Analysis of Verbal Emotional Expression in Change Episodes and Throughout the Psychotherapeutic Process: Main Communicative Patterns Used to Work on Emotional Contents[1]

Análisis de la Expresión Emocional Verbal durante Episodios de Cambio y a lo largo del Proceso Psicoterapéutico: Principales Patrones Comunicacionales usados para trabajar Contenidos Emocionales

Nelson Valdés Sánchez
Pontificia Universidad Católica de Chile, Chile

Abstract. Three main Communicative Patterns (CPs) are used to work on emotional content during Change Episodes: *Affective exploration*, *Affective attunement* and *Affective resignification*. Each of these patterns reveals a particular formal structure used to express a communicative purpose about such emotional contents (Valdés, Tomicic, Krause, & Espinosa, 2011b). Objective: To analyze the trajectory of the main CPs within Change Episodes, and throughout the different phases of the psychotherapeutic process. Method: The Therapeutic Activity Coding System (TACS-1.0) was used to analyze both patients' and therapists' verbal expressions in Change and Stuck Episodes identified within two individual psychodynamic psychotherapies. The results showed significant differences in the trajectory of the different patterns depending, not only on the role of the participant and the episode type, but also depending on the stage of the episode and the phase of the psychotherapeutic process.
*Keywords:*change episodes, communicative patterns, psychotherapeutic process.

Resumen. Existen tres Patrones Comunicacionales (PCs) utilizados para trabajar contenidos emocionales durante Episodios de Cambio: *Exploración afectiva*, *Sintonía afectiva* y *Resginificación afectiva*. Cada uno de estos patrones tiene una estructura formal particular utilizada para expresar un propósito comunicacional acerca de dichos contenidos emocionales (Valdés, Tomicic, Krause, & Espinosa, 2011b). Objetivo: Analizar la trayectoria de los principales PCs al interior del Episodio de Cambio, y a lo largo de las diferentes fases de la terapia. Método: Se analizaron las expresiones verbales de pacientes y terapeutas presentes en Episodios de Cambio y Estancamiento identificados en dos terapias psicodinámicas indi-

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La correspondencia sobre este artículo debe enviarse al autor, al e-mail: *nlvaldes@uc.cl*

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viduales, utilizando para ello el Sistema de Codificación de la Actividad Terapéutica (SCAT-1.0). Los resultados mostraron diferencias significativas en la trayectoria de los distintos patrones dependiendo no sólo del rol del participante y del tipo de episodio, sino también de la etapa del episodio y de la fase del proceso psicoterapéutico.
Palabras clave: episodios de cambio, patrones comunicacionales, proceso psicoterapéuticos.

It was been proven that working on affective contents during therapy is a useful tool to promote positive changes in the patient, regardless of the therapist's therapeutic approach. Other studies have demonstrated the existence of mutual influence patterns, used by patients to regulate their own affective conflicts during therapeutic conversation (Bänninger-Huber, 1992; Greenberg & Safran, 1989). Previous research has identified certain characteristics of the verbal communication between the participants of therapeutic dialog during their work on emotional contents in relevant moments of the session (Valdés, Krause, Tomicic, & Espinosa, 2011b). In this specific type of therapeutic activity, the verbal expressions of patients and therapists take the form of Communicative Patterns (CP) which are used exclusively by the patients to give information, clarify a point, and/or direct the therapists' attention towards certain emotional contents (Affective Exploration), while others are used exclusively by the therapists to provide their patients with feedback about certain emotional contents (Affective Attunement), and others are used by both participants to co-construct and/or consolidate new meanings for such emotional contents (Affective Resignification) (Valdés, et al., 2011b). There is sufficient evidence to support the notion that the conscious activation of certain emotional contents, along with their verbal expression during the session, are important elements to explain psychotherapeutic change (Hill, O'Grady, & Elkin, 1992; Timulak, 2007; Valdés, Krause, & Álamo, 2011a). In addition, there is evidence that high levels of emotional experience are associated with the patient's attainment of insight and with specific phases of the therapeutic process. Upon this basis, and understanding psychotherapy as a process which involves a series of phases characterized by the performance of certain activities which lead to the achievement of specific goals, the present study will analyze the main Communicative Patterns (CP) in order to determine their behavior within Change Episodes and during the phases of the psychotherapeutic process.

Over the last 60 years, various methods have been developed to understand patient change during psychotherapy. However, studies analyzing patient-therapist interaction microanalytically are the least frequent in process research (Elliott, 2010), as most studies have focused on the effect of certain therapeutic interventions during the entire session or the entire therapy, using questionnaires to measure the therapeutic outcomes (Chatoor & Krupnick, 2001; Elliott, Slatick, & Urman, 2001; Froján, 2011; Gazzola, Iwakabe, & Stalikas, 2003; Greenberg, 2007; Klein, & Elliott, 2006; Luborsky, 2000; Valdés, 2010; Valdés, et al., 2011a; Valdés, et al., 2010a; Valdés, Tomicic, Pérez, & Krause, 2010b; Williams & Hill, 2001). Although there is a strong tendency among researchers to consider emotions as a part of cognitive processes, or as a phenomenon that depends on them, it must be stressed that emotional contents include certain information that differs from all other contents, because they are experienced subjectively by individuals (Izard, 2002). This has led researchers to study the process of change experienced during the help relationship, in order to expand the theoretical fundamentals of the structure of this type of interpersonal relationship and thus put emotions back in their right place within process research.

Nowadays, it has been shown that a large part of the therapeutic outcome can be explained by certain patient factors (Asay & Lambert, 1999), but in addition to this: (a) in therapeutic dialog, patients produce specific affective reactions in their therapists, while the latter show their patients how such expressions influence the type of interaction during therapy; (b) the performance of actions that increase the patient's emotional involvement during the therapeutic process appears to be a factor that promotes cognitive and behavioral changes (Castonguay,

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Goldfried, Wiser, Raue, & Hayes, 1996; Goldman, Greenberg, & Pos, 2005); and (c) successful therapeutic outcomes tend to display specific characteristics during the patient-therapist affective exchange (Dreher, Mengele, Krause, & Kämmerer, 2001). These conclusions apply to all therapeutic approaches and modes. Most of these approaches accept that working on emotional contents throughout the therapeutic process is essential for obtaining successful outcomes (Henretty, Levitt, & Mathews, 2008). In other words, performing actions that facilitate emotional expression and reflecting on certain emotional contents during the session are elements which result in deeper emotional transformations and therapeutic outcomes (Greenberg, 2008; Greenberg & Pascual-Leone, 2006; Mackay, Barkham, & Stiles, 1998). For this reason, there is growing interest in studying how emotional contents are dealt with during the therapeutic dialog, through the use of certain verbal expressions which reveal the type of interaction between the participants throughout the psychotherapeutic process.

Emotional expression plays a critical role in the physical and social adaptation of individuals (Izard, 2002) not only because it has the function of conveying information about the subjective experience of the individual through verbal and nonverbal external manifestations, but also because it contributes to the development of a prosocial behavior and creative problem-solving (Fredrickson, 2003). This adaptive function of emotional expression can be defined in terms of the actions oriented towards a specific purpose, or of the individual's intention to exercise an influence over another. In this regard, psychotherapeutic dialog is the micronanalytic dimension in which the patient's therapeutic change is constructed (Boisvert & Faust, 2003; Elliot et al., 2001; Krause, et al., 2007; Llewelyn & Hardy, 2001; Orlinsky, Ronnestad, & Willutzki, 2004; Wallerstein, 2001). For the analysis of therapeutic conversation several systems have been developed to classify patients' and therapists' verbalizations and their forms of intervention throughout the therapy (see Table 1). For instance, a study by Elliott, Hill, Stiles, Friedlander, Mahrer and Marginson (1987) identified six forms of therapist intervention: questions, information, advice, reflection, self-expression, and interpretation, with the latter type displaying the strongest correlation with positive evaluations of treatment. Specifically, they identified a positive association between a successful therapeutic outcome and the frequency of the therapist's interpretations of patients' emotions during the transferential relationship, which are very similar to those experienced in their relationship with parents and other significant people (Marziali, 1984). Likewise, patients who receive therapeutic interventions such as reflection, recognition, or interventions perceived as fostering bonding, generally remain in a highly affective state (Wiser & Goldfried, 1998), precisely because they have the feeling of being understood (Bänninger-Huber & Widmer, 1999; Popp-Baier, 2001; Valdés, et al., 2011b).

Therefore, therapeutic work performed at an affective level tends to be deeper, have a more relevant impact on therapeutic outcomes, and persist for a longer period than when interventions only involve the cognitive level (Orlinsky & Howard, 1987). In addition, experts have developed systems to classify both patient and therapist verbalizations (see Table 1); however, many of them were constructed considering a specific therapeutic approach, or were aimed at analyzing a single therapeutic issue. In this context, the Therapeutic Activity Coding System (TACS-1.0, Valdés, et al., 2010b) was developed as a thorough classification system to account for all the relevant dimensions of patient-therapist dialog. This system is based on a performative notion of language, which assumes that "saying something is doing something". From this perspective, language is regarded not as a mere reflection of reality, but as one of its constitutive elements (Arístegui, et al., 2004; Krause, et al., 2006; Reyes et al., 2008; Searle, 1969, 1979, 1980), and therefore, patient-therapist therapeutic conversation makes it possible to configure new realities, which are part of the patient's psychological change. However, language also involves the transmission of contents by the speakers, which are directly associated with the object of therapeutic work. This twofold notion of communication —performance of actions and conveyance of contents— has made it possible to analyze the verbal actions whereby both actors influence each other during therapeutic con-

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Table 1. Systems for the Classification of Psychotherapeutic Dialog

Classification systems	Categories	Role Psychoterapeutic approach		Problem
Counselor Verbal Response Category System (Hill, 1978)	Open questions, closed questions, information, direct guidance, restatement, reflection, non verbal reference, interpretation, self-disclosure, approvalreassurance, confrontación and minimal encourager	Psychotherapist	–	–
Friedlander (1982)	Approval, information, guidance, open questions, closed questions, reformulation, interpretation, confrontation and free association	Psychotherapist	–	–
Conversational Therapy Rating System (Goldberg, Hobson, Maguire, Margison, O Dowd, Osborn, et al., 1984)	Closed questions, open questions, questions of understanding, definition of the process, information-explanation, definition of the subject area, general instructions,advice, restatement, understanding hypothesis and therapist-owned	Psychotherapist	–	–
Taxononomy of Procedures and Operations in Psychotherapy (Mahrer, Nadler, Stalikas, Schachter, & Sterner, 1988).	inquire about ongoing self, simple explanations, agreements or disagreements, general structure, problem identification, reflection, simple answers, patients' andPsychoterapists' explanation.	Psychotherapist	–	–
Elliott (1984)	Questions, information, advice, reflection, interpretation and selfexpression.	Psychotherapist	–	–
Wiser & Goldfried (1996)	Question, reflection, interpretation and advice.	Psychotherapist	–	–
Watzke, Koch, & Schulz (2006)	interpretation, confrontation, cognitive interventions, behavioral interventions, directive interventions and focusing (to emotions, interpersonal relationships, intransference, in therapeutic relationship or group interventions)	Psychotherapist	–	–
Verbal Response Modes (Stiles, 1992; Shaikh, Knobloch, & Stiles, 2001)	Disclosure, edification, advice, confirmation, question, recognition, and interpretation andreflection	Psychotherapist	–	–
Psychotherapy Process Q-Set (Jones, Cumming, & Pulos, 1991)	Attitudes, behaviors and patient's experiences; attitudes psychotherapist's behaviors; and interaction structure	Psychotherapist Patient	–	–
Cognitive Elaboration Rating System (Connolly, Chris Christoph, Shappell, Barber, & Luborsky, 1998).	Past or present experiences, past or present emotions or past or present thoughts,experiences, emotions or thoughts (news or developing)	Psychotherapist Patient	–	–
Collaborative Study Psychotherapy Rating Scale (Evans, Piasecki, Kriss, & Hollon, 1984)	Psychotherapist's actions to ensure the adherence to treatment, explicit anddirective actions, and methods and enabling conditions	Psychotherapist	–	Specific (depression)
Etchebarne, Fernández, & Roussos (2008)	Specifics interventions, non specifics interventions and common interventions	Psychotherapist,	Psychodynamic cognitive and interpersonal	–
Comprehensive Psychotherapeutic Interventions Rating Scale (Trijsburg, Lietaer, Colijn, Abrahamse, Joosten, & Duivenvoorden, 2004)	Facilitating interventions, experiential interventions, psychodynamic interventions, directive behavioral interventions, cognitive interventions, psychodynamic group interventions and sistemic interventions			–

versation, but without losing track of content, as both dimensions participate in the construction of psychotherapeutic change. (Valdés, et al., 2011a; Valdés, et al., 2011b). The TACS-1.0 not only has proven to be sensitive enough to describe the main Communicative Actions used by patients and therapists during the therapeutic conversation, but has also revealed the presence of certain Communicative Patterns (CP) used by the participants of therapeutic dialog to work on emotional contents; furthermore, it has lead to the identification of differences and similarities between different episode

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types based on the analysis of certain patterns (Valdés, et al., 2011a; Valdés, et al., 2011b). However, a pending step is to analyze the characteristics of patient-therapist conversation throughout the psychotherapeutic process, which is why this study is specifically aimed at describing how such Communicative Patterns (CP) behave within Change Episodes and during the phases of the psychotherapeutic process.

The present study is intended to find an answer to the following research questions: based on the analysis of Communicative Patterns (CPs) used by patients and therapists to work on emotional contents, Which are the main characteristics of therapeutic conversation during the initial and final stages of Change Episodes?, What are the main characteristics of therapeutic conversation during each of the phases of the psychotherapeutic process?, Which are the differences and similarities between patients' and therapists' verbalizations, depending on the therapeutic phase and the type of episode?.

Method

Sample

Two short weekly individual psychodynamic therapies (A and B), conducted by male psychoanalysts with a vast clinical experience, were analyzed. Both patients were female and had a similar reason for seeking help, and gave their informed consent to participate in the present study (see Table II).

All sessions in both therapies were included (N =

Table 2. Characteristics of the sample

	Psychotherapeutic Processes	
	Therapy A	Therapy B
Patients	Woman	Woman
Age	38 years old	43 years old
Focus of therapy	Development of mourning for separation and recent losses	Expression of needs; strengthen autonomy; increase quality of relationships
Enfoque Psicoterapéutico	Psychodynamic approach	
Therapists	2 Psychoanalyst-Psychiatrists (Men)	
Total number of sessions (N=39)	18	21
Change Episodes (N=38)	14	24
Speaking turns (N=825)	352	473
Total of number of segments (N=1016)	437	579
Segments coded with a type of content (N=692)		
Segments coded with emotional contents and f >5 (N=161)	81	80
Stuck Episodes (N=19)	7	12
Speaking turns (N=449)	213	236
Total number of segments (N=581)	289	292
Segments coded with a type of content (N=383)		
Segments coded with emotional contents and f >5 (N=61)	45	16

Note. The same sample was used in the study "Verbal Emotional Expression During Change Episodes: Analysis of the Communicative Patterns used by Patients and Therapists to Work on Emotional Contents" (Valdés, et al., 2011b).

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39), during which 38 Change Episodes were identified, delimited, transcribed, and analyzed (A = 14, B = 24). Each episode was made up by patients' and therapists' speaking turns (N = 825), which begin with the start of one participant's verbalization and end when the other's starts (Krause et al., 2009). Each speaking turn was segmented depending on the presence of two or more Communicative Patterns (CPs) within a single speaking turn (see Figure I). Out of the 1016 segments available, only 692 were coded with some type of content (cognitive, emotional, or behavioral). As the objective of this study was to analyze the patterns used by patients and therapists specifically to work on emotional contents during the conversation, it only considered the segments which included one of the Communicative Patterns (CPs) used for this end, and which displayed a frequency above five for at least one of the participants (patient and therapist).

In addition, in order to have a group for comparison, 19 Stuck Episodes were identified (A = 7, B = 12), which were delimited, transcribed, coded with a type of content, and analyzed to identify in them the Communicative Patterns (CPs) more frequently used for working on emotional contents (f > 5). Thus, the total sample was made up by 161 emotional segments in Change Episodes (P = 79, T = 82), and 61 emotional segments in Stuck Episodes (P = 35, T = 26).

Variables, instruments and procedures

Therapeutic Outcome and Change. The variable "Therapeutic Outcome" was estimated using the Outcome Questionnaire (OQ-45.2), developed by Lambert, Hansen, Umpress, Lunnen, Okiishi and Burlingame (1996), and validated for Chile by Von Bergen and De la Parra (2002). A high total score in the questionnaire means that the patients reported a high level of unhappiness with their high quality of life, which is expressed through their symptoms, interpersonal relationships, and social role. The interpretation of the results was based on a cut-off score (in Chile, 73) derived from comparing a clinical sample with a non-clinical one, which led to the identification of a functional and a dysfunctional population and resulted in a Reliable Change Index (RCI) which determines whether the patient's change at the end of the treatment was clinically significant (RCI for Chile = 17; Jacobson & Truax, 1991). In this case, Patient A started the therapy with a total score of 68 and ended it with 48.4 (RCI = 19.6), whereas Patient B started the therapy with a total score of 111 and ended it with 91 (RCI = 20). This means that both patients displayed a significant degree of change during the therapy, even though Patient A started below the cut-off score and Patient B above it.

On the other hand, from the perspective of Generic Change Indicators List (GCI, Krause et al., 2007), both therapies were successful, considering the number of change moments during the session (A = 14, B = 24), but especially due to their level in the hierarchy of indicators (Altimir, et al, 2010; Echávarri, et.al, 2009). GCIs are grouped into three levels which reflect the evolution of the change process (see Figure II).

The largest percentage of change indicators was associated with an increase in the patients' openness to new forms of understanding (Level II). The consolidation of the structure of the therapeutic relationship (Level I) was more frequent during the initial stages of the therapy; also, both patients were capable of constructing and consolidating a new way of understanding themselves (Level III). Therefore, it can be concluded that both therapies displayed a positive evolution from the point of view of Generic Change Indicators (GCI).

Delimitation of Change Episodes and Stuck Episodes. The complexity of the series of processes involved in therapeutic interaction has highlighted the necessity of studying said processes using different levels of analysis to attain a deeper understanding of them, and of developing new research methodologies for the systematic analysis of what occurs during the sessions (Hageman & Arrindell, 1999; Williams & Hill, 2001; Valdés, 2010; Valdés, et al., 2005). More specifically, this has led to the segmentation of the session into change episodes or therapeutically relevant episodes (Bastine, Fiedler, & Kommer, 1989; Goldfried, Raue, & Castonguay, 1998; Valdés, et al., 2005; Vanaerschot & Lietaer, 2007) as useful strategy for studying the sessions in

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Figure 1. Segmentation of speaking turns

CE8, S7, T5, GCI5, 1-20 (20 speaking turns, 26 segments)

T_1 Therapist: tell me, what did you think?

T_2 Patient: let me see, at the end of the session the last time I was very bad, and the truth is that I really do not want to come back again, but my husband said "no, you must go, you most finish your therapy and see what happens". That is. I did not want to come back because of the topics we were talking the last time. It made me feel very distressed, I do not know, maybe I will be more confused. My husband says "no, that is all you need right now because you need to discover some aspects you need to accept, but also you need to know what really happened. So, I do not know. Also I was very decayed, nervous, and tearful

T_3 Therapist: so, why did you come?

T_4 Patient: because my husband asked me to come, even when I was doing a job. I do not want to come

T_5 Therapist: you were expecting to lose the session.

T_6 Patient: of course, □ that is true.

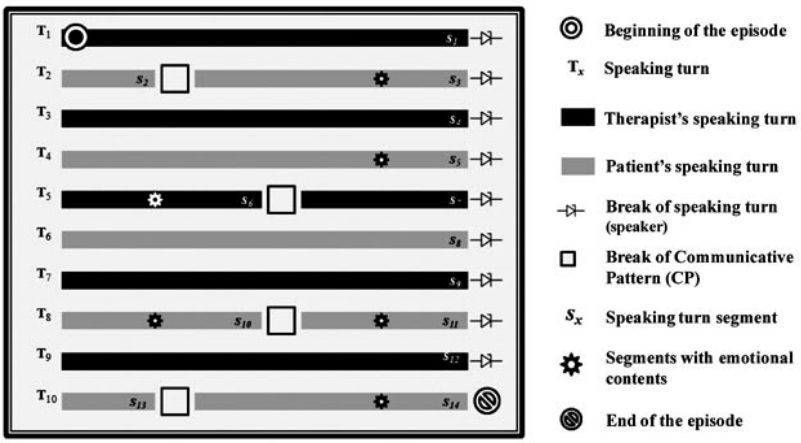
T_7 Therapist: so, are you telling me that you are not going to resist because the last session was difficult for you □ Is that true?

T_8 Patient: yes, it is, □ that bothers me. I always feel sad at the end of the session. I always have a lot of doubts and questions at the end of the session. I think that distracts me, for example sometimes I am working and I remember something you asked me, and I lost time thinking about that. Finally, I do not finish the work I need to do.

T_9 Therapist: you know, when you were saying that, I was thinking that maybe this is your mechanism for resolving problems. You decided to be a little girl who needs someone else to solve your problems. In fact your husband pressured you to come. You become a little girl if you had decided not to come to tell me your problems.

T_{10} Therapist: so, he treats you like a Little girl who does not want to the doctor, saying "no, you must go because it is better for you".

T_{11} Patient: yes, □ it is true. It is very true. Sometimes I think that I cannot decide for myself and let him decide for me.



which psychotherapeutic change occurs. For example, Fitzpatrick, Janzen, Chamodraka and Park (2006) analyzed "critical moments" in early therapeutic stages and concluded that when a certain meaning was positively perceived by the patient, he/she became more open and attained higher levels of exploration. Russell, Jones and Miller (2007) also studied the main mechanisms of change during interaction, focusing on the temporal (moment-by-moment) analysis of emotional patterns in order to determine which factors or processes facilitated or hindered the patient's recovery. The factors identified included: patient affects, therapeutic work, relationships, and information search.

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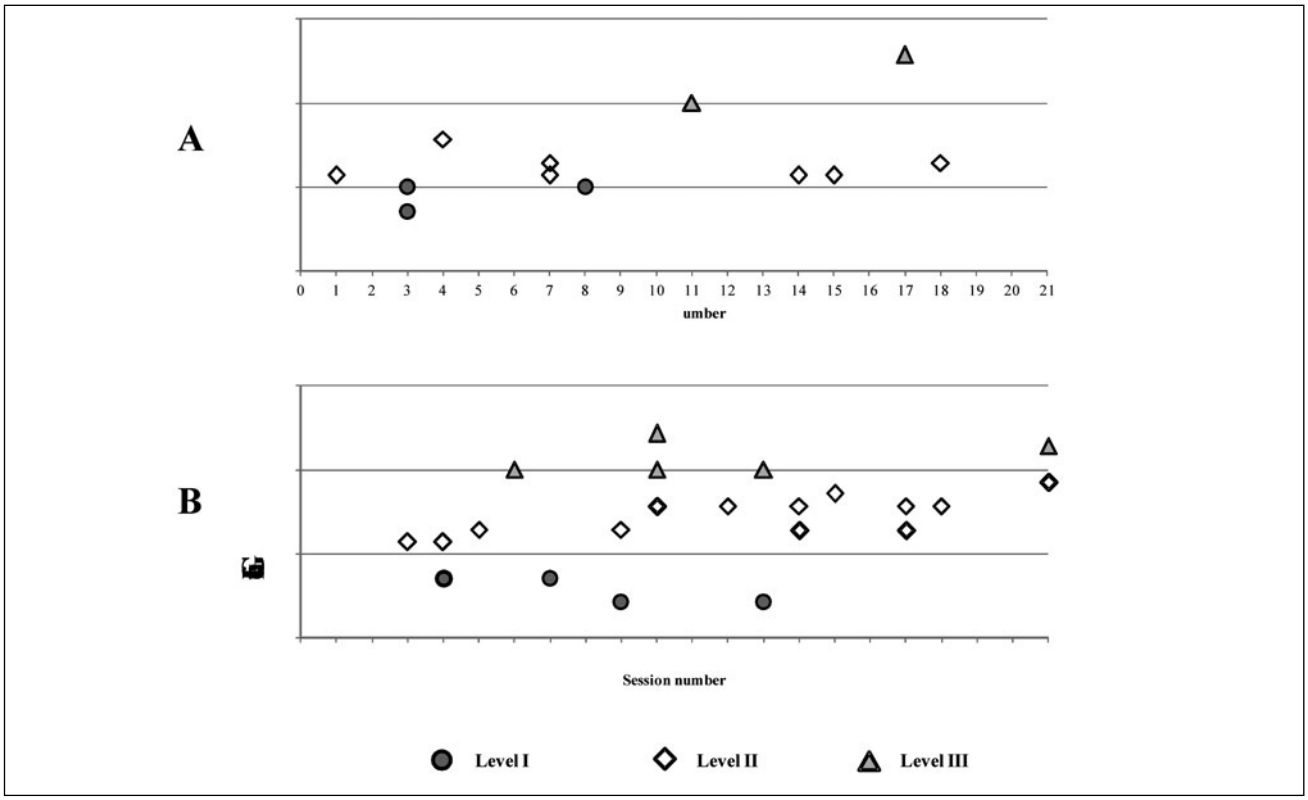
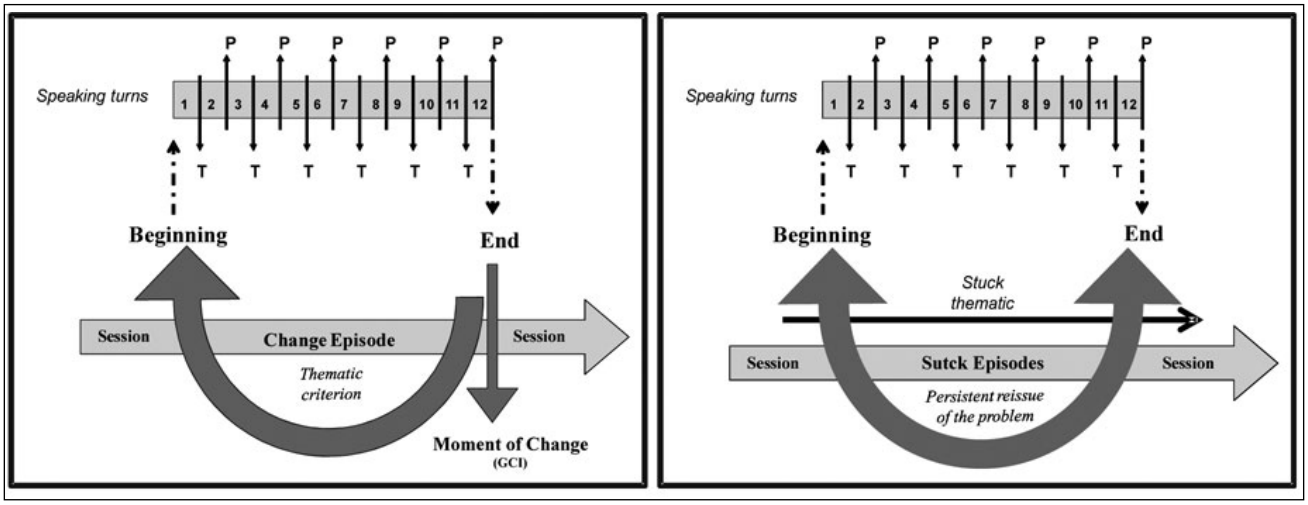
Clínica y Salud
Vol. 23, n.° 2, 2012 - Págs. 153-179

Figure 2. Distribution of Generic Change Indicators (GCI) in therapies A and B



Both therapies were recorded audiovisually and observed through a one-way mirror by expert raters trained in the use of: (a) the protocol for guiding observation and for detecting and identifying change moments; (b) the hierarchical List of Change Indicators (Krause, et al., 2007); and (c) the List of Stuck Episode Topics. The sessions were listed in chronological order and transcribed to facilitate the subsequent delimitation of Change Episodes. As shown in Figure III, the moment of change marks the end of the episode. Said moment of change must meet the criteria of theoretical correspondence, novelty, topicality, and consistency; that is, it must match one of the indicators from the list of Generic Change Indicators (GCIs), be new, occur during the session, and persist over time (Krause, et al., 2007). Afterwards, using a thematic criterion, the beginning of the therapeutic interaction referring to the

Figure 3. Delimitation of Change Episodes and Stuck Episodes (Valdés, et al., 2011b)



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content of the moment of change is tracked in order to define the start of the Change Episode.

In the case of Stuck Episodes, it was necessary to identify the existence of periods of the session in which there was a temporary halting of the patient's change process due to a reissue of the problem, that is, episodes of the session characterized by a lack of progressive construction of new meanings, or an argumentative persistence in the patient's discourse which did not contribute to the objective of change (Herrera, et al., 2009). A Stuck Episode must meet the criteria of theoretical correspondence, novelty, and nonverbal consistency; that is, it must match one of the topics from the List of Stuck Moment Topics, occur during the session, and be nonverbally consistent with the topic of the Stuck Episode. In addition, Stuck Episodes must comply with the following methodological criterion: be at least three minutes long and be at least 10 minutes apart from a Change Episode in the same session. Change Episodes and Stuck Episodes were made up by patient and therapist speaking turns, which were segmented if more than one Communicative Pattern (CP) was identified (Valdés, et al., 2010b).

Configuration of Communicative Patterns (CPs). The Therapeutic Activity Coding System (TACS-1.0, Valdés, et al., 2010b) was used for manually coding patients' and therapists' verbalizations in each speaking turn segment during Change and Stuck Episodes. This system was developed to account for the complexity and multidimensionality of communicative interaction in psychotherapy. Patient and therapist verbalizations were termed Communicative Actions, because they had the double purpose of conveying information (Contents) and exerting an influence on the other participant and the reality constructed by both (Action). Thus, the trained coders must independently code each speaking turn segment according to the five TACS-1.0 (Valdés, et al., 2010b) analysis categories: three belonging to the Action dimension and two to the Content dimension (see Figure IV). The categories that include 22 Action codes are: Basic Form (5 codes), Communicative Intention (3 codes), and Technique (14 codes). The categories that include nine Content codes are: Domain (3 codes) and Reference (6 codes). Each coder must follow the Coding Manual developed by Krause, Valdés and Tomicic (2009, in progress).

A reliability analysis was carried out to evaluate the coders' degree of agreement about the speaking turn segments in Change and Stuck Episodes. In order to do this, 15% of the total number of segments was selected at random (N = 268). SPSS 19.0 was used to calculate Cohen's Kappa for each of the five TACS-1.0 categories. The Kappa indexes obtained were: Basic Form (k=0.95, p = .00), Communicative Intention (k = 0.70, p = .00), Technique (k = 0.51, p = .00), Domain (k = 0.73, p = .00), and Reference (k = 0.79, p = .00). Therefore, the reliability of the raters' coding of both episode types ranged from average to very good.

Once all segments in both episode types were coded, the resulting code configuration of each of them was analyzed. This combination was termed Communicative Pattern (CP), and was made up by six digits which correspond to each of the TACS-1.0 categories (Valdés, et al., 2011b). The first digit corresponds to the coding of the Basic Form category, the second digit to the Communicative Intention category, the third to the Domain category, the fourth to the Reference category, and the last two to the Technique category. Each Communicative Pattern (CP) is made up by two levels separated by a hyphen (for example, CP213-101). The first level includes the first three digits and is referred to as Structural Level. This level corresponds to specific contents associated with the object of therapeutic work, which is transmitted with a certain purpose and using a certain formal structure. The second level includes the last three digits and is referred to as Articulative Level. This level specifies the Communicative Pattern (CP) used, and is associated with the participant that emits the information (the protagonist of therapeutic work in that given moment) and with the presence or absence of any techniques (communicative or therapeutic) used by the speaker to provide support for the purpose of his/her verbalization (Communicative Intention). In other words, a Communicative Pattern (CP) can have the same characteristics at the Structural Level, but, at the same time, it can be articulated differently depending on the circumstances present in a given

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Clínica y Salud
Vol. 23, n.° 2, 2012 - Págs. 153-179

Table 3. Characteristics of the Communicative Patterns (CPs) used to work on emotional contents

Communicative Patterns (CPs) and their Specific Types	Characteristics
AFFECTIVE EXPLORATION (CP^{213})	Communicative pattern used by patients only, regardless of the type of episode. At the Structural Level, it is characterized by the presence of the Assert basic form, and is used to convey a content, clarify it, and/or direct the other participant's attention to certain emotional contents during therapeutic conversation.
Emotional Description ($CP_{213\text{-}100}$)	Specific type of the Affective Exploration pattern (PC213), used by patients to provide novel information about emotional contents that refer to themselves. At the Articulative Level, it is characterized by the absence of (communicative or therapeutic) techniques and by the use of the first person singular.
Argumentative Emotional Clarification ($CP_{213\text{-}101}$) ($CP_{213\text{-}501}$)	Specific type of the Affective Exploration pattern (PC213), used by patients to clarify and/or direct the conversation to certain emotional contents about themselves or their relationship with a third party. At the Articulative Level, it is characterized by the presence of the Argumentation technique, and by the use of the first person singular, third person singular, or first person plural.
AFECTIVE ATTUNEMENT (CP^{223})	Communicative pattern used by therapists only, regardless of the type of episode. At the Structural Level, it is characterized by the presence of the Assert basic form, and is used to show understanding, generate harmony, or provide feedback about certain emotional contents verbalized by the patients during the therapeutic conversation.
Emotional Empathy ($CP_{223\text{-}212}$)	Specific type of Affective Attunement (PC223) used by therapists to mirror patients' affective states expressed by them "here and now". At the Articulative Level, it is characterized by the absence of the Reflection technique and by the use of the second person singular.
AFFECTIVE RESIGNIFICATION (CP^{233})	Communicative Pattern used by patients and therapists during Change Episodes, and only by therapists during Stuck Episodes. At the Structural Level, it is characterized by the presence of the Assert basic form, and is used to co-construct and/or consolidate new meanings for certain emotional contents during therapeutic conversation.
Emotional Self-resignification ($CP_{233\text{-}100}$)	Specific type of the Affective Resignification pattern (PC233), used exclusively by patients to co-construct new meanings for certain emotional contents about themselves. At the Articulative Level, it is characterized by the absence of (communicative or therapeutic) techniques and by the use of the first person singular.
Argumentative Emotional Self-resignification ($CP_{233\text{-}101}$)	Specific type of the Affective Resignification pattern (PC233), used exclusively by patients to co-construct new meanings for certain emotional contents about themselves. At the Articulative Level, it is characterized by use of the Argumentation technique and the first person singular.
Emotional Resignification ($CP_{233\text{-}200}$)	Specific type of the Affective Resignification pattern (PC233), used exclusively by therapists to co-construct new meanings for certain emotional contents about the other person present (patients). At the Articulative Level, it is characterized by the absence of (communicative or therapeutic) techniques and by the use of the second person singular.
Argumentative Emotional Resignification ($CP_{233\text{-}201}$)	Specific type of the Affective Resignification pattern (PC233), used exclusively by therapists to co-construct new meanings for certain emotional contents about the other person present (patients). At the Articulative Level, it is characterized by use of the Argumentation technique and the second person singular.
Interpretative Emotional Resignification ($CP_{233\text{-}207}$)	Specific type of the Affective Resignification pattern (PC233), used exclusively by therapists to co-construct new meanings for certain emotional contents about the other person present (patients). At the Articulative Level, it is characterized by use of the Interpretation technique and the second person singular.
Transferential Emotional Resignification ($CP_{233\text{-}407}$)	Specific type of the Affective Resignification pattern (PC233), used exclusively by therapists to co-construct new meanings for certain emotional contents about the therapeutic relationship. At the Articulative Level, it is characterized by the presence of the Interpretation technique and the first person plural, or by the use of first and second person singular during the same speaking turn.

Note . Communicative Patterns (CPs) with theris respective definitions are a result of previous studies (Valdés, et al., 2011b).

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moment of the conversation, which does not affect its structure. Table III presents the main Communicative Patterns (CPs) used by patients and therapists to work on emotional contents during Change Episodes, along with their specific types at the Articulative Level. The characteristics mentioned for each Communicative Pattern (CP) are the result of previous studies which are still unpublished (Valdés, et al., 2011b).

Data analysis

Data analysis involved two successive stages. The first stage consisted in the application of the Chi Square test (^{2}) in order to establish whether there was an association between the different patterns, the stage of the episode, and the phase of the therapy. The second stage involved calculating the *Z-ratio* to compare independent proportions, and estimating 95% Confidence Intervals (CI) when the value of *Z*could not be estimated. Logistic Regression was used to detect the variables which best predict the use of each Communicative Pattern (CP).

Results

The results of this study will be presented in two parts: the first referring to the characteristics of verbal emotional expression within Change Episodes, and the second to the characteristics of verbal emotional expression throughout the phases of the psychotherapeutic process.

Characteristics of verbal emotional expression within Change Episodes

In the first part of the study, each Change and Stuck Episode was divided into three stages as similar as possible, depending on the total number of speaking turn segments present in each episode. Given that the objective of the study was to determine the characteristics of the Communicative Patterns (CPs) used as the Change Episode progressed, what occurred at the beginning of the episode was compared with what happened at the end, but also considering the therapeutic stage[2]. Therefore, the analysis involved 64 speaking turn segments from the initial stage of Change Episodes belonging to the initial, middle, and final phases of the therapy (24, 21, and 19, respectively), and 39 speaking turn segments from the final stage of Change Episodes belonging to the initial, middle, and final phases of the therapy (16, 15, and 8, respectively). No association was observed between the stage of the episode and the therapeutic phase, thus, the participants' work on emotional contents during Change Episodes was performed at the beginning and at the end of the episodes in a similar proportion, regardless of the therapeutic phase. Nevertheless, in the last third of the therapy, work on emotional contents was more frequent in the initial stage of Change Episodes. In the case of Stuck Episodes, the analysis involved 27 speaking turn segments from the initial stage of episodes belonging to the initial, middle, and final phases of the therapy (1, 19, and 17, respectively), and 17 speaking turn segments from the final stage of episodes belonging to the initial, middle, and final phases of the therapy (1, 8, and 8, respectively). No association was observed between the stage of the episode and the therapeutic phase; however, in the middle phase of the therapy, work on emotional contents was more frequent in the initial stage of Stuck Episodes.

When the Change Episodes were analyzed, regardless of the participant's role (patient or therapist), no association was found between the stage of the episode and the type of Communicative Pattern (PC) used to work on emotional contents; likewise, no association was observed between said patterns and the participant's role. Nevertheless, certain significant differences were observed within each of the stages of the Change Episodes (see Table IV). During the initial stage of the episodes, the patients verbalized a larger proportion of Affective Exploration[3] (68.75%),

[2] Both therapeutic processes (A and B) were also divided into three thirds, depending on their total number of sessions: initial stage, middle stage, and final stage.

[3] For presenting the results, the Communicative Patterns used for working on emotional contents (Affective Exploration, Affective Attunement, and Affective Resignification) will be underlined, while their specific types will be *italicized*.

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compared with the proportion of Affective Resignifications (31.25%) performed during this stage $Z = 3.000$, $p = .00$. On the other hand, the therapists verbalized a larger proportion of Affective Resignifications (71.87%) compared with the proportion of Affective Attunement (28.13%) shown to their patients $Z = 3.500$, $p = .00$, and also compared with the Affective Resignifications (31.25%) used by the patients during this stage $Z = 3.252$, $p = .00$. During the final stage of Change Episodes, the patients performed a similar proportion of Affective Explorations (45.45%) and Affective Resignifications (54.55%); also, the Affective Resignifications (82.35%) performed by the therapists continued to be 64.71% [95% CI = 31.64 - 80.91] more frequent than the Affective Attunement (17.65%) shown to their patients. There were no significant differences between patients' and therapists' use of Affective Resignifications during this stage of the episode (82.35% and 54.55%). The same analysis, when applied to Stuck Episodes, was even less effective at establishing an association between the stage of the episode and the Communicative Patterns (CPs) used due to their absence or low frequency during these episodes. As Table IV shows, there were no significant differences between the initial and the final stages of Stuck Episodes in terms of the proportion of Affective Explorations performed by the patients. This Communicative Pattern (CP) was the only one used by the patients to work on emotional contents, and did not display any variations in proportion during Stuck Episodes. During Stuck Episodes, like during Change Episodes, the therapists focused on the co-construction of new meanings for certain emotional contents, but there was no collaborative work leading to change.

Finally, a comparison of both episode types in terms of the proportion of Communicative Patterns (CPs) in both stages of the episode revealed that the Affective Explorations performed by the patients were 31.25% [95% CI = 5.94 - 48.57] and 54.55% [95% CI = 21.91 - 73.08] more frequent during the initial and final stages of Stuck Episodes (100%), respectively; also, the patients not only performed Affective Resignifications exclusively during Change Episodes, but did so in similar percentages during both stages of the episode, and with a tendency to increase during the final stage. The therapists performed practically the same resignification work during the different stages of both episode types.

Characteristics of verbal emotional expression throughout the therapeutic process

The second part of the study was aimed at analyzing the distribution of the Communicative Patterns (CPs) used to work on emotional contents during the different phases of the therapeutic process. In order to do this, each therapy was divided into three phases, depending on their total number of sessions. Thus, the initial phase was made up by 13 Change

Table 4. Distribution of Communicative Patterns (CPs) within the episode

Communicative Patterns (CPs)	Stages of the Change Episode			Stages of the Stuck Episode		
	Initial	Final	Total (f)	Initial	Final	Total (f)
Patients						
Affective Exploration	68.75% (22)	45.45% (10)	32	100% (14)	100% (11)	25
Affective Attunement	0% (0)	0% (0)	0	0% (0)	0% (0)	0
Affective Resignification	31.25% (10)	54.55% (12)	22	0% (0)	0% (0)	0
Therapists						
Affective Exploration	0% (0)	0% (0)	0	0% (0	0% (0)	0
Affective Attunement	28.13% (9)	17.65% (3)	12	23.08% (3)	0% (0)	3
Affective Resignification	71.87% (23)	82.35% (14)	37	76.92% (10)	100% (6)	6
Total (f)	64	39	103	27	17	44

Note . The scores are expressed as a percentages (%) with their respective frequencies in parentheses. The totals are expressed as frequencies (f).

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Episodes (A = 5; B = 8), the middle phase, by 14 Change Episodes (A = 4; B=10), and the final phase, by 11 Change Episodes (A = 5; B = 6). No significant differences were observed in the proportion of Change Episodes present in the two therapies or within each phase. Therefore, the distribution of Change Episodes was also homogeneous. Regarding the distribution of Stuck Episodes, a significant difference was only present during the middle phase of both therapies, which was taken into account when performing the analyses below (see Table V).

The analysis of the behavior of Communicative Patterns (CPs) throughout the therapeutic process, regardless of the participant's role, revealed an association between the Communicative Patterns (CPs) used to work on emotional contents during Change Episodes and the therapeutic phase [^{2} (4, N = 161) = 10.201, p = .04], which means that there was a larger proportion of Affective Explorations during the initial phase of the therapeutic process and a larger proportion of Affective Resignifications during its final phase. No associations were observed between the Affective Attunement displayed and the phase of the therapy (see Table VI). In other words, the start of the therapeutic process was mainly characterized by the purveyance of novel information, the clarification of some points, and/or the focalization of the conversation on certain emotional contents (Affective Exploration), whereas its final phase was characterized by the co-construction and/or consolidation of new meanings associated with certain emotional contents (Affective Resignification). The participants showed understanding, generated harmony, or provided feedback about emotional contents (Affective Attunement) regardless of the therapeutic phase.

A comparison of both episodes regardless of the participant's role revealed a larger proportion of Affective Resignifications during Change Episodes, Z = 1.956, p = .05 (CE = 61.54%, SE = 40.54%), and a larger proportion of Affective Explorations during Stuck Episodes, Z = 2.399, p = .02 (SE = 54.05%, CE = 28.85%). This situation remained constant when comparing both episode types in the

Table 5. Distribution of Change and Stuck Episodes by therapeutic phase

	Fases del proceso terapéutico			
	Inicial	Media	Final	Total
Terapia A				
Cantidad de sesiones	6	6	6	18
+ Episodios de Cambio (ECs)	35.71% (5)	28.57% (4)	35.71% (5)	14
+ Episodios de Estancamiento (EEs)	0% (0)	57.14% (4)	42.86% (3)	7
Terapia B				
Cantidad de sesiones	7	7	7	21
+ Episodios de Cambio (ECs) 33.33% (8)	41.67% (10)	25.00% (6)	24	
+ Episodios de Estancamiento (EEs) †	33.33% (4)	8.33% (1)	58.33% (7)	12

†MayorproporcióndeEEs durantelafasemediadelaTerapiaA,[IC=6.83a76.70],p<0.05(A=57.14%yB=8.33%).
The scores are expressed as a percentages (%) with their respective frequencies in parentheses.

Table 6. Distribution of Communicative Patterns (CPs) by therapeutic phase and episode type

Communicative Patterns (CPs)	Change Episodes				Stuck Episodes			
	Phases of the Psychoterapeutic Process				Phases of the Psychotherapeutic Process			
	Initial	Middle	Final	Total (f)	Initial	Middle	Final	Total (f)
Affective Exploration (CP213)	33.33% (21)	28.85% (15)	13.04% (6)	42	75.00% (3)	54.05% (20)	60.00% (12)	35
Affective Attunement (CP223)	17.46% (11)	9.61% (5)	8.70% (4)	20	0% (0)	5.41% (2)	5.00% (1)	3
Affective Resignification (CP233)	48.39% (30)	62.26% (33)	78.26% (36)	99	25.00% (1)	40.54% (15)	35.00% (7)	23
Total (f)	62	53	6	161	4	37	20	61

Note. The scores are expressed as a percentages (%) with their respective frequencies in parentheses. The totals are expressed in frequencies (f).

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Clínica y Salud
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final phase, which again displayed a larger proportion of Affective Explorations during Stuck Episodes, $Z = 3.936$, $p < .00$ (SE = 60.00%, CE = 13.04%) and a larger proportion of Affective Resignifications during Change Episodes, $Z = 3.390$, $p = .00$ (CE = 78.26%, SE = 35.00%).

Evolution of CPs throughout the Therapeutic Process, by Role. Assuming the existence of an association between the Communicative Patterns (CPs) used to work on emotional contents during Change Episodes and the therapeutic phase, the next step was to analyze the distribution of the frequency of such patterns within each phase of the therapeutic process, but considering the participant's role.

Initial phase of the process. In this phase, statistically significant differences were observed in the proportion of Affective Explorations and Affective Resignifications performed by the patients, $Z = 3.098$, p=.002 (CP213 = 70.00%, CP233 = 30.00%), as well as in the proportion of Affective Attunement and Affective Resignifications performed by the therapists, $Z = 2.708$, $p = .01$ (CP233 = 66.67%, CP223 = 33.33%). The proportion of Affective Resignifications performed by the therapists in the initial phase of the therapy was higher in comparison with the patients, $Z = 2.907$, $p = .00$ (T = 66.67%, P = 30.00%) (see Figure IV).

Middle phase of the process. In contrast with the previous phase, no significant differences were observed in the proportion of Affective Explorations and Affective Resignifications performed by the patients, however, significant differences remained in the proportion of Affective Attunement and Affective Resignifications performed by the therapists, $Z = 3.618$, $p = .00$ (CP233 = 77.27%, CP223 = 2.73%). In the middle phase, most Affective Resignifications were still performed by the therapists Z = 1.997, $p = .05$ (T = 77.27%; P = 50.00%) (see Figure IV).

Final phase of the process. During this phase, significant differences were again observed in the proportion of Affective Explorations and Affective Resignifications performed by the patients $Z = 2.271$, $p = .02$ (CP233 = 68.42% and CP213 = 31.58%); also, the proportion of Affective Resignifications by the therapists continued to be 70.37% [95% CI = 45.39 - 82.96] more frequent in comparison with the Affective Attunement displayed in this phase. During the final phase, there was a 16.76% difference [95% CI = -7.21 - 40.88] between the proportion of Affective Resignifications by the patients and the therapists (T = 85.19%, P = 68.42%); however, this difference was shown to be non significant (see Figure IV).

Comparison between the phases. A comparison of the phases of the therapeutic process revealed significant differences in the proportion of the Communicative Patterns (CPs) used by the patients during Change Episodes: compared with the initial phase of the therapy, the patients performed fewer Affective Explorations $Z = 2.635$, $p = .01$ (70.00%, 31.58%) and a larger proportion of Affective Resignifications $Z = 2.635$, $p = .01$ (68.42%, 30.00%) during the final phase of the therapy; on the other hand, there were no significant differences in the Communicative Patterns (CPs) used by the therapists to work on emotional contents during the different phases of the psychotherapeutic process.

Comparison between episode types. As previously mentioned, due to the low frequency of some Communicative Patterns (CPs) during the Stuck Episodes contained in some phases of the therapeutic process ($f < 5$), it was not possible to observe an association between such patterns and the phase of the therapy. Therefore, it was only possible to analyze the proportion of Affective Exploration and Affective Resignification when comparing the initial and the final phase of the process. Unlike in Change Episodes, there were no significant differences between the middle and the final phase of the therapy in terms of the proportion of Affective Exploration performed by the patients, nor in the case of the Affective Resignification performed by the therapists. In other words, no changes were observed in the Communicative Patterns (CPs) used by the patients during Stuck Episodes: their work throughout the phases of the process was limited to providing information, clarifying points, or steering the conversation towards other emotional contents (Affective Exploration), while the therapists performed the same resignification work that they did during Change Episodes, only without the corresponding resignification response by the patients.

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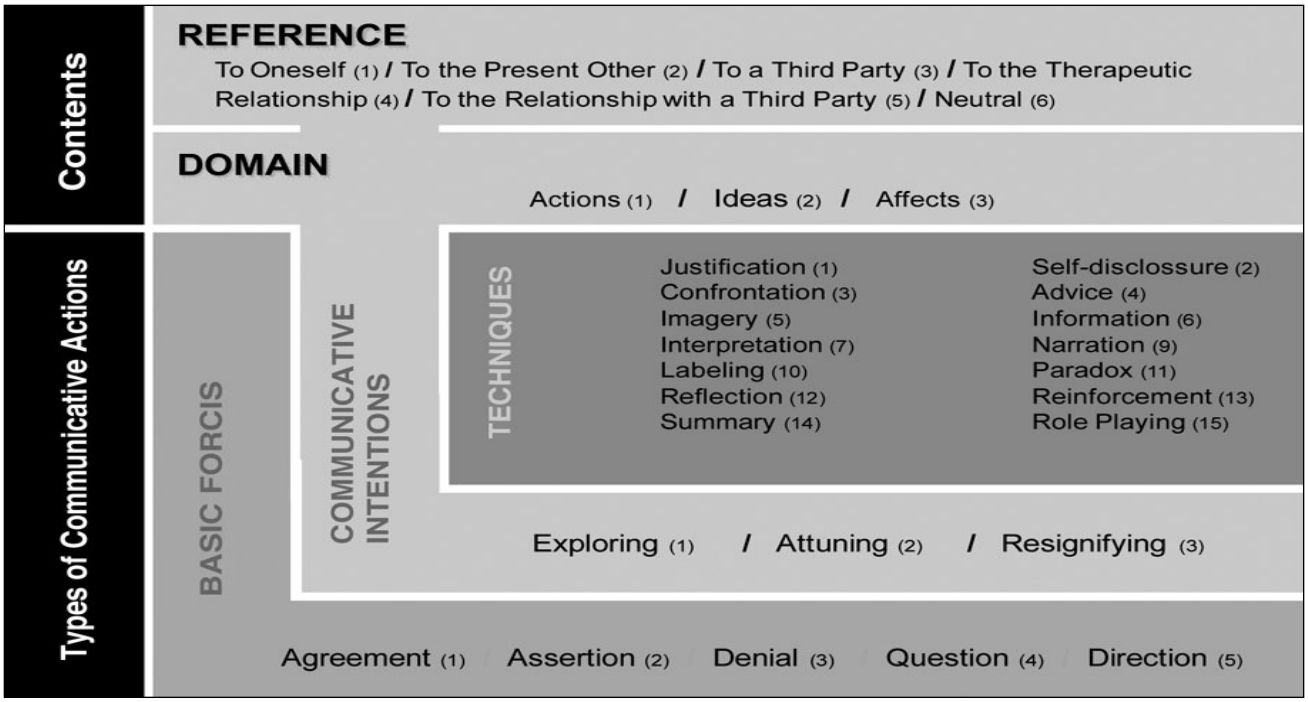
Figure 4. Dimensions, categories and action codes of the Therapeutic Activity Coding System (Valdés, et al., 2010)



Evolution of specific CP types throughout the process. Based on the assumption that there are significant differences in the proportion of certain Communicative Patterns (CPs) during Change Episodes in the three phases of the therapy, the study focused on the analysis of the proportion of specific CPs types, considering the participant's role.

Initial phase of the process. During this phase, the patients performed a similar proportion of *Emotional Descriptions* and *Argumentative Emotional Clarifications*, along with a similar proportion of *Emotional Self-resignifications* and *Argumentative Emotional Self-resignifications* (see Figure V). However, the latter pattern was used by the patients 26.66% [95% CI = 6.33 - 45.19] less than *Argumentative Emotional Clarifications*, which constitutes a significant difference. On the other hand, the therapists displayed *Emotional Empathy* and performed *Argumentative Emotional Resignifications* and *Interpretative Emotional Resignifications* in a similar proportion. During the initial phase, in the case of the therapists, *Interpretative Emotional Resignifications* were: 33.33% [95% CI = 14.57 - 50.54] more frequent than *Transferential Emotional Resignifications*; 30.30% [95% CI = 10.70 - 47.88] more frequent than *Emotional Resignifications*; and 24.24% [95% CI = 3.45 - 42.76] more frequent than *Argumentative Emotional Resignifications*, all of which constitute significant differences. A comparison of the sum of the specific types CP233-100 and CP233-101 used by the patients with the sum of the specific types CP233-200 and CP233-201 used by the therapists did not reveal significant differences between the participants during the initial phase; however, some differences were observed when including the *Interpretative Emotional Resignifications* performed by the therapists, $Z = 2.820$, $p = .00$ (T = 54.55%, P = 20.00%) (see Figure V).

Middle phase of the process. During this phase, the patients performed *Emotional Descriptions*, *Argumentative Emotional Clarifications*, *Emotional Self-resignifications*, and *Argumentative Emotional Self-resignifications* in a similar proportion; whereas the therapists displayed *Emotional Empathy* and used specific types to resignify emotional contents in a similar proportion (see Figure V). During the middle phase, the proportion of *Transferential Emotional Resignifications* performed by the therapists was 22.72% [95% CI = 0.43 - 43.94] less frequent than the proportion of *Interpretative Emotional Resignifications*, which constitutes a significant difference. A comparison of the sum of the specific types CP233-100 and CP233-101 used by

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the patients with the sum of the specific types CP233-200 and CP233-201 used by the therapists did not reveal significant differences between the participants during the middle phase, even when including the *Interpretative Emotional Resignifications* performed by the therapists.

Final phase of the process. During this phase, the patients performed *Emotional Descriptions* and *Argumentative Emotional Clarifications* in a similar proportion, however, in contrast with previous phases, the *Argumentative Emotional Self-resignfications* performed by the patients during this phase were 31.58% [95% CI = 3.38 - 54.49] more frequent than *Emotional Self-resignifications* (see Figure V). Although the therapists displayed *Emotional Empathy*, they did so 29.63% [95% CI = 6.17 - 49.53] less frequently than they performed *Transferential Emotional Resignifications*, which in turn were 25.93% [95% CI = 1.94 - 46.48] more frequent than *Interpretative Emotional Resignifications*.

One of the most interesting findings resulting from this study was the fact that, during the final phase, the resignification work performed by the patients using the specific types CP233-100 and CP233-101 jointly, was 41.52% [95% CI = 14.59 - 62.83] more frequent than the therapists' work using the specific types CP233-200 and CP233-201 jointly, which constitutes a significant difference. These differences between the participants only disappeared when including the proportion of *Interpretative Emotional Resignifications* performed by the therapists as part of their resignification work.

Comparison between the phases. In comparison with the initial phase of the process, the *Argumentative Emotional Self-resignifications* performed by the patients were 20.00% [95% CI = 0.75 - 38.42] more frequent during the middle phase. Although no significant differences were observed between the middle and the final phases in this aspect, the *Argumentative Emotional Resignifications* performed by the patients were 35.44% [95% CI = 11.47 - 57.59] more frequent during the final phase than in the initial phase. On the other hand, the *Transferential Emotional Resignifications* performed by the therapists during the final phase of the process were 36.19% [95% CI = 12.51 - 55.10] more frequent than during the middle phase, and 37.71% [95% CI = 17.36 - 56.41] more frequent than in the initial phase, while the rest of the specific Communicative Pattern (CP) types maintained a similar proportion during all phases of

Figure 5. Distribution of the Communicative Patterns (CPs) used to work on emotional contents, by role and episode type. The scores of the Y axis are expressed as a percentage (%)

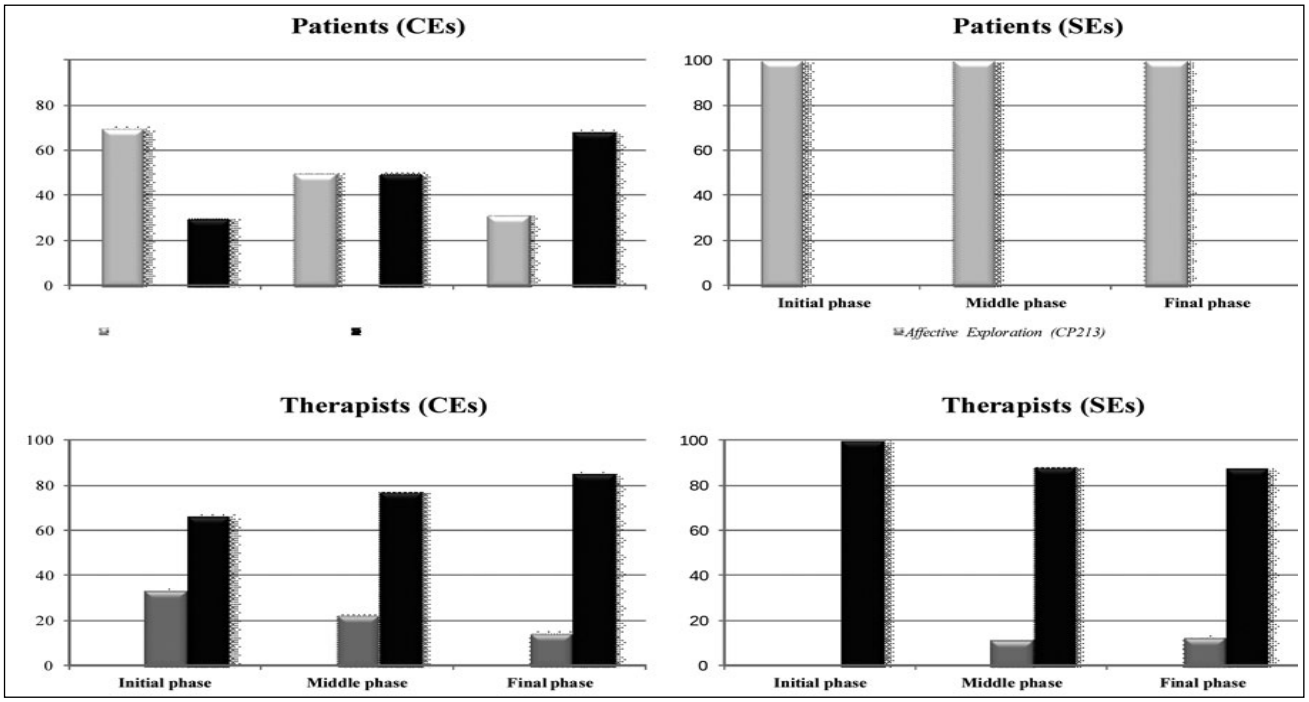

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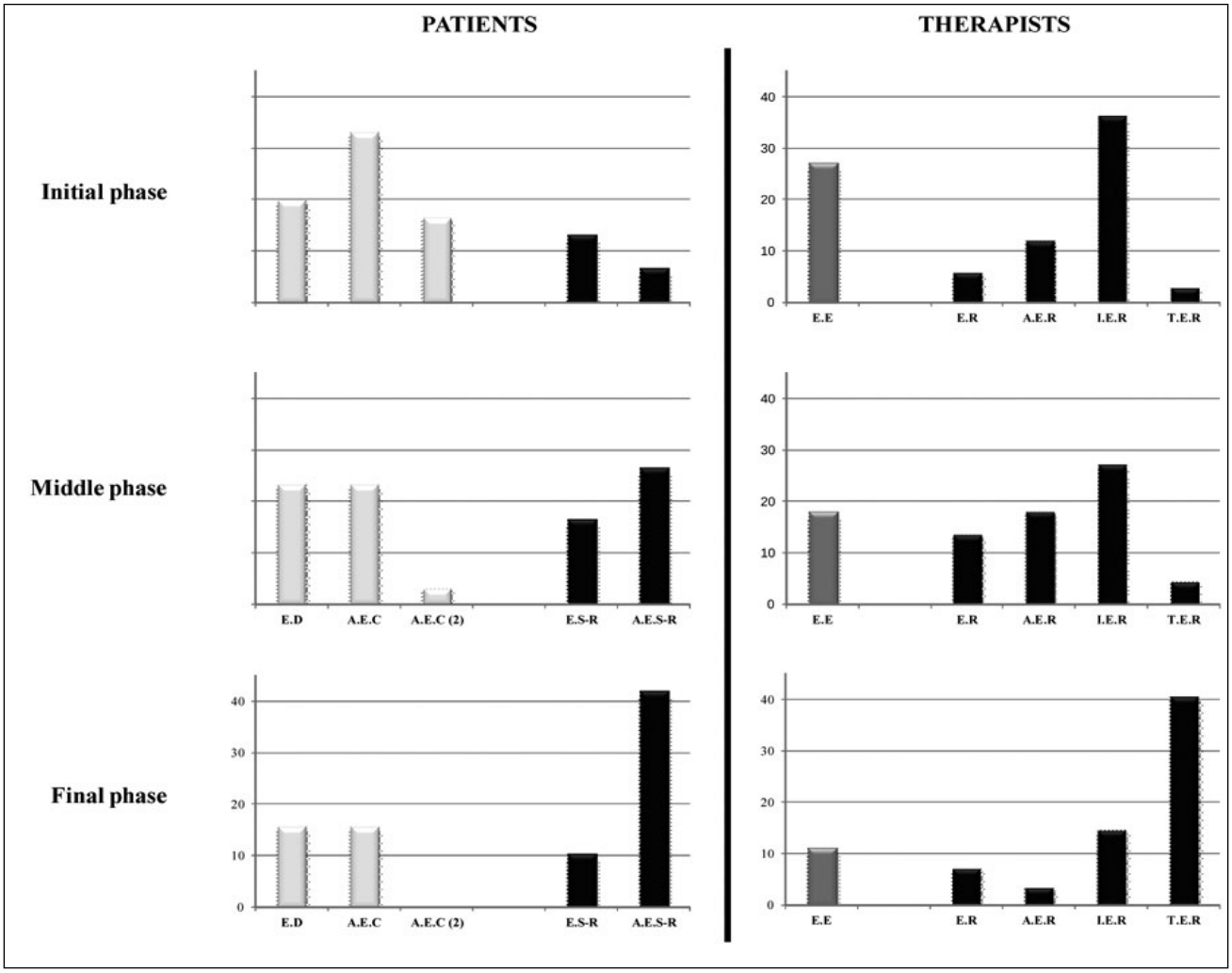
Figure 6. Distribution of the specific Communicative Patterns (CPs) types used to work on emotional contents during Change Episodes: ED=*Emotional Description*; AEC=*Argumentative Emotional Clarification* about the patients themselves; $AEC_{(2)}$=*Argumentative Emotional Clarification* about the relationship with another person; ES-R=*Emotional Self-resignification*; AES-R=*Argumentative Emotional Self-resignification*; EE=*Emotional Empathy*; ER=*Emotional Resignification*; AER=*Argumentative Emotional Resignification*; IER=*Interpretative Emotional Resignification*; and TER=*Transferential Emotional Resignification*. The scores of the Y axis are expressed as a percentage (%)



the psychotherapeutic process. The *Transferential Emotional Resignifications* performed by the therapists during Stuck Episodes were 30.74% [95% CI = 5.83 - 54.45] more frequent during the middle phase of the process.

Finally, a logistic regression analysis was conducted to predict the appearance of each of the Communicative Pattern (PC) types used to work on emotional contents during the therapeutic conversation, considering the following variables: episode type, role of the participant, and therapeutic phase. When predicting the Affective Exploration pattern, the logistic regression model yielded a correct estimate [χ^2 (4, N = 222) = 184.65, p < .00] of 86.50% of cases; thus, it entered the equation as the only variable with predictive value in the initial phase of the therapy (Wald = 6.527, p < .05). Once controlling for the effects of the variables present in the equation, it is less likely that in the final phase the participants provide information, clarify a point, and/or steer the focus of the conversation towards certain emotional contents (Affective Exploration) compared to the initial phase. Regarding the prediction of the Affective Attunement pattern, the logistic regression model yielded a correct estimate [χ^2 (4, N=222) = 40.938, p < .00] of 89.60% of cases, and so no variables that predicted the action of showing understanding, generating harmony, and/or providing feedback about certain emotional contents (Affective Attunement) were included in the equation. For the prediction of

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the Affective Resignification pattern, the logistic regression model yielded a correct estimate [χ^2 (4, N = 222) = 69.248, p < .00] of 75.70% of cases, and thus the following variables entered the equation as predictors: the middle phase of the therapy (Wald = 5.850, p < .05), the final phase of the therapy (Wald = 8.819, p <.01), Change Episodes (Wald = 13.304, p < .00), and the therapist's role (Wald = 42.332, p < .00). Therefore, after controlling for the effects of the variables included in the equation, it is more likely that the participants construct new meanings for certain emotional contents (Affective Resignifica-tion) in the middle and final phases than in the initial phase; in addition, the therapists are more likely to perform this resignification during Change Episodes.

Conclusions and discussion

Communicative Actions are a relevant element in the psychotherapeutic process, because they make it possible to characterize the verbalizations of patients and therapists during therapeutic dialog (Valdés, et al., 2011b). These actions are directly related with the object of therapeutic work, and do not only convey contents when speaking, but also construct a new reality upon the basis of language (Reyes, et. al., 2008; Vetlesen, 1994). Each of the speakers' verbalizations is characterized by the following dimensions: a formal structure, a purpose, a specific type of contents, a protagonist of therapeutic work, and the presence or absence of communicative or therapeutic techniques used to support the speaker's communicative intention (Valdés, et al., 2011b). Therefore, verbalizations acquire a specific configuration with certain characteristics which depend on the way in which all these dimensions fit together during the speaking turns of each of the participants of therapeutic dialog. Such configurations are termed Communicative Patterns (CPs), and are used by patients and therapists to work on various contents and influence each other during the conversation (Valdés, et al., 2011b).

Previous studies have shown that Communicative Patterns (CPs), depending on their structural and articulative levels, make it possible to characterize the verbal expression of patients and therapists, associated with therapeutic work on emotional contents (Valdés, et al., 2011b). They have also helped to establish similarities and differences between Change and Stuck Episodes, and to identify temporal interaction sequences between Communicative Patterns (CPs), depending on the type of episode and the participant's role (Valdés, et al., 2011b). On the other hand, psychotherapy, in any of its forms, is understood as a process involving a series of phases characterized by the need to attain specific objectives, based on actions conducted by both participants of the therapeutic dialog. One of the methodological problems of previous studies is their approach: studying the therapeutic process as a whole, instead of breaking it up into stags (Goates-Jones, Hill, Stahl, & Doschek, 2009). In this regard, the present study not only provides a novel analysis methodology, but also makes it possible to identify similarities and differences in the behavior of Communicative Patterns (CPs) in Change and Stuck Episodes, and throughout the phases of the psychotherapeutic process.

The results of the first part of the study suggest the presence of significant differences within Change Episodes, in terms of the Communicative Patterns (CPs) used by patients and therapists to work on emotional contents. The initial stage of Change Episodes was characterized by the construction of new meanings for certain emotional contents (Affective Resignification), mostly performed by the therapists, whereas the patients focused on providing information, clarifying points, and and/or steering the conversation towards certain emotional contents verbalized in the conversation (Affective Exploration); on the other hand, in the final stage of Change Episodes, the patients also provided information or clarified points about certain emotional contents, but while they co-constructed new meanings for such contents (Affective Resignification), thus collaborating with the resignification work conducted by the therapists from the beginning of the episode. The behavior of Communicative Patterns (CPs) was different during Stuck Episodes: the patients provided information, clarified certain points, and focused the conversation on certain contents (Affective Exploration) throughout the episode; in contrast, the therapists worked on the

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

resignification of emotional contents, but without a collaborative response by the patients. Therefore, regardless of the episode type, the therapists constantly provided alternative ways of understanding emotional contents; however, it was only during Change Episodes that the patients displayed a collaborative response, which appeared to increase as such episodes progressed. This is consistent with previous studies, which mention the existence of moments which are more beneficial than others therapeutically speaking (Elliott, 1985; Krause, et al., 2007; Martin & Stelmaczonek, 1988; Timulak, 2007), during which patients become more aware of their life experiences and therefore attain a deeper knowledge of themselves; in contrast, there exist less beneficial moments, conceptualized as hindering events (Grafanaki & McLeod, 1999; Herrera, et al., 2009), during which no new meanings are constructed by the patient in his/her interaction with the therapist. In this regard, it can be said that during Change Episodes, therapeutic work led to the emergence of a change moment in the patients, and that during such episodes the participants jointly used Affective Resignification in order to co-construct new meanings associated with such change moment.

The second part of the study was aimed at determining how these Communicative Patterns (CPs) behaved during the phases of the therapeutic process, which were defined based on a temporal criterion, depending on the total number of sessions of each therapy. The analysis of such patterns during Change Episodes, regardless of the participant's role, resulted in the conclusion that the initial phase of the therapeutic process was mainly characterized by Affective Exploration work, whereas the final phase was characterized by Affective Resignification. This is consistent with Elliott and Shapiro (1992), who state that episodes in the session are windows into the therapeutic process, as Communicative Patterns (CPs) had roughly the same behavior within Change Episodes. However, when analyzing the patterns during Stuck Episodes, regardless of the participant's role, no association was observed between them and the phase of the therapy, which can be partly explained by the absence or low frequency ($f < 5$) of some patterns in all phases of the therapeutic process, which may have resulted from the number of Stuck Episodes in comparison with Change Episodes. However, it may be regarded as a result in itself that there were no changes in the behavior of Communicative Patterns (PCs) within Stuck Episodes.

Based on the results obtained, the next step was to analyze the distribution of Communicative Patterns (CPs) within the phases of the psychotherapeutic process, but considering the participants' role. During the initial phase of the therapy, therapeutic activity was characterized by the patients' use of Affective Exploration, through the purveyance of novel information about certain emotional contents (*emotional descriptions*), but mainly by using generalizations or justifications to clarify a point or focus the conversation on certain emotional contents about themselves (*argumentative emotional clarifications*). Likewise, it was significant that both participants performed Affective Resignifications to construct new meanings for the emotional contents verbalized, which could be interpreted as a higher response level reached by the patients (Beutler, Clarkin, & Bongar, 2000; Kernberg, Yeomans, Clarkin, & Levy, 2008) during the resignification work carried out during Change Episodes. It seems that a therapist's degree of directiveness, that is, how active he/she is during the therapeutic process, is moderated by the patient's response or resistance to his/her influences (Beutler & Clarkin, 1990; Beutler, et al., 1991). In this regard, less directive interventions are associated with better outcomes if they are performed in the moments when patients resist external influence, while more directive ones have a stronger impact when patients are open to be influenced by the other (Beutler & Clarkin, 1990). It is likely that, during Change Episodes, the therapists' discourse was perceived by the patients as a source of possibilities to attain insight or new perspectives, which were accepted without displaying resistance to change (Knox, Hess, Petersen, & Hill, 1997). Even more so, this resignification work was often performed based on meanings proposed by the patients themselves during the conversation (*emotional self-resignifications* and *argumentative emotional self-resignifications*), and by the therapists (*argumentative emotional resignifications* and *interpretative emotional resignifications*) considering all

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

the information provided by the patients. It must be mentioned that, although resignification work was conducted by both participants, it was dominated by the therapists during the initial phase of the process, as they often provided new meanings based on how they understood the information given by the patients (*interpretative emotional resignifications*), compared to their use of arguments, examples, generalizations, or justifications taken from the patients' discourse to consolidate a new meaning (*argumentative emotional resignifications*). The therapists' resignification was associated with the establishment of hypotheses formulated upon the basis of certain aspects of the patients' history which the patients had not yet taken into account; therefore, in order to perform this therapeutic action, the therapists needed to have as much clarity as possible about the information provided by the patients. Another important finding was that, during the initial phase, the therapists provided very few meanings for emotional contents about the therapeutic relationship (*transferential emotional resignifications*). It must be stressed that the therapists interpreted transference using one of the most active interventions for achieving long-term changes in the psychodynamic model (Gabbard & Westen, 2003). Patient-therapist interaction is strongly influenced by the patient's past relationships and his/her affective experiences, therefore, focusing on the conflicts and issues which emerge in the therapeutic relationship can have an immediate affective resonance which reflects the nature of the patient's relational problems outside the therapy. Considering this, it may be that using this type of intervention excessively, or too soon, may increase the patients' anxiety (Piper, Azim, Joyce, & McCallum, 1991), so that only patients with more extensive psychological resources or more mature relationships may benefit from such interventions in short psychotherapies (Gabbard, 2006). It is not surprising, then, that in the therapies analyzed the proportion of *transferential emotional resignifications* was lower at the beginning of the therapy, and that therapists focused on the resignification of the patients' relationships outside the therapy (Frances & Perry, 1983; Høglend, 2003). It is also noteworthy that mirroring the patients' affective states "here and now", in order to show understanding, generate harmony, and/or provide feedback about certain emotional contents (*emotional empathy*) was another of the interventions favored by the therapists, at a level similar to that of the *argumentative emotional resignifications* and *interpretative emotional resignifications* carried out during this phase. This result confirms the suggestions of Wiser and Goldfried (1998) that patients maintain a high level of therapeutic work when the therapists use the Reflection technique, and that therapists need empathy to facilitate patients' work during the therapy (Sachse & Elliott, 2002).

The middle phase of the therapeutic process was again characterized by the patients' use of the Affective Exploration pattern, through the purveyance of novel information about certain emotional contents referencing themselves (*emotional descriptions*); however, this time, they used it in a similar proportion as *argumentative emotional clarifications* (generalizations or justifications to clarify a point or focus the conversation on certain emotional contents about themselves). During this phase, both participants continued using the Affective Resignification pattern, through the purveyance of new meanings proposed by the patients during the conversation (*emotional self-resignifications* and *argumentative emotional self-resignifications*), and of new meanings proposed by the therapists based on the information given by the patients (*argumentative emotional resignifications* and *interpretative emotional resignifications*). During the middle phase of the therapy, although resignification work was still conducted jointly by the patients and the therapists, it was still dominated by the latter, due to the proportion of *interpretative emotional resignifications* that they used; however, the main difference with the initial phase was that the patients carried out exploration and resignification work simultaneously during the middle phase. On the other hand, the therapists continued co-constructing new meanings for certain emotional contents (*interpretative emotional resignification*) and consolidating such meanings (*argumentative emotional resignification*) while at the same time showing understanding and/or providing feedback to their patients about such contents (*emotional empathy*). Again, the ascription of new meanings to emotional contents about the therapeu-

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

tic relationship *transferential emotional resignifications*) remained low, and its frequency was smaller than that of the *interpretative emotional resignifications* performed by the therapists.

The main characteristic of the final therapeutic phase was the co-construction of new meanings for emotional contents verbalized during the conversation (Affective Resignification), which, in addition to being performed by the patients and the therapists together, was used in a similar proportion by both participants, in contrast with previous phases in which said activity had mostly been conducted by the therapists. During the final phase, the patients continued performing *emotional descriptions* and *argumentative emotional clarifications* in a similar proportion, however, unlike in previous phases, patients were more likely to consolidate meanings (*argumentative emotional self-resignifications*). Although the therapists continued to display *emotional empathy* during the final phase, they did so with a lower frequency compared to their co-construction of new meanings for emotional contents about the therapeutic relationship (*transferential emotional resignifications*). The latter actions were performed more frequently than *interpretative emotional resignifications*, which had been predominant up to that point. These changes in transference may suggest that the termination of therapy could be an appropriate decision, in the sense that the patients may have displayed less resistance during the *transferential emotional resignifications* performed by the therapists (Novick, 1997). Even when not considering the *interpretative emotional resignifications* performed by the therapists during the final phase, the patients' resignification work (*emotional self-resignifications* and *argumentative emotional re-significations*) was more extensive than that carried out by the therapists (*emotional resignifications* and *argumentative emotional resignifications*). It is interesting to observe that the therapists' use of Affective Attunement decreased towards the end of the process, which suggests the question of whether the more frequent presence of this pattern in the initial phase reflected the therapists' interest that their patients performed more therapeutic work —so that after achieving the necessary level of activity— the therapists diminished their use of it.

A comparison of the phases of the therapeutic process led to the identification of three important findings: (a) in comparison with the initial phase, the patients used the Affective Exploration pattern less frequently in the final phase, which was manifested through a decrease of *emotional descriptions* and *argumentative emotional clarifications*; (b) in comparison with the initial phase, the patients used the Affective Resignification pattern mores frequently during the final phase, which was observable through an increase in *argumentative emotional self-resignifications* from the middle phase onwards; and (c) although no significant differences were observed in the Communicative Patterns (CPs) used by the therapists to work on emotional contents during the phases of the therapeutic process, *transferential emotional resignifications* were used more often in the final phase than in the initial and middle ones, which may reflect an increase in the patients' comprehension (Sachse, 1992; Sachse & Elliott, 2002).

The analysis of the distribution of Communicative Patterns (CPs) within Stuck Episodes according to the phase of the therapy did not reveal any associations between such patterns and therapeutic phases. Although this situation may be due to the low frequency of such patterns during these episodes, which could be regarded as a result in itself, it is mostly connected with the absence of Affective Resignifications by the patients. A hypothesis for future studies may be that, during Stuck Episodes, certain Communicative Patterns (CPs) appear that make it possible to work on other contents, such as cognitive ones. In view of this situation, Stuck Episodes were described in terms of the Affective Explorations performed by the patients, and the Affective Resignifications conducted by the therapists during the middle and final phases of the process. Stuck Episodes in the middle and the final phases of the therapy, as opposed to Change Episodes, displayed a similar proportion of Affective Explorations by the patients, and a similar proportion of Affective Resignifications by the therapists. It seems that there are moments in the therapy in which patients feel satisfied with their therapists' interpretations (Hill, Rochlen, Zack, McCready, & Dematatis, 2003) and decide to participate in the co-construction of new

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

meanings, although there are others when they feel less happy with them. In this regard, it may be thought that the therapists' use of the Affective Resignification pattern by the therapists could in fact be more efficient depending on the moment of the session, that is, whether it is applied during a Change or a Stuck Episode.

A comparison of both episode types revealed that: (a) in Change Episodes, the patients performed Affective Explorations and Affective Resignifications in different proportions depending on the therapeutic phase, while in Stuck Episodes they provided information, clarified points, or steered the conversation towards certain emotional contents (Affective Exploration); (b) the therapists used the same resignification patterns in both episode types, however, Change Episodes were characterized by the exclusive presence of *argumentative emotional resignifications*, which were also used by the patients in these episodes, and which was interpreted as a way of creating a link between the new meanings acquired in the therapeutic context with the patients' direct extratherapeutic context; and (c) while Change Episodes from the final phase were characterized by a higher proportion of *transferential emotional resignifications*, Stuck Episodes from this phase displayed a higher proportion of *interpretative emotional resignifications*.

The present study showed that Affective Exploration and Affective Resignification are not phases of the process as proposed by Hill (2004), but Communicative Patterns performed throughout the therapy by one or both participants of the therapeutic conversation. In other words, it is possible to observe exploration work carried out by the patients both at the beginning and at the end of the therapy, along with resignification by the therapists during the whole process. In this regard, the patients will always have novel information to provide during the therapeutic conversation, even towards the end of the therapy, given that much of this novel information can be associated with their new way of understanding themselves and their context.

The analysis methodology used in the present study has revealed that Communicative Patterns (CPs) are used by patients and therapists differently depending on the type of episode involved (Valdés, et al., 2011b), and that such patterns are used in different proportions depending on the stage of the episode, and even according to the therapeutic phase. Working on emotional contents throughout the therapy not only allows patients to be in closer contact with their emotions, but also to pay attention and work on other content types (cognitive or behavioral) during the therapeutic process. Patients tend to permanently give information about their life experiences. A shared characteristic of these experiences narrated during the conversation, and which holds them all together, is the patients' verbalization of emotions (Raingruber, 2000), which have an adaptive function as a result of the integration between the cognitive and affective domains (Greenberg & Bolger, 2001).

Therapeutic conversation is a space for the patient to construct new subjective theories about him/herself aided by his/her therapist (Hill, 2004; Farber, Berano, & Capobianco, 2004; Krause, et al., 2007), based on the possibilities emerging from the dialog, and about which he/she was not conscious beforehand. For patients, this requires a learning process that involves experiencing, recognizing, verbalizing, and resignifying certain emotional contents which are fundamental for developing new ways of understanding themselves (Raingruber, 2000). For therapists, on the other hand, working on certain emotional contents verbalized by patients during the conversation also entails a learning process during the therapeutic activity which involves, for example, learning to identify the moments of the session in which showing understanding, generating harmony, or providing feedback about a certain content conveyed by a patient (*emotional empathy*) can be more effective, or learning to identify the moments in which a patient's process of change has temporarily halted due to a reissue of the problem during the session, and so abstain from providing new meanings for certain emotional contents (*interpretative emotional resignification*) which could be dealt with more effectively in other moments of the therapy. Working on emotional contents during the therapy is an activity which entails the use of certain Communicative Patterns (CPs) by both patients and therapists, depending not only on the moment of the session, but also on the therapeutic phase. This ther-

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

apeutic activity performed specifically with emotional contents allows patients to eventually construct a new way of understanding themselves, and to understand emotions as a type of content that involves information that differs from all other information, because it is experienced subjectively (Izard, 2002).

One of the limitations of the present study is that its findings cannot be generalized, because the size of the sample was greatly reduced by only analyzing speaking turns with Communicative Patterns (CPs) used to work on emotional contents, along with the fact that only patterns with a frequency higher than 5 were considered in the analysis. However, its main limitation was that less Stuck Episodes than Change episodes were analyzed, a situation caused by the fact that the former were less frequent than the latter in the two psychotherapeutic processes studied. Therefore, this study should be replicated using a larger number of processes in order to confirm its findings.

References

Altimir, C., Krause, M., de la Parra, G., Dagnino, P., Tomicic, A., Valdés, N., et al. (2010). Clients', therapists' and observers' perspectives on moments and contents of therapeutic change, *Psychotherapy Research, 20,* 1-16. doi: 10.1080/1050330100370587.1

Arístegui, R., Reyes, L., Tomicic, A., Vilches, O., Krause, M., de la Parra, G. et al. (2004). Actos de habla en la conversación terapéutica [Speech Acts during the Therapeutic Conversation]. *Terapia Psicológica, 22,* 131-143.

Asay, T. P. & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart & soul of change. What works in therapy* (pp. 23-55). Washington, DC: American Psychological Association. doi: 10.1037/11132-001

Bänninger-Huber, E. (1992). Prototypical affective microsequences in psychotherapeutic interaction. *Psychotherapy Research, 2,* 291-306. doi: 10.1080/10503309212331333044

Bänninger-Huber, E. & Widmer, C. (1999). Affective relationship patterns and psychotherapeutic change. *Psychotherapy Research, 9,* 74-87. doi: 10.1080/10503309912331332601

Bastine, R., Fiedler, P., & Kommer, D. (1989). Was ist therapeutisch an der Psychotherapie? Versuch einer Bestandsaufnahme und Systematisierung der Psychotherapeutischen. *Prozeßforschung Zeitschrift für klinische Psychologie, 18,* 3-22.

Beutler, L. E. & Clarkin, J. F. (1990). *Systematic Treatment Selection: Toward Targeted Therapeutic Interventions.* New York: Brunner-Mazel.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guidelines for the Systematic Treatment of the Depressed Patient.* New York: Oxford Univ. Press. doi: 10.1093/acprof:oso/9780195105308.001.0001

Beutler, L. E., Engle, D., Mohr, D., Daldrup, R. J., Bergan, J., Meredith, K., & Merry, W. (1991). Predictors of differential response to cognitive, experimental and self-directed psychotherapeutic procedures. *Journal of Consulting and Clinical Psychology, 59,* 333-340. doi: 10.1037/0022-006X.59.2.333

Boisvert, C. & Faust, D. (2003). Leading researchers' consensus on psychotherapy research findings: Implications for the teaching and conduct of psychotherapy. *Professional Psychology: Research and Practice,* 34, 508-513. doi: 10.1037/0735-7028.34.5.508

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497-504. doi: 10.1037//0022-006X.64.3.497

Chatoor, I. & Krupnick, J. (2001). The role of nonspecific factors in treatment outcome of psychotherapy studies. *European Child & Adolescent Psychiatry, 10,* 119-125. doi: 10.1007/s007870170004

Dreher, M., Mengele, U., Krause, R., & Kämmerer, A. (2001). Affective indicators of the psychotherapeutic process: an empirical case study. *Psychotherapy Research, 11,* 99-117. doi: 10.1080/713663855

Echávarri, O., González, A., Krause, M., Tomicic, A., Pérez, C., Dagnino, P., et al. (2009). Cuatro

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

terapias psicodinámicas breves exitosas estudiadas a través de los Indicadores Genéricos de Cambio [Four successful brief psychodynamic therapies studied through the generic change indicators]. *Revista Argentina de Clínica Psicológica, Vol. XVIII* (1), 5-19.

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology, 32,* 307-322. doi: 10.1037//0022-0167.32.3.307

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20,* 123-135. doi: 10.1080/10503300903470743

Elliot, R., Hill, C. E., Stiles, W. B., Friedlander, M. L., Mahrer, A. R., & Margison, F. R. (1987). Primary therapist response modes: A comparison of six rating systems. *Journal of Consulting and Clinical Psychology, 55,* 218-223.

Elliott, R. & Shapiro, D.A. (1992). Clients and therapist as analysis of significant events. In S.G. Toukmanian & D.L. Rennie (Eds.), Two perspectives on psychotherapeutic change: Theory-guided and phenomenological research strategies (pp. 163-186). Newbury Park, CA: Sage. Research Program.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D.L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp. 69-111). Lengerich, Germany: Pabst Science. doi: 10.1080/14733140112331385050

Farber, B. A., Berano, K. C., & Capobianco, J. A. (2004). Clients'perceptions of the process and consequences of self-disclosure in psychotherapy. *Journal of Counseling Psychology, 51,* 340-346. doi: 10.1037/002-0167.51.3.340

Fitzpatrick, M. R., Janzen, J., Chamodraka, M., & Park, J. (2006). Client critical incidents in the process of early alliance development: a positive emotion-exploration spiral. *Psychotherapy Research, 16,* 486-498. doi: 10.1080/10503300500485391

Frances, A. & Perry, S. (1983). Transference interpretations in focal therapy. *American Journal of Psychiatry, 140,* 405-409.

Fredrickson, B. L. (2003). The value of positive emotions. *American Scientist, 91,* 330-335. doi:10.1511/2003.4.330

Froján, M. X. (2011). ¿Por qué Funcionan los Tratamientos Psicológicos? *Clínica y Salud, 22,* 201-204. doi: http://dx.doi.org/10.5093/cl2011v22n3a1

Gabbard, G. O. (2006). When is transference work useful in dynamic psychotherapy? (editorial). *American Journal of Psychiatry, 163,* 1667-1669. doi: 10.1176/appi.aip.163.10.1667

Gabbard, G. O. & Westen, D. (2003). Rethinking therapeutic action. *International Journal of Psychoanalysis, 84,* 823-841. doi: 10.1516/N4T0-4D5G-NNPL-H7NL

Gazzola, N., Iwakabe, S., & Stalikas, A. (2003). Counsellor interpretations and the occurrence of in-session client change moments in non-dynamic psychotherapies. *Counselling Psychology Quarterly, 16,* 81-94. doi: 10.1080/09515070302757

Goates-Jones, M. K., Hill, C. E., Stahl, J. V., & Doschek, E. E. (2009). Therapist response modes in the exploration stage: timing and effectiveness. *Counselling Psychology Quarterly, 22,* 221-231. doi: 10.1080/09515070903185256

Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: a comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66,* 803-810. doi: 10.1037//0022-006X.66.5.803

Goldman, R. N., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 15,* 248-260. doi: 10.1080/10503300512331385188

Grafanaki, S. & McLeod, J. (1999). Narrative processes in the construction of helpful and hindering events in experiential psychotherapy. Psychotherapy Research, 9, 289–303. doi:10.1080/10503309912331332771

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research, 17,* 15-30. doi: 10.1080/10503300600720390

Greenberg, L. S. (2008). Emotion and cognition in psychotherapy: The transforming power of affect.

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

Canadian Psychology, 49, 49-59. doi: 10.1037/0708-5591.49.1.49.

Greenberg, L. S. & Bolger, E. (2001). An Emotion-Focused Approach to the overregulation of emotion and emotional pain. *Psychotherapy in Practice, 57,* 197-211. doi: 10.1002/1097-4679(200102)57:2<197::AID-JCLP6>3.0.CO;2-0

Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology, 62,* 611-630. doi: 10.1002/jclp.20252

Greenberg, L. S. & Safran, J. (1989). Emotion in Psychotherapy. *American Psychologist, 44,* 19-29. doi: 10.1037//0003-066X.44.1.19

Hageman, W. J., & Arrindell, W. A. (1999). Clinically significant and practical enhancing precision does make a difference: reply to McGlinchey and Jacobson, Hsu, and Speer. *Behaviour Research & Therapy, 37,* 1219-1233.

Henretty, J. R., Levitt, H. M., & Mathews, S. S. (2008). Clients' experiences of moments of sadness in psychotherapy: A grounded theory analysis. *Psychotherapy Research, 18,* 243-255. doi: 10.1080/10503300701765831

Herrera, P., Fernández, O., Krause, M., Vilches, M., Valdés, N., & Dagnino, P. (2009). Revisión teórica y metodológica de las dificultades en psicoterapia: Propuesta de un modelo ordenador [Theoretical and methodological review of the difficulties in psychotherapy: Proposal for an ordered model]. *Terapia Psicológica, 27,* 169-179.

Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action*. Washington, DC: American Psychological Association.

Hill, C. E., O'Grady, K. E., & Elkin, I. (1992). Applying the Collaborative Study Psychotherapy Rating Scale to rate therapist adherence in cognitive-behavior therapy, interpersonal therapy, and clinical management. *Journal of Consulting and Clinical Psychology, 60,* 73-79. doi: 10.1037//0022-006X.60.1.73

Hill, C. E., Rochlen, A. B., Zack, J. S., McCready, T., & Dematatis, A. (2003). *Therapists vs. computers: Are therapists needed for dream interpretation?* Paper presented at the Annual Conference of the Society of Psychotherapy Research, Santa Barbara, CA.

Høglend, P. (2003). Long-term effects of brief dynamic psychotherapy. *Psychotherapy Research, 13,* 271-292.

Izard, C. E. (2002). Translating emotion theory and research into preventive interventions. *Psychological Bulletin, 128,* 796-824. doi: 10.1037//0033-2909.128.5.796

Jacobson, N. & Truax, P., (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19. doi: 10.1037//0022-006X.59.1.12

Kernberg, O. F., Yeomans, F. E., Clarkin, J. F., & Levy, K. N. (2008). Transference focused psychotherapy: Overview and update. *International Journal of Psychoanalysis, 89,* 601-620. doi: 10.1111/j.1745-8315.2008.00046.x

Klein, M. J., & Elliott, R. (2006). Client accounts of personal change in process-experiential psychotherapy: A methodologically pluralistic approach. *Psychotherapy Research, 16,* 91-105. doi: 10.1080/10503300500090993

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44,* 274–283. doi: 10.1037//0022-0167.44.3.274

Krause, M., de la Parra, G., Arístegui, R., Dagnino, P., Tomicic, A., Valdés, N., et al. (2006). Indicadores de cambio genéricos en el proceso terapéutico [Generic Change Indicators in the psychotherapeutic process]. *Revista Latinoamericana de Psicología, 38,* 299-325.

Krause, M., De la Parra, G., Arístegui, R., Dagnino, P., Tomicic, A., Valdés, N., et al. (2007). The evolution of therapeutic change studied through generic change indicators. *Psychotherapy Research, 17,* 673-689. doi: 10.1080/10503300601158814

Krause, M., Valdés, N., & Tomicic, A. (2009). *Sistema de Codificación de la Actividad Terapéutica (SCAT-1.0): Manual de Procedimiento* [Therapeutic Activity Coding System (TACS-1.0): Manual of Procedure]. Proyecto Fondecyt

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

Nº1080136, Psychotherapy and Change Chilean Research Program (Manuscript in progress).

Lambert, M. J., Hansen, N. B.,Umpress, V., Lunnen, K., Okiishi, J., & Burlingame, G. M. (1996). *Administration and Scoring Manual for the OQ-45.2*. Wilmington, DE: American Professional Credentialing Services LLC. USA.

Llewelyn, S. P. & Hardy, G. (2001). Process research in the practice of psychological therapy. *British Journal of Clinical Psychology, 40,* 1-21. doi: 10.1348/014466501163436

Luborsky, L. (2000). A current reader s response to the article of 50 years ago by Karpman, B. (1949): the principles and methods of objective psychotherapy. *Journal of Clinical Psychology, 56,* 889-896. doi: 10.1002/1097-4679(200007) 56:7<889::AID-JCLP7>3.0.CO;2-#

Mackay, H. C., Barkham, M., & Stiles,W. B. (1998). Staying with the feeling: An anger event in psychodynamic-interpersonal therapy. *Journal of Counseling Psychology, 45,* 279-289. doi: 10.1037//0022-0167.45.3.279

Marziali, E. A. (1984). Prediction of outcome of brief psychotherapy from therapist interpretive interventions. *Archives of General Psychiatry, 41,* 301-304. doi: 10.1001/archpsyc.1984.01790140091011

Martin, J. & Stelmaczonek, K. (1988). Participants' identification and recall of important moments in counselling. *Journal of Counseling Psychology, 35,* 385-390. doi: 10.1037//0022-0167.35.4.385

Novick, J. (1997). Termination conceivable and inconceivable. *Psychoanalytic Psychology, 14,* 145-162. doi: 10.1037//0736-9735.14.2.145

Orlinsky, D. & Howard, K.J. (1987). A generic model of psychotherapy. *Journal of Integrative and Eclectic Psychotherapy, 6,* 6-27.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. Lambert, Ed., *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change,* 5th ed. (pp. 307-393). New York: Wiley.

Piper, W. E., Azim, H., Joyce, A.S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48,* 946-953. doi: 10.1001/archpsyc.1991.01810340078010

Popp-Baier, U. (2001). Narrating Embodied Aims. Self-transformation in Conversion Narratives - A Psychological Analysis. *Forum Qualitative Sozialforschung, 2,* 3. Extraído en http://qualitative-research.net/fqs/fqs-eng.htm.

Raingruber, B. (2000). Being with feelings as a recognition practice: developing clients' self-understanding. *Perspectives in Psychiatric Care, 36,* 41-50. doi: 10.1111/j.1744-6163.2000.tb00690.x

Reyes, L., Arístegui, R., Krause, M., Strasser, K., de la Parra, G., Tomicic, A., et al. (2008). Language and therapeutic change: A speech acts analysis. *Psychotherapy Research 18, 355-362*. doi: 10.1080/10503300701576360

Russell, R. L., Jones, M. E., & Miller, S. A. (2007). Core process components in psychotherapy: A synthetic review of P-technique studies. *Psychotherapy Research, 17,* 271-288. doi: 10.1080/10503300500529388

Sachse, R. (1992). Differential effects of processing proposals and content references on the explication process of clients with different starting conditions. *Psychotherapy Research, 2,* 235-251. doi: 10.1080/10503309212331333004

Sachse, R. & Elliott, R. (2002). Process-outcome research in client-centered and experiential therapies. In D. Cain & J. Seeman (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 83-115). Washington, DC: American Psychological Association. doi: 10.1037/10439-003

Searle, J. R. (1969). *Speech Acts: An Essay in the Philosophy of Language*. Cambridge University Press.

Searle, J. R. (1979). *Speech acts*. New York: Cambridge University Press.

Searle, J. R. (1980). *Actos del Habla*. Madrid: Cátedra.

Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: a qualitative meta-analysis. *Psychotherapy Research, 17,* 305-314. doi: 10.1080/10503300600608116

Valdés, N. (2010). Análisis de los estilos lingüísticos

ISSN: 1130-5274 - http://dx.doi.org/10.5093/cl2012a10

de paciente y terapeuta durante la conversación terapéutica en Episodios de Cambio, utilizando el Buscador Lingüístico y Contador de Palabras (LIWC) [Analysis of Linguistic Style in Patient and Therapist during Therapeutic Conversation in Change Episodes using the Linguistic Inquiry and Word Count (LIWC)]. *Subjetividad y Procesos Cognitivos, 14,* 314-332.

Valdés, N., Dagnino, P., Krause, M., Pérez, J., Altimir, C., Tomicic, A., et al. (2010a). Analysis of the verbalized emotions in the psychotherapeutic dialogue during change episodes. *Psychotherapy Research, 20,* 136-150. doi: 10.1080/10503300903170921

Valdés, N., Krause, M., & Álamo, N. (2011a). ¿Qué dicen y cómo lo dicen?: Análisis de la comunicación verbal de pacientes y terapeutas en Episodios de Cambio [What do they say and how do they say it?: Analysis of patients' and therapists' Verbal Communication during Change Episodes]. *Revista Argentina de Clínica Psicológica, XX,* 15-28.

Valdés, N., Krause, M., Vilches, O., Dagnino, P., Echávarri, O., Ben-Dov, P., et al. (2005). Proceso de cambio psicoterapéutico: análisis de episodios relevantes en una terapia grupal con pacientes adictos [Psychotherapeutic Change: Analysis of Change Episodes within a drug group therapy]. *Revista Psykhe, 14,* 3-18. doi: 10.4067/S0718-22282005000200001

Valdés, N., Krause, M., Tomicic, A., & Espinosa, H.D. (2011b). Expresión emocional verbal durante Episodios de Cambio: Análisis de los Patrones Comunicacionales utilizados por pacientes y terapeutas para trabajar contenidos emocionales [Verbal Emotional Expression During Change Episodes: Analysis of the Communicative Pat-terns used by Patients and Therapists to Work on Emotional Contents]. *Revista Argentina de Clínica Psicológica* (Submitted article).

Valdés, N., Tomicic, A., Pérez, J.C., & Krause, M. (2010b). Sistema de Codificación de la Actividad Terapéutica (SCAT-1.0): Dimensiones y categorías de las acciones comunicacionales de pacientes y psicoterapeutas [Dimensions and Categories of the Patients' and Therapists' Communicative Actions]. *Revista Argentina de Clínica Psicológica, XIX,* 117-129.

Vanaerschot, G. & Lietaer, G. (2007). Therapeutic ingredients in helping session with observer-rated low and high empathic attunement: a content analysis of client and therapist postsession perceptions in three cases. *Psychotherapy Research, 17,* 329-342. doi: 10.1080/10503300600650910

Vetlesen, A. J. (1994). *Perception, empathy and judgment: An inquiry into the preconditions of moral performances*. University Park, PA: Pennsylvania State University Press.

Von Bergen, A. & de la Parra, G. (2002). OQ-45.2, Outcome Questionnaire and evolution of Psychotherapy: Adaptation, Validation and Guidelines for its implementation and interpretation. *Terapia Psicológica, 20,* 161- 176.

Wallerstein, R. (2001). The generations of psychotherapy research: An overview. *Psychoanalytic Psychology, 18,* 243-267. doi: 10.1037//0736-9735.18.2.243

Williams, E. N. & Hill, C. E. (2001). Evolving connections: research that is relevant to clinical practice. *American Journal of Psychotherapy, 55,* 336-343.

Wiser, S. & Goldfried, M. R. (1998). Therapist interventions and client emotional experience in expert psychodynamic-interpersonal and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology, 66,* 634-640. doi: 10.1037//0022-006X.66.4.634

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