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"If my Plan Doesn't Work, I'll Follow the Doctor's Orders". A Dialogical Self Analysis of Chronic Patients' Medical Treatment Ambivalence

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ABSTRACT

A patient's ambivalence toward medical and psychotherapeutic treatment is a strong predictor of its outcome. This is especially relevant in the treatment of common chronic conditions such as hypertension (HT), in which most patients do not maintain the lifestyle changes that lie at the heart of the medical treatment. Despite the growing theoretical interest, there is little empirical research on how patients deal with and resolve their ambivalence, and almost all of the studies focus on psychotherapy clients, not on chronic illness patients. This study aims to understand how patients with AHT deal with their ambivalence toward their medical treatment, using dialogical self-theory and qualitative research methods. We interviewed 51 hypertensive patients to identify their anti and pro adherence "voices" and the different strategies patients use for dealing with their ambivalence. Results describe *integration* strategies, which allow both opposing voices to express themselves and be heard, and *domination* strategies which reject or dismiss one of the voices. The temporal dynamics between PRO and ANTI adherence voices during the interviews are also explored. These results are discussed to contribute to the research on ambivalence and support concrete guidelines for dealing with patient nonadherence.

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Introduction

Human contradiction: an ancient question

Resistance to change and human contradiction have been fascinating topics of study for centuries. Since at least Aristotle, philosophers, economists, and psychotherapists have wondered why some people seem to behave against their own best interest (Ariely, 2008; Beutler et al., 2002; Freud, 1958; Whitman, 2012). Investing time and money in treatment and then not cooperating fully with it (or actively sabotaging it), holding on to toxic relationships, paying for an -unused- monthly fee in a gym; these are just a few of the many examples of this phenomenon. In philosophy, this has been called *Akrasia* (Romaioli et al., 2008); in Health Psychology: *nonadherence*, and in Psychotherapy: *resistance*. It has been understood as self-sabotage, repetition compulsion, death wish, or

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merely irrational behavior (Kurzban, 2011). In psychotherapy, patients who seem uncooperative have been called resistant, reactant, oppositional, noncompliant, or intractable (Beutler et al., 2002), sharing the implicit view that resistance signals a character defect of the patient, or at least that it is an enemy to be fought. Common to all these concepts is the observation that sometimes we have strong motivations to change, but we do not do what we need to do to implement that change.

These ideas can help understand nonadherence in the medical treatment of chronic conditions and resistance to change in psychotherapy processes. Both contexts have essential differences (e.g., psychotherapeutic goals are not reduced to behavioral change; the patient-caregiver relationship is quite different). However, both share the goal of changing stable behavioral patterns. More crucially, in both contexts, numerous patients have the possibility and motivation to change but, at the same time, show behaviors and attitudes that obstruct that change (e.g., missing appointments, not engaging with therapeutic tasks, not taking their medications). This cross-referencing between clinical practice domains has been explored before by psychodynamic researchers (Goodman, 1992; Weatherby, 2005) and, more extensively, by authors using the Motivational Interviewing (MI) model. MI has been applied widely to address resistance to change in chronic medical conditions (Coyne & Correnti, 2014) and psychotherapy settings (Westra et al., 2016). This study follows in their footsteps.

Patients' level of cooperation and resistance to change are key outcome predictors of both psychotherapeutic and medical interventions (Crits-Christoph & Gibbons, 2013; Engle & Arkowitz, 2006; Zhang et al., 2014). In the psychotherapy field, client resistance is strongly correlated to poor outcomes (Ribeiro, et al., 2014b). It is one of the most critical challenges for psychotherapists, limiting the client's response to the treatment (Aviram et al., 2016). Improving client outcomes is extremely important as only 50% of psychotherapy clients improve substantially after treatment, 20% dropout prematurely, and 5-10% finish therapy worse than when they started (Lambert, 2013; Ribeiro et al., 2016). Similar findings have been observed in the medical field, especially about treating chronic conditions in which the patient requires lifestyle changes and is the primary change agent in the treatment (Holman & Lorig, 2004). For example, it has been shown that only 30-60% of chronic disease patients regularly take their medication, and an even lower percentage make the diet and exercise changes required by their treatment (Dunbar-Jacob et al., 2012; Martin et al., 2005; Zhang et al., 2014). For these reasons, studying resistance to change has been one of the main interest foci for understanding and preventing negative results in psychotherapy and other behavioral interventions (Lambert, 2013; Ribeiro et al., 2016).

Resistance as ambivalence

Trying to understand the roots of client resistance, Prochaska and Prochaska (1999) proposed that people don't change for two main reasons: (a) some clients don't have the necessary information or resources to carry out the change, which is resolved through psychoeducation and developing coping skills; (b) others show ambivalence toward changing (Arkowitz, 2002; Beutler et al., 2011; Frankel & Levitt, 2006; Moyers & Rollnick, 2002; Prochaska & Prochaska, 1999). Engle and Arkowitz define ambivalence

as “a subset of resistance in which there are movements toward change as well as movements away from change” (2006, p. 3), due to fears or apprehensions (conscious or unconscious) regarding the desired change, and/or the methods required to make the change happen. This can be observed when the patients show both behaviors and expressions in favor of changing (e.g., attending therapy sessions, showing suffering for the present situation, etc.) and against the change process (e.g., missing sessions, not completing homework, minimizing the need to change behavior patterns, etc.).

In health psychology, this ambivalence has been conceptualized as the “behavior-intention gap": the breach between the patient’s intention to adhere to the treatment and the real nonadherent behavior (Sheeran & Webb, 2016). It has been argued that treatment models based on a rational assessment of cost/benefit are effective in improving patients intention to adhere, but they don’t necessarily predict their future behavior change (Bosworth et al., 2006; Christensen, 2004; Webb & Sheeran, 2006; Westra, 2011).

In psychotherapy, ambivalence markers appear more in unsuccessful cases, and they tend to decrease as the therapy progresses (Di Noia & Prochaska, 2010; Ribeiro et al., 2014a; 2016). However, there are very few studies that allow us to understand how clients’ ambivalence is managed and resolved (Braga et al., 2017). Thus, this type of resistance remains one of the most important and least studied phenomena in clinical practice (Beutler et al., 2002; Cowan & Presbury, 2000; Engle & Arkowitz, 2006; Frankel & Levitt, 2006; Moyers & Rollnick, 2002; Wachtel, 1999). The following section will present the main empirical and theoretical contributions about understanding and helping resolve clients’ ambivalence toward change.

How ambivalence is resolved

Most traditional models regard ambivalence toward change as a product of irrational beliefs and biases, a problematic force that needs to be overthrown. Either implicitly or explicitly, they propose that the intervention should reinforce the part that wants to change or challenge the part that opposes change (Beutler et al., 2002; Levensky, 2006). However, several authors have questioned this logic, suggesting that ambivalence resolution requires both parts’ validation and integration. Some authors have differentiated between “dominance” and “negotiation” paradigms to describe these two main ways of understanding resistance (Braga et al., 2018; Herrera, 2013). These paradigms are often implicit and can be present in different theoretical models.

Dominance or confrontation paradigm

It assumes that clients’ resistance is a product of their lack of information or resources (internal or external). Coherently, interventions focus on reinforcing the motivations toward change, giving information about the benefits of changing, confronting the cognitive or practical barriers toward change, and developing clients coping skills. Ambivalence is either not acknowledged or regarded as an enemy of the treatment (Cowan & Presbury, 2000; Engle & Arkowitz, 2006). These assumptions arise on most theoretical models and interventions, for example: (a) when caregivers psycho-educate patients on the dangers of not adhering (M. Ortiz & Ortiz, 2007; Zhang et al., 2014);

(b) when we interpret client resistance in psychotherapy using Freudian concepts such as the death drive (Corsi, 2002); (c) when we challenge irrational beliefs about the treatment (Aviram & Westra, 2011); (d) when we "push" clients to overcome their fears and express their emotions to the empty chair in Humanistic psychotherapies (Perls, 1974); (e) when we look for exceptions to the client's problematic narrative in solution-oriented approaches (Trepper et al., 2006). Even some aspects of motivational interviewing can be included in this list because, even though it is non-directive and explores ambivalence, it has the explicit aim of strengthening clients' intrinsic motivations for changing.

Negotiation or integration paradigm

Recent findings in psychotherapy and evolutionary psychology have proposed that client resistance is not a manifestation of irrational or destructive aspects of their personality, but an expression of different parts, positions, modules or voices of the self (Dimaggio & Stiles, 2007; Hermans et al., 1992; Honos-Webb & Stiles, 1998). From this perspective, ambivalence signals a coexistence of both "pro" and "anti" change voices, with the latter being often implicit or unconscious. Unlike confrontation models, integration approaches propose that unilateral dominance of one part of the self over another is problematic, and there is no "destructive" part of the self. Therefore, the therapeutic aim is to help clients to acknowledge and embrace the hidden or disowned parts of their Self, such as the "anti-change" or "anti-treatment" voices (Arkowitz, 2002; Dimaggio & Stiles, 2007; Greenberg et al., 1996).

This paradigm also assumes the internal coherence of the self. This means that every activity of the mind, conscious or unconscious, is coherent with its current construction of meaning (Ecker & Hulley, 1996). Therefore, "people behave essentially according to what they construct as the most adaptive alternative, from their current perceptions (schemas, constructions) of themselves and their situation" (Greenberg et al., 1996, p. 107), in a purposeful attempt to satisfy desires and interests established by those constructions of meaning (Ecker & Hulley, 1996). As Arkowitz argues, "there are reasons for resistance that need to be respected and understood […] When people erect obstacles to personal change, they are doing so for reasons that are valid and important, whether or not these reasons are available to conscious awareness" (2002, p. 220).

From this perspective, the intervention should not be solely focused on reinforcing the "pro-change" voices, which are often the only ones acknowledged by researchers, clinicians, and even patients. For lasting change to occur, the implicit "anti-change" voices must be recognized, embraced, and assimilated, not challenged, ignored, or rejected (Engle & Arkowitz, 2006; Honos-Webb & Stiles, 1998). If the problematic behavior has a positive function, it must be satisfied or addressed, or the patient will show resistance to protect that critical purpose. After hearing and validating these implicit anti-change voices, the therapist must help the patient embrace and satisfy both aspects of the Self (Nir, 2011).

A previous study provides some examples of these "anti-change" voices in the context of chronic patients who need to change aspects of their lifestyle to adhere to hypertensive treatment (Herrera et al., 2017). Many interviewed patients associated adhering to losing their freedom and autonomy (e.g., "I do not like to be slaved by the treatment or

the doctor or anybody"). In these cases, the therapists should not scold the patients or remind them about the dangers of nonadherence but instead establish a co-constructed and collaborative relationship in which the client feels empowered and respected. The assumption is that if the “anti-change” values of freedom and autonomy are validated, the patient will show more cooperation with the treatment. This would make it substantially easier to pursue the “pro-change” values and motivations.

Empirical research on the ambivalence resolution process: advances and limitations

Despite the increasing number of authors that support the negotiation paradigm of resistance (Ecker & Hulley, 1996; Engle & Arkowitz, 2006; Frankel & Levitt, 2006; Greenberg et al., 1996; Herrera, 2013; Honos-Webb & Stiles, 1998; Johnson, 1992; Ribeiro, et al., 2014b; Winter, 1992), there is surprisingly little empirical research exploring these ideas. When health psychology researchers try to understand “why” patients do not adhere, they use quantitative self-report methods (Hornsey et al., 2018; Letelier et al., 2011) or qualitative interviews/focus groups (Bommelé et al., 2014; Pound et al., 2005). However, these studies concentrate on explicit and conscious reasons for nonadherence and do not explore how to resolve the patient’s ambivalence. Dialogical self theories stress the importance of implicit meanings and the often problematic interaction of different “voices” within the Self (Hermans, 2003; Valsiner, 2002), but these developments have been mostly theoretical. Some of the few empirical studies that have explored the implicit meanings of an illness and its treatment have examined chronic fatigue patients (Fuchs et al., 2013), while others have used the assimilation model with psychotherapy case studies (Mosher et al., 2008; Stiles, 2001). In the psychotherapy context, these studies have shown that integrating a previously disowned or rejected self voice is correlated with a good outcome.

Based on dialogical self theories, recent studies have created a methodology to explore ambivalence moments and their resolution in psychotherapy cases (Braga et al., 2018, 2017; Oliveira, Gonçalves, & Braga et al., 2016). This framework includes an observational tool to identify moments in which the client expresses ambivalence (e.g. “I am entitled to my own opinion… but I am worried about being judged by others because of this") and also how this moment is resolved (or left unresolved) in the subsequent speaking turns. The authors share the same differentiation detailed before between integration and dominance strategies and have begun researching psychotherapy sessions with depressed clients. In the dominance solution, ambivalence is resolved with a strong affirmation of the “pro-change” voice. In the negotiation solution, both “pro” and “anti” change voices are taken into account and start a non-confrontational dialogue. So far, they have found that both dominance and integration strategies appear in successful cases. However, recovered cases present a higher proportion of the negotiation type of resolution, while unchanged cases maintain high dominance levels and almost no negotiation during the whole psychotherapy process (Braga et al., 2017).

Aim of the study and potential contribution

This paper aims to understand how patients deal with their ambivalence toward change, as defined by Engle and Arkowitz (2006). The focus is on a particular sample of patients in which this ambivalence is evident: people with a chronic health condition that can improve their adherence, wish to do so, but for some reason fail to adhere to their treatments. Ambivalence is explored with hypertensive patients because they have powerful motives to change their behavior, and their treatment includes lifestyle changes (diet, exercise, and other habits, besides taking medication). This study presents some differences compared with the previous literature: (a) it uses specific interviewing techniques designed to elicit implicit "anti-change" voices; (b) it explores in detail whole interviews, not only ambivalence micro-moments; (c) it uses grounded theory and an emergent methodology with a relatively large sample of patients (N = 51) to discover different patterns in which ambivalence expresses itself and is dealt with in the patients' dialogue, proposing a theoretical model based on these observations; (d) it uses psychotherapy research methodologies and theoretical models to understand a problem often studied only within health psychology.

Methods

Research design

The design of this study was non-experimental, cross-sectional, exploratory, descriptive, and comparative. Qualitative content analysis was used in order to explore patients' experiences and subjective processes. Some aspects of Grounded theory and Consensual Qualitative Research were used for the sampling, data recollection, and analysis procedures (Glaser & Strauss, 1967; Hill et al., 2005). Data recollection consisted of multiple recursive data collection-data analysis processes, according to Grounded Theory guidelines.

The research team was composed of this paper's author, two psychologists studying their master's degree, three psychology students doing their final thesis, and one senior external auditor. The interviews were conducted by the author and the master's degree students, and the author analyzed the data with the help of the whole research team.

This study analyzed the same set of interviews used for another previously published paper (Herrera et al., 2017). Still, while the previous article described the different *pro* and *anti*-treatment voices, this one aims to understand the relationship and dynamics between these voices of the self.

Sample

The whole sample consisted of 51 in-depth interviews of hypertensive patients. Theoretical sampling was used, gathering more data until the theoretical saturation criterion was met (Glaser & Strauss, 1967). The public health sample was selected from two primary care public health institutions in Santiago, Chile. The private health sample was selected using snowball sampling, recurring to the researcher's networks.

Table 1. Composition of the sample (adherence and health system).

Adherence level	Private health	Public health
Optimal	7	8
Sufficient	7	8
Insufficient	9	8
Total dropout	1	3
Total Sample	*24*	*27*

- The *inclusion criteria* were: Arterial Hypertension diagnosis, between 25 and 80 years of age, self-reliant (does not depend on others to make health and treatment decisions), voluntary participation for at least one month in a public or private hypertension medical treatment program (except for the participants in the "total dropout" adherence level), living in Santiago de Chile with Chilean nationality and required to make lifestyle changes as part of the medical treatment.
- *Exclusion criteria* were: Cognitive impairment, psychiatric illness, current comorbidity with another acute illness.

To make the sample diverse and represent different adherence and ambivalence resolution, we classified the patients according to their treatment adherence level. After a literature review and consulting with different healthcare professionals, we defined the following criteria for the adherence levels:

1. *Optimal*: Compensated arterial pressure (<140/90) in the last two medical checkups. Furthermore, the patient is satisfied with his adherence to the treatment's different aspects (diet, drugs, exercise, others), without the need or desire to adhere more.
2. *Sufficient*: Compensated arterial pressure ($100 < 140/60 < 90$) in the last two medical checkups. The patient adheres partially, not as much as he would like or think they need.
3. *Insufficient*: The same as the "sufficient" group, but their arterial pressure is not compensated (>140/90).
4. *Total dropout*: They have not been to medical checkups for at least two years. They adhere minimally, if at all. These participants are exempted from the inclusion criteria of participating in a hypertension treatment for at least a month, as they are not in any kind of treatment for their hypertension.

The final sample is shown in Table 1:

Data collection instruments

We collected all the data using in-depth interviews with hypertensive patients. These explored in detail different episodes of patient-caregiver interaction (including physicians, nutritionists, and nurses), milestones in the patient's history with his illness, his coping strategies, and utilized specific questions to explore implicit pro and anti-treatment motivations and adherence-related schemas (based on the "viewing from a symptom-free position" technique, as explained in Ecker & Hulley, 1996, p. 183).

Table 2. Adherence interview.

Elements of HTA treatment	Real % (according to patient)	Wished % (by the patient)	Expected % in the future (by the patient)
Medical checkups attendance			
Medication			
Diet			
Exercise			
Alcohol, tobacco, etc.			
Others: Mealtimes, rest, sleep			

Complementarily, all interviews gathered information about patients' adherence to different aspects of the medical treatment and their perception that they should or should not adhere more (see Table 2). Interviewers were given precise instructions on how to facilitate a judgment-free climate for the interviewee to be able to express her difficulties and apprehensions toward the treatment. We triangulated the patients' self-report information with data from their medical records (weight, blood pressure, and assistance to medical checkup sessions) for the public health participants only (as this information was not available for the private health participants).

All interview sessions lasted between 40 and 120 minutes, with an average of about 75 minutes of length (one session per participant), and were conducted in the interviewees' homes or, if they so preferred, in the medical center where they received the medical checkups. All interviews were videotaped and later transcribed. Only the Interviewer and interviewee participated in the sessions. After analyzing the first set of data, we used an iterative process to modify the interview guide for the subsequent interviews (Beebe, 2001).

Data analysis

For the data analysis, we followed the general guidelines of the Grounded Theory and Consensual Qualitative Research (Hill et al., 2005; Strauss & Corbin, 2002): several judgments throughout the data analysis process to foster multiple perspectives; consensus to arrive at judgments about the meaning of the recollected data; one auditor to check the work of the primary research team; and cross-analyses of domains and core ideas. We conducted all analyses using the transcripts from the interviews. We also used Qualitative Research Software to help with the coding procedure (Atlas.ti 7).

For the data analysis, we considered different analysis units: (1) 51 individual interviews; (2) 523 response units related to adhering or not adhering to the medical treatment (approx. 11 per interview); (3) 4 adherence topics per interview: exercising, taking medications, following the diet, and "other aspects of the treatment". We differentiated between these aspects because each one was a potential focus of ambivalence, as each participant could have different adherence levels and different ways of coping with their ambivalence for each aspect of the treatment; and (4) a Global level that included the whole sample of participants.

The analysis procedure had several steps:

1.1. Identifying significant Response Units: We analyzed every interview individually, selecting fragments (units of meaning, varying in length between one word and

several sentences) in which the interviewee spoke about acknowledging the illness or following the treatment plan, positively or negatively (e.g., utterances about the personal meaning of adhering, the consequences of adhering, traits associated with people who adhere or not adhere).

1.2. Identifying *Pro/Anti* Treatment Voices within Response Units: In each interview, we coded every fragment according to these initial domains: *anti-treatment voice* (expressions that had a negative association with adhering to treatment, and thus the sensible action would be not to adhere) or *pro-treatment voice* (any expression that had a positive association with adherence, and thus the sensible action would be to adhere).

2.1. Exploring ambivalence within Individual interviews: For each interview, we classified all the PRO and ANTI treatment voices according to the different aspects of the treatment (e.g., Exercising, taking medication, following the diet). If there were no traces of ambivalence in an interview, we discarded that participant for the next steps of the analysis and classified the interaction as a *monologue*.

2.2. Exploring ambivalence within Individual interviews (part 2): For each interview, and for each aspect of the treatment, we analyzed the dynamics and relationships between all the PRO and ANTI treatment voices related to that specific aspect (e.g., exercising). We noted: when each voice appeared or disappeared, if they contradicted each other or supported each other, etc. For this, we followed the method suggested by Cunha et al. (2012), and were inspired by Valsiner (2002). Then we created codes representing the different types of dialogue and interaction between PRO-ANTI voices.

3.1. Formulating a Model at the Global Sample level: After selecting a sub-sample of 15 interviews according to the maximum differences criteria (from different levels of adherence), we analyzed and classified all coded fragments in emergent subdomains. We then selected and labeled these sub-domains according to the different ways the PRO & ANTI voices related to each other. We ceifferent codes were created and reviewed until they captured the different strategies used by the patients. At this point, an initial list of *strategies for dealing with ambivalence* was created.

3.2. Formulating a Model at the Global Sample level (part 2): With this initial list of *strategies for dealing with ambivalence*, we coded all the other interviews, creating or modifying the codes until no new domains or core ideas emerged (theoretical saturation point), at which point we completed a list of 7 different *strategies for dealing with ambivalence* grouped in three meta-strategies (monologue, integration & domination), which were representative of the whole sample.

We will illustrate steps 1.1, 1.2, 2.1 & 2.2 with an example (Patient 31, Sufficient adherence):

> Interviewer: Do you want to tell me about your attempts to follow a diet? Because you say that you've tried several times to lose weight, but it doesn't work, and you do not know why.
>
> Patient: Yes, the thing is, my work is very stressful, and I do not drink or smoke, and so my only way to cope with anxiety is to eat. So, I have a problem. Either I kill myself through stress, or I reduce it by eating, and on the other hand, I want to lose weight. But

> if I start smoking like before, when I smoked two packets a day, I think it's better to be a little fat than to start smoking, so there are other forces at stake.

In this excerpt, we identify a significant response unit (step 1.1), as the patient associates adhering to the ideal diet with increasing his stress. Furthermore, we identify an anti-treatment voice (step 1.2) when he states that adhering more would lead him to increased stress or to smoke again. So, this is a voice that aims to have good health and quality of life, even though it "pushes" the patient to deviate from his ideal diet.

In the rest of this interview, there is only one other reference about this part of the treatment plan (changing his diet): when he says that he should lose weight because he is fat and lacks energy. This was classified as a pro-treatment voice. As the same topic (diet) is associated with both *pro* and *anti*-treatment voices, we identified the presence of *ambivalence* (step 2.1). Finally, in order to describe the type of ambivalence or interaction between these voices (step 2.2), we observed that the patient's actual behavior was coherent with the *anti-treatment voice* (he didn't follow the ideal diet) and did not satisfy the *pro-treatment voice*, which continued to appear as self-criticism ("I'm too fat and should lose weight"). So, we described an interaction in which the anti-treatment voice dominates, but the pro-treatment voice is still present and pushing for recognition, producing future failed attempts to increase adherence.

Ethical considerations

In order to preserve participants' autonomy and confidentiality, we recorded all the information using anonymous codes and not real names. Only consenting adults were included in the study, and no personal information was shared with anyone except the Interviewer and the research team. The interviewers were all licensed psychotherapists with at least 5 years of professional experience and specific training for this kind of interview. The ethics committee of the Catholic Pontifical University of Chile approved the study.

Results

First, the different types of dialogue and interaction observed between PRO and ANTI adherence voices are presented. An emergent result is then shown: a special kind of temporal dynamics between PRO and ANTI adherence voices during the interviews observed on some of the cases.

Different types of dialogue and interaction between PRO/anti adherence voices

Almost every patient revealed a conjoint presence of both *anti* and *pro*-adherence voices. When only *pro* or *anti* adherence voices were present (2 cases), there was no interaction or ambivalence, so those scenarios were called a *monologue*. When both kinds of voices were present (49 patients), two meta-strategies for resolving ambivalence were observed: *Integration* & *Domination*. *Integration* was classified when patients acknowledged and accepted both voices and was further divided between *win-win* and *compromise* (following standard negotiation terminology). *Domination* was when one voice

Table 3. Integration strategies are associated with higher and/or more stable patient adherence*.

Adherence	Pro Monologue	Win-Win	Compromise	Pro domination	Anti Domination	Domination & Rebellion	Anti Monologue
High	1 (general)	4 (typical)	9 (variant)	3 (typical)		1 (rare)	
Good Enough		2 (variant)	9 (variant)	1 (rare)	9 (variant)	2 (rare)	
Insufficient			7 (variant)	1 (rare)	9 (variant)	6 (variant)	
Dropout					2 (rare)	2 (rare)	1
Total	1	6	25	5	20	11	1

Each patient can use more than one strategy for resolving ambivalence, for example if he uses one for the diet behavior and other for taking medication.

tried to subjugate the other and was divided between *Pro domination*, *Anti domination* & *Domination & rebellion* (see Table 3)

Monologue

In the *Pro Monologue*, there are only *pro adherence* voices detectable in the interview. There are no “response units” in which adhering has a negative association or not adhering a positive one, so there is no ambivalence or conflict. This happens in only one patient, who shows optimal adherence and says that *"adhering is something good I do for myself because I take care of myself and I’m self-reliant"* (Patient 6, optimal adherence). She was a patient who did not have to change her health habits after her HT diagnosis because several of her family members have the same illness, and they were all following a salt-less diet. Having HT does not scare her or make her angry. She thinks the illness is genetic, and its symptoms can be managed with a lifestyle that suits her and does not require much effort.

In the *Anti Monologue*, there are only *anti adherence* voices detectable in the interview, so there is no ambivalence. It can be said that the patient is in the pre-contemplation stage. This happens in only one patient, who has dropped out entirely from the health care system and expresses that *"hypertension runs in the family, I can’t do anything about it, and besides, every time I go to the doctor I come home worse afterward"* (Patient 21, dropout). She hates the “extreme” diet that the doctors have imposed (“*the last thing I can stand is food being taken away from me*”), believes that improving her health is something out of her control (“*God has the last word*”) and has a traumatic history with doctors at least since her aunt died because of medical malpractice. She has reacted with intense fear to the medical instructions and has abandoned the treatment after an impasse with the medical team, instead of talking about it or looking for another professional. Most of her family members are obese, and their diet and exercise habits are entirely different from the ones prescribed for her HT treatment, so adhering would require tremendous effort.

Integration

Win-win integration. In the *Win-win* integration, both voices are accommodated and their goals accomplished, so both are “satisfied", and conflict is therefore resolved. This strategy appears to be stable in time in the interviews and is associated with high adherence, but it’s only present in 12% of the sample.

For example, one patient was terrified of having a stroke and losing autonomy (*pro adherence voice*), but at the same time, he hated having too much discipline in his life and giving up control to the medical staff (*anti adherence voices*). So, he decided to stick to a diet with a medium-term perspective, leaving room for occasional exceptions. Also, to go to the doctor but just to check if he was doing well with his strategy, using the professional as a health consultant, and not giving up control. This had been a successful solution for the patient, who expressed: *"I'm going to try it like this, if it works I'll do as I say, if it doesn't I'll do as the doctor says"* (Patient 31, sufficient adherence). This way, the patient manages to acknowledge and satisfy the voice that seeks autonomy and flexibility in the treatment (in this case, the *anti adherence voice*), and also the voice that aims to take care of himself in order to remain self-reliant in the future and not depend on caretakers (the *pro adherence voice*). The patient was at peace with himself, and this solution seemed to be sustainable in time.

Compromise integration. In the *Compromise* integration, there is no option available to satisfy entirely both anti & pro adherence voices. So, the patient arrives at a compromise solution, in which both voices are heard, and both have to yield. This solution also appears to be sustainable for long periods and is associated with good enough adherence, being observed in 49% of patients. It is as if both voices arrived at a good enough truce and were at peace with it, even though none were completely satisfied.

For example, a patient wants to improve her treatment adherence to have better health, share more with her family, and preserve her independence (*pro adherence voices*). At the same time, she does not like to do more exercise because it takes away time from her professional activities, and she has her HT compensated, so there is no need to adhere more (*anti adherence voices*). So, instead of exercising three times a week, she does it only once, reaching a point of equilibrium in which protest from both voices is diminished. She says, *"if I take more care of myself and use my time going to the gym instead of doing what I do now, I would say I could live longer, but frustrated"* (Patient 16, sufficient adherence). In this case, even though the patient is aware that she is not doing the ideal amount of exercise, she accepts this as a good enough compromise and feels at peace with herself, having found a sustainable solution in time.

Domination

Pro domination. In the Pro domination strategy, the patient has powerful motivations to adhere, mainly because she is terrified of what could happen to her. She has some anti adherence voices remaining, but those can't be expressed because she "must" adhere 100%. So, those anti voices are subjugated, and the pro voices dominate. This strategy helps the patient adhere strongly in the short term, but there are signs that it is not sustainable. Patients who used this strategy before the interview reported that, after a while, the fear decreased, they "relaxed" and started adhering less, blaming themselves for that. So, this strategy does not appear to be stable and is associated with high adherence only in the short term, being observed in 10% of the sample. It does not seem stable because it produces inner tension: the anti-adherence voices are not being heard, and thus they keep protesting and pushing for recognition. This generates frustration and requires tremendous willpower to sustain new habits. So, when pro-adherence voices weaken their strength (for example, when the patient is less afraid of a sudden cardiac accident), adherence diminishes again.

> For example, one patient recently had a stroke and is now in partial recovery. He vows to adhere 100% to everything the medical staff says because he is afraid of another stroke (*pro adherence voice*). At the same time, he hates feeling controlled and leading a joyless life based only on healthy food (*anti-adherence voice*). Faced with this ambivalence, and because his fear is so intense, he oppresses his *anti* voices, stating that *"regrettably, now I have to abide. I have to start forgetting the tasty stuff"* (Patient 7, optimal adherence). He expresses clearly how his current position implies bowing his head and conforming, showing sorrow and frustration in the interview. His solution does not allow the *anti-adherence voice* to be acknowledged or satisfied at all, and possibly it is challenging to sustain in the long term.

> In another example, a truck driver shares the story of how adhering was complicated for him because of his work routine and little spare time. However, he adhered 100% to the treatment immediately after the HT diagnosis, motivated by his terror of having a stroke. He even lost around 60 pounds of weight in the first six months of changing his diet. *"I think at the beginning it was because of the fear. And then you start little by little eating this, eating a bit of that [smiles], thinking I'm in a hurry, so I take two sandwiches and a coke, or diet coke [smiles] (…) It's too hard because I travel all night, sleep a bit in the morning, unload the truck, then load it again and come back, then I don't have a fixed schedule. But none of the other patients with HT that I know have kept their diet for long, it's the fear of the first few months that keeps you there"* (Patient 47, sufficient adherence). This second example shows the familiar pattern hypothesized before: when fear starts to subside (*pro adherence voices* lose their urgency), adherence decreases, and the interaction between the voices changes.

Anti domination. In *Anti domination*, the patient has *pro adherence voices*, but even though he wants to adhere more, he feels that he *cannot*. So, he lowers his adherence, but the *pro* voices are left dissatisfied and keep complaining and criticizing him for not doing what he should do. This strategy is more associated with insufficient adherence and was observed in 39% of the sample. This solution also does not appear to be stable long term because *pro adherence voices* remain present and pushing for recognition, which produces future failed attempts to increase adherence. These recurrent failures to adhere make the *pro voices* manifest themselves in maladaptive ways as guilt and shame. This guilt is maladaptive as it does not motivate the patient effectively to increase his adherence; it only produces dissatisfaction, self-criticism, and despair.

> For example, a patient wants to adhere to the diet because he wants to continue taking care of his children (*pro adherence voice*), but he uses food to regulate his work-related stress, so adhering to the diet implies increasing his anxiety (*anti adherence voice*). Faced with this ambivalence, he eats more than he wants to but blames himself, saying: *"I don't know why I don't have the willpower to do it"* (Patient 31, sufficient adherence). He describes that over the years, he has made multiple failed attempts to change his diet. This confuses and unsettles him, as he is a person known for his willpower and orientation towards achieving his goals. He feels constant frustration and a sense of permanent failure regarding this topic.

Domination & rebellion. Finally, in *Domination & Rebellion*, there is a power struggle between *pro* & *anti* voices. The patient wants to dominate her *anti* voices, but they are not easily pushed away and keep appearing in dysfunctional ways, or there is an alternation between *pro* and *anti* voices that can be observed even during the interview.

Both voices fight for supremacy, and when one is consciously available, the other is seen as incomprehensible and malicious. There is no dialogue between the opposing voices, and the person is in obvious inner tension. In this strategy, none of the voices is satisfied, and this oscillation (similar to the mutual in-feeding pattern described by Valsiner) was observed in 22% of the sample, especially patients with insufficient adherence. This kind of dialogue seems specially unstable, as the patients oscillate between *pro & anti adherence* domination. Often, they try to adhere in a very rigid and demanding way and then actively rebel against those demands, but other times they appear to be unable to meet them sustainably. Either way, they feel profound tension, guilt, and frustration.

> For example, a patient wants to adhere 100% to the diet and exercise because she wants to be a good example to her children and a good patient for her doctor (*pro adherence voices*). Simultaneously, she feels weak and sick if she needs to be on a diet and needs medication for life, and hates it when her children are supervising her meals (*anti-adherence voices*). Faced with this ambivalence, she tries hard to adhere, but sometimes she is tempted to have a soft drink, and when she yields, she feels that all her effort went to waste. Other times, she strives to get to 100% adherence, but she cannot help herself and buys a Coke hidden from her family to avoid being scolded. She says: *"then I bring a bottle, and I drink half of it, and then I look at it and say 'Oh my God, why did I do that at 3, 4 am?" (Patient 10, insufficient adherence)*. In this situation, the patient starts the day with a *pro-domination* period in which she deprives herself of things she likes (fully satisfying the *pro-adherence voices*) with intense effort and suffering (leaving the *anti-adherence voices* completely unsatisfied). Then, the roles are reversed, and she ends the day with an *anti-domination* period, in which the *anti-adherence voices* guide her behavior, and the *pro-adherence voices* appear in the form of intense guilt and fear of consequences.

> Another example is from a patient who values adhering to the recommended diet for her wellbeing and not bothering her family and neighbors (*pro adherence voices*). At the same time, she complains that with old age came the *"restrictions, restrictions, restrictions"*. Also, when her doctor tells her that *"she can't eat this, or that and that"*, she answers: *"So I better off not eating anything doctor, I feed on air"*. These restrictions and limitations affect her even more, when they prohibit chocolate and other sweets that bring joy to her life (*"chocolate is my life"*) and help her forget her constant problems (*anti adherence voices*). Faced with this ambivalence, she shares a recent episode in which she ate three chocolate bars, producing constant fear that is evident even during the interview: *"I told myself: I don't have to eat chocolate, I don't have to eat chocolate […] chocolate for me is a sign of evil, a cake is a sign of evil. So my motivation is knowing that if I have a relapse, it's my fault, not the doctor's or whoever lives with me […]. I eat a chocolate bar and risk my life, and I ate three. So I told myself: I'm getting myself into trouble, so I kept thinking about that"* (Patient 27, sufficient adherence).

In the next section, we will focus on this kind of dynamic with more detail.

Dynamics of the multi-voiced self during the interviews

Another emergent finding was that during the interviews, the *pro* and *anti*-adherence voices often did not communicate between them, and only one was consciously available at any given time. This meant that a patient could explain in understandable terms why it made no sense for her to adhere more, and minutes later declare that she did not know why she could not adhere more. This was regarded as a sign that sometimes

the *anti*-treatment voice is more salient or consciously aware, and other times it is implicit, hidden, or not consciously available.

Below is a detailed extract of the interview with patient 5, a 25-year-old female of upper-middle-class socioeconomic background. Along with the transcript are comments to highlight the presence of *pro & anti adherence voices*, their meaning, and associated purposes. They are extracted from the middle section of the 60-minute interview.

> It's the same mentality, it's like now I'm gonna take all the medication every day, and I've done that a million times, but I'm not capable, something stops me … it doesn't matter to me, something … and I give up ***[signs of ambivalence and that the anti adherence voices are not consciously available and remain a mystery]***
>
> *[Interviewer asks about what she thinks will happen if she continues adhering like this]* Nothing ***[anti adherence voice: it doesn't make sense to adhere]***, that's the problem, I feel like nothing will happen to me, I feel immortal, you know? ***[pro adherence voice that criticizes the anti-voice]***.
>
> I don't feel like a have an illness. I feel like my future is gonna be just like everyone else's, but … I know I have an illness and that it's not gonna be the same, and I'll have to be more careful, but I don't picture that, for me, it's gonna be normal, the same as everyone else's, and if I have an accident then I'll have an accident ***[again the oscillation between pro and anti-adherence voices: if she doesn't have an illness then it's not necessary to adhere. We interpreted this anti adherence voice as related to being normal and not weak-different. In Chilean culture it is very rare to have a chronic condition at 25 years old, so this voice might be protecting her self-image by denying the grief process associated with accepting the chronic condition]***.
>
> [Interviewer asks how she pictures herself at 60 years old] The same … that's the problem, probably I won't, but that's my fantasy ***[both pro and anti adherence voices in the same sentence]***
>
> [Interviewer asks about the moment she received the diagnosis] Nothing really, emotionally, it didn't mean anything for me, and they gave me more pills than anyone else … it's like an anecdote, it's like hahahaha I'm hyper-tense, I don't know … ***[the anti treatment voice again, diminishing the importance of the chronic condition and contradicting the previous pro adherence voice completely]***.
>
> This year, maybe 6 months ago, my mom found out I wasn't taking my pills, and I swear it was one of the worst scoldings I've ever had in my life … I get along fine with my mom, but she was talking to me like I was three years old; of course, that's the age I behave with this issue ***[the pro-adherence voice views the anti-voice as a rebellious 3 y/o girl. This again shows the inner conflict and the dominance & rebellion pattern]***. She was very harsh on me, she told me that I had disappointed her … and then I took the pills for four months ***[the scolding is initially effective for increasing adherence, showing a Pro domination strategy]***, but then I stopped because I ran out of pills and had to go to the doctor to get the new recipe and I never went, but I told my mom that I did ***[however, the scolding produces only short term results and a rebellious behavior from the scolded voice]*** … then I didn't take anything for a month, then I took the pills again ***[the cyclical pattern continues]***

Discussion

This paper argues that most people who need to make lifestyle changes face some ambivalence between pro and anti-treatment voices. Those voices can also be "heard" at

different moments in time (even in the same interview). Sometimes, they do not seem to acknowledge each other, evidencing a lack of communication within the Self. Furthermore, different strategies for working through inner ambivalence toward adherence were described: *integration* strategies allow both opposed voices to express themselves and be heard. In contrast, *domination* strategies reject or dismiss one of the voices. These results complement the ones presented in a previous paper by the same author (Herrera et al., 2017). That study argued that both *pro* & *anti*-treatment voices aimed to preserve important personal values. The specific contents for the *anti*-voices were: self-worth, wellbeing, affiliation, autonomy & "it's not worth the effort". For the *pro* voices, the contents were: self-worth, wellbeing, affiliation, autonomy & "it's not a big effort".

Different studies present similar broad categories of ambivalence resolution (Braga et al., 2018, 2017; Herrera, 2013). Of particular interest is the work of the psychotherapy researchers at Minho University, Portugal, who also identify dominance & negotiation/integration strategies, although they have studied psychotherapy clients with depressive symptoms. In both their study and the one I present here, we reach the same conclusion: it seems that integration strategies could be necessary for sustainable long-term change, both in psychotherapeutic and medical contexts. This contributes further empirical support for authors such as Stiles (Honos-Webb & Stiles, 1998), Perls (1974), Beisser (1970), Zinker (1979), and Johnson (1992), and their thesis that therapeutic change occurs through acceptance and integration of the disowned aspects of the Self. A possible explanation of this phenomenon is that when one voice is dominated, this rejected aspect of the Self lingers on as an "unfinished business" that drains the person's energy and resources (Greenberg et al., 1996; Perls et al., 1951, Zeigarnik, 1927).

This study's results can also inform ways in which future research projects on nonadherence can improve their methods. First, it is important to distinguish three levels of resolution of ambivalence in order to assess the outcome of interventions: (1) micro-interactions observed in 1-2 speaking turns that illustrate an ambivalence moment (such as the ones studied by Gonçalves' team at Minho University); (2) more extended interactions that allow us to observe how the pro/anti voices are dialoguing in a period of the person's life (as observed in this study); and (3) longer-term resolutions that allow assessing if the patient has arrived at a sustainable solution regarding her adherence. The difference between micro-interactions (e.g., ambivalence resolution episodes) and longer interactions is significant because, as shown in the results, a patient can express pro dominance strongly in one minute, and in the same interview show anti-dominance. This could be mistaken as two different resolved ambivalence resolution episodes when it is better understood as evidence of a "domination & rebellion" dynamic, in which ambivalence is not resolved.

Second, to give patients' anti treatment motivations its due relevance, it's necessary to develop methods and techniques to explore the different voices that determine patients' adherence, paying particular attention to implicit affective meanings (van Geelen, 2010). From this perspective, using a self-report questionnaire to assess conscious rational beliefs, even though it's the most common and least expensive method, would not be the most appropriate, as it only allows access to the most consciously available voice, the one active when completing the questionnaire. Thus, this method obscures the other

voices of the Self, the ones responsible for the resistant behavior (van Geelen, 2010). The present study illustrates how some psychotherapy exploration techniques could be adapted for these research purposes.

These results can also inform future improvements in the interventions that aim to improve patients' adherence. As previously argued, most intervention programs employ a "pro-domination" strategy, making it very difficult for *anti-adherence* motivations to appear and be heard. This establishes a context of social desirability in which the patient fears scolding and self-blame for not behaving in the right way and lacking the willpower or strength to adhere more. Even empathic caregivers, interested in understanding patients' noncompliance reasons, probably hear rationalizations and excuses (because they are often implicit and not easily available for conscious reflection). This reinforces the idea that these are irrational or maladaptive voices and do not deserve special attention.

This means that often the family, the medical system, and most well-intentioned therapists engage the patient, implicitly, with a dominating-critical stance. The commonsense belief is that adhering is good, and not adhering is bad. When thinking about his nonadherence, even the patient himself often does it from a critical, judgmental, and non-nurturing way. From a constructivist and dialogical perspective, every time we say that nonadherence is bad, irrational, unhealthy, incomprehensible, or self-destructive, we are judging and rejecting the patient's position that experiences nonadherent behavior as the most adaptive response (the *anti-adherence voice*). Therefore, we are helping the *anti-adherence* position become rebellious and resistant. As has been stated, domination/submission strategies can work for a while, but they are not sustainable over time, and sooner or later, patients "relax" and stop adhering to the letter. This dominating, demanding and judgmental view toward patients' adherence permits them little latitude for having a bad day in their treatment plan (Stanton et al., 2007), and can make them feel so bad after a perceived failure that they are less likely to continue striving toward their health goal (Neff et al., 2005).

These results suggest that adherence interventions, to be effective and sustainable in the long-term, should acknowledge all the different voices that command the patient's behavior (McEvoy & Nathan, 2007). Treatment goals should not be "100% adherence for everyone" because that's not realistic or appropriate to most patients' experience. Maybe some patients are, all in all, better off reaching a compromise between these opposing voices. In the sample used for this project, almost all patients had more values at stake than just higher or lower blood pressure. Thus, patients had to balance their desire for lower blood pressure and other important values such as freedom, self-worth, and even preventing iatrogenic effects on other health variables. Future intervention protocols should dedicate time to co-construct specific goals for each patient, so their pro and anti-treatment voices can be heard, and changes can be sustainable by the patient in her specific life situation, as they must be for managing a chronic condition.

Finally, this study presents an argument against Domination or rejecting strategies (either inter or intrapersonal) and in favor of constructing more compassionate and accepting relationships with our patients and with ourselves. Both Intra and Interpersonally, Domination generates power struggles and incites rebellion or subjugation. Hopefully, these results can help caregivers empathize with their resistant patients, and resistant patients empathize with themselves.

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