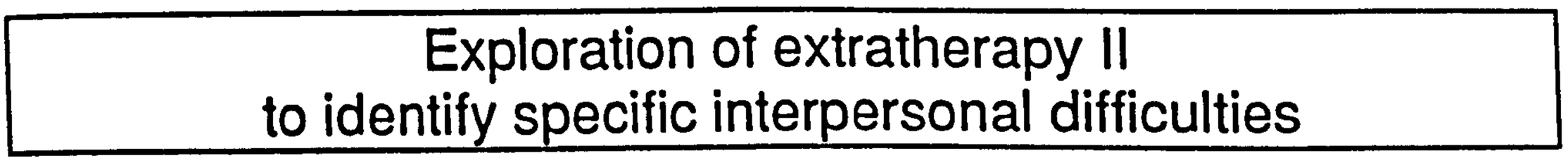
Revisions were proposed to the stages and the activities making up those stages of the Rational Model. In place of the Rational Model's linear and discrete movement from Negotiation to Exploration, the Performance Model proposed these stages are interdependent and mutually informative. A 'spiralling' between Negotiation of in-therapy Challenge origins and Exploration of extratherapy parallels was proposed thus:

Negotiation-Exploration Spiralling









Negotiation of the in-therapy origins of the Challenge was proposed to proceed in two stages; the second of these (Stage IV in the Revised Model) made more concrete and specific the shared understanding which had been achieved in the first Negotiation attempt (Stage II of the Revised Model). The two Negotiation attempts resulted in a shared understanding of the moment to moment specifics of the in-therapy activities, experiences and understandings that had contributed to the client making her Challenges. The Revised Model similarly proposed that Exploration of the extratherapy parallels proceeded in two stages: In the first of these, in Stage III of the Revised Model, a general relationship pattern, which specifies the commonalities between the dynamics of the Challenge in the therapeutic relationship and relationships outside therapy, is identified. In the second of the Exploration attempts, in Stage V of the Revised Model, the specific operation of the pattern, within and across particular situations, in a specified relationship are explored.

Within-stage revisions were proposed to the Rational Model's Negotiation stage. Three substages were proposed; 'Recognition and Direction'; 'Negotiation Cycle' and

'Consolidation'. In the Recognition and Direction substage the Challenge is recognised and the client explicitly directed to Negotiation of its origins; in the Negotiation Cycle, the client's and then the therapist's understanding of these origins are adjusted and finally shared and in the Consolidation substage their consensualised understanding is reiterated and the value of the Challenge as providing a focus for Exploratory work made explicit. Two features of the particular activities constituting these substages should be stressed here. Firstly, Negotiating the in-session origins of the Confrontation Challenge is proposed to focus first and foremost on the client's in-session experience and her understanding of the therapist's contributions to this; the therapist activities encourage her articulation of these. Secondly, the style of the therapist's communication in this Negotiation is proposed as systematic, explicit, open, careful, and attentive. As the client expresses and develops her understanding, the therapist attentively communicates and clarifies his understanding of her experience. Once the client's experience and understanding has been 'taken on' in this way, a shared understanding of respective contributions, taking into account the therapeutic roles and rationale, can be negotiated.

These revisions are expressed in the Revised Model of Best Confrontation Challenge Resolution Performance (below). The Performance Model represents a task analytic answer to the question, 'How best to resolve Client Confrontation Challenges in Exploratory therapy?'; the answer will be discussed in Chapter Ten.

Acknowledge Challenge and associated feelings

Negotiate in-therapy origins of Challenge

Recognition & Direction

Negotiation Cycle

Consolidation

Explore Parallels

Identify general relationship pattern/s

Renegotiate specific in-therapy origins

Recognition & Direction

Negotiation Cycle

Consolidation

Further Explore

Specifics of relationship, situation and way of relating

Positive contributions for therapy & client's potential change

Chapter Ten

10.1 Introduction

The Introduction identified the two foci of this thesis, one substantive and one methodological, and attributed them equal weight. This discussion of the preceding chapters shares these foci and their equal weighting. To reorient the reader to the 'whole' of the thesis, the separate chapters' contributions and their part in the whole will be reviewed (10.2). Thereafter the substantive (10.3) and methodological (10.4) contributions of the 'whole' are interpreted and evaluated. To close, the main points made in these discussions are summarised (10.5).

10.2 Review of the thesis

10.2.1 The starting points

This thesis had two startpoints. The first was the theoretically and practically important question the author wanted to explore empirically; this was,

'How are Client Confrontation Challenges to the therapeutic relationship in Sheffield's Psychodynamic Interpersonal (PI) therapy ('Exploratory') therapy best addressed by client and therapist?'.

The second startpoint was the recognition that, if the empirical findings to this micro-level, processual question were to be informative of the Exploratory theory and practice, then traditional research paradigms were inappropriate for its exploration.

10.2.2 The whole in parts

Chapter One presented the theoretical and practical rationale for the question that was explored empirically. Client Confrontation Challenges were illustrated with examples from Exploratory sessions: a client saying in a clipped, hurt and angry tone,

"I thought you were giving me an alternative...and then I felt you accused me, and I felt it was an accusation, of taking the wrong alternative"

and a client saying with studied, controlled fury,

"the more I thought about it, I was quite angry with you..for what felt like you set me up and then told me off".

In theory and in practice, these moments destabilise the therapeutic relationship; they were labelled 'make or break' moments in Exploratory therapy. They challenge the therapeutic relationship which, as the medium of, a prerequisite for and the vehicle of change, functions therapeutically. They are also difficult, moments in the therapeutic process, which are anxiety-provoking for therapist and client. Successfully addressed, however, Challenges can be productive of significant therapeutic change; collaboration between client and therapist can be strengthened and their shared

understanding of learned ways of relating in structured role relationships can be enhanced. Thus understanding how Confrontation Challenges are best addressed is theoretically and practically important.

To the 'how to' question proposed in Chapter One, **Chapter Two** put together and evaluated a 'state of the art', empirically-based, answer. Set in the context of 20 years of therapeutic alliance research, empirically-based relations between client hostility and outcome; patient hostility, therapist behaviour and outcome; behaviours associated with the improvement or otherwise of poor early alliances were reviewed. Two criticisms of the answer provided by research to date were made. Firstly, implicitly or explicitly, most research identified the hostility and poor alliance quality with the patient, and ameliorative responses with the therapist. In contrast the present thesis explicitly considers both Challenge and response a function of the cumulative, conjunctive and transactive contributions of client and therapist. Secondly, rather than a 'how to' answer to the question, the relevant research was considered to provide a 'what to do (and not do)' answer that left practitioners with a 'processual gap'.

To understand how a more 'how to' answer may be provided, **Chapter Three** examined traditional and new approaches to researching psychotherapy. The research providing Chapter Two's 'what rather than how' answer followed a traditional, paradigmatic approach; Chapter Three critiqued this approach and presented the new paradigm in psychotherapy research. Traditional, relational and group comparative designs imply a drug metaphor conceptualisation of psychotherapy and are not sensitive to process-outcome and client-therapist synergies, complexities of in-session process, the time course and location of change and between and within individual differences. Inappropriate and over-subscription to this paradigmatic approach has had the effects of limiting the questions researched, of micro-level, moment-to-moment clinical practice not being informed and clinical theories not being developed by psychotherapy research. The new Change Process Research paradigm promises to address these limitations. Outcome is conceptualised as a heterogeneous and continuous process, including immediate in-session impacts (a process-outcome), post-session impacts (a little 'o') and post-therapy impacts (a big 'O'). Change Process Research is more 'micro'; proximal rather than distal outcomes and clinically meaningful, contextualised units, (episodes, events) are investigated in order that the processes of change can be tracked (and so provide more 'how to' answers). Evident from the rationale set out in Chapter One, Client Confrontation Challenges meet the criteria for selecting Significant Change Events for study. Confrontation Challenge Resolution Events access a key process of change and can be productive of exponential therapeutic change. Chapter Three selected the new paradigm's Events-based strategy as the approach to exploring the research question.

In **Chapter Four,** Task Analysis, one of the intensive, process analytic methods presented in the first statement of the Events-based strategy, was presented and its implementation in this work planned. In the task analytic approach, the researcher's understanding of task resolutions observed in practice is used to revise an initial, rational, 'best guess' at how task resolution may proceed and a model of how best to perform task resolution is proposed. In contrast with previous implementations, focussing on Task Resolution Events occurring within a single, clinical case; taking a nonparadigmatic, narrative approach to their description (in the Emprical Analysis) and explicitly considering their resolution a function of dyadic communications were planned. Chapters Five through Seven presented the groundwork essential to the task analytic method.

Chapter Five developed a Rational Model of Confrontation Challenge Resolution in Sheffield's PI therapy, 'Exploratory' therapy. Grounded in the principles and practice of Exploratory therapy, this is a rationally-derived 'best guess' at how Confrontation Challenges may be resolved. The author and two experienced, clinical researchers proposed four stages to resolution (Acknowledgement, Negotiation, Exploration and Closure) and specific activities that may achieve each stage. The reasoning on which this 'best guess' was based was articulated by the author.

Chapter Six then verified Chapter Five's Rational Analysis. Three Challenges made by Jane in her second session with the most experienced Exploratory therapist were intensively and critically analysed to assess the extent to which Chapter Five's 'best guess' cohered with the researcher's understanding of resolution practice. As required the session transcript material was considered to demonstrate the general applicability of the Rational Model to Challenge Resolution Events occurring in representative Exploratory therapy.

Chapter Seven concluded the groundwork to the Task Analysis of Challenge Resolution by establishing that Confrontation Challenges could be reliably discerned. A system was developed for identifying and categorising the Challenge Markers that indicate the opening of a Change Event. Applicable to any case of Exploratory therapy, this system ensures the homogeneity of the Events identified for substantive Empirical and Rational-Empirical stages of this work. Three external coders and the author (their 'trainer') applied this system to identify Confrontation Challenges in a single clinical case. They agreed in their understanding of the session material; Anita made four Confrontation Challenges in her second session. Understanding how Anita's Challenges were resolved was the aim of the next two chapters.

Chapter Eight began the substantive work of the Task Analysis by describing the resolution performances taking place in Anita's second and third sessions - the sessions in which client and therapist agreed their difficulties were negotiated. This Empirical Analysis was firmly grounded in the moment-to-moment, particulars of Anita's therapy case. The author's understanding of how resolution occurred was narrated and each resolution attempt was represented diagrammatically. The characterisation of each resolution attempt in a single sentence provided the following story of how resolution proceeded from Anita's first Challenge; "if I say the word black you'll pounce and say, black now what does that mean":

THE STORY OF HOW ANITA'S FOUR CONFRONTATION CHALLENGES WERE RESOLVED
Anita wanted to tell the therapist how his behaviour had contributed to her having said this; but, as she'd described, the therapist wanted to explore its meaning (CRA1). The therapist relented and Anita accepted his explanation for his similar behaviour in the previous session (CRA2). Concentrated work on the here-and-now of the present session preceded concentrated work on there and then parallels with their difficulties, from outside therapy, (CRA3). Not much more 'work' was done but they affirmed their roles, the rationale and a focus for further work; Anita's relationships with men (CRA4 at the close of Session Two). Both in relation to and separate from this agreed focus, they attentively and thoroughly specified, clarified and explored their difficulties in the previous session. Then, they switched to work specifically and in detail on situations between Anita and her father (CRA5)

Additionally informative to Chapter Nine's final analysis were the author's understandings of 'steps' of significant movement toward resolution; tension between Negotiation and Exploration; the 'pace' of resolution; and the association between therapist's links back to the here-and-now relationship and Anita's presentation of a further Challenge to that relationship.

Using the understanding resulting from these analyses, **Chapter Nine** presented the task analytic answer to the question proposed in Chapter One. The Rational Model was revised to propose a Performance Model; the Performance Model of Best Confrontation Challenge Resolution is a task analytic answer to the question, 'How are Client Confrontation Challenges to the therapeutic relationship in Sheffield's Psychodynamic Interpersonal (PI) therapy ('Exploratory') therapy best addressed by client and therapist?'. Revisions were arrived at by iteratively comparing (a) the Rational Model (Chapter Five and Chapter Six) with the Narratives of the five resolution attempts (Chapter Eight) and (b) the revisions suggested by the successive resolution attempts and (c) the researcher's evaluation of both. Thus located in, but abstracted from, the clinical practice observed, the Performance Model proposes the specific configuration and sequencing of activities that the researcher considers would be most facilitative of Challenge Resolution. Discussed in detail in the next section, these revisions will be summarised here.

The Rational Model assumed cycling within and between stages; this cycling was specified in the Revised Model. Negotiation and Exploration were proposed to 'spiral' as interdependent and mutually informative (rather than separate and discrete) stages. Negotiation provides understanding and agreement of in-therapy Challenge origins; this understanding provides for Exploration to identify a general relationship pattern; this pattern informs Re-negotiation of the specifics of the in-therapy communcations originating the Challenge; this understanding of the in-therapy interchange provides for Further Exploration of the specifics of the parallel, extratherapy situation and the client's ways of relating therein. Thus, the Revised Model of Challenge Resolution proposed six stages of resolution (compared with the Rational Model's four). Within the stages, revisions were proposed to the Negotiation stage. Three substages were proposed; Recognition (of the Challenge) and Direction (to negotiate an understanding of its in-therapy origins); a Negotiation Cycle and Consolidation (of the negotiated understanding). In Chapter Nine, the Negotiation stage's differentiated activities and their specific sequencing were understood to operationalise propositions regarding (a) the priority of the client's understanding of the Challenge's origins and (b) the therapist's systematic, explicit, open, careful and attentive communication. Chapter Nine presented these revisions and re-located them in Anita's second and third sessions. As the task analytic response to Chapter One's question regarding effective Confrontation Challenge Resolution they will next be considered in relation to PI theory and research.

This review of the whole thesis has highlighted the contribution and interlinking of each of the thesis's parts. Its substantive and methodological contributions will now be understood and evaluated.

10.3 The substantive contribution: The Revised Model of Confrontation Challenge Resolution:

10.3.1 Introduction

The substantive contribution of this thesis is Chapter Nine's Revised Performance Model of Confrontation Challenge Resolution. Here the Revised Model's propositions for effective Confrontation Challenge Resolution are interpreted and discussed in relation to clinical and empirical literatures.

The Revised, Performance Model is a task analytic answer to the question posed for empirical exploration in Chapter One. In the next section (10.3.2), the performance that the Model proposes may be effective in resolving Confrontation Challenges is explained. This explanation will be cast in terms that are not specific to either the details of a clinical case (Chapter Eight) or of a Task Analysis (Chapter Nine) but in terms that are generalisable to other PI therapies having change processes in common with Exploratory therapy (see Chapter Four, 4.4.4).

It should be noted that a degree of overlap with the previous chapter is acceptable here; this section is focussed on the previous chapter's Revised Model. It will be evident, however, that the more thorough going interpretation presented here builds on that begun in Chapter Nine (see 9.4).

Prior to presenting the author's interpretation of the Revised Model, it may be timely to reiterate the understanding of Client Confrontation Challenges held throughout this thesis and to add a further observation regarding Anita's Challenges from which the Revised Model was abstracted. Throughout, Confrontation Challenges have been understood as destabilising or disrupting the established 'baseline' of client-therapist communications and thus provoking anxieties for both participants. In addition, Anita's Challenges made explicit reference to the therapist and his activities. In shortterm PI and interpersonal therapies, these are both circumstances in which priority should be given to engaging the client in active and collaborative exploration of the contemporaneous transactions (Kiesler, 1982; Strupp and Binder, 1984).

10.3.2 Interpretation of the Revised Model

This interpretation will progress from the more micro-level revisions, made to the Negotiation stage, to the more macro-level revisions, to the relations between the Negotiation and Exploration stages.

Negotiation was proposed to proceed through three substages; Recognition and Direction; the Negotiation Cycle and Consolidation. The RECOGNITION AND DIRECTION SUBSTAGE "freezes the action" (Strupp and Binder, 1984, p. 188) in the moments immediately subsequent to the Challenge; "actively holds" the client's here-and-now feelings (Casement, 1985; 1990, p.132); actively maintains (or, in the face of the therapist responding reciprocally to the client's transference pull, re-establishes) the therapist in the therapeutic role (Dewald, 1982; Sandler, 1976a); explicitly casts the client's Challenge as a "shared event" within the therapeutic relationship (Bordin, 1994; Gill, 1982; Safran et al, 1990) and casts the negotiation of the Challenge as purposeful and informative in therapeutic work (Casement, 1985).

The first activity proposed in this Recognition and Direction substage was the **therapist paraphrasing his understanding of the client's feelings associated with her Challenge.** The therapist's paraphrase makes sense of the client's feelings and conveys this sense to the client; by definition, this is containing. Expressed empathically (cf accusingly) the therapist's paraphrase is a positive, affiliative, holding action. **The therapist then makes explicit the possibility of him having contributed to the Challenge's in-session origins.** The therapist indicating his role and responsibility militates against

client and therapist becoming locked into self-validating, countertherapeutic positions and is an initial move toward the Challenge's mutual exploration (Kiesler, 1982; 1988). The client's Challenge may encourage each to adopting a 'me against you' position, in which case the client will feel blamed and attacked for her Challenge. The therapist including himself and his role in his initial understanding of the immediate situation promotes a sense of 'we-ness'; this may help "free up" the client to engage in collaborative negotiation (Safran et al, 1990; p. 160). The therapist acknowledging his role serves an important second function; it confirms the therapist's, here-and-now, role-congruent 'reality' to the client (Dewald, 1982). When the client's own responses may seem disproportionate, confusing or irrational or when she is locked into transference enactment, the therapist's role and responsibility statement reminds her of the current context in which her feelings and actions can be understood. This is enhanced by the therapist then **indicating the positive value of understanding the Challenge's origins.** This recognises the client's Challenge as a communication that is purposeful and meaningful for the therapeutic relationship and 'lets the client into' the necessary therapeutic process. Recognising that the client's Challenge is purposeful, even when its origins cannot be precisely located in prior transactions, 'unhooks' the therapist and thus reduces the "serious risk that the therapist will respond unhelpfully by avoidance or by behaving in a way that is experienced by the patient as retaliation" (Casement, 1985, p. 153-4). **The therapist initiating discussion of the Challenges location** offers further, positive containment by 'taking the pressure off' the client and directing her to reflect on their prior transactions.

The **Negotiation Cycle** gives priority to exploring the here-and-now therapeutic relationship (rather than potentially pathologising the client by immediately searching for historical origins) (Gill, 1982; Strupp and Binder, 1984);
models "a powerful and unusual [metacommunication] technique for communicating with persons who are significant in the client's life" (Kiesler, 1982, p. 285) and makes comprehensible to the client PI's focus on contemporary transactions (Schafer, 1976) .
First and foremost, the client's experience and understanding of the therapist and therapeutic relationship is explored (Kiesler, 1982; 1988; Strupp and Binder, 1984).
To facilitate this the therapist effectively "takes a one-down position" in its Negotiation (Coyne and Segal, 1982, p. 258); the therapist is active in not 'making his reality a measure of the client's' but active in seeking to know the client's (Barnes, 1983). As indicated in Chapter Nine and above, 'it matters ... how the Negotiation is put into words' (Barnes, 1983; p.28); in short, whilst the therapist's attitude is open, his communications stay close to what the client is expressing overtly (rather than seek to explore covert messages) and actively hold the client's anxieties as she articulates her experience of relating with the therapist.

The therapist acknowledges, paraphrases and clarifies the client's experience and understanding of their prior transactions. The therapist's attitude to the client's articulation of her experience is open, "rational and dispassionate" (Strupp and Binder, 1984, p. 159), expectant (Dewald, 1982) and positively affiliative (Kiesler, 1982; 1988). Building the client's meaning frames (her dyadic referential options, expressing feelings, evaluations and attitudes regarding different objects; Kiesler, 1982) is progressive and systematic (Strupp and Binder, 1984). Building these requires actively "going slow" (Coyne and Segal, 1982, p. 258) and actively attending to client-client and client-meaning frames (Kiesler, 1982; 1988). The therapist listens to the client express her understanding of the interactional sequence and communicates his understanding of this to the client (Kiesler, 1982; 1988). His paraphrasing and clarifying communicates both his understanding of and his being engaged with developing the client's understanding. These actions are also confirming of client's self esteem which may have been threatened by the fears associated with the Challenge (Safran et al, 1990). The client's experience and understanding is related to their transactions prior to her making the Challenge (Strupp and Binder, 1984). The aim is to make conscious and explicit to both contributors the client's perceptions of their overt and covert manoeuvres in relating with one another (Villard and Whipple, 1976). The therapist establishing and communicating his accurate and empathic understanding of the client's experience and Challenge are essential to the following Negotiation and its therapeutic metacommunication (Safran et al, 1990).

With a coherent understanding of the client's experience articulated and validated by the therapist, **the therapist presents his understanding of his contributions to the client's Challenge.** This represents a movement from the client-therapist meaning frame to the therapist-client meaning frame (Kiesler, 1982; 1973). The therapist's understanding may be informed by the client's expressed understanding, by his having listened to the interactional sequence as it transpired and by his awareness of his own feelings, impact responses and 'pulls' therein and by his awareness of his therapeutic role. Informed by the client's understanding of her experience, the therapist can carefully schedule the expression of his understanding and the identification of discrepancies between the two. The therapist's recognition of his own feelings in communicating with the client are crucial in his understanding and accepting responsibility for his having contributed to originating the Challenge. Without accurate identification of his feelings, the therapist's actions and interpretations will be complex, incongruent, confusing and potentially countertherapeutic (Henry and Strupp; 1994; Kiesler, 1982; 1988; Safran et al, 1990; Henry, Schacht and Strupp, 1986). The earlier and more accurately impact responses are identified and labelled, the easier is the therapist's disengagement from corresponding affect and complementary role enactments (Kiesler, 1982). The

therapist's feelings do not need to be made explicit to the client for them to be used therapeutically. Indeed, even when the therapist can pinpoint instances of the client's actions which elicited his feelings, articulating these to the client may perpetuate her feeling criticised or blamed and may precipitate a need for self-protective manoeuvering (for example, a repeated Challenge). For the reasons stated above, the therapist explicitly and simply accepting his responsibility and clarifying his role in the interaction may be sufficient to facilitate negotiation of their discrepant understandings.

The therapist's understanding may include references to the rationale underlying the therapeutic tasks and goals; this lets the client into the therapeutic process. References to the therapeutic model must be carefully expressed. The therapist understanding his contributions solely in terms of his prescribed way of working disclaims his responsibility for his actions (Barnes, 1983). As stated, the therapist acknowledging his role 'frees up' the situation in order that discrepancies between their understandings can then be jointly negotiated. As stated, the therapist's understanding gives a here-and-now context to the feelings and understanding the client acted on in making her Challenge. This context, along with the therapist's metacommunication and the discrepancies between understandings confronts each with their mutually impactful contributions; this confrontation is the first step in working through (Greenson, 1968). Distinctive patterns and meanings attributed to their contributions are attended to and labelled during this negotiation (Kiesler, 1982); "clients may find themselves behaving in problematic ways that are strikingly similar (and with similar complexes of feelings) to those they had described in seeking out the change goals" (Bordin, 1994, p.27). The negotiated understanding, specifying **how each contributed to originating the Challenge, is stated.** This statement indicates the achieved integration of client-therapist and therapist-client meaning-frames and makes accessible client and therapist's shared understanding of the dynamics of their transactions and their respective contributions to the shared event of the client's Challenge.

Crucial to such close examinations of here-and-now transactions is the inclusion of positive impacts (Kiesler, 1982). The CONSOLIDATION substage presents their shared understanding as a positive achievement of the Negotiation Cycle and repeats (from the Recognition and Direction substage) its value for therapeutic work.

As indicated, there is movement between three meaning frames in the Negotiation Cycle. The startpoint for Negotiation is the client-therapist meaning frame; once this and its associated client-client frame is elaborated, the focus shifts to the therapist-client frame and, with this, a degree of integration, or sharing, of the frames is

negotiated. The SPIRALLING OF NEGOTIATION WITH EXPLORATION increases the number of meaning frames that influence the Challenge's Resolution. What is proposed to occur in the Negotiation-Exploration spiralling Kiesler (1982) described as "shuttling" between client-client, client-therapist and therapist-client frames within the sessions and between client-client, client-other and other-client frames as they are relevant outside the sessions in the client's relationships to significant others. This 'shuttling' he argued is necessary to identify, and establish the validity and generality of the client's maladaptive transactive patterns. The Revised Model proposed two Negotiation-Exploration spirals. The first **Exploration I** is proposed to use and expand the negotiated understanding of the here-and-now transactions by searching for parallel experiences in the client's significant relationships outside therapy. The therapist is proposed to direct the client to consider relationships outside therapy in order that possible parallels can be Explored. The Negotiation immediately following the Client's anxiety-provoking Challenge has immediately foregrounded the client and therapist's contemporanous transactions and their attendant responsibilites. Whilst this is necessary, Negotiating a preliminary, 'working' understanding of these transactions is tense and testing for client and therapist. Focussing outside therapy in Exploration I relieves a measure of this tension. The client's particular stylistic mode of structuring relationships thus identified then informs a re-working and expansion of client's and therapist's understanding of its influence in their transactions culminating in the Client's Challenge. This **Re-negotiation** specifies the covert and overt manoeuvres of client and therapist that conjunctively contributed to the Client's Challenge; specifies their self-protective and self defeating functionning for the client and recognises how their future communications might prevent a difficulty of similar severity occurring.

Thus concretising of the client's and therapist's understanding of their contemporaneous transactions and securing their future, permits **Further Exploration** of the client's parallel interpersonal difficulties in significant relationships outside; client-client, client-other and other-client meaning frames are informed by the shared understanding of the client-therapist, therapist-client frames. Linking to relationships outside therapy enhances client's and therapist's appreciation of the influence of established role relationships in current interpersonal encounters and relatedly, evidences the ways in which these current encounters can 'echo' with previous and internalised interpersonal dynamics (Strupp and Binder, 1984). Highlighting these similarities provides the client insight into the connectedness of her past and present interpersonal transactions. Within this, interpretive linking, promoting the client's awareness of conflicting interpersonal experiences, their differentiation and integration (Neubauer, 1980) is an option, rather than a necessity. What is important is that the "line of inquiry always returns to the therapeutic relationship" (Strupp and Binder,

1984, p. 162); exploring the client's experience of ways of relating and stylised evoking styles in specific situations in specific relationships outside therapy is supported by links to the specific and concretised understanding of the client-therapist dynamics. The concrete particulars of this understanding provide the client a vivid example of how, in particular interpersonal situations, her learned, stylised ways of relating operate to maintain and limit her relatedness. This is important to the client's search for alternate ways of relating; the search is made realistic to the client by referring back to the way in which client and therapist conjunctively resolved her Confrontation Challenge.

10.3.3 The Revised Model's relations with clinical literature

Thus articulated, how do the Revised Model's propositions regarding effective Confrontation Challenge Resolution relate to the clinical literature referred to in this thesis? What contribution is made by the task analytic answer to the question regarding how best to resolve Confrontation Challenges? These questions are addressed here. At the outset, it is appropriate to remind the reader of how the Task Analytic approach limits the terms in which these questions can be addressed.

A Task Analysis proceeds in two phases; the first provides a Revised Performance Model of Task Resolution and the second verifies this Revised Model. Thus, in proposing a Revised Model of Confrontation Challenges in Exploratory therapy, the present work has completed the first of these task analytic stages. The Revised Model is clearly, appropriately considered as a theoretically-, clinically- and empirically-grounded proposal for effective Challenge Resolution. That is, in a Task Analysis, the Revised Model is an essential, substantial but preliminary contribution. Given the absence of the second phase's verification of the Revised Model (see 10.4), in what terms is it appropriate to consider relations between the Revised Model proposed here with other clinical and empirical work?

Chapter Three (see 3.1.3) presented Krumboltz's (1968) 'test of relevance' as the most stringent criterion for assessing the relations between research and practice; relevant research was research that affected what clinicians do in practice. Rich (1977) described this as 'instrumental research use' and Cohen, Sargent and Sechrest (1986) described this as 'implementing research'. In general, this straightforward, direct and linear implementation of research findings in practice is rare (Gelso, Betz, Friedlander, Helms, Hill, Patton, Super and Wampold, 1988) and, in the absence of verification, it is premature to consider that the Revised Model's propositions could be taken off the research shelf and applied in that way, used instrumentally, in clinical practice. Practitioners' desire for research to 'articulate the doing of psychotherapy', in its moment-to-moment specifics (Morrow-Bradley and Elliott, 1986) is clearly

dependent on appropriate verification of the Revised Model. However, research can be used in other ways and can have other than direct, linear impacts on practice (Cohen, Sechrest and Sargent, 1986; Gelso et al, 1988; Shapiro, 1980; Strupp, 1981, 1986). Practitioners can 'consider' research during their clinical practice (Cohen, Sechrest and Sargent, 1986) and practitioners thinking about their clinical practice can be informed by research (Gelso et a, 1988; Shapiro, 1980). In sharpening clinical observations and critical thinking about clinical practice, research can inform practice (Strupp, 1981, 1986). The verification of the Revised Model withstanding, this discussion is appropriately limited to considering how the Revised Model informs practical, clinical work and other empirical work.

Firstly, the interpretation of the Revised Model makes evident parallels between its propositions and recommendations made in the Psychodynamic-Interpersonal psychotherapeutic literature for dealing with moments similar to Client Confrontation Challenges (alliance tears, critical points, manageable transference failures, role relationship dilemmas, etc). These parallels can be summarised as follows: Providing a "containing/soothing response" that is accepting of the patient's affect and behaviour (eg Frieswyk et al, 1994, p.220); resisting the pressure to repeat the established scenario through frustrating, rejecting or retaliating responses (eg Searles, 1979); evidencing that the patient's difficulties in the relationship are a shared event for the patient and therapist (Basch, 1980; 1982) and one that can be experienced as necessary and understandable rather as a "glitch in the process" (Bordin, 1994, p. 27); exploring conflicts in the here-and-now relationship with the therapist (eg Basch, 1980); exploring problematic reactions in extratherapy relationships, past and present (eg Greenson, 1968); confronting the patient's defences against their feelings (Menninger, 1958). Remembering that psychotherapeutic theory was closely examined to develop the Rational Model and that practical examples of Challenge Resolution were closely examined to revise the Rational Model, how is this coherence to be understood? The coherence, in general terms, between recommendations for clinical practice and the Revised Model is, on the one hand expectable, and on the other hand reassuring that the Revised Model may inform Challenge Resolution in practice.

Secondly, the interpretation of the Revised Model suggests a reconceptualisation of Challenge Resolution that may be useful in thinking about Challenge Resolution in practice. In the initial 'best guess' at Challenge Resolution, the Rational Model suggested that resolution proceeded through four stages; Acknowledgement, Negotiation, Exploration and Closure (see Chapter Five). At this stage in the Task Analysis, cycling within and between these stages was assumed. This cycling was specified by the Rational Empirical Comparison; the six stages proposed in the

Revised Model captured cycling between the Negotiation (I and III) and Exploration (II and IV) stages of resolution. However, the interpretation of this cycling as a *spiralling* between Negotiation and Exploration suggests a different conceptualisation of Challenge Resolution. If the therapeutic task is Challenge Resolution and each of the proposed stages of Challenge Resolution are considered to achieve Resolution sub-goals, then the Rational Model's 'cycling through' the proposed resolution stages implies the following thinking about Challenge Resolution: 'Stage A achieves subgoal A; then Stage B achieves subgoal B; then back to Stage A to rework subgoal A; then back to Stage B to rework subgoal B'. That is, the Rational Model cast Challenge Resolution as repeated cycling through separate stages that cumulate to Challenge Resolution. In contrast, spiralling between the proposed resolution stages can be thought of as; Achieving subgoal A informs achieving subgoal B, which informs reworking subgoal A, which informs reworking subgoal B'. That is, the Revised Model and its interpretation cast Challenge Resolution as a cumulative achievement of interdependent and mutually informative subgoals. Interrelated activities that are oriented to and over time achieve a particular sub-goal (for example Negotiation), at the same time, inform the achievement of a different, but related, subgoal (for example, Exploration), which itself is reciprocally informative in reworking the Negotiation intially achieved.

It is suggested that rather than a movement through a series of discrete stages, Challenge Resolution may more usefully be thought of as a process constituted by two differently oriented, but mutually informative, subprocesses; Negotiation and Exploration. In the Negotiation subprocess, the Client's Confrontation Challenge is contained and its Resolution is located in the therapeutic relationship. The goal of this subprocess, negotiating the Challenge within the therapeutic relationship, is contributed to by the achievement of two micro-outcomes; negotiating a shared understanding of the in-session transactions that led to the Challenge and, on the basis of that understanding, renegotiating roles and ways of relating to enable future work. In the Exploration subprocess, the Client's Confrontation Challenge is expansively explored and linked to relationships, past and present, outside therapy. The goal of this subprocess, locating the Challenge in the client's learned ways of relating and stylised relationship patterns, is similarly achieved by a series of micro-outcomes which is suggested as: specifying a general relationship pattern or interpersonal theme; identifying this in a number of relationships; focussing on specific, situational examples in a specific relationship and focussing then on the client's ways of relating in these. Throughout this expansive Exploratory subprocess links are made back to the therapeutic relationship. It is axiomatic that these links evidence the interdependence of the two subprocesses; they are both (a) informed by the Exploration and Negotiation subprocesses and (b) informative of the Negotiation

subprocess and the understanding progressively and in parallel being developed therein. The mutually informative and cumulative contributions of the Negotiation and Exploration subprocesses can resolve the Client's Confrontation Challenge; that is, they restore and strengthen the working alliance and further understanding of the client's self-defeating and self-limiting interpersonal strategies.

Thirdly, it is suggested that the therapist's immediate response to the client making a Confrontation Challenge may have a particular character, that this may be associated with particular microstrategies (distincitive and organised patterns of interlocking therapist interventions; Mahrer, Sterner, Lawson et al, 1986) and that these may be worthy of consideration in Challenge Resolution practice. The Revised Model and its interpretation suggest that, in keeping with Schlesinger's (1982) and Casement's (1985) thinking, an effective initial response can be characterised as 'Going with but containing the Challenge'. The therapist's aim is to allow and hold that process which is both serving some necessary purpose for the client and is importantly worked with in therapy (Bordin, 1994; Hobson, 1985; Schlesinger, 1982). The therapist does not aim to stop the process in which the client is engaged and of which the client's Challenge is an overt and critical expression.

Required in 'going with' the Challenge is its acceptance as quintessentially part and parcel of the therapeutic process; not as exceptional to that process or as something to be overcome and finished with. Going with the Challenge can be difficult; the Challenge may be experienced as hostile and attacking (Strupp and Binder, 1984); as disruptive of the communication baseline (Kiesler, 1982); the therapist may have become locked into the countertransference pull or the therapist may be resisting the role relationship assigned him in the client's scenario (Kiesler, 1982; 1988; Schlesinger, 1982). In both the first Challenge Resolution Attempt in Anita's therapy and earlier resolution attempts in Jane's therapy (see Chapters 8 and 9, respectively), the difficulty in 'going along with' the Client's Challenge was observed in the tension between the therapist 'taking on' their Challenges and the therapist persisting to 'work' in 'textbook' Exploratory mode. Such rigid adherence to technique is a means of avoiding, rather than taking on, the negative complimentarity that may predate and follow the client's Challenge (Casement, 1985; Henry, Strupp, Butler, Schacht and Binder, 1993). Schlesinger (1982) suggested a means by which the client's process can be stopped rather than 'gone along with'. He argued that, if the alliance is unstable and the therapist's communication is at all complex or contradictory, 'confronting' the client may further increase the client's anxieties to the point of stopping the process.

In sum, 'going with but containing the Challenge' means responding to, rather than resisting, the Challenge and limiting, safely for client and therapist, rather than expanding, the client's difficulties in the process. In Shapiro's (1994, p. 15) terms, this requires that the therapist is both responsive ("pliable, showing the client that what the client is and does affects the therapist's behaviour") and containing ("predictable, orderly, secure, proof against the client's attempts to derail him or her from the therapeutic agenda"). In Schlesinger's (1982) terms, this requires that the therapist has cultivated and/or regained the "therapeutic split" in which,

> "He must be able to allow the patient to communicate his problems by molding the transference object and he must allow himself to be sufficiently plastic that the patient can reenact his conflicts in the transference to a useful degree. At the same time the therapist must keep part of himself split off, uninvolved in the transference enactment, and able to observe the interaction between patient and transference figure from various vantage points. Chiefly, the therapist views the interaction from over the patient's shoulder - viewing the transference figure as the patient sees him. From this viewpoint the therapist can empathise with the patient's fears and his need for the defences he expresses...Since the patient ... is preoccupied with threat and defense, the therapist will want to assist him by empathising with him in his difficulty with the transference figure, not by educating, cajoling or scolding him out of it" (Schlesinger, 1982, p. 39).

Microstrategies suggested by the Revised Model as effective in the 'Going with but containing' response to Confrontation Challenges are the therapist paraphrasing his immediate understanding of the Challenge and the therapist making explicit the possibility that he has contributed to her making the Challenge; these microstrategies communicate that the therapist is 'there' in the process with (rather than against) the client. In combination with this, the microstrategy of paraphrasing (not reflecting or exploring) understanding of the feelings and perceptions the client is expressing in the here-and-now (rather than in advance or in retrospect) communicates that the therapist can and is 'containing' the process occurring between them. The therapist explaining the positive contribution the Challenge is making to their work, of directing the client to and of initiating the Negotiation of the Challenge are microstrategies that 'let the client into' the therapeutic process. They can be thought of as the therapist metacommunicating some of his 'internal supervision' (Casement, 1985; 1990) in facilitation of both therapist and client "squirming loose" to more comfortable positions in their Challenge dynamic (Kielser, 1982; p. 282).

To conclude, the New Paradigm reconceptualisation of therapy as a "complex, multivariate process" constituted by a number of different processes has been adopted here (Greenberg, 1994, p. 116). The processes are specific to different therapeutic approaches, are differentially important depending on the particular therapeutic context and are supported by general factors such as the expectation of and hope for change. Confrontation Challenge Resolution Events were selected for

study on the basis that they encapsulate a key process of change in Exploratory therapy (Rice and Greenberg, 1984); the process of effecting change through directly attending to the client-therapist transactions and here-and-now transference enactments. Here it has been suggested that Confrontation Challenge Resolution can be thought of as entailing two mutually informative and interdependent subprocesses; these are Negotiation and Exploratory subprocesses.

Given the selection of Significant Change Events for the access they provide to theoretically and practically significant processes, the results of an events-based investigation inform the theory and practice of other therapies that, following a similar approach, attach the same significance to the same processes (see Chapter Four). Effective Confrontation Challenge Resolution has been thought of here as responding to a Confrontation Challenge by 'Going with but containing the Challenge' and thereafter managing and utilising Negotiation and Exploratory subprocesses. This thinking is consistent with Exploratory and other shortterm PI therapies' emphases, in theory and in practice, on starting from the client's affective state; facilitating expression of what the client is saying; working with the client's surface presentation; dealing first with defences against affect; encouraging the client to be an active collaborator in the treatment and the therapist taking an active, participative and responsible role in the therapeutic process (Basch, 1980; 1982; Hobson, 1985; Schlesinger, 1982; Strupp and Binder, 1984). This suggests that further verification of the Revised Model of Confrontation Challenge Resolution in Exploratory therapy may develop a clinically, theoretically and empirically grounded 'microtheory' of Challenge Resolution that may be applicable to the practice of Exploratory and other, shortterm PI therapies.

10.3.4 The Revised Model's relations with the empirical literature

The relation between the Revised Model and the earlier review of empirical work informing the question of how to address Confrontation Challenges to the therapeutic relationship is considered here. Chapter Two closed by identifying a processual gap between the results of relevant alliance research and the question being addressed. The processual gap indicated that, rather than a 'how to' answer, relevant alliance research had provided 'what to do' and 'what not to do' answers. The substantive contribution of the present work is related to these observations. Chapter Two also indicated that, despite the considerable import attached to Bordin's (1979; 1980) conceptual work, empirical attention paid alliance ruptures is only recent and still minimal. To build on the understanding of Challenge Resolution presented in the preceding subsections, the present work is then discussed in relation to one of Bordin's (1994) latest recommendations which previous research has not addressed.

The Revised Model's propositions regarding Challenge Resolution accords with previous work's 'what to do and what not to do' answers. The therapist being warm and exploratory, the therapist taking a here-and-now orientation, the therapist addressing the patient's defences, guilt and expectations of punishment, the therapist addressing the patient's difficult feelings in the here-and-now therapeutic relationship and the therapist linking the patient's difficulties in the therapeutic relationship with her/his defences against these feelings were found to be effective in responding to client hostility and initially poor alliances. These therapist behaviours were evident in the Revised Model's propositions regarding effective Confrontation Challenge Resolution.

Of the studies reviewed, Foreman and Marmar's (1985) exploratory study was considered most relevant to the present work and was seen to be particularly well regarded. From observations of moment-to-moment, in-session behaviours, they identified specific, theoretically-consistent, therapist actions (listed above) that seemed effective in addressing initially poor alliances in six therapy cases. The previous subsections (10.3.2 and 10.3.3) suggestions regarding both therapist and client contributions, therapist communication style and microstrategies and two interdependent, resolution subprocesses move further toward a processual answer to the question of how to address Challenges to the therapeutic relationship.

In 1979, Bordin proposed a formulation of the working alliance between client and therapist that incorporated their mutual understanding and agreement on change *goals* and on the *tasks* necessary to achieve these goals, together with *bonds* which would support the collaborators' work. In 1980, he argued that the self defeating interpersonal behaviours which brought the client to seek therapy in the first place would interact with the particular therapy's demands and tasks to develop alliance strains or ruptures; "I promised that the resolution of these strains would be an important key to change" (Bordin, 1994, p. 13). This argument was obviously adopted in the present work. In 1994 Bordin argued that a crucial distinction be made in researching alliance ruptures; he argued that early alliance ruptures be distinguished from ruptures occurring once an alliance has been formed. He premised this argument thus:

"I believe that a rupture's function as a vivid reflection of self-sabotage can be used to highlight the [interpersonal] schema's dysfunctional properties. Thus, it must be brought to the person's attention at a point after he or she has fully committed to the change goal and understanding the relevance of the ongoing work to its achievement. These conditions facilitate a recognition of the self-defeating character of the rupture event. This recognition is further facilitated if it happens to correspond with past behaviour that is seen as self-defeating and has been accepted as connected with the change goal. ... The clarity of this critical choice is clouded when then necessary

conditions of alliance have not been fulfilled (ie there is an insufficient initial alliance" (Bordin, 1994, p. 20).

Firstly, Jane's (Chapter Six) and Anita's (Chapters Eight and Nine) early relationship Challenges suggest an important observation regarding 'the fulfillment of the necessary conditions of alliance'. Jane and Anita were both clients Bordin would consider capable of forming an initially viable alliance within a single session. Initial alliance formation considered largely a function of the client's object relations capacities, Bordin (1994, p. 19) argued that within a single session "a viable initial level of working alliance" can be achieved by a "skilful therapist" and a client with "mild to moderate neurotic problems". They both made their Challenges in the second session and located the Challenges' origins in their first sessions. In Jane's case the Challenges she made in her second session epitomised and brought to a climax Challenges she had made in the previous session. Both Jane and Anita's Challenges expressed uncertainties regarding the tasks, ground rules and roles of therapy in addition to dissatisfactions with the therapist's activities. Whilst it's possible that viable alliances had been established in their first sessions and that the tasks and goals of therapy had been agreed, it's arguable that the goals and tasks of Exploratory therapy had either not been fully accepted by or not been realised as 'knowledge in action' by Jane and Anita. Their Challenges and the resolution of their Challenges may have made 'real' and operationalised the tasks and goals of therapy for Jane and Anita. This is suggested as an important, subsidiary, outcome of Challenge Resolution and as an important means by which initially viable working alliances can be strengthened. That their Challenges made real Exploratory therapy's tasks and goals is also suggested as a possible explanation for the therapist's observation that Anita's Challenges 'had to happen', 'were necessary' (see Chapter Eight).

Secondly, observations made during the present analyses suggest that Bordin's distinction between the different therapeutic functioning of early and late ruptures is confounded by the length of the therapy. Jane and Anita were contracted for eight sessions of Exploratory therapy with the same therapist. In their second sessions they both challenged the therapist's activities and located the origination of their dissatisfactions to his activities in their first sessions. Their experience of these has been reported. To summarise, Anita's experience of his activities was that the therapist was "testing her" in the same way that she was "testing him", that they were "defining where they stood"; the author observed that the therapist's pace was "too much, too soon, too ahead of" Anita (Chapters Eight and Nine). Jane felt that she had to "fight her corner"; the therapist felt he "moved too fast without empathising sufficiently" (Chapter Six). How are these observations related to Bordin's distinctions between the different therapeutic functioning of early and late ruptures?

Kiesler (1982, p. 281) observed that

"from the moment the client first enters the therapist's office, the therapy dyad is off and running. Already this therapist is being pushed into a constricted, narrow range of responding to the client" (Kiesler, 1982, p. 281).

Eight session Exploratory therapy is necessarily focussed (Koss and Shiang, 1994) and the Sheffield Exploratory therapist is concerned that foci are identified in the first of these eight sessions (Shapiro and Firth, 1987). The high degree of speed and precision in the planning process, and the therapist's structuring and control of the therapeutic process have been identified as "catalysts" which accelerate the process of change in brief therapies (Eckert, 1993, p. 241). 'Initial testing and getting in synch' has been suggested as a common source of alliance rupture events (Jilton, Batchelder, Muran et al, 1994). Clients' constant engagement in 'transference tests' with their therapists and the therapeutic importance of the therapist disconfirming the pathogenic beliefs therein has been demonstrated (Weiss and Sampson, 1987). It is suggested that the therapist's immediate and pressured 'testing' of foci and of work that could be done with the client on these foci may have been more confirming than disconfirming of the clients' pathogenic beliefs. In combination with Anita's and Jane's initial anxieties regarding their therapeutic roles, tasks and goals, the therapist's focus-oriented activities may have culminated to a cycle of negative complimentarity (Henry and Strupp, 1994). Jane and Anita's, Confrontation Challenges (as transference tests) may have expressed their reciprocal responses to the therapist's 'trial by fire' style of identifying foci for and initiation of therapeutic work. Bordin suggested early alliance ruptures be taken to indicate incompetely formed alliances and late alliance ruptures be used to indicate engrained interpersonal scenarios. What's being suggested here is that, as a function of the brevity of the therapy, Anita's and Jane's Challenges expressed both. That is, Bordin's 'critical choice' regarding the therapeutic use to which alliance ruptures can be put is 'clouded' by the demands of brief PI therapies.

This subsection will be closed by returning to one of alliance research's repeated findings. Anita and Jane made their critical Confrontation Challenges in their second sessions; 25% the way through their eight sessions of Exploratory therapy. Alliance quality at the 25% mark has repeatedly been found to be predictive of therapy's macro-outcomes (that is, post-therapy and at follow-up). The preceding analyses showed that Jane's Challenges were resolved in the second session and that Anita considered that the work begun on the relationship difficulties expressed in her Challenges was concluded in her third session. Consistent with the repeated finding, Confrontation Challenge Resolution improved Anita's and Jane's therapeutic

relationships and, according to standardised outcome measures, both cases had successful macro-outcomes.

10.4 Methodological contributions

10.4.1 Introduction

In the previous section the task analytic answer to the substantive question explored was interpreted and this interpretation discussed. The Model's propositions and associated observations were discussed in terms not specific to task analysis or Exploratory therapy but in terms which were limited; the Revised Model requires verification. Prior to considering how the Revised Model may be verified in future work, the 'strengths and weaknesses' of the present work are evaluated. The contributions made by the present work to new paradigm thinking and methods are highlighted (10.4.2) and the recognised limitations of the present work are framed in terms of Stiles's (1993) critieria for quality control in qualitative psychotherapy research (10.4.3). These evaluations inform how verification of the Revised Model may be proceeded; to close this section, a verification strategy is suggested (10.4.4.).

10.4.2 Contributions to New Paradigm thinking and methods

Despite recommendations and commendations for new paradigm research being more common than implementation in research practice, Chapter Three showed that the new paradigm has influenced research thinking and that distinct lines of research are developing (see 3.7). Task Analysis, an Events-based, new paradigm method was used to explore Confrontation Challenge Resolution. What does the present work contribute to the new paradigm in general and Task Analysis in particular?

Firstly, Chapter Four argued that the new paradigm's reconceptualisation of therapy process suggests that task resolution within a single Change Event is unlikely; therefore, to maximally inform an understanding of change processes, series of Change Events occurring within single therapy cases should be studied; this is considered a contribution to new paradigm thinking. The new paradigm reconceptualises therapy as process and that process as fluid, heterogeneous and continuous. Significant Change Events are in-therapy events in which there is good reason to believe that change processes that are key to the particular therapy are operating. Task Analysis analyses psychotherapeutic tasks; these are affective tasks that are signified by behavioural markers of the client's state within the therapy process. If change is a continuous process, cumulating during, between and after therapy sessions, then task resolution occurs similarly: cumulatively and progressively during a number of Change Events. Therefore task resolution and the change processes operating therein are most informatively studied by examining resolution attempts occurring within the course of a single clinical case.

The implications these arguments have for the Change Events research strategy and the Task Analysis method will now be considered. Consistent with the reconceptualisation of process, Confrontation Challenges have been considered as in-session moments that express the cumulative, transactive process occurring between client and therapist to that point in the therapy. A system was developed with which to reliably identify and categorise Challenge Markers in Exploratory therapy sessions. Their resolution within the process of therapy has been presented as 'Going with but containing' and thereafter managing and utilising Negotiation and Exploratory subprocesses. Anita's case was informative of the place of Challenge Resolution in the process of change (see Chapter Eight). The researcher used the client's and therapist's words to locate Challenge Resolution within their sessions. Client and therapist considered that resolution was achieved over two sessions. Thereafter, in the five sessions to the end of her therapy, the resolution and their understanding of how it was achieved was reworked and used to inform Anita's situation-specific pattern of "going silent" in significant relationships. Thus, the spiralling between the Negotiation and Exploration subprocesses can be argued to have continued beyond the point at which client and therapist considered their difficulties resolved. These statements indicate that the Change Events strategy's identification of the start (or opening) of the Event and its end in Resolution are methodological conventions which are inconsistent with the new paradigm's conceptualisation of the process of change. If the aim is to better triangulate research methods with theoretical and practical thinking then the Challenge Marker should be recast as the point at which a defined and already-occurring client process can be reliably recognised and Challenge Resolution should be considered to continue beyond the client and therapist's agreement that the therapeutic relationship has been restabilised. Clarification of these ideas in the language of the research strategy and methods may be useful. An Event Marker may be redefined as 'an overt, behavioural expression of an affective state that is problematic for the client and calls for immediate attention within the therapeutic process'. Task Resolution may be simply recast as 'immediate task management'. In an explicitly interpersonal therapy, the Change Event's 'end' or Task Resolution may be recast as 'some in-session signification of client's and therapist's estimations that the micro-outcome of immediate task management has been achieved'.

Secondly, and again aiming to maximally triangulate research methods with psychotherapeutic theory and practice, Chapter Four argued for a narrative approach to the description and representation entailed in a task analytic Empirical Analysis and against the paradigmatic assumptions on which 'discovery-oriented' process research is seen to rest; this is considered a contribution to new paradigm thinking. The

narrative approach to understanding and explanation cohered with Exploratory therapy's emphases on the development of meanings and understandings being active, involved and negotiated. In contrast to the discovery-oriented approach commonly proposed in association with new style process research, the narrative approach does not assume an intrinsic, objective reality, that is latent in the data and discoverable by the reseacher.

Following a narrative approach, the researcher is explicitly cast as active in understanding the situation s/he is observing; all reflexively construct contextualised and particularised understandings of the situation (Rennie, 1992; McNamee and Gergen, 1992). The researcher's narrative account of the situation is a plausible, coherent account of the situation (Robinson and Hapwe, 1986); is constructed according to the author's logic (Stiles, 1993); shows the dialectical relationship between description and analysis (Wolcott, 1990) and is availiable for the consensus of its consumers (Rennie and Toukmanien, 1992). As a form of accounting,

> "Narrative offers a useful, discursive opportunity for the fusing of memory and attribution, or of event description and causal explanation, in that the events are generally recounted in ways that attend to their causal, intentional and plausible sequential connections" (Edwards and Potter, 1992, p.161)

Albeit informally, this was the approach followed in the present work. Future work could usefully follow Madill (1994a; Madill, Widdicome, Barkham and Shapiro, 1994b, 1994c) in applying the qualitative, social constructionist approach to discourse analysis (eg Potter and Wetherell, 1987; Edwards and Potter, 1992; Potter, Edwards and Wetherell, 1993) to client therapist transactions in Challenge Resolution Events.

10.4.3 Limitations of the present work

Stiles (1993) argued that,

> "qualitative research's epistemological shift of focus, from the truth of statements to understanding by people, entails a shift in criteria for evaluating interpretations" (p. 607).

He considered the following criteria particularly relevant "to interpretations of results that are linguistic, empathic, polydimensional, contextual and nonlinear" (p. 607); triangulation, coherence, uncovering, testimonial validity, catalytic validity, replication and reflexive validity. Given their relevance to the approach taken in the present work, Stiles' critieria will be used to frame the author's understanding of its limitations. The researcher is unable to evaluate the present work against certain of these criteria. However, since all are criteria against which the present work may be assessed, all

are included for the reader's reference. The reasoning for their not being used is stated; those about which least can be said are presented first.

The Replication criterion, in Stiles's terms, "reflects [other] investigators' judgements of fit between observation and interpretation" (p. 612). Other researchers' 'judgements of fit' between the author's observations and interpretations (Chapters Six, Eight, Nine and Ten) are required. Additionally required by the author are practitioner's judgements. What Stiles calls 'testimonial validity' and Guba and Lincoln (1981) called 'credibility' refers to the

"isomorphism between the constructed realities of respondents and reconstructions attributed to them by investigators" (Guba and Lincoln, 1981, p. 237).

The therapist's evaluation of the credibility may be, but for the purposes of this thesis, has not been sought. Regrettably, neither Jane nor Anita's evaluations were available to the researcher. Contractual agreements with Sheffield clients prior to the start of this work prevented their contributions.

Relatedly the present study did not to any significant degree 'triangulate' perspectives or data sources. This is a frustrating limitation, again attributable to (a) contractual arrangements made with clients, (b) measure selection made prior to the beginning of the present work, and (c) the therapist's other commitments. In the author's estimation this limitation would be best addressed by enlisting client and therapist as co-narrators in the analyses of their Challenge Resolution Events. In order that client and therapists became collaborators in the analysis of their own significant therapy events, Elliott and Shapiro (1992),combined a derivative of the IPR interview (called Brief Structured Recall; BSR; Elliott and Shapiro, 1988) with a systematic, qualitative research procedure for analysing significant events (Comprehensive Process Analysis; CPA: Elliott, 1989). Rees, Hardy, Barkham and Shapiro (1994) used this same combination of methods to analyse client and therapist transactions during the client's dramatic movement from, in her words, "whingeing" to "working" in a session of Exploratory therapy. Combining these methods in the analysis of Confrontation Challenge Events would address the limited perspectives available to the present study.

conducting Interpersonal Process Recall interviews (IPR; see for example, Elliott, 1986; Rennie, 1992) with both client and therapist after sessions in which the client considered that s/he Challenged the therapist. Using IPR as a research method provides some indication of the extensive processing, agency and reflexivity engaged in by clients as well as therapists in therapy sessions (Rennie, 1992).

Safran, Muran and Samstag (1994) took a different approach to the triangulation criterion in their Task Analysis of Withdrawal Alliance Ruptures in Cognitive-Interpersonal therapy. They used a convergent measurement strategy to describe and represent the process of resolution in these events. On the basis that no one measure could comprehesively capture the features of clinical process, they acquired process ratings on four, relevant measures; The Structural Analysis of Social Behaviour (SASB; eg Benjamin, 1974); the Patient Experiencing Scale (eg Klein, Mathieu-Coughlan and Kiesler, 1986); the Therapist Experiencing Scale (Klein et al, 1986) and the Client Vocal Quality Scale (Rice and Kerr, 1986). As noted in Chapter Four, a similar strategy was unavailable to the present research. In principle, were a project similar to the present to be undertaken and a convergent measurement strategy was selected, the measures required as minimum would be the SASB measure (used for example by Henry, Schacht and Strupp (1986, 1990) to link patient and therapist introjects, interpersonal process and outcomes) and an PI-relevant alliance measure (for example, CALPAS; Marmar et al, 1986).

Another means of increasing the limited perspectives, and one that also may address comments below regarding catalytic validity, would be to employ several researchers analysing the same material. Hill (1988) has described what she called a legalistic model of process analysis in which a number of people, of varying levels of expertise (eg the author is not clinically trained), variously intimately related to the session material (eg therapists, therapists' supervisors), with various therapeutic orientations (eg psychodynamic, experiential and psychoanalytic) undertake an analysis of the same session material. Elliott (1984), for example, has used this model. The model is called legalistic because the aim is to achieve consensus between all the group's members. Given the preceding arguments for a narrative approach in new paradigm psychotherapy research, this aim is incongruous to the author. Rennie's (1992) view that the nonparadigmatic approach,

> "can never be objective and that its logic of justification entails consensus about constructed representations...This agreement reflects a complex process...derived in part from the analyst's ability to demonstrate the grounding of the conceptualisation in the data giving rise to it. It is also derived, however, from the extent to which the conceptualisation makes sense to the reader in the light of his or her experience with the phenomenon in question. With respect to comprehensiveness, the fact remains that every analysis is conducted within a particular framework. ...Group work, however, is neither necessary nor sufficient for the achievement of [groundedness and comprehensiveness]" (Rennie, 1992, p. 217),

is held by the author.

Rennie's observations relate to the fourth of Stiles criteria; coherence, or in Spence's (1982) terms, 'narrative truth'. Directly assessed by the reader coherence,

"refers to the apparent quality of the interpretation itself. Does it hang together?...Coherence includes internal consistency, comprehensiveness of the elements to be interpreted and the relations between the elements, and usefulness in encompassing new elements as they come into view" (Stiles, 1993, p. 608).

Lincoln and Guba (1981) identified an aspect of coherence that is appropriately assessed by the researcher (as well as others). They called the fit of a study's observation with the researcher's theory and belief system, the interpretation's 'resonance' for the author. For the author, the preceding analyses could well be supplimented by analyses of client's and therapist's gender (eg Usher, 1991) and/or of client's and therapist's subject positions (eg Burman, 1992). The present study has been firmly grounded in PI theory. This grounding aimed to maximally triangulate therapy, theory and method to inform micro-level practice. This said, the prototypical examples of Confrontation Challenges analysed here were identified in male therapist-female client dyads. In the view of the author, analyses taking into account gender-related dynamics of the Confrontation Challenges and their resolution would be usefully integrated with those presented here.

Finally, Stiles proposed a criterion called catalytic validity; this is the degree to which the research process reorients, focusses and energises participants. In this case, the author is the primary participant in the present work. Given the 'new-ness' of the new paradigm, at least in terms of its practical implementation, the author's understanding of the research process may be usefully stated. Firstly, Safran et al's (1988) statement regarding the process of task analytic and intensive process analytic research is fully supported;

intensive analysis approach *is a conceptually demanding, methodologically rigorous, and labour intensive process which should not be relegated to the status of 'pilot work' which takes place before the real research begins*"(Safran, Rice and Greenberg, 1988, p. 15; italics in original).

Secondly, and in relation to their observations regarding the possible 'relegation' of this type of process research, the sources of the limitations of the present work are worth further consideration. The limitations of the present work's credibility and triangulation were attributed to the relationship between the research reported here and its supporting research programmes (Shapiro et al, 1991). If new style process research is to be maximally informative of micro-level clinical practice, it is suggested that its programming is required and that this requirement has been underestimated. The author considers that programmatic planning of and support for the new style process research is necessary for the new research paradigm to maximally impact on psychotherapy practice.

Finally, in the author's view, both addressing the criticisms made here and verifying the Revised Model presented above are important, and both require empirical attention.

10.4.4 A strategy for verifying the Revised Model of Confrontation Challenge Resolution

In a Task Analysis, developing and verifiying the Model is a never-ending process (Safran et al, 1988). Greenberg and Safran's (1992) Revised Models of Affective Change Events in Gestalt therapy were similarly tentative to that presented here. Their planned verification strategy, summarised as follows,

"The investigator could attempt to verify the model of allowing and accepting by comparing a number of successful and unsuccessful change events of the phenomenon and demonstrating that particular components of competence, predicted by the model, could significantly distinguish successful from unsuccessful performances. Once this has been done, therapeutic outcomes based on the occurrence of the rigorously identifiable performance patterns in the model could be predicted and these predictions tested" (Greenberg and Safran, 1992, p. 304),

could be appropriately followed in furthering the work reported here.

10.5 Summary

The main points made in the preceding discussion of the substantive and methodological contributions of the thesis will be summarised here.

To inform clinical thinking regarding Client Confrontation Challenges, the task analytic answer to the question regarding how best to address these Challenges to the relationship in Exploratory therapy was interpreted as proposing a process of Confrontation Challenge Resolution. Effective in the resolution process is immediately 'Going with but containing the Challenge' and thereafter actively managing the spiralling of two differently oriented, mutually informative subprocesses; Negotiation and Exploration.

A distinctive communication style and specific therapist microstrategies were associated with the therapist's immediate 'going with but containing' response. The communication style expresses an open, expectant and positively affiliative attitude to the client and unhooks both therapist and client from their previous communication routines. Developing understanding of the client's experience and perspective on the Challenge progresses systematically and by 'actively going slow'. The therapist at the outset making explicit his recognition that he may have contributed to the Challenge's in-session origins and repeatedly paraphrasing and clarifying his understanding are

microstrategies that communicate the therapist is there in the process with (rather than against) the client. Paraphrasing (not reflecting or exploring) understanding of the feelings and perceptions the client is expressing in the here-and-now (rather than in advance or in retrospect) communicates that the therapist can and is 'containing' the process occurring between them. Explaining the positive contribution the Challenge is making to therapeutic work, of directing the client to and of initiating the Negotiation of the Challenge are microstrategies that 'let the client into' the therapeutic process; the Challenge is explicitly a shared event.

The Negotiation and Exploration subprocesses are interdependent and mutually informative; they are distinguished by their micro-outcomes and their location. The Negotiation subprocess contains the Challenge and locates its Resolution in the therapeutic relationship. The Exploration subprocess is expansive; the Challenge is explored and linked to relationships outside therapy, always returning to the therapeutic relationship. The Negotiation subprocess achieves two Resolution micro-outcomes; negotiating a shared understanding of the in-session transactions that led to the Challenge and, on the basis of that understanding, renegotiating roles and ways of relating to enable future work. The Exploration subprocess progressively locates the client's Challenge and the shared understanding of the Challenge in the client's learned ways of relating and stylised relationship patterns.

Considered in relation to the empirical investigations of interrelations between client hostility, poor alliances, therapist behaviours and outcome (reviewed in Chapter Two), these propositions are consistent with the 'what to do' answer provided by previous, relevant, research. In addition, it was suggested that the above propositions represent a significant move towards achieving a more 'how to do it', processual answer to the question regarding effective Confrontation Challenge Resolution in Exploratory and other PI therapies.

Bordin (1979, 1980) first drew attention to the significant opportunity for change presented by, in his terms, alliance ruptures or, in this case, Confrontation Challenges. Only in the last few years has his conceptual work begun to receive empirical attention. Observations made during the foregoing analyses of Anita's and Jane's Confrontation Challenges were considered in relation to Bordin's (1994) most recent statement regarding the therapeutic functioning of ruptures. Firstly, it was suggested that both Anita's and Jane's Challenges may have been contributed to by their role and the tasks and goals of Exploratory therapy having been agreed, but not having been fully accepted or realised as 'knowledge with which they could act'. Clients' abilities to understand and engage with their therapeutic role and its associated tasks

and goals was proposed as an important, subsidiary outcome of Challenge Resolution and one that may significantly strengthen working alliances.
Secondly, it was suggested that both Anita's and Jane's Challenges, made in the second of their eight sessions and originated in their first, may have been contributed to by the way in which the therapist operationalised demands specific to a brief Exploratory intervention. These are the demands that the identification of foci for work is precise and speedy and that the therapist structure and control the therapeutic process which contribute to an accelerated process of change in brief therapies. It was suggested that in operationalising these, the therapist's 'initial testing' (Jilton, Batchelder, Muran et al, 1994) in combination with Jane's and Anita's role, task and goal-related anxieties contributed to a cycle of negative complimentarity and their Confrontation Challenges. These observations were understood to indicate that the length of therapy necessarily confounds Bordin's differentiation of the therapeutic functioning of early and late alliances

How has the Change Process Paradigm and it's Task Analysis method been developed by the present work? The methodological contributions made here aimed to maximally triangulate research methods and thinking with therapeutic theory and practice. In the first contribution, the analytic approach was related to fundamental assumptions of Psychodynamic Interpersonal therapy; a narrative (cf paradigmatic) approach was taken to the Empirical Analysis's description of Resolution Performances occurring in clinical practice.

In the second contribution, fundamentals of the Change Process Paradigm's thinking were applied in selecting Significant Change Events for intensive process analysis. The new paradigm reconceptualises therapy as process and that process as fluid, heterogeneous and continuous. Significant Change Events are in-therapy events in which there is good reason to believe that change processes that are key to the particular therapy are operating. Task Analysis analyses psychotherapeutic tasks; these are affective tasks that are signified by behavioural markers of the client's state within the therapy process. If change is a continuous process, cumulating during, between and after therapy sessions, then task resolution occurs similarly; cumulatively and progressively during a number of Change Events. Therefore it was argued that task resolution and the change processes operating therein was most informatively studied by examining resolution attempts occurring within the course of a single clinical case.

In the third contribution, the same fundamentals of the Change Process Paradigm were related to the Events-based research strategy and the task analytic method used in the present work. It was argued that certain of their methodological conventions

and terms, the notions of a Task's Resolution and an Events' start and end, are inconsistent with the new paradigm's conceptualisation of change as a continuous and cumulative process; redefintions were suggested. An Event Marker may be redefined as 'an overt, behavioural expression of an affective state that is problematic for the client and calls for immediate attention within the therapeutic process'. Task Resolution may be simply recast as 'immediate task management'. In an explicitly interpersonal therapy, the Change Event's 'end' or Task Resolution may be recast as 'some in-session signification of client's and therapist's estimations that the micro-outcome of immediate task management has been achieved'.

Limitations of the present work were discussed in relation to Stiles (1993) criteria for quality control in qualitative psychotherapy research. Discussing recognised limitations of the present work suggested strategies that may be beneficially employed in future investigations of Challenge Resolution Events. Firstly, further work may be enhanced by formally adopting a social constructionist approach to analysing the discourse during Challenge Resolution Events. Secondly, if clients and therapists are unavailable as co-researchers, combining Interpersonal Process Recall with Comprehensive Process Analysis was suggested as a means of engaging clients and therapists as analysts of their Challenge Resolution Events. Thirdly, analyses of client's and therapist's 'subject positions' would suppliment those reported above and would permit account to be taken of gender-related dynamics.

In Stiles terms, the present work is limited in its 'testimonial validity' (the isomorphism between the constructed realities of client and therapist and the reconstructions attributed them by researchers - here, the author) and its 'triangulation' (the research's reference to multiple perspectives and data sources). These limitations were considered in relation to an aspect of the research's 'catalytic validity'; the research process. It was suggested that the programmatic planning of and support for new style process reseach is required if Change Process Research is to maximally impact on micro-level therapeutic practice.

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