Rehearsing Renewal of Identity: Reconceptualization on the Move

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The self is both stable and ever in motion and it is shaped by a person's telling of stories – to oneself and to others. In fact, the telling of a life story is an act that allows the creation of a stable, yet changing, image of oneself. From this metaphor of people as storytellers (Bruner, 1990; McAdams, 1993; Sarbin, 1986), we have been developing a research program that tracks the emergence of novelties in people's lives, trying to figure out the transformation process of self-narratives (see Gonçalves, Matos & Santos, 2009; Gonçalves, Mendes, Cruz, A. Ribeiro, Angus & Greenberg, 2011). For this purpose we created a coding system – the Innovative Moment Coding System (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) – that allows the tracking of novelties, which emerge in discourse, called innovative moments (or IMs). IMs are exceptions to a dominant self-narrative. Whereas the dominant self-narrative is the rule (of behaving, feeling, thinking), IMs are the exceptions (like new actions, feelings, thoughts or intentions, for example). According to this model of narrative change (Gonçalves et al., 2009) the expansion of

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these exceptions are central in self-narrative transformations. People' self-narratives are stabilized around a dominant framework, in which a voice or a coalition of voices is occupying the narrator's position. Every time a meaningful change occurs in this dominant framework, alternative voices -- new ones or previously dominated -- come to the foreground, occupying the role of narrators. Thus, we conceive IMs as non-dominant voices that have the potential to disrupt a previously dominant self-narrative (see Gonçalves & A. Ribeiro, 2012, for an elaboration of the dialogical processes involved in self-narrative transformations).

Often in psychotherapy – our main domain of research – dominant self-narratives become so overriding that they exclude all the dialogical alternatives, becoming reduced to a "single theme" (Hermans & Hermans-Jansen, 1995, p. 164). In this sense, dysfunctional self-narratives are more close to a monological outcome since they exclude dialogical alternatives.

Innovative Moments as Resistance to Monological Narratives: A Conceptual Model

Before we proceed, we will briefly summarize our main findings using the Innovative Moments Coding System to study psychotherapy. These findings emerged from the study of psychotherapy samples (Gonçalves, Mendes et al., 2010; Matos, Santos, Gonçalves & Martins, 2009; Mendes, A. Ribeiro, Angus, Greenberg & Gonçalves, 2010) and intensive cases-studies (Gonçalves, Mendes, A. Ribeiro, Greenberg & Angus, 2010; A. Ribeiro, Bento, Salgado, Stiles & Gonçalves, 2011; Santos, Gonçalves, Matos & Salvatore; 2009). The transformation of self-narratives involves

IMs' emergence and expansion, in a clear patterned way that is visible in successful cases of psychotherapy (Gonçalves et al., 2009; Gonçalves, Santos et al., 2010). The first signs of change are made evident from the emergence of three types of IMs: action, reflection and protest (see table 1). Action IMs refer to single actions in which the person challenges the dominance of the previous self-narrative; that is, the person acts in a way somehow not predicted by the dominant narrative. Reflection IMs refer to cognitive products that represent exceptions to the way the dominant self-narrative leads the person to think (this can emerge in the form of thoughts, fantasies, intentions, and so on). Finally, protest IMs could be an action or a thought but represent a more proactive way to refuse the dominant self-narrative. The person enacts, with protest IMs, an attitudinal refusal of the assumptions of the previous dominant self-narrative. The sequence of these three types varies. In some cases, the person starts with action IMs, acting in a way that challenges the former dominant narrative and from here reflection or protest IMs, that are congruent with these actions, emerge. Other times action almost does not emerge and change starts mainly from protest and reflection IMs. Finally, in some cases, change starts with reflection and only after some elaboration of these IMs, protest appears and develops.

Insert table 1 here

After some elaboration of these three types of IMs (action, reflection and protest), reconceptualization IMs (see table 1) emerge and become the dominant IM type in successful psychotherapy. In reconceptualization IMs, the person not only narrates a

change between a past and a present condition (*before I was X, now I'm feeling Y*), but also describes the process that allowed this transition. Dialogically, reconceptualization involves what Hermans (2003) calls a metaposition that frequently acts as a trigger of innovation in the self (e.g. Hermans & Kempen, 1993). This concept can be defined as:

> … a perspective from which the client phrases the linkages between several significant positions in a self-reflective way. (Hermans & Hermans-Jansen, 2004, p. 133)

Finally, performing change IMs emerge in the process. These are projections into the future (e.g., plans, projects) about the change that is occurring. This process is depicted in figure 1.

Insert figure 1

Thus, reconceptualization IMs seem to be a very powerful type of innovation in the path to a new self-narrative. Several findings support this claim. First, they are almost absent (or even completely absent) in unsuccessful psychotherapy (Gonçalves et al., 2009; Gonçalves, Mendes et al., 2010; Matos et al., 2009; Mendes et al., 2010). Second, they increase their emergence from the middle to the end of psychotherapy and are clearly necessary to stabilize emerging changes. Third, reconceptualization keeps repeating itself, which means that the person does not change after the first reconceptualization but needs some consolidation of these IMs that requires a working through in the perspective conveyed by this meta-position in order to strengthen the change process (we will return to this later on).

We have also proposed (Gonçalves et al., 2009; Gonçalves & A. Ribeiro, 2012; Ribeiro, Bento, Gonçalves & Salgado, 2011) that when reconceptualization does not

emerge, or appears only in an incipient way, the person is often caught in a vicious circle called mutual in-feeding (Valsiner, 2002). In this process IMs emerge but are soon aborted by the re-emergence of a problematic voice (e.g. "*I would like to feel more confident to express myself* [IM], *but I am afraid others will not like me that way* [re-emergence of the problematic voice]"). Mutual in-feeding is a process that maintains stability in the self by displaying a redundant circularity between contrasting voices that follow each other, where the last immediately counteracts the first[2] (Valsiner, 2002).

Our focus in this chapter is to understand how reconceptualization process leads to successful change. More specifically, we can ask: *How and why these narratives reflect the developing process of self-narratives during therapy evolution?* And also *how does the therapist participate in the process of facilitating these changes and restoring self-continuity in the client?* Consequently, this chapter represents a theory-building effort through the intensive analysis of a single case-study (Stiles, 2007). There are two aims: i) to explore the emergence and changing quality of reconceptualization IMs in psychotherapy, trying to further understand the function of these IMs in the ongoing development of a new self-narrative; and also ii) to address how the therapist can facilitate this narrative shift.

Grasping Transitions in the Self through Reconceptualization

[2] This circularity between voices or positions in the case of mutual in-feeding is frequently achieved through the use of circumvention strategies. These discursive devices change the outcome of the person's meaning making (or conduct and feelings) regardless of the initial direction, regulating opposing or ambiguous meanings through a return to an original more familiar position (Josephs & Valsiner, 1998).

We believe that several ingredients of reconceptualization are central in transforming self-narratives. We will explore three theoretical arguments to justify our claim. First, through reconceptualization, the other IMs can become integrated in a more complex narrative that provides a sense of direction towards change. This calls for a new sense of agency and authorship, consolidating a broader and integrative view of the developing self in time (a synthesis in the self – Hermans & Kempen, 1993; see also Santos & Gonçalves, 2009).

Second, as we stated before, reconceptualization IMs highlight the adoption of a meta-perspective stance in the self that allows the person to become aware of a transformation process (i.e., Here-And-Now contrasted with There-In-the Past) and to depict a differentiation between alternative self-versions (i.e., Self-As-Was and Self-As-Is). This meta-perspective refers to the key ability to take a step-back and adopt a metaposition towards the problematic experience (Hermans & Kempen, 1993, referred to also as an observer position – Leiman & Stiles, 2001). This creates a psychological distance that facilitates a retrospective observation and reflection upon oneself while reacting in a problematic situation. More broadly, this process converges also with the importance attributed to the concept of insight in the promotion of change (e.g. Castonguay & Hill, 2006) and also with the role played by metacognition in the change process, another concept that has received growing attention in the psychological literature (e.g. Semerari, Carcione, Dimaggio, Falcone, Nicolo, Procacci, & Alleva, 2003).

Our third and final argument for the importance of reconceptualization is our view that these narratives represent signs of a rupture or a discontinuity in the self. According

to Zittoun (2007), identity ruptures are seen as subjectively perceived interruptions or discontinuities in the normal sense of self that can lead a person to a questioning of one's own identity. This usually triggers a transition; that is, sense-making efforts that aim to restore continuity and integrity in the self while reducing uncertainty by creating an understanding of the rupture. This is, in our view, where reconceptualization IMs play an important part in the development of a new self-narrative: they function as communicational and semiotic devices that allow one to restore self-continuity. And this is carried out in a two-fold direction: both internally toward the person and externally toward others one engages in dialogue with. By bridging past, present and future through an understanding of what happened during the transition, reconceptualization links the old and the new self, what the person *WAS*, *IS* and *IS-NOT-YET*, making different self-experiences seem more consistent in a flowing narrative. Furthermore, in the context of psychotherapy, therapists can even enhance this process of meaning making in identity transitions, since therapists are specially attuned to the client's perceived self-changes and particularly interested in inquiring and fostering meaning about them. Reconceptualization IMs are usually felt as a positive, rewarding and motivating experience in psychotherapy, especially when they match the desired direction towards change (Santos & Gonçalves, 2009). Nevertheless, they can also possibly emerge from ambivalence and ambiguity, or even from intense inner-contradiction (Abbey & Valsiner, 2005; Valsiner, 2007). In these circumstances they also have the potential to become disquieting experiences.

Hence, we consider the emergence and evolution of reconceptualization IMs as interesting phenomena to study – not solely as an outcome (i.e. a marker for change) –

but as the window to an organizing process in identity (Zittoun, 2006). We will address this issue through an intensive case-analysis.

Sarah: A Case-Study

Sarah (pseudonym) was a thirty-five year-old part-time college student, a German immigrant to Canada who participated in the York I Depression Study (Greenberg & Watson, 1998; Honos-Webb, Stiles & Greenberg, 2003). Sarah looked for therapy one year after her divorce that ended 8 years of marriage with no children. In the first session, Sarah disclosed to her therapist that she wanted help to act upon her depressive feelings and increasing sense of isolation (see also Honos-Webb et al., 2003, for a prior publication that focuses on this case-study). At therapy intake, she presented some of the typical symptoms of depression, and these had lasted for several months. She was assigned to the Emotion Focused Therapy (EFT) modality and attended 18 sessions of psychotherapy. According to the improvement this client exhibited in the outcome measures used in this study (Greenberg & Watson, 1998; Honos-Webb et al., 2003), she was considered a successful case.

Her therapist was a female clinical psychology doctoral student aged 33 years old, trained in client-centered therapy (for 3 years) and in emotion-focused therapy (for 1 year). She received additional 24 weeks of training for the referred study (cf. Greenberg & Watson, 1998; Honos-Webb et al., 2003).

At the beginning of therapy, Sarah attributed her depressive symptoms to an increased social isolation and withdrawal. Further exploration of her difficulties in the first sessions of therapy uncovered three main intertwined problematic themes: 1) lack of

assertiveness and self-boundaries in interpersonal relations; 2) feeling fused with and manipulated by the men in her intimate relationships; and 3) feelings of being neglected, ignored and undermined as a person by her parents (and especially her father). In her daily activities these problems became apparent in her difficulty to make personal decisions, sometimes procrastinating over important activities and becoming excessively reliant on the approval of others. Her tendency to frequently dismiss her own desires and needs in regards to others lead her to sense a very low confidence in discerning her own choices and preferences. On top of this, whenever she followed her own feelings and intuitions, she frequently was distressed by self-doubt and guilt, becoming afraid of losing other people's appreciation. At the same time, she felt her social life becoming more and more restricted with an increasing sense of loneliness and difficulty joining new groups, along with social withdrawal. When talking specifically about significant romantic relationships (usually a former boyfriend and her ex-husband), Sarah usually talked about herself as the caretaker who freed these men from responsibilities, in order to let them develop their creative paths.

She linked the present difficulties with her social experiences growing up, both in school and with her family, emphasizing that she was always told to act politely and in consideration of other people's needs and suggestions, disregarding her own. Sarah talked about her family, as her mother always attending to her father's needs – he was the sole economic provider for the family and a very strict, conservative man in his appreciation of the societal role of women. In Sarah's perspective, her parents consistently ignored her needs and opinions, and later on, her vocational interests in an art career. Even at the present moment, her father was not supportive of her choices: moving to Canada,

divorcing her husband, pursuing art school (and not a more "feminine" professional field), always trying to dissuade her and encouraging her to come back to her country and settle down as a wife and mother. This, to Sarah, was like being undermined as a woman and invalidated as a resourceful individual.

Although the therapeutic tasks addressed the several dimensions of Sarah's presenting problems, our analysis here will focus on the main problematic theme that is being dealt with in therapy: namely, lack of assertiveness and self-boundaries in current interpersonal relationships. Our decision to follow the development of the main theme was taken for two main reasons: 1) its extension in the therapeutic conversation (it consists of 77% of the transcripts) and 2) to increase clarity in this presentation, by selecting excerpts related to the same problem.

Development of IMs in the case of Sarah: A general overview

The therapeutic process of Sarah was coded for the presence of IMs and their textual salience (number of words occupied by the IMs, compared to the total number of words in a session). Figure 2 represents the distribution of the textual salience of IMs throughout the treatment. Several aspects are worth noting. First of all, the types of IMs that appear earliest are reflection and protest, which keep rising in their salience from session 1 to 8. From then on, an irregular pattern becomes visible concerning the textual salience of IMs and the diversity of types present (sometimes becoming more limited than in the sessions before).

Insert figure 2

In a straightforward interpretation of the above graphic, we notice an increasing amplification in the diversity and textual salience of IMs until session 8, and also the emergence of a re-conceptualization IM in session 7 (being the predominant IM in session 8 – we will focus on this excerpt below). However, in clear contrast to this movement, session 9 presents a noteworthy fall not only in the overall textual salience but also in the types of IMs exhibited. Afterwards, several periods of remarkable increase followed by yet other decreasing periods lead us to claim that the evolution of IMs in Sarah's case indicates several progressive and regressive lines in the evolution towards narrative innovation. Figure 3 represents these progressive and regressive lines more clearly, by displaying the global salience of IMs.

Insert figure 3 here

We will now elaborate upon different excerpts of this case, trying to understand how reconceptualization IMs evolve and develop, reflecting the links with the progressive and regressive lines in the process.

Exploring the path to reconceptualization

Session 5 represents a major breakthrough in the therapeutic tasks, as Sarah agreed to perform the first empty-chair dialogue[3]. This happened as an attempt to work on

[3] Emotion Focused Therapy (or EFT) intends to facilitate the client's process of experiencing and exploration of core organismic needs, transforming maladaptive emotions into adaptive ones (Greenberg, 2004, 2006; Pos & Greenberg, 2007). This is accomplished by the integration of a client-centered relationship stance with more active interventions, derived from *Gestalt* therapy (e.g. Perls, Herline, & Goodman, 1951) and proposed after the detection of certain process markers. Some examples of such active techniques are the empty-chair and two-chair exercises. The first case is suited for the resolution of

lingering resentful feelings towards her father while performing an imaginary dialogue with him. This exercise can be considered a major instigator of the narrative changes she achieves in the following period, since it allowed her to understand and realize how her main difficulties (lack of assertiveness and social withdrawal) were related to a defensiveness towards others and an emotional blockage that were felt as needed while growing up in her family environment.

Thus, in the following sessions, Sarah was more able to reflect about her problems and tried to act differently. This potentiates a qualitative change in Sarah's IMs exhibited by the emergence of the first reconceptualization in session 7. For example, in session 6 Sarah began by reporting to her therapist that she tried to celebrate the Christmas holidays differently: rather than being alone, withdrawn and depressive as was usual throughout the festivities, she decided to invite some acquaintances that were, like her, far away from home, and hosted a small gathering to celebrate with them. In the exploration of the meaning of this exceptional experience, Sarah described what could be considered as a plan of new intentions and self-instructions to follow in order to achieve practical and positive changes in her daily life. Her therapist, in turn, amplified the meaning making movement and motivation towards change that occurs in this session and this reinforces Sarah to achieve some concrete changes, which are reflected ahead. We will

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an unfinished business with a negative other, that the client imaginatively sits in the empty chair and talks to, trying to express the hurt that was caused by the other person. In the second case, the two-chair exercises are more suited for situations when there is a highly critical part in the self that restricts the will of a more fragile part or interrupts its wishes (as a self-critical split or a self-interruption process). The goal becomes to put the different parts in dialogue and arrive at a mutual understanding (Greenberg, Rice & Elliott, 1993).

explore them as we focus now on the emergence of the first reconceptualization IM in session 7.

Sarah starts this session recognizing to her therapist that, even though some of the old difficulties are still present, some actual changes had actually been achieved during the week:

Excerpt 1: Session 7 – The first reconceptualization IM

Client (C): (…) [Reconceptualization IM, in italic, begins here] before it would get to the point where I would get up and kind of do really basic things and then take a lot of breaks and rest during the day and that… kind of, not really disappeared, it's just simply because I'm so busy, I don't have the chance… And I guess the sudden – well it was kind of gradual, I suppose – but it leaves me pretty tired for things, but it's kind of a nice change of things.

Therapist (T): So it's hard to get started but once you're into it, it keeps you moving through the day.

C: Yeah and I guess the thing really is that, if I'm on my own, I really let it go, let myself go, so I'm kind of trying to keep myself busy and involved, especially with other people. If I have to do something on my own at home, it's just really difficult to get a move on things and… Well, I don't know, it's just how it works right now.

T: So it sounds like you're trying to give yourself some structure… You know you have to be at certain places at certain times…

C: Yeah, that kind of puts that certain amount of… pressure is maybe not the right word but just, I'm aware of what's going on and what is the best way to deal with it. (T: Mm-hm.) So, that really helps… and also I'm kind of getting the hang of it… Like what makes me uncomfortable when I'm with other people… (T: Mm-hm.) And really try my best, as soon as I notice it, to deal

with it, to let them know that – no, this is not acceptable to me!, or – no, I can't deal with it for whatever reason but it's just too much and it works really well (laughs)

We notice here that the client reports more innovative actions happening during the week and begins to draw a contrast between her past usual functioning ("*before it would get to the point where I would get up and kind of do really basic things…"*) and her present functioning ("*so I'm kind of trying to keep myself busy and involved…"*). This is Sarah's first reconceptualization IM. In this IM, there is the acknowledgement of a self-discontinuity ("*it's kind of a nice change of things"*), although not the full acknowledgement of a rupture by the person (Zittoun, 2007), since Sarah still does not assume a complete identification with a new self-version, as evidenced by the instrumental nature of it. That is, at this point she has identified mere strategies to avoid feeling depressed (e.g. arranging commitments with others to be pushed to leave home and increase her level of activity). Nevertheless, this discontinuity starts building hope and positive feelings: "*a nice change of things"*.

The acknowledgement of this first self-discontinuity, however, emerges from an intense ambivalence intertwined all over the reconceptualization IM and after it. Several expressions illustrate quite well this ambivalence in the above example, like "*and that… kind of not really disappeared"*; "*it's just really difficult to get a move on things*." The therapist, attuned to Sarah, acknowledges these difficulties and tries to amplify and clarify the innovation achieved: note that she says "*it's hard to get started <u>but</u> once you're into it…"* This movement directs Sarah towards the further exploration of innovation and is paralleled by the client in her following intervention, though finished with some hesitation ("*<u>I don't know</u>, it's how it works right now."*). The therapist, then, tries to

amplify the recognition of these differences and how they are achieved, by eliciting an explicit elaboration upon what is different: more structure, increasing involvement. This intervention pushes Sarah to adopt a more abstract observer point of view towards her own reactions. She now recognizes her own attempts to become more familiar with this novel way of functioning ("*I'm getting the hang of it"*), reaffirming the need to become self-assertive ("*really try my best… this is not acceptable to me!"*) and reinforcing the positive feelings that accompany this new attitude. The therapist extends this movement of consolidation of novelty by paraphrasing and nominating the two things that *are* different – so that Sarah now adopts a more definitive appreciation of the changes. And Sarah also now recalls her values, goals and desires ("*really try my best, as soon as I notice it, to deal with it"*), renewing her motivation to keep changing ("*it works really well"*).

But at this point ambivalence re-appears in the conversation:

Excerpt 2: Session 7 – The first reconceptualization IM and after

C: [Reconceptualization IM continued from excerpt 1] *Even though it creates, at the time (some anxiety)… And then I think – okay, right now this is it. I have to do or say something, otherwise it's going to happen again and people are going to start wondering like what my problem is or, you know… So, I get kind of tense about it but then I say or do whatever it is and like, it's just… I can't believe how difficult I find it, to do this, to be assertive (T: Hmm.) about things…* [Reconceptualization IM, in italic]

T: So it feels like it shouldn't be so difficult.

C: Yeah because I feel kind of guilty about it. [that is, to be assertive] (T: Hmm-hmm.) For somewhere around a day almost, you know, like *I was entitled really to do this. (T: Hmm-hmm.)*

You know, such as – did I, did I hurt the other person? It's always like I'm more concerned about what I do to the other person than saying – well, this is me, I have to look at myself first, other people are doing it and I have to let them know where the limit is, that they do have to look for a different approach or that they definitely overstepped it. [Protest IM, in italic]

In this part of the conversation, Sarah starts to implicitly recognize the difficulties she had been feeling in regard to change ("*even though it creates, at the time"*). The therapist captures how poignant Sarah's ambivalence is, and acknowledges it, reflecting it towards her ("*it feels like it shouldn't be so difficult"*). Sarah appears here still very much engaged in her usual way of relating to others, labeling her discomfort feelings as *guiltiness* about self-empowerment. However, as soon as she expresses her guilt feelings, she immediately repositions herself in a more assertive way – as entitled – and dissuades her doubts ("*I have to look at myself first"*). These difficulties in being spontaneously assertive were immediately circumvented ("*right now, this is it"* –Josephs & Valsiner, 1998, call these discursive devices as circumvention strategies), interrupting her self-doubts and directing her, again, to self-assertion: "*I have to do or say something"*. The reestablishment of the movement towards change was also accomplished by another circumvention strategy that relied on an adversative conjunction ("*I get kind of tense about it <u>but</u> then I say or do whatever"*). In this process, she is progressively and gradually distancing herself from the problematic self-narrative, reinforcing an innovative alternative: a protest IM appears.

As we can see, this step forward towards self-assertion, that prompts innovation in the form of a protest IM, is achieved after a recursive movement – in a step back into her

old self – when she elaborates on her difficulties and ambivalence in pursuing her desired changes: "*I can't believe how difficult I find it…"* Her ambivalence can be illustrated as follows (figure 4).

Insert figure 4

In this first reconceptualization, even though there is a contrast between present (self-assertion) and past (passivity), there isn't yet a clear identification with a new self-narrative. This ambivalence is related to an oscillation between the old self-version and the new (yet not totally integrated) self-version. In our view, this excerpt illustrates – not a complete return to the problem – as it happens in mutual in-feeding –, but a recursive process that seems needed to boost and maintain the directionality towards change. Thus, we see the client moving – gradually – towards a distancing (or disengagement) from the problematic position and getting closer to a new self-assertive position. In other words, Sarah is not identifying herself anymore with the problematic narrative in this moment of the therapeutic process, but the identification with a new self-narrative (e.g. self-assertive) is not yet complete. In this sense, the ambivalence is not between problem and innovation (*I am insecure* vs. *I should be assertive*, as in the case of mutual in-feeding) but between innovation and the meta-reflection upon it: *I was able to be assertive* [innovative voice in the experiencing self] vs. "*I can't believe how difficult it is!"* [metaposition]. Nevertheless, although there is ambivalence felt at the level of the metaposition, the client does not seem to jeopardize her motivation towards change.

The emergent self-assertive position, since it is still new and unfamiliar, requires self-reflexivity and a lot of conscious effort in adopting a new behavioral attitude. Here, then, is a moment of highly noticeable inner-dialogicality. The expression of this ambivalence towards an accepting other (the therapist) seems also productive in order for Sarah to elaborate further her motivation to change – entailing a back and forth movement. Thus, the ambivalence that appears in this reconceptualization IM is then progressively dissolved in the therapeutic conversation as Sarah moves herself, more and more, to an identification with a new self-version, while being empathically understood by a therapist that is attuned to the difficulties implied by this transitional process. Thus, as soon as she revisits the past, she can then embrace more fully the future, in her present transitional journey.

This first reconceptualization IM and the following dialogue around it is, for us, an example of an important *scaffolding* process of development (Valsiner, 2005) that happens in the context of a socially constructed *zone of proximal development* (ZPD –a concept by Vygotsky, 1978, cited by Leiman & Stiles, 2001) towards change and innovation. The concept of ZPD derived from Vygotsky (1978), when applied to the field of psychotherapy, can be referred to the therapist's actions that globally aim to promote the client's development (cf. Leiman & Stiles, 2001; Ribeiro, Ribeiro, Gonçalves, Stiles, & Horvath, in press). In the dialogue that we analyzed from the excerpts above, it was actually the acknowledgment of the difficulties and the validation of Sarah's perspective (reaching the client at the level where she was) that we see as key in the resolution of this ambivalence and the reinforcement of the directionality towards change

The consolidation of reconceptualization: Working-through in the metaposition

We turn now to a reconceptualization that appears in session 10, trying to elaborate upon the evolution between reconceptualization IMs along the therapeutic process. We will focus essentially on how reconceptualization develops within the conversation and how it relates to Sarah's experience, contrasting this moment with the first reconceptualization that we analyzed previously. Sarah begins this session by reporting to her therapist that she has been committed to experiment with a more open social attitude, trying to connect with others. In turn, this more open attitude has generated some interesting and surprising experiences.

Excerpt 3: session 10

C: (…) *these barriers I mean, they are still there to a certain extent but it just seems to be much easier all of a sudden just talking to people, and with people I have known for sometime as well. I guess it depends on everybody including myself, like waiting at a bus stop or at a grocery store, it's just like: Let's see, you know, can I do this?* [Reflection IM, in italic, ends here] (T: Hmm.) And most of the time it's like people just want to talk, you know.

T: Yeah, you realize it works. […]

T: So people really respond and you're able to get things moving and make changes. (C: Yeah.) Almost like, one thing leads to another, kind of.

C: Yeah. And it definitely gives me, I don't know if I really want to call it a sense of control, [Reconceptualization IM, in italic, begins] *but it's like, with opening up, it creates more possibilities… And naturally – yes, there are still going to be times where people are going to say no and not respond to it – but it doesn't take me from the chances of meeting or running into people (…) whereas before I just wouldn't do anything and just limit myself severely.*

T: I think you're saying that before the risk that someone might not respond to you used to stop you from trying.[Therapist recapitulates the problematic voice, using indirect speech] *(C: Yeah, yeah.) And somehow now you say: Okay, maybe they won't respond but some will, and go with the positive.* [Therapist recapitulates the innovative voice, using active speech]

C: Yeah, yeah, yeah. Oh yeah, even though it's sometimes hard, I guess I like to talk to people and hear the no three times and then maybe at the fourth or fifth time you get finally a yes or they have the answer or a solution to it, but I just keep telling myself that it really helps.

T: So you tell yourself what… Keep persisting or just don't give up hope?

C: Yeah and don't feel bad about it. Like it doesn't have anything to do with myself, it's just whatever their circumstances are, they don't have the resources or something prevents them. They just can't, they probably want to but just leave it and don't try to force. I guess the major thing is also not trying to figure out all the reasons for it. (T: mm-hm.) Just: Okay the if, when, but… - who cares about it?!

T: That's okay.

C: Yeah, that's okay, exactly. Yeah.

*T: It sounds like a very important sort of way, a **new** step or something, that you don't take it on yourself or start feeling like: Oh, what did I do wrong? They don't like me! It's more like: Well, those were their circumstances and who knows about them?*

C: Exactly and then at the same time, I guess one of the things in the past is that I just really catered too much for other people and now when something comes up it's like: Do I really want to, do I really feel like it, does it really suit me? And also if it doesn't, then it is a no and that's it.

*T: So there's sort of a **new** stage where you might accommodate other people but you first stop and check out if that's really what you want to do?*

C: Yeah, if it really is okay with me, if it really suits me, yeah. [Reconceptualization IM continues further in the session]

In this case, we notice that the client starts by revisiting the past: her prior self-narrative in a reflection IM, but then immediately disengages herself from it through a circumvention strategy and emphasizes how easy it is now to behave differently ("*these barriers they are still there to a certain extent* <u>but</u> *it just seems to be much easier all of a sudden just talking to people"*). The therapist reinforces this movement towards innovation, trying to amplify the elaboration upon what has changed ("*you realize it works"*). This amplification is successful, since it triggers more elaboration and reflection at the level of the metaposition of the client, prompting a reconceptualization IM. At this point, Sarah has already identified herself with the new assertive self-position (in contrast with the first reconceptualization IM in session 7), and actively tries to establish the continuity through the self-rupture, integrating the contrast between past and present: "*yes there are still going to be times where people are going to say no and not respond to it* [past non-assertive self] <u>but</u> *it doesn't take me from the chances of meeting or running into people"* [present changed self]. Actually, this connection is what Brinegar, Salvi, Stiles and Greenberg (2006) call a meaning bridge. A meaning bridge expresses an understanding between opposites (e.g. contrasting affective experiences, opposing perspectives between self and other or between parts of oneself) and is considered a powerful semiotic tool to achieve self-integration and reconciliation in therapy (Brinegar et al., 2006).

We also note here again the important meaning making movement of recapitulating the past as a way to increase the contrast with the present and thereby, amplify it. This is what Sarah does during the reconceptualization IM and this contrast is again paralleled

and expanded by the therapist as she interprets Sarah's experiences. More specifically, the therapist uses here several strategies that help in the effort to consolidate novelty.

First, the therapist voices the problematic and innovative positions in several turns, shifting from the problematic voice to the innovative voice: "*you're saying that before the risk that someone might not respond to you used to stop you from trying.* [Therapist referring to the problematic position in passive speech] *And somehow now you say: Okay, maybe they won't respond but some will,* and *go with the positive."* [Therapist recapitulates the innovative position through active speech]. Second, the therapist introduces and calls upon higher order values – persistence and hope – linking them to change, the therapist also strengthens Sarah's efforts, framing current difficulties as opportunities and not anymore as obstacles to change. Third, as the therapist persists, dismissing the importance in the possibility of others' not responding to Sarah's attempts to increase social contact and become assertive, she adopts a repeated labeling process that pinpoints these events (i.e. "***new****"*) and several metaphors that qualify them ("*a new step"; "sort of a new stage").*

As Sarah agrees with her therapist, recapitulating the difficulties ("*even so it's sometimes hard…"*) and circumventing them ("*but I just keep telling myself that it really helps"*), the end result is the persistence in the elaboration around innovation. We consider the use of these circumvention strategies important here for the maintenance of the directionality and persistence towards change. This also helps to potentiate the work at the level of the client's metaposition, since Sarah recognizes that she is no longer wholly interested in accommodating other people and is now more focused on her own needs ("*if it suits me, yeah"*).

In the two reconceptualization IMs selected here (the first one from session 7 and another from session 10), we see how the client is faced with the need to recapitulate the past as a way to increase the contrast with the present, thereby allowing a meaning bridge that unites past and present self-narratives. This integration, accomplished through these therapeutic strategies and semiotic tools (like the establishment of meaning bridges) and through a mutual coordination in meaning making efforts around the elaboration and understanding of changes carried out by client and therapist, seem to be a crucial aspect in the innovation, rehearsal and development of a new identity.

Rethinking who I am: Sarah' self-doubts return

Until now, reconceptualization IMs are present consistently in relation to the main problematic theme since their emergence in session 7 (they frequently appeared several times within a single session). Session 9 is an exception to this path but somehow seems to preview the regressive line that develops from sessions 12 to 15 (see figure 2). This regressive line starts appearing mildly in session 12, associated to some negative events that happened to Sarah during the week, which were a topic for reflection in the therapeutic conversation. During both session 12 and 13, although Sarah is still capable of exploring meaning making in innovative fields, IMs are much more circumscribed than in earlier sessions (their textual salience drops by a half). In session 13, Sarah even begins by reporting to her therapist how she has been alternating between positive and negative periods. During these two sessions, several self-split empty experiential exercises were conducted with the aim of addressing her inner ambivalence between assertiveness and self-doubts. This emotional exploration and reflection seems to be powerful enough to

trigger reconceptualization IMs. Nevertheless, it is in sessions 14 and 15 that Sarah gives a wider expression to her ambivalent feelings and starts doubting the meaning of the changes appreciated up until then. In these two sessions, reconceptualization and performing change IMs do not appear at all (until the very end of session 15) and all IMs are materialized in the form of protest and reflection, similar to the phase prior to reconceptualization (i.e., before sessions 6 and 7). We will focus now on a specific excerpt from this period.

In session 15, Sarah begins by telling that she is feeling a bit negative but is not fully aware of the reasons why, partly because she tries not to think about it too much. During the session, her therapist tries to engage her in emotional exploration and self-reflection as a way to explore Sarah's feelings (a strategy called focusing in EFT – Greenberg et al., 1993). Sarah starts explaining how she has been trying to find a job more suited to her artistic interests and how she feels distressed and angry when other people do not support her wishes. Sarah and her therapist then explore how this anger is felt as not being recognized or validated by others, which in turn triggers Sarah's self-doubts about her own desires. Noting this self-conflict, her therapist proposes a dialogue with her inner critical part, where Sarah explores how her inner-criticisms frequently inhibit her to struggle for her own goals and pursue what she believes. Afterwards, Sarah and her therapist reflect upon these experiential exercises:

Excerpt 4: Session 15

T: But it seems like there's this really strong message whether it's from your father or from other people or something that you partly get and in your own mind as well because of your upbringing... All these messages of how you should be and sort of this thing about wanting too much for yourself... I mean, I guess where we got into today is what happens when you hear those

things... Is that you just sort of give up? You feel overwhelmed and you can't do any of those things?

C: Yeah, yeah... Well, I just thought that people really actually told me, to my face, that I'm never satisfied and with my mood swings, that I'm difficult... Well, that's not their words, but I'm saying that I'm difficult to control, but who wants to be controlled? *And that just makes me furious, you know, because you don't have to tell me this, like this is your problem, like this is the way I am and don't you tell me you are in a good mood all the time, you know... And if I'm not in a good mood and you can't cope with it, I don't expect you to talk to me or spend time with me, you know* [Protest IM, in italic, ends here]

T: You see, I think there's part of you that gets furious and says that's not true and I'm not like that, and there's another part that sort of buys the party line.

C: Oh yeah.

T: And I think that is maybe the struggle... (C: Yeah, yeah.) And at times when you feel the energy and to hell with them, you're up and doing stuff. Then at other times, it's like maybe they're right, maybe I can't or...

C: Oh yes, oh, yes, absolutely. **[**Reflection IM, in italic, mainly elaborated by the therapist, ends here**] (**T: yeah) Yeah, because I mean again that happened. Well, there was a time when two or three people, within a very short period of time told me all these things and it's just like "It must be true" (laughs) and it's just really difficult then to say **"**Oh, to hell with it, you know, I'm going to continue or do whatever I want to do"

T: It is difficult and we all have our own self-doubts and we want encouragement and when other people tell us one thing, we start to question ourselves... It sounds like you've been told from very young what your limits are and what they should be and it's hard to believe that you could – as a little child – say: I won't listen or I won't let it sink in...

C: Yeah, yeah, for sure **[**Reflection IM, in italic, mainly elaborated by the therapist, ends here**]**

T: Those things maybe did to some extent sink in and almost get re-activated when you hear things like that from other people or you sense things like that from other people.

C: Yeah, for sure, because I just don't know how to cope with it, I just can't generate this energy to overcome all these hurdles.

T: I think what we've started doing in the last few weeks and today and what we need to continue doing is really get a sense of what those messages are that get to you. (...) Even if we haven't solved how to get past them, it's very important to recognize what's happening at those times when you... you know, you said so clearly: I just have no energy to even turn on the computer, I just feel so drained and so hopeless and so...

C: Yeah. I have all these doubts about myself and about other people, so when people actually say and do certain things, I don't even realize at the time what triggers it... (T: Hmm-hm.) *I mean it has gotten better... In the past I didn't notice it at all, because it was just so engrained, but at least now, probably not all the time, but I feel that really a lot of times when things like that happen that I notice it. And even so maybe at the time I agree with the person and say: well, yeah, maybe I should do this... I don't find it too difficult to get back to them and say: By the way, no! And this is something that is really good because I don't feel too bad that I wasn't able to respond to it right away, I'm still able to make a point of getting back to them and almost like correcting the situation. (T: Hmm-hm.) And I just have to keep on working on this* (laughs) [Reconceptualization IM]

In this excerpt, we see a very active therapist, summarizing what was understood in the session and challenging the client to develop her insight about her present difficulties. The therapist begins by explicitly linking Sarah's internalization of negative messages from others while she was growing up, with her present self-doubts and lack of confidence. Her emphasis at this time appears to be on the promotion of insight through

the exploration of her experience during the problematic event and working at the level of the metaposition ("*All these messages of how you should be and about not wanting too much for yourself… You feel overwhelmed…"*). This fosters the emergence of a protest IM that seems to be important for reinstating again the directionality towards self-assertion: at this moment Sarah recognizes the injustice of not being validated and how her past still impacts the present. In the following turns, the therapist continues to expand reflection at the level of a metaposition, through a reflection IM that is mainly elaborated by the therapist. Afterwards, the therapist also frames the client's current difficulties and ambivalence towards change as something expected and understandable when taking into account her experiences while growing up ("*It sounds like you've been told from very young what your limits are and (…) it's hard to believe that you could – as a little child – say I won't listen or I won't let it sink in…"*)

This leads Sarah to a recognition of her difficulties and lack of resources to overcome this barrier – in a full return to the problem ("*I don't know how to cope with it because I just can't generate this energy to overcome that"*). In her turn, her therapist reinforces the emphasis in the direction of change by recapitulating their prior efforts, disconfirming Sarah's sense of incompetence and reaffirming the need to keep working on these issues, pushing towards innovation and change as something on the way. She demonstrates this with concrete examples of the past, assuming her client's voice to increase persuasion and accentuating what still needs to be done without complying with Sarah's discouragement.

We consider that these interventions from Sarah's therapist can be again considered as attempts to foster development within the ZPD – note how the therapist validates

Sarah's struggles and negative experiences but frames them in a positive way. The therapist aims to build hope by redirecting Sarah to keep her motivation to change when she emphasizes what has been already achieved and presenting difficulties as something to be expected and still to be worked upon, without discouragement. And this emphasis seems to be successful since Sarah picks up on this contrast towards the past, initiating a reconceptualization IM: "*It has gotten better... In the past I didn't notice it at all, because it was just so engrained, but at least now,* [circumvention strategy to diminish the importance of the past] *probably not all the time* [remnants of the old self-narrative], *but I feel that really a lot of times* [another circumvention strategy to devalue the past] *when things like that happen that I notice it"* [affirms present achievements]. This excerpt demonstrates that the process of Sarah's disengagement with the prior self-narrative and problematic position and identification with an innovative voice, where a changed self-narrative is being consolidated, as the conversation flows in this session: "*And this is something which is really good* [emphasis on the present innovative position and positive feelings associated to self-assertion] *because I don't feel too bad that I wasn't able to respond* [contrast with the old self-narrative] *(...) I'm still able to make a point of getting back to them and almost like correcting the situation"* [identification with a present self-assertive position]. Another example of the disengagement from the problematic position and an identification with the innovative position being rehearsed, could be: *"And even so maybe at the time I agree with the person and say: well, yeah, maybe I should do this*...[Problematic self-position being recapitulated] *I don't find it too difficult to get back to them and say: By the way, no!"* [Identification with the innovative self-position].

Sarah finalizes this reconceptualization IM with an important assumption that directs her motivation to persist and persevere in the path of change ("*And I just have to keep on working on this"*). The contrast that Sarah is able to make here between her past reaction towards the negative messages of others and the present doubt that she places on these messages reinstates a definite progressive line until the end of therapy.

What Can We Learn From Sarah?

This specific case study allowed us to observe some interesting processes taking place in the therapeutic encounter. It also offers several challenges for our theoretical understanding of the evolution of IMs. We will now try to integrate and synthesize the multiple observations that this case study originated.

Change is not a linear process, even after reconceptualization

We began this study with the notion that reconceptualization IMs have the ability to potentiate and amplify the construction of other IMs. Prior case studies had established that, when reconceptualization emerges, not only do we notice an increase in the overall salience of IMs, but also – and most importantly – there is an expansion of meaning making towards innovation that potentiates the disengagement from a previously dominant self-narrative. Thus, the notion of a progressive tendency in the construction of IMs had already been observed in prior case studies, emphasizing what usually happens after reconceptualization (Santos & Gonçalves, 2009).

However, in Sarah's case, we are also faced with regressive movements after the appearance of reconceptualization IMs. Actually, on more than one occasion there was a

decrease in the presence and diversity of IMs, as these regressive lines appear alternating with other progressive movements in the construction of novelty. This finding suggests that some clients may need to deal with the problem *through a recycling* of previous stages in therapy progression, as well as to deal with setbacks (e.g. negative life events) that can occur during the course of therapy (Brinegar et al., 2006). In Sarah's case, we noticed that several negative events appeared in her daily life during the treatment and these were frequently the object of the therapeutic conversation.

Of course, this irregular pattern can also be associated with a multifaceted problem. We believe this is consistent with Sarah's case since her problematic narrative was related to several problematic themes in the beginning of therapy and we consider that not all of them were fully dealt with in this process[4].

The role of recursivity in the consolidation of change

The succession of reconceptualization IMs seen here resembles more a spiral process of meaning making rather than a revolutionary process, in which the new suddenly substitutes de old patterns. Instead of a radical change, the evolution of reconceptualization IMs in Sarah's case proceeds within a back-and-forth, recursive movement. Not only does this process evidence a revisiting of the past but also shows that every time the past is revisited, it is more easily integrated in the present, accompanied by a fading-away of distress and uncertainty. More specifically, a

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These findings are also congruent with the saw-toothed pattern identified before by Brinegar et al. (2006) and characterized by several shifts in the progression towards the assimilation of problematic voices in an emotion-focused therapy case.

movement backward may be needed, on the one hand, to boost and amplify meaning making in the innovative field, and on the other, to rehearse meaning bridges between the problematic past and the more promising present and future. These meaning bridges need to be constructed and rehearsed several times, before they can be fully consolidated and carry out the integration of past experiences as personal resources in a new self-narrative (Brinegar et al., 2006).

Thus, recursivity and circularity do not need to be considered negatively – they can be precisely the necessary ingredients for the rehearsal of a new identity.

The transition to reconceptualization can be highly ambivalent

We can conceive the construction and growth of a new self-narrative as departing from this unit of analysis: *rupture – irruption of uncertainty – transition* (Zittoun, 2007). Hence, reconceptualization IMs seem to emerge precisely from these experiences of rupture and uncertainty and can be thought of as a particular way of meaning making derived from perceived ruptures in the self. Although we assumed that the notion of rupture is already implied at the core of the definition of a reconceptualization IM (given that the person has to contrast the self in the past and the self in the present), Sarah's case-study illustrates how distressing and extensively ambivalent this transition can be, even though it is in the direction of a desired state that is aimed by the client.

The selection and analysis of several moments of emergence of reconceptualization IMs was carried out precisely to understand further the work of a transitional process in the development of a new self-narrative. Sarah's case – because it was so ambivalent – slowed down this transition enough to allow the observation of the initial uncertainty and

the fading-away of these distressing feelings in the evolution of subsequent reconceptualization IMs, as they were being consolidated and validated within and outside therapy. We consider that the uncertainty and ambivalence signaled in this process derived from an initial disengagement of Sarah from her formerly dominant self-narrative, combined with the not yet achieved re-identification with a new self-narrative. We claim that until this re-identification is not carried out, the person can experience deep puzzlement, and will have trouble understanding who she is in the present, now that she is not the same person she was in the past. Sarah's case also shows that the reestablishment of a missing self-continuity through the identification with a changed self-narrative can be a tentative process, where the need to revisit the past and reconnect it to the present may require several rounds before it is fully consolidated and the person feels a new familiarity with it.

The development of a new self-narrative requires distancing and a metaposition

If there is such high distress involved in the emergence of these key IMs, we should ask: how come reconceptualization and subsequent IMs evolve further to a strengthened identification with a new self-narrative, instead of Sarah retreating into the old one? Changes are needed to maintain a certain kind of adjustment to the environment, but it doesn't mean that all changes are developmental (Zittoun, 2007). The paradox of mutual in-feeding is, to us, one example of non-developmental change: the person is flopping, or changing from position X to opposing position non-X, immediately getting back to the initial place. This repetitive process prevents further (qualitative) changes and

undermines the creativity of personal agency by keeping the person in the same state of affairs.

We argue that the development of a new self-narrative and a new way to conceive ourselves implies not only narrative changes, but also psychological development. The notion of development, however, originates from a teleological orientation. A developmental change, thus, is one that fosters further changes, allowing the agent to become more creative and flexible, and more easily able to adjust to the surrounding environment in the next future (Zittoun, 2006, 2007). So, it is this kind of change that we are aiming at when we are talking about the development of a new self-narrative and the role that reconceptualization plays in it.

We believe that psychological development happens in Sarah's case because the ambivalence seen in some reconceptualization IMs involves different levels of generalization of meaning. The ambivalence it is not occurring between the same level of the meaning making process as it occurs in the mutual in-feeding process (Valsiner, 2002), like in two opposing voices (*I want be happy* vs. *I feel miserably*), but between the experience in the self and a metaposition of it. More specifically, Sarah was distancing herself from her problematic experience (acting in a changed way) and commenting and reflecting about it as she developed this metaposition, observing herself in the situation. In other words, Sarah's ambivalence is not typically between two conflicting alternatives within the same level of experience (namely, uncertainty about being passive or assertive), like in a typical mutual in-feeding process. Instead, the ambivalence that we have noticed was between the metaposition and the experiencing self – in other words, it is an inter-level ambivalence. Furthermore, we hypothesize here that this type of

ambivalence can be potentially creative and developmental, while same-level ambivalence is not, since it leads only to redundant changes and not to developmental ones. We have hypothesized additionally that it is this meta-level, self-observing feature of reconceptualization IMs that gives the potential to make them developmental, while other types of IMs do not provide this.

Conclusion

Human development is an indeterminate, creative, sometimes recursive process of present enablement combined with a constraining of future possibilities, while continuously establishing bridges within personal history. We have argued here that human development as it is observed in psychotherapy, needs the recursive movement of revisiting the past to boost the construction of present meaning making directed to the future. In this domain, the process can be described as a spiral path towards psychotherapeutic changes – where evolution implies a succession of progressive and regressive movements that allow a consolidation of further transformations. In the case of reconceptualization IMs, the act of revisiting the past with the purpose of integrating it in a narration of the present seems to be a vital process for the reinstatement of a new self-continuity and the creation of a new self-narrative after a perceived rupture due to the disengagement with a former self-narrative. Moreover, the meta-reflective process implied and achieved by these narratives seems to be the result of conjoint therapeutic efforts in the dyad, particularly the therapist's induction of movement towards the expansion of meanings within the zone of proximal development of the client. In this sense, the therapeutic interaction seems to be a beautifully coordinated and improvised

dance between client and therapist, where each responds to the others cues and creatively engenders next moves and possibilities in meaning making.

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Table 1: Innovative Moments types and examples from Emotion-Focused Therapy

Types of Innovative Moments	**Examples from Emotion-Focused Therapy** (Problematic narrative: depression)
ACTION INNOVATIVE MOMENTS	
Action IMs refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.	*C: I actually took a step the other night and I let my husband know that I thought that my workload was a lot more that his was and that we should share our things more evenly.*
REFLECTION INNOVATIVE MOMENTS	
Reflection IMs refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.	*C: Yeah, because I think that this still affects me now a lot of times… Like I don't really have the courage to come forward with things because I just expect not being heard or people not to being able to relate to it or understand it. So, rather than trying, I'm just so afraid of getting the same treatment, the rejection that I just remain in the same mode I constructed back then.* *T: Right, so it's almost a general thing now – that's how you were treated then and now it's almost an expectation that that's how you'll be treated now?* *C: Yeah.*
PROTEST INNOVATIVE MOMENTS	
Protest IMs involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.	*C: I don´t like you gambling your money, because you work hard for it. I want you to put an effort on trying to solve your problems instead of just shoving them under the carpet or denying it.* *T: I want you to look at your problems.* *C: Yeah, I want you to look at your problems, I believe I´m doing my part and I want you to do yours!* *T: What do you feel towards him?* *C: There, there is a demand. Umm, I'm angry with him.* *T: Tell him about being angry.*

	C: Yeah, I´m mad at you. I´m mad at you!
RECONCEPTUALIZATION INNOVATIVE MOMENTS	
Reconceptualization IMs always involve two dimensions: a) a description of the shift between two positions (past and present) and b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.	*C: I've been, you know, just pretty well. Again, I'm more expressing my feelings now towards things, I find…* *T: Yeah, that's good.* *C: So that's a change for me.* *T: Yeah* *C: And it feels good after I do that because it's, it's important you know* *T: Yeah, you feel good when you do it* *C: Yeah, it should be expressed. I shouldn't have to hold all that in me, so that makes me feel more power, you know, more in control of things* *T: Yeah. So in general you feel more in control and* *C: yeah* *T: you're saying it's related to expressing your feelings.* *C: That's right, yeah. I've been feeling much less helpless or weak or* *T: Hh-huh. You feel stronger when you say what you want.* *C: Right, when I when I do that, yeah.*
PERFORMING CHANGE INNOVATIVE MOMENTS	
Performing change IMs refer to new aims, projects, activities or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.	*C: … but I was able to actually bring up the subject and talk to him about it, as before in the past I was afraid to say something because he'd take it the wrong way, or he'd take it as sort of an attack to him.* *T: So you're feeling kind of more freed up, it sounds* *C: Yes* *T: like to be able to bring up things with him* *C: mm-hm* *T: and talk about things. A lot more, kind of less afraid, less cautious about approaching him.* *C: Mm-hm, right.*

Figure 1: A heuristic model of psychotherapy change in the perspective of innovative moments (Gonçalves, Matos & Santos, 2009)

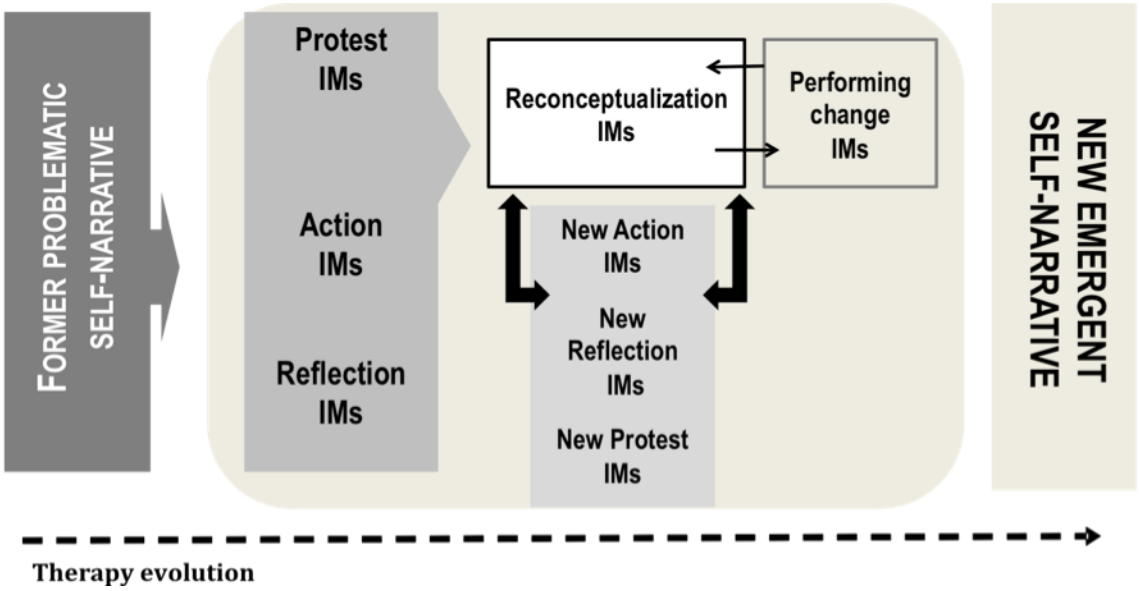

Figure 2: Distribution of the salience of IMs over the course of Sarah's therapy

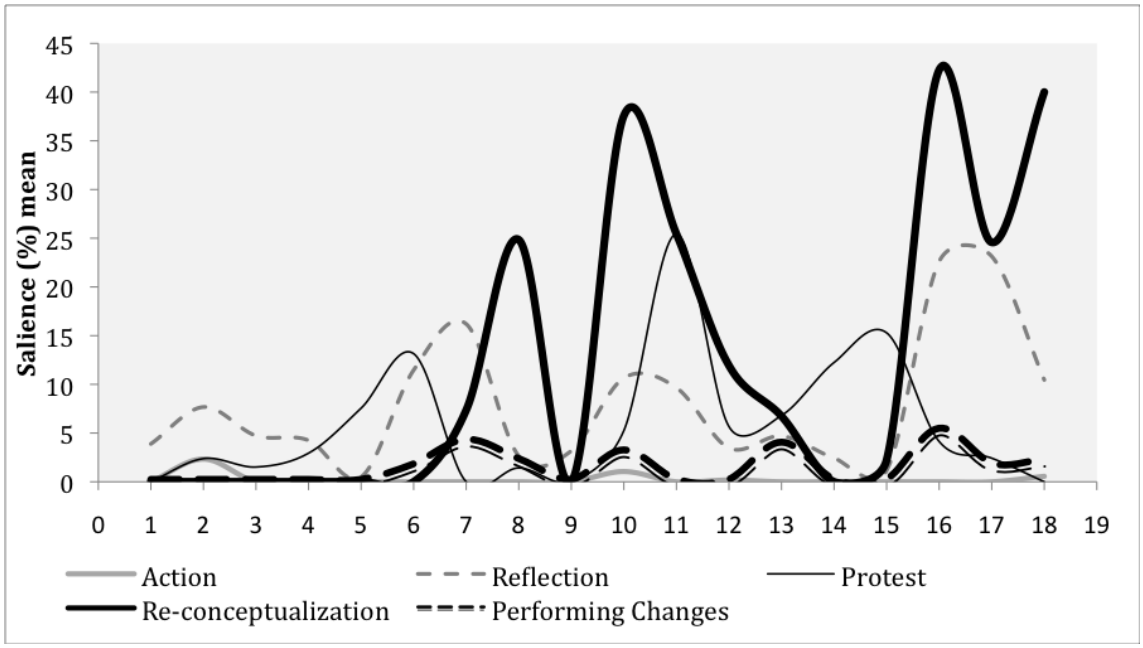

Figure 3: Global progression of IMs' salience in the case of Sarah

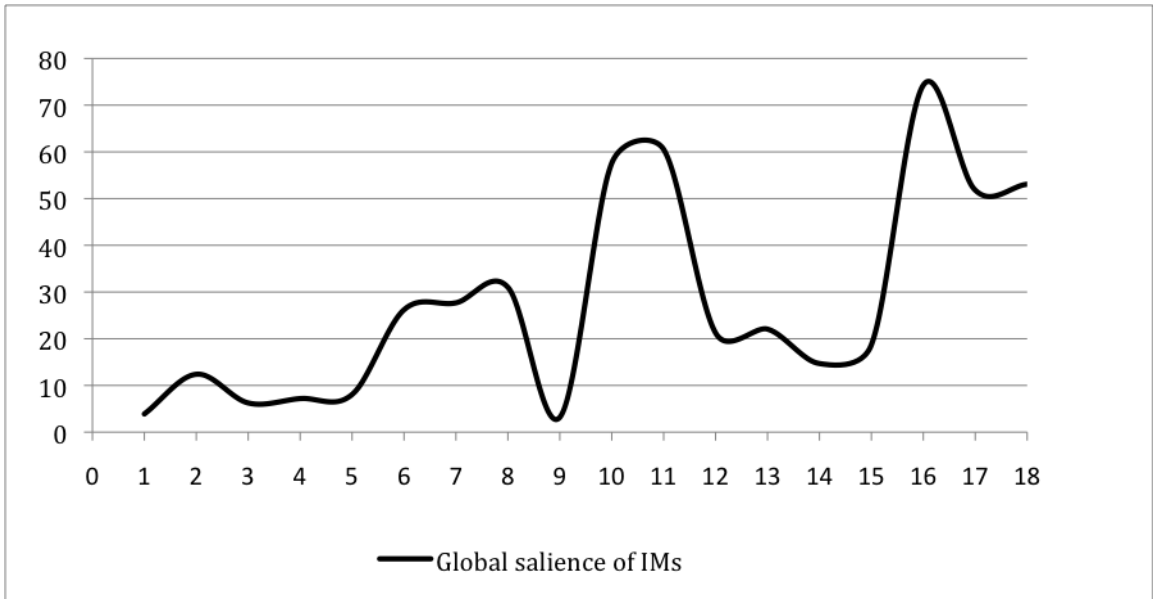

Figure 4: Ambivalence in Sarah's first reconceptualization IM