Universidade do Minho
Escola de Psicologia

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Ambivalence Resolution in Obsessive-Compulsive Disorder: An Exploratory Case Study

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Professor Doutor Miguel Gonçalves
Professora Doutora Cátia Braga

June 2021

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Universidade do Minho, 4 de junho de 2021

Jan Almeida

(Jan Almeida)

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STATEMENT OF INTEGRITY

I hereby declare having conducted this academic work with integrity. I confirm that I have not used plagiarism or any form of undue use of information or falsification of results along the process leading to its elaboration.

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Ambivalence Resolution in Obsessive-Compulsive Disorder: An Exploratory Case Study

Resumo

A Perturbação Obsessivo-Compulsiva é caracterizada por taxas elevadas de desistência, não-adesão, e recaída, possivelmente devido a elevada ambivalência em relação à mudança. Modelos cognitivos da POC destacam a significância pessoal dos temas específicos dos pensamentos intrusivos que caracterizam a POC enquanto central para a sua etiologia e manutenção da sintomatologia. Tanto quanto sabemos, a relação entre o conteúdo específico das intrusões e a ambivalência e o processo de resolução da mesma na POC ainda não foi estudada. Analisámos marcadores processuais de ambivalência e resolução da ambivalência em 20 sessões de um caso recuperado de POC, tratado com o *Unified Protocol*, e analisámos esses momentos com uma análise de conteúdo. Colocámos como hipóteses que 1) a evolução dos AMs e 2) a progressão dos tipos de resolução de ambivalência seriam semelhantes a casos de sucesso com depressão, e 3) o conteúdo das intrusões estaria semanticamente relacionado com o conteúdo das posições do *self* envolvidas na ambivalência. As três hipóteses foram confirmadas. Este estudo apoia a associação entre a resolução da ambivalência e *outcomes* terapêuticos positivos, e destaca a importância de os terapeutas perceberem como o conteúdo específico das intrusões poderá contribuir para a relutância dos pacientes no processo de mudança terapêutica.

Palavras-chave: *Ambivalência; Análise de Conteúdo; Perturbação Obsessivo-Compulsiva; Resolução de Ambivalência*

Ambivalence Resolution in Obsessive-Compulsive Disorder: An Exploratory Case Study

Abstract

Obsessive-compulsive disorder is characterized by high rates of dropout, non-adherence, and relapse, possibly due to high levels of ambivalence towards change. Cognitive models of OCD highlight the personal significance of specific themes of the intrusive thoughts that characterize OCD as central to its etiology and symptom maintenance. To our knowledge, the relation between the specific content of intrusions and patients' ambivalence and ambivalence resolution process in OCD have not yet been studied. We analyzed process markers of ambivalence and ambivalence resolution in 20 sessions of a recovered OCD patient treated with the Unified Protocol, and analyzed those moments through a content analysis. We hypothesized that 1) the evolution of AMs and 2) the progression of ambivalence resolution types would be similar to recovered cases of depression, and 3) that the intrusions' content was semantically related to the content of the positions of the self involved in ambivalence. The three hypotheses were confirmed. The present study further supports the association between ambivalence resolution and successful therapeutic outcomes, and underlines the importance of therapists understanding how the specific content of intrusions may contribute to patients' reluctance in the process of therapeutic change.

Key words: *Ambivalence; Ambivalence Resolution; Content Analysis; Obsessive-Compulsive Disorder.*

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Ambivalence Resolution in Obsessive-Compulsive Disorder: An Exploratory Case Study

In the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013), Obsessive-Compulsive Disorder (OCD) is described as being a psychopathology specifically characterized by obsessions – "recurrent and persistent thoughts, urges, or images that are experienced (...) as intrusive and unwanted, and that in most individuals cause marked anxiety or distress." (APA, 2013, p. 237) – which are commonly followed by compulsions – "repetitive behaviors that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly" (APA, 2013, p. 238). These obsessions or compulsions are time-consuming and/or cause clinically significant distress or impairment to the patient's daily life. OCD is a disorder that is significantly present within the general population, as epidemiological studies (Ruscio et al., 2008) have shown. According to the authors' findings, OCD has a lifetime prevalence of 2.3% (± 0.3), and a 12-month prevalence of 1.3% (± 0.3), which reflects the persistence of symptomatology often associated with this particular disorder.

The main method of psychological intervention in OCD is Exposure with Response Prevention (ERP), which constitutes the only empirically supported psychological treatment for OCD (Abramowitz, Taylor & McKay, 2009; Ruscio et al., 2008). The exposure aspect is described as "entailing systematic, repeated, and prolonged confrontation with stimuli that provoke anxiety and the urge to perform compulsive rituals" (Abramowitz et al., 2009, p. 495), and response prevention as "refraining from performing compulsive rituals" as a reaction to the stimuli. Studies regarding the efficacy of therapy involving ERP for OCD (Neziroglu & Mancusi, 2014) have, however, shown that there is still a significant percentage of patients that do not benefit from this method of intervention. According to the authors, 25% of patients refuse to take part in ERP, or drop out early. Of those who do take part, a further 25% do not show improvement, and a significant number relapse at follow-up.

We hypothesize that one reason why patients may not adhere to treatment is that they are "ambivalent" about change (i.e., experience a conflict between mutually exclusive courses of action) (Simpson & Zuckoff, 2011). In psychotherapy, ambivalence has been conceptualized as an internal conflict between two positions of the self, one in favor of change, and one in favor of maintaining the problematic status quo of the patient (Braga, Ribeiro, Gonçalves, & Sousa, 2019; Engle & Arkowitz, 2007; Gonçalves & Ribeiro, 2011). When studying ambivalence across the whole therapy process, ambivalence markers (AMs) have been used as empirical markers of ambivalence within sessions. These markers appear when, after the occurrence of an innovative moment in the therapeutic dialogue - a novelty or an exception to the maladaptive pattern - clients immediately return to the problematic pattern (Gonçalves &

Ribeiro, 2011). Investigation centered around AMs has indicated that, in unchanged cases, ambivalence either remains unaltered or can even increase along the therapeutic process, whereas in recovered cases, ambivalence tends to decrease along the therapy sessions, suggesting its gradual resolution (Braga et al., 2019; Ribeiro et al., 2016). A recent study has shown that ambivalence markers were able to predict posterior symptoms in cognitive-behavioural therapy (Braga et al., 2019), further stressing the need to properly address ambivalence in treatment in order to support clients in their process of change.

How patients resolve ambivalence in the course of therapy constitutes the main research question of one recent line of process-outcome research (Braga, Oliveira, Ribeiro & Gonçalves, 2016; Braga et al., 2018). In the context of this research, the Ambivalence Resolution Coding System (Braga et al., 2016) has been developed which allowed for the identification of two distinct processes of ambivalence resolution in clients diagnosed with major depression: dominance and negotiation. Dominance consists in a process in which the client imposes the innovative (pro-change) position, while silencing and inhibiting the problematic position. Negotiation, on the other hand, is a process through which the client is able to consider the reasons and validate both the innovative and problematic positions promoting the development of common ground between. Both dominance and negotiation have been associated with significant reduction in ambivalence (measured through AMs for the remainder of the therapy session). However, in one study negotiation has been shown to have an impact that is five times greater than dominance when it comes to this reduction (Braga et al., 2016, 2018). Moreover, recovered cases tend to progressively choose negotiation as a resolution strategy, while unchanged cases reveal a higher frequency of dominance – and virtually no negotiation – from the beginning until the end of treatment. As previously noted, these studies have been conducted with samples of patients diagnosed with major depressive disorder, thus, we do not know if the types of resolution and the progression of these types across sessions applies to other problematics and disorders.

The obsessive–compulsive disorder's cognitive-behavioural models emphasize the influence of beliefs and appraisals in the etiology and maintenance of the disorder (Rachman, 1997; Salkovskis, 1985). These models suggest that intrusive thoughts become clinical obsessions when beliefs about the intrusion lead the person to misinterpret the personal significance of the intrusion (Rachman, 1997; Salkovskis, 1985). Such cognitive distortions involve intolerance of uncertainty, overestimation of threat, and the need to control one's thoughts (Abramowitz, McKay & Storch, 2017). Recently, these cognitive-behavioural models have indicated the potential role of vulnerable self-themes as a concurrent causal mechanism in the development and maintenance of OCD (Aardema & O'Connor, 2007; Aardema et al., 2017; Bhar & Kyrios, 2007, Bhar, Kyrios & Hordern, 2015; Clark & Rhyno, 2005). That is, despite the

observation that (almost) everyone experiences intrusions (Rachman & de Silva, 1978; Radomsky et al., 2014; Salkovskis & Harrison, 1984), the specific content of intrusions varies between individuals and follows specific themes (i.e., concerns about contamination, harm, immorality, or symmetry; Aardema & O'Connor, 2007). This suggests that the content of intrusions is not random and without any inherent meaning, and that these might be determined by specific self-themes. Indeed, Rachman (1997) initially noted that individuals with repugnant obsessions (i.e., unpleasant thoughts about sex, immorality, or violence) are often afraid that these thoughts might reflect hidden and negative characteristics about themselves (e.g., 'I am a sexually violent person'). Aardema and O'Connor (2003, 2007) also noted that individuals with repugnant obsessions often distrust their own self, question their own motivations, and mistakenly attribute negative traits and intentions to themselves. These subsequently give rise to imagined aversive intrusions that are taken as evidence for a severely flawed character.

In this context, the present study has three main objectives. First, and assuming that the high rates of dropout, non-adherence, and relapse (Neziroglu & Mancusi, 2014) may reflect clients' high ambivalence towards change in OCD (McCabe et al., 2019), it comes as particularly striking that research has not addressed, as far as we know, how OCD patients resolve the inner conflict involved in ambivalence. Thus, in this exploratory case study, our first objective is to analyze process markers of ambivalence (AMs; Gonçalves et al., 2009; Gonçalves et al., 2016) in order to understand the evolution of ambivalence in a recovered case of OCD. Secondly, we will analyze process markers of ambivalence resolution (Dominance and Negotiation) (Braga et al., 2016) in order to understand the evolution of ambivalence resolution processes and how that ambivalence is resolved. Thirdly, given the possible role of the personal significance of specific obsession themes in the etiology and maintenance of OCD symptoms (Aardema & O'Connor, 2007; Aardema et al., 2017), we will analyze the specific content of the positions of the self that are involved in ambivalence, and how the specific content of the intrusions relate to the themes of ambivalence toward change. Specifically, we have three hypotheses: concerning the first objective, we hypothesize that, this being a recovered case, AMs are expected to decrease from the beginning to the end of treatment, as ambivalence is frequently resolved in recovered cases. Secondly, and based on what we know about the process of ambivalence resolution in depression samples, the progression of dominance and negotiation will be similar to what happened in recovered cases of depression samples, that is, higher levels of dominance in the beginning of treatment and, as treatment advances, negotiation will be increasingly more frequent. Lastly, and concerning the second objective, we hypothesize that the content of the obsessive intrusions is semantically related to the content of the positions of the self that are involved in ambivalence.

Method

Patient

The case used for this in-depth analysis was that of John (fictional name, with other details distorted to protect client's identity), a 21-year-old single Caucasian man, with a Bachelor's degree in Mechanical Engineering. This case is considered to have a successful outcome, as measured by the Reliable Change Index (Jacobson & Truax, 1991) of the Outcome Questionnaire-45 (OQ-45; Lambert et al. 1996). He had been diagnosed with Obsessive-Compulsive Disorder, as assessed by the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND, Tolin et al., 2016), and underwent therapeutical intervention guided by the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP, Barlow et al., 2011) over 21 sessions at the Psychology Association (APsi) of the University of Minho. The problems the patient presented during the sessions were related to low tolerance to unpleasant thoughts, impulses, and mental images, which led to a need to suppress or neutralize those intrusive thoughts, and in turn created difficulties in social interactions and interpersonal relationships. These intrusive and unpleasant thoughts were exclusively related to the patient's sexuality, and frequently gravitated around the notion that he would be either a homosexual or a paedophile. In his case, the compulsions that John presented with were mainly a constant pattern of questioning his own thoughts repeatedly, in an attempt to find answers that would counter and neutralize his intrusive thoughts.

Therapy

The Unified Protocol consists in a cognitive behavioural approach to the intervention and treatment in emotional disorders, such as depression, anxiety, and OCD. It focuses on the common deficits that are central to several emotional disorders, instead of putting emphasis on the specific symptomatology of the diagnosed disorder.

The goal of therapy with the UP is, instead, to promote adaptative ways to deal with the existing situations and to provide alternatives to deal with the cognitions and emotions felt by the patient. This method of therapy is organized in eight successive modules (M1-M8) that take place over 12 to 18 sessions, on average, and consist of: M1 - Motivation Enhancement for Treatment Engagement; M2 - Psychoeducation and Tracking of Emotional Experiences; M3 - Emotion Awareness Training; M4 - Cognitive Appraisal and Reappraisal; M5 - Emotion Avoidance and Emotion-Driven Behaviors (EDBs); M6 - Awareness and Tolerance of Physical Sensations; M7 - Interoceptive and Situation-Based Emotion Exposures; and M8 - Relapse Prevention. In this case, M3 was implemented between M7 and M8 in order to facilitate relapse prevention.

In this patient's case, all the modules of the UP have been applied successfully over the course of 21 sessions of therapy.

Therapists

The patient was followed in a co-therapy setting by two female therapists with a Master's degree in Psychology, employed by the University of Minho, until session 13. From that session onwards, one of the therapists left the service on maternity leave and was replaced by a male senior therapist with a doctoral degree in Psychology. All therapists were familiar with the UP and its application in a clinical setting.

Measures

Ambivalence Coding System

All 21 sessions were coded with the Ambivalence Coding System (ACS; Gonçalves et al., 2009.) The ACS is a tool that allows for the identification of empirical markers of ambivalence - Ambivalence Markers (AMs). An AM is identified when, after an innovative moment (IM; that is, an exception to the maladaptive pattern), the client immediately offsets the innovation by returning to the maladaptive pattern. This observational measure of ambivalence was applied to the sessions by two independent trained judges, one of which coded the entirety of the sessions, and the other coded half of the sessions (κ=0.83).

Ambivalence Resolution Coding System

The Ambivalence Resolution Coding System (ARCS, Braga et al., 2016) permits the study of the processes involved in the resolution of ambivalence. The ARCS identifies two processes through which ambivalence can be resolved - dominance and negotiation – as described in the Introduction section. This system was applied to all sessions by two trained judges who independently coded the entirety of the sessions (κ=0.85). Disagreements were solved through consensus in the presence of an auditor.

Ambivalence in Psychotherapy Questionnaire

The Ambivalence in Psychotherapy Questionnaire (APQ, Oliveira et al., 2017) is a self-report measure that allows for the assessment of the levels of ambivalence experienced by the patient at any point in time during the therapeutical process. It is divided into two parts, one that positions the patient in relation to change and another that is made up of nine items, divided between two subscales (Demoralization and Wavering), and presents Cronbach's alpha values of 0.85 for the Demoralization scale, 0.82 for the Wavering scale, and 0.87 for the entire scale (Oliveira et al., 2017).

The APQ was applied at the beginning of every session. A score of at least 25 in the APQ is considered to be clinically significant.

Data analysis

As our first objective is to understand the progression of ambivalence in a recovered case with OCD, we analyzed the absolute frequencies of ambivalence markers in all 20 sessions.

For our second objective, in order to understand which processes are involved in the resolution of the inner conflict involved in the patient's ambivalence, we analyzed the absolute frequencies of both types of ambivalence resolution moments (dominance and negotiation) across every session of therapy.

Regarding our third objective, in which we intended to investigate how the specific content of the intrusions relate to the themes of ambivalence toward change, an inductive content analysis was performed (see procedure below) to identify the main content of both the ambivalence and the ambivalence resolution moments across all sessions. The frequency of each identified category was used to describe the evolution of ambivalence and ambivalence resolution across sessions.

Procedure

All 21 sessions of therapy were analyzed and coded integrally by five judges, through the application of the ACS and ARCS.

Regarding the ACS, the entirety of the sessions was coded by a researcher henceforth referred to as Researcher 1, with a doctorate degree in Psychology. 30% of the sessions were also coded by another researcher currently studying for their doctorate in Psychology, referred to from here on out as Researcher 2, and a further 20% of the sessions were coded by Researcher 3, also currently studying for their doctorate in Psychology. Cohen's Kappa for the identification of AMs was 0.83.

In regard to the ARCS, the entirety of the sessions was coded by two researchers currently studying for a Master's degree in Psychology, henceforth referred to as Researchers 4 and 5, under the supervision of Researcher 1. All sessions were coded integrally by both, and all instances of disagreement while coding were resolved through consensus in a process of joint auditing with Researcher 1. Previously, Researchers 4 and 5 underwent training in the application of the ARCS, having coded 13 sessions of a different case where the intervention of choice was Emotion-Focused Therapy. Cohen's Kappa for the identification of resolutions was 0.85.

After the conclusion of coding the sessions with both the ACS and ARCS, Researchers 1 and 4 analyzed the themes of the ambivalence and the ambivalence resolution moments, following the conventional content analysis process as described by Hsieh and Shannon (2005). According to the authors, "conventional content analysis is generally used with a study design whose aim is to describe a phenomenon", which in this case would be the content of John's ambivalent positions. This type of approach is considered to be appropriate when the existing literature on a phenomenon is limited, which explains our choice in this study. In its application, researchers will avoid using any pre-determined

categories, and instead focus on allowing those categories to emerge from the raw data, through immersing themselves in that data to derive codes that that capture key thoughts or concepts and sorting those codes into categories based on how the codes appear to be related with one another. And lastly, by analyzing the relationships between the categories and sub-categories that emerge from the data, diagrams are often formulated to illustrate the way in which researchers conceptualize those relationships.

Focusing on the ambivalence markers identified with the ACS and the resolution moments identified with the ARCS, we applied the content analysis to retrieve information about the underlying content expressed by the patient in every instance of those and organized that content into overarching themes. Themes were consensually defined by both researchers, based on the data, until a level of theoretical saturation was achieved, that is, a point in which the categories defined encompass all the information present in this patient's case. In this case, theoretical saturation was achieved after analyzing the first 8 sessions.

Following the definition of themes, all the AMs and resolutions in the sessions were independently coded by both researchers using the categories defined, and Cohen's Kappa (κ=0.96) calculated for the level of agreement between the two. Extracting the contents present in the AMs and resolutions allowed us to compare them to the contents of the patient's intrusive thoughts, which were identified in the original case formulation.

Results

Figure 1 charts the evolution of AMs per session along with the self-reported values of the APQ for each session. There is a significant decrease in ambivalence values as measured by the APQ, especially from session 19 onwards, at which point the values are no longer considered clinically significant (<25). The AMs also demonstrate a significant decreasing trend from the beginning until the end of therapy, particularly after session 14. From session 19 onward, AMs were no longer observed. Therefore, there seems to be consistency between both measures regarding the decrease in ambivalence, and the moment in which that ambivalence is considered to be resolved (S19).

Figure 1 *Evolution of the number of AMs and APQ scores through all sessions of therapy.*

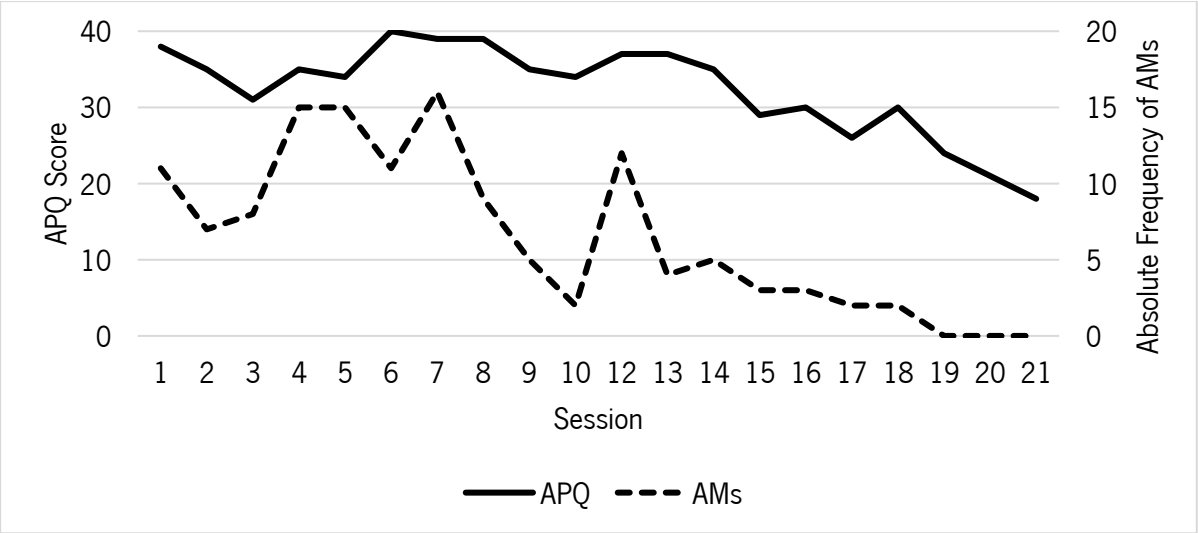


Figure 2 illustrates the evolution of both AMs (ambivalence markers) and resolutions of either type, across all 21 sessions of therapeutic intervention. A decreasing trend is visible in regard to AMs towards the latter sessions, especially from session 14 onwards, and there is an increase in resolutions that mirrors that decrease in AMs from session 17 onwards. Similarly, it is worth noting that throughout the process, the evolutionary tendencies of both AMs and resolutions appear to mirror one another, since in sessions where there is an increase of resolutions there seems to be a correspondent decrease in AMs, and vice versa.

It is also important to note the division of sessions according to the corresponding modules of the UP in order to understand the efficacy of different facets of therapeutical intervention in this case. Module 0 corresponds to the first session; Module 1 corresponds to session 2; Module 2 corresponds to sessions 3 and 4; Module 4 corresponds to sessions 5 and 6; Module 5 corresponds to sessions 7 and 8; Module 6 corresponds to session 9; Module 7 corresponds to sessions 10 to 18; Module 3 corresponds to sessions 19 and 20; and lastly Module 8 corresponds to session 21. Instead of applying the UP as originally designed, in this case the therapeutic intervention was designed with the mindfulness module (M3) coming at the tail end of therapy, after exposure. When taking into account this division of sessions by each corresponding module it becomes evident that both this decrease in AMs from session 14 onwards and the increase in resolutions from session 17 onwards line up with the exposure module.

Figure 2 *Evolution of the number of AMs and Resolutions through all sessions of therapy.*

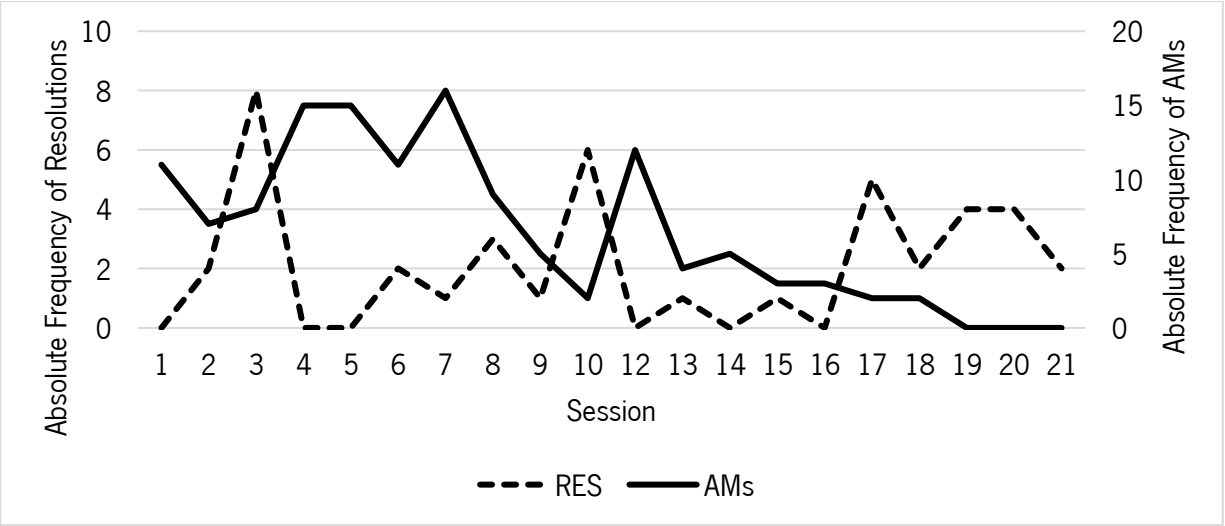
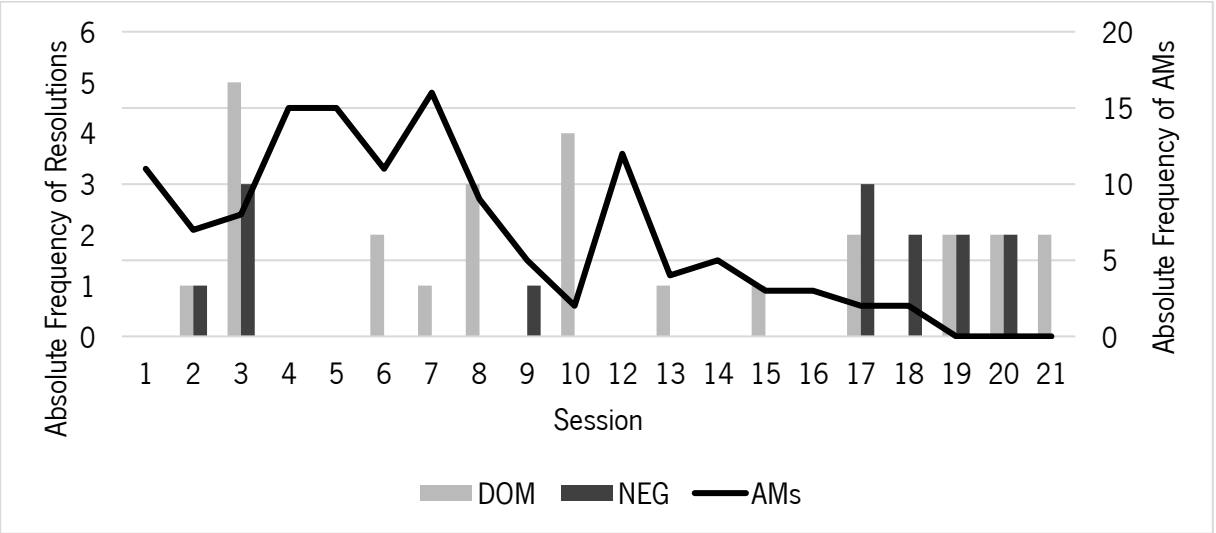


Figure 3 illustrates the evolution in terms of AMs and specific resolution types. By dividing the resolutions according to dominance and negotiation, different patterns emerge regarding these two processes of ambivalence resolution. Dominance appears as the most frequent strategy for resolution, being present throughout the entirety of the sessions, and being particularly prevalent in the middle sessions (S6-S15). Negotiation, on the other hand, becomes more frequent and consistent as a process for ambivalence resolution towards the end of therapy, especially after session 17.

Figure 3 *Evolution of the number of AMs and Resolutions (divided by type) through all sessions of therapy.*



What specific themes can be identified in ambivalence and ambivalence resolution moments?

The content analysis process allowed for the construction of a preliminary coding scheme to categorize and interpret each ambivalence and ambivalence resolution moment, which is represented in table 1. With this scheme, we aimed to specify the latent content of each AM and resolution.

While analyzing the different moments through an inductive lens, guided by the data, different focal points for the patient's ambivalence appeared as central to each specific moment. In this phase, we organized the data in five categories: "Competence and Perfectionism", "Morality and Acceptance from Others", "Travel-Related Anxiety", "Therapeutic Process", and "General Functioning."

The following is a typical example of ambivalence being expressed within the theme of "Competence/Perfectionism": *"So yesterday I left work earlier, but I still felt the need to talk to a colleague from work so he would pass on the information to our bosses once again."*

As evidenced by this quote, John often exhibited this perfectionist perspective and need for control within his professional life, being overbearing and supervising others' work even when it was not his responsibility to do so.

The next excerpt, on the other hand, exemplifies how John expressed ambivalence within the "Morality/Acceptance from others" theme: *"Coming back to the question of homosexuality, I often think...okay, I'm going to set this aside, that's enough, but then in my head I start thinking...you're only doing this to fool yourself, because in truth you really are homosexual."*

The inner conflict evidenced here is central to this theme, as John would often be conflicted by these thoughts that orbited around the notion of being either heterosexual or homosexual, and found himself constantly questioning his own sexuality.

The following is an excerpt of an AM within the "Travel-Related Anxiety" category: *"On one hand, I want to go, but I can't tell them that I'm going, because I'll start to think that if I tell them I'm going, I'm not going to be able to sleep in the days before the trip, and then afterwards during the trip I'm going to feel bad, I'm going to be uncomfortable and want to leave. So I'd rather play it safe and tell them that I'm not going, and in the last few days my thoughts have orbited a lot around that."*

Often the idea of going on a trip with his friends appeared in therapy, and John would present with significant ambivalence regarding this proposition, anticipating that something would go wrong and being unable to commit to travelling with his friends.

Within the category of "Therapeutic Process", John's ambivalence is best illustrated by the following moment: *"Even if a thought comes to me there, I tell myself: do it, ask yourself the questions that the therapists proposed! And sometimes I do ask them, but it's easier for me to try and think of something else in the moment, and ignore my thoughts, and move on. But as the day of my appointment gets closer, that becomes harder and harder to do. Which means, I haven't been able to put that into practice..."*

This category encompasses these specific moments in which John expresses ambivalence

towards therapy itself, or the exercises that the therapists ask him to attempt at home, questioning either his ability to put them into practice, or the effectiveness of therapy itself.

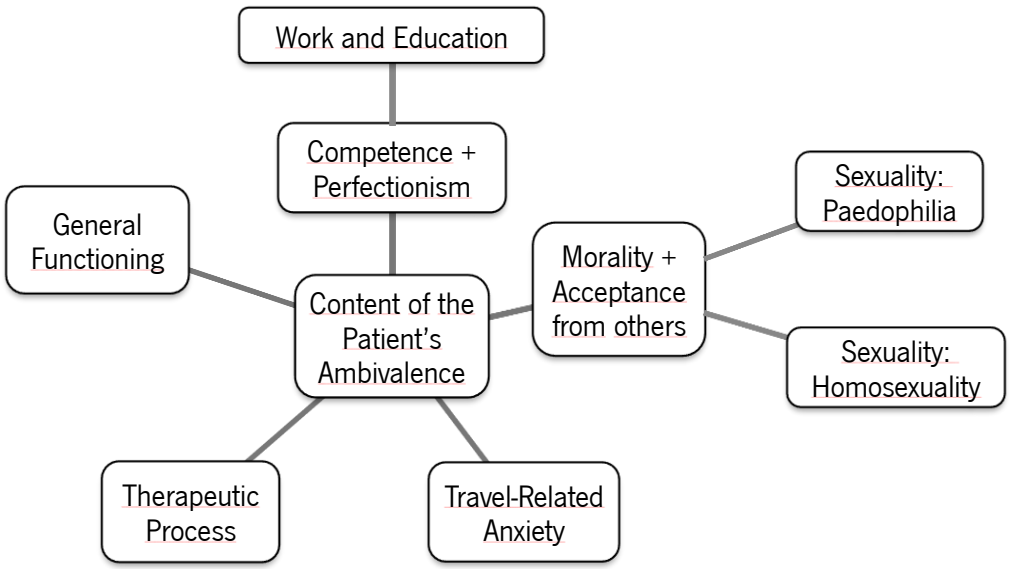
Lastly, this final excerpt illustrates the "General Functioning" category: *"It's almost like...when something happens and I find a solution...I'll as quickly find a solution as that solution will become yet another problem. And I almost don't even have the time to think about that solution, or that possibility."*

This last category encompassed moments in which John expressed ambivalence in a way that was transverse to multiple facets of his life, often describing "the way he is" or "how his mind works" in general terms.

As we analyzed and organized data, we discerned that each of these distinct ambivalence foci were associated with different contexts of the patient's life, such as sexuality (which we further sub-divided into the categories of "Sexuality: Homosexuality" and "Sexuality: Paedophilia") or work and education. As a result, we chose to create a second category that we named "Specific Context" that would also describe the context in which the patient's ambivalence surfaced.

Therefore, our final categorization for the content of the patient's AMs is pictured in Figure 4.

Figure 4 *Final structural model for the content analysis.*



The ambivalence focus categories of "Competence/Perfectionism" and "Morality + Acceptance from Others", together, corresponded to 75% of AMs and 87% of resolutions, embodying the majority of moments of interest in terms of content. As such, for parsimony purposes, we have elected to explore those two categories in further detail, and decided to drop the other, less frequent categories of ambivalence focus from our analysis. Specifically, the category of "Competence/Perfectionism" was present in 48 AMs (37% of the total) and 17 Resolutions (42% of the total), whereas the category of

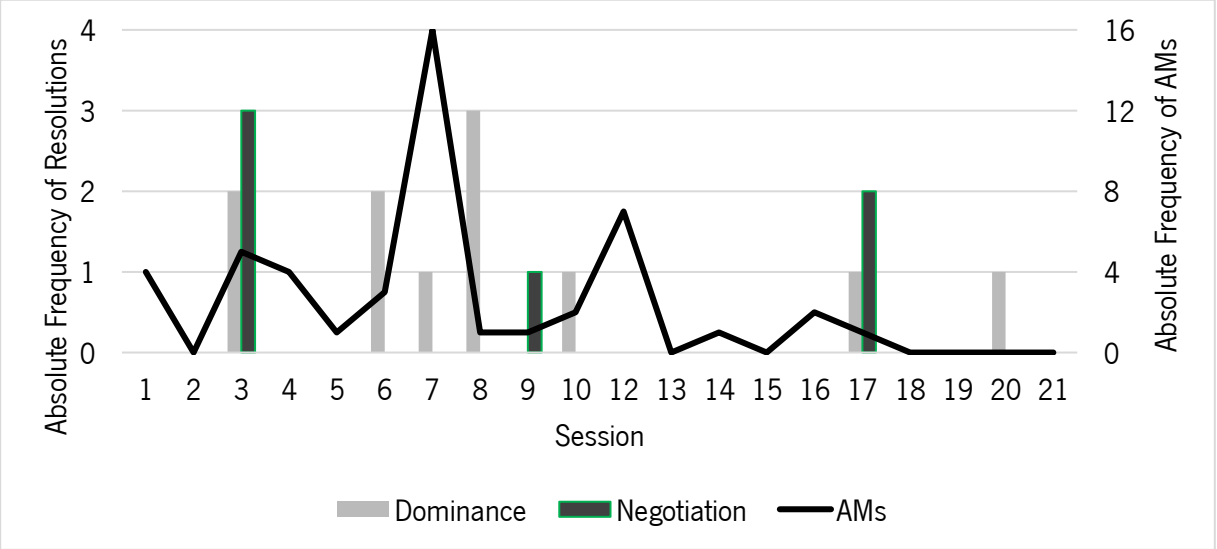
"Morality + Acceptance from Others" was present in 49 AMs (38% of the total) and 18 resolutions (45% of the total).

Furthermore, as presented earlier, the case formulation elaborated by the therapist included the following description of the patient's intrusive thoughts: "the intrusive obsessive thoughts were exclusively related to the patient's sexuality, and provoked a great amount of anxiety by raising doubts about the patient being either a homosexual or a paedophile". As one of the objectives of this study was to understand if the themes of the intrusive thoughts semantically overlapped with the themes of the patient's positions involved in ambivalence, we elected to only keep the aforementioned categories of specific contexts for further analysis, as they seem to be central to the patient's OCD.

How was ambivalence resolved in relation to the theme of "Competence/Perfectionism"?

Figure 5 outlines the evolution of AMs and resolutions for the ambivalence focus of Competence/Perfectionism across all therapy sessions. As previously stated, this focus is mainly related to the patient's work life and education. This theme encompasses 48 AMs and 17 resolutions - 11 Dominance (64,7%), 6 Negotiation (35,3%) - which are mostly present in the first 6 modules of therapy. Of these, 44 AMs and 13 resolutions (9D, 4N) occur before session 13, which lead us to conclude that while this is a central focus of the patient's ambivalent thoughts and expressions, it appears to be resolved mostly until session 13, being the focus of more cognitive-centered modules of therapy and is markedly absent in the sessions where exposure therapy is employed.

Figure 5 *Evolution of AMs and Resolutions (divided according to type) within the ambivalence focus category of "Competence/Perfectionism" through all sessions of therapy.*



The following excerpt is an example of a resolution within this theme, in which John employed dominance as resolution process:

"Well, I did my part, and ideally, just like in the management of any project, you only pass on the

information once. Now, if the other part doesn't do their job, that's their problem."

In this first excerpt, ambivalence is resolved clearly through the innovative position imposing itself (*"that's their problem"*), and the problematic position is in turn inhibited. This is not the case for negotiations, such as the one in the following excerpt:

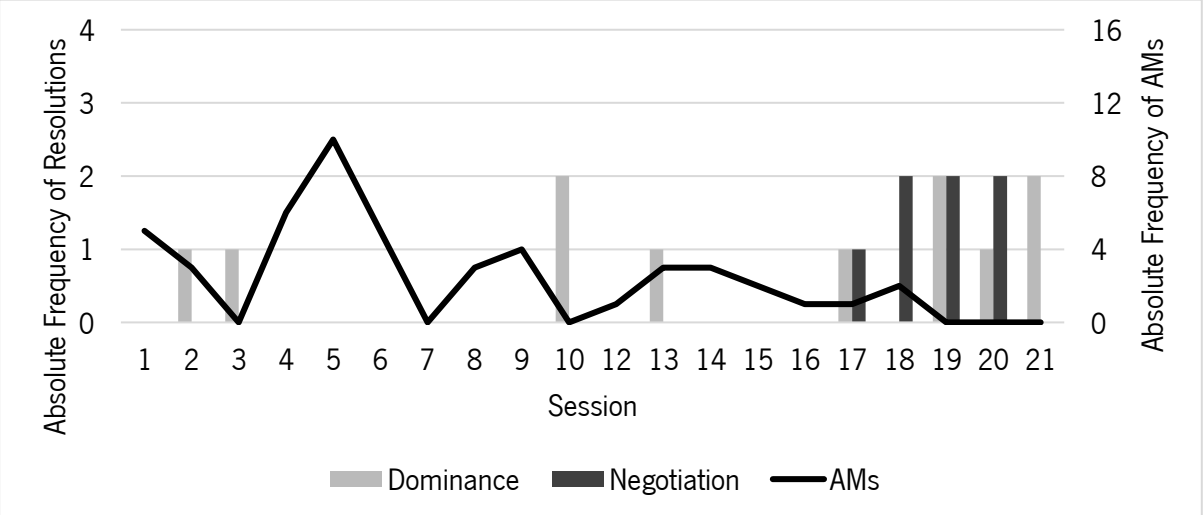
"Little by little...obviously it will be impossible to follow this schedule and leave work at six every day...but at least twice a week I want to be able to leave and go to football matches with my friends."

In this second excerpt, it becomes evident that the conflict between the two positions involved in ambivalence is resolved through negotiation, integrating and articulating the two positions in order to resolve said ambivalence.

How was ambivalence resolved in relation to the theme of "Morality + Acceptance from Others"?

Figure 6, on the other hand, depicts the evolution of AMs and resolutions associated with the ambivalence focus of Morality and Acceptance. This category encompasses contents related to the specific contexts of "Sexuality: Homosexuality" and "Sexuality: Paedophilia", which feature heavily in the patient's intrusive thoughts, and these seem to be the focus of the exposure module. Within this category, we identified 49 AMs and 18 resolutions – 11 Dominance (61,1%) and 7 Negotiation (38,9%). In stark contrast with the "Competence/Perfectionism" focus, the resolutions within this one are heavily concentrated in the final five sessions of therapy, and as such it seems to be addressed and worked on during the latter three modules (M7 – Exposure; M3 – Mindfulness; and M8 - Relapse Prevention). In fact, 13 out of 18 resolutions identified within this theme, and all 7 of the negotiation resolutions, appear in sessions 17-21.

Figure 6 *Evolution of AMs and Resolutions (divided according to type) within the ambivalence focus category of "Morality/Acceptance from Others" through all sessions of therapy.*



In Figures 7 and 8, we further explore the evolution of AMs and resolutions for each type of specific context within the ambivalence focus of Morality and Acceptance, electing to focus on these two categories as they are the most closely related to the patient's intrusive thoughts. For this reason, and taking into account that one of this study's objectives is to ascertain whether there is any overlap between the patient's intrusive thoughts and the positions involved in ambivalence, we decided to look into these specific categories in further detail. Regarding the theme of "Sexuality: Paedophilia", not only do AMs appear mostly isolated in sessions 6 and 8, but there is a single resolution in session 10 within this topic, and these intrusive thoughts do not reappear in any further sessions.

"Sexuality: Homosexuality", however, is a specific context that seems to make up the majority of the Morality and Acceptance category, and largely follows the same distribution of AMs and resolutions throughout the sessions. There are several resolutions, both dominances and negotiations, within this sub-category that appear clustered in the latter sessions (17-21) of therapeutic intervention. As such, it seems that this topic is the main focus of the exposure and mindfulness modules and makes up the majority of the patient's intrusive thoughts which are addressed in those modules, being associated with the ambivalent positions the patient exhibits in these sessions. This leads us to conclude that there is, in fact, a complete overlap between the content of the patient's intrusions, and the content of the positions involved in ambivalence.

Figure 7 *Evolution of AMs and Resolutions (divided according to type) within the specific context category of "Sexuality: Homosexuality" through all sessions of therapy.*

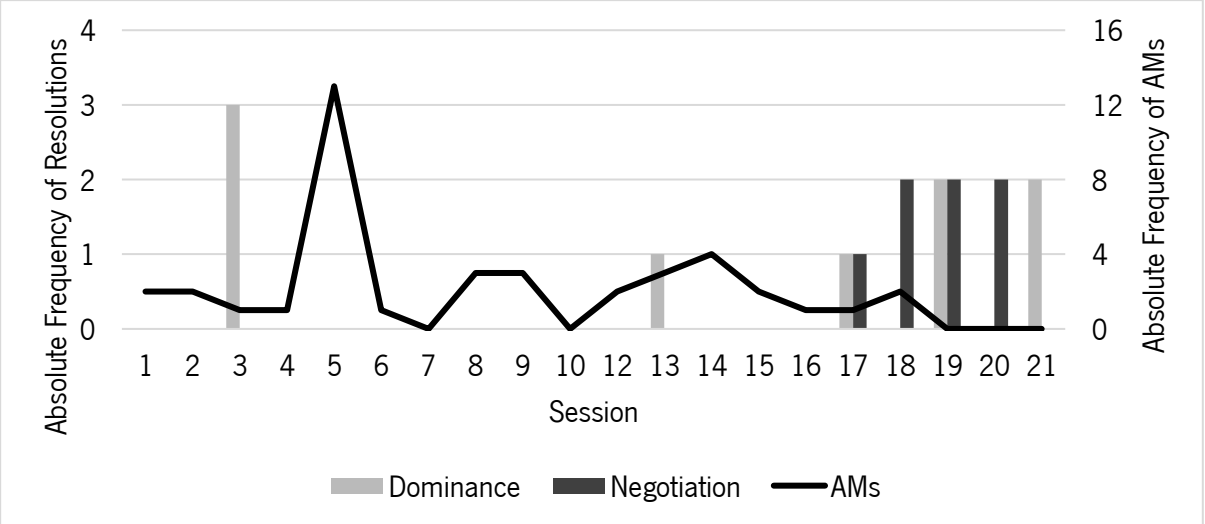
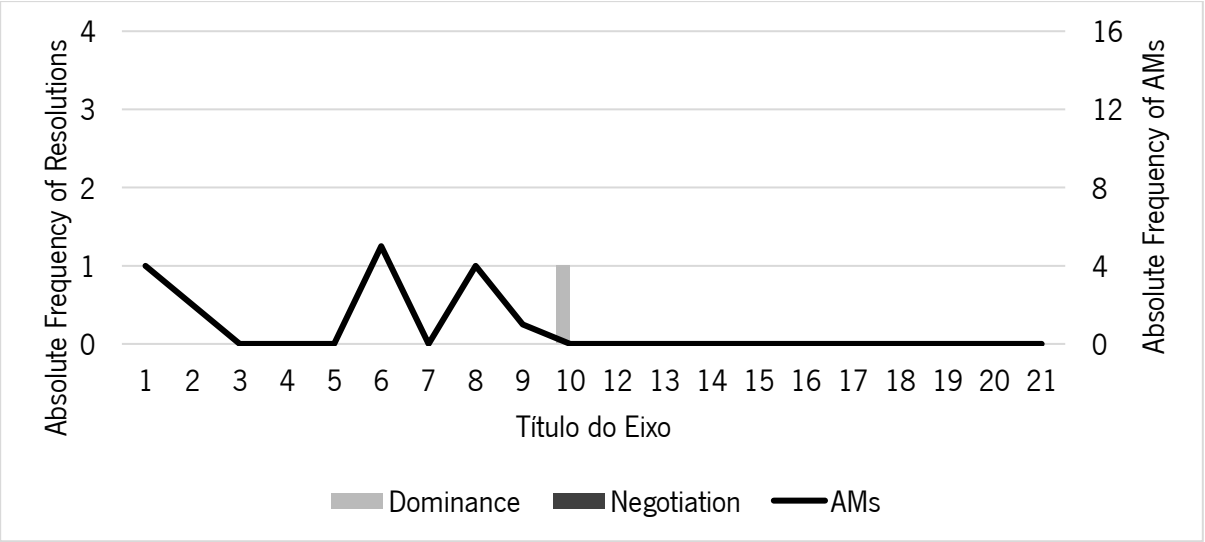


Figure 8 *Evolution of AMs and Resolutions (divided according to type) within the specific context category of "Sexuality: Paedophilia" through all sessions of therapy.*



The following is an excerpt of a dominance-type resolution within the theme of morality:

"We were talking about our friendship which has existed forever, and I hugged him, and the thought came to me – if it was a month and a half ago, I would be stuck thinking about this hug, and in fact I'm not – so much so that everyone is watching, everyone thinks it's normal, my friend thinks it's normal, therefore it's all normal!"

As evidenced by the self-instruction repetition *"it's all normal"*, dominance is the process through which John resolves his ambivalence around the topic in this example, imposing the innovative position that states that hugging his friend is "normal", and inhibiting the problematic position that would infer that hugging a friend would mean he would be sexually attracted to that friend.

The following is an example of a negotiation-type resolution within the same theme:

"Based on what happened more frequently, me being with my male friends and thinking that some feature of theirs was interesting and all...that still happens, but I can, I've been able to understand that in fact that feature was interesting...because it really was."

In this case, instead of inhibiting or silencing the (ex) problematic position, John was able to integrate part of its assertions, thus momentarily dissolving the conflict that characterizes ambivalence.

Discussion

The present study focused on exploring the process of ambivalence resolution in a case of a patient diagnosed with OCD, treated with the UP treatment. We formulated three main hypotheses: the first hypothesis concerned AMs, which were expected to decrease from the beginning to the end of treatment, as ambivalence is frequently resolved in recovered cases.

In terms of the progression of self-reported ambivalence, there was a decrease in ambivalence levels from clinical to non-clinical (<25) values in the APQ. In terms of observed ambivalence, there was

also a decreasing tendency, and zero values of AMs were obtained in the final sessions of treatment. This decrease in both the values of APQ and in AMs is in line with what would be expected for a recovered case, based on previous studies (Braga et al., 2016). This also confirms our first hypothesis.

Our second hypothesis concerned the fact that, this being a recovered case, and based on what we know about the process of ambivalence resolution in depression samples (Braga et al., 2018), the progression of dominance and negotiation would be similar to that of recovered cases of depression samples, that is, higher levels of dominance in the beginning of treatment and, as treatment advances, negotiation becomes increasingly more frequent. Previous studies on ambivalence resolution revealed that in depression samples, dominance was the most frequent process of resolution both in recovered and unchanged cases but that while dominance decreased across sessions, negotiation increased as treatment progressed. These results were in line with the assimilation model's (Stiles, 2002; Stiles et al., 1990) proposal of a progressive integration of opposing elements of the self along successful therapeutic processes. This was also the case for the present study, as dominance was more common, and transversal to all modules of therapy and negotiation, on the other hand, was more frequent and consistent predominantly towards the end of therapy, mostly during the exposure and mindfulness modules. Previous research has also concluded that negotiation seems to have a higher impact than dominance in terms of ambivalence resolution (Braga et al., 2018), and this case seems to follow the same rationale, as the emergence of negotiations towards the end of therapy (S17-S21) is contingent to the reduction of ambivalence levels in those same sessions. Also, these results provide further support for the transdiagnostic nature of both dominance and negotiation processes of resolution and for the ARCS's generalized application.

Our third hypothesis related to the content of the obsessive intrusions, as we hypothesized that it would be semantically related to the content of the positions of the self that are involved in ambivalence. According to our hypothesis, the content of the patient's intrusions that were retrieved from the therapist's case formulation, did appear to be semantically related to the themes that were identified in the positions of the self that were involved in ambivalence. According to the original case formulation, the patient's intrusive thoughts focused on doubts about his sexual orientation, and the fear of being a paedophile. This overlapped with one of the main themes of ambivalence focus, related to morality and the acceptance of others, which was further subdivided into the specific context subthemes of "Sexuality: Homosexuality" and "Sexuality: Paedophilia" in our content analysis. Unlike we initially hypothesized, the patient's ambivalence towards thoughts of paedophilia did not appear to be central to his distress, nor did these thoughts seem to be as prevalent as expected. In fact, not only do AMs appear mostly isolated in sessions

6 and 8, but there is a single resolution in session 10 within this topic, and these intrusive thoughts do not reappear in any further sessions.

The consistent resolution of this internal conflict around morality occurred only after exposure with response prevention (ERP) was initiated, and as such the majority of moments of resolution identified in association with the patient's intrusive thoughts are present towards the final sessions. This suggests that this specific module (M7) contributed to the reduction of ambivalence in this case. When comparing to previous studies focused on different diagnosis, such as depression, there are fewer resolutions of either type in this case than in others (Braga et al., 2016; Braga et al., 2018), even when the UP is also used (Braga et al., 2021). In the study by Braga et al. (2021), resolutions were also consistently present in every session, which is not the case for the present study, as there are sessions (S4, S5, S12, S14, S16) where no resolution was identified. This could be due to the fact that the central conflict around morality – which is semantically related with the content of the intrusions - is resolved only by the end of therapy, particularly from the exposure module (M7) onward. This is clinically reasonable, as we know that ERP is the treatment of choice for OCD (Abramowitz, Taylor & McKay, 2009; Ruscio et al., 2008) and, given that the content of the intrusions was particularly related to this theme, it is reasonable to hypothesize that the client was able to resolve the conflict involved in ambivalence towards change mainly when exposure to the intrusive thoughts was systematically performed. In spite of the effectiveness of the UP, and its equivalence to diagnostic-specific treatments in the treatment of OCD has been supported (Barlow et al., 2017), the results of this particular study raise the question of whether ambivalence could be resolved earlier in treatment if the exposure had been implemented at the beginning of treatment and not by the end of therapy, suggesting interesting venues for future research on the implementation of the UP treatment in this particular disorder.

The other major theme identified in the patient's expressions of ambivalence is related to his own competence and perfectionism within his work life and education. Despite being a major theme and encompassing a vast amount of both AMs and resolutions, it is not semantically related to the patient's intrusive thoughts and is not the focus of intervention through exposure. The ambivalence around this theme is resolved primarily from module 1 (Motivation Enhancement) to module 6 (Awareness and Tolerance of Physical Sensations) of therapy (M0-M6), before the beginning of ERP in Module 7. Research on the cognitive model of OCD (Abramowitz et al., 2017) revealed a number of central dysfunctional beliefs that are frequent in OCD patients: Intolerance of Uncertainty, Overestimation of Threat, Overestimation of Responsibility, Thought-Action Fusion, Need to Control One's Thoughts, Intolerance of Anxiety, and Perfectionism. In addition, and as previously mentioned, other studies indicate ERP as the

treatment of choice in OCD. For this particular case, however, ERP was particularly associated with the resolution of ambivalence in one of the main themes (morality), but not with the other (perfectionism). This raises an interesting hypothesis related to what particular CBT strategies could be particularly relevant for dealing with distinct dysfunctional beliefs in OCD, as the resolutions within the perfectionism theme are concentrated in the first part of treatment, while the resolutions within the morality theme are essentially identified in the last part of treatment, where ERP was performed. These also constitute fruitful and potentially interesting research questions for future studies.

This study has several limitations that should be noted, the first of which relates to the change of therapist in session 13, at the start of the exposure module. This makes it so that we are unable to define whether the subsequent improvement regarding ambivalence around John's sexuality is due to the effect of the exposure module, or due to the introduction of a new therapist. Secondly, it is important to note that all findings from this study are not generalizable beyond this specific case, and should always only be interpreted within the context of this case. Thirdly, we are lacking an unsuccessful case with the same diagnosis in order to contrast the two, which makes it so that we cannot identify potentially distinct evolutionary patterns for AMs and resolutions between successful/unsuccessful cases of patients with OCD treated with this type of intervention. And lastly, the absence of session 11, which corresponds to the beginning of the exposure module, due to sound recording issues, constitutes a problem for the complete analysis of intervention in that phase of therapy.

However, we believe there are also important contributions to existing literature. First, as far as we know, it is the first study to empirically analyze, with an observational measure, the process of ambivalence resolution in a case of OCD diagnosis. Having firstly demonstrated that, similarly to previous studies with diagnosis of depression, dominance and negotiation are also central processes for ambivalence resolution in OCD, and secondly that the evolutionary trend in this recovered case is similar to other recovered cases in other disorders, this constitutes yet another evidence in favor of the transdiagnostic character of these processes, and in favor of the widespread application of the ARCS.

Secondly, this study allowed us to understand in which way intrusions relate to the positions of the *self* that are involved in ambivalence, suggesting that the specific content of those intrusions is pivotal for ambivalence towards change, and therefore constituting further evidence in favor of recent research that highlights the importance of vulnerable *self*-themes as a mechanism in the development and maintenance of OCD (Aardema & O'Connor, 2007; Aardema et al., 2017; Bhar & Kyrios, 2007, Bhar et al., 2015; Clark & Rhyno, 2005). This study suggests that the content of a patient's intrusions is related to the conflict between positions of the *self* that are involved in ambivalence towards change, underlining

the necessity for therapists to understand in which way the content of those intrusions may threaten the stability of the patient's identity, and therefore contribute to their ambivalence towards change.

Lastly, this study allowed us to comprehend which different themes of ambivalence were resolved in different stages of therapy, associated to different modules of the UP and intervention strategies. This raises some poignant questions for future studies regarding the potential advantage of adapting the structure of therapy – namely, the order in which the UP modules are applied – to the specific needs of each patient.

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Universidade do Minho

SECSH

Subcomissão de Ética para as Ciências Sociais e Humanas

Identificação do documento: SECSH 011/2018

Título do projeto: *Eficácia Psicoterapêutica do Protocolo Unificado para o Tratamento Transdiagnóstico das Perturbações Emocionais em Contexto Comunitário*

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PARECER

A Subcomissão de Ética para as Ciências Sociais e Humanas (SECSH) analisou o processo relativo ao projeto intitulado *"Eficácia Psicoterapêutica do Protocolo Unificado para o Tratamento Transdiagnóstico das Perturbações Emocionais em Contexto Comunitário"*.

Os documentos apresentados revelam que o projeto obedece aos requisitos exigidos para as boas práticas na investigação com humanos, em conformidade com as normas nacionais e internacionais que regulam a investigação em Ciências Sociais e Humanas.

Face ao exposto, a SECSH nada tem a opor à realização do projeto.

Braga, 28 de maio de 2018.

O Presidente

Digitally signed by PAULO MANUEL PINTO PEREIRA ALMEIDA MACHADO
Date: 2018.06.04 08:53:21 +01'00'

Paulo Manuel Pinto Pereira Almeida Machado