Universidade do Minho
Escola de Psicologia

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Maintenance and Transformation of Self-narratives in Brief Psychotherapy: Theoretical and Empirical Advances

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Maintenance and Transformation of Self-narratives in Brief Psychotherapy: Theoretical and Empirical Advances

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Professor Doutor William B. Stiles

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MAINTENANCE AND TRANSFORMATION OF SELF-NARRATIVES IN BRIEF PSYCHOTHERAPY: THEORETICAL AND EMPIRICAL ADVANCES

ABSTRACT

This dissertation addresses the question of why people do not change. Specifically, one possible path to therapeutic failure is explored: how problematic self-stability can be maintained, throughout therapy, by a *mutual in-feeding* process, a form of ambivalence characterized by a cyclical movement between two opposing parts of the self: the client's *dominant self-narrative* (usual way of understanding the world) and *Innovative Moments*, which are moments in the therapeutic dialogue when clients challenge their dominant self-narrative. In order to understand (1) how IMs remain captive in the process of ambivalence and (2) also how they develop into a successful outcome (overcoming ambivalence), a set of systematic studies were conducted and presented in this dissertation. The first study tested our narrative-dialogical model of self-stability. We identified *Return-to-the-Problem Markers* (RPMs), which are empirical indicators of the ambivalence process, in passages containing IMs in 10 cases of narrative therapy (five good-outcome cases and five poor-outcome cases) with females who were victims of intimate violence. The poor-outcome group had a significantly higher percentage of IMs with RPMs than the good-outcome group. The results suggest that therapeutic failures may reflect a systematic return to a dominant self-narrative after the emergence of novelties (IMs). The second study investigated the ambivalence process in six cases of major depression treated with emotion-focused therapy (three good-outcome cases and three poor-outcome cases), replicating and extending the first study. Good and poor groups presented a similar overall proportion of IMs containing RPMs. Results contrasted with narrative therapy study in which IMs were much more likely to be followed by RPM in the poor outcome. However, good and poor outcome groups presented different trajectories across treatment: the probability of RPMs decreased in the good outcome group, whereas it remained high in the poor outcome group, corroborating that therapeutic failures may reflect a systematic return to a dominant self-narrative after the emergence of novelties (IMs). The third and forth studies aimed to further the understanding of how IMs progress from ambivalence to the construction of a new self-narrative, leading to successful psychotherapy. The research strategy involved tracking IMs, and the themes expressed therein (or *protonarratives*), and

analyzing the dynamic relation between IMs, protonarratives and RPMs within and across sessions using state space grids in a good-outcome case of constructivist psychotherapy. The concept of protonarrative helped explain how IMs transform a dominant self-narrative into a new, more flexible and less prone to ambivalence, self-narrative. The increased flexibility of the new self-narrative was manifested as an increase in the diversity of IM types and of protonarratives, as well as by a decrease in the proportion of RPMs. Results suggest that new self-narratives may develop through the elaboration of protonarratives present in IMs, yielding an organizing framework that is more flexible than the dominant self-narrative. The fifth and last study used the *Therapeutic Collaboration Coding System* (TCCS), a qualitative coding system developed to micro-analyse the therapeutic collaboration, which we understand as the core of the alliance. With the TCCS we code each speaking turn and assess whether and how therapists are working within the client's *Therapeutic Zone of Proximal Development* (TZPD), defined as the space between the client's actual therapeutic developmental level and their potential developmental level. This study focused on the moment-to-moment analysis of the therapeutic collaboration in instances in which a poor-outcome client in narrative therapy expressed ambivalence. Results showed that ambivalence tended to occur in the context of challenging interventions, suggesting that the dyad was working at the upper limit of the TZPD. When the therapist persisted in challenging the client after the emergence of ambivalence, the client moved from showing ambivalence to showing intolerable risk. This escalation in client's discomfort indicates that the dyad was attempting to work outside of the TZPD. Our results suggest that when therapists do not match clients' developmental level, they may unintentionally contribute to the maintenance of ambivalence in therapy.

ESTABILIDADE E TRANSFORMAÇÃO DE AUTO-NARRATIVAS EM PSICOTERAPIA BREVE: CONTRIBUIÇÕES TEÓRICAS E EMPÍRICAS

RESUMO

A presente dissertação centra-se nos processos que bloqueiam a mudança em psicoterapia. Especificamente, explora-se um processo potencialmente envolvido no insucesso terapêutico: uma forma de ambivalência, entendida como um ciclo oscilatório entre a *auto-narrativa dominante* do cliente (i.e., a sua perspetiva habitual acerca da realidade) e os *Momentos de Inovação*, entendidos como eventos em que o cliente desafia esta auto-narrativa. Trata-se, pois, de um processo de *retro-alimentação* entre duas posições antagónicas do *self*. De forma a compreender (1) de que modo o potencial de mudança dos MIs é bloqueado pelo processo de ambivalência e, pelo contrário (2) como estes se transformam numa auto-narrativa bem sucedida (ultrapassando a ambivalência), conduziu-se um conjunto sistemático de estudos que compõem esta dissertação. No primeiro estudo, testou-se o nosso modelo narrativo-dialógico de estabilidade identitária. Para tal, identificámos *Marcadores de Retorno-ao-Problema* (MRPs), enquanto indicadores empíricos do processo de ambivalência em 10 casos de terapia narrativa com mulheres vítimas de violência na intimidade (cinco casos de sucesso e cinco casos de insucesso). O grupo de insucesso apresentou uma percentagem global de MIs seguidos de MRPs significativamente mais elevada do que o grupo de sucesso. Este resultado sugere que o insucesso terapêutico pode envolver um retorno sistemático à auto-narrativa dominante, imediatamente a seguir à emergência de novidade (MIs). No segundo estudo, investigou-se o processo de ambivalência em seis casos de terapia focada nas emoções no tratamento da depressão (três casos de sucesso and três casos de insucesso), replicando e expandindo o primeiro estudo. Ao contrário do que se verificou no estudo com terapia narrativa, neste estudo os grupos de sucesso e insucesso apresentaram uma percentagem equivalente de MIs seguidos de MRPs. Contudo, os dois grupos apresentaram trajetórias diferentes ao longo do tempo: a probabilidade de MRPs decresceu no grupo de sucesso, mas manteve-se inalterada e elevada no grupo de insucesso. Este resultado corrobora o pressuposto de que o insucesso terapêutico pode estar associado à persistência da ambivalência ao longo do tratamento. Nos terceiro e quarto estudos, procurou-se perceber como é que os MIs progridem da ambivalência para a construção de uma auto-narrativa alternativa,

traduzindo-se num sucesso terapêutico. A estratégia de investigação envolveu a identificação de MIs, dos temas por estes expressos (ou *protonarrativas*) e de MRPs, bem como na análise da interação dinâmica entre estes três processos, através do *state space grids* num caso de sucesso de terapia construtivista. O conceito de protonarrativa ajudou a explicar de que modo a emergência de MIs transformaram a auto-narrativa dominante numa auto-narrativa alternativa, mais flexível e menos propícia à ambivalência. O aumento da flexibilidade da auto-narrativa alternativa manisfestou-se no incremento da diversidade de MIs e protonarrativas, bem como no decréscimo da proporção de MRPs. Os resultados sugerem que a auto-narrativa alternativa se desenvolve através da elaboração das protonarrativas presentes nos MIs, oferecendo um nova perspetiva ou enquadramento mais flexivel do que a auto-narrativa dominante. No quinto e último estudo, utilizou-se o *Sistema de Codificação da Colaboração Terapêutica* (SCCT), um sistema de codificação qualitativo desenvolvido para micro-analisar a colaboração terapêutica, entendida como a dimensão central da aliança. O SCCT envolve a codificação momento-a-momento das falas to terapeuta e do cliente, permitindo avaliar se a díade terapêutica está ou não a trabalhar dentro da *Zona de Desenvolvimento Proximal Terapêutica* (ZDPT), definida como o intervalo entre o nível de desenvolvimento presente do cliente e o nível de desenvolvimento que pode, potencialmente, atingir com a ajuda do terapeuta. Este estudo focou-se na análise da natureza e qualidade da colaboração terapêutica nas interações subsequentes à emergência de ambivalência. Os resultados mostraram que a ambivalência emergiu, maioritariamente, no seguimento de intervenções em que a terapeuta desafiou a perspetiva habitual da cliente, indicando que a díade estava a trabalhar no limite superior da ZDPT. Os resultados mostraram, ainda, que a terapeuta tendeu a responder à ambivalência da cliente com um novo desafio, sendo que a cliente tendeu a invalidar a intervenção da terapeuta, indicando que esta se encontrava fora da ZDPT. Deste modo, quando a terapeuta persistiu no desafio verificou-se, frequentemente, uma escalada no desconforto da cliente e uma deterioração da qualidade da relação terapêutica. Tal sugere que, quando a terapeuta não respeita o nível desenvolvimental do cliente, tende a contribuir inadvertidamente para a manutenção da ambivalência.

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INTRODUCTION

INTRODUCTION[1]

> "Psychotherapy is a laboratory as well as treatment... It offers a more intimate access to human experience than does almost any other arena" (Stiles, 1999, p.1).

One of the most striking finding in the history of psychotherapy research is the so-called *equivalence paradox* – the apparently equivalent effectiveness of different therapies in contrast to the apparent nonequivalence of their processes (Elliott, Stiles, & Shapiro, 1993; Luborsky, Singer, & Luborsky, 1985; Shapiro, 1995; Stiles, 1982; Stiles, Shapiro, & Elliott, 1986; Rosenzweig, 1936). This contradiction presents a dilemma to researchers and practitioners. Numerous possible solutions have been suggested. One account of such findings, which I personally espouse, challenges the seeming differences among treatments, arguing that, despite superficial technical diversity, all or most therapies share a common core of therapeutic processes (Duncan, Miller, Wampold, & Hubble, 2010). My starting point, as a researcher, was one of these elements: the telling and retelling of stories within the therapeutic context (Angus & McLeod, 2004; see also Stiles & Sultan, 1979).

This dissertation is a collection of interrelated studies carried out within the *Innovative Moments* (IMs) research group at the University of Minho (Portugal), from September 2008 to June 2012. My search is not so much for new discoveries as for clear

[1]Segments of this section appear in:

- Gonçalves, M. M., & Ribeiro, A. P. (2012). Narrative processes of innovation and stability within the dialogical self. In H. J. M. Hermans, & T. Gieser (Eds.), *Handbook of Dialogical Self* (pp. 301-318). Cambridge: Cambridge University Press.
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- Ribeiro, E., Ribeiro, A. P., Gonçalves, M. M., Horvath, A. O., Stiles, W. B. (in press). How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy: Theory, Research and Practice*.

ways to understand what I have seen and heard (Stiles, 1999) and for development of more sophisticated and sensitive ways to measure change (Muran, 2002). In order to better understand this research work and its evolution, I use this introduction section to globally frame the research conducted on IMs.

This introduction comprises five sections. I start by clarifying my theoretical background, offering a brief description of two powerful ideas: *self-narratives* and *dialogical self*. I then discuss my perspective with regard to change, presenting the notions of *dominant self-narrative* and IMs. The *Innovative Moments Coding System* (IMCS), its methods and finding are the target of the third section of this introduction. The fourth section explores one possible path for therapeutic failure – a form of ambivalence I refer to as *mutual in-feeding* (Valsiner, 2002) – which is the main target of analysis in the following studies. Finally, the fifth and last section of this introduction describes my paradigmatic underpinnings and presents the several aims and research questions that motivated the following five studies, preparing the reader for the succeeding chapters.

1. SELF-NARRATIVES AND DIALOGICAL SELF

The *narrative metaphor* suggests that "persons live their lives by stories – that these stories are shaping of life, and that have real, not imagined, effects – and that these stories provide the structure of life" (White, 1991, p.28). Persons' lived experience is rich and only a part of our multitude experiences get incorporated into the stories we enact with each other (Freedman & Combs, 1996; White & Epston, 1990). In fact, organizing experience through narratives entails a process of selection and synthesis of life experience (McAdams, 1997). By this process, based upon one's personal past, people construct a macro-narrative (Angus, Levitt, & Hardtke, 1999) or a meta-narrative (Osatuke et al., 2004), that is, a self-told life story by which the events narrated—micro-narratives—"come to be articulated, experienced, and linked together" (Angus et al., 1999, p. 1255).

The notion of self-narrative bears resemblances to analogous concepts in other theoretical approaches. For instance, Frank and Frank (1991) suggests that humans have an intrinsic need for making sense of the world and for that purpose an assumptive system is constructed. Similarities may also be found with the concept of the cognitive schema in cognitive therapy (Beck, 1976), defined as a "cognitive structure for

screening, coding, and evaluating the stimuli that impinge on the organism" (p. 233). From a psychodynamic perspective what Luborsky (1997) refers to as a Core Conflictual Relationship Theme (CCRT) also has similarities with the notion of self-narrative. As Luborsky suggests, the method for extracting a CCRT "is based on the principle that *redundancy* across relationship narratives is a good basis for assessing the central relationship pattern" (p. 59, italics added). Finally, in constructivist therapies, core constructs are defined as abstract and frequently universalized meanings which have critical organizing roles as regards the entirety of our construct systems, ultimately embodying our most basic values and sense of self (Kelly, 1955; Mahoney, 1991).

The process of self-narrative construction is dialogical in the sense that a self-narrative, as Hermans and Hermans-Jansen (1995) have clearly shown, is not the result of an omniscient narrator, but the result of the dynamic interplay between the positions of the self, or *I-positions*, which organize the self at a given moment. The co-existence of various I-positions enables the elaboration of different personal meanings towards the very same experience (Hermans & Kempen, 1993). These I-positions are continuously activated and brought to the foreground as relevant "voices" which give meaning to the current experience. Along these lines, the person is construed as a "multivoiced" active agent who can transcend the here-and-now, acting as if he or she were another (for instance, the client's mother) (Hermans, Kempen, & van Loon, 1992) and imaginatively moving "to a future point in time and then speak to myself about the sense of what I am doing now in my present situation" (Hermans, 1996, p.33).

These several I-positions may then animate inner and outer dialogues, in which several "voices" can be heard and give meaning to the current experience. In sum, self-narratives are the outcome of dialogical processes of negotiation, tension, disagreement, alliance, and so on, between different voices of the self (Hermans & Hermans-Jansen, 1995).

2. NARRATIVE-DIALOGICAL CHANGE IN PSYCHOTHERAPY

2.1. Problematically dominant self-narratives

In accordance with the *Assimilation Model* (Honos-Webb & Stiles, 1998; Stiles, 1999), voices represent traces of the person's experiences or ways of being in the world. Constellations of similar or related experiences become linked or *assimilated* and form a *community of voices*. The community is experienced by the person as their usual sense of self, personality, or center of experience.

Along these lines, people become vulnerable to distress and are likely to appear for therapy if their dominant community of voices is bound together by a self-narrative that is too rigid and systematically excludes significant experiences because they are not congruent with it. From the community's perspective, voices representing experiences that are discrepant from how a person typically perceives him or herself are problematic, and the community of voices wards off, distorts, or actively avoids such voices (Stiles, 1999, 2002; Stiles, Osatuke, Glick, & Mackay, 2004). Although such avoidance can prevent or reduce the distress in the short term, the experiences remain unassimilated and unavailable as resources, so from a clinician's perspective, the dominant self-narrative is problematic.

Dialogically, clients come to therapy because their self-narratives are characterized by an asymmetrical relationship between the different voices involved. There is a voice or a coalition of voices that tries to totalize the interchange (Cooper, 2004), insisting on telling the same story over and over again. It is this redundancy that constitutes the problematic nature of the dominant self-narrative, given that other possible voices, some of them more viable for the current situation, are silenced or rejected. The result of this type of voice arrangement mirrors an attempt to refuse the dialogical nature of existence and communication (Linell & Marková, 1993).

A rigid self-told life story's content is usually "unhelpful, unsatisfying, and dead-ended" and "do[es] not sufficiently encapsulate the person's lived experience" (White & Epston, 1990, p.14). Neimeyer, Herrero and Botella (2006) refer to this type of problematic self-narratives as dominant narratives, in the sense that there is a restriction in the meanings framed by the self-narrative. In such cases, they originate applications of general rules (such as self-devaluation in depression) to the daily life context, becoming restrictive of clients' experiences, given that the same theme keeps repeating itself. Dominant self-narratives emerge in the client's dialogue, usually by the emphasis

on a main theme that can be a specific problem or a problematic situation, or even a set of recurrent themes.

As stated by Hermans and Hermans-Jansen (1995), a problematic self-narrative is a "narrative reduced to a single theme" (p. 164). Obviously, not all forms of dominance are problematic. Most of the time the self is stabilized around a type of dominant narrative, which is flexible enough to allow other narrative accounts to subsequently come to the foreground. By dominant narrative, Neimeyer et al. (2006) are referring to a kind of dominance that precludes any flexibility and other narrative accounts to play a role in the person's life. This is akin to what White and Epston (1990) designates as problem-saturated narrative, in the sense that the problematic story totalizes the self, making other possible narrative accounts invisible. Thus, from now on we use the term dominant narrative, implying this problematic facet, which results from the lack of flexibility and excessive redundancy. In previous work, Gonçalves and co-workers have often used the term *problematic self-narrative* to refer to clients' dominant self-narrative. In this dissertation, however, I prefer to characterize these self-narratives by their role in binding the community together rather than by their value from an external perspective, though, indeed, the dominant self-narratives we chose to study seemed problematic from our perspective.

2.2. Innovative moments

As Bakhtin (1984/2000) suggested, the attempt to suppress the other (external or internalised) is never totally accomplished, given the dialogical nature of existence (Gonçalves & Guilfoyle, 2006; Salgado & Gonçalves, 2007; Valsiner, 2004). Thus, internal (and external) voices are not inert and devoid of agency. They refuse to be treated as objects. They can be temporarily silenced but they are still there, and power unbalances may occur that bring these silenced voices from the background to the foreground (Hermans, 2004). According to this view, dominant self-narratives can be challenged by the emergence and amplification of situations that contradict the undesirable dominant story. These situations yield *unique outcomes* (White & Epston, 1990), which Gonçalves and co-workers call IMs. Those aspects of lived experience that fall outside of the dominant story, which tend to be trivialized or ignored when problematic stories are dominant, constitute a potential "entryway for inviting people to tell and live new stories" (Combs & Freedman, 2004, p. 144) that enable them to

perform new meanings which they will "experience as more helpful, satisfying, and open-ended" (White & Epston, 1990, p. 15).

From a dialogical standpoint, IMs are opportunities for new voices to emerge and to tell their own stories, different from the dominant self-narrative (Gonçalves et al., 2009), or for problematic or unassimilated voices to move from the background to the foreground. Such problematic voices may, then, be assimilated through psychotherapeutic dialogue by building *meaning bridges*, i.e., words or other signs that can represent, link and encompass the previously separated voices and thereby form a new configuration (Stiles, 2011).

Along these lines, change in psychotherapy occurs as clients move from a dominant maladaptive self-narrative, i.e., ways of understanding and experiencing that are dysfunctional since they exclude important internal voices to a more functional self-narrative, one that incorporates the previously excluded problematic voice. Functional self-narratives are meaning bridges that organize and interlink disparate life experiences, providing orderly and smooth access to them (Osatuke, et al., 2004; Stiles, 2011).

3. INNOVATIVE MOMENTS CODING SYSTEM (IMCS)

In this section I present a coding system that allows researchers to track IMs throughout the psychotherapeutic process. Moreover, I present data that supports the validity and reliability of this coding system, which offers researchers a tool that transcends particular therapeutic approaches and allows for in-session changes (see Orlinsky, Rønnestad, & Willutzki, 2004) to be detected from the transcripts or audio/video recordings.

IMCS allows identification of IMs in contrast to the previous problematic pattern that brought the client to therapy. For example, if depressive functioning was identified as a previous problematic pattern and was the target of the therapist's and client's efforts to produce change, whenever this pattern is disrupted or challenged and a new pattern emerges it is treated as an IM. More specifically, if the previous pattern of functioning is characterized by devaluation of own needs and privileging others' wishes (e.g., "there's a lot that makes me feel like I'm a bad person. And I've just got to keep on trying, just accept him [husband] the way he is and just shut up"), an IM would include all the times the person values his or her own needs, emerging in the form of thoughts,

actions or feelings (e.g., “I don't want to live like that anymore, I want to be able to enjoy life, to let out my feelings and thoughts… I deserve that”). Thus, an IM occurs every time the problematic pattern is challenged and a new way of feeling, thinking, and/or acting emerges that is different from what one might expect given the previous functioning.

IMCS allows the tracking of IMs which emerge during therapeutic sessions; for instance, as insight is being developed (in psychodynamic therapy) or as a new pattern of emotional processing is being elaborated (as with chair work in emotion-focused therapy). It also allows the tracking of IMs that have occurred outside the therapeutic session, as when novelties that have taken place between sessions are discussed and reflected upon in the therapeutic session. Either way the IMs are identified in the therapeutic discourse, including both client’s and therapist’s conversations, on the assumption that they are co-constructed in the therapeutic interaction (Angus et al., 1999). IMs can result indirectly from a statement of the therapist (e.g., a question, an interpretation), as long as the client accepts it; they can result directly from the therapist's invitation to elaborate a novelty; or they can even be elicited directly by the client without any therapist’s intervention. The main point here is that both therapist and client are active contributors to the emergence of novelties. The therapist makes efforts to produce change, but the client is also an active partner, often producing IMs without therapist interventions (Bohart & Tallman, 2010).

As I explain below, Gonçalves and co-workers identify the dimensions of the dominant self-narrative as a list of problems, very close to the client’s discourse. This makes the IMCS flexible enough to be adapted and used in a wide variety of individual psychotherapies, since the definition of the problematic pattern and the contrasting novelties are inferred from what therapists and clients discuss in therapy and are not inferred from the theoretical perspective of the researcher.

3.1. Types of IMs

Five possible categories of IMs were previously identified inductively, based on the analysis of psychotherapy sessions of women who were victims of intimate violence, followed in narrative therapy (Matos, Santos, Gonçalves, & Martins, 2009). From this original study, the IMCS was applied to depressive clients followed in narrative therapy (Gonçalves, 2012a), cognitive-behavioral therapy (Gonçalves, 2012b), emotion-focused therapy (Gonçalves, Mendes, A. P. Ribeiro, Angus, & Greenberg,

2010; Mendes et al., 2010) and client-centered therapy (Gonçalves et al., in press). The system has been changed in several ways, but the main five types are still those, which emerged in the original sample. Below, a definition of each IM is provided, along with a clinical vignette to illustrate them. For the purpose of clarity, all vignettes are from a hypothetical client diagnosed with major depression accompanied by severe social isolation.

1. *Action IMs* are actions or specific behaviors that counter the problem or which are not congruent with the problematic pattern (or dominant self-narrative). These actions have the potential to create new meanings.
2. *Reflection IMs* consist of the emergence of new understandings or thoughts that do not support the problem or are not congruent with the problematic pattern.
3. *Protest IMs* are moments of confrontation and defiance toward the problematic pattern, which can involve actions, thoughts, and feelings. They imply the presence of two positions: one that supports the problem (entailed by other persons and/or an internalized position of oneself), which can be implicit; and another one that defies or confronts the first one. They involve proactivity and personal agency on the part of the client, assuming a strong attitudinal position of rejection of the former problematic pattern.
4. *Reconceptualization IMs* imply a kind of meta-reflection level, from where the person not only understands what is different in him or herself, but is also able to describe the processes involved in the transformation. This meta-position enables access to the self in the past (problematic self-narrative), the emerging self, as well as the description of the processes, which allowed for the transformation from the past to the present. In reconceptualization IMs, the perception of a transformation is narrated, clarifying (1) the process involved in its emergence and (2) the contrast between that moment and a former problematic condition.
5. *Performing change IMs* refer to the anticipation or planning of new experiences, projects, or activities at the personal, professional, and relational level. They can also reflect the performance of change or new skills that are akin to the emergent new pattern (e.g., new projects that derive from a new self version). They describe the consequences of the change process developed so far such as, for instance, acquiring new understandings, which are viewed as useful for the future or new skills that were developed after overcoming the problematic

experience. The coding of performing change implies the presence of a marker of change, that is, the client has to narrate the perception of some meaningful transformation.

In order to systematize the procedures of IMs coding, the IMCS was developed. The IMCS is a qualitative method of data analysis, which was developed for studying psychotherapy change. It can also be applied, however, to understanding life change processes, such as change in specific life transitions, daily change, or adaptation to a new health situation (see Meira, Gonçalves, Salgado, & Cunha, 2009) for application to personal change outside psychotherapy). It can be applied to qualitative data, namely discourse or conversation, such as therapeutic sessions, qualitative or in-depth interviews, and biographies, predominantly in video/audio systems or transcript support.

3.2. Reliability and validity of IMCS

In this section, results obtained so far with the IMCS are summarized in two different topics: (1) reliability of single cases and samples studied so far and (2) findings on criterion, convergent and divergent validity.

3.2.1. Inter-judge Reliability

Studies using IMCS showed a good reliability of the coding system across therapeutic models and diagnoses (or problems). The average percentage of agreement ranged from 84% to 94% and the average *Cohen's k* ranged from 0.80 to 0.97, showing a strong agreement between judges (Hill & Lambert, 2004).

3.2.2. Validity

3.2.2.1. Criterion validity. Studies developed with the IMCS were performed with small samples contrasting good and poor outcome cases, and intensive single-case studies (Pinheiro, Gonçalves, & Caro-Gabalda, 2009; A. P. Ribeiro, Gonçalves, & E. Ribeiro, 2009; Rodrigues, Mendes, Gonçalves, & Neimeyer, in press; Santos, Gonçalves, & Matos, 2010; Santos, Gonçalves, Matos, & Salvatore, 2009). Despite the small number of cases, 543 sessions of psychotherapy from different therapeutic models were studied.

The samples studied so far include women who were victims of intimate violence, treated with narrative therapy (N = 10; Matos et al., 2009), and major depression, treated with emotion-focused therapy (N = 6; Mendes et al., 2010), and with client-centered therapy (N = 6; Gonçalves et al., in press). The commonalities between these

studies support the criterion validity of IMCS. First, IMs emerge in both good and poor outcome cases, which suggests that IMs occur in unsuccessful as well as in successful cases. However, despite the emergence in both good and poor outcome cases, the salience [proportion of the session occupied by IMs] is very different in these cases, being significantly higher in the study with narrative therapy (Matos et al., 2009) and in the sample of emotion-focused therapy (Mendes et al., 2010). This suggests that good outcome cases tend to elaborate more IMs than poor outcome cases (the exception being the study with client-centered therapy; Gonçalves et al., in press). Moreover, in all three samples there were differences between good and poor outcome cases in two types of IMs: reconceptualization and performing change IMs appeared with higher salience in good outcome cases and hardly emerged at all in poor outcome cases, or have a residual presence. These differences were statistically significant in the three studies. These differences are the only ones that distinguish good from poor outcome cases, which suggests that the differences obtained in the narrative therapy and in the emotion-focused samples in the global IMs are owed to higher salience in these two specific IMs. Finally, reconceptualization and performing change tend to appear in all studies in the middle of the treatment and increase salience at the end of it in good outcome cases. From these common results, most of which were also replicated in several case studies conducted with the IMCS, Gonçalves and co-workers have devised a model of IMs development and change in brief psychotherapy that assigns a central role to reconceptualization and performing change IMs (Gonçalves et al., 2009).

3.2.2.2. Convergent validity. Two studies support the convergent validity of IMCS, one that compared the IMCS with the *Assimilation of Problematic Experiences Scale* (APES; Stiles et al., 1990; Stiles, 2002) and another that compared the IMCS with the *Generic Change Indicators* (Krause et al., 2007). In the first study, Pinheiro, Gonçalves and Caro-Gabalda (2009) compared the coding done with APES with the coding from IMCS in one case of Linguistic Therapy of Evaluation (Caro, 1996). The coding with IMCS was done without any knowledge of the previous coding with APES. APES comprises a progression as a series of eight stages, numbered from zero to seven, that describe the kind of dialog that occurs between the problematic voices and the community, from the warded-off stage (in which the client is unaware of the problem, the problematic voice being warded off from the community of voices that constitutes the self), to a mastery stage (in which the previously problematic voice is fully assimilated by the self and constitutes a resource to deal with life situations). According

to the results obtained so far with the IMCS it would be expectable that action, reflection and protest IMs would be associated with lower levels of APES, whereas reconceptualization and performing change would be associated with higher stages. This prediction is based on the findings reported above that suggest that reconceptualization and performing change occur later in successful treatment and that these IMs are almost absent in poor outcome cases. Moreover, a study done with APES (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006) shows that stage four is reached in good outcome cases, but not in poor outcome cases. Thus, for APES the level four is a marker of success, while in the IMCS the marker of success is the emergence and development of reconceptualization and performing change IMs. Consistently with what was expected, action, reflection, and protest IMs were more associated with levels two and three of APES, whereas reconceptualization and performing change were more associated with levels four to six of APES. These findings support the idea that reconceptualization and performing change are more developed or complex IMs.

The second study compared the coding of IMCS with that of the Generic Change Indicators model (Krause et al., 2007) that describes an ideal sequence of successive changes, in which level of complexity increases progressively and that begins with the "Acceptance of the existence of a problem" and ends with the "Construction of a biographically grounded subjective theory of self and of his or her relationship with surroundings" (p. 677). Martínez, Mendes, Krause, and Gonçalves (2009) compared the coding done by the two systems in a case of psychodynamic long-term therapy. The coding of the generic change indicators (Krause et al., 2007) had already been done and 70 episodes of change were identified with this system. In 48 of the 70 there was at least one type of IM, which means that a statistically significant association exists between both. Moreover, results also show a connection between the more elaborated IMs and the generic change episodes that correspond to a higher level of complexity (mainly level two) according to the Generic Change Indicators.

3.2.2.3. Divergent validity. Martínez et al. (2009), in the case reported above, also studied episodes of alliance rupture, that were coded according to Eubanks-Carter, Muran, Safran, and Mitchell (2008). The episodes of rupture on the therapeutic alliance are a disruption in the process of intersubjective negotiation, where both participants distance themselves from or confront each other, creating a moment of failure in the communication between them, preventing therapeutic change from occurring (Safran & Muran, 2000). Of the 26 episodes of rupture that were identified, IMs only appear in

two of them. This finding suggests that a negative association exists between the emergence of IMs and the presence of alliance ruptures, that is, alliance ruptures, as expected, are not moments in which novelties could be elaborated.

3.3. Heuristic model of change

From these studies, our research team (see Gonçalves et al., 2010) developed a heuristic model of change, which posits reconceptualization as a central feature of successful psychotherapy. According to this model action, reflection and protest IMs emerge in the beginning of the therapeutic process, starting the development of novelty emergence. However, the emergence of reconceptualization in the middle and late phase of the therapeutic process is central in developing and sustaining meaningful change. Two central features of reconceptualization are nuclear in this process: it establishes a contrast between the former self and the innovative position and it allows for an access to how this transformation between the former and the new position occurred. Thus, reconceptualization posits the person as an *author* of the change process, given the access to the process of change, from a meta-position (Dimaggio, Salvatore, Azzara, & Catania, 2003; Hermans, 2003). By doing so, reconceptualization allows us to give coherence to the other more episodic IMs, namely action, reflection or protest, shaping a new narrative of the self. Performing change, which appears usually after reconceptualization represents the expansion of the change process to the future.

3.4. Final Remarks

IMCS has proved its flexibility up to now insofar as it has been applied to different models of therapy and different samples, such as clients diagnosed with major depression or victims of intimate violence. At the onset of its use, one important question was if it could be applied to models of therapy, which did not entail a narrative framework, given that the concept of IM was clearly rooted in narrative therapy. The possibility of using it with different models of therapy, in which the therapist uses different techniques from the ones prescribed by narrative therapy, is a major asset of this system. In fact, this flexibility is not so unexpected, given that, independently of the theory that organizes the therapist's behavior, all therapists wish to create and sustain novelties in clients' lives.

One interesting finding from the research using IMCS is the common pattern of results obtained in different samples. As stated before, regardless of minor differences

between the samples studied, the major findings are similar, regardless of the type of therapy and even the diagnosis. This suggests that, although therapists use different therapeutic techniques, IMCS allows the identification of a common path of change in brief therapy. These commonalities between therapies support the perspective of common factors (Norcross & Goldfried, 2005; Wampold, 2001) or common principles (Castonguay & Beutler, 2006) in psychotherapy, which asserts that factors or principles shared by all psychotherapies are the main processes through which change takes place. The samples studied are very small and these findings should be regarded with caution, but simultaneously the congruency of findings in several samples and case studies gives cause for some confidence in these results.

So far, IMCS has mainly been used with brief individual therapy and we do not know if this system is applicable to long psychotherapies and to couple (see Jussila, 2009 for a pilot study with couple therapy), family or group therapy. Other exploratory studies could target these possible domains of application in the future. Also, so far, we do not have any studies with patients with disturbances of axes II (DSM-IV, APA, 2000) or highly disturbed patients (e.g., psychotic, eating disorders). Future studies should also address other forms of validity, like construct validity, through exploratory and confirmatory factor analysis, to improve the robustness of IMCS. Another line of research could address the causal relations between IMs and other changes in psychotherapy. So far the research design has been correlational (comparing good with poor outcome cases), but it is important to discover if IMs predict symptom changes, self-narrative changes (e.g., differences in autobiographical narrations from the beginning to the end of therapy), or both.

4. MAPPING SELF-NARRATIVE DEVELOPMENT: INTRODUCING THE CONCEPT OF PROTONARRATIVE

Within the narrative framework, the idea that narrative development is a multidimensional activity that extends through several organizational levels with different characteristics and functions is receiving increasing attention (e.g., Salvatore, Dimaggio, & Semerari, 2004). Globally, these proposals suggest a hierarchy from micro to molar levels of different narrative structures.

IMs are micro-narratives in the sense they are not full-fledged narratives yet according to usual criteria for what constitutes a complete narrative, as required by

narrative theorists (e.g., Mandler, 1984). It has been suggested that the reconstruction of a person's self-narrative, which Neimeyer (2004) defined as 'an overarching cognitive-affective-behavioural structure that organizes the "micro-narratives" of everyday life into a "macro-narrative" that consolidates our self- understanding, establishes our characteristic range of emotions and goals, and guides our performance on the stage of the social world' (pp. 53–54), depends on the structure of relations between IMs, rather than on the mere accumulation of IMs (Gonçalves et al., 2009). Therefore, I am particularly interested in looking at how these novel micro-narratives get extended as they aggregate around themes; that is, how clusters of IMs create a pattern, which we call alternative *protonarrative*. Protonarratives are aggregates of micro-narratives in developmental transition, and the ongoing process of transformation, in which antenarratives are in the process of becoming macro or self-narratives, should be highlighted. Thus, it is more the process of sewing narrative threads, which tie together different micro-narratives, creating intermediate and unstable forms.

Protonarratives are not self-narratives yet and they precede the emergence of new self-narrative. These alternative protonarratives are usually noticeable by the emergence of recurrent themes, different from the ones present in the problematic narrative.

From my perspective, alternative protonarratives are an *emergent quality* of patterns of IMs and encapsulate their latent power to promote change. The distinction between protonarratives and the micro-narratives or macro-narratives is only dependent on a developmental look of the process. Thus, it is a processual distinction and not a formal distinction—it is more a matter of how, instead of a matter of what.

I am interested in the dynamic processes between problematic self-narrative IMs, protonarratives and new emergent self-narratives. It is my hypothesis that several protonarratives may emerge in a given psychotherapeutic process. Some of them may develop into a new self-narrative, others may disappear. Besides, I propose that IMs and protonarratives in a given case may interact with each other in different ways, throughout the process, leading to different outcomes in terms of self-narrative reconstruction. The alternative self-narrative may emerge from the dominance of a specific protonarrative. Instead, it can also emerge from the coalition or interaction between of two or more protonarratives.

Hence, I have developed a research strategy to track the alternative protonarratives and analyse their development throughout time. In two of the following studies, I will briefly present my research strategy, its potential and findings.

5. INNOVATIVE MOMENTS AND PROBLEMATIC SELF-STABILITY

What processes block the path of successful psychotherapy in poor outcome cases? Why do the poor outcome cases fail to follow the pattern of increasing duration of IMs and the development from action, reflection and protest IMs into reconceptualization and performing change, in the middle and late phases of therapy?

Answering these questions involves taking into consideration IMs potential to generate discontinuity and uncertainty, given that every innovation disrupts the usual, taken-for-granted meaning-making processes. In fact, as Abbey and Valsiner (2005) suggest, "all development is inherently based on overcoming uncertainty" (paragraph 14). When a system is disrupted by a significant modification, discontinuity is generated and the system must be rearranged or modified until relative stability is found again (Zittoun, 2007).

Accordingly, Hermans and Dimaggio (2007) have pointed out that although "uncertainty challenges our potential for innovation and creativity to the utmost" it also "entails the risks of a defensive and monological closure of the self and the unjustified dominance of some voices over others" (p. 10).

In this section, I further discuss this defensive movement facing innovation. Sometimes, the emergence of IMs leads the self to restore its sense of continuity from the uncertainty, promoting stability and blocking self-development, which in psychotherapy results in unsuccessful outcome.

Each IM can be construed as a microgenetic *bifurcation point* (Valsiner & Sato, 2006), in which the client has to resolve uncertainty, i.e., the tension between two opposing voices – one expressed in the dominant self-narrative and the other expressed in the emerging IM. The client has to choose the *direction* of meaning construction, which according to Valsiner (2008) can entail either *semiotic attenuation* or *semiotic amplification.*

Semiotic attenuation would refer to the minimization, depreciation or trivialization of a particular innovative way of acting, feeling or thinking, that is, the maintenance of the old patterns. Inversely, semiotic amplification would refer to the expansion of a given innovative way of acting, feeling or thinking, creating an opportunity to change and development to occur. This represents the permanence of the non-dominant (innovative) voice in the foreground, rejecting the control of the dominant voice. Looking at the therapeutic change as a developmental process, I argue

that this microgenetic process, i.e., choosing between IMs attenuation and amplification at each bifurcation point may influence ontogeny by promoting change or protecting stability. This choice depends on the dialogical relations between the dominant voice(s) and innovative ones at a given moment and on the dialogical encounter with an *other* – the therapist.

Frequently, in poor outcome cases, as well as in initial and middle phases of good outcome cases, clients tend to resolve the discontinuity created by the emergence of an IM, by attenuating its meaning, making a quick return to the dominant self-narrative. This may result in the disappearance of a particular innovative way of feeling, thinking, or acting, reinforcing the power of the dominant self-narrative and, thus, promoting self-stability. By doing so, clients temporarily avoid discontinuity, but do not overcome it, as the non-dominant voice continues to be active and, thus, IMs emerge recurrently. Hence, each new IM is a new opportunity for a new attenuation through the return to the dominant self-narrative. In some cases, this struggle between the dominant self-narrative and the IMs keeps going on, during the entire psychotherapeutic process. Here, there are two opposing wishes (expressed by two opposing voices): to keep the self stable, avoiding discontinuity and the uncertainty generated by it; and to change, avoiding the suffering which the dominant self-narrative most of the times implies. When novelty emerges, the person resolves the problem of discontinuity by returning to the dominant narrative. When the client feels too oppressed by the dominant self-narrative, he or she resolves this problem by trying to produce novelty, but of course this poses the problem of discontinuity once again. Thus, the self is trapped in this cyclical relation, making ambivalence impossible to overcome within this form itself. This mirrors a form of stability within the self, in which two opposite voices keep feeding each-other, dominating the self alternatively, which Valsiner (2002; see also Gonçalves et al., 2009) has coined as *mutual in-feeding*.

Mutual in-feeding allows the maintenance of the persons' *status quo* (i.e., the maintenance of the dominant self-narrative) and, thus, might be conceptualized a form of resistance to change. The concept of resistance emerged within psychoanalytical theory (Beutler, Moleiro, & Talebi, 2002). For instance, Greenson (1967, as cited in Mahalik, 1994) observed that "resistance opposes the analytic procedure, the analyst, and the patient's reasonable ego. Resistance defends the neurosis, the old, the familiar, and the infantile from exposure and change" (p. 77). Since then, the concept of resistance has been adapted by other psychotherapy models, such as cognitive-

behavioral therapy (namely Ellis's, Burns's and Beck's models; cf. Leahy, 2001), gestalt therapy (cf. Hengel & Holiman, 2002), and family systems theories (cf. Nichols & Schwartz, 1991), each having its own theory of resistance and how to work with it (Arkovitz & Engle 2008).

My perspective, congruent with the constructivist conceptualization of resistance (Ecker & Hulley, 1996; Feixas, Sánchez, & Gómez-Jarabo, 2002; Fernandes, Senra, & Feixas, 2009; Kelly, 1955; Mahoney, 1991), suggests that "resistance" is almost inevitable as the "desire to change are often countered by fears that change will led to unpredictable and uncontrollability compared with the safety and predictability of the *status quo*" (Arkovitz & Engle, 2007, p. 176).

In the following studies, it is not my intention to fully address why clients "resist" change, but to draw attention to the narrative-dialogical processes involved in the maintenance and transformation of self-narratives in psychotherapy and the way I have been empirically observing them.

6. NARRATIVE CHANGE AND THERAPEUTIC COLLABORATION: A NEW CONCEPTUAL AND METHODOLOGICAL APPROACH

Grafanaki & Mcleod (1999) pointed out that existing narrative approaches to therapy have not given enough attention to the role of the client-therapist relationship in enabling the client to construct a life narrative. In order to fill this gap, I propose a new conceptual and methodological approach, which will be the target of this section.

Therapeutic alliance is "incontrovertibly the most popular researched element of the therapeutic relationship today" (Norcross, 2010, p. 120). Strength of the alliance is arguably the best and most reliable predictor of outcomes (Horvath & Bedi, 2002; Horvath, Del Re, Fluckinger, & Symonds, 2011; Horvath & Symonds, 1991; Norcross, 2002; Wampold, 2001) and is generally considered one of the most important common factors in therapy (Lambert, 2004; Norcross & Goldfried, 2005; Wampold, 2001). It has been argued that the alliance, at its core, is best understood as the quality and strength of the collaborative relationship between client and therapist (Hatcher & Barends, 2006).

Definitions of collaboration differ across theoretical accounts (Horvath et al., 2011) but each formulation captures the elements of shared responsibility for deciding treatment goals and planning activities, active involvement with the therapist's pro-posals, compliance and participation in therapy tasks, and affinitive, cooperative, and

engagement behaviours (Boardman, Catley, Grobe, Litle, & Ahlumalia, 2006; Colli & Lingiardi, 2009; Tyron & Winograd, 2002). Safran and Muran (2000, 2006) argued that it is conceptually more helpful to think in terms of negotiation rather than collaboration, since "the idea that the alliance is negotiated between the therapist and patient on an ongoing basis highlights the fact that the alliance is not a static variable that is necessary for the therapeutic intervention to work but rather a constantly shifting, emergent property of the therapeutic relationship" (p. 288). Similarly, Hatcher (1999) emphasized, collaboration is "a joint achievement of the therapeutic dyad, an emergent property that depends on the effective meshing of individual patient and therapist contributions, contributions to which it cannot however simply be reduced [to one side of the therapeutic dyad]" (p. 418, emphasis added). My view of collaboration captures both Safran and Muran's and Hatcher's uses of the notion of emergent property.

In a literature review on therapeutic collaboration, Lepper and Mergenthaler (2007), referred to several studies that 'suggest that there is a specific quality of communicative action that is of particular clinical value' (p. 557) such as the process of coordination (Westerman, 1998), or complementarity (Tracey, 1993). But, the authors highlighted, 'exactly what happens at the level of the turn-by-turn interaction between therapist and patient remains understudied' (p. 557). In order to fill this gap, Lepper and Mergenthaler (2007) developed an analytical strategy to study the therapeutic interaction that integrated the *Therapeutic Cycles Model* (Lepper and Mergenthaler, 2005, 2007; Mergenthaler, 1996) and *Conversation Analysis* (e.g., Sacks, Schegloff, & Jefferson, 1974). Using this strategy they found, in a series of case studies, a correlation between topic coherence, as a marker collaborative rapport, and periods of affective and cognitive engagement (Lepper & Mergenthaler, 2005, 2007, 2008). In accord with Lepper and Mergenthaler (2007), I argue that it is important to focus on the interactive microprocesses involved in the development of collaboration and its contribution to client's change. I suggest that understanding how collaboration moves the therapy forward requires a conceptual framework that integrates the dialectical work that fosters collaboration with a model of how clients make progress in therapy. A. P. Ribeiro and co-workers present such a conceptual framework. In addition, they developed a coding system – the *Therapeutic Collaboration Coding System* (TCCS; E. Ribeiro, A. P. Ribeiro, Gonçalves, Horvath, & Stiles, in press) – to analyse and track the interaction between therapist and client on a moment-by-moment basis. The goal in developing the

TCCS was to provide a reliable means to assess the ongoing work of therapy in terms of our model.

TCCS conceptual and methodological approach to assessing collaboration makes use of the concept of the *Therapeutic Zone of Proximal Development* (TZPD; see Leiman & Stiles, 2001). The TZPD is an extension of Vygotsky's (1924/1978) concept of the *Zone of Proximal Development* (ZPD). Briefly, the TZPD can be understood as a region within a developmental sequence that clients pass through in successful therapy. From this perspective, therapeutic work is productive when the therapy dialogue takes place within the client's TZPD. Therapeutic interventions within the TZPD are likely to succeed, whereas interventions outside it are likely to fail. The TZPD itself shifts to higher levels as therapeutic progress is made.

Clients usually come to therapy with a limited tolerance or capacity for experiencing the world in alternative ways, and therapists seek to provide a climate in which new experiences or IMs can be tolerated and considered. Accordingly, therapeutic activities are conceptualized as having two main components. First, therapists seek to support their clients and help them feel safe. This usually involves communication of an understanding and accepting of the client's experience within his or her usual perspective (the client's currently dominant but maladaptive self-narrative). Second, therapists may challenge the dominant self-narratives, promoting the occurrence of IMs and revisions in clients' usual perspectives. These components of interactive collaboration are ideally maintained in a dynamic balance within the therapeutic relationship; that is, the therapist must work within a zone in which the client not only feels safe, but is also able to experience IMs. Too much emphasis on safety may overlook opportunities for revision of the dominant self-narrative, whereas too much emphasis on challenge may stimulate excessive anxiety, fostering resistance.

7. INTRODUCING THE CURRENT STUDIES

7.1. Anchoring paradigms

Ponterroto (2005) highlights the complexity of locating a particular qualitative approach in one specific paradigm given that "qualitative researchers often act as *bricoleurs*[2] in achieving their research goals" (p. 134). So, authors frequently use tools,

[2] Denzin and Lincoln (2000) define bricoleur as a "Jack of all trades or a kind of do-it-yourself person [who deploys] whatever strategies, methods, or empirical materials are at hand. (...) If new tools or techniques have to be invented, or pieced together, then the researcher will do this" (p. 4).

instruments and/or methods from several paradigms in the same study. In his review of 49 qualitative studies that appeared in the *Journal of Counselling Psychology* from 1989 to 2003, Ponterroto (2005) found that 19 were based upon a hybrid of post-positivism and constructivism.

I recognize myself as a *bricoleur*, insofar as I embrace the tensions between my constructivist roots and my commitments to post-positivism. The following studies aimed at bringing together "the descriptive depth and richness of constructivist qualitative methods with the post-positivist reliance on interpretative agreement" (Hill, Knox, Thompson, Williams, Hess, & Ladany, 2005, p. 197).

Therefore, in terms of a philosophical assumption about research, the following studies fall somewhere between post-positivism and constructivism. I illuminate this paradigm blend (Morrow, 2005) using Ponterotto's (2005) five constructs of ontology, epistemology, axiology, rhetorical structure, and methods in a similar manner to Hill and colleagues (2005) regarding Consensual Qualitative Research (CQR).

As regards ontology (i.e., the nature of reality), I am largely post-positivist. I am firmly planted in a realist ontology coined by Stiles as the *experiential correspondence* theory of truth (Stiles, 1981, 2005). According to this position, "observations and descriptions of observations, insofar as they represent human experience, they are approximate, fallible, and variable across time and people" (Brinegar, Salvi, Stiles, & Greenberg, 2006, p. 165). Nevertheless a given statement can be conceived as true "to the extent that the experience of hearing it corresponds to the experience of observing the events it describes" (Brinegar et al., 2006, p. 165). On the other hand, "statements may be considered as facts if, additionally, there is agreement – social consensus – that they are accurate" (Stiles, 2005, p. 58). Along these lines, "a good theory, then, is one consistent with the facts, that is, with agreed descriptions of observations" (Stiles, 2005, p. 58).

Hence, "the implication is that there is one true proximal reality, rather than multiple equally valid realities" (Ponterroto, 2005, p.133) – as proposed by constructivist perspectives. By the same token, I rely on inter-judge reliability via the use of multiple judges in an attempt to identify a single proximal reality.

In terms of epistemology (i.e., the relationship between the participant and the researcher), I am guided by constructivist assumptions, as I use empathy with participants as an observation strategy. In order to study meanings through coding verbal data, researchers "must understand what the speaker meant" (Stiles, 1993, p.

595), thus "we use our (imperfect) understanding of participants' reports of inner experience (thoughts, feelings, beliefs, perceptions, intentions) as data and may make inferences about participants' experiences based on observed behavior and circumstances. Empathic understanding draws on the investigator's own experience and self-knowledge and on intersubjective meanings shared within a society, as well on participants' speech and behavior" (Stiles, 1993, p. 595). Nevertheless, there is not a "mutual construction of meaning" (Morrow, 2005, p. 253) since I do not engage with the participant in a deep relation. Thus, I would classify my epistemology as "constructivist with a hint of post-positivism" (Hill et al., 2005, p. 197).

Moving on to axiology (i.e., the role of the researcher's values in the research), I acknowledge that researchers' biases do influence the analysis and the interpretation of the data, and thus I "endeavor to disclose these biases and report how they may have influenced the analysis" (Hill et al., 2005, p. 197). This represents a constructivist perspective, although my endeavors not to let researchers' biases overly influence the results also highlight my latent post-positivist tendencies. Hence, on the axiology continuum, the following studies falls between constructivist and post-positivist paradigms.

Regarding the rhetorical structure (i.e., language used to present the research to the intended audience), I am to some extent post-positivist in that I report data in the third person and I seek to be objective, remaining close to the data. However, I strongly agree that "verbatim passages preserve the richness of the phenomenon being studied and honor clients' words" (Brinegar et al., 2006, p. 169). Thus, I ground my interpretations with extensive quotes that capture the lived experience – *Erlebnis* (Morrow, 2005; Ponterroto, 2005) – of the participants, as in constructivist perspectives. Therefore, I would classify the rhetorical structure of the following studies also as falling between constructivism and post-positivism.

Finally, regarding our methods, I endeavor to "uncover meaning through words and text" (Hill et al., 2005, p. 197), which involves being immersed over time in the participants' world. This approach represents a constructivist perspective. Besides, I do not use experimental or quasi-experimental methods. Nevertheless, I code sessions into categories that do not change from participant to participant. Furthermore, I use inter-judge reliability as a way of offering readers the assurance that several investigators "who were familiar with the raw data found the proposed interpretation convincing"

(Stiles, 1993, p. 612) and I use quantitative methods to triangulate results. Thus, the methods of this dissertation lie midway between constructivism and post-positivism.

To sum up, I may classify the following studies as post-positivist – constructivist. Although, as in other research programs such as CQR (Hill et al., 2005), "individual studies may vary in where they fall along this continuum" (Ponterroto, 2005, p. 133). For instance, I have studies in which samples are compared (which are clearly situated more in the post-positivist pole) and intensive case studies, which use fine-grained analysis (which leans toward the constructivist pole).

7.2. Current studies

The analysis of IMs is still a molar level of understanding change, providing for information similar to a series of a few snapshots taken across a wide span time (Siegler, 1995). From this level, I have constructed more molecular levels of analysis, which enables capturing the movie-like continuous flow of information (Siegler, 1995) underlying IMs development. These methods aim at understanding how IMs are amplified and differentiated from the dominant self-narrative; or, on the contrary, how they are absorbed by it, attenuating the innovative potential that they have for change. I used both hypothesis-testing designs and theory-building case-studies (Stiles, 2009).

The first study's goal (Chapter I) was to shed light on problematic self-stability. I sought to assess whether mutual in-feeding contributes to maintaining the dominant self-narrative. This study was pioneering in measuring mutual in-feeding by if clients' respond to IMs by returning to the dominant self-narrative (i.e., responding with *Return-to-the-Problem's Markers* – RPMs). I expected that in poor-outcome cases, the potential for IMs to create narrative diversity would be prevented by the rapid return to the dominant self-narrative (Santos et al., 2010; Santos & Gonçalves, 2009). In good-outcome cases, on the other hand, IMs should be elaborated, with relatively fewer RPMs, at least in the later stages of therapy (A. P. Ribeiro et al., 2009). Convergently, reconceptualization IMs and performing change IMs, which tend to occur in the late stages of good-outcome cases, seem less likely than other IM to support RPMs. I examined three hypotheses in this study: first, that poor-outcome cases present a higher percentage of IMs with RPMs; second, that the percentage of IMs with RPMs decreases throughout therapy in good-outcome cases but not in poor-outcome cases; and third, that action, reflection and protest IMs present more RPMs than reconceptualization and performing change IMs.

In order to clarify if mutual in-feeding is in fact a common process in unsuccessful psychotherapy, I investigated RPMs in six cases of emotion-focused therapy (three good-outcome cases and three poor-outcome cases), with depressive clients, previously analyzed with the IMCS by Mendes et al. (2010), replicating a previous research that analyzed how IMs developed in Narrative Therapy (NT) with women who were victims of intimate violence. This study is presented in Chapter II.

In Chapter III, I present a study that set out to map self-narrative reconstruction in a good-outcome case. I used State Space Grids, a new methodology in this area, to track the emergence of alternative protonarratives (themes expressed in IMs) and to depict their development across the therapeutic process, seeking a richer understanding of how narrative change occurs. I considered this as a theory-building case study (Stiles, 2005, 2009), in which I examined the fit between case observations and IMs theory, aiming to refine IMs model of change, by adjusting it to accommodate new observations. I explored four main research questions:

1. How do IMs' types and salience evolve across sessions (narrative process)?
2. Which protonarratives emerge in IMs and how does their salience evolve across sessions (narrative content or theme)?
3. How are IMs' types (narrative process) associated with protonarratives across sessions (narrative content, or theme)?
4. How does the flexibility of the alternative self-narrative evolve across sessions?

In chaper IV, I present a study in which I revisited the good-outcome analyzed in the previous study, focusing on how the relation between dominant and non-dominant (or innovative) voices evolve from mutual in-feeding to other forms of dialogical relation. I have identified two processes, using the microgenetic method from a semiotic autoregulatory perspective of the dialogical self: (1) Escalation of the innovative voice(s) and thereby inhibiting the dominant voice and (2) Dominant and innovative voices negotiate and engage in joint action.

Finally, in Chapter V, I present the first empirical application of the *Therapeutic Collaboration Coding System* (TCCS). This coding system was developed to intensively micro-analyse the therapeutic collaboration, which I understand as the core meaning of the alliance. With the TCCS, I code each speaking turn and assess whether and how therapists are working within the client's *Therapeutic Zone of Proximal Development*, defined as the space between the client's actual therapeutic developmental level and

their potential developmental level. The current work focuses on the moment-to-moment analysis of the therapeutic collaboration in instances in which the client expresses ambivalence. This theory-building case study may yield a deeper understanding of how therapists contribute to maintaining ambivalence. I explored four research questions by analyzing a poor outcome case of narrative therapy using TCCS:

1. How does the frequency of ambivalence responses - moving towards safety evolve across therapy?
2. Which type of therapeutic intervention precedes the emergence of ambivalence responses– moving towards safety (RPMs)?
3. How does the therapist respond to client's ambivalence responses – moving towards safety (RPMs)? In other words, how does the therapist's try to restore collaboration or place the dyad within the TZPD?
4. How does the client react to the therapist's response to ambivalence– moving towards safety (RPMs)? To put it in another way, is the therapist's intervention successful in restoring collaboration or place the dyad within the TZPD?

The reader may find some redundancy throughout this thesis since each chapter starts with a brief definition of IMs conceptualization of change and stablilty. This is due to the format of the dissertation, being each chapter an autonomous paper.

CHAPTER I

THE ROLE OF MUTUAL IN-FEEDING IN MAINTAINING DOMINANT SELF-NARRATIVES: EXPLORING ONE PATH TO THERAPEUTIC FAILURE

CHAPTER I[3]

THE ROLE OF MUTUAL IN-FEEDING IN MAINTAINING DOMINANT SELF-NARRATIVES: EXPLORING ONE PATH TO THERAPEUTIC FAILURE

1. ABSTRACT

According to the author's narrative model of change, clients may maintain a problematic self-stability across therapy, leading to therapeutic failure, by a mutual in-feeding process, which involves a cyclical movement between two opposing parts of the self. During *Innovative Moments* (IMs) in the therapy dialogue, clients' dominant self-narrative is interrupted by exceptions to that self-narrative, but subsequently the dominant self-narrative returns. The authors identified *Return-to-the-Problem Markers* (RPMs), which are empirical indicators of the mutual in-feeding process, in passages containing IMs in 10 cases of narrative therapy (five good-outcome cases and five poor-outcome cases) with females who were victims of intimate violence. The poor-outcome group had a significantly higher percentage of IMs with RPMs than the good-outcome group. The results suggest that therapeutic failures may reflect a systematic return to a dominant self-narrative after the emergence of novelties (IMs).

2. INTRODUCTION

Why don't people change? Each therapy model has an account: ''Resistance. Reactance. Noncompliance. Unfinished business. Whatever you call it, we all have had to deal with ambivalence to change in our clients'' (McCarthy & Barber, 2007, p. 504). This article explores one possible path to therapeutic failure: how problematic self-stability can be maintained, throughout therapy, by a mutual in-feeding process (Valsiner, 2002), a cyclical movement between two opposing parts of the self: the client's dominant self-narrative (usual way of understanding the world) and *Innovative Moments* (IMs; M. M. Gonçalves, Matos, & Santos, 2009; M. M. Gonçalves, Santos, et al., 2010), which are moments in the therapeutic dialogue when clients challenge their dominant self-narrative. We investigated mutual in-feeding in 10 cases of narrative therapy (five good-outcome cases and five poor-outcome cases) with women who were

[3] This study was published in the jounal *Psychotherapy Research* with the following authors: M.M. Gonçalves, António.P. Ribeiro, W.B. Stiles, T. Conde, M. Matos, A. Santos, & C. Martins.

victims of intimate violence, previously analyzed with the *Innovative Moments Coding System* (IMCS; M. M. Gonçalves, A. P. Ribeiro, Matos Mendes, & Santos, 2010a; M. M. Gonçalves, A. P. Ribeiro, Matos, Mendes, & Santos 2010b) by Matos, Santos, M. M. Gonçalves, and Martins (2009).

2.1. Dominant self-narratives and IMs

Recent empirical studies of IMs' development in psychotherapy have led to a narrative model of change, which suggests that change in psychotherapy occurs through the emergence and amplification of different types of IMs (M. M. Gonçalves, Mendes, A. P. Ribeiro, Angus, & Greenberg, 2010; Matos et al., 2009; Mendes, A. P. Ribeiro, Angus, Greenberg, Sousa, & M. M. Gonçalves, in press; A. P. Ribeiro, M. M. Gonçalves, & Santos, in press; Santos, M. M. Gonçalves, & Matos, 2010; Santos, M. M. Gonçalves, Matos, & Salvatore, 2009). According to this theory, a self-narrative may manifest itself as implicit rules the person feels bound to follow or as constraints on the way he or she experiences the world (see White, 2007; White & Epston, 1990; Zimmerman & Dickerson, 1994), insofar as a self- narrative ''not only governs which meanings are attributed to events, but it also selects which events are included and which are left out of the story'' (Polkinghorne, 2004, p. 58). Therefore, a self- narrative maintains the person's way of understanding the world, triggering repetition and fostering stability and expectedness in dealing with the uncertainty of the future (Josephs & Valsiner, 1998).

Hermans and Hermans-Jansen (1995) have suggested that self-narratives result not from the activity of an omniscient narrator (equated with the self) but from a dialogical process of negotiation, tension, disagreement, and alliance among different internal positions or voices. Congruently, according to the assimilation model (Honos-Webb & Stiles, 1998; Stiles, 1999, 2002; Stiles et al., 1990), such internal voices represent traces of individuals' experiences or ways of being in the world. The voice metaphor underscores the traces' agency; they can speak and act. Constellations of similar or related experiences become linked, or assimilated, and form a community of voices. The community is experienced by the individuals as their usual sense of self, personality, or center of experience. The voice that is most often speaking is normally a member of this dominant community of voices and is sometimes called a ''dominant voice.''

We suggest that people become vulnerable to distress and are likely to present for

therapy if their dominant community of voices is bound together by a self-narrative that is too rigid and systematically excludes significant experiences because they are not congruent with it. From the community's perspective, voices representing experiences that are discrepant from how individuals typically perceive themselves are problematic, and the community of voices wards off, distorts, or actively avoids such voices (Stiles, 2002; Stiles, Osatuke, Glick, & Mackay, 2004). Although such avoidance can prevent or reduce the distress in the short term, the experiences remain unassimilated and unavailable as resources, so from a clinician's perspective, the dominant self-narrative is problematic.

Unassimilated voices are not inert or devoid of agency. They may be silenced and excluded, but circumstances (including the therapeutic dialogue) may address them, impelling them to move from the background to the foreground (Hermans, 2006; Stiles, Osatuke, Glick, & Mackay, 2004) and producing IMs. When they emerge during IMs, such unassimilated voices challenge the dominant self-narrative. Dialogically, then, IMs are opportunities for unassimilated voices to emerge and to tell their own stories, which differ from the ones told by the dominant community.

The logic of IMs is illustrated by a recent study by Osatuke and Stiles (2010; see also Osatuke et al., 2007), which found a common dialogical pattern in depressive clients: a conflict between an interpersonally submissive but intrapersonally dominant voice, which organizes the majority of experiences (being the dominant narrator), and an autonomous and interpersonally assertive voice that is intrapersonally suppressed by the community of voices that constitutes the self. An IM would be considered as occurring every time the assertive voice was some-how heard, regardless of whether it emerged as a thought, action, wish, or feeling. For the dominant voice in such depressive cases, the process of rejecting and silencing other voices maintains a dominant self-narrative characterized by rigidity and redundancy. Such dominant self-narratives comprise strict rules, such as ''always privilege the wishes of others and ignore your own''. All voices that suggest otherwise are excluded, suppressed, or avoided, creating tension because they are not being heard. Thus, for instance, when the person faces a conflict with others and decides not to be assertive, a tension is created because the nondominant (but assertive) voices fight to be heard. Hearing from a nondominant voice constitutes a novelty in the self-system, which we call an IM. As a nondominant voice is assimilated in the course of successful therapy, it becomes more accessible and less dissociated from the community of voices, and the rigidity and

redundancy of the dominant self- narrative decrease.

2.2. Types of IMs and associations with outcome

The IMCS distinguishes five types of IMs that have been observed in the therapeutic process: action, reflection, protest, reconceptualization, and per-forming change (M. M. Gonçalves, A. P. Ribeiro, et al., 2010a, 2010b, in press; M. M. Gonçalves, Mendes, et al., 2010; M. M. Gonçalves, Santos, et al., 2010; Matos et al., 2009; Mendes et al., in press; A. P. Ribeiro et al., in press; Santos et al., 2010).

1. *Action IMs* are specific behaviors that challenge the dominant self-narrative.
2. *Reflection IMs* are thoughts, feelings, intentions, projects, or other cognitive products that challenge the dominant self-narrative.
3. *Protest IMs* entail new behaviors (like action IMs) and/or thoughts (like reflection IMs) that challenge the dominant self-narrative, representing a refusal of its assumptions. This active refusal is the key feature that allows distinguishing protest from action and reflection.
4. *Reconceptualization IMs* are the most complex type of innovations. The client not only describes some form of contrast between present and past (e.g., ‘‘Now I’ve changed X or Y’’) but also understands the processes that allowed this transformation.
5. *Performing change IMs* (previously labeled as new experiences) are new aims, experiences, activities, or projects, anticipated or in action, as a consequence of change.

Examples of these IMs are shown in Table I. IMs can be coded from transcripts and audio or video recordings of sessions. While coding IMs, coders must keep in mind the main features of the dominant self-narrative – the constraining rules – in order to identify the exceptions to those rules (i.e., the IMs).

Table I. 1: Examples of IMs vis-à-vis a depressive dominant self-narrative

	Contents	Examples
Action	• New coping behaviours facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control ; • Searching for information about the problem(s).	C: *Yesterday, I went to the cinema for the first time in months!*
Reflection	***Creating distance from the problem(s)*** • Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being.	C: *I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go…*
	Centered on the change • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies; implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	C: *I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.*
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s).	C: *What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!?*
	Emergence of new positions • Positions of assertiveness and empowerment;	C: *I am an adult and I am responsible for my life, and I want to acknowledge these feelings and I'm going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.*
Reconceptualization	RC always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	C: *You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…* T: *How did you have this idea of going to the museum?* C: *I called my dad and told him: we're going out today!* T: *This is new, isn't it?* C: *Yes, it's like I tell you… I sense that I'm different…*

Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	T: *You seem to have so many projects for the future now!* C: *Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.*

Studies of brief psychotherapy have shown that poor- and good-outcome cases have different profiles of IMs. Two relevant, replicated findings have been observed in hypothesis-testing studies (Matos et al., 2009; Mendes et al., in press) and case studies (M. M. Gonçalves, Mendes, et al., 2010; A. P. Ribeiro et al., in press; Santos et al., 2010). First, IMs appear in both poor- and good-outcome cases, although in good-outcome cases their salience (i.e., the time devoted to the elaboration of IMs calculated as a percentage of the session) is greater and tends to increase as the treatment develops. Second, reconceptualization and performing change IMs are seldom observed in poor-outcome cases but represent a substantial percentage of the IMs observed in good-outcome cases. In good-outcome cases, reconceptualization IMs tend to occur in the middle of the therapeutic process and increase until the end. Performing change IMs tend to occur after the development of reconceptualization. Hence, poor- and good-outcome cases tend to be similar at the beginning of treatment, but in good-outcome cases action, reflection, and protest IMs progress to reconceptualization and performing change in the middle and later parts of treatment.

2.3. IMs and problematic self-stability: Mutual in-feeding

What processes block the path of successful psychotherapy in poor-outcome cases? Why do poor-outcome cases fail to follow the pattern of increasing IM salience and the evolution from action, reflection, and protest IMs to reconceptualization and performing change IMs in the middle and late phases of therapy?

We argue, along with Hayes, Laurenceau, Feldman, Strauss, and Cardaciotto (2007), that ‘‘therapy provides a stable environment and increases patients' readiness and resources for change, but it also introduces a variety of interventions to interrupt, challenge, and destabilize’’ (p. 717). The emergence and elaboration of IMs in the therapeutic conversation challenges and destabilizes a person's usual way of understanding and experiencing (the dominant self-narrative), generating a sense of

discrepancy or inner contradiction (M. M. Gonçalves & A. P. Ribeiro, in press; A. P. Ribeiro & M. M. Gonçalves, 2010). Congruently, Engle and collaborators (Engle & Arkowitz, 2008; Engle & Holiman, 2002) have emphasized, from a humanistic-experiential perspective, that psychological changes introduce discrepancy or inner contradiction. This discrepancy may be experienced as a threat, evoking a self-protective response in which the discrepant experience is ‘‘distorted, denied, or inadequately symbolized,’’ keeping the client safe from the anxiety produced by the change (Engle & Arkowitz, 2008, p. 391). Hence, IMs represent a window of opportunity for developing a new self- narrative, but they may also create unpredictability and uncontrollability (Arkowitz & Engle, 2007), threatening clients' sense of self-stability. Whether IMs develop into a new self-narrative depends on the way this threat is managed.

We have noticed that in poor-outcome cases (Santos et al., 2010), as well as in initial and middle phases of good-outcome cases (A. P. Ribeiro et al., in press), clients tend to resolve the discrepancies or inner contradictions that characterize IMs by making a quick return to the dominant self-narrative. As Swann (1987) suggested, self-discrepant information (IMs) may prompt people to retrieve information supporting the self-conception that is being contradicted, thus promoting the return to the dominant self-narrative.

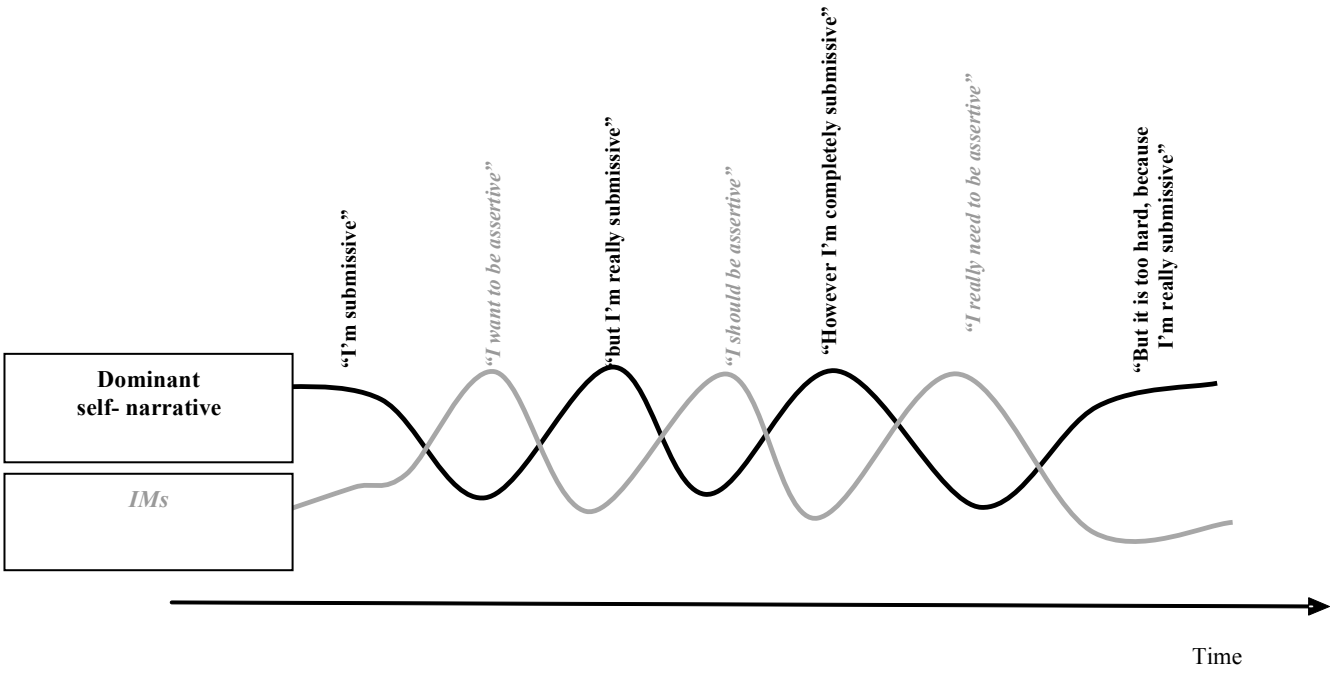
The return to the dominant self-narrative suppresses the innovative way of feeling, thinking, or acting, by bypassing, minimizing, depreciating, or trivializing its meaning, and reinstates the dominant self-narrative, promoting stability. Clients thereby avoid the sense of discrepancy or inner contradiction.

As this sequence repeats, clients oscillate between elaboration of IMs, which temporarily disrupts the dominant narrative, and the return to the dominant self-narrative, reducing the discrepancy created by the innovation. In this repetitive process, expressions of the dominant self-narrative and IMs expressing an alternative self-narrative act as opposite self-positions in a negative feedback loop relation (Figure 1). Valsiner (2002) has called this process ‘‘mutual in-feeding’’.

Mutual in-feeding is thus a form of stability within the self, which may be understood as two opposing parts of the self that keep feeding into each other, expressing themselves alternately. From a dialogical point of view (Valsiner, 2002; see also Hermans, 1996), the client performs a cyclical movement between a voice (dominant self-narrative) and a countervoice (alternative self-narrative) that interferes

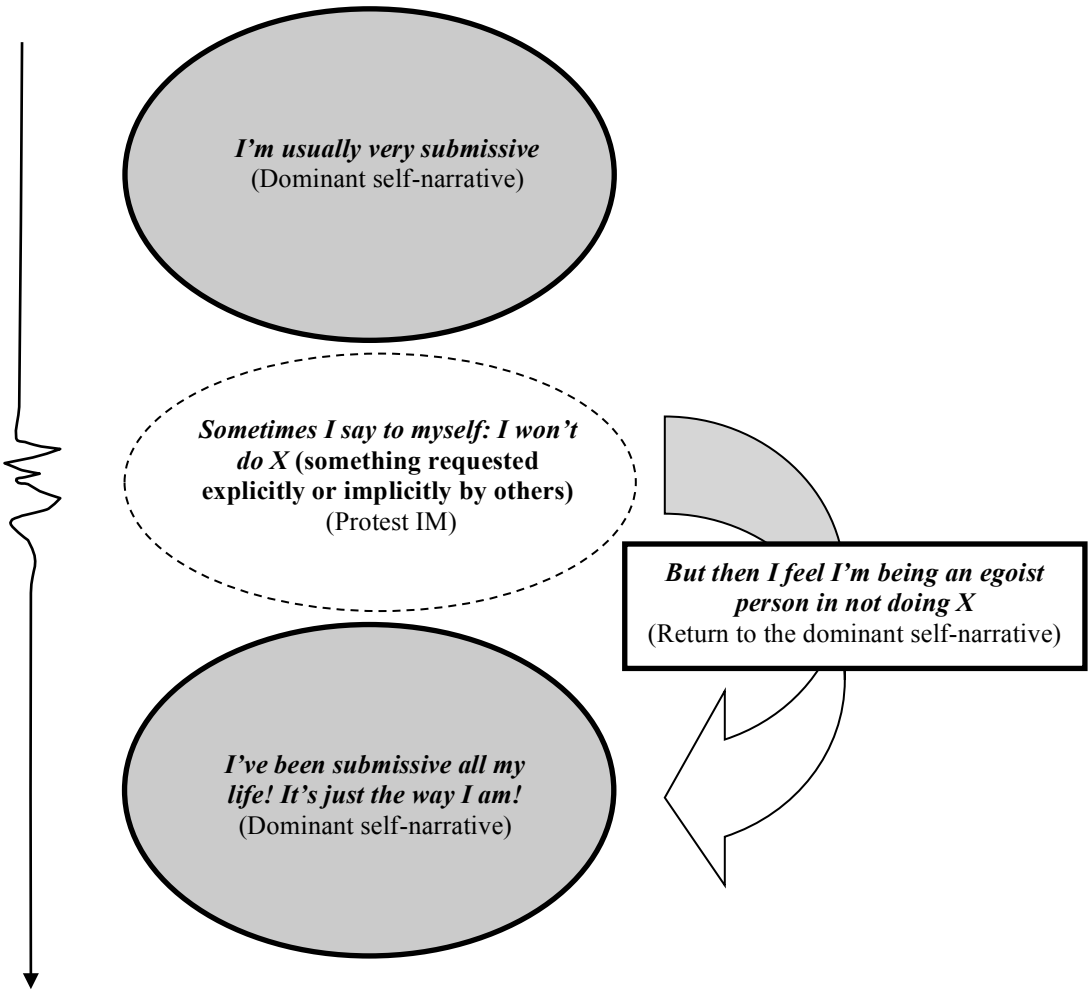
with the development of an inclusive system of meanings in therapy in which these internal voices respectfully listen to each other and engage in joint action.

Figure I. 1: Mutual in-feeding throughout the therapeutic process



As an illustration, imagine that one of the submissive, depressed clients studied by Osatuke and Stiles (2010) said, ‘‘Sometimes I say to myself: I won’t do X [something requested explicitly or implicitly by others]’’. This assertive expression would constitute an IM, because it is a challenge of the dominant self-narrative. This innovative voice might be neutralized if a dominant voice emerged and said something like ‘‘But then I feel I’m being an egotistical person in not doing X’’. If this dominant voice forces again the nondominant (innovative) voice to the background and silences it, neutralization of the novelty has occurred (Figure 2).

Figure I. 2: Avoiding self-discrepancy by returning to the dominant self-narrative



2.4. The Return-to-the-Problem Marker

We propose a measure of the mutual in-feeding process that grew from our observations of therapy passages in which an IM emerged and was immediately followed by a return to the dominant self-narrative. We call such an event a *Return-to-the-Problem Marker* (RPM). Take, for example, the following:

I don't want to be depressed anymore [Reflection IM],

But I just can't [RPM].

In this example, the IM ''I don't want to be depressed anymore'' was followed by a return to the dominant self-narrative, ''but I can't''. This clause introduced by the word but represents opposition or negation toward what is being said and constitutes the RPM.

2.5. Goals and hypotheses

Our goal was to shed light on problematic self-stability. We sought to assess whether clients' responding to IMs by returning to the dominant self-narrative (i.e., responding with RPMs) contributes to maintaining the dominant self-narrative.

We expected that in poor-outcome cases the potential for IMs to create narrative diversity would be prevented by the rapid return to the dominant self-narrative (Santos & M. M. Gonçalves, 2009; Santos et al., 2010). In good-outcome cases, on the other hand, IMs should be elaborated, with relatively fewer RPMs, at least in the later stages of therapy (A. P. Ribeiro et al., in press). Further, reconceptualization IMs and performing change IMs, which tend to occur in the late stages of good-outcome cases, seem less likely than other IMs to support RPMs. Reconceptualization ''requires a meta-level reflexivity that allows the person to become aware of a transformation process'' (Cunha, M. M. Gonçalves, Valsiner, Mendes, & A. P. Ribeiro, in press). Performing change involves generalization of the change process into several life domains, which seems incompatible with mutual in-feeding. Thus, this reasoning too suggests that mutual in-feeding should occur relatively less frequently in these two types of IMs.

We examined three hypotheses in this study: (1) Poor-outcome cases present a higher percentage of IMs with RPMs; (2) the percentage of IMs with RPMs decreases throughout therapy in good-outcome cases but not in poor-outcome cases; and (3) action, reflection, and protest IMs present more RPMs than reconceptualization and performing change IMs.

3. METHOD

Data for the current study were drawn from the Matos et al. (2009) study of IMs in narrative therapy. Relevant parts of that study's method – namely clients, therapist and therapy, measures, IM coding and reliability, and contrasting groups' constitution – are summarized here; please see Matos et al. (2009) for full details.

3.1. Clients

The client sample comprised 10 women with current experience of multidimensional intimate violence. They provided written consent after being informed of the research objectives and procedures. Clients ranged in age from 22 to 57 years. Four had no children and the remaining six had one to four children. Level of education

varied from basic to postgraduate education, and occupations varied from rather unskilled to highly skilled. Seven clients were married, one was cohabitating with the partner, and the other two were dating (without cohabitation). By the end of psychotherapy, four clients had ended the relationship.

The abusive relationships in which these women were involved had lasted from one to 20 years. Four women were victimized for a long period of time (> five years), and for six the violence experience was briefer (< five years). Psychological violence was present in all the cases. Five clients were victims of both physical and sexual aggression.

3.2. Therapist and therapy

Clients attended psychotherapy in a Portuguese university clinic, where they were seen in individual narrative therapy (White & Epston, 1990). All clients were treated by the same female therapist, who at the time had a master's degree in psychology and five years of experience in psychotherapy with battered women. Psychotherapy was supervised to ensure therapist adherence to the narrative therapy model.

The therapy was developed from the narrative model of White and Epston (1990; see also White, 2007) and involved (1) externalization of problems; (2) identification of the cultural and social assumptions that support women's abuse; (3) identification of *Unique Outcomes* (or, as we prefer, IMs); (4) therapeutic questioning around these unique outcomes, trying to create a new, alternative narrative to the one that was externalized; and (5) consolidation of the changes through social validation, trying to make more visible the way change happened (see Matos et al., 2009, for a detailed description of the narrative therapy guidelines).

3.3. Measures

3.3.1. Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). The BSI is a 53-item self-report measurement of distress, with items rated on a 5-point Likert scale. Derogatis reported internal consistency estimates a *Cronbach's* α of .89 and test-retest reliability of .90 for the *Global Severity Index* (GSI). We used the Portuguese adaptation by Canavarro (2007), which presents good psychometric characteristics (*Cronbach's* α for the nine symptom subscales ranges from .62 to .80).

3.3.2. Severity of Victimization Rating Scale (SVRS; Matos, 2006). SVRS assesses abusive actions received (physical, psychological, and/or sexual), their frequency, and severity on a three-point scale (low, medium, high); it is completed by

the therapist based on the client's report.

3.3.3. Scale of beliefs about partner violence (Escala de Crenças Sobre Violência Conjugal [ECVC]; Matos, Machado, & M. M. Gonçalves, 2000). The self-report ECVC evaluates clients' beliefs regarding partner violence. It contains 25 items, which are rated using a 5-point Likert scale. This scale has good reliability (*Cronbach's* α = .9; C. Machado, Matos, & M. M. Gonçalves, 2004).

3.3.4. Working Alliance Inventory (WAI; Horvath, 1982). This questionnaire assesses therapeutic alliance quality. It contains 36 items, which are rated on a 7-point Likert scale. The Portuguese version (P. P. Machado & Horvath, 1999) presents good internal consistency (*Cronbach's* α = .95).

3.3.5. Innovative Moments Coding System (IMCS; M. M. Gonçalves, Ribeiro, et al., 2010a, 2010b). Table 1 provides definitions and examples of the different types of IMs. In the previous studies IMCS proved to be reliable, with *Cohen's k* values of .89 in the study by Matos et al. (2009) and .86 in the study by Mendes et al. (2011). In other case studies the values of *Cohen's k* ranged from .76 (Gonçalves, Mendes, et al., 2010) to .90 (Ribeiro et al., 2009).

3.3.6. Return-to-the-Problem Coding System (RPCS; M. M.Gonçalves, Ribeiro, Santos, J. Gonçalves, & Conde, 2009). The RPCS is a qualitative system that analyses the re-emergence of the problematic self-narrative (through RPMs) immediately after the emergence of an IM or within the client's first speaking turn after the therapist's first intervention following the IM narration.

3.4. Procedure

3.4.1. Outcome and alliance measures administration. BSI was administrated in sessions 1, 4, 8, 12, and 16 and at six-month follow-up. This study used the GSI of the BSI, which considers responses to all items, because this is considered to be the best single predictor of level of distress (Derogatis, 1993). Like the BSI, SVRS was recorded every fourth session, starting with the first. EVCS was administrated in sessions 1 and 16 and at six-month follow-up. WAI was administered in sessions 4, 8, 12, and 16 and at six-month follow-up; versions for client and observers (two independent observers coded recordings of sessions) were applied.

3.4.2. IM coding and reliability. IM coding was based on the IMCS (M. M. Gonçalves, Ribeiro et al., 2010a, 2010b) (Table 1). First, each of three judges read the clinical files and watched the video recordings of each client's sessions in their entirety.

The judges then independently listed the client's problems (themes from the dominant self-narrative that brought the client to therapy) and met to discuss their comprehension of the client's dominant self-narrative. Following this, the client's dominant self-narrative was consensually characterized in a way that remained faithful to the client's words. This procedure set the stage for the identification of IMs, insofar as they include every moment in which the client engaged in actions, thoughts, or emotions that were novel or different from the identified dominant self-narrative.

Next, the judges coded the IMs by viewing each session in video and noting the type and the salience of each IM as it appeared in the session. Salience was assessed by measuring the beginning and the end of each IM to the nearest second. The sessions were coded in the order they occurred. Session recordings were coded by trained judges: Judge A (Anita Santos, who was unaware of the outcomes) coded all the sessions; and Judge B (a team comprising Marlene Matos and another volunteer judge) coded only the sessions in which the outcome assessment instruments were applied (sessions 1, 4, 8, 12, and 16 and six-month follow-up).

Reliability indexes were computed on these sessions (30% of the entire sample). Interjudge agreement on overall salience was calculated as the time identified by both judges divided by the time identified by either judge. The percentage of agreement on overall IMs salience was 86%. Reliability of distinguishing IM types, assessed by *Cohen's k*, was .89 (based on a sample size of 547 IMs). Because of the high interjudge reliability, Matos et al. (2009) based their analyses on Judge A's coding. The results of applying the IMCS were reported previously by Matos et al. (2009) and were preliminary to this study's application of the RPM coding system.

3.4.3. RPM coding and reliability. Two judges participated in the RPM coding procedure (António P. Ribeiro and Tatiana Conde). At the time of coding, both were unaware of the outcome status of the cases. Training for RPM coding began with reading the Manual for the Return to the Problem Coding System (M. M. Gonçalves, Ribeiro et al., 2009), along with theoretical papers and research reports that described relevant assumptions and major empirical findings. Next, the two judges coded RPMs in a workbook that included transcripts of all IMs from one psychotherapy case. This step was followed by a discussion of discrepancies with a group of other RPM judges in training and/or with a skilled RPM judge present. After this discussion, they coded a second workbook that included transcripts of all IMs from another psychotherapy case. Their codes were then compared with the codes of expert judges. New judges were

required to achieve a *Cohen's k* higher than .75 before proceeding (both judges did).

As described in the RPCS manual (M. M. Gonçalves, Ribeiro, et al., 2009), RPMs are coded only when the dominant self-narrative is reasserted immediately after the IM, that is, within the same speaking turn or within the client's first speaking turn that follows the therapist's first intervention after the IM description (see the Appendix for an explanation of exceptions to these criteria), as in the following example:

> *Maybe I'll get what I want after all, I don't know [IM] . . . but I feel weak, psychologically speaking… as if me or someone inside me was incessantly saying 'You cannot, you will not be able to do it.' That's how I feel: weak, invariably sad, not thinking much of myself* [RPM].

RPMs coding comprised two sequential steps: (1) independent coding and (2) resolving disagreements through consensus. The judges independently coded the entire sample (126 sessions), analysing IMs coded by Matos et al. (2009) for the presence of RPMs, following the RPCS manual. The sessions were coded from video recording in the order they occurred. Reliability of identifying RPMs, assessed by *Cohen's k*, was .93, based on the initial independent coding of a sample size of 1,596 IMs.

Throughout the coding process, the two judges met after coding each session and noted differences in their perspectives of the problems and in their RPM coding. When differences were detected, they were resolved through consensual discussion. During the collaborative meetings, the judges discussed the strengths of each other's coding and the criteria used to achieve them. Through this interactive procedure, the judges were able to integrate each other's strengths, which facilitated the coding of subsequent sessions (cf. Brinegar et al., 2006). Because we privileged false-negative over false-positive results, IMs on which the investigators could not reach an agreement were eliminated (Krause et al., 2007). The analysis was then based on the consensus between the two judges.

3.5. Contrasting groups' constitution

We used contrasting groups constructed by Matos et al. (2009), who distinguished a good-outcome group (n = 5) and a poor-outcome group (n = 5) based on two criteria. A good-outcome occurred when (1) there was an evolution toward a no-relevant symptom condition, as assessed by BSI, from the beginning to the end of therapy (based on a GSI cutoff score of 51.32; Matos, 2006) and (2) simultaneously victimization by the partner ended or showed a very significant change from the beginning to the end of

therapy, according to the client's report. Meeting this criterion required a significant change in victimization pattern, although the client might still experience relatively minor forms of violence (e.g., insulting, shouting) as well as a modification of episode frequency from continuous to occasional.

3.5.1. Good- and poor-outcome group demographics and alliance. Matos et al. (2009) reported no significant differences between the good- and poor-outcome groups in age, education level, relationship duration, victimization duration, initial scores on the GSI (symptoms) or the attitudes toward partner violence, as assessed by the ECVC. WAI results showed that the therapeutic alliance was high in both groups and in all the sessions evaluated, with a nominally significant difference in the perspective of one of the observers, according to whom the therapeutic alliance was better in the good-outcome group at session four. There were no significant WAI differences in the perspective of the other observer, the clients, or the therapist.

3.5.2. IMs in good- and poor-outcome groups. Matos et al. (2009) reported that reconceptualization and performing change IMs were very rare in poor-outcome cases, and their salience was very low. The global salience of IMs was higher in the good-outcome group; this disparity was entirely attributable to the differences in reconceptualization and performing change IMs. In the majority of good-outcome cases, reconceptualization and performing change IMs emerged in the middle of the therapy and increased through the final phase, whereas they were almost absent throughout therapy in the poor-outcome cases.

4. RESULTS

4.1. RPMs in good- and poor-outcome groups: Analytic strategy

We used parametric tests (*t* test for Hypothesis 1 and two-way mixed analyses of variance [*ANOVA*s] for Hypotheses 2 and 3). We confirmed that our conclusions would not change when applying nonparametric tests, as proposed by Fife-Schaw (2006).

Significance levels were set at $\alpha = .05$. In the *ANOVA*, Greenhouse-Geisser ε-corrected *p* values were reported to correct for violations of the sphericity assumption. According to Cohen (1988, 1992), effect sizes *f* were computed for *ANOVA* effects and effect sizes *d* for *t* test mean differences.

The number of sessions varied from 12 to 16 in the good-outcome group ($M = 14.60$, $SD = 1.67$) and from six to 16 in the poor-outcome group ($M = 10.60$, $SD = 4.34$;

see Table 2), but the mean number of sessions was not significantly different, $t(8) = 1.93$, $p = .09$. Likewise, we found no differences in the frequency of IMs per session between the good-outcome ($M = 14.53$, $SD = 4.76$) and the poor-outcome ($M = 10.58$, $SD = 3.38$) groups, $t(8) = 1.51$, $p = .17$. Therefore, there was no need to use the number of coded sessions as a covariate.

Table I. 2: Number of sessions in good- and poor-outcome groups

Good-outcome group		Poor-outcome group	
Case	No. sessions	Case	No. sessions
1	14	6	10
2	15	7	6
3	12	8	7
4	16	9	16
5	16	10	14

4.2. Hypothesis 1: The emergence of RPMs in good- and poor-outcome groups

Consistent with our hypothesis, RPMs were less frequent in the good-outcome group ($M = 16.20$, $SD = 4.82$) than in the poor-outcome group ($M = 42.00$, $SD = 21.76$), a statistically significant difference, $t(8) = 2.59$, $p = .03$, effect size $d = 1.64$.

Because the number of IMs varied substantially across cases, we also computed the percentage of IMs with RPMs (frequency of IMs with RPMs/total frequency of IMs *100). The poor-outcome group ($M = 38.94$, $SD = 13.15$) had a significantly higher percentage of IMs with RPMs than did the good-outcome group ($M = 7.84$, $SD = 1.51$), $t(8) = 5.25$, $p = .001$, $d = 3.32$.

4.3. Hypothesis 2: The evolution of RPMs in good-and poor-outcome groups

Contrary to our hypothesis, the percentage of IMs with RPMs did not change from the first to the last session. The poor-outcome group had a higher percentage of IMs with RPMs than did the good-outcome group in both their first ($M_{good} = 11.36$, $SD = 7.34$; $M_{poor} = 47.03$, $SD = 35.47$) and last ($M_{good} = 4.32$, $SD = 4.04$; $M_{poor} = 40.85$, $SD = 20.45$) sessions. In a two-way mixed *ANOVA* with group as the between-subjects factor and session as the within-subject factor, the main effect of group was significant, $F(1,8) = 9.82$, $p = .01$, effect size $f = 1.11$; however, the main effect of session was not, $F(1,8) = .1.04$, $p = .34$, $f = .11$, nor was the Session*Group interaction, $F(1, 8) = .00$, $p = .95$, $f = .03$.

4.4. Hypothesis 3: The occurrence of RPMs in different types of IMs

The five types of IMs showed greatly different likelihood of including RPMs in a pattern that partially supported Hypothesis 3 (Table 3). A two-way mixed *ANOVA* with group as the between-subjects factor and the type of IM as the within-subject factor found a significant main effect of type of IM, $F(2.19,17.54) = 19.22$, $p = .000$, $f = 1.55$. Pairwise comparisons revealed that RPMs were less likely in reconceptualization than in reflection and protest IMs and less likely in performing change than in reflection, protest, and reconceptualization IMs. Consistent with Hypothesis 3, the likelihood of RPMs in reconceptualization and performing change IMs was significantly lower than in reflection or in protest IMs. Contrary to Hypothesis 3, however, the likelihood of RPMs in action IMs was not significantly different than in reconceptualization or in performing change IMs.

As Table 3 shows, the profile of likelihoods was similar in the good- and poor-outcome groups. The main effect of group was not significant, $F(1,8) = 0.00$, $p = 1$, $f = .00$, nor was the Type of IM*Group interaction, $F(2.19, 17.54) = 0.75$, $p = .50$, $f = .31$.

Table I. 3: Mean percentage of RPMs in different types of IMs

	Good-outcome group (*n* = 5) *Mean* (*SD*)	**Poor-outcome group (*n* = 5) *Mean* (*SD*)**
Action	16.76 (18.97)	11.28 (11.02)
Reflection	44.09 (14.00)	45.30 (13.97)
Protest	25.16 (7.59)	35.07 (13.85)
Reconceptualization	12.74 (4.31)	5.45 (7.67)
Performing Change	1.25 (2.80)	2.90 (5.44)

5. DISCUSSION

In accord with our first hypothesis, IMs were much more likely to be followed by a return to the dominant narrative in the five poor-outcome cases than in the five good-outcome cases. Even though the groups had similar levels of symptom severity at intake, they showed dramatically different percentages of IMs containing RPMs. This observation is consistent with the theoretical suggestion that mutual in-feeding between the dominant self-narrative and IMs can interfere with therapeutic progress or at least mark the lack of progress (M. M. Gonçalves, Matos et al., 2009).

Contrary to our second hypothesis, that the different likelihood of RPMs would occur only later in therapy, the lower likelihood of RPMs in the good-outcome group was apparent in the first as well as the last session. Perhaps clients in these groups, despite their similar levels of symptom severity, entered therapy at different stages of change. Stage models of psychological change suggest that certain tasks have to be accomplished before others can be undertaken. Two prominent examples of such models are the assimilation model (Honos-Webb & Stiles, 1998; Stiles, 2002; Stiles et al., 1990) and the TransTheoretical Model of behavior change (TTM; Napper et al., 2008; Prochaska & DiClemente, 1982; Prochaska & Norcross, 2001). According to the assimilation model, clients' incremental assimilation of their problematic experiences proceeds in eight stages (Stiles, 2002), from complete dissociation to smooth integration of the formerly nondominant (problematic) voices into the self.

According to the TTM, change proceeds through five stages: precontemplation, contemplation, preparation, action, and maintenance. Studies framed within each of these models have suggested that clients entering therapy at earlier stages are less likely to have successful outcomes than those entering at later stages (Emmerling & Whelton, 2009; Honos-Webb, Stiles, Greenberg, & Goldman, 1998; Stiles, 2006). Perhaps clients in this study's poor-outcome group entered therapy at lower stages of the change process (e.g., precontemplation in the TTM sequence or unwanted thoughts/avoidance in the assimilation sequence), whereas those in good-outcome cases entered therapy at higher stages. Alternatively, perhaps clients from the good-outcome group entered treatment with more psychological and social resources or were more involved in therapy (although there were no significant between-group differences in age, education level, relationship duration, victimization duration, or initial scores on symptomatology as assessed by the BSI or the attitudes toward partner violence, as assessed by the

ECVC). Unfortunately, we have no data that allow us to distinguish conclusively among these possibilities.

Finding a lower incidence of RPMs in reconceptualization and performing change IMs than in reflection and protest IMs is congruent with theoretical assumptions (see M. M. Gonçalves, Matos et al., 2009), corroborating reconceptualization and performing change as markers of sustained therapeutic change (Hypothesis 3). Action IMs were intermediate: less likely to contain RPMs than reflection and protest and more likely to contain RPMs than reconceptualization and performing change. Action IMs are overt and tend to be more visible to the client and others than protest and reflection IMs. Perhaps they are experienced as ‘‘real proofs that I am changing’’ and consequently less vulnerable to mutual in-feeding.

Several limitations should be noted. Confidence in the generality of our findings about psychotherapeutic failure is limited by the small size of our sample and its restriction to victims of intimate violence. Application of our new method for coding RPMs to other samples may clarify whether RPMs are also associated with unsuccessful psychotherapy of other types and in other groups.

Practitioners are likely to encounter the mutual in-feeding process at some point in their clinical practice, and RPMs might offer information useful for identifying and addressing unproductive stagnation of the therapeutic process (Santos et al., 2010). Understanding RPMs may help therapists deal with ambivalence in therapy. Identifying these processes opens the option to act upon them, inviting clients to position themselves in new ways and resolving therapeutic impasses.

We did not assess clients’ stage of change (e.g., according to the APES or the TTM), so we could not assess whether this accounted for the group differences in RPMs at the beginning of treatment. In future studies, evaluating clients’ stage of change at the beginning of therapy would contribute to understanding this possibility. When therapists try to stimulate or amplify IMs in ways that do not match clients’ stage of change, they may unintentionally contribute to the oscillatory cycle between the IMs and the problem (Santos et al., 2010). For example, if therapists respond to clients’ return to the dominant self-narrative by trying to convince them that they are changing, clients may feel misunderstood, invoking a ‘‘strong reactance on the part of the client, often hardening the client’s stuck position’’ (Engle & Arkowitz, 2008, p. 390). Engle and Arkowitz suggested that “therapists need to monitor their frustration, resist the temptation to ‘help’ the client by pushing for change, and to direct his or her efforts

toward an understanding of what it is in the client's experience that prevents easy change" (p. 391).

RPMs may not always represent therapeutic stagnation. In studies of two good-outcome cases, Brinegar et al. (2006) identified the rapid cross-fire phenomenon: an alternation of opposing expressions that appears to qualify as an RPM. They identified rapid cross-fire as a substage in the successful assimilation of specific problematic experiences in those cases, although importantly it occurred in only a few sessions during the middle of treatment, in contrast to its continued presence throughout treatment in our poor-outcome cases. Nevertheless, the possibility that RPMs may sometimes signal or contribute to therapeutic movement deserves further study.

Mutual in-feeding is an interpersonal process and needs to be understood in the interpersonal context in which it occurs: the intersubjective field created in all interactions between the therapist and the client (Engle & Arkowitz, 2008). According to Engle and Arkowitz, "therapists can facilitate the resolution of resistant ambivalence by creating in-session exercises that increase awareness and integration of disowned aspects of the self" (p. 393), in the context of a safe and accepting relationship. Focused theory-building case studies (Stiles, 2009) could yield a deeper understanding of how therapists contribute to maintaining or overcoming mutual in-feeding.

6. APPENDIX: SOME SUBTLETIES OF RPM CODING

Normally, an RPM is coded only if the return takes place within the same speaking turn or in the client's first speaking turn that follows the therapist's first intervention after the IM. However, two sorts of therapist response are not considered as interventions for this purpose.

6.1. Minimal encouragers

We do not consider minimal encouragers, such as minimal verbal utterances (e.g., ''Umm'' and ''Uh-huh''), or repetition of key words and direct restatement as the therapist's first interventions, as in the following example:

Client: *Lately, perhaps since I moved . . . about two weeks ago, I've been feeling better* [IM].

Therapist: *Uh-huh* [Minimal encourager; not to be considered as the first therapist intervention].

Client: *I moved because my apartment was too expensive . . . this new one ischeaper and it's closer to my job*.

Therapist: *So you've been feeling better, is that right?* [Should be considered as the therapist's first intervention after IM description].

Client: *Not really, I keep crying all the time!* [Client's first speaking turn after therapist's first intervention, representing an RPM].

By the same token, we do not consider the client's minimal verbal utterances (e.g., ''Umm'' and ''Uh- huh'') as the first speaking turn after the therapist first intervention, as in the following example:

Client: *Lately, perhaps since I moved . . . about two weeks ago, I've been feeling better* [IM].

Therapist: *I have been noticing that you are different* [Therapist's first intervention].

Client: *Uh-huh* [Minimal encourager; not to be considered as client's first speaking turn after therapist's first intervention].

Therapist: *You seem more active, happier*.

Client: *Although I seem happier, I don't I feel happier! Although I don't cry as much as I used to, the problems don't seem to set apart!* [Should be considered as client's first speaking turn after therapist's first intervention, representing an RPM].

6.2. Therapist's intervention not centred on IM content

We only consider the client's first speaking turn that follows the therapist's first intervention after the IM description, when this intervention is centred on the IM's content. Hence, we do not consider an RPM when the therapist intervention clearly invites the client to speak about the problem, as in the following example:

Client: *Although I still find it hard to get going in the mornings, I kind of don't try to sweep away things that much anymore, that's I guess one major change* [IM].

Therapist: *You said it's hard to get going. Is the sadness more intense in the mornings?* [Therapist's question clearly invites client to speak about the problem].

Client: *Yes, indeed* [Client's first speaking turn that follows the therapist's first intervention after IM description; should not be coded as an RPM].

7. REFERENCES

Arkovitz, H., & Engle, D. (2007). Understanding and working with resistant ambivalence in psychotherapy. In S. G. Hofmann, & J. Weinberg (Eds.), *The art and science of psychotherapy* (pp. 171-190). New York: Routledge.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building

Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180.

Canavarro, M.C. (2007). Inventário de Sintomas Psicopatológicos (BSI): Uma revisão crítica dos estudos realizados em Portugal. In M. R. Simões, C. Machado, M. M. Gonçalves e L. S. Almeida (Eds.), *Avaliação Psicológica: Instrumentos validados para a população portuguesa* – Vol. III (pp. 305-331). [Psychological assessment: Validated instruments for the Portuguese population – Vol. III]. Coimbra: Quarteto.

Cohen, J. (1988). *Statistical power analysis for behavioral science*. New York: Erlbaum.

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*, 155-159.

Cooper, M. (2004). Encountering self-otherness: "I-I and "I-Me" modes of self relating. In H. J. M. Hermans & G. Dimaggio (Eds.), *The Dialogical self in Psychotherapy* (pp. 60-73). New York: Brunner-Routledge.

Cunha, C. & Gonçalves, M. M. (2009). Rehearsing renewal of identity: Reconceptualization on the move. Manuscript in preparation.

Derogatis L. R. & Melisaratos, N. (1983). The Brief Symptom Inventory: an introductory report. *Psychological Medicine*, *13*, 595-605.

Derogatis, L. R. (1993). *BSI – Brief Symptom Inventory. Administration, Scoring, and Procedures Manual* (4th Ed.). Minneapolis, MN: National Computer Systems.

Dimaggio, G. (2006). Disorganized narratives in clinical practice. *Journal of Constructivist Psychology, 19*, 103-108.

Ecker, B., & Hulley, L. (2000). The order in clinical disorders: Symtom coherence in depth-oriented brief therapy. In R. A. Neimeyer & J. D. Raskin (Eds.), *Construction of disorder: Meaning-making frameworks for psychotherapy* (pp. 63-89). Washington, DC: American Psychological Association.

Emmerling, M. & Whelton, W. (2009). Stages of change and the working alliance in psychotherapy. *Psychotherapy Research, 19*, 1-12.

Engle, D., & Arkowitz, H. (2008). Viewing resistance as ambivalence: integrative strategies for working with ambivalence. *Journal of Humanistic Psychology, 48,* 389-412.

Engle, D., & Holiman, M. (2002). A gestalt-experiential perspective on resistance. *JCLP/In Sessions: Psychotherapy in Practice, 58*, 175-183.

Feixas, G., Sánchez, V., & Gómez-Jarabo, G. (2002). La resistencia en psicoterapia: El papel de la reactância, la construcción del sí mismo y el tipo de demanda [Resistance in psychotherapy: The role of reactance, self-construction, and the type of request]. *Análisis y modificación de conducta, 28*, 235-286.

Fernandes, E., Senra, E., & Feixas, G. (in press). *Terapia construtivista centrada em dilemas implicativos* [Constructivist Psychotherapy focused on implicative dilemmas]. Braga: Psiquilíbrios.

Fife-Schaw, C. (2006). Levels of measurement In G. M. Breakwell, S. Hammond, C. Fife-Schaw, & J. A. Smith (Eds), *Research methods in psychology* (pp. 50-63). London: Sage.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L., & Greenberg, L. (in press). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology*.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Santos, A., & Mendes, I. (in press). The Innovative Moments Coding System: A coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.)*, YIS: Yearbook of Idiographic Science 2009 - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, M. M. & Ribeiro, A. P. (2010). Narrative processes of innovation and stability within the dialogical self. Manuscript in preparation.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Mendes, I., & Santos, A. (2010). Tracking novelties in psychotherapy research process: The innovative moment coding system. Manuscript in preparation.

Gonçalves, M. M., Ribeiro, A. P., Santos, A., Gonçalves, J. & Conde, T. (2009). *Manual for the Return to the Problem Coding System – version 2*. Unpublished manuscript, University of Minho, Braga, Portugal.

Gonçalves, M. M., Santos, A., Salgado, J., Matos, M., Mendes, I., Ribeiro, A. P., Cunha, C., & Gonçalves, J. (2010). Innovations in psychotherapy: Tracking the narrative construction of change. In J. D. Raskin, S. K. Bridges, & R. Neimeyer (Eds.), *Studies in meaning 4: Constructivist Perspectives on Theory, Practice, and Social Justice* (pp. 29-64). New York: Pace University Press.

Hayes, A. M., Laurenceau, J. P., Feldman, G. C., Strauss, J. L., & Cardaciotto, L. A. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review, 27*, 715−723.

Hermans, H. J. (1996). Opposites in a dialogical self: constructs as characters. *Journal of Constructivist Psychology, 9*, 1-26.

Hermans, H. J. M. & Kempen, H. J. G. (1993). *The dialogical self: Meaning as movement*. San Diego: Academic Press.

Hermans, H. J. M., Kempen, H., & van Loon, R. J. P. (1992). The dialogical self: beyond individualism and rationalism. *American Psychologist, 47*, 23-33.

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35*, 23-33.

Honos-Webb, L., Stiles, W. B., Greenberg, L. S., & Goldman, R. (1998). Assimilation analysis of process-experiential psychotherapy: A comparison of two cases. *Psychotherapy Research*, *8*, 264-286.

Horvath, A. O. (1982). *Users' manual of the Working Alliance Inventory*. Unpublished manuscript, Simon Fraser University, Burnaby, Canada.

Josephs, I. & Valsiner, J., (1998). How does autodialogue work? Miracles of meaning maintenance and circumvention strategies. *Social Psychology Quarterly*, *61*, 68 – 83.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

Krause, M., de la Parra, G., Arístegui, R., Dagnino, P., Tominic, A., Valdés, N., Echávarri, O., Strasser, K., Reyes, L., Altimir, C., Ramírez, I., Vilches, O., & Ben-dov, P. (2007). The evolution of therapeutic change studied through generic change indicators. *Psychotherapy Research, 17*, 673-679.

Machado, C., & Matos, M., & Gonçalves, M. M. (2004). Escala de crenças sobre a violência conjugal (ECVC). In L. S. Almeida, M. R. Simões, C. Machado, & M. M. Gonçalves (Eds.), *Avaliação psicológica: Instrumentos validados para a população portuguesa – Vol. II* (pp.127-140). [Psychological assessment: Validated instruments for the Portuguese population – Vol. II].

Machado, P. P., & Horvath, A. O. (1999). Inventário da aliança terapêutica – WAI. In M. R. Simões, M. M. Gonçalves, & L. S.Almeida (Eds.), *Testes e provas psicológicas em Portugal – Vol. II* (pp. 87-94). [Tests and psychological instruments in Portugal – Volume II].

Matos, M. (2006). Violência nas relações de intimidade. Estudo sobre a mudança psicoterapêutica da mulher [Violence in intimate relationships: A research about the psychotherapeutic change in women]. Unpublished Doctoral Dissertation, University of Minho, Braga, Portugal.

McCarthy, K., & Barber, J.P. (2007). Book Reviews. *Psychotherapy Research, 17*, 504-507.

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Matos, M. (2006). Violência nas relações de intimidade. Estudo sobre a mudança psicoterapêutica da mulher [Violence in intimate relationships: A research about the psychotherapeutic change in women]. Unpublished Doctoral Dissertation, University of Minho, Braga, Portugal.

Matos, M., Machado, C., & Gonçalves, M. M. (2000). ECVC – Escala de crenças sobre a violência conjugal [Scale of beliefs of marital violence]. Unpublished manuscript, University of Minho Braga, Portugal.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

Mendes, I., Gonçalves, M. M., Ribeiro, A. P., Angus, L., & Greenberg, L. (2009). Innovative moments and change in emotion-focused therapy. Manuscript in preparation.

Napper, L., Fisher, D., Reynolds, G., Wood, M., Jaffe, A., & Klahn, J. (2008). Convergent and discriminant validity of three measures of stage of change. *Psychology of Addictive Behaviors, 22*, 362 – 371.

Osatuke, K., Mosher, J. K., Goldsmith, J. Z., Stiles, W. B., Shapiro, D. A., Hardy, G. E., & Barkham, M. (2007). Submissive voices dominate in depression: Assimilation analysis of a helpful session. *Journal of Clinical Psychology, 63,* 153-164.

Osatuke, K. & Stiles, W. B. (2010). Dialogical self and depression: The assimilation model perspective. Manuscript submitted for publication.

Polkinghorne, D. E. (2004). Narrative therapy and postmodernism. In L. E. Angus & J.McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory and research* (pp. 53-68). Thousand Oaks: Sage.

Prochaska, J. O. & Norcross, J. (2001). Stages of change. *Psychotherapy, 38,* 443-448.

Prochaska, J. O., & DiClemente, C. (1982). Transtheoretical therapy: toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19,* 276-288.

Ribeiro, A. P., & Gonçalves, M. M. (2010). Innovation and stability within the dialogical self: The centrality of ambivalence. *Culture & Psychology, 16*, 116-126.

Ribeiro, A. P., Gonçalves, M. M., & Santos, A. (in press). Innovative moments in psychotherapy: From the narrative outputs to the semiotic-dialogical processes. In S. Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.), *YIS: Yearbook of Idiographic Science 2010 – Volume 3.* Rome: Firera Publishing Group.

Santos, A., & Gonçalves, M. M. (2009). Innovative moments and change processes in psychotherapy: An exercise in new methodology. In J. Valsiner, P. C. M., Molenaar, M. C. D. P., Lyra, & N. Chaudhary (Eds.), *Dynamic process methodology in the social and developmental sciences* (pp. 493-526). New York: Springer.

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449–466.

Santos, A., Gonçalves, M. M., & Matos, M. (2011). Innovative moments and poor-outcome in narrative therapy. *Counselling and Psychotherapy Research*, *11*, 129-139.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1-21.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York: Oxford University Press.

Stiles, W. B. (2006). Assimilation and the process of outcome: Introduction to a special section. *Psychotherapy Research, 16,* 389-392.

Stiles, W. B., Elliott, R., Llewelyn, S. P., Firth-Cozens, J. A., Margison, F. R., Shapiro, D. A., & Hardy, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy, 27,* 411–420.

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Swann, W. B. (1987). Identity negotiation: Where two roads meet. *Journal of Personality and Social Psychology, 53,* 1038-1051.

Valsiner, J. (2002). Forms of dialogical relations and semiotic autoregulation within the self. *Theory and Psychology*, *12*, 251-265.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

White, M. (2007). *Maps of Narrative Practice*. New York: Norton.

Zimmerman, J. L., & Dickerson, V. C. (1994). Using a narrative metaphor: Implications for theory and clinical practice. *Family Process*, *33*, 233-246.

CHAPTER II

AMBIVALENCE IN EMOTION-FOCUSED THERAPY FOR DEPRESSION: HOW MUTUAL IN-FEEDING CONTRIBUTES TO THE MAINTENANCE OF PROBLEMATIC SELF-STABILITY

CHAPTER II[4]

AMBIVALENCE IN EMOTION-FOCUSED THERAPY FOR DEPRESSION: HOW MUTUAL IN-FEEDING CONTRIBUTES TO THE MAINTENANCE OF PROBLEMATIC SELF-STABILITY

1. ABSTRACT

This article explores the role of ambivalence in therapeutic-failure, shedding light on how clients may maintain a problematic self-stability across therapy by a mutual in-feeding process, which involves a cyclical movement between two opposing parts of the self. In this process an *Innovative Moment* (IM) is produced, challenging the problematically dominant self-narrative, but it is after attenuated or minimized by a return to the dominant self-narrative. The authors identified these *Return-to-the-Problem Markers* (RPMs) in passages containing IMs in six clients with major depression treated with emotion-focused therapy (three good-outcome cases and three poor-outcome cases). The percentage of IMs with RPMs decreased across therapy in the good-outcome group, whereas it remained unchanged and high in the poor-outcome group. The results suggest that some therapeutic failures may reflect a systematic return to a dominant self-narrative after the emergence of novelties (IMs).

2. INTRODUCTION

This study explored one possible path to therapeutic failure: how problematic self-stability can be maintained throughout therapy by a *mutual in-feeding* process (Valsiner, 2002), a cyclical movement between two opposing parts of the self. In the present study, we focused on the cyclical movement between clients' problematically dominant self-narrative (usual way of understanding the world) and *Innovative Moments*[1] (IMs) (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011), which are moments in the therapeutic dialogue when clients challenge their dominant self-narrative. Mutual in-feeding is a form of ambivalence that might be conceptualized as resistance to change, which has been described as one of the

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most important, yet highly under-investigated phenomena in clinical practice (Engle & Arkowitz, 2006; Wachtel, 1999).

We investigated the mutual in-feeding process in six cases of major depression treated with emotion-focused therapy (three good-outcome cases and three poor-outcome cases), previously analyzed with the *Innovative Moments Coding System* (IMCS; Gonçalves, Ribeiro, Mendes, et al., 2011) by Mendes et al. (2010). It was designed to replicate and extend a study from Gonçalves, Ribeiro, Stiles et al. (2011) that analyzed how IMs developed in Narrative Therapy (NT) with women who were victims of intimate violence.

2.1. A model of change in psychotherapy

2.1.1. Our conceptualization of the self. In line with Gonçalves and collaborators (2009), we propose that human beings construct meaning from the ongoing flow of experiences in the form of self-narratives (Bruner, 1986; Hermans & Hermans-Jansen, 1995; McAdams, 1993; Polkinghorne, 1988; Sarbin, 1986; White, 2007; White & Epston, 1990; see also Dimaggio, Salvatore, Azzara, Catania, Semerari, et al., 2003, for a review of this topic). We also propose that self-narratives result from dialogical processes of negotiation, tension, disagreement, alliance, and so on, between different internal positions or voices of the self (Hermans & Hermans-Jansen, 1995). In accordance with the Assimilation Model (Honos-Webb & Stiles, 1998; Stiles, 1999), we conceive voices as representing traces of the person's experiences or ways of being in the world. Constellations of similar or related experiences become linked or *assimilated* and form a *community of voices*, which is experienced by the person as their usual sense of self, personality, or center of experience.

2.1.2. Our conceptualization of problems. From the community of voices perspective, voices representing experiences that are discrepant from how individuals typically perceive themselves are problematic, and the community of voices wards off, distorts, or actively avoids such voices (Stiles, 2002; Stiles, Osatuke, Glick, & Mackay, 2004). Disconnection of such voices from the community underlies many forms of psychological distress, as, each aspect of a person's being has a positive potentiality (e.g., Rogers, 1959) and, thus, by losing touch with them, "an individual locks up part of his or her full potentiality" (Cooper, 2003, p. 146). In our view, a voice may become problematic to the rest of the self – and hence excluded – if the self-narrative is too rigid (Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011). In such cases, client's initial

(presenting) self-narrative is maladaptive because, by failing to acknowledge important parts of the client's life experience, it doesn't provide an effective guide to one's action (Dimaggio, 2003). In other words, "their map of the world is poor, and this restricts them in their orientation and exploration" (Dimaggio, 2003, p. 156).

2.1.3. Our conceptualization of change. Because unassimilated voices are traces of important, albeit painful experiences, they are expressions of vital elements of our being. Although silenced, they do not disappear. Instead, it is virtually inevitable that at certain times these voices emerge and express themselves. When they do, they may cause distress and maladaptive behavior. Such problematic voices may be assimilated through psychotherapeutic dialogue by building *meaning bridges* (Stiles, 2011), i.e., words or other signs that can represent, link and encompass the previously separated voices and thereby form a new configuration (as shown in numerous case studies; e.g., Honos-Webb et al., 1998; Osatuke et al., 2007).

A self-narrative is a meaning bridge that organizes many of a person's experiences, forming a new configuration of voices, giving smooth access to all so that they are available as resources. Thus, change in psychotherapy occurs as clients move from a dysfunctional dominant maladaptive self-narrative – i.e., ways of understanding that exclude important internal voices – to a more functional self-narrative that incorporates previously excluded (problematic) voices. We have proposed that this process occurs through the emergence, accumulation and articulation of IMs, which conceptually correspond to instances in which unassimilated voices express themselves. When non-dominant voices express themselves during IMs, the dominance of the current community of voices is disrupted, at least temporarily, and an opportunity for developing meaning bridges emerges.

Five types of IMs have been observed in the therapeutic process: action, reflection, protest, reconceptualization and performing change (Gonçalves, Ribeiro, Mendes et al., 2011). Examples of these IMs are shown in Table 1. Studies of brief psychotherapy have shown that poor- and good-outcome cases have different profiles of IMs. Two relevant, replicated findings, observed in hypothesis-testing studies (Gonçalves, Mendes et al., 2012; Matos et al., 2009; Mendes et al., 2010) and case studies (Alves, Mendes, Gonçalves, & Neimeyer, in press; Gonçalves, Mendes et al., 2010; Ribeiro, et al., 2011; Santos et al., 2010; Santos et al., 2009) are the following:

(1) IMs appear in both poor- and good-outcome cases, although in good outcome cases the IMs' *salience* (i.e., the proportion of the session devoted to the

elaboration of IMs) is longer and tends to increase as the treatment develops.

(2) Reconceptualization and performing change are seldom observed in poor-outcome cases but represent a substantial percentage of the IMs observed in good-outcome cases. In good-outcome cases, reconceptualization IMs tend to begin to occur in the middle of the therapeutic process and increase until the end of it. Performing change IMs tend to occur after the development of reconceptualization.

These results suggest not only that IMs plays a role in the change process, but also that they have different features and distinct and complementary functions, as good-outcome cases present a highest presence of IMs, as well as highest diversity of IMs (i.e., simultaneous presence of different types of IMs).

Table II. 1: Examples of IMs vis-à-vis a depressive dominant self-narrative

	Contents	Examples
Action	• New coping behaviours facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control; • Searching for information about the problem(s).	C: *Yesterday, I went to the cinema for the first time in months!*
Reflection	***Creating distance from the problem(s)*** • Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being.	C: *I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go…*
	Centered on the change • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies; implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	C: *I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.*
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s).	C: *What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!?*
	Emergence of new positions • Positions of assertiveness and empowerment;	C: *I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.*

Reconceptualization	RC always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	C: *You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…* T: *How did you have this idea of going to the museum?* C: *I called my dad and told him: we're going out today!* T: *This is new, isn't it?* C: *Yes, it's like I tell you… I sense that I'm different…*
Performing Change	• Generalization into the future and other life dimensions of good-outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	T: *You seem to have so many projects for the future now!* C: *Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.*

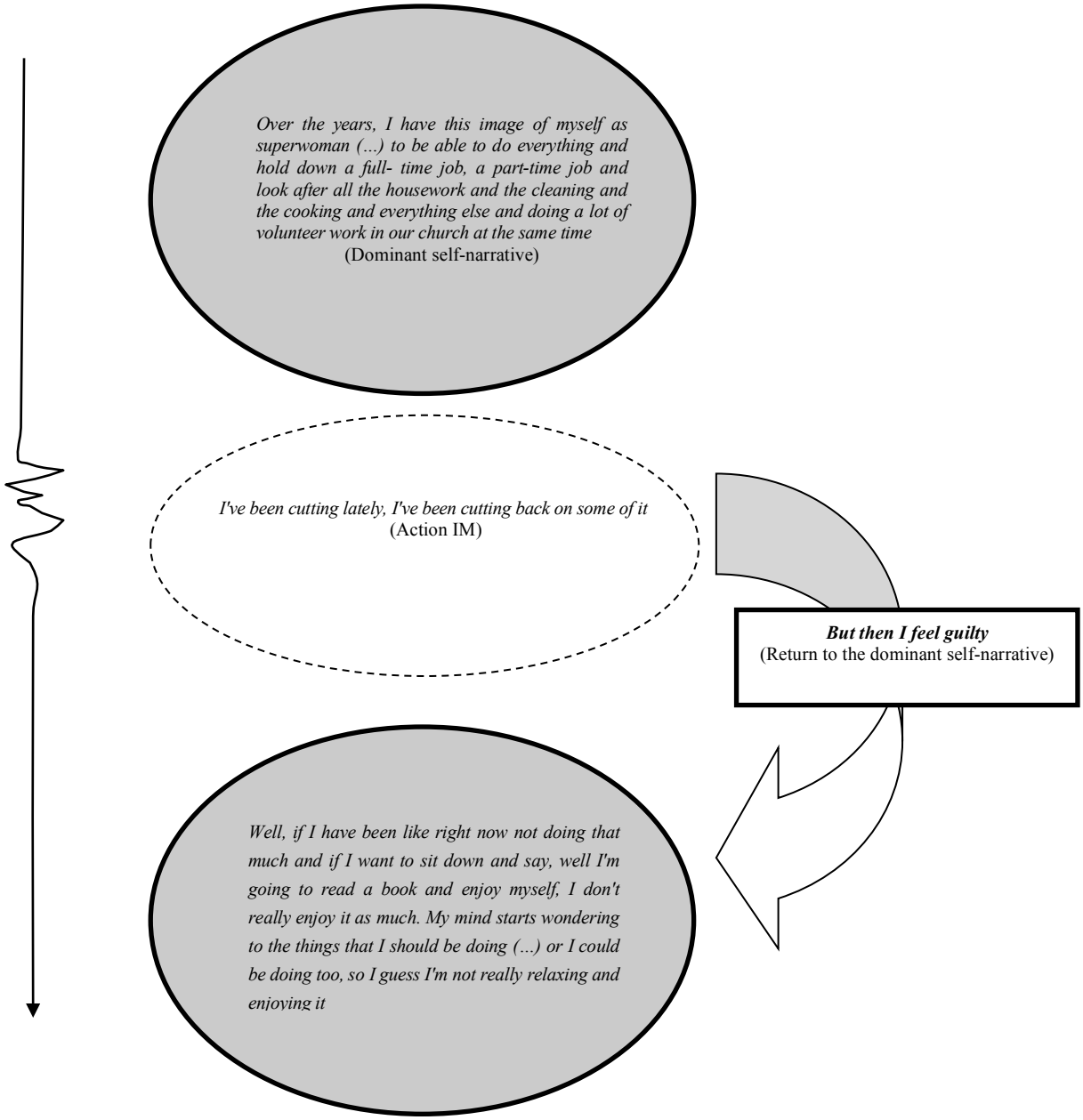
2.1.4. Our Perspective on Resistance. The emergence and elaboration of IMs in the therapeutic conversation challenges and destabilizes a person's usual way of understanding and experiencing (the dominant self-narrative), creating unpredictability and uncontrollability, threatening clients' sense of self-stability (Ribeiro & Gonçalves, 2010). Congruently, Engle and collaborators (Engle & Arkovitz, 2008; Engle & Holiman, 2002) have emphasized, from a humanistic-experiential perspective, that psychological changes introduce discrepancy or inner contradiction. This discrepancy may be experienced as a threat, evoking a self-protective response in which the discrepant experience is "distorted, denied, or inadequately symbolized" (Engle & Arkovitz, 2008, p. 391), keeping the client safe from the anxiety produced by the change. Whether IMs develop into a new self-narrative depends on the way this threat is managed.

We have noticed that in poor-outcome cases, as well as in initial and middle phases of good-outcome cases, clients tend to resolve the discrepancies or inner-contradictions that characterize IMs by making a quick return to the dominant self-narrative (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro et al., 2011; Santos et al., 2010). As Swann (1987) suggested, self-discrepant information (IMs) may prompt people to retrieve information supporting the self-conception that is being contradicted, thus promoting the return to the self-problematic narrative.

The return to the problematic self-narrative suppresses the innovative way of

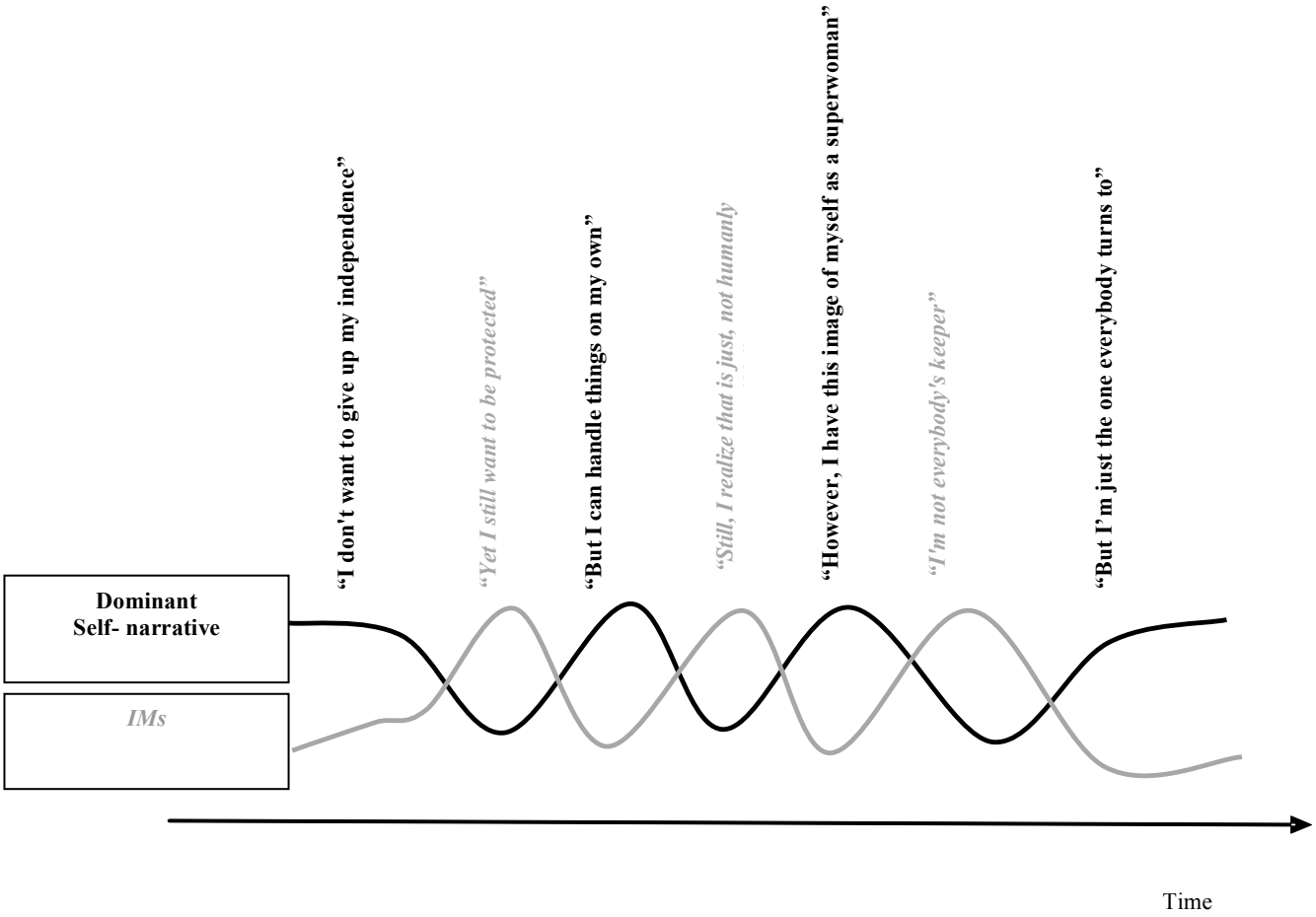
feeling, thinking, or acting by bypassing, minimizing, depreciating, or trivializing its meaning, and reinstates the problematic self-narrative, promoting stability. For instance, in the beginning of therapy, whenever Jan (a good-outcome case of EFT from the York I Depression Study; Greenberg & Watson, 1998) expressed feelings of dependency and weakness (unassimilated voice), i.e., experienced IMs, she frequently restated the need of being strong and independent (dominant voice), returning to the problematic self-narrative (Figure 1).

Figure II. 1: Avoiding self-discrepancy by returning to the dominant self-narrative: The case of Jan (session 1)



As this sequence repeats, the client oscillates between elaboration of IMs, which temporarily disrupts the problematic narrative, and the return to the dominant self-narrative, reducing the discrepancy created by the innovation. In this repetitive process, the problematic self-narrative and IMs act as opposite self-positions in a negative feedback loop relation (Figure 2). Valsiner (2002) has called this process *mutual in-feeding*.

Figure II. 2: Mutual in-feeding: The case of Jan



Mutual in-feeding is thus a form of stability within the self, which may be understood as two opposing parts of the self that keep feeding into each other, dominating the self alternately. From a dialogical point of view (Valsiner, 2002; see also Hermans, 1996), the client performs a cyclical movement between a voice (problematic self-narrative) and a counter-voice (IM) that interferes with further development. Rather than moving toward an inclusive system of meanings in therapy in which opposite internal voices respectfully listen to each other and engage in joint action (see Brinegar et al., 2006), mutual in-feeding may lead to an "impasse or a state of 'stuckness' (cf. Perls, 1969)" (Honos-Webb &Stiles, 1998, p. 28).

The term *rapid cross-fire* describes opposing expressions by two contradictory internal voices (Brinegar et al., 2006). Although the opposing voices are internal, their expressions are overt and explicit within the therapy, a phenomenon characterized as

intrapersonal dialogue; each voice triggers contradiction by the other, so they seem "to fight for possession of the floor" (Brinegar et al., 2006, p. 170). Emotion-Focused Therapy (EFT; Greenberg, Rice, & Elliot, 1993) also proposes a concept that describes instances in which there is a sense of struggle between two opposite aspects of the self that pull the person in different directions – *conflict splits*. In each of these characterizations of conflicting internal self-positions, the dialogue maintains the person's *status quo* and, thus, might be conceptualized as forms of resistance to change. With Arkovitz and Engle (2007), we understand resistance as ambivalence, which may be overcome by the development of relationships between the two opposite voices as they build meaning bridges (Brinegar et al., 2006).

2.1.5. Mutual in-feeding and association with outcomes. We have proposed a measure of the mutual in-feeding process that grew from our observations of therapy passages in which an IM emerged and was immediately followed by a return to the problematic experience. We called such events a *Return-to-the-Problem Marker* (RPM; Gonçalves, Ribeiro, Stiles, et al., 2011*)*. Let us take the example of George (a poor-outcome case of EFT from the York I Depression Study; Greenberg & Watson, 1998), whose depression was related to his feelings of inadequacy and inability to provide for his family. This view of himself as a failure permeated his relationships with significant others, particularly with his mother, with whom he had a distant relationship. Throughout his therapeutic process, George experienced several IMs, but they were usually followed by a RPM, as in the following excerpt:

Session 7

C: *I would like my mother to understand that perhaps one of the reasons why I have not been more forthcoming in visiting her in (country), is that whole problem, I just can't afford it, I mean, you know, I can barely make it from one pay day to the next*.

T: *So then partly you would like to explain what might be perceived by her as a lack of interest?*

C: *Yes, I think so*.

T: *Yeah, yeah, so somehow conveying to her that it's not a reflection of a lack of caring on your part...*

C: *That's right* [IM] (...) ***and yet it is this tremendous admission of failure.***

T: ***So part of you does not want to admit it?***

C: ***That's right*** **[RPM].**

In this example, George described an IM – "I would like my mother to understand

that perhaps one of the reasons why I have not been more forthcoming in visiting her in (country), is that (...) I just can't afford it" – and then returned to the dominant self-narrative by saying "and yet it is this tremendous admission of failure". This clause introduced by the word *yet,* represents opposition or negation towards what's being said and hence constitutes a RPM.

The results obtained in a sample of narrative therapy with women who were victims of intimate violence (N = 10; Gonçalves, Ribeiro, Stiles, et al., 2011) showed that IMs were much more likely to be followed by a RPM in poor-outcome cases than in good-outcome cases. Even though the cases had similar levels of symptom severity at intake, poor-outcome cases showed dramatically higher percentages of RPMs. This observation is consistent with the theoretical suggestion that mutual in-feeding between the dominant self-narrative and IMs can interfere with the therapeutic progress. Furthermore, we found a lower incidence of RPMs in reconceptualization and performing change IMs, which corroborates their role in the change process.

A recent longitudinal analysis of the narrative sample, suggests that the proportion of RPMs decreases in sessions, which present a greater diversity of IMs types (Ribeiro et al., 2012a). Interestingly, preliminary results obtained in a sample of depressive clients followed in Client-Centered Therapy (CCT; N = 6; Ribeiro et al., 2012b) corroborates this observation, which is congruent with the Gonçalves et al. (2009) suggestion that "in the reauthoring process, the development of a coherent, thick description of the experience of change emerges by the articulation of several different kinds of IMs" (p. 11).

2.2. Goals and hypotheses

In this study we extended our method for coding RPMs to another type of therapy – EFT – and another client group – depressive clients. We examined four hypotheses in this study: First, we hypothesized that that both good- and poor-outcome cases would present RPMs, as the emergence of IMs would threatens clients' sense of self-stability, evoking a self-protective response. However, we expected poor-outcome cases to present a relatively higher percentage of IMs followed by RPMs, based on their hypothesized contribution to therapeutic impasses. Second, we hypothesized that the probability of IMs containing RPMs decreases throughout treatment in good-outcome but not in poor-outcome cases. Third, we hypothesized that the probability of IMs containing RPMs decreases in sessions, which present a greater diversity of IMs types

(four or five), regardless of the outcome. Fourth, we hypothesized that action, reflection and protest IMs are more often followed by RPMs than are reconceptualization and performing change IMs, regardless of the outcome of the case.

3. METHOD

Data were drawn from the Mendes et al. (2010) study of IMs in EFT. Relevant parts of that study's method are summarized here; please see Mendes et al. (2010) for other details.

3.1. Clients

Cases were selected from a pool of clients who received EFT as participants in the York I Depression Study (Greenberg & Watson, 1998), a project designed to assess and compare process-experiential treatment (also known as EFT) and CCT for major depression. EFT entailed 16 to 20 sessions of individual psychotherapy once a week. Six of the 17 EFT cases had complete transcripts, which would allow for intensive process analyses. Four were women and two were men (age range = 27-63 years, M=45.50, SD = 13.78). Five of the clients were married, and one was divorced.

3.2. Therapists and therapy

EFT incorporates the client-centered relational conditions (Rogers, 1957) and adds experiential and gestalt interventions to facilitate the resolution of maladaptive affective-cognitive processing. EFT interventions included focusing (Gendlin, 1981) at a marker of an unclear felt sense, systematic evocative unfolding for problematic reactions, two-chair dialogue for self-evaluative and self-interruptive conflict splits, and empty-chair dialogue for unfinished business with a significant other (Elliott, Watson, & Greenberg, 2004; Greenberg et al., 1993; Greenberg & Watson, 2006).

Five therapists (four women, one man) conducted the individual therapy for the six clients analyzed in this study. Their levels of education varied from advanced doctoral students in clinical psychology to PhD clinical psychologists. Four therapists were Caucasian and one was Indian. All therapists received 24 weeks of training according to the York I Depression Study manual (Greenberg et al., 1993): eight weeks of CCT, six weeks of systematic evocative unfolding training, six weeks of two-chair dialogue training, and four weeks of empty-chair dialogue training.

3.3. Measures

3.3.1. Beck Depression Inventory (BDI). The BDI is a 21-item self-report instrument assessing symptoms of depression (Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The items are rated on a 4-point Likert scale, from 0 to 3, with total scores ranging from 0 to 63.

3.3.2. Innovative Moments Coding System (IMCS). Table 1 provides definitions and examples of the different types of IMs. In the previous studies, the IMCS (Gonçalves, Ribeiro, Mendes et al., 2011) proved to be reliable, with *Cohen's k* values of .89 in the study by Matos et al. (2009) and .86 in the study by Mendes et al. (2011). In other case studies the values of *Cohen's k* ranged from .76 (Gonçalves, Mendes, et al., 2010) to .90 (Ribeiro et al., 2011).

3.3.3. Return-to-the-Problem Coding System (RPCS). As described in the *Return-to-the-Problem Coding System* manual (Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2009), this is a qualitative system that analyses the re-emergence of the dominant self-narrative (through RPMs) immediately after the emergence of an IM or within the client's first speaking turn after the therapist's first intervention following the IM narration. Gonçalves, Ribeiro et al., (2011) reported a reliable agreement between judges on RPM's coding, with a *Cohen's k* of .93.

3.4. Procedure

3.4.1. IMs coding and reliability. Mendes et al. (2010) applied the IMCS (Gonçalves, Ribeiro, Mendes et al., 2011) (Table 1) to all session transcripts of the six selected EFT cases. Two judges participated; both were PhD students in psychology and authors of this paper and Mendes et al. (2010). One judge (this paper's second author) coded the entire sample and another judge (this paper's first author) independently coded 50% of the sessions of the sample (n = 53). Reliability indexes were computed on the 50% of sessions coded by both judges. The percentage of agreement on overall IMs salience was 88.7%. Reliability of distinguishing IM types, assessed by *Cohen's k*, was .86.

3.4.2. RPM coding and reliability. The same two judges participated in the RPM coding procedure as participated in the IMCS coding. Training for RPM coding began with reading the Manual for the RPCS (Gonçalves, Ribeiro, et al., 2009). Next, the two judges coded RPMs in a workbook that included transcripts of all IMs from one psychotherapy case. This step was followed by a discussion of discrepancies with a

group of other RPM judges in training and/or with a skilled RPM judge. After this discussion, they coded a second workbook that included transcripts of all IMs from another psychotherapy case. Their codes were then compared with the codes of expert judges. Judges were considered reliable if they achieve a *Cohen's k* higher than .75, which was the case.

RPMs coding comprised two sequential steps: (1) independent coding and (2) resolving disagreements through consensus. Both judges coded the entire sample (1260 IMs), analyzing IMs coded by Mendes et al. (2010) for the presence of RPMs, following the RPCS manual. The sessions were coded from the transcripts in the order they occurred. Reliability of identifying RPMs, assessed by *Cohen's k*, was .85, based on the initial independent coding of a sample size of 1333 IMs. Throughout the coding process, the two judges met after coding each session and noted differences in their perspectives of the problems and in their RPM coding. When differences were detected, they were resolved through consensual discussion. During the collaborative meetings, the judges discussed the strengths of each other's coding and the criteria used to achieve them. Through this interactive procedure, the judges were able to integrate each other's strengths, which facilitated the coding of subsequent sessions (cf. Brinegar et al., 2006). The analysis was then based on the consensus between the two judges.

3.4.3. Contrasting groups constitution. Clients were classified as having good- or poor-outcome based on a *Reliable Change Index* (RCI) analysis of the Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) pre-post therapy scores. Based on a BDI cutoff score of 14.29 and RCI of 8.46 proposed by Seggar, Lambert, and Hansen (2002), three clients were identified as ''recovered'' (i.e. with a good-outcome) and three were classified as ''unchanged'' (i.e. with a poor-outcome) at treatment termination. More specifically, BDI scores for the three good-outcome cases changed, pretest to posttest, from 25 to 3, from 30 to 5, and from 35 to 4, respectively, compared with 15 to 13, 23 to 22, and 24 to 18, respectively, for the poor-outcome cases.

No significant differences between the good-outcome and poor-outcome cases were found for number of sessions. The level of symptom severity on the pretreatment BDI was significantly different between the two outcome groups, with good-outcome clients scoring significantly higher (greater severity) than poor-outcome clients.

3.5. IMs in good- and poor-outcome groups

Mendes et al. (2010) reported that the global salience of IMs (proportion of session transcript text devoted to IMs) was higher in the good-outcome group than in the poor-outcome group and that this difference was entirely attributable to the differences in reconceptualization and performing change IMs. In the majority of good-outcome cases, reconceptualization and performing change IMs emerged in the middle of the therapy and increased through the final phase. In poor-outcome cases, reconceptualization IMs were almost absent and performing change IMs were absent throughout therapy.

4. RESULTS

We used a *Mann-Whitney* test to analyse Hypothesis 1 and we used *Generalized Linear Model* (GLM) to analyse Hypothesis 2 to 4. The GLM analysis allowed us to construct a regression model of the probabilities as a linear function of the explanatory variables through the logit link function (this function allows outcomes vary between 0 and 1) (McCullagh & Nelder, 1989). Significance levels were set at $\alpha = .05$. Because the number of IMs varied substantially across cases, we computed the percentage of IMs with RPMs (frequency of IMs with RPMs/total frequency of IMs*100) and used this measure instead of the frequency of RPMs in the analysis conducted to test hypothesis 1. By the same token, instead of using the frequency of RPMs in the different types of IMs, we computed the percentage of action, reflection, protest, reconceptualization and performing change IMs with RPMs (frequency of a given type of IM with RPMs/total frequency of this specific IM*100) and used this measure in the analysis conducted to test hypothesis 2.

4.1. Hypothesis 1: The emergence of RPMs in good- and poor-outcome groups

To test hypothesis 1 (both groups present RPMS but the poor-outcome group present a higher percentage of IMs with RPM), we conducted a *Mann-Whitney* test. Contrary to hypothesis 1, there were no significant differences between good- (M=21.70; SD = 2.92) and poor-outcome cases (M = 29.77; SD = 10.38), U = 6,00, p=.51, in the overall percentage of IMs followed by RPMs.

4.2. Hypothesis 2 and 3: The evolution of RPMs in good- and poor-outcome groups

To analyze hypothesis 2 and 3, we modeled the probability of IMs containing RPMs with a GLM, in particular a Binomial Model, assuming a link function between that probability and the linear predictor. That is, considering p = probability of RPM, than

$$p = \frac{\exp(linearpredictors)}{1+\exp(linearpredictors)} = \frac{\exp(X\beta)}{1+\exp(X\beta)}$$

for the linear predictor we used a linear function of the explanatory variables, as

$$linear\ predictor = X * \beta$$

Therefore, we considered the proportion of RPMs as the response variable, and time (from session 1 to 20), type of outcome (poor and good) and diversity of IMs types as explanatory variables. We considered two categories for IMs diversity: (1) *low diversity* (1, 2 or 3 types); and (2) *high diversity* (4 or 5 types). This option allows us to have a category in which there is necessarily at least one type of IM associated with good-outcome.

We included a subject specific random effect to take variability among individuals into account given that we expected that measurements (RPMs) from the same client would be correlated.

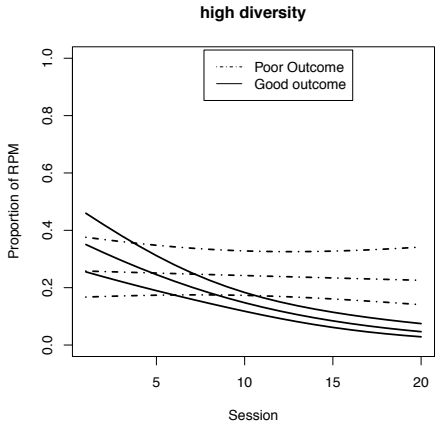
The results are presented in Figure 3, in which the y axis represents the probability of RPM occurring and the x axis therapy sessions over time. The estimated probability of RPMs at baseline was 35.8% for poor-outcome and 48.7% for good-outcome. Results indicated that these probabilities were statistically different (p = .045). In what concerns the estimated probability of RPMs at the last session, the poor-outcome group presented 31.4%, whereas the good-outcome group presented 4,5%. Again, these probabilities were statistically different (p < .0001).

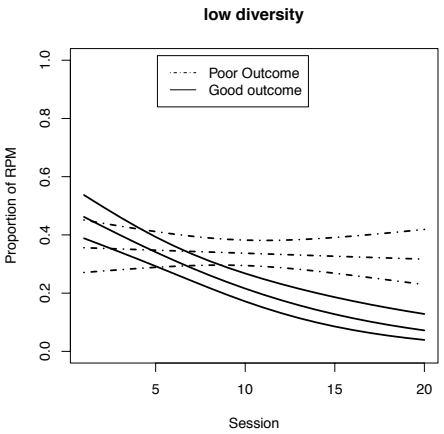
Moreover, the effect of interaction between time and outcome was statistically significant (p < .001). This means that the slope of two outcomes were significantly different: the probability of RPM decreased in the good-outcome group, whereas it remained unchanged in the poor-outcome group.

The effect of IMs diversity was also significant, that is, sessions with 4 or 5 types of IM presented statistically different probabilities of RPMs than sessions with 1, 2 or 3 types (p = 0.016). Specifically, the probability of RPMs decreased 38.6% in

sessions with higher diversity of IMs types independently of the outcome of the cases, given that there was an absence of interaction between outcome and diversity.

Figure II. 3: The evolution of RPMs in good- and poor-outcome groups





4.3. Hypothesis 4: The occurrence of RPMs in different types of IMs

In order to analysis hypothesis 4, we modeled the probability of IMs containing RPMs with a GLM, in particular a Binomial Model, assuming a link function between that probability and the linear predictor. That is, considering p = probability of RPM, than

$$p = \frac{\exp(linearpredictors)}{1+\exp(linearpredictors)} = \frac{\exp(X\beta)}{1+\exp(X\beta)}$$

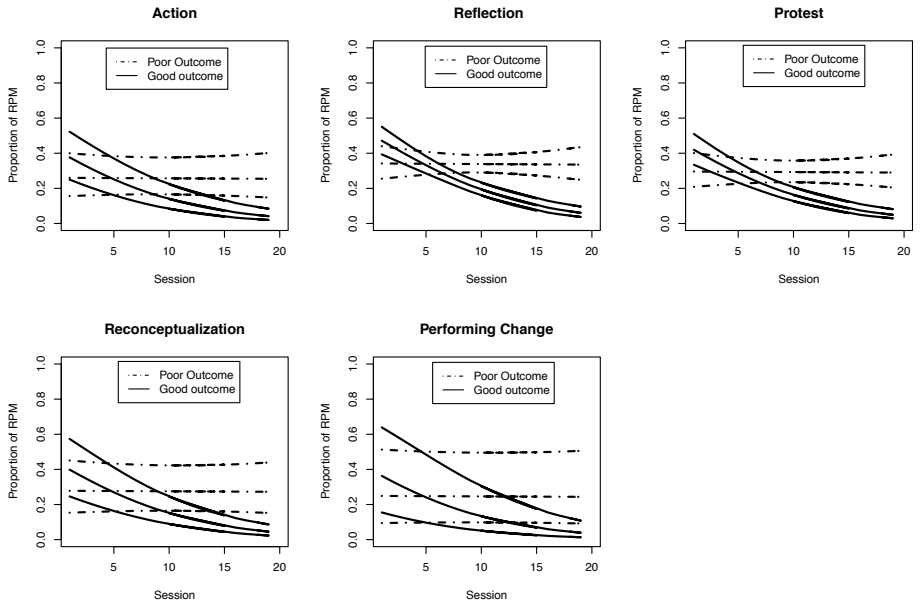
for the linear predictor we used a linear function of the explanatory variables, as

$$linear\ predictor = X * \beta$$

In this model, we have also considered the proportion of RPMs as the response variable, but we add the type of IM as an explanatory variable.

As shown in Figure 4, the effect of type of IM was not significant ($p > .05$ for all types), meaning that the probability of an RPM decreased in good-outcome group ($p<.001$), whereas it remained unchanged in the poor-outcome group, regardless of the IMs type.

Figure II. 4: The evolution of RPMs in different types of IMs



5. DISCUSSION

Results makes clear that RPMs are present in both groups, which corroborates the assumption that resistance in the form of ambivalence may be a natural part of the change process (Mahoney, 2003) and may be interpreted as a form of self-protection (Engle & Holiman, 2002), as people often experience fear and anxiety in the process of changing from something familiar into something unknown. However, in opposition to hypothesis 1, good- and poor-outcome groups presented a similar overall proportion of IMs containing RPMs. These results contrast with narrative therapy study (Gonçalves, Ribeiro et al., 2011) in which IMs were much more likely to be followed by RPM in the poor-outcome.

However, in line with hypothesis 2, good- and poor-outcome groups presented different trajectories across treatment: the probability of RPMs decreased in the good-outcome group, whereas it remained high in the poor-outcome group. Curiously, these results are congruent with EFT's epistemology, as this therapeutic approach is based on a dialectical constructivist view of the self in which the awareness and "confrontation between two opposing prior self-organizations", facilitated, for instance, by chair work, (Greenberg & Watson, 2006, p. 40) intends to facilitate a sense of integration between these two discrepant parts of self and the construction and consolidation of new meanings into a new self-organization (Greenberg & Watson, 2006; Elliott et al., 2004). Thus, in the good-outcome group RPMs decreased throughout the therapeutic process, consistent with the view that clients attain a sense of integration between the two parts of the self or two voices. On the contrary, in the poor-outcome group the probability of RPMs remained high until the end, meaning that clients did not resolve the conflicts between the two parts of the self.

As resistance is an interpersonal phenomenon, therapist's response to ambivalence may also account for the differences between good- and poor-outcome cases across sessions. In a recent study, using this EFT sample, Cunha et al. (2012), explored the association between therapist skills – exploration, insight and action (*Helping Skills System*; Hill, 2009) – and IMs and found two interestingly and probably related results. First, in contrast to good-outcome cases, in the poor-outcome cases, therapist use of action skills steadily increased across therapy. Second, insight skills were used more often in all phases of poor-outcome cases. Authors speculate that therapists were not able to engage clients as readily in the therapeutic tasks in the poor-

outcome cases and then kept trying to engage them later when it may have been too late, producing the increase of action skills. This is probably consistent with higher presence of insight skills in poor-outcome cases leading authors to speculate that in poor-outcome cases therapists were trying to find some way to help the clients when the more typically prescribed exploration skills were not working. In sum, Cunha et al. found higher levels of therapist directiveness toward change in poor-outcome cases, which are associated with higher levels of client resistance (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985; cf. Anderson, Knobloch-Fedders, Stiles, Ordonez, Heckman, in press). However, the possibility that therapist may contribute to the persistence of RPMs deserves further study.

Consistent with hypothesis 3, the probability of an RPM decreased in sessions which presented 4 or 5 types of IMs (high diversity) in both groups. This finding corroborates Gonçalves et al. (2009) suggestion that a new narrative constructed with low diversity of IMs types is not only an impoverished (and monotonous) type of story, but also more likely to be blocked by the mutual in-feeding process. This finding also suggest that different types of IMs have, in fact, different and complementary functions in the process of change and, specifically, in the process of overcoming mutual in-feeding.

However, contrary to narrative therapy in which we found a lower incidence of RPMs in reconceptualization and performing change IMs, in this study there was not an effect of type of IMs in the probability of RPMs, thus contradicting hypothesis 4. The role of reconceptualization IMs in overcoming mutual in-feeding, which has been previously suggested (Gonçalves & Ribeiro, 2012a, 2012b) calls for further research, as preliminary results in CCT (Ribeiro et al., 2012) also suggest that the emergence of reconceptualization decreases the probability of IMs containing RPMs.

Finally, the poor-outcome group showed dramatically lower probability of IMs containing RPMs in the first session. This finding may suggest that poor-outcome clients in this study's entered therapy at lower stages of the change process - avoidance in the assimilation sequence - whereas clients in EFT good-outcome group entered therapy at higher stages - rapid cross-fire, an alternation of opposing expressions (which appears to qualify as an RPM). The therapists' work in activating maladaptive core experiences is one of the primary goals in EFT for depression (Greenberg & Watson, 2006) but sometimes clients experience difficulty accessing their core issue and this may be an hypothesis of why in this study the poor-outcome group present a lower

probability of RPMs in the first session when compared to the good-outcome group. This result suggests that ambivalence in the initial phase of therapy may be looked at as marker of readiness for change and in-session productivity.

6. LIMITATIONS

Given the small sample size, our ability to generalize findings about psychotherapeutic failure is restricted. To begin with, the findings are limited to clients who have depression and who were willing to participate in research. Another limitation regarding this sample is the fact that we used heterogeneous contrasting groups: the two outcome groups (composed by these six clients) initiated EFT treatment with different levels of depression (i.e., the good-outcome group started with severe depression while the poor-outcome group started therapy with moderate depression). Despite these limitations, the fact that some results replicate findings obtained with other samples contributes for some confidence on these results.

7. REFERENCES

Alves, D., Mendes, I., Gonçalves, M. M., & Neimeyer, R. A. (in press). Innovative moments in grief therapy: Reconstructing meaning following perinatal death. *Death Studies*.

Anderson, T., Knobloch-Fedders, L., Stiles, W. B., Ordonez, T., & Heckman, B. D. (in press). The power of subtle interpersonal hostility in psychodynamic psychotherapy: A speech acts analysis. *Psychotherapy Research*.

Arkovitz, H., & Engle, D. (2007). Understanding and working with resistant ambivalence in psychotherapy. In S. G. Hofmann, & J. Weinberg (Eds.), *The art and science of psychotherapy* (pp. 171-190). New York: Routledge.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Cooper, M. (2003). "I-I" and "I-ME": Transposing Buber's Interpersonal Attitudes to the Intrapersonal Plane. *Journal of Constructivist Psychology, 16*, 131-153.

Cunha, C., Gonçalves, M. M., Hill, C., Sousa, I., Mendes, I., Ribeiro, A. P., Angus, L., & Greenberg, L. (in press). Therapist interventions and client innovative moments in emotion-focused therapy for depression. *Psychotherapy*.

Dimaggio, G., Salvatore, G., Azzara, C., Catania, D., Semerari, A., & Hermans, H. J. M. (2003). Dialogical relationships in impoverished narratives: From theory to clinical practice. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 385-409.

Elliott, R., Watson, J. C., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.

Engle, D., & Arkowitz, H. (2008). Viewing resistance as ambivalence: integrative strategies for working with ambivalence. *Journal of Humanistic Psychology, 48,* 389-412.

Engle, D., & Holiman, M. (2002). A gestalt-experiential perspective on resistance. *JCLP/In Sessions: Psychotherapy in Practice, 58*, 175-183.

Gendlin, E. T. (1981). *Focusing* (2nd Ed.). New York: Bantam Books.

Gonçalves, M. M., & Ribeiro, A. P. (2012a). Therapeutic change, innovative moments and the reconceptualization of the self: A dialogical account. *International Journal of Dialogical Science*, *6*, 81-98.

Gonçalves, M. M., & Ribeiro, A. P. (2012b). Narrative processes of innovation and stability within the dialogical self. In H. J. M. Hermans & T. Gieser (Eds.), *Handbook of Dialogical Self* (pp. 301-318). Cambridge: Cambridge University Press.

Gonçalves, M. M., Ribeiro, A. P., Santos, A., Gonçalves, J. & Conde, T. (2009). *Manual for the Return to the Problem Coding System – version 2*. Unpublished manuscript, University of Minho, Braga, Portugal.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Mendes, I, & Santos, A. (2011). Tracking novelties in psychotherapy process research: The Innovative Moments Coding System. *Psychotherapy Research, 21*, 497-509.

Gonçalves, M. M., Ribeiro, A. P., Stiles, W. B., Conde, T., Santos, A., Matos, M., & Martins, C. (2011). The role of mutual in-feeding in maintaining problematic self-narratives: Exploring one path to therapeutic failure. *Psychotherapy Research*, *21*, 27-40.

Gonçalves, M. M., & Stiles, W. B. (2011). Introducing the special section on narrative and psychotherapy. *Psychotherapy Research, 21*, 1-3.

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology*, *23*, 267–294.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-focused therapy for depression*. Washington, DC: American Psychological Association.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: The Guilford Press.

Hermans, H. J. (1996). Opposites in a dialogical self: constructs as characters. *Journal of Constructivist Psychology, 9*, 1-26.

Hermans, H. J. M., & Hermans-Jansen, E. (1995). *Self-narratives: The construction of meaning in psychotherapy*. New York: Guilford.

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35*, 23-33.

Mahoney, M. J. (2003). *Constructive psychotherapy: Practices, processes, and personal revolutions*. New York: Guilford.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McCullagh, P., & Nelder, J. (1989). *Generalized linear model*. London: Chapman & Hall.

Mendes, I., Ribeiro, A. P., Angus, L., & Greenberg, L., Gonçalves, M. M. (2010). Innovative moments and change in emotion-focused therapy. *Psychotherapy Research*, *20*, 692-701.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*, 455-461.

Osatuke, K., Mosher, J. K., Goldsmith, J. Z., Stiles, W. B., Shapiro, D. A., Hardy, G. E., & Barkham, M. (2007). Submissive voices dominate in depression: Assimilation analysis of a helpful session. *Journal of Clinical Psychology, 63,* 153-164.

Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology, 53*, 846-851.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Ribeiro, A. P., Cruz, G., Mendes, I., Stiles, W. B., & Gonçalves, M. M. (2012). Ambivalence in Client-Centered Therapy. Manuscript in preparation.

Ribeiro, A. P., Conde, T., Stiles, W. B., Santos, A., Matos, M., Sousa, I., & Gonçalves, M. M. (2012). Ambivalence in Narrative Therapy. Manuscript in preparation.

Ribeiro, A. P., Bento, T., Salgado, J., Stiles, W. B., & Gonçalves, M. M. (2011). A dynamic look at narrative change in psychotherapy: A case-study tracking innovative moments and protonarratives using state-space grids. *Psychotherapy Research*, *21*, 34-69.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of psychotherapeutic personality changes. *Journal of Counselling Psychology, 21*, 95-103.

Santos, A., Gonçalves, M. M., & Matos, M. (2010). Innovative moments and poor-outcome in narrative therapy. *Counselling and Psychotherapy Research.* Advance online publication doi: 10.1080/14733140903398153.

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449–466.

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Seggar, L. B., Lambert, M. J., & Hansen, N. B. (2002). Assessing clinical significance: Application to the Beck Depression Inventory. *Behavior Therapy, 33*, 253-269.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1-21.

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367-384.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York: Oxford University Press.

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans, & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Swann, W. B. (1987). Identity negotiation: Where two roads meet. *Journal of Personality and Social Psychology, 53,* 1038-1051.

Valsiner, J. (2002). Forms of dialogical relations and semiotic autoregulation within the self. *Theory and Psychology*, *12*, 251-265.

Wachtel, P. L. (1999), Resistance as a problem for practice and theory. *Journal of Psychotherapy Integration, 9*, 103-118.

White, M. (2007). *Maps of Narrative Practice*. New York: Norton.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

CHAPTER III

A DYNAMIC LOOK AT NARRATIVE CHANGE IN PSYCHOTHERAPY: A CASE STUDY TRACKING INNOVATIVE MOMENTS AND PROTONARRATIVES USING STATE SPACE GRIDS

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1. ABSTRACT

This study aims to further the understanding of how *Innovative Moments* (IMs), which are exceptions to a client's problematically dominant self-narrative in the therapy dialogue, progress to the construction of a new self-narrative, leading to successful psychotherapy. The authors' research strategy involved tracking IMs, and the themes expressed therein (or *protonarratives*), and analysing the dynamic relation between IMs and protonarratives within and across sessions using state space grids in a good-outcome case of constructivist psychotherapy. The concept of protonarrative helped explain how IMs transform a dominant self-narrative into a new, more flexible, self-narrative. The increased flexibility of the new self-narrative was manifested as an increase in the diversity of IM types and of protonarratives. Results suggest that new self-narratives may develop through the elaboration of protonarratives present in IMs, yielding an organizing framework that is more flexible than the dominant self-narrative.

2. INTRODUCTION

We assume that human beings construct meaning from the ongoing flow of experiences in the form of self-narratives (Bruner, 1986; Hermans & Hermans-Jansen, 1995; McAdams, 1993; Polkinghorne, 1988; Sarbin, 1986; White, 2007; White & Epston, 1990; see also Dimaggio, Salvatore, Azzara, Catania, Semerari, et al., 2003, for a review of this topic). Self-narratives can be viewed as rules of action and worldviews that "play a vital self-organizing function for the individual" (Neimeyer, Herrero, & Botella, 2006, p. 129), preventing psychological chaos and allowing a sense of self (Dimaggio, Salvatore, Azzara, Catania, Semerari, et al., 2003; Neimeyer, 1995), or as *meaning bridges*, gving smooth access to a person's diverse experiences and self-states (Osatuke et al., 2004).

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Self-narratives can become problematic when they restrict cognitive and affective diversity, thus limiting behavioral possibilities. For instance, depressive clients often organize their self-narratives around the themes of loss, inability, and hopelessness, thus preventing other possible themes from being constructed (O. F. Gonçalves & Machado, 1999). We present a conceptualization of how problematically dominant self-narratives can be replaced by alternative, more flexible, self-narratives in successful psychotherapy and a case study that highlights this process of narrative change.

2.1. Innovative Moments

Significant changes in a client's problematic self-narrative, such as those that occur in successful psychotherapy, start with the emergence of novelty, which White and Epston (1990) called *Unique Outcomes* and we call *Innovative Moments* (IMs; M. M. Gonçalves, Matos, & Santos, 2009; Matos, Santos, M. M. Gonçalves, & Martins, 2009). IMs can be conceived as exceptions to the problematic rules that organize a client's life. For instance, if the rules that organize the self-narrative of a depressive client are lack of assertion and feelings of inability, then an exception to these rules in the form of an assertive thought, action, or feeling would be considered an IM (see M. M. Gonçalves, Santos, et al., 2010). This study aimed to examine how IMs led to the construction of a new self-narrative in a successful psychotherapy.

Previous research has shown that IMs can be reliably identified using the *Innovative Moments Coding System* (IMCS; M. M. Gonçalves, A. P. Ribeiro, Matos, Mendes, & Santos, 2010a, 2010b), and that IMs occur in different kinds of brief therapy, namely narrative (Matos et al., 2009; Santos, M. M. Gonçalves, & Matos, 2010; Santos, M.M. Gonçalves,Matos, & Salvatore, 2009), emotion-focused (M. M. Gonçalves, Mendes, A. P. Ribeiro, Angus, & Greenberg, 2010; Mendes, A. P. Ribeiro, Angus, Greenberg, Sousa, & M. M. Gonçalves, in press), client-centered (M. M. Gonçalves, Mendes, et al., 2010), and constructivist (A. P. Ribeiro, M. M. Gonçalves, & E. Ribeiro, 2009; A. P. Ribeiro, M. M. Gonçalves, & Santos, in press) therapies, thus representing a pattern of change common to several different approaches. The IMCS distinguishes five different IM categories. IMs may contain both client and therapist turn-taking, insofar as change is understood to be co-constructed between therapist and client (Angus, Levitt, & Hardtke, 1999). In the following, we give a definition of each IM, along with an illustrative clinical vignette. To aid comparisons, we constructed all vignettes for a hypothetical client diagnosed with major depression with severe social

withdrawal.

1. *Action IMs*: specific behaviors that challenge the dominant self-narrative.

Client: *Yesterday, I went to the cinema for the first time in months!*

2. *Reflection IMs*: thoughts, feelings, intentions, projects, or other cognitive products that challenge the dominant self-narrative.

Client: *I realize that the more I isolate myself, the more depression gets overwhelming.*

3. *Protest IMs*: new behaviors (like action IMs) and/or thoughts (like reflection IMs) that challenge the dominant self-narrative, representing a refusal of its assumptions. This active refusal is the key feature that allows distinguishing protest from action and reflection.

Client: *I'm feeling stronger now and won't let depression rule my life anymore! I want to experience life, I want to grow, and it feels good to be in charge of my own life*.

4. *Reconceptualization IMs*: the most complex type of innovation in which the client not only describes some form of contrast between present and past (e.g., "*Now I've changed X or Y*") but also understands the processes that allowed this transformation.

Client: *You know . . . when I was there at the museum, I thought to myself, 'You really are different . . . A year ago you wouldn't be able to go to the supermarket!' Ever since I started going out, I started feeling less depressed . . . it is also related to our conversations and changing jobs.*

Therapist: *How did you have this idea of going to the museum?*

Client: *I called my Dad and told him: 'We're going out today!'.*

Therapist: *This is new, isn't it?*

5. *Performing change IMs*: new aims, experiences, activities, or projects, anticipated or in action, as a consequence of change.

Therapist: *You seem to have so many projects for the future now!*

Client: *Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences, and to feel the complicity in my life again.*

Findings from IM research using quantitative, qualitative, and mixed methods, including both hypothesis-testing studies with samples and intensive case studies, suggest that there is a common pattern of change across different therapeutic approaches. Poor- and good-outcome cases tend to be similar in the beginning of the therapeutic process, presenting IMs of action, reflection, and protest. However, by the middle of the process, good-outcome cases present a relatively greater salience (i.e., a larger percentage of time during sessions) in reconceptualization and performing change IMs. In fact, reconceptualization and performing change IMs are almost absent in poor-outcome cases (Matos et al., 2009; Mendes et al., in press; A. P. Ribeiro et al., 2009, in press; Santos et al., 2009, 2010; see M. M. Gonçalves, Santos, et al., 2010, for a review).

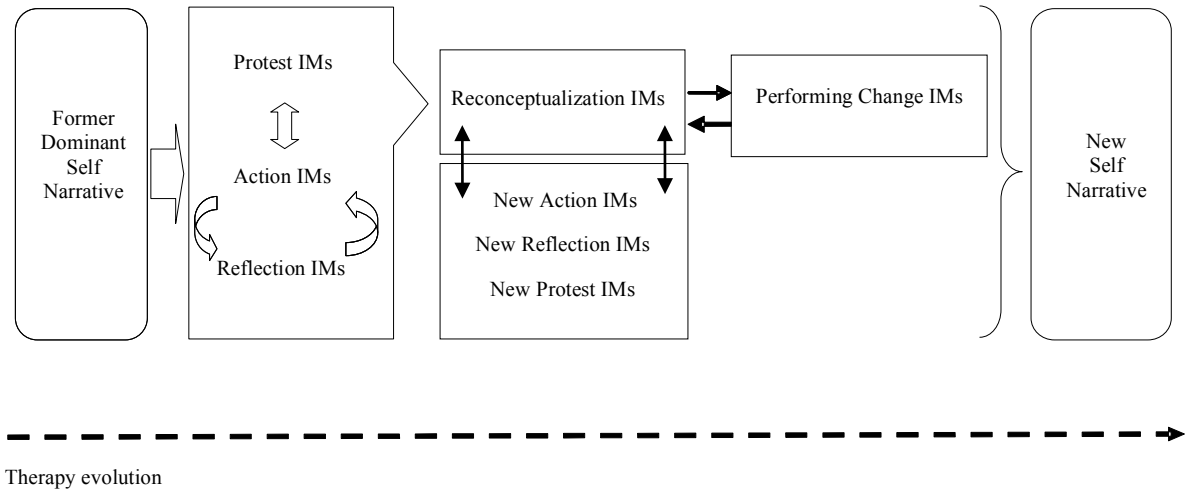
Based on these studies, a heuristic model of narrative change in psychotherapy was developed (M. M. Gonçalves et al., 2009; see Figure 1), according to which change starts with action and reflection IMs. These are considered the most elementary kind of novelty, in which the person starts wondering about how life could be different (reflection IMs), which may instigate new actions (action IMs) congruent with these reflections (or vice versa, from action to reflection). Several cycles of action and reflection (or, inversely, reflection and action) may be needed to ensure, to the person and to significant others that something really different from the dominant self-narrative is happening.

Sometimes, protest IMs emerge alongside action and reflection IMs at the beginning of therapy, while other times protest IMs emerge only after some development of reflection and action IMs. Protest IMs represent a client's objection to the dominant self-narrative's assumptions, allowing the client to reposition him- or herself toward the problem and toward significant others who may support it. By protesting, the client assumes a position of assertiveness, empowerment, and agency in the process of self-reconstruction.

In successful therapies, reconceptualization emerges around the middle of the therapeutic process. Reconceptualization's two ingredients – contrast between present and past and reflective understanding of the process of change – both appear important in sustaining meaningful change. First, the contrast between past and present integrates material that emerged in the more episodic IMs that occurred before (action, reflection, and protest). Second, reflective understanding of the process of change positions the client as an active author of the change process insofar as the novelty was not just

something that happened but was something that the client was responsible for. This component of reconceptualization involves a metaposition (see Dimaggio, Salvatore, Azzara, & Catania, 2003), which seems to be vital in the process of change. The reconceptualization, following cycles of action, reflection, and protest IMs, builds a new narrative of the self, which may compete with the dominant self-narrative. Performing change IMs eventually emerge, representing the generalization of the new narrative into different life areas.

Figure III. 1: Heuristic model of change



Note. From *Narrative therapy and the nature of "innovative moments" in the construction of change* by M. M. Gonçalves, M. Matos, & A. Santos, 2009. Adapted with permission.

2.2. Protonarratives

Theoretically, each IM involves the emergence of divergent narrative content or a theme that contrasts with the dominant self-narrative. In the course of the therapeutic process, some of these innovative contents recur frequently. We propose to identify such recurrent contents or themes as protonarratives[6]. Whereas IMs (e.g., action, reflection) are types of narrative processes, protonarratives are the specific contents that

[6] Other authors have used ''protonarrative'' in different ways. For instance, Salvatore, Dimaggio, and Semerari (2004) defined it as ''micro-sequences of mental images continuously occupying our consciousness'' (p. 236). Therapy may help clients to focus on these preexisting but unarticulated conscious elements of their life (protonarratives in Salvatore et al.'s sense) until they become fully fledged ones: IMs.

emerge in a client's IMs.

As an illustration, consider the process of change in a hypothetical client's dominant self-narrative centered on the lack of assertiveness. Initially, IMs might be focused on (1) acknowledging the client's needs, (2) being assertive, or (3) expressing anger toward those who neglected the client's needs over time (e.g., his or her parents) and avoiding contact with them. All three represent exceptions to the dominant self-narrative (lack of assertion). Suppose we observe recurrent IMs focused on expressing anger. The redundancy around this theme may be understood as the emergence of a resentment protonarrative. The resentment protonarrative might emerge in several types of IMs, from action to performing change. This protonarrative could be transitory, giving way to a new one centered on the client accepting that others did their best and trying to establish a new kind of relationship with them by asserting his or her needs; this is an acceptance protonarrative. If the acceptance protonarrative expanded and became dominant in the client's life, it could be considered as a new self-narrative.

Protonarratives contain elements of new potential self-narratives insofar as they may be considered as comprising a new set of rules (e.g., ''Instead of privileging other people's wishes, I should respect my own wishes''). Thus, they represent the specific content of the change that a client's IMs promote. As the prior example illustrates, not all protonarratives become stable or viable. Some become stronger (e.g., the acceptance protonarrative), while others fade away (e.g., the resentment protonarrative). Progress toward a new self-narrative may be indicated by IMs shifting from one recurrent protonarrative (e.g., resentment) to another (e.g., acceptance).

As IMs occur during the therapeutic conversation, facilitated by different therapeutic techniques (e.g., empty chair in emotion-focused therapy; externalization in narrative therapy), they make the corresponding protonarratives available for elaboration. In the course of the therapeutic conversation following an IM, the protonarratives become more detailed; the possible meanings and implications become clearer. In turn, this fosters the occurrence of new IMs and the exploration of new cognitive, emotional, and behavioral possibilities.

Both protonarratives and IMs can be identified and classified in the therapeutic dialogue. To us, combining these two sorts of measurement seemed a promising research strategy to develop an understanding of the change process. Therefore, we have adopted a research strategy that involved (1) tracking IMs, (2) tracking alternative protonarratives, and (3) analyzing the dynamic relations between IMs types and

protonarratives during the therapeutic process (A. P. Ribeiro, Bento, M. M. Gonçalves, & Salgado, 2010).

Theoretically, increase in diversity in types of IMs and protonarratives across the sessions is consistent with successful change, because flexibility is considered a central characteristic of the meaning-making processes involved in the alternative self-narrative construction. Rigidity of these processes would cause stability and dominance of certain meanings over other possible ones, consequently blocking their emergence and expansion (White & Epston, 1990).

2.3. State space grids

To analyze the development of IMs and protonarratives and their dynamic interactions across therapy sessions, we used *State Space Grids* (SSGs; Lewis, Lamey, & Douglas, 1999; Lewis, Zimmerman, Hollenstein, & Lamey, 2004). SSGs are a means of data analysis proposed in the context of developmental psychology for the study of two synchronized time series of categorical or ordinal variables (Lewis et al., 1999, 2004).

In constructing SSGs, two time series are considered to constitute a dynamic system (Thelen & Smith, 1998) with a finite number of possible states. The system's state at a given moment in time is defined by the positions of the two variables that constitute the system. The system's complete range of possible states is called state space, which can be represented by a matrix in which categories of one variable are represented on the x-axis and categories of the second variable are represented on the y-axis. Each cell in the matrix then corresponds to one of the system's possible states. Although a wide range of states is possible, systems typically occupy only a limited number within a given time interval. Systems tend to persevere and stabilize in certain states, and these more frequent and recurrent states are called attractors. Attractors may be characterized as ''absorbing'' or ''pulling'' states (Granic & Hollenstein, 2003) or as pushing the system away from other possible states.

Research using SSGs has focused on dyadic interaction between infants and caregivers (e.g., Granic & Lamey, 2002; Granic, Hollenstein, Dishion, & Patterson, 2003; Granic, O'Hara, Pepler, & Lewis, 2007; Hollenstein, Granic, Stoolmiller, & Snyder, 2004; Hollenstein & Lewis, 2006), adolescent friendship (Dishion, Nelson, Winter, & Bullock, 2004), emotional system of married couples (Gardner & Wampler, 2008), and social dynamics in the preschool (Granic & Hollenstein, 2003; Martin,

Fables, Hanish, & Hollenstein, 2005; see Hollenstein, 2007, for a review). We applied SSGs in a single-case design, reasoning that ‘‘individual time course data can facilitate movement beyond the question of whether change occurs and toward an understanding of how change occurs (Barkham, Stiles, & Shapiro, 1993)’’ (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007, p. 717).

2.4. The present study

The present study set out to map self-narrative reconstruction in a good-outcome case. We used SSGs, a new methodology in this area, to track the emergence of alternative protonarratives in IMs and to depict their development across the therapeutic process, seeking a richer understanding of how narrative change occurs. We considered this as a theory-building case study (Stiles, 2005, 2009), in which we examined the fit between case observations and our theory, aiming to refine our model of change by adjusting it to accommodate new observations. We explored four main research questions:

1. How do IM types and salience evolve across sessions (narrative process)?

2. Which protonarratives emerge in IMs, and how does their salience evolve across sessions (narrative content or theme)?

3. How are IM types (narrative process) associated with protonarratives across sessions (narrative content or theme)?

4. How does the flexibility of the alternative self- narrative evolve across sessions?

3. METHOD

3.1. Client

Caroline (a pseudonym) was a 20-year-old White woman who gave permission for her materials to be used for research. She reported as her main problems feelings of sadness, hopelessness, and worthlessness after her entrance in the university and beginning a romantic relationship, which impaired her interpersonal relationships and her academic functioning. She described difficulties with being assertive (especially with her boyfriend), satisfying the needs of others to the detriment of her own. She usually took responsibility for her parents’ problems, trying to protect her mother from her father, who used to stalk her even after divorce. During therapy, Caroline was able to make connections between these different problems and realize how they were all

part of a larger functioning pattern: pessimism.

3.2.Therapy and therapist

Caroline participated in brief and individual constructivist therapy focused on implicative dilemmas (Fernandes, 2007; Fernandes, Senra, & Feixas, 2009; Senra, Feixas, & Fernandes, 2007) for 12 sessions as well as one follow-up session at her university's clinic. Therapy terminated by mutual decision after completion of the treatment manual, when Caroline and her therapist agreed that the main goals had been achieved. Video recordings were made of all 12 sessions. However, sessions 1 and 11 failed to record because of technical problems, leaving 10 sessions available for analysis.

According to Senra and E. Ribeiro (2009), ''implicative dilemmas represent a form of blockage in the individual's constructing activity, where an undesired construction is strongly related to other, positive and self-defining, construction(s). As a result, the person can't move towards a desired construction as that would imply abandoning some nuclear features of the self, or embracing some undesired aspects that correlate with the wanted one'' (p. 1). Senra et al. (2007; see also Fernandes, 2007) developed a brief therapy aimed at solving these impasses in client constructions, organized in five stages: (1) assessment, (2) reframing the problem as a dilemma, (3) dilemma elaboration, (4) alternative enactment, and (5) treatment termination. Sessions are structured in terms of goals and tasks, but there is time flexibility for their completion. Their proposal adopts a hermeneutic and phenomenological perspective, using predominantly explorative interventions, privileging reflection and elaboration of the client's personal meanings.

The therapist was a 25 year-old White female doctoral student in clinical psychology, with three years of prior clinical experience as psychotherapist, who had undergone training in the therapeutic model before participation in the study and attended weekly group supervision for this case.

3.3. Researchers

The qualitative IM analysis was conducted by António P. Ribeiro and two volunteer judges. All three were doctoral students in clinical psychology, and all were well versed in the IMCS (M. M. Gonçalves, A. P. Ribeiro, et al., 2010a, b). The protonarrative analysis was conducted via discussions between António P. Ribeiro and the IMs research team. Miguel M. Gonçalves, a university faculty member in clinical

psychology and A. P. Ribeiro's advisor, served as an auditor of protonarrative identification, reviewing and checking the judgments made by the team. Tiago Bento, a doctoral student in clinical psychology, and João Salgado, a university faculty member in clinical psychology, conducted the analysis of SSGs. William B. Stiles, a university faculty member in clinical psychology and A. P. Ribeiro's co-advisor, contributed to conceptualizing and writing this report.

3.4. Measures

3.4.1 Outcome Questionnaire (OQ-45.2; Lambert et al., 1996). The OQ-45.2 is a brief self-report instrument, composed of 45 items, designed for repeated measurement of client status through the course of therapy and at termination. It monitors the client's progress in three dimensions: subjective discomfort, interpersonal relationships and social role functioning. The items are rated on a 5-point Likert scale, from 0 to 4, with total scores ranging from 0 to 180. A Portuguese version was developed by Machado and Klein (2006). The internal consistency (*Cronbach's* α) values for the OQ-45 total and respective subscales were in satisfactory ranges (0.69 to 0.92). The *Reliable Change Index* (RCI; Jacobson & Truax, 1991) is 18 points and the cut-off score is 62.

3.4.2. Innovative Moments Coding System (IMCS; M. M. Gonçalves, Ribeiro et al., 2010a, b). The IMCS (Table 1) is a system of qualitative analysis that differentiates five meaning categories, designated as *Innovative Moments* (IMs): action, reflection, protest, reconceptualization and performing change. Previous studies using the IMCS (e.g., Matos et al., 2009; Mendes et al., 2010) reported a reliable agreement between judges on IM's coding, with *Cohen's k* between .86 and .97.

3.4.3. Protonarratives Coding System (PCS; A. P. Ribeiro, M. M. Gonçalves, & Bento, 2010). The PCS analyses the underlying theme of each IM, designating a central protonarrative.

3.5. Procedure

Our research strategy involved three major steps of analysis: (1) identifying IMs, (2) identifying protonarratives, and (3) depicting and explaining the relations between these protonarratives and IMs during Caroline's therapy.

3.5.1. Case categorization. Caroline was diagnosed with an adaptation disorder with depressive symptoms, according to DSM IV (American Psychiatric Association, 1994). Her case was considered a good-outcome case on the basis of significant symptomatic change evidenced in the pre-post OQ-45.2 total score (Lambert et al.

1996; Portuguese version adapted by Machado & Klein, 2006). Her pre-therapy OQ-45.2 total score of 99 dropped to 50 at therapy termination, which allow us to classify Caroline as having met criteria for recovery (i.e., passed both a OQ-45.2 cut-off score and RCI criteria; Machado & Fassnacht, 2010) at treatment termination (see Jacobson & Truax, 1991; McGlinchey et al., 2002).

3.5.2. Identifying IMs: Coding procedures and reliability. Session recordings were coded according to the IMCS (M. M. Gonçalves, A. P. Ribeiro, et al., 2010a, 2010b) by three judges: Judge 1 (António P. Ribeiro) coded all the sessions available (10 sessions); and Judges 2 and 3 (who were unaware of the outcomes) independently coded five sessions each. Before beginning their independent coding, the judges discussed their understanding of the client's problems (dominant self-narrative). This step was guided by the question: "What is the central rule/ framework that organizes Caroline's suffering?" This discussion aimed to generate a consensual definition of the client's main self-narrative rules so that all could code the exceptions to the rules (IMs). Caroline's dominant self-narrative was characterized as the "pessimism" rule, that is, the idea that whatever efforts she would be engaged in would never achieve positive results, and that she was not worthy. As Caroline put it in the third session, "I see myself as a rather negativistic sort of person these days, always thinking the worst, and I don't trust myself that much". Keeping the pessimism rule in mind, judges coded IMs from the video, identifying the onset and offset of each to the nearest second.

We computed the salience of each of the five IM types (the percentage of time in the session devoted to that specific type of IM) as well as the mean salience of each type throughout the process. We also computed the overall salience of IMs as the total percentage of time in the session devoted to any of the five types (i.e., the sum of the salience of the five types of IMs) as well as the mean salience of IMs throughout the process.

Interjudge agreement on salience was calculated as the overlapping time identified by both judges (Judges 1 and 2 or Judges 1 and 3) divided by the total time identified by either judge (or, equivalently, twice the agreed time spent on IMs divided by the sum of IM saliences independently identified by the two judges). The agreement on overall IM salience was 84.1%. Reliability of distinguishing IM type, assessed by *Cohen's k*, was .90, showing strong agreement between judges (Hill & Lambert, 2004). Because of the high interjudge reliability, we based our analyses on the coding of Judge 1.

3.5.3. Identifying Caroline's protonarratives: coding procedures and reliability.

We analyzed each IM in sequence and described the underlying protonarrative. This step was guided by the question: "What is the potential counter-rule/framework of behaving (acts, thoughts, emotions) present in this IM?" or, in a different but equivalent formulation, "If this IM expands itself to a new self-narrative, what would be the rule that shapes this new self-narrative?" We tried to capture the answer to this question in the form of a sentence or a word. The protonarrative for each successive IM was then compared with the protonarratives previously described, looking for convergences and divergences. Whenever strong convergences were found, the new IM was understood as sharing the previously described protonarrative. When strong divergences were found, a new protonarrative was formulated to incorporate the new meanings.

During this process, the protonarratives constantly underwent modification to incorporate new IMs and were continually interrogated for coherence and explanatory capacity. This process ceased when the emergent protonarratives were dense and complex enough to capture all of the variations in the IMs. This procedure was inspired by the method of constant comparison, rooted in grounded theory analysis (Fassinger, 2005).

The procedure for coding protonarratives involved discussion between A. P. Ribeiro and the IM research team, which included anywhere from two to 12 individuals, as well as an auditing process (Hill et al., 2005), as described next. A. P. Ribeiro worked independently and periodically presented his work to the research team. During these meetings, collaborators were invited to discuss the interpretation of the data. Whenever divergences were found, A. P. Ribeiro and the research team discussed the strengths of each other's interpretation and the criteria used to achieve them.

After the meetings, A. P. Ribeiro returned to independent work. He modified and improved his analysis, drawing on what he had learned at the meeting. Through this interactive procedure, strengths of each other were integrated, building consensus (Morrow, 2005; Schielke, Fishman, Osatuke, & Stiles, 2009; Stiles, 2003).

Miguel M. Gonçalves served as an external auditor. His role was one of "questioning and critiquing: Does the organization of the categories make logical and conceptual sense? Is there another way of organizing the categories that better explicates the essence of the data?" (Hill et al., 2005, p. 201).

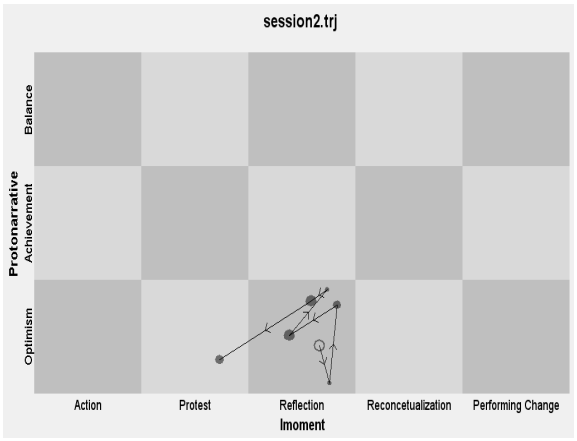
The salience of each protonarrative was computed for each session as the sum of the salience of IMs in which they emerged. We also computed the mean salience of

each protonarrative throughout the process.

3.5.4. Illustrating the evolution of protonarratives with SSGs. We used SSGs (Lewis et al., 1999, 2004) to illustrate the evolution of Caroline's protonarratives and their relations with IMs across sessions. In the graphic representations of SSGs, a system behavior across time is plotted as dots in the corresponding cells. When a new event takes place, another dot is added and a line that connects them is plotted to represent the direction of change. Thus, the system's evolution is plotted as a trajectory across the grid of cells that represent the system's possible states, yielding a two-dimensional topographic representation of the system's behavior during a given time interval. In this way, SSGs also offer quantification of this process, because a number of quantitative measures can be calculated from the graphic representation (see Results section), thereby bringing together quantitative and qualitative analysis. SSGs make it possible to focus simultaneously on content (because the states – the different cells – represent a given quality of the behavior or phenomenon under observation), structure (through the identification of attractors), and their unfolding through time.

To construct SSGs, we used GridWare, a software package developed by Lamey, Hollenstein, Lewis, and Granic (2004). A separate grid was constructed to depict the system's evolution within each of Caroline's psychotherapy sessions (see Figure 2 for an example of the grid constructed for session 2).

Figure III. 2: Example of SSG for session 2



In each grid, three variables were plotted: two categorical variables (IM type [x-axis: narrative process] and protonarrative type [y-axis: narrative content or theme]) and one continuous variable (salience of each IM [represented by circle size]). Each circle in the grid characterizes an event as representing a state of the system, defined by an IM type and a protonarrative. The hollow circle represents the first IM in the session. Placement of the circles within the cells is arbitrary; circles are arranged to allow representation of successive events of the same type. Lines represent transitions from one event to the next, and the arrows represent the direction of that transition.

To address the research question "How are IM types (narrative process) associated with protonarratives across session (narrative content or theme)?" grids were quantitatively analyzed to identify attractor regions (Lewis et al., 1999), that is, groups of events involving the same combination of IM types and protonarratives (criteria for identifying attractors are clarified in the Results section).

To pursue the research question "How does the flexibility of the alternative self-narrative, in terms of diversity in IMs and protonarratives, evolve across sessions?", a quantitative index of overall flexibility of the system (dispersion; Granic et al., 2007; Hollenstein & Lewis, 2006) was computed (criteria for computing dispersion is clarified in the Results section).

4. RESULTS

4.1. How do IM types and salience evolve across sessions (Narrative Process)?

Across the 10 sessions available for analysis, 26.84% of all the therapeutic conversation was devoted to IMs. This result is consistent with those from other good-outcome cases, in which the average overall salience of IMs is about 25% (e.g., Mendes et al., in press; Santos et al., 2009). The most common type of IM was reflection (15.6%), followed by reconceptualization (6.84%). Action occupied 2% of the entire therapy, and protest (1.47%) and performing change (0.93%) had relatively low salience. Examples of each type of IM are provided in Table 1.

Table III. 1: Examples of innovative moments

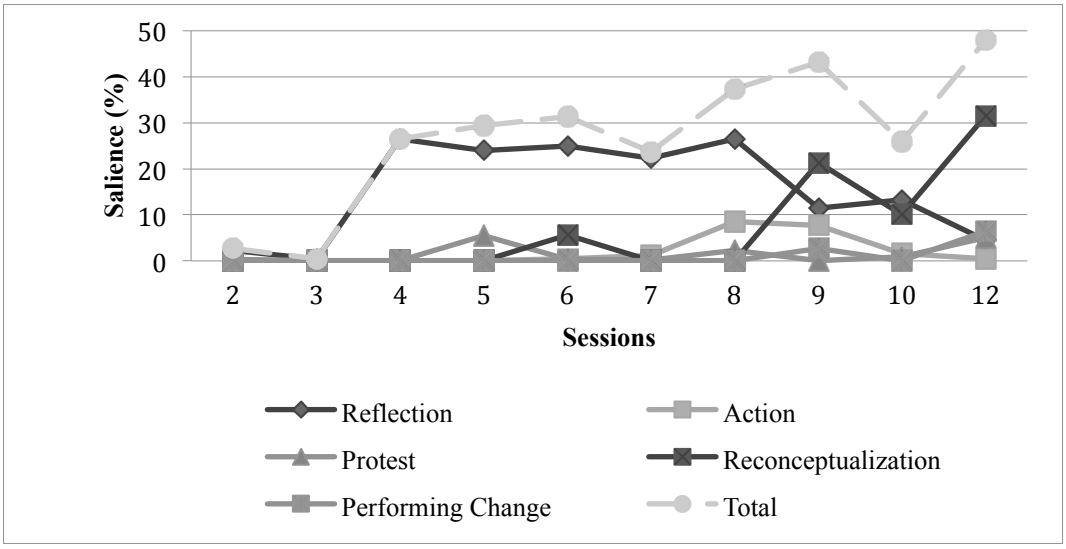
	Contents	Examples (Dominant self-narrative: Pessimism)
Action	• New coping behaviours facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control ; • Searching for information about the problem(s).	**Caroline**: *I connected myself to the Internet and Ruth was there... I told her: 'I really have to study' and I disconnected.* **Therapist:** Very good. You got to do what you could not do with your mother the other time... **Calorine**: *Yes, I told her and then I disconnected... we agreed it had to be like that (...) It happened exactly the same thing with my mother, she had something very important to tell me and I told her: 'wait for dinner time, Mum, I can't help you just now, I must do this now' and that's what I did... I studied!*
Reflection	• Comprehension–Reconsidering problem(s)' causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being. • Reflecting about the therapeutic process; • Considering the process and strategies implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	**Caroline**: *I would like to be optimistic, for I do believe that to be a great feature to live a better life*.
Protest	• Repositioning oneself towards the problem(s). • Positions of assertiveness and empowerment;	**Caroline**: *I do not wish to be pessimistic, for I do not want to, I do not wish to live life with such dark, unfruitful eyes, for pessimism is indeed unfruitful after all!*
Reconceptualization	RC always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	**Caroline**: *I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it. And that's as I'm telling you: this effort that I made, all this hard work, something that I must improve yet, when I got to the exam I told myself 'at least you studied, you tried' (...) I felt I was fighting for it, I was doing my utmost, working hard for something I really need (…) I felt I was struggling, I was being able to put things in their right place, I felt I was fighting…*

Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	**Caroline**: *I thought I was not good company, because I was unhappy, I felt bad about myself and with myself and therefore I thought my misfortune would be passed on to others. It isn't so these days, so I moved away, you see, I tried to run from crowds, didn't feel like going to classes (...) because it would be so full of people... It isn't so these days, nowadays I believe I am more receptive and, at the same time, I am receptive to that and I let myself go a little more to that, as well, looking for people to talk with, go to the library, even for a little coffee, have a snack... they are nice, opposite to what I often thought, they are nice and talk to me and worry about me.*

The total percentage of time devoted to IMs tended to increase as the treatment progressed, and the mixture of IMs changed (see Figure 3). In the first five sessions, only reflection and protest IMs were present. Action emerged for the first time in session 6 and was always present afterward. Reconceptualization emerged for the first time in session 6 but had substantial salience only in the last three sessions. Likewise, performing change IMs were present in the last three sessions only (see Figure 3).

Globally, these results corroborated the heuristic model of change summarized in Figure 1 (M. M. Gonçalves et al., 2009). That is, the overall salience of IMs increased throughout the process, and reflection and protest IMs progressed to reconceptualization and performing change IMs in the last sessions.

Figure III. 3: IMs salience throughout the process



4.2. Which protonarratives emerge in IMs and How does their salience evolve across sessions (Narrative Content or Theme)?

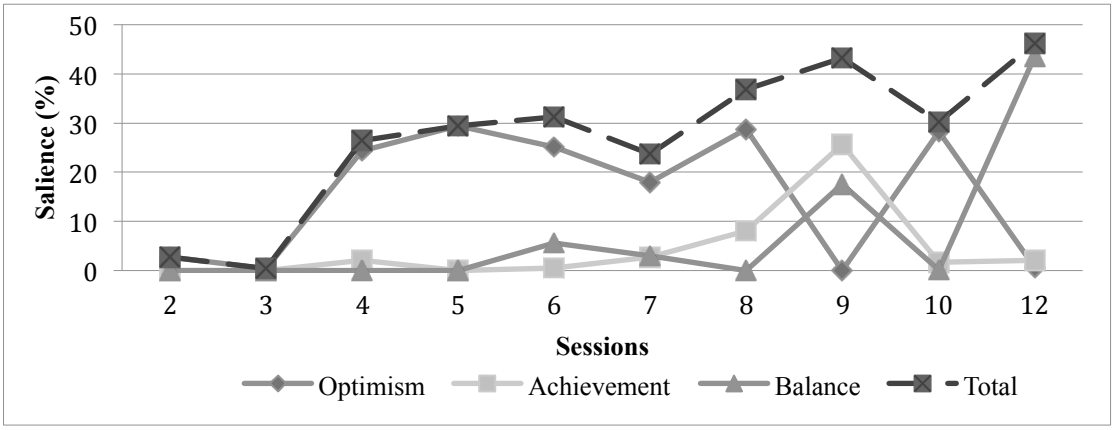
Our qualitative analysis identified three protonarratives: optimism (mean salience=15.77%), achievement (mean salience = 4.29%), and balance (mean salience=6.98%; see Table 2 for a summary).

Table III. 2: Protonarratives in Caroline's case

Protonarrative	Contents
Optimism	• Life areas and/or capacities not dominated by pessimism • Intention to overcome pessimism • Comprehension of pessimism causes • Awareness of pessimism effects
Achievement	• Strategies implemented to overcome pessimism • Well-being
Balance	• Balanced relationship between pessimism and optimism • Balanced relationship between her own needs and other's needs • Balanced relationship between study/work and leisure

As shown in Figure 4, sessions differed with respect to the presence of protonarratives. Sessions 2 and 3 were characterized by only occasional instances of optimism exclusively. In session 4 optimism and achievement were present, and in session 5 only optimism was present again. In sessions 6 and 7 the three protonarratives were present. In sessions 8 and 9 two protonarratives were present again: optimism and achievement in session 8 and achievement and balance in session 9. Sessions 10 and 12 were characterized by the presence of the three protonarratives again.

Figure III. 4: Protonarratives salience throughout the process



In more clinical terms, in much of her therapy, Caroline expressed a counter-rule, optimism, in relation to her current (problematic) rule or framework, pessimism. Up until session 8, and again in Session 10, her IMs were mostly focused on the opposite of the dominant self-narrative, by centering her on the capacities she had shown in the past and her capacity to achieve change, as illustrated by her comment in Session 2: "Maybe I'll get what I want after all, I don't know". This IM content is the exact opposite of what she defined as the "pessimism" rule.

In session 4, Caroline started to elaborate on new ways of dealing with her problems, leading to the emergence of a new protonarrative – achievement: "Well, I don't give up, you see, I keep on studying and realizing what my needs are… this week, for instance, I was rather quiet, managed to study".

Later, in session 6, a further protonarrative that proposed an equilibrium between pessimism and optimism emerged – balance: "I also believe that, sometimes, being pessimistic creates some kind of balance because if you are too optimistic, you start trusting yourself too much and you'll not strive".

Note that the problem (pessimism) was progressively integrated in these successive protonarratives. Optimism was a mere opposition of pessimism, achievement involved a more empowered relation with pessimism, and balance enabled a conditional movement between optimism and pessimism rather than a fixation on one of them. Thus, although our procedure distinguished these three as different protonarratives, they might also be considered as cumulative or as steps in a developmental sequence leading toward an alternative self-narrative.

4.3. How are IM types (Narrative Process) associated with protonarratives across sessions (Narrative Content or Theme)?

The SSGs shed light on the way Caroline's protonarratives evolved throughout the therapy. Figure 5 shows the 10 grids corresponding to sessions 2 to 10 and session 12 (the 10 sessions available for analysis). Also illustrated is the previously noted increase in the diversity of IMs (and their salience) and an increase in the diversity of protonarratives across treatment. Theoretically, diversity in types of IMs and protonarratives is consistent with successful change. As Caroline proceeded to explore each protonarrative, it occurred in progressively more types of IMs. At the same time, the exploration tended to give rise to new themes, leading to new protonarratives.

We identified attractors using the *winnowing* procedure developed by Lewis et al. (1999), which defines an attractor as a cell or group of cells that accounts for 50% of grid heterogeneity. Heterogeneity is calculated first for each visited cell in the grid according the formula

$$[(D/n)-d]^2/(D/n)],$$

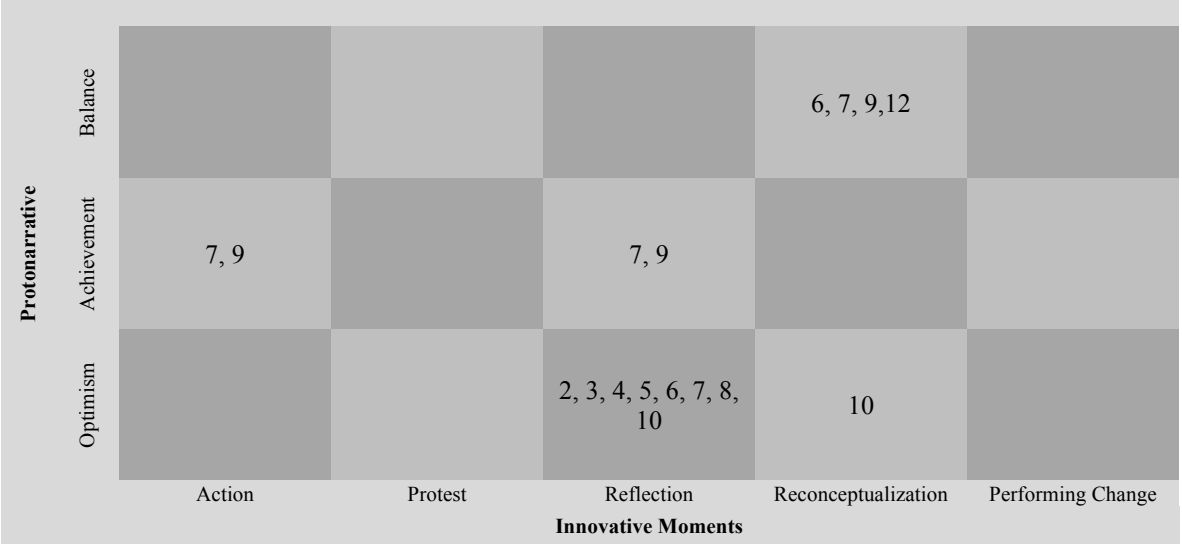
where 'd' is the cell duration, 'D' is the total grid duration, and 'n' is the number of visited cells in the grid. Heterogeneity is then calculated for the entire grid according to the formula

$$[n\Sigma(c)/n],$$

where 'c' is each cell heterogeneity score and 'n' is the number of visited cells. The process is repeated, withdrawing from the analysis the cell with the lowest duration score at each round.

The heterogeneity score for each round is then divided by the heterogeneity score for the entire grid. The process stops when the heterogeneity score drops below 50%. Conceptually, attractors pinpoint central tendencies or preferred states. The grid states that constitute attractors represent the more central, stable, salient processes (IMs) and contents (protonarratives) of Caroline's therapy in each session. The attractors (combinations of protonarrative and the IMs) that were identified in Caroline's case are pinpointed with squares in Figure 5 and summarized in Table 3.

Table III. 3: Atractors summary



Note. Numbers inside cells represent sessions in which that cell was an attractor cell.

It was possible to identify attractors in all of the sessions. Every protonarrative and three of the five IM types (action, reflection, and reconceptualization) participated in attractors in some session. Optimism was associated with reflection and reconceptualization IMs, achievement with both action and reflection IMs, and balance with reconceptualization IMs only.

The evolution of attractors across sessions seemed to show an initial period (session 2–5) of rigidity and stability of the optimism protonarrative expressed in reflection IMs. That is, alternative meanings to the dominant self-narrative emerged initially in straight opposition to it and in the form of reflection IMs.

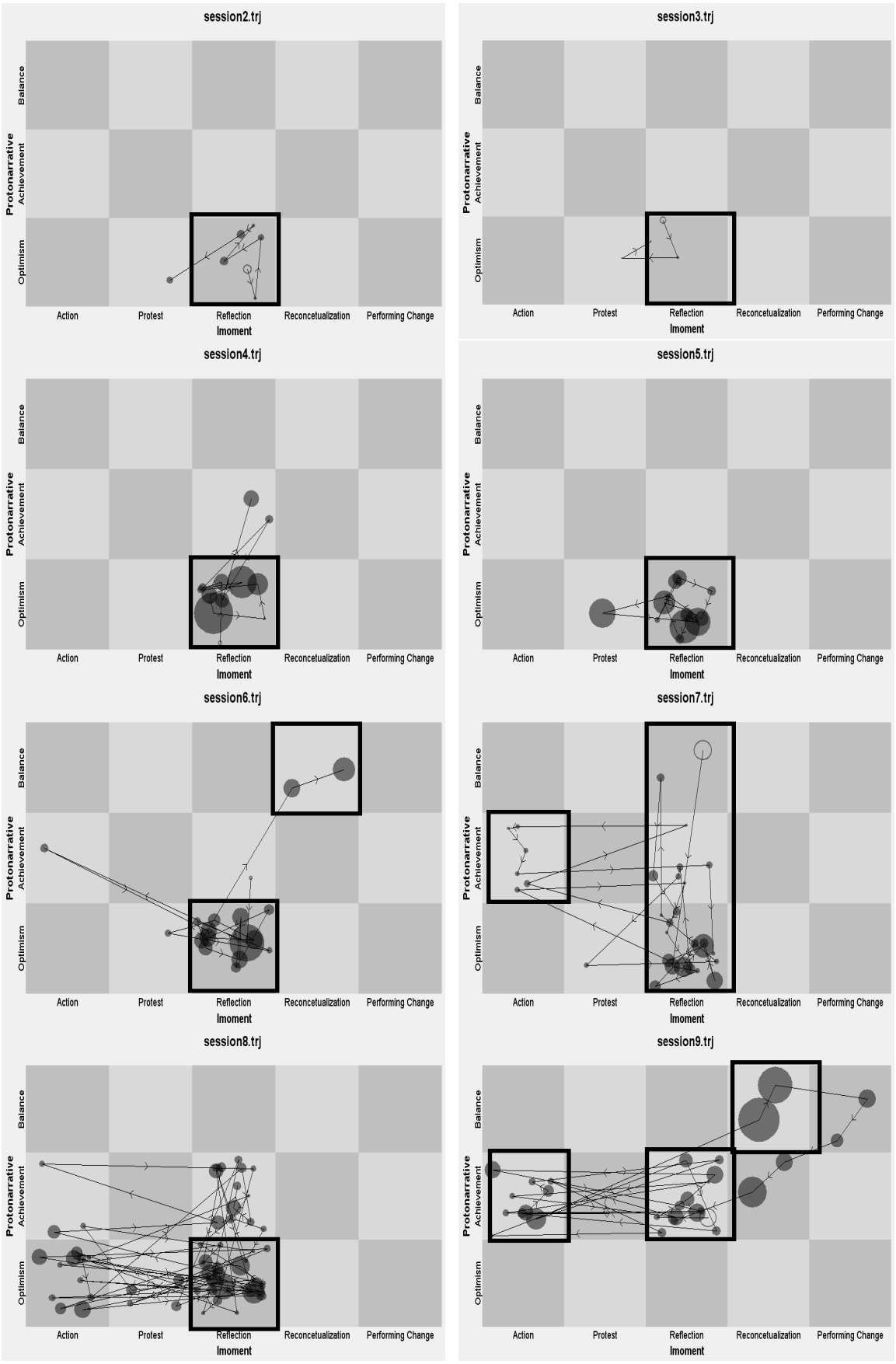
This was followed by a period of expansion of attractors, with the emergence of the third protonarrative in session 6 (Balance*Reconceptualization) and by the simultaneous presence of the three protonarratives in session 7 (Optimism*Reflection, Achievement*Action and Reflection, and Balance*Reflection). Session 8 was marked by the return to the initial pattern optimism expressed in reflection IMs. In this session, Caroline narrated episodes in which she was optimistic in the past, that is, she reflected about how she used to manage her difficulties. Sessions 9 and 10 involved different attractors. In session 9, achievement was expressed in action and reflection IMs (similarly to session 7), in the form of several cycles of action and reflection or, inversely, of reflection and action, demonstrated by the recurrent transitions between

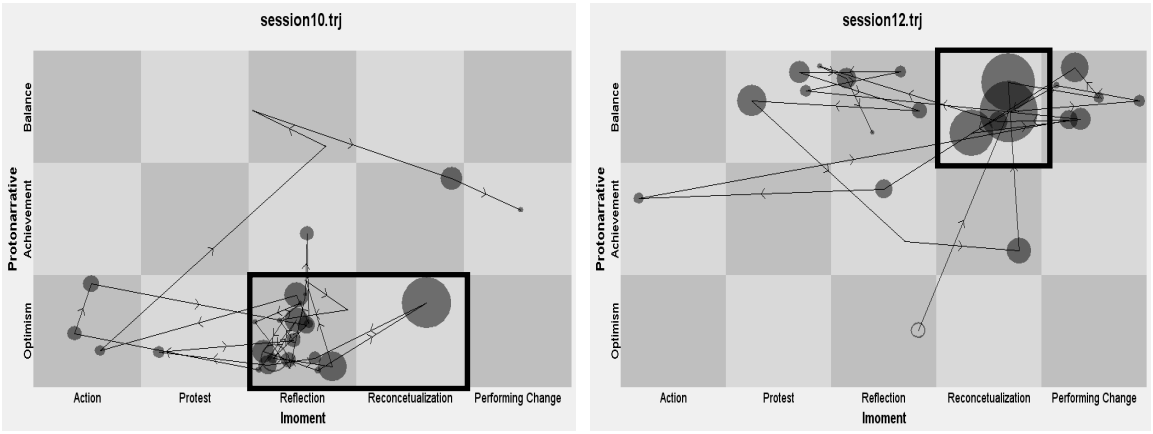
these two types (see Figure 5). Balance was expressed in reconceptualization IMs, as Caroline described episodes in which she was able to take action to manage her difficulties and reflected about the meaning of these actions. Session 10's attractors returned to the optimism protonarrative expressed in reflection and reconceptualization IMs, as Caroline described being optimistic in the past regarding how she used to manage her difficulties (reflection IMs), overcoming pessimism and looking at herself from an optimistic standpoint (reconceptualization IMs).

The last session (session 12) was characterized by balance expressed in reconceptualization IMs. This was technically a contraction, given that the attractor included only one protonarrative and one IM type; however, in contrast with previous moments of contraction, meanings inconsistent with the attractor's theme (optimism and achievement) and narrative processes (action, reflection, protest and performing change) were also present (see Figure 5). In effect, the characteristics of final sessions seemed to correspond to the theoretical characteristics that have been attributed to alternative self-narratives, that is, its flexibility. Globally, attractors changed throughout Caroline's therapy, with periods of increased and constant change intermediated by returns to the narrative processes and meanings that were characteristic of the beginning of the therapy.

In contrast to the other protonarratives, the achievement protonarrative never constituted a central theme of Caroline's therapy on its own; it appeared as a nuclear content only when associated with other protonarratives. Perhaps it represented a transition between the initial organizing protonarrative (optimism) and the final organizing protonarrative (balance). It is also interesting that the more complex protonarrative (balance) was strictly associated with reconceptualization IMs, which is a central IM in the change process according to our change model (see Figure 1).

Figure III. 5: SSGs for Caroline's therapy





4.4. How does the flexibility of the alternative self-narrative evolve across sessions?

Finally, we focused on the evolution of the alternative self-narrative across Caroline's therapy. A dynamic system's flexibility has been considered to be a function of its dispersion (Granic et al., 2007; Hollenstein & Lewis, 2006). Dispersion is a composite measure of the range and duration of states of the system. It incorporates duration of each type of IM, total duration of protonarratives, and number of IM types according to the formula

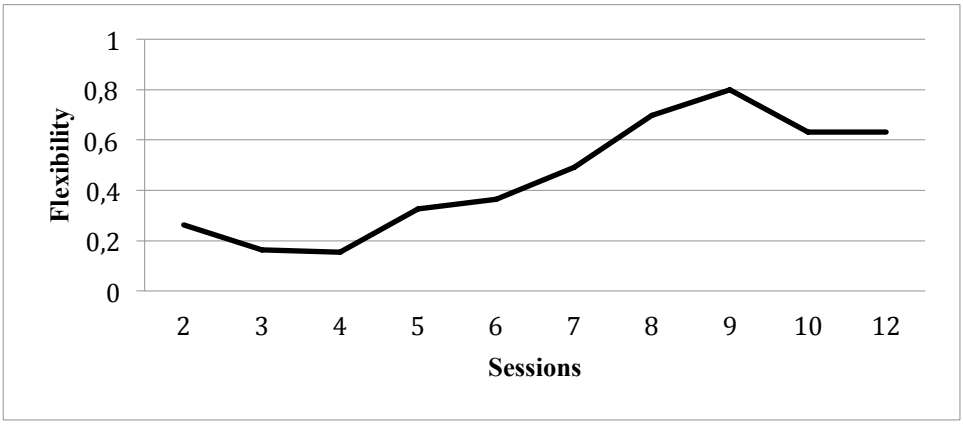
$$[(n\Sigma(d_i=D)^1\text{-}1/n\text{-}1].$$

In SSGs, 'd_i' is duration in cell 'i', 'D' is total duration of the visited cells, and 'n' is the number of cells visited. This measure is directly calculated by GridWare and varies between 0 and 1. Low values mean low range and duration of system states and indicate low overall dispersion. Because dispersion combines both duration and number of states, fluctuations in dispersion may reflect changes in either protonarrative duration or the number of types of IMs that express them.

As shown in Figure 6, overall flexibility increased from sessions 4 to 9 and stabilized in the last sessions at a higher level. That is, across these sessions, the number of IM types and protonarratives that were simultaneously present increased, and the time spent on them tended to be similarly distributed across all of them. This increasing overall flexibility across sessions reflected a progressive expansion of protonarratives and IM types (see Figure 5). In other words, the process by which dominant self-narratives gave way to alternative self-narratives seemed to be characterized by an increase in flexibility. Psychologically, the meanings that organized the new protonarrative (balance) were less rigid than the ones that organized the protonarrative

at the beginning of the therapy (optimism).

Figure III. 6. Overall flexibility across sessions



5. DISCUSSION

The analysis of protonarratives using SSGs shed light on how IMs contributed to the reconstruction of Caroline's self-narrative. First, our observations were consistent with the IMs heuristic model of change (M. M. Gonçalves et al., 2009). In particular, IM salience and diversity increased throughout therapy, and reflection, protest, and action IMs were prevalent in the initial and intermediate phases, whereas reconceptualization and performing change IMs were prevalent in the final phase.

Second, this study's observations helped us to refine and extend the model of change.

1. There was an increase in the diversity of innovative narrative contents or protonarratives throughout therapy, which corroborates our core premise. Globally, flexibility of the meaning processes increased throughout therapy.

2. There was a progressive integration of the problem in the emergent protonarratives. The relation between the previous narrative rule and the new narrative rule evolved from opposition (optimism) to an empowered relation (achievement) to assimilation (balance). It might be sensible to think of the three identified protonarratives as elements or stages in the development of a single alternative self-narrative rather than as independent potential self-narratives.

3. This process is seemingly facilitated by different types of IMs, which play an organizing role in protonarratives' emergence and development. Initially, reflection IMs (optimism) seem to enhance Caroline's understanding of how pessimism constrained her life and also to consolidate hope. Later, cycles of action and reflection IMs (or, inversely, reflection and action, i.e., achievement) seem to facilitate self-confidence and empowerment. Finally, reconceptualization IMs (balance) seem to represent the achievement of what has been called a "meaning bridge" within the assimilation model (Brinegar, Salvi, Stiles, & Greenberg, 2006; Osatuke et al., 2004; Stiles, 1999, 2002). A meaning bridge is a sign (a word, phrase, story, theory, image, gesture, or other expression) that represents the same meaning for divergent parts of the self (in this case, pessimism and optimism). The "balance" meaning bridge seemed to assimilate a wider range of Caroline's experiences, allowing the varied parts of her to communicate smoothly with one another and engage in joint action. It thus allowed both pessimism and optimism to serve as resources. One may hypothesize that the more empowered relation to pessimism expressed by the achievement protonarrative might have facilitated the elaboration of the limitations of optimism (e.g., the potentially bad consequences of an overly optimistic perspective), therefore promoting a linkage between pessimism and optimism and consequently the inclusion of pessimism in a more balanced narrative trend (i.e., balance).

4. Attractors seemed to change throughout therapy, with periods of increased change countered by a return to processes that were characteristic of the beginning of therapy. This process seems congruent with Fogel, Garvey, Hsu, and West-Stroming's (2006) suggestion, referring to changing patterns in early mother baby interaction, that the "return to the past" for brief periods seems to stabilize the system during developmental change, regulating the "potentially chaotic effect of reorganization" (p. 66). This finding is certainly interesting but merits much more empirical research, although it intuitively makes sense: when disturbed by the novelty, the system can find some stability by returning temporarily to previous patterns of functioning. Alternatively, the apparent setbacks might reflect turning attention to newer, less developed strands of the dominant self-narrative (Caro-Gabalda & Stiles, 2009, submitted). Furthermore, Caroline's alternative self-narrative, at the last session, was structured enough to constitute an organizer framework, that is, an attractor composed by a central theme (balance) and

narrative process (reconceptualization) but nevertheless more flexible (i.e., open to other meanings inconsistent to its theme [optimism and achievement] and narrative processes [action, reflection, protest, and performing change]).

We conclude that studying the emergence of protonarratives makes IMCS content sensitive and, therefore, enriches its analysis.

6. LIMITATIONS AND IMPLICATIONS

Although we presented only one case, it would be misleading to say that "N = 1". Rather, this was a theory-building case study (Stiles, 2005, 2009), in which we presented a substantial number of theoretically relevant quantitative and qualitative observations that supported and elaborated previous conceptualizations. That said, other cases are likely to differ from Caroline in important ways, so, of course, more research is needed. Among other things, Caroline presented relatively simple clinical complaints. Other, more disturbed clients might present different or more complex patterns of protonarrative evolution.

Conceptually, our observations of Caroline's protonarratives suggest that they might represent a process of dialectical development. The three protonarratives (optimism, achievement, balance) seemed to represent a sequence of increasing integration, each one encompassing the previous ones as well as more aspects of the dominant self-narrative. This suggestion is congruent with the assimilation model's description of the construction of meaning bridges between different parts of the self, in which some metamorphosis in the successive versions is required to accommodate more aspects of initially conflicting parts (Brinegar et al., 2006; Stiles, 1999). It is similarly congruent with M. M. Gonçalves et al.'s (2009) proposal that reconceptualization IMs are essential in transforming self-narratives by articulating links between heterogeneous dimensions of the self or the self-narrative. It is consistent that Caroline's balance protonarrative was closely associated with reconceptualization IMs. Future researchers might usefully attend to whether successive protonarratives represent increasing assimilation of the client's disparate experiences or meanings and whether the more integrative protonarratives are differentially associated with reconceptualization IMs.

Clinically, increasing the flexibility of a client's system of meanings should facilitate change. Thus, as in the case of Caroline, we suggest that exploration of diverse protonarratives allows a client to construct more viable alternatives, a favorable element

of the change process. Therapists-in-training might profitably learn to recognize alternative protonarratives and IMs as they emerge during treatment.

7. REFERENCES

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental* Disorders (4th ed.). Washington, DC: American Psychiatric Association.

Barkham, M., Stiles, W. B., & Shapiro, D. A. (1993). The shape of change in psychotherapy: Longitudinal assessment of personal problems. *Journal of Consulting and Clinical Psychology*, *61*, 667-677.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53,* 165-180.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Caro-Gabalda, I., & Stiles, W. B. (2009). Retrocessos no contexto de terapia linguística de avaliação [Setbacks in the context of linguistic therapy of evaluation]. *Análise Psicológica, 27,* 199-212.

Caro-Gabalda, I., & Stiles, W. B. (2009). Irregular assimilation progress: Setbacks in the context of Linguistic Therapy of Evaluation. Manuscript in preparation.

Dimaggio, G., Salvatore, G., Azzara, C., & Catania, D. (2003). Rewritting self-narratives: The therapeutic process. *Journal of Constructivist Psychology, 16,* 155–181.

Dimaggio, G., Salvatore, G., Azzara, C., Catania, D., Semerari, A., & Hermans, H. J. M. (2003). Dialogical relationships in impoverished narratives: From theory to clinical practice. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 385-409.

Dishion, T., Nelson, S., Winter, C., & Bullock, B. (2004). Adolescent friendship as a dynamic system: Entropy and deviance in the etiology and course of male antisocial behavior. *Journal of Abnormal Child Psychology, 32*, 651-663.

Fassinger, R. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*, 156–166.

Fernandes, E. (2007). When what I wish makes me worse... to make the coherence flexible. *Psychology and Psychotherapy: Theory, Research and Practice*, *80*, 165-180.

Fernandes, E., Senra, J., & Feixas, G., (2009). *Terapia construtivista centrada em dilemas implicativos* [Constructivist psychotherapy focused on implicative dilemmas]. Braga: Psiquilíbrios.

Fogel, A., Garvey, A., Hsu, H. C., & West-Stroming, D. (2006). *Change processes in relationships: A relational-historical approach*. New York: Cambridge University Press.

Gardner, B., & Wampler, K. (2008). Uncovering dynamical properties in the emotional system of married couples. *Contemporary Family Therapy, 30*, 111-126.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A. P., Angus, L., & Greenberg, L. S. (2010). Narrative change in Client-Centered Therapy: A comparison of innovative moments development with Emotion-Focused Therapy. Manuscript in preparation.

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L., & Greenberg, L. S. (in press). Innovative moments and change in Emotion Focused Therapy: The case of Lisa. *Journal of Constructivist Psychology*.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Santos, A., & Mendes, I. (in press). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.)*, YIS: Yearbook of Idiographic Science - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Mendes, I., Santos, A. (2010). Tracking novelties in psychotherapy research process: The innovative moment coding system. Manuscript in preparation.

Gonçalves, M. M., Santos, A., Salgado, J., Matos, M., Mendes, I., Ribeiro, A. P., Cunha, C., & Gonçalves, J. (2010). Innovations in psychotherapy: Tracking the narrative construction of change. In J. D. Raskin, S. K. Bridges, & R. Neimeyer (Eds.), *Studies in meaning 4: Constructivist Perspectives on Theory, Practice, and Social Justice* (pp. 29-64). New York: Pace University Press.

Gonçalves, O. F., & Machado, P. P. P. (1999). Narrative in psychotherapy: The emerging metaphor [Special issue]. *Journal of Clinical Psychology, 55*, 1175-1177.

Granic, I., & Hollenstein, T. (2003). Dynamic systems methods for models of developmental psychopathology. *Development and Psychopathology, 15*, 641-669.

Granic, I., Hollenstein, T., Dishion, T. J., & Patterson, G. R. (2003). Longitudinal analysis of flexibility and reorganization in early adolescence: A dynamic systems study of family interactions. *Developmental Psychology, 39*, 606-617.

Granic, I., & Lamey, A. (2002). Combining dynamic systems and multivariate analyses to compare the mother-child interactions of externalizing subtypes. *Journal of Abnormal Child Psychology, 30*, 265-283.

Granic, I., O'Hara, A., Pepler, D., & Lewis, M. D. (2006). A dynamic systems analysis of parent-child changes associated with successful "real-world" interventions for aggressive children. *Journal of Abnormal Child Psychology, 35*, 845 – 857.

Hayes, A. M., Laurenceau, J. P., Feldman, G. C., Strauss, J. L., & Cardaciotto, L. A. (2007). Change is not always linear: The study of nonlinear and discontinuous patterns of change in psychotherapy. *Clinical Psychology Review, 27*, 715−723.

Hermans, H. J. M., & Hermans-Jansen, E. (1995). *Self-narratives: The construction of meaning in psychotherapy*. New York: Guilford.

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert, (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change (5th Ed.)* (pp. 84 - 135). New York: John Wiley & Sons, Inc.

Hill, C. A., Knox, S., Thompson, B. J., Nutt Williams, E., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An Update. *Journal of Counseling Psychology,* 52, 196–205.

Hollenstein, T. (2007). State space grids: Analyzing dynamics across development. *International Journal of Behavioral Development, 31*, 384 - 396.

Hollenstein, T., & Lewis, M. (2006). A state space analysis of emotion and flexibility in parent-child interactions. *Emotion, 6*, 656-662.

Hollenstein, T., Granic, I., Stoolmiller, M., & Snyder, J. (2004). Rigidity in parent-child interactions and the development of externalizing and internalizing behavior in early childhood. *Journal of Abnormal Child Psychology, 32*, 595-607.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12–19.

Kowalik, Z., Schiepek, G., Kumpf, K., Roberts, R., & Elbert, E. (1997). Psychotherapy as a chaotic process II. The application of nonlinear analysis methods on quasi time series of the client-therapist interaction: A nonstationary approach. *Psychotherapy Research, 7*, 197-218.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G.C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249-258.

Lamey, A., Hollenstein, T., Lewis, M. D., & Granic, I. (2004). *GridWare* (Version 1.1). [Computer software]. http://statespacegrids.org.

Lewis, M. D., Lamey, A. V., & Douglas, L. (1999). A new dynamic systems method for the analysis of early socioemotional development. *Developmental Science, 2*, 458-476.

Lewis, M. D., Zimmerman, S., Hollenstein, T., & Lamey, A. V. (2004). Reorganization in coping behavior at 1 1/2 years: Dynamic systems and normative change. *Developmental Science, 7*, 56-73.

Machado, P. P., & Fassnacht, D. (2010). The Outcome Questionnaire (OQ-45) in a Portuguese population: Psychometric properties, ANOVAS, and confirmatory factor analysis. Manuscript in preparation.

Machado, P. P., & Klein, J. (2006). *Outcome Questionraire-45: Portuguese psychometric data with a non-clinical sample*. Poster presented at the 37th Annual Meeting of the Society for Psychotherapy Research. Edinburgh, Scotland.

Martin, C., Fables, R., Hanish, L., & Hollenstein, T. (2005). Social dynamics in the preschool. *Developmental Review, 25*, 299-327.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

McGlinchey, J. B., Atkins, D. C., & Jacobson, N. S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy*, *33*, 529–550.

Mendes, I., Gonçalves, M. M., Ribeiro, A. P., Angus, L., & Greenberg, L. (2009). Innovative moments and change in emotion-focused therapy. Manuscript in preparation.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*, 250-260.

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology, 19*, 127-145.

Neimeyer, R. A. (1995). Client-generated narratives in psychotherapy. In R. A. Neimeyer, & M. J. Mahoney (Eds.). Constructivism in psychotherapy (pp. 231-246). Washington, DC: American Psychological Association.

Osatuke, K., Glick, M. J., Gray, M. A., Reynolds, D. J., Jr., Humphreys, C. L., Salvi, L. M., & Stiles, W. B. (2004). Assimilation and narrative: Stories as meaning bridges. In L. Angus, & J. McLeod (Eds.), *Handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 193-210). Thousand Oaks, CA: Sage.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Ribeiro, A. P., Bento, T., Gonçalves, M. M., Salgado, J. (in press). Self-narrative reconstruction in psychotherapy: Looking at different levels of narrative development. *Culture & Psychology*.

Ribeiro, A. P., Gonçalves, M. M., & Bento, T. (2010). *Protonarratives Coding System*. Unpublished manuscript, Universidade do Minho, Braga, Portugal.

Ribeiro, A. P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia construtivista [Narrative change in psychotherapy: A good-outcome case of construstivist therapy]. *Psychologica, 50*, 181-203.

Ribeiro, A. P., Gonçalves, M. M., & Santos, A. (in press). Innovative moments in psychotherapy: From the narrative outputs to the semiotic-dialogical processes. In S. Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.), *YIS: Yearbook of Idiographic Science 2010 – Volume 3.* Rome: Firera Publishing Group.

Salvatore, G., Dimaggio, G., & Semerari, A. (2004). A model of narrative development: Implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*, 231–254.

Santos, A., Gonçalves, M. M., & Matos, M. (in press). Innovative moments and poor-outcome in narrative therapy. *Counselling and Psychotherapy Research.*

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good-outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449–466.

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Schielke, H. J., Fishman, J. L., Osatuke, K., & Stiles, W. B. (2009). Creative consensus on interpretations of qualitative data: The ward method. *Psychotherapy Research*, *19*, 558-565.

Schiepek, G., Kowalik, Z., Schütz, A., Köhler, M., Richter, K., Strunk, G., Mühlnickel, W., Elbert, T. (1997). Psychotherapy as a chaotic process I. Coding the client-therapist interaction by means of sequential plan analysis and the search for chaos: A stationary approach. *Psychotherapy Research*, *7*, 173-194.

Senra, J., & Ribeiro, E. (2009). The process of change in implicative dilemmas: The case of Rose. Manuscript in preparation.

Senra, J., Feixas, G., & Fernandes, E. (2007). Manual de intervención en dilemas implicativos. [Manual of intervention in implicative dilemmas]. *Revista de Psicoterapia, 63/64,* 179-201.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1-21.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York: Oxford University Press.

Stiles, W. B. (2003). Qualitative research: Evaluating the process and the product. In S. P. Llewelyn, & P. Kennedy (Eds.), *Handbook of clinical health psychology* (pp. 477-499). London: Wiley.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy*, *5*, 9-22.

Thelen, E., & Smith, L. B. (1998). Dynamic systems theories. In R. Lerner (Ed.), *Handbook of Child Psychology, 5th Edition, Vol. 1* (pp. 563-633). New York: Wiley.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

White, M. (2007). *Maps of Narrative Practice*. New York: Norton.

CHAPTER IV

MAINTENANCE AND TRANSFORMATION OF DOMINANT SELF-NARRATIVES: A SEMIOTIC-DIALOGICAL APPROACH

CHAPTER IV[7]

MAINTENANCE AND TRANSFORMATION OF DOMINANT SELF-NARRATIVES: A SEMIOTIC-DIALOGICAL APPROACH

1. ABSTRACT

This study focuses on how the emergence of *Innovative Moments* (IMs), which are exceptions to a person's dominant self-narrative (i.e., his or her usual way of understanding and experiencing), progresses to the construction of a new self-narrative. IMs challenge a person's current framework of understanding and experiencing, generating uncertainty. When uncertainty is excessively threatening, a semiotic strategy to deal with it often emerges: attenuation of novelty's meanings and implications by a quick return to the dominant self-narrative. From a dialogical perspective, a dominant voice (which organizes one's current self-narrative) and a non-dominant or innovative voice (expressed during IMs) establish a cyclical relation, *mutual in-feeding*, blocking self-development. In this article, we analyze a successful psychotherapeutic case focusing on how the relation between dominant and non-dominant voices evolves from mutual in-feeding to other forms of dialogical relation. We have identified two processes: (1) escalation of the innovative voice(s) thereby inhibiting the dominant voice and (2) dominant and innovative voices negotiating and engaging in joint action.

2. INTRODUCTION

We have been developing a research program (see M. M. Gonçalves et al. 2010c for a review) that addresses human change processes in psychotherapy and in everyday life by tracking the way novelties emerge in former patterns of acting, feeling, thinking and relating. We consider these exceptions–which we call *Innovative Moments* (IMs). Previous research has consistently shown that IMs can be reliably identified by use of the *Innovative Moments Coding System* (IMCS; M. M. Gonçalves et al. 2010a, 2010b), and that they occur in psychotherapeutic change in different models of brief therapy (M.

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M. Gonçalves et al. 2010c). Furthermore, research suggests that there are five different categories of IMs, which correspond to different narrative processes: action, reflection, protest, reconceptualization and performing change. From these studies, our research team developed a heuristic model of change (see M. M. Gonçalves et al., 2010c).

As we will see below, after the emergence of an IM one possible path of development is the amplification of the IM's meaning, which precipitates new IMs and eventually leads to a significant change in the former pattern. When this process is developing uncertainty may be a by-product of the change that is occurring, since the person is now facing an unfamiliar pattern of acting, relating, feeling and so on. Thus, when change occurs, a discontinuity has to be resolved. In this paper we elaborate on how the process of restoration of continuity that follows an IM – a potential opportunity for development to occur – may end up promoting stability and blocking self-development. We aim to deepen our understanding of how meanings are transformed or, conversely, remain stable.

2.1. Self-narratives and the dialogical self

Every narrative has some narrator who is telling a story to an audience (Salgado & M. M. Gonçalves, 2007). Thus, every meaning construction involves an addressee: "The I emerges by reference with an Other" (Salgado & Hermans, 2005, p. 10). Consequently, at each moment the person assumes a semiotic position (see also Leiman, 2002) toward the world and toward others. In other words, the person responds to the lived situation and each and every utterance or thought has this dialogical basis. Therefore, life becomes a dance of constant repositioning from moment to moment. These several positions, called I-positions within the *Dialogical Self Theory* (DST; Hermans, 2001; Hermans & Hermans-Konopka, 2010), may then animate inner and outer dialogues, in which several "voices" can be heard.

According to DST, multivocality means that self-narratives, besides their temporal organization, also have a spatial dimension (see Hermans & Hermans-Jansen, 1995), resulting from the possibility that the self has metaphorically to move from one position to the other, giving voice to different authors and producing different narratives of the events. That is, for the same topic or event, different voices can emerge, representing different positions of the self. Thus, as Hermans (e.g., Hermans & Dimaggio, 2004) has suggested, the self is similar to a community of voices, making the interpersonal processes that occur between people equivalent to the intrapersonal processes.

Consequently, self-narratives are the outcome of dialogical processes of negotiation, tension, disagreement, alliance and so on between different voices of the self (Hermans & Hermans-Jansen 1995).

2.2. Dominant self-narratives

When a dominant community of voices is bound together by a self-narrative that is too rigid and systematically excludes significant experiences because they are not congruent with it, people become vulnerable to distress (M. M. Gonçalves et al. 2010d). Along with Stiles (Stiles, 2002; Stiles et al. 2004), we suggest that from the dominant community's perspective voices representing experiences that are different from how a person typically perceives him or herself are problematic, and the community of voices wards off, distorts, or actively avoids such voices. Although such avoidance can prevent or reduce distress in the short term, the experiences remain unassimilated and unavailable as resources. From a clinician's perspective, the exclusion of non-dominant voices represents a form of narrative dominance (Neimeyer et al., 2006). Narrative dominance is problematic given that it produces a high redundancy in the way the person attributes meaning to experience. Of course, not all forms of dominance are problematic. On the contrary, dominance is a common pattern in everyday life, responsible for people taking a position, assuming a certain perspective (e.g., political), or even involving themselves in meaningful actions. We refer here to a form of dominance in which the person is telling the same self-narrative over and over again, independently of the circumstances. Clinical depression can be seen as a good prototype of this. No matter how events change, the same (depressiogenic) interpretation is repeated over and over again (see Beck, 1976).

2.3. Innovative Moments (IMs)

Problematic dominance involves a form of monologization of the self, in which the difference is rejected or denied. For instance, the depressiogenic interpretation of reality is maintained by a denial of alternative formulations, marginalizing other voices. As Bakhtin (1981) suggested, however, the attempt to suppress the other (external or internalized) is never completely achieved (Goncalves & Guilfoyle, 2006; Salgado & M. M. Gonçalves, 2007; Valsiner, 2004). Accordingly, Stiles (e.g., Stiles, Osatuke, Glick, & Mackay, 2004) suggests that unassimilated voices are not inert or devoid of agency. They may be silenced and excluded, but circumstances (including the therapeutic dialog) may address them, compelling them to move to the foreground.

When this occurs IMs emerge, and the dominance of the previous self-narrative is disrupted. Dialogically, then, IMs are opportunities for unassimilated voices to emerge and to tell their own stories, which differ from the ones told by the dominant community.

We have been developing a methodological tool that allows tracking of IMs in psychotherapy and everyday life, trying to understand how a new, more flexible, self-narrative is constructed – the *Innovative Moments Coding System* (IMCS; M. M. Gonçalves et al., 2010a, b). It is important to note that although our method is inspired in a narrative framework, it tracks micro-narratives, not, self-narratives. These micro-narratives are not full-fledged narratives since they do not meet the usual criteria for what constitutes a complete narrative, as required by narrative theorists (e.g., Mandler, 1984) but they could be part of more molar narrative structures.

2.4. Protonarratives

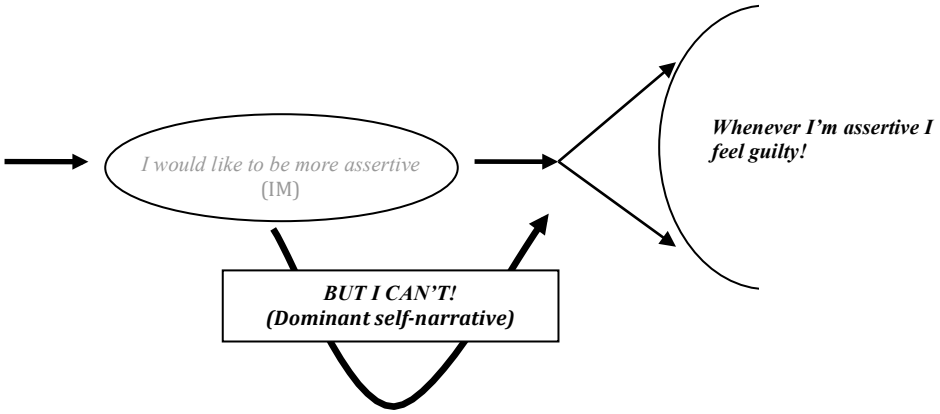
In the development of the problematic self-narrative into an alternative one, IMs with several different meanings start to occur. In the course of change, IMs tend to become organized in clusters of themes. We have called such recurrent meanings or themes *protonarratives* (A. P. Ribeiro et al., 2010a, b). Protonarratives are noticeable as recurrent themes that differ from the ones present in the dominant self-narrative. Protonarratives are not yet self-narratives because of their provisional nature, but they can develop into a self-narrative throughout the therapeutic process, which justifies the prefix proto. We have suggested that, in successful therapy, the alternative self-narrative develops as a sequence of protonarratives, which are successively revised and refined in the light of continuing experience (A. P. Ribeiro et al., 2010a, b).

2.5. Innovative Moments as bifurcation points

The emergence of IMs and corresponding protonarratives generates uncertainty, since the individual has to face a discontinuity that challenges his or her usual framework of understanding (A. P. Ribeiro & M. M. Gonçalves, 2010). When this discontinuity is highly accentuated it could trigger a felt sense of contradiction or self-discrepancy, thus creating dysphoric feelings of unpredictability and uncontrollability (Arkowitz & Engle, 2007). From a dialogical perspective, a non-dominant (or innovative) voice strives to gain power, challenging the dominant one(s), leading the dialogical self to rearrange or modify its configuration until it finds relative stability, i.e., restores continuity.

IMs can thus be construed as a microgenetic bifurcation point (Valsiner & Sato, 2006), in which the client has to resolve uncertainty, i.e., the tension between two opposing voices – one expressed in the dominant self-narrative (e.g., submissive) and another expressed in the emerging IM (e.g., assertive) – drawing upon semiotic strategies such as attenuation or amplification (Valsiner, 2008). *Semiotic attenuation* refers to the minimization, depreciation or trivialization of a particular meaning present in an IM, resulting in the maintenance of the old patterns (Figure 1).

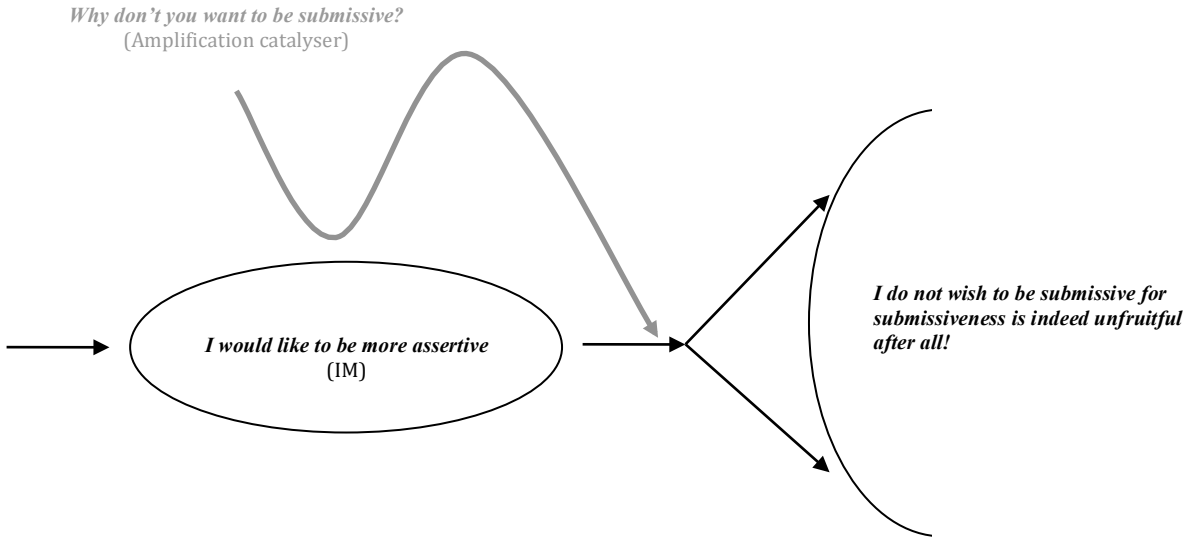
Figure IV. 1: Semiotic attenuation



Note. From "Constraining one's self within the fluid social worlds" by Valsiner, 2008. Adapted with permission.

Conversely, *semiotic amplification* refers to the expansion of a given meaning present in an IM, creating an opportunity for development to occur. For instance, an IM can be amplified by means of therapist interventions that catalyze further elaboration of a particular IM (e.g., "Why don't you want to be submissive?") or enhance its meaning ("So, what would your life be like if you were more assertive?") (Figure 2).

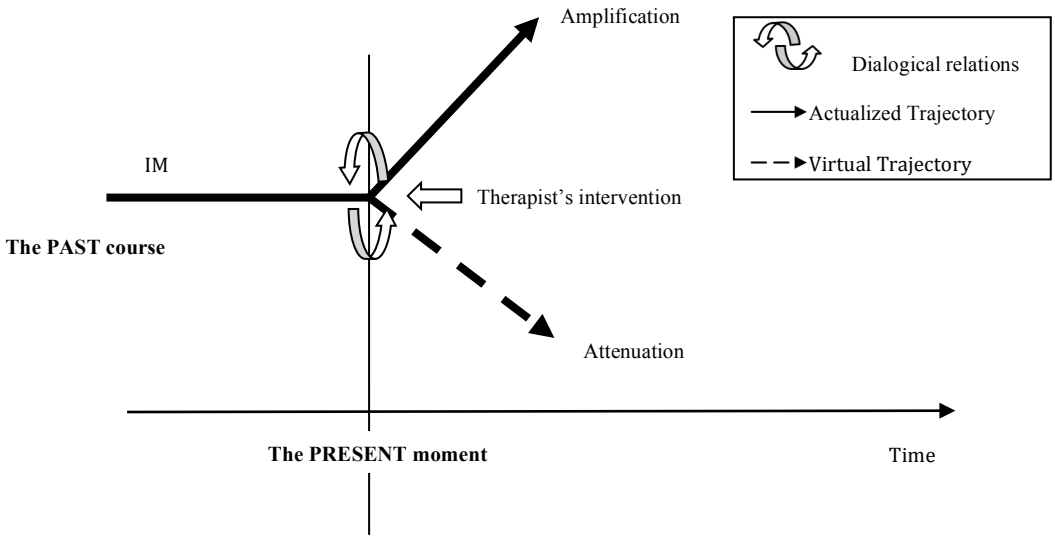
Figure IV. 2: Semiotic amplification



Note. From "Constraining one's self within the fluid social worlds" by Valsiner, 2008. Adapted with permission.

The way uncertainty is resolved at each IM regulates and is regulated by the dialogical relations between the dominant voice(s) expressed in the dominant self-narrative and the innovative voice(s) expressed in IMs, as well as in the therapist's interventions (M. M. Gonçalves & A. P. Ribeiro, 2010) (Figure 3). Development is fostered if the innovative voice (the one that is narrating the IM) is given priority, by semiotic amplification ultimately producing a new self-narrative. On the other hand, if the meaning of IMs is recurrently attenuated, the innovative voice stays dominated, and the problematic self-narrative maintains or even reinforces its power.

Figure IV.3: IMs as bifurcation points



Note. From "Depicting the Dynamics of Living the Life: The Trajectory Equifinality Model", by Sato et al., 2009. Adapted with permission.

2.6. The role of mutual in-feeding in maintaining dominant self-narratives

Frequently in unsuccessful psychotherapy cases, as well as in initial and middle phases of successful ones (M. M. Gonçalves, A. P. Ribeiro et al., 2011; A. P. Ribeiro et al., 2009; A. P. Ribeiro et al., 2012a, 2012b), clients tend to resolve the uncertainty created by the emergence of an IM by attenuating its meaning, making a quick return to the dominant self-narrative. This may result in the disappearance of a particular innovative way of feeling, thinking, or acting, reinforcing the power of the dominant self-narrative and thus promoting self-stability.

Dialogically, a new voice (or a previously non-dominant one) has its change potential aborted by the reaffirmation of the dominant voice. By doing this, clients temporarily avoid discontinuity but do not overcome it as the non-dominant voice continues active and thus IMs emerge recurrently. As M. M. Gonçalves and A. P. Ribeiro (2010, p. 12) have stated:

> In some cases this struggle between the dominant self-narrative and the IMs keeps going on, during the entire psychotherapeutic process. We have here two opposing wishes (expressed by two opposing voices): to keep the self stable, avoiding discontinuity and the uncertainty generated by it; and to change, avoiding the suffering which the dominant self-narrative most of the times

implies. When novelty emerges, the person resolves the problem of discontinuity by returning to the dominant narrative. When the client feels too oppressed by the dominant self-narrative he or she resolves this problem by trying to produce novelty, but of course this poses the problem of discontinuity once again. Thus, the self is trapped in this cyclical relation, making ambivalence impossible to overcome within this form itself.

The process described above mirrors a form of stability within the self, in which two opposite voices keep feeding each other, dominating the self alternatively, that Valsiner (2002) has termed mutual in-feeding. Mutual in-feeding allows the maintenance of the dominant self-narrative, despite the emergence of novelties.

2.7. Observing mutual in-feeding

We have proposed a measure of the mutual in-feeding process that grew from our observations of therapy passages in which an IM emerged and is immediately followed by a return to the dominant experience. We call such events a *Return-to-the-Problem Marker* (RPM). For example:

"I don't want to be submissive anymore (IM), but I just can't" (RPM).

In this example, the client described an IM – "I don't want to be submissive anymore" – and then returned to the dominant self-narrative by saying "but I can't". This clause, introduced by the word 'but', represents opposition or negation towards the innovative voice and hence constitutes the RPM.

The results obtained in a sample of emotion-focused therapy (A. P. Ribeiro et al., 2012a), and in a sample of client-centered therapy for depression (A. P. Ribeiro et al., 2012a), showed that the probability of IMs containing RPMs decreases throughout therapy in successful cases, whereas it remains stable and high in unsuccessful ones.

2.8. The present study

In what follows we will analyze IMs emergence in a successful psychotherapeutic case, focusing on the semiotic processes that regulate the dialogical relations between the dominant voice(s) present in the dominant self-narrative and the non-dominant voices present in IMs. We have been studying these micro-processes using the microgenetic method[8] from a semiotic-dialogical perspective (Valsiner, 2004; see also

[8] Microgenetic analysis is a method for studying how change develops in a certain period of time in a given individual. It involves intensive analysis of the transformation mechanisms and it has been widely applied in developmental studies of children (Flynn et al. 2007; Siegler, & Crowley, 1991).

Josephs et al., 1999). In the following section, we elaborate on Josephs and colleagues'(1999; Josephs & Valsiner, 1998) dialogical-dialectical approach to meaning-making and apply this framework in the context of a theory-building case study (Stiles, 2005, 2009).

2.9. Meaning-making: A Dialogical-Dialectical approach

According to Josephs and colleagues (1999; Josephs & Valsiner, 1998) the construction of meaning entails the regulation of dialogical relations between signs, construed as *meaning complexes* composed of dual fields: the field {A} and {non A}. The field {non-A} operates as *negativum* in relation to {A} (see Josephs et al., 1999). These dual fields emerge together (explicitly or implicitly), being {A} the sign and {non A} the countersign of {A}, as in {A} the foreground and {non A} the background. For instance, if {A} is worthlessness, it is associated also with a whole range of its opposites – happiness, hopefulness, confidence, etc. – defined by the field {non A}, composing both the meaning complex {worthlessness and non-worthlessness}. The meaning of worthlessness is intrinsically dependent on the meaning of its opposites.

The field {A} is composed of a sign or signs with a specific meaning, to which we can relate synonyms and various versions by using *semantic qualifiers* (cf. Josephs & Valsiner, 1998). Qualifiers usually modify the meaning of the field, either opening it to transformation or closing it. Therefore, the meaning of the field {A} could be opened up for transformation by the use of qualifiers, which are signs that limit or modify the meaning of the field, such as "sometimes" or "all the time." For instance, "I feel a bit worthless sometimes" is different from "I see myself as a rather negativistic sort of person these days, always thinking the worst..." The latter entails a sense of totality of the person's life and actually closes the meaning complex to transformation. The {non A} field emerges together with the previous {A}, although in an unstructured or fuzzy way. The relation between {A} and {non A} can be tensional or harmonious. When both opposites co-occur with no tension at all, they tend to close the meaning complex. On the other hand, if tension occurs it enables the complex to transform, as it allows the establishment of dialogical relations with other meaning complexes.

On the one hand, meaning transformation can occur through a process of growth of the {A – worthlessness} field. It can become progressively differentiated into {A' – defeated}, {A" – impotent} or {A"' – negativistic}, and so on. In these transformations, the similarity to the {A} field is maintained. On the other hand, meaning transformation

can occur through a process of constructive elaboration of the {non A} field. For instance, in the example "I feel a bit worthless sometimes" ({A}), the word 'sometimes' (a semantic qualifier) highlights that there are times in which the speaker does not feel worthless. Hence, we can assume that the word 'sometimes' corresponds to an elaboration of the field {non A} (that is, there are times when the person does not feel worthless). This elaboration on {non A} increases the tension between the field {A: feeling worthless} and the implicit opposite field {non A: not feeling worthless}, fostering the emergence of a new meaning complex ({B}) that establishes a dialogical relation with the first one. For instance, this new field ({B}) could be "I've been feeling more cheerful these last few days".

To sum up, we can consider, for the purpose of this work, the field {A} as the meaning complex that organizes the dominant voice and {non A} as the whole range of oppositions related to it. In therapeutic conversation, if the client chooses to elaborate on the field {non A}, either voluntarily or at the therapist's suggestion, it is most likely to lead to the development of a novelty, or to an IM, as some version of {non A}. The elaboration of the field {non A} can lead to another meaning field {B}, originating the meaning complex {B<>non B}. We also assume that the field {non B} could entail features of the field {A}. For instance, if {A} is worthlessness and {B} worthiness, {non B} could entail meanings of {A}. Thus, through the insertion of {B<>non B}, a relation is established between the new meaning complex present in IMs and the previous complex present in the dominant self-narrative, which leads to a contrast of the two meaning complexes. This contrast can take different forms depending on how the individual regulates the [{A<>non A} {B<>non B}] relationship.

Meaning-making entails the regulation of dialogical relations between meaning complexes, {A} and {B}. They can have dialogical relations of two different natures: harmonious or tensional. In harmonious coexistence, {A} and {B} can coexist without rivalry:

> "That's how I feel − weak, invariably sad, not thinking much of myself..." [{A}] and "It's not what I do at work or at school, because I believe I have some kind of value" [{B}].

In the previous example the coexistence between {A} and {B} is clear as they co-occur without any sort of tension. When tension is present some kind of resolution is needed:

"Sometimes, with my boyfriend...I still let some things go by, because, well, I am

still afraid of being that pain-in-the-neck sort of person, always insisting on this and that. Sometimes I still find it difficult to realize whether what I am thinking should be discussed with him or not, I remain in the twilight of doubt, obscurity, is it really? Is it really not? [{A}] but the truth is that I try to lead our relationship in a softer, easier way [{B}]."

In this example, the use of the word 'sometimes' underscores that the statement "I still let some things go by" ({A}) is valid only for a specific moment. Then a new meaning is elaborated {B: "I try to lead our relationship in a softer, easier way"}. We can assume that the person resolved the tension between {A:"I still let some things go by"} and {B: "I try to lead our relationship in a softer, easier way"} by using the expression 'the truth is' to insure that pessimism did not interfere. Therefore, the tension was resolved by the takeover of {A – worthlessness}.

As in the previous excerpt, people regulate the relations between meanings complexes by means of *circumvention strategies* (Josephs & Valsiner, 1998; Josephs et al., 1999). They are semiotic tools used by people instantly in the task of organizing the flow of everyday experience. They can strengthen a given meaning, resulting in semiotic amplification, or overcome it, resulting in semiotic attenuation. Their role is to give meanings a marginal or central importance, engendering their maintenance or change. Circumvention strategies can act in a number of ways (see Josephs & Valsiner, 1998 for further elaboration). In what follows, we describe two circumvention strategies that we found useful for understanding dialogical processes involved in IMs attenuation and amplification:

1. *Circumvention of meaning by focusing on a competing goal and/or highlighting personal preferences* – the person bypasses a given meaning as he or she highlights a motivational goal that rivals the previous meaning (e.g., "I see myself as a rather negativistic sort of person these days, but I want to improve! I want to go back to my old good self!").

2. *Circumventing of meaning by means of focusing on semantic qualifiers* – expressions that somehow emphasize an absolutist and determinist fashion in IMs, such as "I truly believe things are on the right track, I do feel a lot better" can be used, but others that seem to promote some instability in meaning can also be used, like "I feel a bit worthless sometimes," which can open the meaning to further elaboration.

3. METHOD

Data for the current study were drawn from the A. P. Ribeiro et al.'s (2009) study of IMs and RPMs in constructivist therapy and A. P. Ribeiro et al. (2010b) study of protonarratives in constructivist therapy. Relevant parts of those studies' method and results are summarized here; please see A. P. Ribeiro et al. (2009) and (2010b) for full details.

3.1. Client

Caroline was a 20-year-old White female who gave permission for her materials to be used for research. She reported as her main problems feelings of sadness, hopelessness and worthlessness, following her entrance to university and the beginning of a romantic relationship, which impaired her interpersonal relationships and her academic functioning. She described difficulties with being assertive (especially with her boyfriend), satisfying the needs of others to the detriment of her own needs. She usually took responsibility for her parents' problems, trying to protect her mother from her father, who used to stalk her even after divorce. During therapy, Caroline was able to make connections between these different problems and realize how they were all part of a larger functioning pattern: pessimism.

3.2. Therapy and therapist

Caroline was seen in brief and individual constructivist therapy focused on implicative dilemmas (Fernandes, 2007; Fernandes et al., 2009; Senra et al., 2007) for 12 sessions and one follow-up session, at her university's clinic. Therapy terminated by mutual decision after completion of the treatment manual, as therapist and client agreed that the main goals had been achieved. Video and audio recordings were made of all 12 sessions. Sessions 1 and 11 were not recorded owing to technical problems, leaving ten sessions available for our analysis.

According to Senra and E. Ribeiro (2009), "implicative dilemmas represent a form of blockage in the individual's constructing activity, where an undesired construction is strongly related to other, positive and self-defining, construction(s). As a result, the person can't move towards a desired construction as that would imply abandoning some nuclear features of the self, or embracing some undesired aspects that correlate with the wanted one" (p. 1). Senra et al. (2007; see also Fernandes, 2007) developed a brief therapy aimed at solving these impasses in the clients' constructions

organized in five stages: (1) assessment, (2) reframing the problem as a dilemma, (3) dilemma elaboration, (4) alternative enactment and (5) treatment termination. Sessions are structured in terms of goals and tasks, but there is time flexibility for their completion. Their proposal adopts a hermeneutic and phenomenological perspective, using predominantly explorative interventions, privileging reflection and elaboration of the client's personal meanings.

The therapist was a 25-year-old White female doctoral student of clinical psychology, with three years of prior clinical experience as psychotherapist, who had undergone training in the therapeutic model prior to the therapeutic intervention and attended weekly group supervision for this case.

3.3. Measures

3.3.1 Outcome Questionnaire (OQ-45.2; Lambert et al., 1996). The OQ-45.2 is a brief self-report instrument, composed of 45 items, designed for repeated measurement of client status through the course of therapy and at termination. It monitors the client's progress in three dimensions: subjective discomfort, interpersonal relationships and social role functioning. The items are rated on a 5-point Likert scale, from 0 to 4, with total scores ranging from 0 to 180. A Portuguese version was developed by Machado and Klein (2006). The internal consistency (*Cronbach's* α) values for the OQ-45.2 total and respective subscales were in satisfactory ranges (0.69 to 0.92). The *Reliable Change Index* (RCI; Jacobson & Truax, 1991) is 18 points and the cut-off score is 62.

3.3.2. Innovative Moments Coding System (IMCS; M. M. Gonçalves et al. 2010a, 2010b). The IMCS (Table 1) is a system of qualitative analysis that differentiates five meaning categories, designated as IMs: action, reflection, protest, reconceptualization and performing change. Previous studies using the IMCS (e.g., Matos et al., 2009; Mendes et al., 2010) reported a reliable agreement between judges on IM's coding, with *Cohen's k* between .86 and .97.

3.3.3. Return to the Problem Coding System (RPCS; M. M. Gonçalves, A. P. Ribeiro, Santos, J. Gonçalves, & Conde, 2009). The RPCS is a qualitative system that analyses the re-emergence of the problematic self-narrative (through RPMs) immediately after the emergence of an IM or within the client's first speaking turn after the therapist's first intervention following the IM narration. Previous studies using the RPCS (M. M. Gonçalves et al., 2011; A. P. Ribeiro et al., 2011; A. P. Ribeiro et al., 2012) reported a reliable agreement between judges on RPM's coding, with a *Cohen's k*

between .85 and .93.

3.3.4. Protonarratives Coding System (PCS; A. P. Ribeiro, M. M. Gonçalves, & Bento, 2010). The PCS analyses the underlying theme of each IM, designating a central protonarrative.

3.4. Procedure

Our research strategy involved four major steps of analysis: (1) identifying IMs (previously carried out by A. P. Ribeiro et al., 2009); (2) identifying RPMs (previously carried out by A. P. Ribeiro et al., 2009); (3) identifying protonarratives (previously carried out by A. P. Ribeiro et al., 2010b); and (4) depicting the processes by which the protonarratives emerged and evolved throughout therapy and their relation with mutual in-feeding.

3.4.1. Case categorization. Caroline was diagnosed with an adaptation disorder with depressive symptoms, according to DSM-IV (American Psychiatric Association, 1994). Her case was considered a good-outcome case on the basis of significant symptomatic change evidenced in the pre-post OQ-45.2 total score (Lambert et al., 1996; Portuguese version adapted by Machado & Klein, 2006). Her pre-therapy OQ-45.2 total score of 99 dropped to 50 at therapy termination, which allow us to classify Caroline as having met criteria for recovery (i.e., passed both a OQ-45.2 cut-off score and RCI criteria; Machado & Fassnacht, 2010) at treatment termination (see Jacobson & Truax, 1991; McGlinchey et al., 2002).

3.4.2. Identifying Innovative Moments: Coding procedures and reliability. Session recordings were coded according to the IMCS (M. M. Gonçalves et al., 2010a, b) by three judges: Judge 1 coded all the sessions available (10 sessions); and Judges 2 and 3 (who were unaware of the outcomes) independently coded five sessions each. Before beginning their independent coding of IMs, the judges discussed their understanding of the client's problems (dominant self-narrative). This step was guided by the question: "What is the central rule/framework that organizes Caroline's suffering?". This discussion aimed to generate a consensual definition of the client's main self-narrative rules so that the exceptions to the rules (IMs) could be coded. Caroline's dominant self-narrative was characterized as the "pessimism" rule, that is, the idea that no matter what efforts she made she would never achieve positive results, and that she was not worthy. Consider the following:

Caroline: *I see myself as a rather negativistic sort of person these days, always thinking the worst, and I don't trust myself that much (...) I feel gloomy and not wishing to socialize with anyone (...) I don't see myself as willing or ready to face conquest, I feel myself impotent to fight against or whichever for, unable to go and search what I need (...) I feel kind of defeated, with no muscle to fight (...) I feel rather low (...) For instance, haven't got the slightest wish ever to undertake some sort of physical activity that I like (...) I know that I'll be worrying with something else or I'll be feeling that deep anguish, that uneasiness I see myself in, with my mind sort of frozen, blocked, and I won't be able to do other things (...) There's something inside me that prevents me from moving forward, have guts, feel the power (...) Last Saturday, for instance, I did nothing, absolutely no-thing, I was either in the Internet talking with Rachel (a friend), or who-whatever came by, I wanted to put the computer aside and study and I just couldn't!*

This self-narrative is highly contaminated by intense sadness, hopelessness and worthlessness. Keeping the pessimism rule in mind, judges coded IMs from video and audio recordings, identifying each IM's onset and offset to the nearest second. We computed the total percentage of time in the session devoted to IMs (we termed this measure IM salience). The percentage of agreement on overall IM salience was 84.1%. Because of the high inter-judge reliability, we based our analyses on Judge 1's coding.

3.4.3. Identifying Return-to-the-Problem Markers: Coding procedures and reliability. Two judges participated in the RPM coding procedure. RPMs coding comprised two sequential steps: (1) independent coding; and (2) resolving disagreements through consensus. The judges independently coded the entire sample (10 sessions), analyzing previously coded IMs regarding the presence of RPMs. The sessions were coded from video and audio recording in the order in which they occurred. Reliability of identifying RPMs, assessed by *Cohen's k*, was .93, based on the initial independent coding.

3.4.4. Identifying Caroline's protonarratives: Coding procedures and reliability. Coding protonarratives involved a discussion between the first author and a team that ranged from 2 to 12 researchers, along with an auditing process (Hill et al., 2005). This step was guided by the question: "What is the potential counter-rule/framework of behaving (acts, thoughts, emotions) present in this IM?" or in a different but equivalent formulation: "If this IM expands itself to a new self-narrative, what would be the rule that shapes this new self-narrative?". The authors tried to capture the answer to this

question in the form of a sentence or a word. The protonarrative for each successive IM was then compared with the protonarratives previously described, to look for convergences and divergences. Whenever strong convergences were found, the new IM was understood as sharing the previously described protonarrative. When strong divergences were found, a new protonarrative was formulated to incorporate the new meanings.

The salience of each protonarrative was computed for each session as the sum of the salience of IMs in which they emerged. The mean salience of each protonarrative throughout the process was also computed.

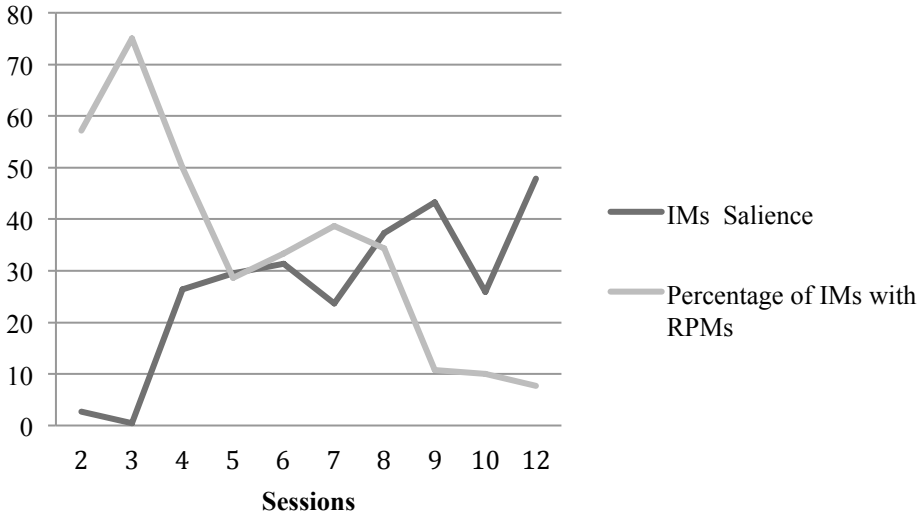
3.4.5. Depicting the processes by which the protonarratives emerged and evolved throughout therapy and their relation with mutual in-feeding. We adopted Josephs and collaborators' dialogical-dialectical approach to meaning-making (Josephs & Valsiner, 1998; Josephs et al., 1999; see also Santos & M. M. Gonçalves, 2009) to understand how IMs emerge, how they remain captive in the process of mutual in-feeding and also how they develop into a successful outcome (resolving mutual in-feeding).

4. RESULTS AND DISCUSSION

4.1. IMs and RPMs across therapy

In Figure 4 we have represented the evolution of percentage of time in the session occupied by IMs – which we term salience – and the percentage of IMs with RPMs. In this case, IM salience presented an increasing trend, while IM with RPM has a decreasing one. The percentage of IMs with RPMs was very high until the third session, decreasing afterwards, but remaining above 30% until session 9 (see A. P. Ribeiro et al., 2009).

Figure IV.4: IMs salience and percentage of IMs with RPMs across therapy



4.2. Protonarratives across therapy

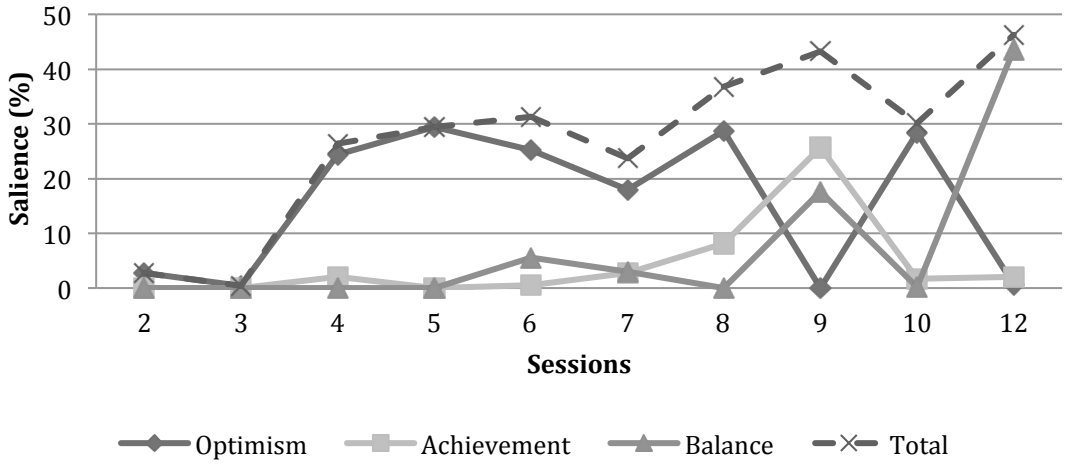
After an in-depth analysis of Caroline's IMs, A. P. Ribeiro et al. (2010a, b, c) identified three protonarratives summarized in Table 1: optimism (Mean salience = 15.77%), achievement (Mean salience = 4.29%) and balance (Mean salience = 6.98%).

Table IV.1: Protonarratives in Caroline's case

Protonarratives	Contents
{Optimism}	• Life areas and/or capacities not dominated by pessimism • Intention to overcome pessimism • Comprehension of pessimism causes • Awareness of pessimism effects
{Achievement }	• Strategies implemented to overcome pessimism • Well-being
{Balance}	• Balanced relationship between pessimism and optimism • Balanced relationship between her own needs and other's needs • Balanced relationship between study/work and leisure

As shown in Figure 5, sessions differed with respect to the presence of protonarratives. Sessions 2 and 3 were characterized by only occasional instances of {Optimism} exclusively. In session 4 {Optimism} and {Achievement} were present and in session 5 only {Optimism} was present again. In sessions 6 and 7 the three protonarratives were present. In sessions 8 and 9 two protonarratives were present again: {Optimism} and {Achievement} in session 8 and {Achievement} and {Balance} in session 9. Sessions 10 and 12 were characterized by the presence of the three protonarratives again.

Figure IV.5: Protonarratives Salience across Therapy

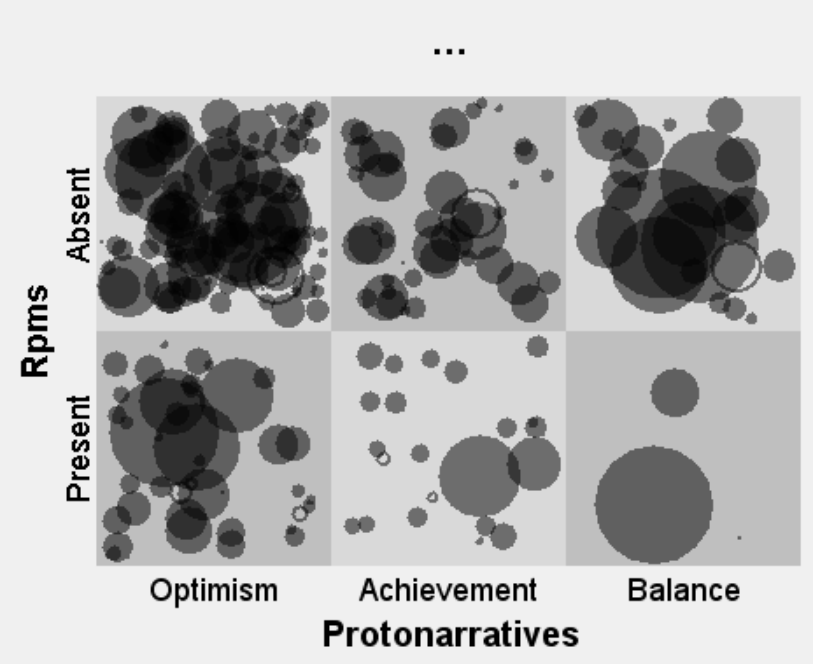


4.3. Protonarratives and mutual in-feeding

Figure 6 plots three variables: protonarratives (axis x), RPMs (axis y), and the salience of each IM (represented by size of circles). Placement of the circles within the cells is arbitrary; circles are arranged to allow representation of successive events of the same type, using computer software: the Gridware (Lamey et al., 2004).

As shown in Figure 6, the three protonarratives showed different likelihoods of including RPMs. The first protonarratives to emerge, {Optimism} and {Achievement}, presented a higher percentage of IMs with RPMs (29.1% and 33.8%, respectively) than {Balance}, which was the last to emerge (10.7%).

Figure IV.6: Protonarratives and RPMs



4.4. Protonarratives emergence and mutual in-feeding maintenance and transformation

In what follows, we will shed light on the microgenetic semiotic-dialogical processes by which these protonarratives emerged and evolved throughout the therapy and their relation to mutual in-feeding maintenance and transformation.

4.4.1. Optimism: Mutual in-feeding between dominant and innovative voice(s). IMs focused on {Optimism} were mostly centered on considerations about the capacities Caroline had in the past and also on her self-capacity to achieve change. This content is the exact opposite of what Caroline defined as the "pessimism" rule, that is, the idea that whatever she did, she would never achieve positive results, and that she was not worthy. Let us look at the following excerpt:

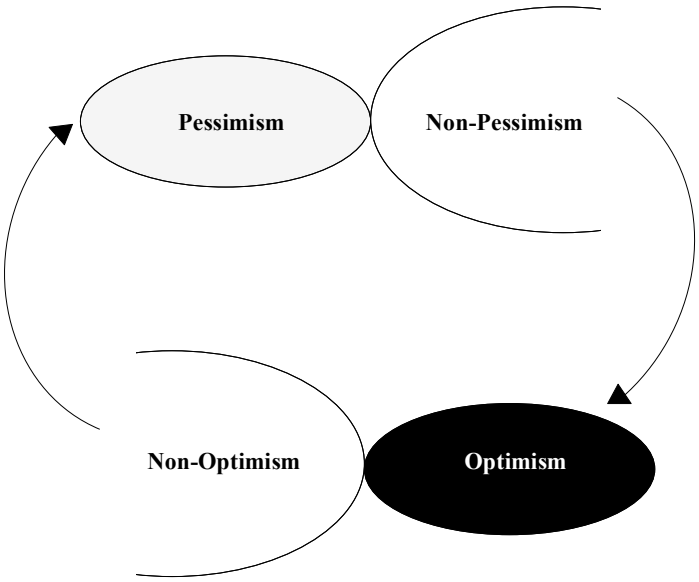
Second session

Caroline: *Maybe because I felt inclined to impose myself targets all my life and do my utmost to achieve them, always with a lot of hard work, but I always managed to get there somehow...* [emergence of an IM {Optimism}] *and nowadays... I realize I don't have that strength any longer* [RPM – {Pessimism} – IM's attenuation]. *Maybe I'll get what I want after all, I don't know ...* [emergence of

an IM {Optimism}] *but I feel weak, psychologically speaking… like me or someone inside me was incessantly saying 'you cannot, you will not be able to do it'. That's how I feel – weak, invariably sad, not thinking much of myself...* [RPM—{Pessimism}– IM's attenuation].

In this excerpt, first Caroline emphasized her self-worth, enacting an IM – {Optimism: "Maybe because I felt inclined to impose myself targets all my life and do my utmost to achieve them"}. She employed the past tense, however, relegating her capacities to the past. Also, the field {Optimism} is followed by considerations about the difficulties she had in achieving her goals – "always with a lot of hard work" – which are an expression of the field {non-Optimism}, with characteristics easily identified with {Pessimism}. The elaboration of the {non-Optimism field} seems to have fostered the re-emergence of the {Pessimism} field as she soon returns to the problem when she says "... and nowadays... I realize I don't have that strength any longer". By doing so, she attenuated the meaning of the previous IM. After that, Caroline elaborated another IM {Optimism: "Maybe I'll get what I want after all, I don't know"}. Yet, the expression "I don't know" can be conceptualized as a {non-Optimism} being rather close to the {Pessimism} meaning complex, once it stresses that the IM's meaning was not structured enough (also denoted by the word 'maybe'). Although a new meaning complex ("Maybe I'll get what I want after all, I don't know") was brought into therapeutic conversation, its potential for development was immediately bypassed. In this sense, Caroline actually returned to and strengthened the meaning of the dominant meaning complex, despite the emergence of the IM, as she said {Pessimism: "but I feel weak, psychologically speaking ... like me or someone inside me was incessantly saying 'you cannot, you will not be able to do it'. That's how I feel – weak, invariably sad, not thinking much of myself"}. This meaning complex was clearly related to (or even expressed by) the dominant self-narrative. The employment of the words 'invariably' and 'incessantly' (i.e., semantic qualifiers) showed how definite and determinist this organizer had been in Caroline's life. This is a circumvention strategy for taking over the "I'll get what I want" statement, expressing "you cannot, you will not be able to do it" and thus attenuating the IM's meaning (see Figure 7).

Figure IV.7: A dialectical understanding of mutual in-feeding



Note. From "The process of meaning construction – dissecting the flow of semiotic activity", by I. Josephs, J. Valsiner, & S. Surgan, 1999. Adapted with permission.

These excerpts enabled us to see a repetitive pattern in IMs emergence at the beginning of therapy. They were often a mere opposition to the problem, which without considering specific strategies that could be catalytic of change, made the return to the problem – and thus the attenuation of IM meaning – also predictable (Santos et al., 2010).

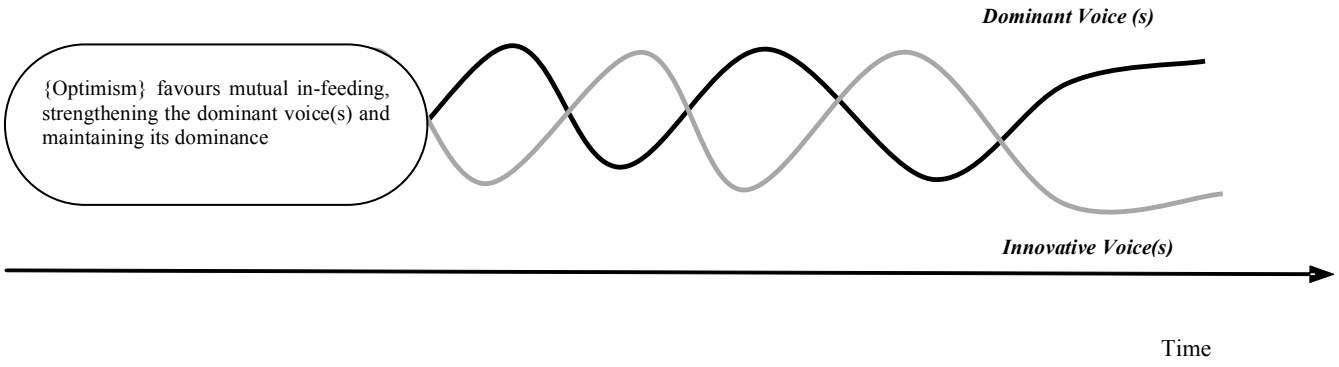
In the analyzed excerpts, the meanings present in IMs were frequently followed and consequently attenuated by the dominant self-narrative. It seemed that IMs were systematically trivialized, neglected or simply taken over by the immediate emergence of the {Pessimism}. So, dialogical relations of opposition and rivalry between the {Pessimism} and the {Optimism} were "solved" by an immediate return to the problem–attenuation. The high frequency of IMs focused on {Optimism} with RPMs seemingly mirrors a dynamic stability between the dominant voice(s) and the innovative one(s), in which they relate in a way that feed each other, in a mutual in-feeding process. The opposing voices seemed "to fight for possession of the floor" (Brinegar et

al., 2006, p. 170). This self-contradictory speech, in which innovative meanings seemed to trigger contradictory dominant meanings, and vice versa, is akin to what Stiles and collaborators call *Rapid Cross Fire* (e.g., Brinegar et al., 2006).

In this sense, IMs did not evolve to the construction of other possible voices, as they were absorbed into the vicious cycle (see Figure 8). Innovative voice(s) seemed to work as a shadow of the dominant voice(s) (Gustafson, 1992), allowing its perpetuation and closing down the meanings system. This process ended by strengthening the dominant voice(s) and maintaining its dominance not only because it was still present, but because it prevented other possible voices from developing.

The asymmetric rigidified stability that characterizes the dialogical relationships between the dominant voice(s) and the innovative ones in the initial phase was progressively surpassed throughout the treatment. In the following sections, we illustrate how the emergence of {Achievement} and {Balance} protonarratives helped to transform mutual in-feeding into a different dialogical modality.

Figure IV.8: Mutual in-feeding



4.4.2. Achievement: Escalation of the innovative voice(s), thereby inhibiting the dominant voice(s). Achievement emerged for the first time in the fourth session. Its content reveals a more empowered relation to the problem, as we can observe in the following example:

Fourth session

Caroline: ... *I'd very much like to get there, particularly now with my studies*. [emergence of an IM – {Optimism}]. *I'm in the 2nd grade of the degree X and getting to the end is sounding quite an unachievable goal* [RPM {Pessimism}],

I'd like to... [emergence of an IM – {Optimism}].

Therapist: *We need to change things here, exactly at this point, you say you haven't been able to ... get some sort of stability in order to be able to...* [Therapist elaborates on {non-Pessimism}, catalyzing the amplification of the previous IMs].

Caroline: *To get going because* [emergence of an IM – {Optimism}], *well, I don't give up, you see, I keep on studying and realizing what my needs are... this week, for instance, I was rather quiet, managed to study* [emergence of an IM – {Achievement}] *(...) At least I know I did study, I read* [emergence of an IM – {Achievement}] *(...) This week I felt a bit more, well, a bit more loose* [emergence of an IM – {Achievement}].

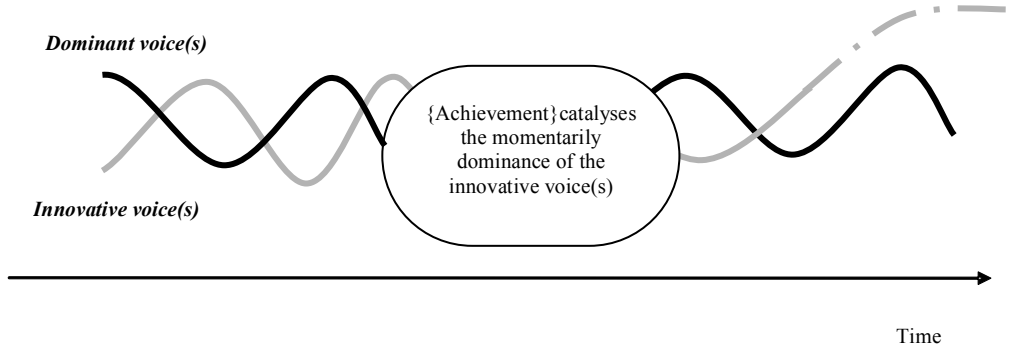
The previous example has two IMs with different content. Initially, Caroline enacts an IM acknowledging that she wanted to change ({Optimism}). This IM was then circumvented by a personal competing goal "is sounding quite an unachievable goal" – attenuation. Nevertheless, Caroline soon bypassed this meaning (that supports the problem), by focusing on self-preferences, as she said "...I'd like to..." The therapist explored this window of opportunity, by elaborating on {non-Pessimism}, which seems to have fostered the elaboration in {Optimism} – amplifying the previous IM–, and then the emergence of {Achievement}. Indeed, Caroline acknowledged the therapist's meaning "get some sort of stability in order to be able to" by saying "To get going" from where she enacted another IM ("This week I felt a bit more, well, a bit more loose"), as she stated an actual change of starting to feel better.

Caroline seemed to be able to identify a set of new self-capacities, grounded in specific actions {Achievement: "I did study, I read"}, that are not limited to the dichotomy pessimism *vs* optimism. The emergence of {Achievement}, that encompasses both actions (e.g., "I did study, I read"), implemented to defy the problem, and reflections about the change process (e.g., "This week I felt a bit more, well, a bit more loose") seem to have taken over both {Pessimism} and {Optimism} fields. The neutralization of these fields appears to play a pivotal role in overcoming mutual in-feeding and opening the opportunity to the emergence of new self-meanings that are not, by their nature, close to the {Pessimism} meaning.

This process seemingly promotes an escalation of the innovative voice(s), which may inhibit the power of the dominant one(s) (see Figure 9). Hermans (1996a, b) has characterized this process as a form of dominance reversal: the position that was once dominant is now dominated. The dominance reversal in this case is temporary, given

that IMs focused on {Achievement} still present a considerable number of RPMs.

Figure IV.9: Escalation of the innovative voice(s) and thereby inhibiting the dominant voice



4.4.3. Balance: Dominant and innovative voice(s) negotiate and engage in joint action. At the sixth session, a new protonarrative {Balance} emerged, through the contrast between the old – {Pessimism} – and the new – {Optimism} and {Achievement}, integrating characteristics from the previous ones. The following example shows a more balanced relationship between pessimism and optimism.

Sixth session

Caroline: *I also believe that, sometimes, being pessimistic creates some kind of balance because if you are too optimistic, you start trusting yourself too much and you'll not try. So, I think something good about being pessimistic is not to create too many expectations regarding the future... not to create expectations and excessively believe in ourselves, which forbids us to make the effort to attain a task. Usually, if we trust too much in ourselves, we may be led to assume 'Oh, I'm not going to study, I can do it...' And a bit of fear is not harmful, either, it makes us work harder and do our utmost*.

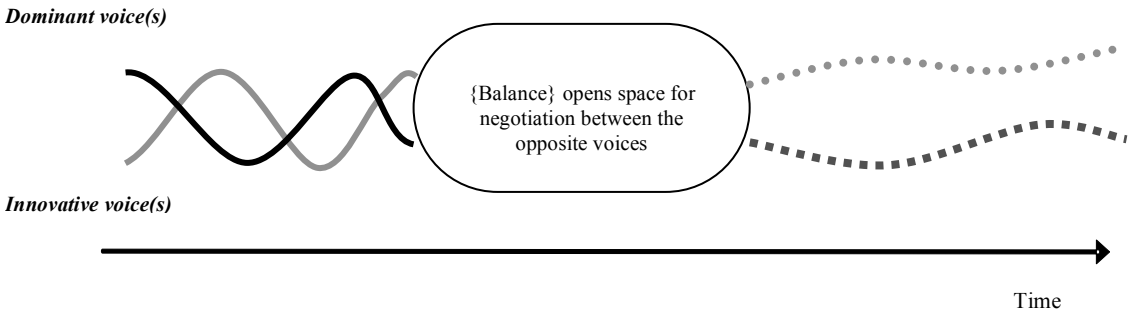
Therapist: *The purpose is really that: see the advantages of optimism and the disadvantages of that extreme, as well...*

Caroline: *Right, try to find some sort of balance...* [emergence of an IM – {Balance}].

As we have stated, IMs focused on {Optimism} were a mere opposition to the

problem, facilitating the return to it. Inversely, {Balance} opens up room for negotiation between the dominant and the innovative voice(s) (see Figure 10). In this IM, the opposite voices appeared to be respectfully listening to one another by building a *meaning bridge* (Brinegar et al., 2006). A meaning bridge is a sign (a word, phrase, story, theory, image, gesture, or other expression) that represents the same meaning for the dominant and non-dominant voices. In this case, the protonarrative {Balance} connects pessimism and optimism, allowing the two poles to communicate with one another and engage in joint action. This meaning bridge thus allows both pessimism and optimism to serve as resources.

Figure IV.10: Dominant and innovative voices negotiate and engage in joint action



5. CONCLUSION

Individuals constantly construct meanings through auto- and hetero-dialogues as a pre-adaptation mechanism, orienting themselves toward the immediately potential future, reducing its uncertainty and unpredictability and mediating the relation with the surrounding world (Josephs & Valsiner, 1998; Valsiner, 2002). Moreover, "uncertainty challenges our potential for innovation and creativity to the utmost" (Hermans & Dimaggio, 2007, p. 10). Along these lines, life events or contexts, which challenge the client's usual way of constructing meaning, such as a new dialogical encounter with a therapist, foster self-innovation or development (Cunha, 2007). Obviously, these processes of innovation and development also occur in life outside therapy, but therapy offers a natural laboratory where often changes occur at a faster pace.

Either way, inside or outside therapy, change creates uncertainty, given that the past forms of adaptation are in a sense compromised (Kelly, 1955), making the future

less predictable. Thus, even when change is desired (Arkowitz & Engle, 2007), if the degree of associated uncertainty is too threatening for the person, a "defensive and monological closure of the self and the unjustified dominance of some voices over others" (p. 10) could occur, since it challenges the feeling of *quasi* stability which people seek to maintain (Molina & del Río, 2008).

In this paper we explored a specific way the dialogical self protects itself from uncertainty – the mutual in-feeding process between innovative voices (expressed in IMs) and dominant ones (expressed in the dominant self-narrative). The semiotic-dialogical approach enabled us to study the rapid flow of micro-processes that were involved in mutual in-feeding maintenance and transformation throughout Caroline's therapeutic process. The evolution of Caroline's case from meaning maintenance to meaning transformation seemed dependent on the semiotic regulated dialogical interchanges between the dominant voice(s) and the innovative one(s).

Initially, IMs focused on Optimism protonarrative were a mere opposition to the dominant self-narrative (Pessimism) and thus facilitated a mutual in-feeding relation between the dominant and the innovative voices. The resolution of mutual in-feeding seems to be promoted by the emergence of the Achievement protonarrative, which allowed an escalation of the innovative voice(s). Then Balance protonarrative led to an integration of both dominant and innovative voices to form an alternative self-narrative, making the opposition, as in mutual in-feeding, virtually impossible.

Indeed, Balance protonarrative became a source of flexibility in dialogical self insofar as it appeared to enable a conditional dynamic movement between the previously opposing voices rather than a fixation on one of them (J. Valsiner, personal communication December 16, 2008). This is akin to "the absence of identification with any particular subject position" that characterizes Bakhtin's novelist (in a polyphonic novel) and "which implies freedom from the compulsion to construe the world from a perspective only" (Michel & Wortham, 2002, pp. 11–12).

The analysis of Caroline's case which initiates a line of intensive qualitative research into how return to the problem can turn into therapeutic movement that is, how the relation between innovative voices and the dominant voices evolve from mutual in-feeding to another form of dialogical relation. We identified two forms of solving the mutual in-feeding process: (1) escalation of the innovative voice(s) thereby inhibiting the dominant voice and (2) negotiating and engaging in joint action. In the future, it is our aim to explore if these processes emerge in different cases, as well as in non-

therapeutic change.

Furthermore, the role of the therapist in turning mutual in-feeding into a therapeutic movement still needs to be studied in detail (see E. Ribeiro, A. P. Ribeiro, M. M. Gonçalves, Horvath, & Stiles, 2010). Indeed, mutual in-feeding needs to be understood in the interpersonal context in which it occurs – the intersubjective field created in all interactions between the therapist and the client (Engle & Arkowitz, 2008). According to Engle and Arkowitz (2008), "therapists can facilitate the resolution of resistant ambivalence by creating in-session exercises that increase awareness and integration of disowned aspects of the self" (p. 393), in the context of a safe and accepting relationship.

6. REFERENCES

Abbey, E., & Valsiner, J. (2005). Emergence of meanings through ambivalence. *Forum Qualitative Sozialforschung /Forum: Qualitative Social Research*, *6*, 58 paragraphs. Retrieved 13th of December, 2008, from http://www.qualitative research.net/fqs/fqs-texte/1-05-1-23-e.htm.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental* Disorders (4th ed.). Washington, DC: American Psychiatric Association.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders.* New York International Universities Press.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counseling Psychology, 53*, 165-180.

Cooper, M. (2004). Encountering self-otherness: "I-I and "I-Me" modes of self relating. In H. J. M. Hermans, & G. Dimaggio (eds.), *The Dialogical self in Psychotherapy* (pp. 60-73). New York: Brunner-Routledge.

Fernandes, E. (2007). When what I wish makes me worse... to make the coherence flexible. *Psychology and Psychotherapy: Theory, Research and Practice*, *80*, 165-180.

Fernandes, E., Senra, J., & Feixas, G., (2009). *Terapia construtivista centrada em dilemas implicativos* [Constructivist psychotherapy focused on implicative dilemmas]. Braga: Psiquilíbrios.

Flynn, E., Pine, K., & Lewis, C. (2007). Using the microgenetic method to investigate cognitive development: An introduction. *Infant and Child Development, 16,* 1–6.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Gonçalves, M. M., Mendes, I., Ribeiro, A. P., Angus, L., & Greenberg, L. (in press). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology*.

Gonçalves, M. M., & Ribeiro, A. P. (in press). Narrative processes of innovation and stability within the dialogical self. In H. J. M. Hermans, & T. Gieser (Eds.), *Handbook of Dialogical Self*. Cambridge: Cambridge University Press.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Mendes, I., Santos, A. (2010). Tracking novelties in psychotherapy research process: The innovative moment coding system. Manuscript in preparation.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Santos, A., & Mendes, I. (in press). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.)*, YIS: Yearbook of Idiographic Science - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, M. M, Ribeiro, A. P., Santos, A., Gonçalves, J., Conde, T. (2019). *Manual for the Return to the Problem Coding System*. Unpublished manuscript, Universidade do Minho, Braga, Portugal.

Gonçalves, M. M., Ribeiro, A. P., Stiles, W. B., Conde, T., Santos, A., Matos, M., & Martins, C. (2010). The role of mutual in-feeding in maintaining problematic self-narratives: Exploring one path to therapeutic failure. Manuscript submitted for publication.

Gonçalves, M. M., Santos, A., Salgado, J., Matos, M., Mendes, I., Ribeiro, A. P., Cunha, C., & Gonçalves, J. (2010). Innovations in psychotherapy: Tracking the narrative construction of change. In J. D. Raskin, S. K. Bridges, & R. Neimeyer (Eds.), *Studies in meaning 4: Constructivist Perspectives on Theory, Practice, and Social Justice* (pp. 29-64). New York: Pace University Press.

Gustafson, J. P. (1992). *Self-delight in a harsh world*. New York: Norton.

Hermans, H. J. (1996a). Opposites in a dialogical self: constructs as characters. *Journal of Constructivist Psychology, 9*, 1-26.

Hermans, H. J. M. (1996b). Voicing the self: From information processing to dialogical interchange. *Psychological Bulletin*, *119*, 31–50.

Hermans, H. J. M., & Dimaggio, G. (2007). Self, identity, and globalization in times of uncertainty: A dialogical analysis. *Review of General Psychology*, *11*, 31-61.

Hermans, H. J. M., & Kempen, H. J. G. (1993). *The dialogical self: Meaning as movement*. San Diego: Academic Press.

Hermans, H. J. M., Kempen, H., & van Loon, R. J. P. (1992). The dialogical self: beyond individualism and rationalism. *American Psychologist, 47*, 23-33.

Hill, C. A., Knox, S., Thompson, B. J., Nutt Williams, E., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An Update. *Journal of Counseling Psycholog, 52*, 196–205.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12–19.

Josephs, I., & Valsiner, J. (1998). How does autodialogue work? Miracles of meaning maintenance and circumvention strategies. *Social Psychology Quarterly*, *61*, 68 – 83.

Josephs, I., Valsiner, J., & Surgan, S. E. (1999). The process of meaning construction – dissecting the flow of semiotic activity. In J. Brandstadter, & R. M. Lerner (Eds.), *Action and Development. Theory and research through the life span.* London: Sage Publications.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249-258.

Lamey, A., Hollenstein, T., Lewis, M. D., & Granic, I. (2004). *GridWare* (Version 1.1). [Computer software]. http://statespacegrids.org.

Machado, P. P., & Fassnacht, D. (2010). The Outcome Questionnaire (OQ-45) in a Portuguese population: Psychometric properties, ANOVAS, and confirmatory factor analysis. Manuscript in preparation.

Machado, P. P., & Klein, J. (2006). *Outcome Questionraire-45: Portuguese psychometric data with a non-clinical sample*. Poster presented at the 37th Annual Meeting of the Society for Psychotherapy Research. Edinburgh, Scotland.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McGlinchey, J. B., Atkins, D. C., & Jacobson, N. S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy*, *33*, 529–550.

Michel, A., & Wortham, S. (2002). Clearing away the self. *Theory and Psychology*, *12*, 625-650.

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology, 19*, 127-145.

Ribeiro, A. P., Bento, T., Gonçalves, M. M., & Salgado, J. (2010). Self-narrative reconstruction in psychotherapy: Looking at different levels of narrative development. *Culture & Psychology*, *16*, 195-212.

Ribeiro, A. P., Bento, T., Salgado, J., Stiles, W. B., & Gonçalves, M. M. (2010). A dynamic look at narrative change in psychotherapy: A case-study tracking innovative moments and protonarratives using state-space grids. Manuscript submitted for publication.

Ribeiro, A. P., & Gonçalves, M. M. (2010). Innovation and stability within the dialogical self: The centrality of ambivalence. *Culture & Psychology, 16*, 116-126.

Ribeiro, A. P., Gonçalves, M. M., & Bento, T. (2010). Protonarratives Coding System. Unpublished manuscript, Universidade do Minho, Braga, Portugal.

Ribeiro, A. P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia construtivista [Narrative change in psychotherapy: A good-outcome case of construstivist therapy]. *Psychologica, 50*, 181-203.

Ribeiro, A. P., Gonçalves, M. M., & Santos, A. (in press). Innovative moments in psychotherapy: From the narrative outputs to the semiotic-dialogical processes. In S. Salvatore, J. Valsiner, S. Strout, & J. Clegg (Eds.), *YIS: Yearbook of Idiographic Science 2010 – Volume 3*. Rome: Firera Publishing Group.

Salgado, J. & Gonçalves, M. M. (2007). The dialogical self: Social, personal, and (un)conscious. In J. Valsiner, & A. Rosa (Eds.), *The Cambridge handbook of sociocultural psychology* (pp. 608–621). Cambridge, UK: Cambridge University Press.

Santos, A., & Gonçalves, M. M. (2009). Innovative moments and change processes in psychotherapy: An exercise in new methodology. In J. Valsiner, P. C. M., Molenaar, M. C. D. P., Lyra, & N. Chaudhary (Eds.), *Dynamic process methodology in the social and developmental sciences* (pp. 493-526). New York: Springer.

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449–466.

Santos, A., Gonçalves, M. M., & Matos, M. (2010). Innovative moments and poor-outcome in narrative therapy. *Counselling and Psychotherapy Research.* Advance online publication doi: 10.1080/14733140903398153.

Sato, T., Hidaka, T., & Fukuda, M. (in press). Depicting the dynamics of living the life: The trajectory equifinality model. In J. Valsiner, P. Molenaar, M. Lyra, & N. Chaudhary (Eds.), *Dynamic process methodology in the social and developmental sciences*. New York: Springer.

Senra, J., Feixas, G., & Fernandes, E. (2007). Manual de Intervención en Dilemas Implicativos. [Manual of intervention in implicative dilemmas]. *Revista de Psicoterapia, 63/64,* 179-201.

Senra, J., & Ribeiro, E. (2009). The process of change in implicative dilemmas: The case of Rose. Manuscript in preparation.

Siegler, R., & Crowley, K. (1991). The microgenetic method: A direct for studying cognitive development. *American Psychologist, 46,* 606-620.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York: Oxford University Press.

Stiles, W. B. (2003). Qualitative research: Evaluating the process and the product. In S. P. Llewelyn, & P. Kennedy (Eds.), *Handbook of clinical health psychology* (pp. 477-499). London: Wiley.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy*, *5*, 9-22.

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans, & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Valsiner, J. (2001). Process structure of semiotic mediation in human development. *Human Development*, *44* ,84-97.

Valsiner, J. (2002). Forms of dialogical relations and semiotic autoregulation within the self. *Theory and Psychology*, *12*, 251-265.

Valsiner, J. (2004). Temporal integration of stuctures within dialogical self. Keynote lecture at the 3rd International Conference on the Dialogical Self, Warsaw.

Valsiner, J. (2008). Constraining one's self within the fluid social worlds. Paper presented at the 20th Biennial ISSBD meeting, Würzburg.

Valsiner, J., & Sato, T. (2006). Historically structured sampling (HSS): How can psychology's methodology become tuned into the reality of the historical nature of cultural psychology? In J. Straub, C. Kölbl, D. Weidemann, & B. Zielke (Eds.), *Pursuit of meaning: Theoretical and methodological advances in cultural and cross-cultural psychology* (pp. 215-251). Bielefeld: Transcript.

CHAPTER V

THERAPEUTIC COLLABORATION AND RESISTANCE: DESCRIBING THE NATURE AND QUALITY OF THERAPEUTIC RELATIONSHIP WITHIN AMBIVALENCE EVENTS USING THE THERAPEUTIC COLLABORATION CODING SYSTEM

CHAPTER V[9]

THERAPEUTIC COLLABORATION AND RESISTANCE: DESCRIBING THE NATURE AND QUALITY OF THERAPEUTIC RELATIONSHIP WITHIN AMBIVALENCE EVENTS USING THE THERAPEUTIC COLLABORATION CODING SYSTEM

1. ABSTRACT

The *Therapeutic Collaboration Coding System* (TCCS) was developed to micro-analyse the therapeutic collaboration, which we understand as the core of the alliance. With the TCCS we code each speaking turn and assess whether and how therapists are working within the client's *Therapeutic Zone of Proximal Development* (TZPD), defined as the space between the client's actual therapeutic developmental level and their potential developmental level. This study focused on the moment-to-moment analysis of the therapeutic collaboration in instances in which a poor-outcome client in narrative therapy expressed resistance in the form of ambivalence. Results showed that ambivalence tended to occur in the context of challenging interventions, suggesting that the dyad was working at the upper limit of the TZPD. When the therapist persisted in challenging the client after the emergence of ambivalence, the client moved from showing ambivalence to showing intolerable risk. This escalation in client's discomfort indicates that the dyad was attempting to work outside of the TZPD. Our results suggest that when therapists do not match clients' developmental level, they may unintentionally contribute to the maintenance of ambivalence in therapy.

2. INTRODUCTION

Regardless of their orientation, therapists report phenomena that can easily be recognized as resistance (Wachtel, 1982, 1999). With Moyers and Rollnick (2002), we conceptualize resistance as an interpersonal phenomenon that reflects both the client's ambivalence about change, understood as the degree of internal conflict regarding change, and the way the therapist responds to this ambivalence. The therapist's response is critical because robust empirical evidence indicates that higher levels of resistance are

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consistently associated to poor therapy outcomes, as well as premature termination of treatment (for a review, see Beutler, Rocco, Moleiro, & Talebi, 2001).

Wachtel (1999) claimed that the quality of the therapeutic relationship plays a central role in determining the level of resistance. Increased resistance can be a sign that the patient feels unsafe, which can reflect the therapist relating to the client in a way he or she experiences as threatening (Wachtel, 1993). Attention to the therapeutic relationship is thus a crucial factor in reducing resistance (Wachtel, 1999).

2.1. Ambivalence as a reaction to innovative moments

We understand ambivalence as a cyclical movement between two opposing parts of the self: the client's usual way of understanding the world (the client's currently dominant but maladaptive self-narrative) and alternative understandings that emerge in *Innovative Moments* (IMs) (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Mendes, & Matos, & Santos, 2011), which are moments in the therapeutic dialogue when clients challenge their dominant self-narrative. We have referred to this form of ambivalence as a *mutual in-feeding* (Valsiner, 2002) process, given that there is an alternation between two opposed parts of the self – the dominant self-narrative and the alternative perspective – that keep feeding each other. Ambivalence might be conceptualized as resistance to change, which is has been referred as one of the most important, yet highly under-investigated phenomena in clinical practice (Engle & Arkowitz, 2006; Wachtel, 1999).

We have proposed a measure of ambivalence that grew from our observations of therapy passages in which an IM was immediately followed by a return to the dominant self-narrative, as in the following example. We called such events a *Return-to the-Problem's Marker* (RPM).

> Therapist: *Lately, you have been changing a lot!*
> Client: *Yes, that's true I've been having moments in which I feel much better* [IM], *but at the end of the day I still feel worthless* [RPM]!

Theoretically, the return to the dominant self-narrative suppresses the innovative way of feeling, thinking, or acting by passing, minimizing, depreciating, or trivializing its meaning, and reinstates the dominant self-narrative, promoting stability. The client thereby avoids the sense of discrepancy or inner-contradiction generated by IMs (Gonçalves, A. P. Ribeiro, Stiles, et al., 2011; Gonçalves & A. P. Ribeiro, 2012; A.

P. Ribeiro et al., 2012). As this sequence repeats in time, expressions of the dominant self-narrative and alternative self-narrative act as opposite self-positions in a negative feedback loop relation, manifested clinically as ambivalence.

Ambivalence fosters stability within the self, which may be understood as two opposing parts of the self, or internal voices, feeding into each other, expressing themselves alternately. This cyclical movement interferes with the development of an inclusive system of meanings in therapy in which these internal voices respectfully listen to each other and engage in joint action. Ambivalence as we measured it in this study (see below) is congruent with a variety of other formulations of clients' resistance to psychotherapeutic change (Arkovitz & Engle, 2007; Feixas, Sánchez, & Gómez-Jarabo, 2002).

Research on cases of Emotion-Focused Therapy (N=6), Client-Centered Therapy (N=6), and Narrative Therapy (N=10), showed that the percentage of IMs followed by RPMs decreased across therapy in good-outcome cases whereas it remained unchanged and consistently high in poor-outcome cases. This observation suggests that ambivalence between the dominant self-narrative and the alternative perspective can interfere with therapeutic progress (Gonçalves et al., 2009).

2.2. The Therapeutic Collaboration Coding System and the therapeutic zone of proximal development

The *Therapeutic Collaboration Coding System* (TCCS; Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, in press) yields a moment-to-moment analysis of the therapeutic collaboration, which we understand as the core meaning of the alliance. This approach of assessing collaboration uses the concept of the *Therapeutic Zone of Proximal Development* (TZPD; see Leiman & Stiles, 2001). The TZPD is an extension of Vygotsky's (1924/1978) concept of the *Zone of Proximal Development* (ZPD). The TZPD assumes that therapeutic progress proceeds along a therapeutic developmental sequence or continuum such as the one described by the assimilation model (Stiles, 2002, 2011), which scales a problem's progress toward resolution. The TZPD is defined as the space along the therapeutic developmental continuum between the client's actual developmental level and a potential developmental level that can be reached in collaboration with the therapist. It can be understood as an "intersubjective field, or playground, on which the client's potential for therapeutic change are externalized" (Leiman & Stiles, 2001, p. 316). From this perspective, productive therapeutic work

takes place when the therapy dialogue occurs within the client's TZPD. The TZPD itself shifts to higher levels in the therapeutic developmental sequence as progress is made. Therapeutic interventions within the TZPD are likely to succeed, whereas interventions outside it are likely to fail. This paper presents the first empirical application of the TCCS.

The TCCS codes each speaking turn with respect to whether and how therapists are working within the client's TZPD. It can be used to study ambivalence, overcoming ambivalence, and the processes that impede overcoming ambivalence.

2.3. Our view of the self and conceptualization of change

TCCS construes narratives as psychological tools individuals use to join together life events (emotions, mental images, representations of bodily states and memories of the past) in coherent units (Dimaggio et al., 2003). To put in another way, human beings reconstruct their significant experiences in the form of narratives and then use them as schemata to decode and make sense of the continuous flow of events. These narratives are the result of the continuous dialogue between multiple parts of the self or internal voices, each possessing its own characteristics and ways of being in the world (Hermans, 1996, 2001a, 2001b; Hermans & Dimaggio, 2004; Hermans & Kempen, 1993; Leiman, 1997, 2002; Osatuke et al., 2004).

In line with the assimilation model (Stiles, 2002, 2011), we propose that constellations of similar or related voices become linked or *assimilated* and constitute a *community of voices,* (experienced by the person as their usual sense of self, personality, or center of experience), and we look at psychological distress as a product of the disconnection of certain voices. The self-narrative is the *meaning bridge* or linking framework that binds the experiences/voices together, giving smooth access to experiential resources and enabling joint action by members of the community of voices. A voice may become dissociated and, thus, problematic to the community if the self-narrative is too rigid and excludes the voice from the community of voices (Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011). Along these lines, a client's initial (presenting) dominant self-narrative may be maladaptive because it fails to acknowledge important parts of the client's life experience.

We construe change in psychotherapy as a developmental process in which clients move from a dominant maladaptive self-narrative – ways of understanding and experiencing that are dysfunctional since they exclude important internal voices – to a

more functional self-narrative, one that integrates the previously excluded problematic voice. Such narratives, are co-constructed through psychotherapeutic dialogue by building meaning bridges, i.e., words or other signs that can represent, link and encompass the previously separated voices and thereby form a new configuration (Stiles, 2011).

In accord with Gonçalves and co-workers' narrative perspective, occurrences in which unassimilated voices express themselves, constitutes *exceptions* to the dominant self-narrative and are identified as IMs (Gonçalves, Matos, & Santos, 2009; see Gonçalves, A. P. Ribeiro, Mendes et al., 2011 for a revision of general findings across different therapeutic approaches). The accumulation and articulation of IMs facilitates the development of an alternative self-narrative, since when non-dominant voices express themselves, the dominance of the current community of voices is disrupted, at least temporarily, and an opportunity for meaning bridges to develop emerges.

2.4. TCCS: Therapeutic interventions and Therapeutic Zone of Proximal Development

Clients usually enter therapy with a restricted capacity for experiencing the world in alternative ways, so that IMs are painful or threatening. Therapy needs to develop a climate in which new experiences are tolerated and considered. Hence, we conceptualize therapeutic activities has having two main components. The first is supporting the client and helping the client to feel safe. This usually involves explicit understanding and accepting of the client's experience within his or her usual perspective (the client's currently dominant but maladaptive narrative). The second is challenging the dominant narrative by using strategies that encourage clients to revise their usual perspective and facilitate IMs. We believe that these components of collaboration must remain in balance. The therapist must keep working within a zone in which the client feels comfortable but is also able to experience a different perspective. Too much support risks maintaining the client's dominant narrative, precluding change; whereas too much challenge risks of creating excessive anxiety, fostering resistance.

The point of balance between support and challenge changes systematically as therapy progresses along the developmental continuum that represents the current self-narrative adequacy in accommodating the client's emerging experiences. As change takes place, the TZPD moves, turning what was formerly a potential level into an actual one, and extending the client's potential level towards greater ability to accommodate the

challenging novelties.

Supporting consists of working closer to the TZPD actual level, confirming and elaborating upon client's perspective of his or her experience. We assume that if the client feels that his or her experience is validated by the therapist, he or she will probably experience a sense of *safety*. Supporting can be focused on the dominant narrative that brought the client to therapy, as when therapist tries to understand the role the problem plays in the client's life from the client's perspective.

Therapists may also focus on emerging novelties in supportive ways, as when therapist tries to understand how IMs emerged, although support focused on the dominant self-narrative is more likely to generate safety than is support focused on IMs. Focusing on IMs could amplify the contrast with the current framework, which may trigger in the client a felt sense of contradiction or self-discrepancy, challenging the old framework and creating dysphoric feelings of unpredictability and uncontrollability (Arkovitz & Engle, 2007).

Challenging consists of working closer to the TZPD potential level, i.e., moving beyond the client's dominant narrative, which may encourage the client to revise it, generating an experience of *risk* (Ecker & Hulley, 2000; Engle & Arkovitz, 2008; Engle & Holiman, 2002; Gonçalves, A. P. Ribeiro, Stiles, et al., 2011; Kelly, 1955; Mahoney, 1991; A. P. Ribeiro & Gonçalves, 2010). The success of these interventions depends on the therapist's capacity to ascertain the client's tolerance for risk, that is the limits of the client's TZPD. The client's response to the therapeutic intervention may indicate whether the therapist worked within the TZPD, or instead, worked out of TZPD, or at the limit of the TZPD. In what follows we explore these interactional possibilities.

2.5. TCCS: Clients response and Therapeutic Zone of Proximal Development

Scoring categories for the TCCS, along with the rationale for each category, have been presented elsewhere (Ribeiro E., et al., in press). This section is a summary.

2.5.1. Working within the TZPD. Theoretically, when the therapist works within TZPD, clients feel either safe following supporting interventions or tolerable risk following challenging interventions. In either case, clients tend to validate therapist's intervention. *Validation* refers to the client explicitly or implicitly accepting the therapist's invitation to look at his or her experience from the proposed perspective.

The client may validate therapist's intervention implicitly by responding within

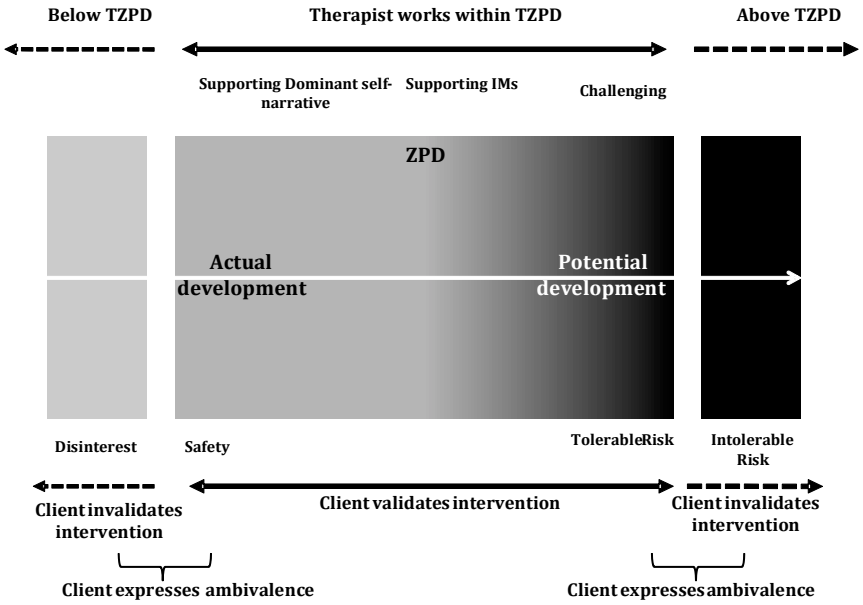
the TZPD near the developmental level proposed by the therapist (see Figure 1):

(1) The client may respond at the same developmental level as the therapist. For example, if both therapist and client are closer to the *actual developmental level*, a sequence might be as follows: the client elaborates the currently dominant self-narrative; the therapist supports it and the client keeps elaborating that framework. If therapist and client are closer to the *potential developmental level*, the sequence might be as this: the client elaborates upon the dominant self-narrative; the therapist challenges; the client accepts the therapist's intervention, elaborating an IM and extending it.

(2) The client may lag behind the level the therapist proposes. For example, if the therapist is closer to the *potential developmental level*, whereas the client is closer to the *actual developmental level*, a sequence might be the following: the client elaborates upon the dominant self-narrative; the therapist challenges it; the client accepts the therapist's intervention, elaborating an IM, but does not extend it.

(3) Finally, the client may work beyond the level the therapist proposes. For example, if the therapist is closer to the *actual developmental level* whereas the client is closer to the *potential developmental level*, then a sequence might be as this: the client elaborates upon the dominant self-narrative; the therapist supports it; the client accepts the therapist's intervention but follows up by raising an IM.

Figure V.1: Segment of the therapeutic developmental continuum showing the therapeutic zone of proximal development



2.5.2. Working outside of the TZPD. Theoretically, when the therapist works outside of TZPD, the client will probably invalidate the intervention. *Invalidation* refers to declining an invitation to look at his or her experience from the perspective offered by the therapist.

When the therapist pushes the client too far, that is, works above the upper limit of the TZPD, he or she will probably experience *intolerable risk* and, thus, will invalidate therapist's intervention, for example by changing the subject, misunderstanding, or becoming defensive as a self-protective mechanism. Invalidation may also occur when therapist works below the lower limit of the TZPD, since the client may feel that the therapist is being redundant (not getting anywhere) and may become bored and disinterested.

The TZPD constantly evolves throughout the therapeutic process, redefining its limits moment by moment. What was risky (closer to the potential level) for the client at a given moment may later become safe (closer to actual level). On the other hand, as setbacks inevitably occur (Caro-Gabalda & Stiles, 2009, 2012), what seemed safe at one moment may become risky in the next. New perspectives co-constructed in psychotherapy are fragile, and the safety experienced by the client is usually temporary or provisional. Consequently, when the client invalidates therapist's intervention this

need not to imply that the therapist was not attuned to the client.

2.5.3. Working at the upper or lower limit of the TZPD. When the therapist works at the limit of the TZPD, the client is more likely to exhibit ambivalence than invalidation – to begin to accept the perspective proposed by the therapist but then take an opposite perspective. This can happen whether the therapist is working at the upper limit or at the lower limit of the TZPD.

If the therapist works closer to the upper limit of TZPD, by challenging the client of supporting IMs, client's ambivalence response may indicate he or she lags behind the proposed level, *moving towards safety*. Such behaviors are akin to what we described above as an RPM in the IMs Model (Goncalves & A. P. Ribeiro, 2012; Gonçalves, A. P. Ribeiro, Stiles, et al., 2011; A. P. Ribeiro & Gonçalves, 2010).

In contrast, if the therapist works closer to the lower limit of TZPD, by supporting the dominant self-narrative, client's ambivalence response may indicate he or she extends beyond the level proposed by the therapist, *moving towards risk*.

2.6. The present study

The present study focused on the events in which a previously studied (Matos et al., 2009; Gonçalves, A. P. Ribeiro et al., 2011) poor-outcome client experienced ambivalence, that is, in which she began to validate (accept) the therapist's invitation to elaborate an IM (by means of a challenging or supporting intervention) but then invalidated the intervention by returning to the dominant self-narrative (assessed by an RPM). This was a theory-building case study (Stiles, 2009), which sought a deeper theoretical understanding of how therapists may contribute to maintaining ambivalence.

We explored 3 research questions:

1. Which types of therapeutic intervention precede the emergence of RPMs (as empirical markers of ambivalence)?
2. How does the therapist respond to client's RPMs? In other words, how does the therapist's try to restore collaboration or keep the dyad within the TZPD?
3. How does the client react to the therapist's response to RPMs? To put in another way, is the therapist's intervention successful in restoring collaboration or place the dyad within the TZPD?

3. METHOD

Data for the current study was drawn from Matos et al. (2009) sample of IMs in narrative therapy. This poor-outcome case of narrative therapy had been previously coded for RPMs by Gonçalves, A. P. Ribeiro et al. (2011). Relevant parts of these studies' method are summarized here; please see Gonçalves, A. P. Ribeiro et al. (2011) for further details.

3.1. Client

Maria was a 47-year-old retired industrial worker, married for 20 years. Maria's outcome was relatively poor, as compared to the rest of a sample of women who were victims of intimate violence (Matos et al., 2009). Maria was recommended for therapy by an institution for crime victims. She presented severe symptoms of depression (e.g. sadness, hopelessness, social withdrawal, isolation).

Maria was from a very poor family. Her mother died when she was six years old and she had a bad relationship with her father, who was also physically violent toward her during her childhood. Her husband's locomotor disability had been an obstacle to her wishes to leave the relationship, because she pitied him. This resulted in being submissive to her husband and his family. She also had relational problems with her oldest son, and she blamed herself for not being a good mother. Her intent was to leave home with her youngest child to a temporary crime victims' shelter. Her main obstacles were lack of financial independence and the impossibility of taking her oldest son with her.

3.2. Therapy and therapist

Maria attended psychotherapy in a Portuguese university clinic, where she underwent individual narrative therapy (White & Epston, 1990). This case evolved through 15 sessions, initially four weekly sessions and then twice a month, plus one follow-up (after six months). She was treated by a female therapist. At the time the therapy was conducted, the therapist had a master's degree in Psychology and five years of experience in psychotherapy with battered women. Psychotherapy was supervised to ensure adherence of the therapist to the narrative therapy model.

The therapy was developed from the narrative model of White and Epston (1990; see also White, 2007) and involved the (a) externalization of problems, (b) identification of the cultural and social assumptions that support women's abuse, (c)

identification of unique outcomes (or, as we prefer, IMs), (d) therapeutic questioning around these unique outcomes, trying to create a new alternative narrative to the one that was externalized, (e) consolidation of the changes through social validation, trying to make more visible the way change happened (see Matos et al., 2009, for a detailed description of the narrative therapy guidelines).

3.3. Researchers

The qualitative TCCS analysis was conducted by the first author, a doctoral student in clinical psychology and co-author of TCCS and the second author, a master's student in clinical psychology. Both were well versed in the TCCS. The third author, a university faculty member in clinical psychology, served as auditor of TCCS coding, reviewing and checking the judgments made by the judges.

3.4. Measures

3.4.1 Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). The BSI is a 53-item self-report rating scale of distress, using a 5 points Likert scale. We used the Portuguese adaptation by Canavarro (2007), which has good psychometric characteristics (*Cronbach's* α for the 9 symptom subscales ranges from .62 to .80).

3.4.2. Severity of Victimization Rating Scale (SVRS; Matos, 2006). SVRS assesses abusive actions received (physical, psychological, and/or sexual), their frequency, and severity on a 3-point scale (low, medium, high); it is completed by the therapist based on the client's report.

3.4.3. Working Alliance Inventory (WAI; Horvath, 1982). The WAI is a 36-item questionnaire, which uses a 7 point Likert scale to assess therapeutic alliance quality. The Portuguese version (Machado & Horvath, 1999) presents good internal consistency (*Cronbach's* α = .95).

3.4.4. Return-to-the-Problem Coding System (RPCS; Gonçalves, A. P. Ribeiro et al., 2009). The RPCS is a qualitative system that analyses the re-emergence of the dominant self-narrative immediately after the emergence of an IM. This system tracks RPMs, that is, discursive signs that represent a devaluation of the previous IM by an emphasis on the dominant self-narrative. Previous studies using the RPCS (M. Gonçalves et al., 2011; A. P. Ribeiro et al., 2011; A. P. Ribeiro et al., 2012) reported a reliable agreement between judges on RPM's coding, with a *Cohen's k* between .85 and .93.

3.4.5. Therapeutic Collaboration Coding System (TCCS; E. Ribeiro et al., in press). We used the TCCS to study the therapist's reaction to RPMs and its impact on therapeutic collaboration. TCCS is transcript-based coding system designed to analyze therapeutic collaboration on a moment-to-moment basis. An initial study showed good reliability, with mean *Cohen's k* values of .92 for therapist interventions and .93 for client responses (Ribeiro E. et al., in press).

Comparisons of therapist's intervention and client's response categories are interpreted as reflecting the position of the exchange relative to the TZPD. In Table 4 and Figures 2–4 (from Ribeiro E. et al., in press), we describe the 15 alternative types of therapeutic exchanges that can result from such comparisons and their relation to the TZPD. The contents of the cells of Table 4 are hypothetical descriptions of the interplay between the two dimensions. They represent our theoretical expectation of how clients would respond to therapist interventions below, within, at the limit, or beyond the current TZPD. For the sake of clarity, the illustrative vignettes were constructed for a hypothetical client diagnosed with Major Depression whose dominant self-narrative was focused on the idea 'I should be a superman'. Within this self-narrative, sadness was regarded as weakness and followed by guilt.

Figure V. 2: Therapeutic exchanges of supporting dominant maladaptive self-narrative

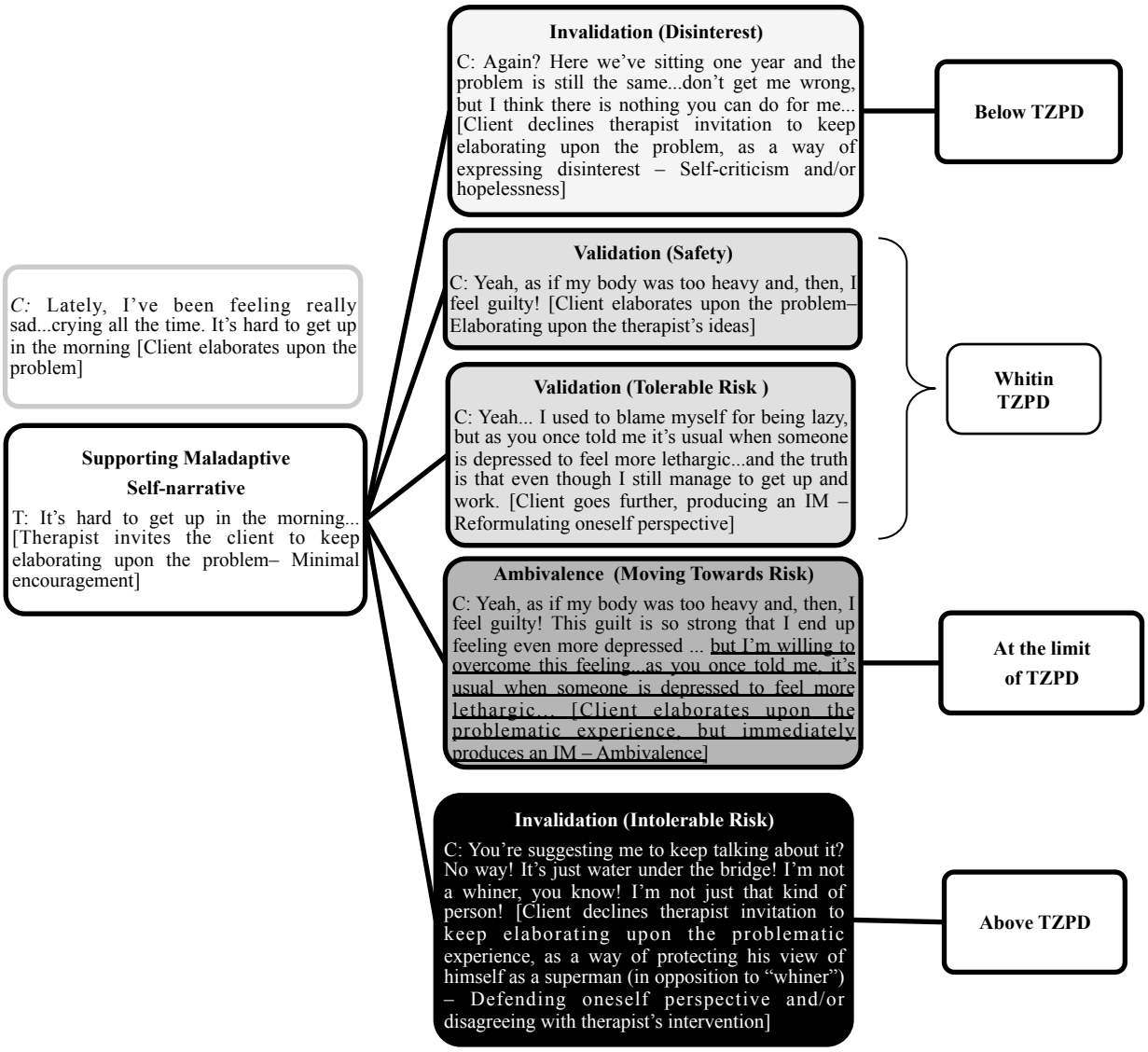


Figure V. 3. Therapeutic exchanges of supporting innovative moments

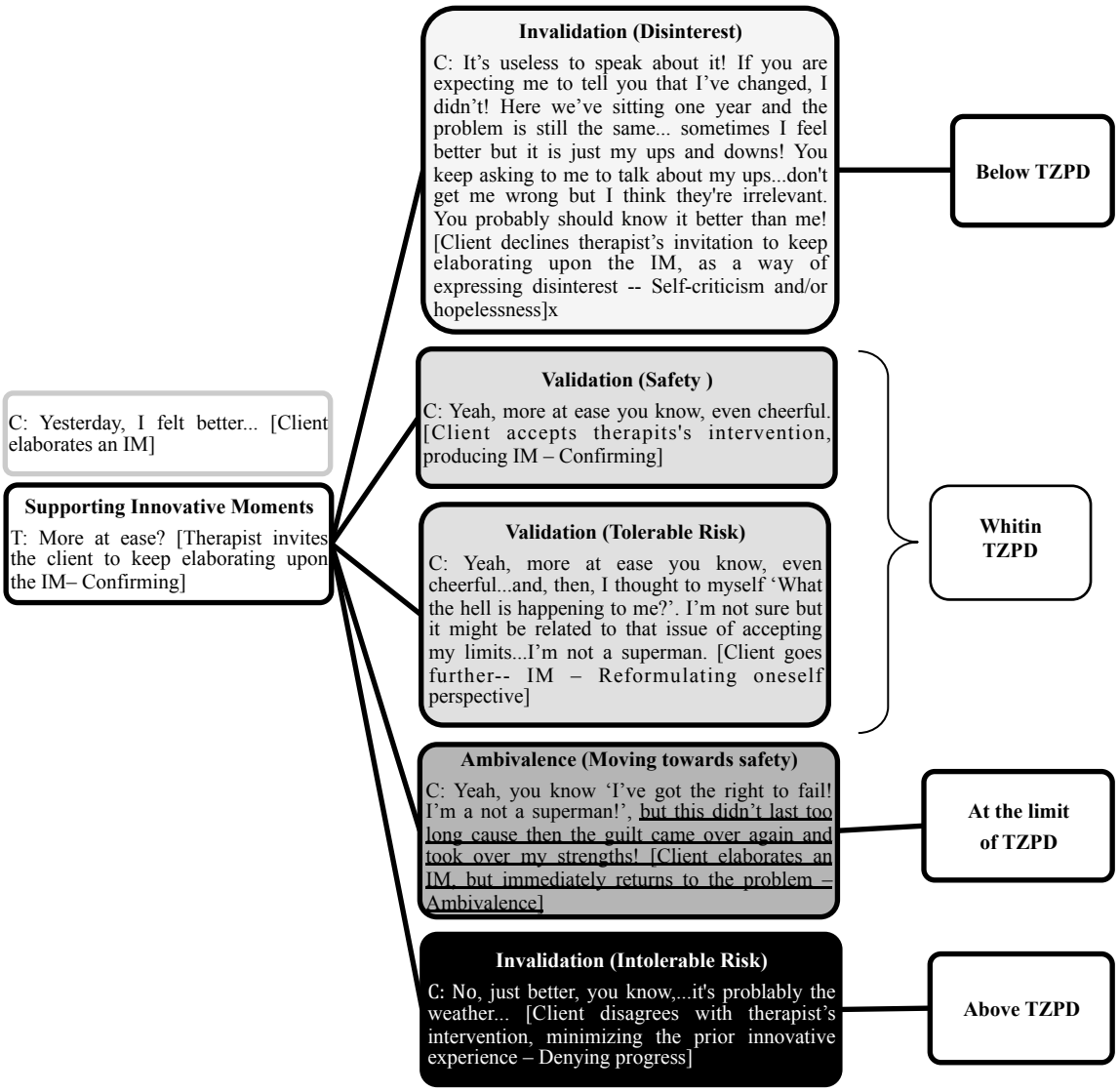


Figure V. 4: Therapeutic exchanges of challenging the dominant maladaptive self-narrative

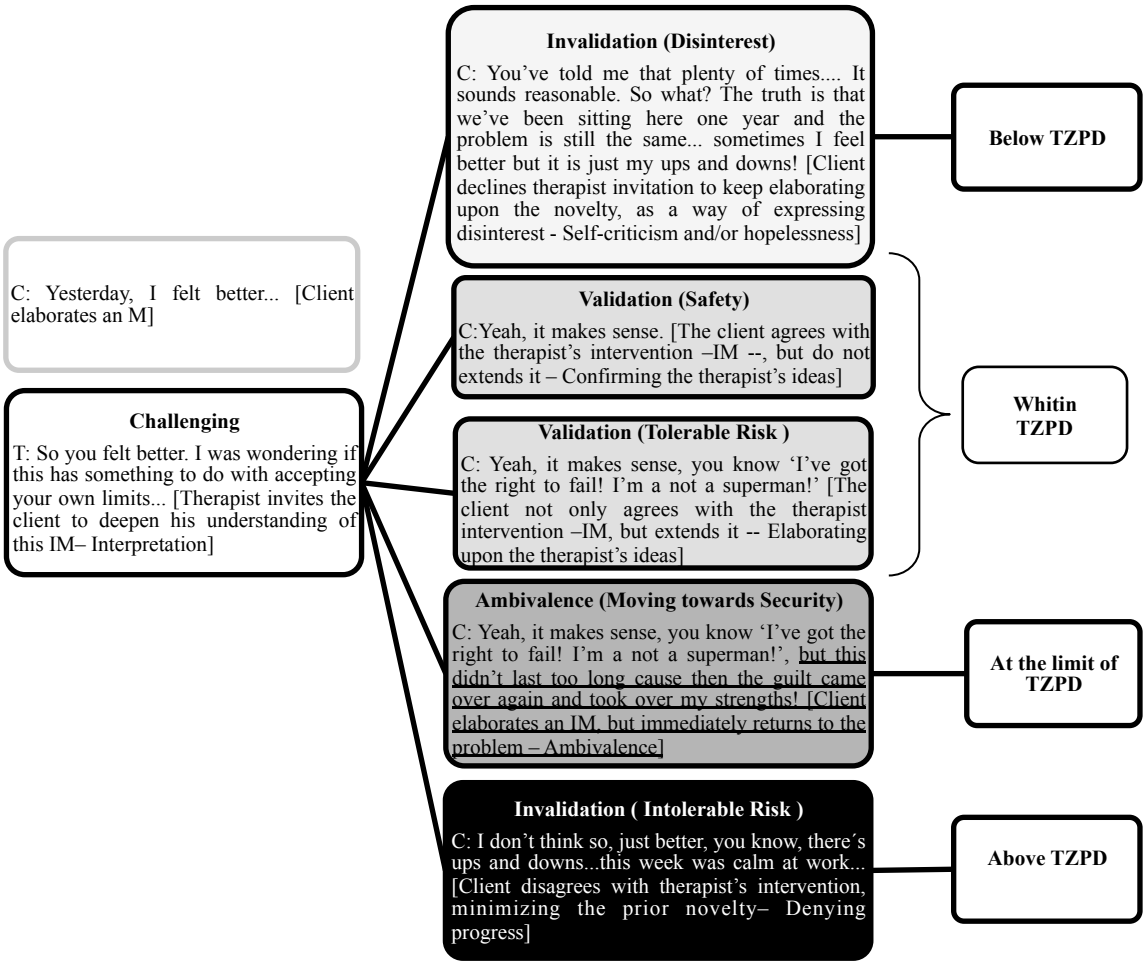


Table V. 1: Types of therapeutic exchanges

		Client's Response -Experience					
		Invalidation-Disinterest Client sates that is experiencing the therapist as being redundant.	**Ambivalence - Moving towards Risk** Client validates therapist's intervention (elaborates upon the problem) but immediately invalidates it (elaborates an IM).	**Validation - Safety** Client confirms or gives information.	**Validation - Tolerable Risk** Client extends or reformulate oneself perspective (elaborates an IM).	**Ambivalence – Moving towards safety** Client validates therapist's intervention (elaborates an IM) but immediately invalidates it (returns to the problem).	**Invalidation-Intolerable Risk** Client expresses that is he or she is not able to *follow* the therapist, without stating that is experiencing the therapist as being redundant.
Therapist's Intervention	**Supporting Dominant Self-narrative**	Below TZPD	At the lower limit of the TZPD	Within TZPD – *Client responds at the same level as the intervention*	Within TZPD – *Client extends beyond the intervention*		Above TZPD
	Supporting Innovative Moments					At the upper limit of the TZPD	
	Challenging			Within TZPD – Client *lag behind the level proposed by the therapist*	Within TZPD – *Client responds at the same level as the intervention.*		

3.5. Procedure

3.5.1. Analytical Strategy. Our research strategy comprised two main steps: (1) Identification of RPMs (previously conducted by Gonçalves, A. P. Ribeiro et al., 2011); and (2) Description of therapeutic exchanges immediately before and after RPMs using TCCS. This second step involved three tasks: a) Categorization of the therapist's intervention that occurred immediately before the client's RPMs; b) Categorization of therapist's intervention that occurred immediately after client's RPMs; and c) Categorization of client's reaction to it (interpreted as its impact on therapeutic collaboration).

3.5.2. Outcome and alliance measures administration. The BSI was administrated in sessions 1, 4, 8, 12, and 16 and at six-month follow-up. This study used the *Global Severity Index* (GSI) of the BSI, which considers responses to all items, because this is considered to be the best single predictor of level of distress (Derogatis, 1993). Like the BSI, the SVRS was recorded every fourth session, starting with the first. The WAI was administered in sessions 4, 8, 12, and 14 and at six-month follow-up. Versions for client and observers (two independent observers coded recordings of sessions) were applied (see Table 2).

3.5.3. Criteria for case categorization and selection. Maria was considered a relatively poor-outcome case because: (a) Although her symptom intensity declined from her initial to post therapy assessments, it had returned to clinical levels at follow-up (initial GSI = 2.66; final GSI = .62; follow-up GSI = 1.64; GSI cut-off score of ≤ 1.32; Matos, 2006); and (b) there was no change in the level of intimate violence from the beginning to the end of therapy according to the SVRS. The quality of alliance assessed by the WAI (Horvath, 1982; Portuguese version, Machado & Horvath, 1999) was high and stable across therapy (see Table 2). In comparison to the rest of the sample (Matos et al., 2009), Maria showed the highest value on the GSI at the follow-up session, the lowest presence of IMs, and the highest presence of RPMs.

Table V.2: Outcome and alliance measures

	SVRS	BSI(GSI)	WAI Observer A	WAI Observer B	WAI Client
Session 1	3	2.66			
Session 4	3	1.35	5.4	5.3	5.71
Session 8	3	1.2	5.5	6	6.41
Session 12	3	1.41	5.7	5.9	6.11
Session 15	3	.62	6.2	5.5	6.55
Follow-up	3	1.64	6.5	5.9	6.63

***3.5.4. RPMs coding and reliability*.** As reported by Gonçalves, A. P. Ribeiro et al. (2010), two trained judges independently coded sessions video recording, analyzing IMs coded by Matos et al. (2009) for the presence of RPMs, following the RPCS manual. Reliability of identifying RPMs, assessed by *Cohen's k*, was .90.

***3.5.5. TCCS coding and reliability*.** Two trained judges (first and second authors) began by watching the video recordings of each session in their entirety and reading the transcripts. The judges then independently listed the client's problems (themes from the dominant self-narrative that brought the client to therapy) and met to discuss their comprehension of the client's dominant self-narrative. Following this, the client's dominant self-narrative was consensually characterized in a way that remained faithful to the client's words.

Following this, the judges classified each therapist's speaking turn before and after each episode in which there was an IM followed by an RPM, into a Supporting category or a Challenging category (see Table 3). For Supporting categories, they further decided whether it focused on the dominant self-narrative or focused on the IM.

Finally, the judges classified the client's speaking turn after each therapist response to an RPM, into a Validation sub-category, or in an Invalidation sub-category (see Table 4). In coding a Validation category, judges further assessed whether clients *lagged behind* the intervention on the therapeutic developmental continuum, responded *at the same level* as the intervention, or extended *beyond the level* of the intervention, using the specific sub-categories of client response shown in Table 3. In coding an Invalidation category, judges assessed whether the therapist worked below the lower limit or above the upper limit of the TZPD. The distinctive feature of exchanges below

the TZPD is the presence of markers that indicated the client experienced the therapist as being redundant.

Sessions 8 and 9 were not coded due to technical problems with video recording procedures. The follow-up session was not analyzed either, since its nature, goals and structure was very different from the regular sessions. The last session, was not coded for therapist's interventions and client's responses because it did not present RPMs. It is important to note that the pair of judges met after coding each session to assess reliability (using *Cohen's k*) and to note any differences in their perspectives on their coding. Whenever differences were detected, they were resolved through consensual discussion/coding. Reliability of identifying therapist's intervention, assessed by *Cohen's k*, was .95. Reliability of identifying client's response, assessed by *Cohen's k*, was .95. The consensus version of the TCCS coding was audited by an external auditor (third author) who then met with the pair of judges to discuss his feedback. His role was one of "questioning and critiquing" (Hill et al., 2005, p. 201).

Table V.3: Therapist intervention coding subcategories

Supporting Subcategories	Definitions
Reflecting	The therapist reflects the content, meaning or feeling present in the client's words. He or she uses his/her or client's words but doesn't add any new content in the reflection, asking for an implicit or explicit feedback.
Confirming	The therapist makes sure he/she understood the content of the client's speech, asking the client in an explicit and direct mode.
Summarizing	The therapist synthesizes the client's discourse, using his/her own and client's words, asking for feedback (implicit or explicit)
Demonstrating interest/attention	The therapist shows/ affirms interest on client's discourse.
Open questioning	The therapist explores clients experience using open questioning**.** The question opens to a variety of answers, not anticipated and/or linked to contents that the client doesn't reported or only reported briefly. This includes the therapist asking for feedback of the session or of the therapeutic task.
Minimal encouragement	The therapist makes minimal encouragement of client's speech, repeating client's words, in an affirmative or interrogative mode. (ambiguous expressions with different possible meanings are not codified, like a simple "Hum… hum" or "ok").
Specifying information	The therapist asks for concretization or clarification of the (imprecise) information given by the client, using closed questions, specific focused questions, asking for examples.
Challenging Markers	**Definitions**
Interpretating	The therapist proposes to the client a new perspective over his or her perspective, by using his or her own words (instead of client words). There is, although, a sense of continuity in relation to the client's previous speaking turn.

Confronting	The therapist proposes to the client a new perspective over his or her perspective or questions the client about a new perspective over his or her perspective. There is a clear discontinuity (i.e., opposition) with in relation to the client's speaking turn.
Inviting to adopt a new perspective	The therapist invites (implicitly or explicitly) the client to understand a given experience in an alternative
Inviting to put into practice a new action	The therapist invites the client to act in a different way, in the session or out of the session
Inviting to explore hypothetical scenarios	The therapist invites the client to imagine hypothetical scenarios, i.e., cognitive, emotional and/or behavioral possibilities that are different from client's usual way of understanding and experiencing.
Changing level of analysis	The therapist changes the level of the analysis of the client's experience from the descriptive and concrete level to a more abstract one or vice-versa.
Emphasizing novelty	The therapist invites the client to elaborate upon the emergence of novelty.
Debating client's beliefs	The therapist debates the evidence or logic of the client's believes and thoughts.
Tracking change evidence	The therapist searches for markers of change, and tries to highlight them.

Table V.4: Client response coding subcategories

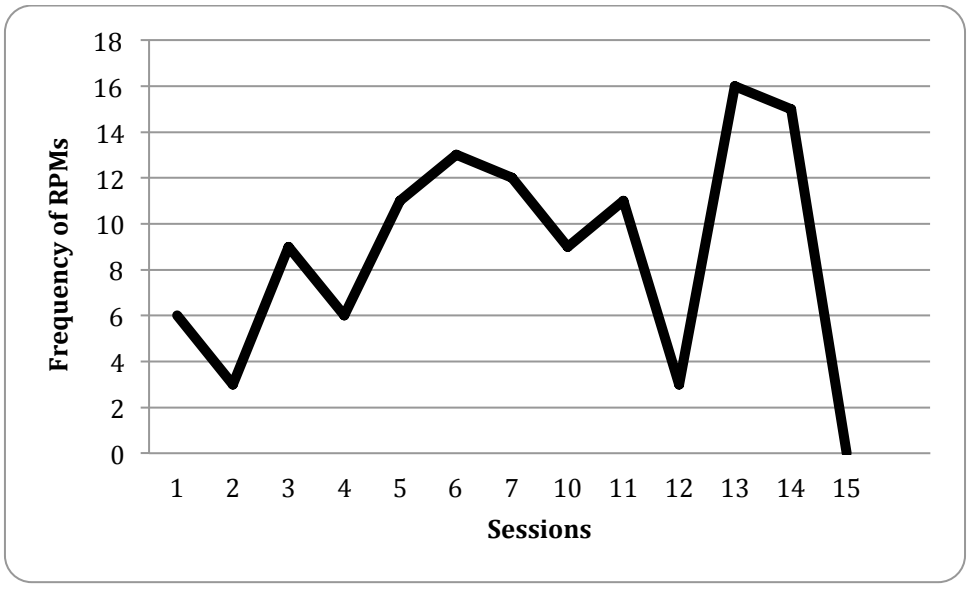
Validation Subcategories	Definitions
Confirming	The client agrees with the therapist's intervention, but does not extend it.
Extending	The client not only agrees with the therapist intervention, but expands it (i.e., going further).
Giving information	The client provides information according to therapist's specific request.
Reformulating oneself perspective	The client answers the therapist's question or reflects upon the therapist's prior affirmation and, in doing so, reformulates his or her perspective over the experience being explored.
Clarifying	The client attempts to clarify the sense of his or her response to the therapist prior intervention or clarify the sense of the therapist's intervention itself.
Invalidation Subcategories	**Definition**
Expressing confusion	Client feels confused and/or states his or her inability to answer the therapist's question.
Focusing/Persisting on the dominant maladaptive self-narrative	Client persists on looking at a specific experience or topic from his or her standpoint.
Defending oneself perspective and/or disagreeing with therapist's intervention	Client defends his/her thoughts, feelings, or behavior by using self-enhancing strategies or self-justifying statements.
Denying progress	Client states the absence of change (novelty) or progress.
Self-criticism and/or hopelessness	Client is self-critical or self-blaming and becomes absorbed in a process of hopelessness (e.g., client doubts about the progress that can be made)

Lack of involvement in response	Client gives minimal responses to therapist's efforts to explore and understand client's experience.
Shifting topic	Client changes topic or tangentially answers the therapist
Topic /focus disconnection	The client persists in elaborating upon a given topic despite the therapist's efforts to engage in the discussion of a new one.
Non meaningful storytelling and/or focusing on others' reactions	Client talks in a wordy manner or overly elaborates non-significant stories to explain an experience and/or spends inordinate amount of time talking about other people.
Sarcastic answer	The client questions therapist's intervention or is ironic towards therapist's intervention.

3.6. RPMs' evolution across therapy

Gonçalves, A.P. Ribeiro, et al. (2011) identified 114 RPMs in Maria's case. The frequency of RPMs showed an increasing trend, as shown in Figure 5, except that the last session did not include any RPMs. Authors interpreted this as suggesting that ambivalence was not resolved across the therapeutic process. It is important to note that authors did not interpret this absence of RPMs in the final session as reflecting ambivalence resolution but instead as result of the nature of the last session: the dyad reviewed the client's change process and did not engage in specific therapeutic work.

Figure V. 5: Emergence of RPMs across therapy



4. RESULTS

To assess the evolution of therapist intervention immediately before and after RPMs and Maria's responses to them we used a *Generalized Linear Model* (GLM; McCullagh & Nelder, 1989) to model: (a) the probability of each category of therapeutic intervention given the client's previous response; and (b) the probability of each category of client's response given the previous therapeutic intervention. GLM analysis allows us to perform a regression model of the probabilities as a linear function of the explanatory variables through the logit link function (i.e., a logit function that allows outcomes to be between 0 and 1). Significance levels were set at $\alpha = .05$.

4.1. Which type of therapeutic intervention precedes the emergence RPMs?

To determine if there were statistically significant differences in the type of therapeutic intervention that preceded the emergence of RPMs, we used a GLM, so that we could estimate the probability of each intervention throughtout therapy. Therefore, we considered the probability of intervention as the response variable, explained by time (from session 1 to the last one) and type of intervention.

We fitted the selected linear model (adjusted for each intervention) to the probability of intervention in a speaking turn (j), given that the client's response in the subsequent speaking turn (j+1) was RPM, as shown in the following equation:

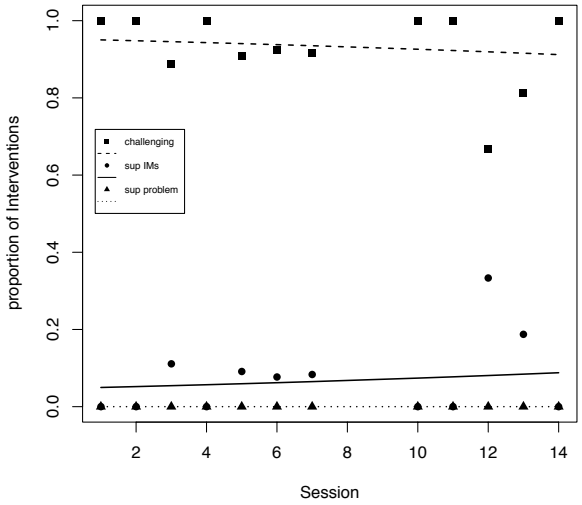
$$P(intervention_j \mid response_{j-1} = RPM) = \exp(\mu)/(1+\exp(\mu))$$

With

$$\mu = \beta_1 * If\,(intervention = 1) + \beta_2 * If\,(intervention = 2) + \beta_3 * If\,(intervention = 3) + \beta_4 * session + \beta_5 * session * If\,(intervention = 2) + \beta_6 * session * If\,(intervention = 3)$$

The results are presented in Figure 6, in which the y axis represents the probability of therapeutic interventions occurring and the x axis therapy sessions over time. Results indicated that RPM emerged significantly more often after a challenging intervention (95.2%) than after a supporting IMs intervention (4.8%) ($p<.001$). There was not any occurrence of RPM after a supporting dominant self-narrative intervention. Moreover, the effect of time (sessions progression) on the probability of therapeutic interventions occurring was not significant, meaning that there was not a significant change in the slope of these two therapeutic interventions along therapy.

Figure V. 6: Therapeutic intervention before RPMs



4.2. How does the therapist respond to client's RPMs?

In order to analyse whether there were statistically significant differences in the type of therapeutic intervention used to respond to client's RPMs, we also used a GLM, so that we could estimate the probability of each intervention throughout therapy. Hence, we considered the probability of intervention as the response variable, explained by time (from session 1 to the last one) and type of intervention.

We fitted the selected linear model (adjusted for each intervention) to the probability of intervention in a speaking turn (j), given that the client's response in the previous speaking turn (j-1) was RPM, as shown in the following equation:

$$P(intervention \mid response_{j-1} = RPM) = \exp(\mu)/(1+\exp(\mu))$$

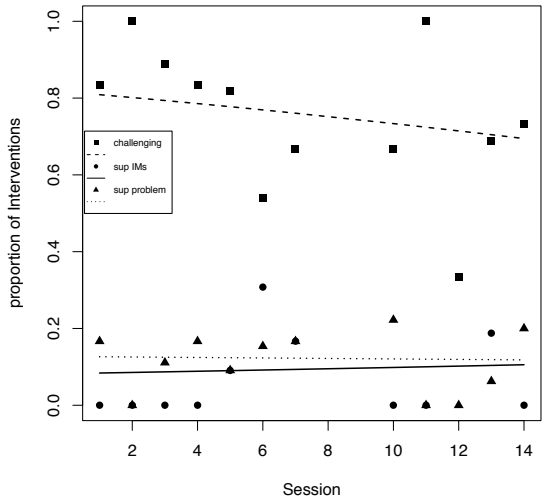
With

$$\mu = \beta_1 * If\,(intervention = 1) + \beta_2 * If\,(intervention = 2) + \beta_3 * If\,(intervention = 3) + \beta_4 * session + \beta_5 * session * If\,(intervention = 2) + \beta_6 * session * If\,(intervention = 3)$$

As shown in Figure 7, results indicated that the therapist responded significantly more often to RPM using a challenging intervention (81.6%) than a supporting

dominant self-narrative (12.7%; $p< .001$) or a supporting IMs intervention (5.7%; $p <.001$). Similarly to the first analysis, the effect of time on the probability of therapeutic interventions occurring was not significant, meaning that there was not a significant change in the slope of different therapeutic interventions along therapy.

Figure V.7: Therapeutic intervention after RPMs



4.3. How does the client respond to the therapist's intervention following RPMs?

In order to analyse if there were statistically significant differences in the way the client responded to each category of therapeutic intervention following RPMs, we performed a third GLM. We considered the probability of client's response as the response variable, explained by time (from session 1 to the last one), type of therapeutic intervention and type of client's response.

We fitted the selected linear model to the probability of each type of response in a speaking turn (j), given the type of intervention in the previous speaking turn(j-1) and the response in the prior speaking turn (j-2) was RPM, as shown in the following equation:

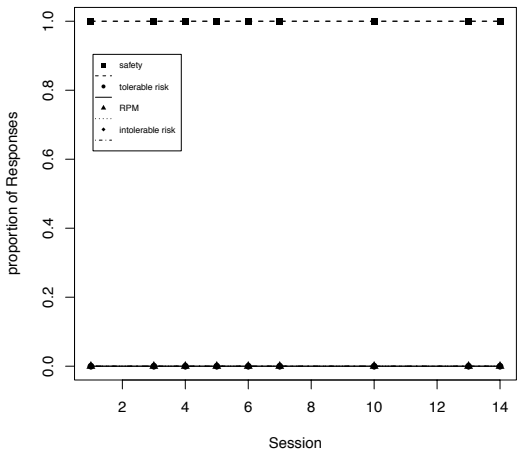
$$P(response \mid intervention_{j-1} = intr \wedge response_{j-2} = ambivalence) = \exp(\mu)/(1+\exp(\mu))$$

With

$$\begin{aligned}\mu = {} & \beta_1 * If(response = 1) + \beta_2 * If(response = 2) + \beta_3 * If(response = 3) \\ & + \beta_4 * If(response = 4) + \beta_5 * If(intervention = 2) + \beta_6 * If(intervention = 3) \\ & + \beta_7 * If(resp = 2, inter = 2) + \beta_8 * If(resp = 3, inter = 2) + \beta_9 * If(resp = 4, inter = 2) \\ & + \beta_{10} * If(resp = 2, inter = 3) + \beta_{11} * If(resp = 3, inter = 3) + \beta_{12} * If(resp = 4, inter = 3)\end{aligned}$$

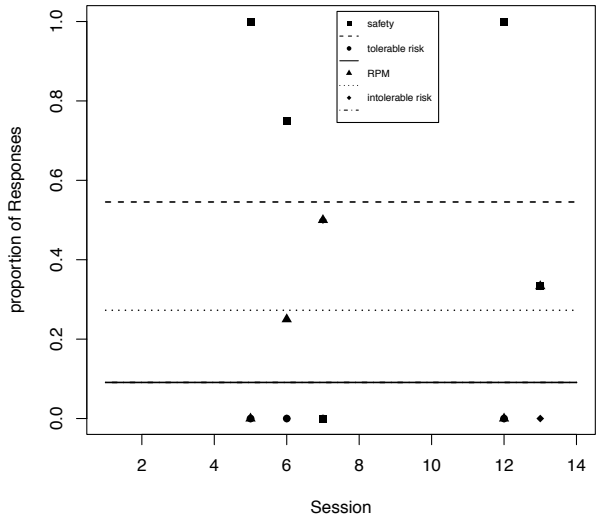
As represented in Figure 8, results indicated that when the therapist responded to RPMs by supporting dominant self-narrative, the client invariably validated therapist's intervention (100%), which may indicate she experienced safety, working at the level proposed by the therapist.

Figure V. 8: Client responses after supporting dominant maladaptive self-narrative interventions



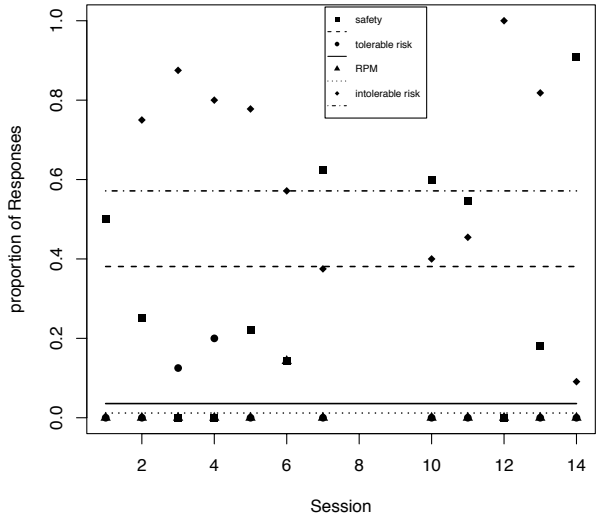
In situations in which the therapist responded to RPMs by supporting IMs (Figure 9), the client tended to validate therapist's intervention (54.5%), which may indicate she experienced safety, working at the level proposed by the therapist or express ambivalence, by elaborating a new RPM (27.3%), lagging behind the level proposed by the therapist and moving towards safety. The probability of safety was statistically higher than the other three categories of response ($p < .0001$ for all comparisons).

Figure V. 9: Client responses after supporting IMs interventions



When the therapist responded to RPMs by challenging the client (Figure 10), the client tended to invalidate therapist's intervention (57.1%), which may indicate she experienced intolerable risk, or minimally validate it (38.1%), lagging behind the level proposed by the therapist. Only, 3.6% of the times, the client responded at the level proposed by the therapist, by elaborating an IM. The probability of occurring intolerable risk response was statistically higher than the other three categories of response (p = .014 for comparison with safety and p < .0001 for tolerable risk and RPM).

Figure V.10: Client responses after challenging interventions



Interestingly, the effect of time was no statistically significant for any of the categories of response, meaning that the client tended to respond in similar way to a given category of therapeutic interaction along therapy.

4.4. Clinical illustration

A clinical vignette is provided to illustrate the contents of the therapeutic process corresponding to the patterns depicted by the quantitative measurement. By doing so, we intend to make the quantitative analysis clinically meaningful as well as improve reader's understanding of Maria's case (see Table5).

Table V. 5: Clinical Illustration

T: You said that 'partly' there's a voice that says there's no use making any effort because you will never get anywhere. But is there another voice? C: Yes, there's another part that seems that I can [do] everything! [IM] **But suddenly, it falls down! Like a castle of cards that we build and then suddenly falls apart!** [RPM]	**Challenging-Ambivalence**
T: These are the two voices you told me about previously? The strength of the first one is 10 in a scale of 1 to 10 and the other's strength is 1, is that right? C: Yes, that's it.	**Supporting Problem-Safety**
T: And the other voice? The one which strength is 1…I know this voice is often silent, but tell me more about the moments in which it appears… C: In that moments it seems that I can do everything and that I will change [IM], **but again it's like lighting a match…there's this big and beautiful flame that disappears if don't strive to keep it lighted…**[RPM]	**Challenging-ambivalence**
T: Let's explore the voice whose strength is 10. Let's try to reduce its strength because it makes you suffer C: Yes	**Challenging-Safety**
T: It is that voice that makes you not trust others and consider committing suicide… C: Yes T: Feeling lonely? C: Yes. T: Feeling sad? C: Yes. T: Losing interest in almost everything? C: Pretty much… T: Feeling that others don't like you… C: Hmm. T: Feeling worthless… C: Yes	**Supporting Problem-Safety**
T: We need to reduce this voice's power, because if we do that these difficulties will disappear (…) All these difficulties are a result of the dominance of this voice whose strength is 10… C: I would be less impaired if this voice's strength were 5 and the other 5 too (…) [IM] **But the other voice is so weak, so weak... my husband has destroyed me! And If I leave him, he will try to convince everybody that it was my fault!**[RPM]	**Challenging-Ambivalence**

T: I understand this is important to you, but look… if you are prepared to fight him, even if he does that he will not be able to destroy you. You have to create some defenses, some barriers. C: I just can't, he has a lot of power … I can't leave him; it is not worth it…I just can't!	**Challenging-Intolerable Risk**

5. DISCUSSION

Maria's RPMs, that is, her ambivalence responses, tended to emerge after challenging interventions, that is, when the therapist worked close to her potential developmental level (upper limit of the TZPD), consistently with our hypothesis that RPMs act as a self-protective mechanism to manage the felt risk of contradicting the dominant self-narrative.

Most times (81%), the therapist responded to Maria's RPMs by further challenging. Interestingly, after instances in which the therapist responded to an RPM with a challenging intervention, the therapeutic dialogue tended to move out of the TZPD, producing an escalation in clients' level of risk. That is, not only did the therapist fail in restoring collaboration, but she also seemingly contributed to a (momentary) deterioration in the quality of the therapeutic collaboration.

There were also instances in which the client only minimally validated therapist's intervention, lagging behind the level proposed by the therapist within the TZPD. In both of these types of therapeutic exchange the therapist was beyond the client's level in the therapeutic sequence. Curiously enough, the absence of a significant effect of time either on the therapist category of intervention and on client's type of response indicates that both participants showed no flexibility in their positions throughout therapy.

Our observations converge with previous work in suggesting that when therapists challenge their clients, trying to stimulate or amplify IMs in ways that do not match the clients' developmental level, they may unintentionally contribute to the oscillatory cycle between the IMs and the problematic self-narrative (Santos et al., 2010) and even reinforce the dominance of the problematic self-narrative. If therapists respond to a clients' RPMs by insisting that they revise their dominant self-narrative or by trying to convince them that they changing, the clients may feel misunderstood, invoking a "strong reactance on the part of the client, often hardening

the client's stuck position" (Engle & Arkovitz, 2008, p. 390). This is consistent with research suggesting that higher levels of therapist demand or directiveness toward change are associated with higher levels of client resistance, while more supportive approaches diminish resistance (Miller, Benefield, & Tonigan, 1993; Patterson & Forgatch, 1985).

Maria's invalidation responses could be interpreted as a marker of being in need of more support before being able to accept challenges. Supportive responses were relatively successful. Not only supporting focused on the dominant self-narrative, but also supporting focused on the IMs was followed by responses on the level proposed by the therapist. That is, when therapist supported Maria's client's IMs she seemed able to keep working within the TZPD, validating the therapeutic intervention and even extending it, responding with tolerable risk.

It is important to note that Maria evaluated the therapy as being helpful and did not prematurely terminate the process. Perhaps Maria simply needed more time to change. In accord with developmental models of change (Proachaska & DiClemente, 1982; Stiles et al., 1990) that one of the most common characteristics of poor-outcome cases is the lower readiness for change, which might call for greater amount of therapeutic work.

Consistently with the Maria's informal evaluation of therapy, the quality of alliance assessed by the WAI (Horvath, 1982; Portuguese version, Machado & Horvath, 1999) was high and stable across therapy. This finding is rather paradoxical, since we found many events in which there is a mismatch between the level proposed by the therapist and the level of development of the client, i.e., instances in which Maria experienced intolerable risk in the relationship with the therapist. This finding suggests that although alliance inventories are informative, a moment-to-moment fine-grained analysis might give a clearer picture of the nature and quality of the collaboration and of the capacity of the dyad to negotiate this collaboration. This idea is consistent with some studies on alliance ruptures (defined as breakdowns or tensions on the alliance), comparing client's self reports on the quality of the alliance and observer-based coding systems of alliance ruptures. These studies suggest frequent discrepancies between observer and client perspectives. In addition to the discrepancy between perspectives, the observations show how resistance to therapeutic progress may be substantial even when the alliance is strong.

6. IMPLICATIONS, LIMITATIONS AND FUTURE DIRECTIONS

Client resistance in the ongoing therapy process on a moment-to-moment basis is a consistently potent predictor of treatment outcomes (Aviram et al., 2010) and thus, building an understanding the process of maintaining resistance, as we have attempted in this study, is an important research priority. The present study not only supports some aspects of our model, but also allows us to draw some implications for training and practice.

Maria's therapist offered more empathy to Maria's alternative perspective or non-dominant voice than to her dominant self-narrative or dominant community of voices. Stiles and Glick (2002) suggested that therapists should adopt an attitude toward client's multiple internal voices similar to multilateral partiality in family therapy (Boszormenyi-Nagy & Spark, 1973), in order that conflicting internal voices can be heard and come to respect each other, a central step on the way to developing internal meaning bridges. To do so, with Engle and Arkovitz (2008), we might suggest "therapists need to monitor their frustration" and "resist the temptation to 'help' the client by pushing for change" (p. 391).

In particular, a therapist may "direct his or her efforts toward an understanding of what it is in the client's experience that prevents easy change" (Ahmed et al., 2010; Binder & Strupp, 1997; Engle & Arkovitz, 2008, p. 391; Miller & Rollnick, 2002). Put differently, therapists whose clients show resistance by continually returning to the perspective of a problematic dominant self-narrative may need to decrease the level of risk experienced by the client by reducing the degree of challenging, and increasing the degree of supporting.

Of course, we cannot be confident that if Maria's therapist had responded to her RPMs by supporting her perspective instead of challenging it that this would led to a positive outcome. Further research is needed. Intensive analysis of how therapists responded to RPMs in cases in which RPMs decreased across treatment would support our suggestion. It would aid such research if alliance and outcome measures were administered at every session.

Although the TCCS was developed as a research tool, we think that it might also be useful for training. It could be used to help sensitize trainees to the dyad's position in relation to the TZPD, allowing them to intervene accordingly. Likewise it might, with further validation and development, serve as a diagnostic tool to identify

challenges that are mistimed or too threatening for clients, or, conversely, situations where there are opportunities for more challenging exploration.

7. REFERENCES

Ahmed, M., Westra, H. A., & Constantino, M. J. (2010). *Interpersonal process during resistance in CBT associated with high vs low client outcome expectations: A micro-process analysis.* Paper presented at the annual meeting of the Society for Psychotherapy Research, Asilomar.

Arkovitz, H., & Engle, D. (2007). Understanding and working with resistant ambivalence in psychotherapy. In S. G. Hofmann, & J. Weinberg (Eds.), *The art and science of psychotherapy* (pp. 171-190). New York: Routledge.

Aviram, A., Westra, H. A., & Kertes, A. (2010). *The impact of motivational interviewing on resistance in CBT for GAD: A process analysis.* Paper presented at the annual meeting of the Society for Psychotherapy Research, Asilomar.

Beutler, L. E., Rocco, F., Moleiro, C. M., & Talebi, H. (2001). Resistance. *Psychotherapy: Theory, Research, Practice, Training, 38,* 431–436.

Binder, J. L., & Strupp, H. H. (1997). "Negative process": A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology: Science and Practice, 4,* 121–139.

Boszormenyi-Nagy, I., & Spark, G. M. (1973). *Invisible loyalties: reciprocity in intergenerational family therapy*. Hagerstown, MD: Harper & Row.

Canavarro, M. C. (2007). Inventário de Sintomas Psicopatológicos (BSI): Uma revisão crítica dos estudos realizados em Portugal. In M. R. Simões, C. Machado, M. M. Gonçalves, & L. S. Almeida (Eds.), *Avaliação Psicológica: Instrumentos validados para a população portuguesa* – Vol. III (pp. 305-331). [Psychological assessment: Validated instruments for the Portuguese population – Vol. III]. Coimbra: Quarteto.

Caro-Gabalda, I., & Stiles, W. B. (2009). Retrocessos no contexto de terapia linguística de avaliação [Setbacks in the context of linguistic therapy of evaluation]. *Análise Psicológica, 27,* 199-212.

Caro-Gabalda, I., & Stiles, W. B. (in press). Irregular assimilation progress: Setbacks in the context of Linguistic Therapy of Evaluation. *Psychotherapy Research*.

Derogatis L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine*, *13*, 595-605.

Derogatis, L. R. (1993). *BSI – Brief Symptom Inventory. Administration, Scoring, and Procedures Manual* (4th Ed.). Minneapolis, MN: National Computer Systems.

Dimaggio, G., Salvatore, G., Azzara, C., Catania, D., Semerari, A., & Hermans, H. J. M. (2003). Dialogical relationships in impoverished narratives: From theory to clinical practice. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 385-409.

Engle, D., & Arkowitz, H. (2008). Viewing resistance as ambivalence: Integrative strategies for working with ambivalence. *Journal of Humanistic Psychology, 48,* 389-412.

Feixas, G., Sánchez, V., & Gómez-Jarabo, G. (2002). La resistencia en psicoterapia: El papel de la reactância, la construcción del sí mismo y el tipo de demanda [Resistance in psychotherapy: The role of reactance, self-construction, and the type of request]. *Análisis y modificación de conducta, 28*, 235-286.

Gonçalves, M. M., & Ribeiro, A. P. (2012). Narrative processes of innovation and stability within the dialogical self. In H. J. M. Hermans, & T. Gieser (Eds.), *Handbook of Dialogical Self* (pp. 301-318). Cambridge: Cambridge University Press.

Gonçalves, M. M., Ribeiro, A. P., Santos, A., Gonçalves, J., & Conde, T. (2009). *Manual for the Return to the Problem Coding System – version 2*. Unpublished manuscript, University of Minho, Braga, Portugal.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Mendes, I., & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research, 21*, 497-509.

Gonçalves, M. M., Ribeiro, A. P., Stiles, W. B., Conde, T., Santos, A., Matos, M., & Martins, C. (2011). The role of mutual in-feeding in maintaining problematic self-narratives: Exploring one path to therapeutic failure. *Psychotherapy Research*, *21*, 27-40.

Hermans, H. J. (1996a). Opposites in a dialogical self: Constructs as characters. *Journal of Constructivist Psychology, 9*, 1-26.

Hermans, H. J. M. (1996b). Voicing the self: From information processing to dialogical interchange. *Psychological Bulletin*, *119*, 31–50.

Hermans, H. J. M. (2001a). The construction of a personal position repertoire: Method and practice. *Culture & Psychology*, *7*, 324–366.

Hermans, H. J. M. (2001b). The dialogical self: Toward a theory of personal and cultural positioning. *Culture & Psychology*, *7*, 243–281.

Hermans, H. J. M. & Kempen, H. J. G. (1993). *The dialogical self: Meaning as movement*. San Diego: Academic Press.

Hermans, H. J. M. &, G. (2007). Self, identity, and globalization in times of uncertainty: A dialogical analysis. *Review of General Psychology*, *11*, 31-61.

Hermans, H. J. M., Kempen, H., & van Loon, R. J. P. (1992). The dialogical self: beyond individualism and rationalism. *American Psychologist, 47*, 23-33.

Hill, C. A., Knox, S., Thompson, B. J., Nutt Williams, E., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psycholog, 52*, 196–205.

Horvath, A. O. (1982). *Users' manual of the working alliance inventory*. Unpublished manuscript, Simon Fraser University, Burnaby, Canada.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

Leiman, M. (1997). Procedures as dialogical sequences: A revised version of the fundamental concept in cognitive analytic therapy. *British Journal of Medical Psychology*, *70*, 193–207.

Leiman, M. (2002). Toward semiotic dialogism. *Theory and Psychology, 12*, 221-235.

Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11*, 311–330.

Machado, C., Matos, M., & Gonçalves, M. M. (2004). Escala de crenças sobre a violência conjugal (ECVC). In L. S. Almeida, M. R. Simões, C. Machado, & M. M. Gonçalves (Eds.), *Avaliação psicológica: Instrumentos validados para a população portuguesa – Vol. II* (pp.127-140). [Psychological assessment: Validated instruments for the Portuguese population – Vol. II].

Machado, P. P., & Horvath, A. O. (1999). Inventário da aliança terapêutica WAI. In M. R. Simões, M. M. Gonçalves, & L. S. Almeida (Eds.), *Testes e provas psicológicas em Portugal – Vol. II* (pp. 87-94). [Tests and psychological instruments in Portugal – Volume II].

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Mahoney, M. J. (2003). *Constructive psychotherapy: Practices, processes, and personal revolutions*. New York: Guilford.

Matos, M. (2006). Violência nas relações de intimidade. Estudo sobre a mudança psicoterapêutica da mulher [Violence in intimate relationships: A research about the psychotherapeutic change in women]. Unpublished Doctoral Dissertation, University of Minho, Braga, Portugal.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McCullagh, P., & Nelder, J. (1989). *Generalized Linear Model*. London: Chapman & Hall.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* New York, NY: Guilford Press.

Moyers, T. B., & Rollnick, S. (2002). A motivational interviewing perspective on resistance in psychotherapy. *Journal of Clinical Psychology, 58,* 185–193.

Osatuke, K., Glick, M. J., Gray, M. A., Reynolds, D. J., Humphreys, C. L., Salvi, L. M., & Stiles, W. B. (2004). Assimilation and narrative: Stories as meaning bridges. In L. E. Angus, & J. Mcleod (Eds.), *The handbook of narrative psychotherapy: Practice, theory and research* (pp. 87-102). London: Sage.

Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology, 53*, 846-851.

Prochaska, J. O., & Norcross, J. (2001). Stages of change. *Psychotherapy, 38,* 443-448.

Prochaska, J. O., & DiClemente, C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19,* 276-288.

Ribeiro, A. P., Bento, T., Salgado, J., Stiles, W. B., & Gonçalves, M. M. (2011). A dynamic look at narrative change in psychotherapy: A case-study tracking innovative moments and protonarratives using state-space grids. *Psychotherapy Research*, *21*, 34-69.

Ribeiro, A. P., Cruz, G., Mendes, I., Stiles, W. B., & Gonçalves, M. M. (2012). Ambivalence in Client-Centered Therapy. Manuscript in preparation.

Ribeiro, A. P., & Gonçalves, M. M. (2010). Innovation and stability within the dialogical self: The centrality of ambivalence. *Culture & Psychology, 16*, 116-126.

Ribeiro, E., Ribeiro, A.P., Gonçalves, M.M., Horvath, A.O., Stiles, W.B. (in press). How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy: Theory, Research and Practice*.

Santos, A., Gonçalves, M. M., & Matos, M. (2011). Innovative moments and poor-outcome in narrative therapy. *Counselling and Psychotherapy Research*, *11*, 129-139.

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449–466.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1-21.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York: Oxford University Press.

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367-384.

Stiles, W. B., & Glick, M. J. (2002). Client-centered therapy with multivoiced clients: Empathy with whom?. In J. C. Watson, R. Goldman, & M. S. Warner (Eds.), *Client-centered and experiential therapy in the 21st century: Advances in theory, research, and practice* (pp. 406–414). London: PCCS Books.

Valsiner, J. (2002). Forms of dialogical relations and semiotic autoregulation within the self. *Theory and Psychology*, *12*, 251-265.

Wachtel, P. L. (Ed.) (1982). *Resistance: Psychodynamic and behavioral approaches.* New York: Plenum.

Wachtel, P. L. (1993). *Therapeutic communication: Knowing what to say when.* New York: Guilford.

Wachtel, P. L. (1999), Resistance as a problem for practice and theory. *Journal of Psychotherapy Integration, 9*, 103-118.

White, M. (2007). *Maps of Narrative Practice*. New York: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

CONCLUSION

CONCLUSION

> "To succeed, the new story must be close enough to the client's experience so that she may view as her; on the other hand, it must be different enough from the old story, so as to allow new meanings and options to be perceived" (Omer & Alon, 1997, p. 10).

Over the last decades, narrative theory has become a keystone inspiration in psychotherapy research (Angus & Mcleod, 2004; Gonçalves & Stiles, 2011). Specifically, the idea that self-narratives are psychological devices through which we attribute meaning to our world has given rise to many recent developments in psychotherapy theories and research methodologies (see Avdi & Georgaca, 2007; Avdi & Georgaca, 2009; Meier, 2002 for reviews) and has been one of the major integrative themes in contemporary approaches to psychotherapy (Grafanaki & Mcleod, 1999). Despite the rising popularity of narrative approaches to psychotherapy, as Meier's (2002) review has concluded, these approaches lack a theory that explicates effectively how the re-authoring of narratives foster changes and how a client's multiple narratives come to be integrated in successful psychotherapy. Likewise, the processes that impede self-narrative reconstruction remain largely unexplored.

Bento, A. P. Ribeiro, Salgado, & Gonçalves (2012) suggested, "the absence of such a theory is particularly significant in face of current reviews of psychotherapy process research that conclude the need for further theoretical development of the principles of therapeutic change and its exploration in clinical cases for the advancement of our understanding of how therapy works (e.g., Laurenceau, Hayes, & Feldman, 2007; Pachankis & Goldfried, 2007)" (p. 3). This question has been crucial in psychotherapy research (Drozd & Goldfried, 1996; Greenberg, 1986; Lambert, 2004; Rice & Greenberg, 1984; Stiles, Shapiro, & Elliott, 1986). More than twenty years ago, Stiles, Shapiro, and Elliott (1986) pointed out the potentiality of a research strategy, referred to as *change process research,* in addressing this question. As Greenberg (1986) argued, "a focus on processes of change serves to transcend the dichotomy between process and outcome that has previously hindered the field (Kiesler, 1983)", since "in studying the process of change, both beginning points and

endpoints are taken into account, as well as the form of the function between these points" (p. 4).

The studies included in this dissertation follow this tradition, specifically the research paradigm Elliot (2010) refers to as *significant events research paradigm* (Elliott, 2010), by presenting "an interpretive, theory-building framework" (p. 129) and combining (1) the identification of important therapeutic moments (either productive and unproductive); (2) the development of qualitative sequential description of what happened across sessions and/or cases; and (3) linking in-session processes to post-therapy outcomes. I used several methods to track important moments in therapy throughout sessions in several therapeutic cases taking into account the outcome status of the case, aiming to further develop a conceptual framework that synthesizes the process of narrative transformation, but also narrative maintenance, in brief psychotherapy.

In the final part of this dissertation, I reflect upon the contributions offered by the previous chapters. I organized the present conclusion around the three cornerstones of this collection of research studies: (1) Ambivalence and Return-to-the-Problem Markers (RPMS); (2) Protonarratives; and (3) Therapeutic Collaboration Coding System. I devoted one section to each of these concepts/methods, reflecting upon: a) main results; b) its implications for research and practice; and c) new paths for future research.

1. AMBIVALENCE AND RETURN-TO-THE-PROBLEM MARKERS

This dissertation reports the first systematic effort to empirically explore the process of mutual in-feeding, through the identification of RPMs. One of the most relevant results concerns the applicability of our method for coding RPMs to different therapeutic models and to different problems: narrative therapy with victims of intimate violence (N=10; Chapter I), Emotion-Focused Therapy (EFT) for depression (N=6; Chapter II) and constructivist therapy focused on implicative dilemmas with a client diagnosed with adaptation disorder (Chapter IV). A study on Client-Centered Therapy (CCT) for depression (N=6; A. P. Ribeiro, Cruz, Mendes, Stiles, & Gonçalves, 2012) was also conducted but was not reported for space reasons. Other studies are in progress in our research team and preliminary results give additional support to this finding, for example the applicability of the RPMs method to

constructivist therapy with complicated grief (Alves et al., 2012a), narrative therapy for depression (Gonçalves, 2012c) and cognitive-behavioral therapy for depression (Gonçalves, 2012d). This work shows that the Return-to-the-Problem Coding System is a reliable and transtheoretical methodological tool for identifying ambivalence in psychotherapy.

Results from narrative therapy, EFT and CCT, suggest that IMs are followed by RPMs in both good- and poor-outcome cases, which supports our hypothesis that ambivalence is a natural part of the change process and may be looked at as a form of self-protection (Engle & Holiman, 2002), as people often experience fear and anxiety in the process of changing from something familiar into something unknown. However, results also suggest that good- and poor-outcome cases present significantly different profiles of RPMs. In narrative therapy, good-outcome cases tended to enter therapy with a lower proportion of RPMs than poor-outcome cases and maintain low values across therapy. In contrast, both in EFT and CCT samples, good-outcome cases tended to enter therapy with a higher proportion of RPMs than poor-outcome cases. The proportion of RPMs tended to decrease throughout therapy, whereas it remained unchanged or increased in the poor-outcome cases.

Moreover, results suggest that reconceptualization and performing change IMs might be less likely to prompt RPMs, as reconceptualization IMs present a lower proportion of RPMs than the other types of IMs both in narrative therapy and CCT studies, and performing change presents a lower proportion of RPMs than the other types of IMs in the narrative therapy study. Moreover, in the three samples studied so far, sessions which present 4 or 5 types of IMs have a lower proportion of RPMs that sessions with 1, 2 or 3 types of IMs. This finding corroborates Gonçalves et al.'s (2009) assumption that successful self-narrative reconstruction emerges by the articulation of several different kinds of IMs. By the same token, a new narrative constructed with low diversity of IMs types is not only an impoverished type of story, but also more likely to prompt setbacks in the form of RPMs.

Findings from Chapters I, II and IV also suggest that RPMs may not always represent therapeutic stagnation; it is not their presence but their persistence in later stages of therapy that interferes with therapeutic progress. In fact, findings suggest that when ambivalence is overcome, this could facilitate the change process, given that the struggle between the opposing sides is solved. Therefore, I have initiated a line of intensive qualitative research into how RPMs can turn into therapeutic

movement, that is, how the relation between non-dominant voices and the dominant voices evolve from mutual in-feeding to another form of dialogical relation (Chapter IV). Hitherto, I have empirically identified two possible processes: (1) *Escalation of the non-dominant voice(s) and inhibiting the dominant voice* and (2) *negotiating and engaging in joint action*. In the first one, the non-dominant voice, present in the IM, takes over the formerly dominant voice, present in the dominant self-narrative, and becomes a dominant position in the self. In the second form of resolution the two opposed positions present in mutual in-feeding are transformed in the dialogue between both. The positions are not just reacting to each other, asserting its primacy when the other emerges; they are now involved into a negotiation process, listening to each other and transforming themselves in this dialogue.

The first type of resolution can move towards a *monological* outcome since, although the opposing voices are in dialogue, the type of interaction is very asymmetrical. Hermans (1996a, 1996b) has characterized this process as a form of dominance reversal: the position that was once dominant is now dominated. One can argue that the process of escalating one voice and inhibiting the other may have the risk of creating another dominant narrative, given that once again a dominant voice took-over the others. However, I suspect that sometimes, meaningful clinical changes occur by this process. First, the new dominant voice is more adjusted and congruent with client's preferences. Second, the dominance resulted from a client's choice. I also propose that this is mediated by a meta-position over the reversal process, without which a reversal of positions may have been a mere substitution of one problematic pattern by another. Actually, this meta-position is present in the reconceptualization IMs as it was described before.

From Gonçalves and A. P. Ribeiro (2012a, 2012b) narrative view, and following Sarbin (1986), the problematic dominance, which is present in the beginning of therapy, positions clients as actors in a narrative that they did not author. In the latter form of dominance, clients are the authors of their own plot. The meta-position involved in the dominance reversal is essential to assure this position of authorship. One important reason is that there is not only one position, which dominates and silences others, but a third one, which manages the kind of dominance involved. Instead of two forces opposing each other, three positions are present: the dominant, the non-dominant and the meta-position, which manages them. Thus, this

new form of dominance is much more flexible than the previous one, and this flexibility is in part assured by the meta-position (or authorship) involved.

In some cases, as in the case analysed in Chapter IV, this asymmetrical regulation may be a transitory stage in the process of change, facilitating the client's adaptation to the immediate future in a given moment (e.g., a specific decision-making process: to leave or not to leave the relationship, in a case of intimate violence). Congruently, these moments of *monologization*, in which a specific voice considered as helpful "function[s] at a certain moment as an anchorage point around which the entire self-system organizes itself (Hermans, Kempen & van Loon, 1992)" (Rosa & Gonçalves, 2008, p. 103) may be efficient in the reduction of the ambivalence. Thus, this process of voice reversal may be a temporary stage, which facilitates other meaningful changes.

Along these lines, regardless of their differences in terms of dialogical outcome, both processes involve the development of a meta-position, present in the reconceptualization IM, which is capable of communicating openly and effectively with other positions, having a function of management and coordination (Gonçalves & A. P. Ribeiro, 2012a, 2012b). The suggestions about the importance of the meta-position involved in reconceptualization IMs are congruent with other dialogical scholars' proposals. For example, Hermans (2003) has suggested that an observer position, which manages the repertoire of positions is a necessary condition for successful psychotherapeutic change. This same process has been repeatedly researched by Dimaggio and colleagues (Dimaggio & Lysaker, 2010), regarding meta-cognitive processes in therapy. *Meta-cognition* is a set of abilities, involving the capability to understand one's own (and others') emotional and cognitive processes and change them, which are stimulated in the psychotherapeutic process. This research makes it clear that these abilities are dysfunctional in the most disturbed patients (e.g., personality and psychotic disorders**).**

Subsequent studies, not reported here, suggest that the kind of resolution depends on the type of therapeutic strategies used. Specific strategies or exercises focused on fostering clients' resistance toward the problem (e.g., cognitive restructuring in cognitive-behavioural therapy or externalization in narrative therapy) may support the escalation of previously silenced voices, and the inhibition of the dominant voice, whereas strategies as two-chair dialogue in EFT may open the space to negotiation between opposing voices, transforming the dichotomy through mutual

regulation. Moreover, the type of resolution may depend on the problem the client is facing. For instance, in situations in which the suffering is very disturbing, as in intimate violence or other destructive situation, the inhibition of the maladaptive dominant voice can be a necessary starting point to more complex changes. On the other side, when the suffering is less intense perhaps stimulating a cooperative dialogue between voices is an important resource to transform the dominant self-narrative.

In the future, besides studying the multiple forms of overcoming mutual in-feeding, it is my aim to distinguish different forms of mutual in-feeding and their role and impact on the change process, as present data as well recent studies differentiate multiple forms of resistance, confirming that we can no longer construe it as a homogeneous phenomenon, but rather as a complex and multifaceted one (Frankel & Lewitt, 2009).

2. PROTONARRATIVES

The possibility that IMs emergence and expansion lies at the center of the narrative change process has been receiving increasing empirical support (Gonçalves, A. P. Ribeiro et al., 2011). These studies suggest that IMs are present in therapy regardless of the therapeutic model. The process through which IMs are expanded allows for the transformation of the previously dominant problematic self-narrative into an alternative one in successful therapies. This dissertation contributes to addressing this issue. In Chapter III, I suggest that IMs organize themselves narratively, through their thematic content, in provisional narratives termed protonarratives (A. P. Ribeiro, Bento, Salgado, & Gonçalves, 2010; A. P. Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011).

Protonarratives are defined as recurrent themes that aggregate IMs of several types (e.g. action, reconceptualization) in narrative threads that do not yet constitute fully developed self-narratives (see A. P. Ribeiro et al., 2010). They express new potential narrative frameworks of behaving, thinking and feeling that contrast with the problematic self-narratives. As they are addressed in therapeutic dialogue these protonarratives may be abandoned, or they may evolve into more complex narrative plots that eventually become alternative self-narratives.

Along these lines, I conceptualize each IM as having two related dimensions: process (e.g. action, protest) and content. The content is the theme that emerges, which allows us to infer a given protonarrative. As protonarratives successfully develop in therapy they become more diversified in their contents and in the IMs that constitute them.

In the first case study conducted using this concept/method (Chapter III; A. P. Ribeiro et al., 2011) the final protonarrative was a synthesis of two previous ones that emerged earlier on in treatment, which suggests that the development of narrative flexibility (versus rigidity) may be associated with adaptive narrative building (Hermans, 2006; Lysaker & Lysaker, 2006). Moreover, the final protonarrative seemed to assimilate a wider range of client's experiences, allowing the varied parts of her self to communicate smoothly with one another and engage in joint action and, by doing so, contributed to the resolution of mutual in-feeding.

This study suggests that in successful therapy one of the protonarratives present during treatment became increasingly central: it occupied more time in sessions and showed more diverse types of IMs. By the end of therapy, it became an alternative self-narrative, corroborating the hypothesis that narrative integration or coherence (versus fragmentation) is a fundamental feature of adaptive self-narratives, and thus of therapeutic change (Dimaggio, 2006; Neimeyer, 2004; Singer & Rexhaj, 2006).

Protonarratives have proven to be a helpful concept in describing how narrative innovation processes in therapy generate and consolidate an alternative self-narrative (A. P. Ribeiro et al., 2011) and how clients overcome ambivalence. Currently, we are developing new studies using this method, aiming not only to further validate its applicability to different therapeutic models and problems, but also to refine our model of change: EFT with depressive clients, constructivist therapy with complicated grief (Alves et al., 2012b), narrative therapy for depression (Gonçalves, 2012e) and cognitive-behavioral therapy for depression (Gonçalves, 2012f).

In a recent study (contrasting one good- and one poor-outcome EFT cases from the York I Depression Study, Greenberg & Watson, 1998), Bento et al. (2012) concluded that despite the same number of protonarratives in both cases, critical differences in their development throughout treatment were observed. It was found that in the good-outcome case there was a higher dispersion of the different IMs types

and protonarratives than in the poor-outcome case. An increased ability to make frequent transitions between the different components of narrative innovation was also present in the good-outcome in comparison to the poor-outcome case. Taken together, these two results suggest that the process of narrative innovation was more flexible in the good- than in the poor-outcome case.

In the good-outcome case, one of the protonarratives was dominant throughout the therapeutic process and this seemed to be more accentuated in the working and final phases of therapy. Globally, this dominant protonarrative was not only more salient (i.e., elaborated for significant periods of time), but also higher in dispersion (higher diversity of IMs types) than the other protonarratives. These results seem consistent with a process of development and consolidation of one central protonarrative that organizes the alternative self-narrative and around which further IMs become aggregated. Authors hypothesize that this process of recurrently focusing in the same innovative content (protonarrative) while varying the processes of narrative innovation (IMs) may help explain the expansion and increase complexity, diversity and dominance of one protonarrative. Thus, globally, the good-outcome case reveals a pattern of high flexibility associated with the dominance of one protonarrative. This pattern is consistent with the features of adaptive self-narratives described by Singer and Rexhaj (2006) and by McAdams (2006). These researchers equated narrative adaptation both with coherence and flexibility. This pattern contrasted with the one observed in the poor-outcome case, in which the therapeutic dialogue was scattered around different protonarratives, without any of them assuming a clear dominance. Also, the development of protonarratives in terms of salience was not followed by an increase in their flexibility (i.e., diversity of IMs types). Globally, constant changes between protonarratives, associated with relative rigidity, seemed prevent any one protonarrative from emerging as a central alternative self-narrative. Thus, authors suggest that in the poor-outcome case the instability of the protonarratives may have blocked further change.

One interesting result was the presence in the good-outcome case of all the protonarratives from the first session. This contrasts with the case study (A. P. Ribeiro et al., 2011) presented in Chapters III and IV, which revealed a more progressive development of protonarratives, characterized by the emergence of more complex protonarratives over the course of therapy. This observation suggests that it could be important to further explore the possibility that protonarratives development

in good-outcome cases may follow different patterns. Future research should also explore the contribution of clients' characteristics and therapeutic strategies for such differences.

These were only three intensive case studies and, naturally, further efforts should be made to support these hypotheses and explore new ones related to the narrative model of therapeutic change. It remains unclear how generalizable the developmental patterns of flexibility displayed by these two cases are. Despite these limitations, these studies are in line with IMs theory of the process by which meaning rigidity of problematic self-narratives is first destabilized and next replaced by an alternative, more diversified and complex system of meanings.

3. THERAPEUTIC COLLABORATION CODING SYSTEM

Up until now, the focus under the IMs research group has been on the client, through an understanding of client process in several therapeutic modalities (see Elliott, 1991 for the distinction of three *foci* in relation to the elements of the therapeutic system: client, therapist or dyad). Chapters I to IV are examples of this focus on the client. In line with the IMs research group recent efforts to expand the research focus to the analysis of the therapist, as "paying attention to the therapists' contributions is an important step for fulfilling the promise of clinical applications deriving from the IMs' perspective" (Cunha, 2011, p. 217), in Chapter V, I approached narrative change from a dyadic perspective. This study inaugurated a research program aimed at understanding how the relationship between therapist and client in general, and the collaboration in particular, contributes to clients' growth and development in therapy, from a narrative perspective.

E. Ribeiro, A. P. Ribeiro, Gonçalves, Horvath, and Stiles (in press) have articulated an integrative theoretical framework that utilized the concepts of *Therapeutic Zone of Proximal Development* (TZPD; Leiman & Stiles, 2001), the assimilation model of therapeutic gains (Stiles, 2011), and Gonçalves' narrative concept of IMs (Gonçalves et al., 2009). This model integrates the role of the relationship element and techniques by conceptualizing the process of therapeutic progress as a cyclical and dynamic collaboration between therapist and client in which the therapist attempts to balance the clients need for safety with the goal of exploring novel, innovative versions of his or her self-narratives within the TZPD.

We see the negotiation of the limits of the TZPD as fluid and dynamic since the clients tolerance for the anxiety provoked by challenging the upper boundary of the TZPD is limited and limiting; but each episode of novel conceptualization of self (IM) has the potential of moving the TZPD foreword.

To observe and monitor these moment-to-moment dynamics, we developed the *Therapeutic Collaboration Coding System* (TCCS). This coding system is based on an intensive analysis of both good- and poor-outcome therapies treated by therapists with narrative or CBT orientation. The TCCS can be used to analyze therapist–client interaction sequences in context. We distinguished 15 classes of interactive sequences corresponding to six possible positions in which the therapeutic dyad might be located, considering the TZPD. Fourteen of these 15 positions have been corroborated in the data reported in this study. Preliminary results indicate that the instrument has adequate reliability for research use.

Chapter IV presents the first empirical application of the TCCS. This study focuses on the moment-to-moment analysis of the therapeutic collaboration in instances in which the client expresses RPMs. My aim was to shed light on the processes, which impede overcoming ambivalence during the therapeutic process, by analysing a poor-outcome case of narrative therapy. Results showed that ambivalence tended to occur in the context of challenging interventions, thus, indicating that the dyad was working at the upper limit of the TZPD. Furthermore, results showed that when the therapist persisted in challenging the client after the emergence of ambivalence, the therapeutic dialogue tended to move from ambivalence to intolerable risk, suggesting that there was an escalation in client's discomfort and indicating that the dyad is working out of the TZPD. These findings suggest that when therapists do not match clients' developmental level, they may unintentionally contribute to the maintenance of ambivalence. Further research is needed; in particular, intensive analysis of how therapists respond to RPMs in cases in which RPMs decrease during the process would help us draw therapeutic implications.

I believe that the TCCS could be useful in building upon IMs model, as it can be used not only to keep exploring ambivalence maintenance and resolution, but also to study how the therapist helps the client to elaborate an IM (specifically, reconceptualization IMs) and how they further expand these therapeutic innovations.

The TCCS may also be used outside of the IMs model, examining how significant events, such as alliance ruptures and resolution, unfold sequentially within

the collaborative therapeutic interaction. It could also be used in quantitative studies using indexes that can be computed from the coding, such as the frequency or percentage of exchanges within the TZPD, at the limit of the TZPD, or outside of the TZPD. Such indexes could assess the evolution of therapeutic collaboration within single sessions or across whole treatments.

While the TCCS was developed as a research tool, I think that if future studies confirm our initial results, it might be useful for training since it could be used to help sensitize trainees to better locate the TZPD within which the potential of therapeutic gains may be maximized. Likewise it might, with further validation and development, serve as a diagnostic tool to identify challenges that are miss timed or too threatening for clients, as well as situations where there are unutilized opportunities for more challenging exploration.

A study comparing a good- and a poor-outcome case from Cognitive-Behavioural Therapy, using the TCCS, showed that challenging was the most common type of therapeutic intervention in this therapy both in the good- and in the poor-outcome cases. However, in the poor-outcome case there was a significant increase in the probability of challenging as therapy proceeded, even after a clients response of invalidation, which suggested that higher levels of therapist directiveness was present in the poor-outcome case. This result is congruent with Chapter V results. Moreover, on average, the probability of supporting client's IMs increased significantly more in the good-outcome case, which suggests that the client became progressively less dependent on the therapist to elaborate IMs. Also, in the good-outcome case the probability of the client working beyond the level proposed by the therapist and the probability of the client responding to challenge with tolerable risk were much higher than in the poor-outcome case.

Some of the limitations inherent in the current stage of our research include the limits that the number of different therapeutic orientations we have explored so far, one of the 15 positions have not been instantiated in a clinical sample, and we have yet to confirm that ratings of similar accuracy and reliability can be achieved outside our research programme.

4. CONCLUDING REMARKS

The studies that constitute this dissertation have several limitations that I acknowledged in the corresponding chapters. Overall, due to the small size of the samples, I am aware that results may not generalize to other therapeutic dyads. Thus, it would be important to expand these studies to a larger sample of dyads of different therapeutic modalities and problems. Up until now, IMs research team have been obtaining consistent results in different client samples and therapy modalities, which makes this replication even more appealing. Furthermore, the intensive analysis of single cases similarly to what was done in Chapters III, IV, and V is, in my view, worth of pursuing our theory-building efforts.

Nevertheless, this dissertation uses different theoretical approaches and research methods to investigate a coherent set of questions, arriving at consistent results across studies and building upon them from one study to the next. In particular, it allowed understanding in more detail the role of ambivalence in the process of change. In addition, this work represents a further contribution to the understanding of self-narrative transformation by introducing the concept of protonarrative. Finally, this work articulates the therapeutic collaboration and change process, approaching IMs and ambivalence from a dyadic perspective. It is important to note that its contributions are both empirical (by proposing three different interrelated coding systems) and theoretical (by articulating an integrative model of self-narrative maintenance and transformation).

To conclude this work, I would now like to stress the importance of incorporating this knowledge about narrative change in the practice and training of psychotherapy. As outcome measures inform therapists of the ongoing therapeutic process, also process measures can inform therapists of the ongoing change process. These in-session events may depict the change process throughout therapy but the purpose and meaning of these narrative innovative details are "often not apparent at the time they are told" (Stiles, Honos-Webb, & Lani, 1999, p.1218). Hence, helping therapists to pay attention to IMs, RPMs, his or her response to both these processes and its impact, should be clinically relevant.

REFERENCES

REFERENCES

Abbey, E., & Valsiner, J. (2005). Emergence of meanings through ambivalence. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *6*. Retrieved 13 December 2008 from: http://www.qualitative research.net/ fqs/fqs-texte/1–05–1–23-e.htm.

Altimir, C., Krause, M., de la Parra, G., Dagnino, P., Tomicic, A., Valdés, N., et al. (in press). Clients', therapists' and observers' perspectives on moments and contents of therapeutic change. *Psychotherapy Research*.

Alves, D., Fernández-Navarro, P., Ribeiro, A. P., Ribeiro, E., & Gonçalves, M. M. (2012). Ambivalence in constructivist grief therapy. Manuscript in preparation.

Alves, D., Fernández-Navarro, P., Ribeiro, A. P., Ribeiro, E., & Gonçalves, M. M. (2012). Protonarratives in constructivist grief therapy. Manuscript in preparation.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed). American Psychiatric Association: Washington, DC.

Angus, L., & McLeod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.

Angus, L., Levitt, H., & Hardtke, K. (1999). The narrative process coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology*, *55*, 1255-1270.

Avdi, E., & Georgaca, E. (2007). Narrative research in psychotherapy: A critical review. *Psychology and Psychotherapy: Theory, Research and Practice, 80,* 407-419.

Avdi, E., & Georgaca, E. (2009). Narrative and discursive approaches to the analysis of subjectivity in psychotherapy. *Social and Personality Psychology Compass, 3,* 654-670.

Bakhtin, M. (1984/2000). *Problems of Dostoevsky's Poetics. Minneapolis*. MN: University of Minnesota Press.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders.* New York: International Universities Press.

Bento, T., Ribeiro, A. P., Salgado, J., Gonçalves, M. M., & Mendes, I. (2012). Narrative model of therapeutic change: An exploratory study tracking innovative moments and protonarratives using state space grids. Manuscript in preparation.

Beutler, L. E., Moleiro, C. M., & Talebi, H. (2002). Resistance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 129-144). Oxford: Oxford University Press.

Boardman, M. P. H., Catley, D., Grobe, J. E., Litle, T., & Ahlumalia, J. S. (2006). Using motivational interviewing with smokers: Do therapist behaviors relate to engagement and therapeutic alliance? *Journal of Substance Abuse Treatment, 31*, 329–339.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. C. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (*2nd ed*.). Washington: APA.

Brinegar, M. G., Salvi, L. M., Stiles, W. B., & Greenberg, L. S. (2006). Building a meaning bridge: Therapeutic progress from problem formulation to understanding. *Journal of Counselling Psychology, 53*, 165-180.

Caro-Gabalda, I. (1996). The linguistic therapy of evaluation: A perspective on language in psychotherapy. *Journal of Cognitive Psychotherapy, 10*, 83-104.

Castonguay, L. G., & Beutler, L. E. (Eds.) (2006). *Principles of therapeutic change that work: Integrating relationship, treatment, client, and therapist factors*. New York: Oxford University Press.

Colli, A., & Lingiardi, V. (2009). The collaborative interactions scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research, 19*, 718–734.

Combs, G., & Freedman, J. (2004). A poststructuralist approach to narrative work. In L. E. Angus, & J. Mcleod (Eds.), *The handbook of narrative psychotherapy: Practice, theory and research* (pp. 137-155). London: Sage.

Cooper, M. (2004). Encountering self-otherness: "I-I and "I-Me" modes of self relating. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The Dialogical self in psychotherapy* (pp. 60-73). New york: Brunner-routledge.

Cunha, C. (2011). Narrative change in emotion-focused therapy: Co-constructing innovative self-narratives. Unpublished Doctoral Dissertation, University of Minho, Braga, Portugal.

Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1–28). Thousand Oaks, CA: Sage.

Detert, N. B., Llewelyn, S., Hardy, G. E., Barkham, M., & Stiles, W. B. (2006). Assimilation in good- and poor-outcome cases of very brief psychotherapy for mild depression. *Psychotherapy Research, 16*, 393-407.

Dimaggio, G. (2006). Disorganized narratives in clinical practice [Special issue]. *Journal of Constructivist Psychology, 19,* 103-108.

Dimaggio, G., & Lysaker, P. H. (Eds.) (2010). *Metacognition and severe adult mental disorders: From basic research to treatment*. London: Routledge.

Drozd, J. F., & Goldfried, M. R. (1996). A critical evaluation of the state-of-art in psychotherapy outcome research. *Psychotherapy, 33*, 171-180.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.) (2010). *The heart and soul of change: Delivering what works*. Washington: American Psychological Association.

Ecker, B., & Hulley, L. (2000). The order in clinical disorders: Symtom coherence in Depth-Oriented Brief Therapy. In R. A. Neimeyer, & J. D. Raskin (Eds.), *Construction of Disorder: Meaning-making frameworks for psychotherapy* (pp. 63-89). Washington, DC: American Psychological Association.

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

Elliott, R., Stiles, W. B., & Shapiro, D. A. (1993). "Are some psychotherapies more equivalent than others?" In T. R. Giles (Ed.), *Handbook of effective psychotherapy* (pp. 455-479). New York: Plenum Press.

Engle, D., & Arkowitz, H. (2008). Viewing resistance as ambivalence: Integrative strategies for working with ambivalence. *Journal of Humanistic Psychology, 48,* 389-412.

Engle, D., & Holiman, M. (2002). A gestalt-experiential perspective on resistance. *JCLP/In Sessions: Psychotherapy in Practice, 58*, 175-183.

Eubanks-Carter, C., Muran, J. C., Safran, J. D., & Mitchell, A. (2008, June). *Development of an observer-based rupture resolution rating system*. Paper presented at the annual meeting of the Society for Psychotherapy Research, Barcelona, Spain.

Feixas, G., Sánchez, V., & Gómez-Jarabo, G. (2002). La resistencia en psicoterapia: El papel de la reactância, la construcción del sí mismo y el tipo de demanda [Resistance in psychotherapy: The role of reactance, self-construction, and the type of request]. *Análisis y Modificación de Conducta, 28*, 235-286.

Fernandes, E., Senra, E., & Feixas, G., (2009). *Psicoterapia Construtivista: Um modelo centrado em dilemas* [Constructivist Psychotherapy: A dilemma-focused model]. Braga: Psiquilíbrios.

Frankel, Z., & Levitt, H. M. (2009). Clients' experiences of disengaged moments in psychotherapy: A grounded theory analysis. *Journal of Contemporary Psychotherapy, 39*,171-186.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.

Goldman, R., & Greenberg, L. (1997). Case formulation in experiential therapy. In T. Eells, *Handbook of Psychotherapy Case Formulation* (pp. 402-429). New York: Guilford Press.

Gonçalves, M. M. (2012a). Innovative moments in narrative therapy for depression. Manuscript in preparation.

Gonçalves, M. M. (2012b). Innovative moments in cognitive therapy for depression. Manuscript in preparation.

Gonçalves, M. M. (2012c). Ambivalence in narrative therapy for depression. Manuscript in preparation.

Gonçalves, M. M. (2012d). Ambivalence in cognitive therapy for depression. Manuscript in preparation.

Gonçalves, M. M. (2012e). Protonarratives in narrative therapy for depression. Manuscript in preparation.

Gonçalves, M. M. (2012f). Protonarratives in cognitive therapy for depression. Manuscript in preparation.

Gonçalves, M. M., & Guilfoyle, M. (2006) Dialogism and psychotherapy: Therapists' and clients' beliefs supporting monologism. *Journal of Constructivist Psychology, 19*, 251–271.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Gonçalves, M. M, Mendes, I., Cruz, G., Ribeiro, A. P., Sousa, I., Angus, L., & Greenberg, L., (in press). Innovative moments and change in client-centered therapy. *Psychotherapy Research*.

Gonçalves, M. M., & Ribeiro, A. P. (2012a). Narrative processes of innovation and stability within the dialogical self. In H. J. M. Hermans, & T. Gieser (Eds.), *Handbook of Dialogical Self* (pp. 301-318). Cambridge: Cambridge University Press.

Gonçalves, M. M., & Ribeiro, A.P. (2012b). Therapeutic change, innovative moments and the reconceptualization of the self: A dialogical account. *International Journal of Dialogical Science*, *6*, 81-98.

Gonçalves, M. M., Ribeiro, A. P., Matos, M., Mendes, I, & Santos, A. (2011). Tracking novelties in psychotherapy process research: The innovative moments coding system. *Psychotherapy Research, 21*, 497-509.

Gonçalves, M. M., & Stiles, W. B. (2011). Introducing the special section on narrative and psychotherapy. *Psychotherapy Research, 21*, 1-3.

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

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client–centered relationship conditions and process interventions. *Psychotherapy Research, 8*, 210–224.

Hatcher, R. (1999). Therapists' views of treatment alliance and collaboration in therapy. *Psychotherapy Research, 9*, 405–423.

Hermans, H. J. M. (1996a). Opposites in a dialogical self: Constructs as characters. *Journal of Constructivist Psychology, 9*, 1-26.

Hermans, H. J. M. (1996b). Voicing the self: From information processing to dialogical interchange. *Psychological Bulletin*, *119*, 31–50.

Hermans, H. J. M. (2004). The dialogical self: Between exchange and power. In H. J. M. Hermans, & G. Dimaggio (Eds.), *The Dialogical Self in Psychotherapy* (pp. 608–621). New York: Brunner-Routledge.

Hermans, H. J. M. (2006). The self as a theater of voices: Disorganization an reorganization of a position repertoire. *Journal of Constructivist Psychology, 19*, 147-169.

Hermans, H. J. M., & Dimaggio, G. (2007). Self, identity, and globalization in times of uncertainty: A dialogical analysis, *Review of General Psychology, 11*, 31–61.

Hermans, H. J. M., & Kempen, H. J. G. (1993). *The dialogical self: Meaning as movement*. San Diego: Academic Press.

Hermans, H. J. M., Kempen, H. J. G., & van Loon, R. P. J. (1992). The dialogical self: Beyond individualism and rationalism. *American Psychologist, 47,* 23-33.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counselling Psychology, 52,* 196–205.

Hill, C., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert, (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (pp. 84-135). New York: Wiley.

Honos-Webb, L., & Stiles, W. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy, 35*, 23-33.

Honos-Webb, L., Surko, M., Stiles, W., & Greenberg, L. (1999). Assimilation of voices in psychotherapy: The case of Jan. *Journal of Counseling Psychology, 46*, 448-460.

Horvath, A. O., & Bedi, R. (2002). The alliance. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). Oxford: Oxford University Press.

Horvath, A. O., Del Re, A., Flu¨ckiger, C., & Symonds, B. D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (*2nd ed.*). New York: Oxford University Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and the outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139–149.

Jussila, N. (2009). Innovatiiviset hetket masennuksen pariterapiassa [Innovative moments in couple therapy for depression]. Unpublished Master Thesis, University of Jyväskylä, Finland.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

Krause, M., de la Parra, G., Arístegui, R., Dagnino, P., Tominic, A., Valdés, N., Echávarri, O., Strasser, K., Reyes, L., Altimir, C., Ramírez, I., Vilches, O., & Ben-dov, P. (2007). The evolution of therapeutic change studied through generic change indicators. *Psychotherapy Research, 17*, 673-679.

Lambert, M. L. (Ed.) (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change* (*5th ed.)*. New York: Wiley.

Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the assimilation model: The case of Jan revisited. *Psychotherapy Research, 11*, 311–330.

Lepper, G., & Mergenthaler, E. (2005). Exploring group process. *Psychotherapy Research, 15*, 433–444.

Lepper, G., & Mergenthaler, E. (2007). Therapeutic collaboration: How does it work?. *Psychotherapy Research, 17*, 576–587.

Lepper, G., & Mergenthaler, E. (2008). Observing therapeutic interaction in the "Lisa" case. *Psychotherapy Research, 18*, 634–644.

Linell, P., & Marková, I. (1993). Acts in discourse: From monological speech acts to dialogical interact. *The Journal for the Theory of Social Behaviour*, *23*, 173-195.

Luborsky, L. (1997). The Core Conflictual Relationship Theme (CCRT): A basic case formulation method. In T. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 58-83). New York: Guilford.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "Everyone has won and all must have prizes"?. *Archives of General Psychiatry, 32,* 995-1008.

Lysaker, P., & Lysaker, P. (2006). A typology of narrative impoverishment in schizophrenia: Implications for understanding the process of establishing and sustaining dialogue in individual psychotherapy. *Counseling Psychology Quarterly, 19*, 57-68.

Mahalik, J. R. (1994). Development of the client resistance scale. *Journal of Counseling Psychology, 41*, 58-68.

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy*. New York: Basic Books.

Mandler, J. (1984). *Scripts, stories, and scenes: Aspects of schema theory*. Hillsdale, NJ: Erlbaum.

Martínez, C., Mendes, I., Gonçalves, M. M., & Krause, M. (2009). *Exploring the construct validity of the innovative moments*. 7th SPR European Conference. October 1-3, Bolzano, Italy.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McAdams, D. P. (1993). The stories we live by: Personal myths and the making of the self. New York: William Morrow.

McAdams, D. P. (2006). The problem of narrative coherence. *Journal of Constructivist Psychology, 19,* 109-125.

Meier, A. (2002). Narrative in psychotherapy theory, practice, and research: A critical review. *Counseling and Psychotherapy Research, 2,* 239-251.

Meira, L., Gonçalves, M. M., Salgado, J., & Cunha, C. (2009). Everyday life change: Contribution to the understanding of daily human change. In M. Todman (Ed.), *Self-Regulation and social competence: Psychological studies in identity, achievement and work-family dynamics* (pp. 145-154). Athens: ATINER.

Mendes, I., Ribeiro, A. P., Angus, L., Greenberg, L., Gonçalves, M. M. (2010). Narrative change in Emotion-Focused Therapy: How is change constructed through the lens of the innovative moments coding system?. *Psychotherapy Research, 20,* 692-701.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology, 52*, 250-260.

Muran, J. C. (2002). A relational approach to understanding change: Plurality & contextualism in a psychotherapy research program. *Psychotherapy Research, 12*, 113-138.

Neimeyer, R. A. (2004). Fostering posttraumatic growth: A narrative contribution. *Psychological Inquiry, 15*, 53-59.

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos to coherence: Psychotherapeutic integration of traumatic loss. *Journal of Constructivist Psychology, 19*, 127-145.

Nichols, M. P., & Schwartz, R. C. (1991). *Family therapy concepts and methods*. Needham Heights: Allyn and Bacon.

Norcross, J. C. (2002). Empirically supported therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 3–16). New York: Oxford University Press.

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Ducan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change* (pp. 113–142). Washington, DC: American Psychological Association.

Norcross, J. C., & Goldfried, M. (Eds.) (2005). *Handbook of psychotherapy integration* (*2nd ed.*). New York: Oxford University Press.

Omer, H., & Alon, N. (1997). *Constructing therapeutic narratives*. Northvale, NJ: Jason Aronson.

Orlinsky, D. E., Rønnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (*5th ed*.) (pp.307-389). New York: Wiley.

Osatuke, K., Glick, M. J., Gray, M. A., Reynolds, D. J., Humphreys, C. L., Salvi, L. M., & Stiles, W. B. (2004). Assimilation and narrative: Stories as meaning bridges. In L. E. Angus, & J. Mcleod (Eds.), *The handbook of narrative psychotherapy: Practice, theory and research* (pp. 87-102). London: Sage.

Pinheiro, P., Gonçalves, M. M., & Gabalda, I. (2009). Assimilation of problematic experiences and innovative moments: A case-study using the linguistic therapy of evaluation. 40th SPR International Meeting. June 24-27, Santiago del Chile, Chile.

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52,* 126-136.

Ribeiro, A. P., Bento, T., Gonçalves, M. M., & Salgado, J. (2010). Self-narrative reconstruction in psychotherapy: Looking at different levels of narrative development. *Culture & Psychology*, *16*, 195-212.

Ribeiro, A. P., Bento, T., Salgado, J., Stiles, W. B., & Gonçalves, M. M. (2011). A dynamic look at narrative change in psychotherapy: A case-study tracking innovative moments and protonarratives using state-space grids. *Psychotherapy Research*, *21*, 34-69.

Ribeiro, A. P., Cruz, G., Mendes, I., Stiles, W. B., & Gonçalves, M. M. (2012). Ambivalence in Client-Centered Therapy. Manuscript in preparation.

Ribeiro, A. P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia construtivista [Narrative change in psychotherapy: A good-outcome case of construstivist therapy]. *Psychologica, 50*, 181-203.

Rice, L. N., & Greenberg, L. S. (Eds.) (1984). *Patterns of change*. New York: Guilford Press.

Rodrigues, D., Mendes, I., Gonçalves, M. M, & Neimeyer, R. (2010). Innovative moments and narrative change in constructivist grief psychotherapy: The case of Cara. Manuscript in preparation.

Rosa, C., & Gonçalves, M. M. (2008). Dialogical self and close relationships: Looking for ambivalences. *Studia Psychologica, 8*, 89–108.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*, 412–415.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance, a relational treatment guide*. New York: Guilford Press.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness?. *Psychotherapy: Theory, research, practice, training, 43*, 286–291.

Salgado, J., & Gonçalves, M. M. (2007) The dialogical self: Social, personal, and (un)conscious. In J. Valsiner, & A. Rosa (Eds), T*he Cambridge Handbook of Sociocultural Psychology* (pp. 608–621). Cambridge: Cambridge University Press.,

Salvatore, G., Dimaggio, G., & Semerari, A. (2004). A model of narrative development: Implications for understanding psychopathology and guiding therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*, 231–254.

Santos, A., Gonçalves, M. M., & Matos, M. (2011). Innovative moments and poor-outcome in narrative therapy. *Counselling and Psychotherapy Research*, *11*, 129-139.

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449-466.

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3-21). New York: Praeger.

Shapiro, D. A. (1985). Recent applications of meta-analysis in clinical research. *Clinical Psyhological Review, 5*, 13-34.

Singer, J., & Rexhaj, B. (2006). Narrative coherence and psychotherapy: A commentary. *Journal of Constructivist Psychology, 19*, 207-217.

Stiles, W. B. (1981). Science, experience, and truth: A conversation with myself. *Teaching of Psychology, 8,* 227–230.

Stiles,W. B. (1982). Psychotherapeutic process:Is there acornmoncore? In L. E. Abt, & I. R. Stuart (Eds.), *The newer therapies: A sourcebook* (pp. 4-17). New York: Van Nostrand Reinhold.

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*, 593-618.

Stiles, W. B. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*, 1-21.

Stiles, W. B. (2002). Assimilation of problematic experiences. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 357–365). New York: Oxford University Press.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2009). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy, 5*, 9-22.

Stiles, W. B. (2011). Coming to terms. *Psychotherapy Research, 21*, 367-384.

Stiles, W. B., Honos-Webb, L., & Lani, J. A. (1999). Some functions of narrative in the assimilation of problematic experiences. *Journal of Clinical Psychology, 55*, 1213-1226.

Stiles, W. B., Osatuke, K., Glick, M. J., & Mackay, H. C. (2004). Encounters between internal voices generate emotion: An elaboration of the assimilation model. In H. H. Hermans, & G. Dimaggio (Eds.), *The dialogical self in psychotherapy* (pp. 91-107). New York: Brunner-Routledge.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). "Are all psychotherapies equivalent?". *American Psychologist, 41*, 165-180.

Stiles, W. B. & Sultan, F. E. (1979). Verbal response mode use by clients in psychotherapy. *Journal of Consulting and Clinical Psychology, 47,* 611-613.

Tracey, T. J. (1993). An interpersonal stage model of the therapeutic process. *Journal of Counseling Psychology, 40*, 396–409.

Tyron, G. S., & Winograd, G. (2002). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 109–128). New York: Oxford University Press.

Valsiner, J. (2002). Forms of dialogical relations and semiotic autoregulation within the self. *Theory & Psychology, 12*, 251–265.

Valsiner, J. (2004). Temporal integration of structures within dialogical self. Keynote lecture at the 3rd International Conference on the Dialogical Self, Warsaw.

Valsiner, J. (2008). Constraining one's self within the fluid social worlds. Paper presented at the 20th Biennial ISSBD meeting, Würzburg.

Valsiner, J., & Sato, T. (2006). Historically Structured Sampling (HSS): How can psychology's methodology become tuned into the reality of the historical nature of cultural psychology?. In J. Straub, C. Kölbl, D. Weidemann, & B. Zielke (Eds.), *Pursuit of meaning: Theoretical and methodological advances in cultural and cross-cultural psychology* (pp. 215-251). Bielefeld, Germany: transcript Verlag.

Vygotsky, L. (1924/1978). *Mind in society*. Cambridge, MA: Harvard University Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Westerman, M. A. (1998). Curvilinear trajectory: Patient coordination over the course of short term therapy. *Psychotherapy: Theory, Research, Practice, Training, 35*, 206–219.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

Zittoun, T. (2007). Dynamics of interiority: Ruptures and transitions in self-development. In L. M. Simão, & J. Valsiner (Eds.), *Otherness in question: Labyrinths of the self* (pp. 187–214). Charlotte, NC: Information Age Publishing.