

The Emergence of Innovative Moments in Narrative Therapy for Depression: Exploring Therapist and Client Contributions

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Abstract. According to the narrative framework, clients seek therapeutic help due to the constricting nature of problematic self-narratives and psychotherapy should contribute to the elaboration of narrative novelties and innovative self-narratives. We term these narrative novelties as innovative moments (IMs) and developed the Innovative Moments Coding System (IMCS) to study them in psychotherapeutic discourse, differentiating five types of IMs: action, reflection, protest, reconceptualization and performing change IMs. Previous research studies using the IMCS with narrative therapy, emotion-focused therapy and client-centered therapy show that action, reflection and protest IMs appear in good (GO) and also in poor outcome (PO) cases while, reconceptualization and performing change IMs are more typical of good outcome (GO) cases. In this study, we will address how these IMs are co-constructed in the therapeutic dialogue through the discussion of three particular forms of IMs' emergence in psychotherapy. These forms of emergence refer to different degrees of client and therapist participation: (1) IMs produced by the therapist and accepted by the client; (2) IMs prompted by the therapist and developed by the client; and (3) IMs spontaneously produced by the client. The exploratory analysis of three initial, three middle and three final sessions of contrasting cases (a GO and a PO) of narrative therapy for depression showed that IMs produced by the therapist were more associated to the PO case, while IMs prompted by the therapist were more associated to the GO case.

Keywords: narrative change, innovative moments, co-construction, emergence

Over the last decades, several authors within psychotherapy and personality literature has been acknowledging the centrality of telling stories in human life and how self-narratives play an important role on identity construction and personal change (e.g., Angus & McLeod, 2004; Bruner, 1990; Hermans & Hermans-Jansen, 1995; McAdams, 1993; Sarbin, 1986; White & Epston, 1990). Self-narratives are products of human effort to interpret, select and synthesize experiences, where episodic memories, socio-cultural expectations, shared and private meanings become integrated in the form of stories and personal

accounts of our lives (Adler, Skalina, & McAdams, 2008; Boritz, Angus, Monette, & Hollis-Walker, 2008; Boritz, Angus, Monette, Hollis-Walker, & Warwar, 2011; McAdams, 1993). These self-narratives are not only a product but also a process, as the act of telling them simultaneously reveals us as authors (e.g., which stories we select and retell), narrators (e.g., how we perform the act of self-narrating to others) and social actors [e.g., how we portray ourselves in our stories, and in relation to other people (Cunha et al., 2012; Hermans, 1996; Sarbin, 1986; Wortham, 2001)]. These performances reveal our authorship and agency, seeking for interpersonal validation of these accounts (Cunha, Gonçalves, & Valsiner, 2011; Gonçalves, Matos, & Santos, 2009).

However, in some instances, self-narratives may become problematic and dysfunctional: that is, when these become too redundant, lacking differentiation and flexibility or when these dismiss or dissociate important experiences, constraining personal adaptation (Dimaggio, 2006; Neimeyer, Her-

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rero, & Botella, 2006). Some authors show how problematic narratives emphasize problems and personal deficits (*problem-saturated narratives* according to White and Epston, 1990; White, 2007; or *same-old stories* for Angus and Greenberg, 2011), evidence dominant, rigid perspectives and voices that silence other possible, productive alternatives (Hermans & Kempen, 1993; Salvatore, Gelo, Genaro, Manzo, & Al Radaideh, 2010), show a bias towards negative events on autobiographical recall and perpetuate negative views upon oneself (Boritz et al., 2008, 2011; Gonçalves & Machado, 1999) or become disorganized and incoherent, lacking integration (Botella, Herrero, Pacheco, & Corbella, 2004; Dimaggio, Salvatore, Azzara, & Catania, 2003). These problematic narratives are usually presented by clients at the beginning of psychotherapy and have to be somehow challenged and transformed. Therefore, a fundamental task for psychotherapy process research is to understand how the self is transformed through narratives and how therapists can contribute to the co-construction of narrative change (Cunha, 2011; Gonçalves, Ribeiro, Stiles, et al., 2011b).

The Innovative Moments Coding System: Overview, findings and recent developments

Our research program on the study of narrative change has been trying to depict how the narrative elaboration of new experiences and novelties facilitates the transformation of problematic self-narratives within the psychotherapy context (Gonçalves et al., 2009; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010). For that we created the *Innovative Moments Coding System* (hereafter IMCS; Gonçalves et al., 2009; Gonçalves, Ribeiro, Mendes, et al., 2011a) to track and differentiate exceptions, new experiences and narrative novelties that emerge along the therapeutic conversation. We term these experiences *innovative moments* (IMs): if we consider the problematic narrative presented by a client at the beginning of psychotherapy as a dominant, redundant problematic “rule,” IMs are all the experiences and exceptions which contradict that rule. Thus, IMs usually involve actions, feelings, intentions and thoughts that express an exception towards the dominance of the problematic narrative (Gonçalves et al., 2009; Gonçalves, et al., 2009, 2011a). This was originally inspired in White and Epston’s (1990) notion of “unique outcomes”—i.e., experiences outside the influence of the problem-saturated narratives that clients brought to therapy. According to White (2007), by bringing client’s awareness to these exceptions and helping clients elaborate them, an attentive therapist can help promote psychotherapy changes by facilitating the emergence and consolidation of new self-narratives.

The IMCS differentiates five types of IMs: action, re-

flexion, protest, reconceptualization and performing change IMs (see Table 1). These five types were inductively identified in an initial study of narrative therapy with a sample of women victims of partner violence (Gonçalves et al., 2009). Although some of our studies looked at non-therapeutic change in everyday life (e.g., Meira, Gonçalves, Salgado, & Cunha, 2009), our main focus has been on characterizing how IMs develop within brief psychotherapy processes, usually looking at the evolution of each type across sessions.

Findings with the IMCS

Up until now, we have applied the IMCS to different samples of client problems receiving brief psychotherapy (typically 12 to 20 sessions per case) in different modalities, aiming to depict narrative change along different kinds of psychotherapy. More specifically, these studies analyzed which IMs are typical of good outcome (GO) versus poor outcome (PO) cases and how these evolve along the therapy process, also testing the applicability of the IMCS besides narrative therapy (e.g., client-centered therapy and emotion-focused therapy; for further details see Gonçalves, Mendes, Cruz, et al., 2012; Mendes, Ribeiro, Angus, Greenberg, et al., 2010; Mendes, Ribeiro, Angus, Greenberg, & Gonçalves, 2011).

Overall, these studies have presented consistent findings regarding the emergence of IMs and their pattern of evolution, which are summarized below (see Alves, Mendes, Gonçalves, & Neimeyer, 2012; Gonçalves, Mendes, Ribeiro, et al., 2010; Gonçalves, Mendes, Cruz, et al., 2012; Gonçalves, Ribeiro, Stiles, et al., 2011b; Matos, Santos, Gonçalves, & Martins, 2009; Mendes et al., 2010, 2011; Ribeiro, Gonçalves, & Ribeiro, 2009; Santos, Gonçalves, Matos, & Salvatore, 2009).

The salience of IMs is significantly higher in GO when compared to PO cases

Salience is the proportion of time occupied by an IM and we suggest that this is a measure of narrative elaboration. GO cases are typically characterized by a progressive tendency in the diversity of IMs’ types and their salience, which increases from session to session. PO cases, contrastingly, are typically characterized by a lower diversity and salience of IMs, most of the time without a clear trend to increase from the beginning until the end of treatment.

Different types of IMs appear and evolve in GO and in PO cases

In GO cases, action, reflection and protest IMs start emerging at the beginning of therapy and their salience increases during the sessions; then, in the middle of GO therapy, reconceptualization IMs appear and

Table 1. The Innovative Moments Coding System with examples from narrative therapy (adapted from Cunha et al., 2012, and from Matos, Santos, Gonçalves & Martins, 2009, pp. 7-10)

Types of IMs	Examples from narrative therapy
<p>Action IMs. Refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.</p>	<p>T: Was it difficult for you to take this step [not accepting to be constrained by the fear of the violent husband and deciding to leave him]? C [victim of partner violence]: Yes, it was a huge step. For the last several months I barely got out. Even coming to therapy was a major challenge. I felt really powerless going out. I have to prepare myself really well to be able to do this.</p>
<p>Reflection IMs. Refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.</p>	<p>C: [depressed]: I'm starting to wonder about what my life will be like if I keep feeding my depression. T: It's becoming clear that depression has a hidden agenda for your life? C: Yes, sure. T: What is it that depression wants from you? C: It wants to rule my whole life, and in the end it wants to steal my life from me.</p>
<p>Protest IMs. Involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.</p>	<p>C: [depressed]: I talked about it just to demonstrate what I've been doing until now, fighting for it [...] T: Fighting against the idea that you should do what your parents thought was good for you? C: I was trying to change myself all the time, to please them. But now I'm getting tired, I am realizing that it doesn't make any sense to make this effort. T: That effort keeps you in a position of changing yourself all the time, the way you feel and think [...] C: Yes, sure. And I'm really tired of that. I can't stand it anymore. After all, parents are supposed to love their children and not judge them all the time.</p>
<p>Reconceptualization IMs. Always involve two dimensions: (a) a description of the shift between two positions (past and present) and (b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.</p>	<p>C: [victim of partner violence]: I think I started enjoying myself again. I had a time [...] I think I've stopped in time. I've always been a person that liked myself. There was a time [...] maybe because of my attitude, because of all that was happening, I think there was a time that I was not respecting myself [...] despite the effort to show that I wasn't feeling [...] so well with myself [...] I couldn't feel that joy of living, that I recovered now... and now I keep thinking, "You have to move on and get your life back." T: This position of "you have to move on" has been decisive? C: That was important. I felt so weak at the beginning! I hated feeling like that [...]. Today I think "I'm not weak." In fact, maybe I am very strong, because of all that happened to me. I can still see the good side of people and I don't think I'm being naive [...]. Now when I look at myself, I think, "No, you can really make a difference, and you have value as a person." For a while I couldn't have this dialogue with myself, I couldn't say, "You can do it" nor even think, "I am good at this or that" [...]</p>
<p>Performing change IMs refer to new aims, projects, activities or experiences (anticipated or already acted) that become possible because of the acquired changes. Clients may apply new abilities and resources to daily life or retrieve old plans or intentions postponed due to the dominance of the problem.</p>	<p>T: You seem to have so many projects for the future now! C [victim of partner violence]: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by fear. 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 of others in my life again.</p>

increase until the end of treatment, being followed by performing change IMs (which tend to appear after reconceptualization). PO cases are typically characterized by the presence of action, reflection and protest, without a clear progressive trend in their salience along the treatment. As for reconceptualization and performing change, these types of IMs usually do not appear or have a very low salience in PO cases. Therefore, these findings suggest that action, reflection and protest IMs are more early, initial types of innovative moments (present in both PO and GO cases), while reconceptualization and performing change IMs are more later and complex types of IMs, appearing when changes are being achieved and consolidated and, thus, distinguishing GO cases. Moreover, it seems that PO cases have the initial ingredients necessary for a successful trajectory (i.e., action, reflection and protest IMs), but its development is not fully achieved.

IMs' evolution across therapy samples and models

The consistency of findings on IMs' evolution across therapy samples and models allowed establishing a hypothetical, heuristic model for the development of IMs in GO therapy. According to this model (illustrated in Figure 1), the first signs of narrative change in GO therapy appear in the initial sessions, in the form of action, reflection and protest IMs. These three types of IMs feed each other in cycles in the beginning of treatment, increasing its salience, as the person pays more attention to these new experiences and feels more motivated to defy the problematic narrative through the enactment and narrative elaboration of changes. An important turning point in the change process is the emergence and development of reconceptualization IMs from the middle of therapy until the end, becoming the dominant type of

IM. This is a distinctive feature of GO cases, since reconceptualization IMs are usually absent or residual in PO cases. This is understandable when considering the defining features of this type of IM (see Table 1): the person narrates a contrast between oneself in the past and oneself in the present (i.e., clients become aware of self-transformation) and describes the transformation processes that lead to this transition. Also, the emergence of reconceptualization IMs feeds new action, reflection and protest IMs that act as signs that further transformations are under way and set the stage for performing change IMs, which emphasize the projection of changes into the future. These new projects, plans and aims become possible only because the client became a changed person and is then able to present a transformed self-narrative.

Recent developments in the Innovative Moments Research Project

The latest studies within this perspective have been moving now to two main different directions. First, the effort to understand how the development of narrative changes in PO cases becomes interrupted with the absence of reconceptualization and performing change IMs. A closer look comparing the initial therapy phases of GO and PO cases reveals some commonalities between the groups, particularly in the initial phase of therapy when action, reflection and protest IMs are present (see Gonçalves et al., 2010; Matos et al., 2009; Mendes et al., 2010). Clearer differences appear in the middle of therapy when—in the absence of reconceptualization—the cycles of new action, reflection and protest IMs do not increase in salience and do not foster further narrative changes. Therefore, the overall picture is: despite some innovations, the person shows ambivalence and returns to the same problema-

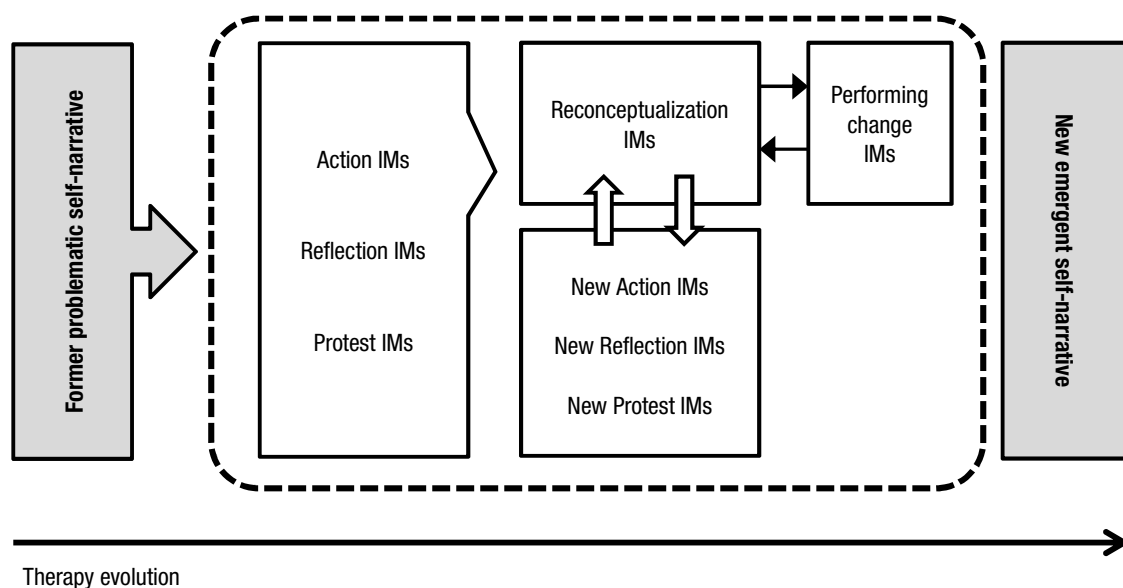


Figure 1. A heuristic model of narrative change on the perspective of innovative moments.

tic self-narrative, not being able to challenge its dominance. This line of research has led to the study of ambivalence and stagnation in PO cases, with promising research and theoretical developments on the way (see Gonçalves et al., 2011b; Ribeiro & Gonçalves, 2010).

A second research direction conducted us to look more specifically at the therapist contributions for the promotion of client narrative change. Up until now, in the earlier line of IMs' research, little attention was paid to the therapist and to exploring how specific therapeutic behaviors or techniques could facilitate IMs (Cunha, 2011; Cunha et al., 2012). Thus, an initial study carried out by Cunha and colleagues (2012) explored how therapist exploration, insight and action skills were related to client IMs across different phases of emotion-focused therapy (EFT) with depressed clients. Findings show that, in GO cases, exploration and insight skills more often preceded action, reflection and protest IMs (the early IMs) in the initial and middle phases of EFT while, in the final phase, these skills more often preceded reconceptualization and performing change IMs (the more complex IMs). As for action skills, these always preceded more often action, reflection and protest IMs (than the other types of IMs) across all therapy phases. This initial study suggests that there are specificities in the way clients respond to specific therapist behaviors and skills along the therapy process. In our view, knowing more about how specific behaviors of therapists are related to client IMs, not only in EFT but also in other modalities, could have implications for therapist training to facilitate IMs. Therefore, further research is needed on this topic.

The present study

Building on previous efforts to understand therapist and client co-construction of narrative change (Cunha et al., 2011, 2012), the present study aims to look at the specific issue of IMs' emergence in the therapeutic conversation. According to narrative therapy, the promotion and narrative elaboration of exceptions to the problematic narrative or IMs—is one of the aims of the therapist that guide the therapeutic process (White, 2007; White & Epston, 1990). Thus, narrative therapy seems to be a suited place to differentiate particular forms of co-construction of narrative novelties and to study the emergence of IMs, exploring how specific forms of therapist behaviors precede the several client IMs.

Therefore, in this first, exploratory study, we will begin by characterizing how client IMs appear and evolve throughout different phases or stages of therapy in two contrasting cases of narrative therapy with depressed clients. Then, addressing the research questions of this study we will explore in these two cases: (1) which forms of emergence are more related to the good and poor outcome case, and (2) which forms of emergence are more related to different

types of client IMs.

For this, we will study three specific forms of emergence and co-construction of IMs in the therapeutic conversation, each referring to different degrees of client and therapist participation. The forms of emergence studied here are: (1) IMs produced by the therapist and accepted by the client; (2) IMs prompted by the therapist and developed by the client; and (3) IMs spontaneously produced by the client (in more detail below).

Globally, the three forms of emergence address different degrees of client and therapist participation in the co-construction of IMs. For categorizing an experience as an IM, it has to be regarded as an exception to the problem (Gonçalves et al., 2011a); however, who points it out and notices this in the conversation, can either be the therapist, the client or both interlocutors. Furthermore, even if one of the interlocutors (e.g., the therapist) notices something new, the other (e.g., the client) can expand its elaboration and address other dimensions of it (for example, its meaning, its impact, the way it felt like).

Thus, a first form of emergence—named *IMs produced by the therapist and accepted by the client* (or more simply, from this point on, *IMs produced by the therapist*)—evidences higher emphasis on therapist participation and minimal client participation in the co-construction of an IM. Here, the client only agrees with the therapist and does not add much to the novelty identified, which suggests lower client autonomy. A second form of emergence—named *IMs prompted by the therapist and developed by the client* (or more simply, from this point on, *IMs prompted by the therapist*)—evidence a greater interaction and collaboration between both interlocutors. That is, as the therapist notes or searches for an exception (for example, enquiring through the use of an open question for any new experiences or changes during the week), the client identifies and develops and/or complements the IM.

This form of emergence suggests that, even though collaboration is at the forefront of an IM, client autonomy is at its background. The third and last form of emergence—named *IMs spontaneously produced by the client* (or more simply, from this point on, *IMs produced by the client*)—evidence higher autonomy from the part of clients, as they spontaneously identify and elaborate an IM in the therapeutic conversation, without therapists bringing it as a topic of discussion or prompting it in any specific way. Table 2 illustrates the three forms of emergence, with examples from other narrative therapy cases. For simplicity reasons, in Table 2 and from this point on in the paper, we will refer to the forms of emergence in a shortened (1) IMs produced by the therapist and accepted by the client; (2) IMs prompted by the therapist and developed by the client; and (3) IMs spontaneously produced by the client.

Table 2. Definition of the three different forms of emergence and illustrative examples

Types of emergence	Examples (IMs appear in bold)
<p>IMs produced by the therapist. The IM is the result of a therapist's statement, in the form of a remark, a question or an interpretation, and the client accepts it, agreeing with the therapist (and does not add anything to the therapist's formulation). This form of emergence demonstrates high directivity by the therapist and low autonomy from the client.</p>	<p>Example 1 T: But you have great confidence that the way you relate with him it's important [...] C: Yes. T: That encourages you [...] C: Yes, yes. [Reflection IM]</p> <p>Example 2 T: Do you mean that value yourself as a woman will always pass by helping others too? C: Yes. T: By devoting part of your time [...] C: Yes. [Reflection IM]</p>
<p>IMs prompted by the therapist. The IM is the result of a therapist's question or statement that promotes its development. The client, in turn, agrees with the therapist and goes a bit beyond what the therapist has said in the elaboration novelties. This form of emergence evidences an intermediate degree of therapist directivity and client autonomy.</p>	<p>Example 1 T: What has been different in your everyday life? From these changes that marriage has become secondary, which has become much more important to your life and value yourself [...] C: I guess I don't pay much attention to it [...] T: Mhm-mhm. C: [...] and there are things that I had before, I don't know, a lot of attention and dedication and now I'm away from it. T: Ok. And that's good for you? Are you okay with that? C: I think so, I guess, by that stage [...] T: Ok. C: [...] because I'm not obsessed by that person, that's what I want [...] [Reflection IM]</p> <p>Example 2 T: This liking people kind of attitude that you have has with people, how is it like? C: I think I like [...] I stay talking, supporting... T: Uh-huh. Ok. C: Even if it is the simple fact of helping take the car, or sit in a chair [...] T: Uh-huh. Ok. C: For me now [...] I feel so good [Reflection IM]</p>
<p>IMs produced by the client. The IM is produced spontaneously by the client, that is, it emerges in the therapeutic conversation without any intervention by the therapist in prompting it. This demonstrates decreased therapist directivity and higher autonomy from the client.</p>	<p>Example 1 C: [...] I said to him that I went to the session, said that I had come here and the words I heard were "You are playing the victim" [...] (T: Mhm-mhm) You are playing the victim". And this bothers me [...] (T: Mhm-mhm) [...] and then I turn and do my work and have the food ready and he does not come to eat, phones and tells me "I am not going to eat because I am with a client" and I think "you make me a servant out of me" [...] [Protest IM]</p> <p>Example 2 C: On Monday she goes, and comes only on Friday. The mother lives in X. She was all upset because the kid vomits, has diarrhea. What can I do and I do not know [...] T: Uh-huh. C: I felt good about calling and asking how the kid was, what do I think she should do [...] T: Uh-huh. C: Because I have more experience as a mother, I know what she can worry about [...] T: Uh-huh. Ok. C: I feel good because I think I'm being helpful, I'm helping! [Reflection IM]</p>

Table 3. Client information

	Case 1	Case 2
Gender	Male	Female
Pre-treatment BDI	41	17
Post-treatment BDI	3	20
Pre-treatment OQ-45	101	90
Post-treatment OQ-45	16	75
Length of treatment	20 sessions	18 sessions
Sessions coded for emergence of IMs	Initial phase: 2,3,4 Middle phase: 9, 10, 11 Final phase: 17, 18, 19	Initial phase: 2,3,4 Middle phase: 9, 10, 11 Final phase: 15, 16, 17
Outcome status	Good outcome	Poor outcome

Method

Participants

Clients. Two clients, one man and one woman, with major depression diagnosis according to the DSM-IV-R (APA, 2000), were recruited for a comparative trial of narrative therapy and cognitive-behavioral therapy for depression conducted in a Portuguese university clinic (Gonçalves, 2007). Both clients gave written consent after being informed of the research goals and were randomly assigned to the narrative therapy condition, receiving 18 to 20 free weekly sessions based on the re-authoring narrative therapy model (White & Epston, 1990).

The male client was 22 years old, single and an undergraduate student (with 16 years of formal education completed). The female client was a widow of 64 years old, retired (with 9 years of formal education completed). Clients were classified as having a GO or PO based on a reliable change index analysis of pre to post-therapy scores of the Beck Depression Inventory (BDI; a 21-item self-report instrument focused on the assessment of depressive symptoms; Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Outcome Questionnaire 45 (OQ-45; a 45-items measure, focused on the assessment of global psychopathological symptoms; Lambert, Gregersen, & Burlingame, 2004). The male client (case 1) was considered a GO case and the female client (case 2) was a PO case. Their scores are shown in Table 3.

The two cases were selected due to the highest and the least improvement in the narrative therapy sample (case 1 is a recovered, good outcome case and case 2 is an unchanged, poor outcome case).

Therapist and treatment. The same male therapist (aged 30), who had a master's degree in psychology, 7 years of clinical experience and 3 years of experience in narrative therapy, treated both clients. He received weekly supervision with a senior therapist

(third author; aged 40 and with 20 years of clinical experience in narrative therapy), in order to assure therapist adherence to the principles and procedures of the narrative model.

The narrative treatment followed the re-authoring model of White and Epston (1990; White, 2007). The following procedures were used throughout the process: (1) deconstruction of the problematic narrative (through *externalization*, the problem is seen as an external entity); (2) identification of *unique outcomes* (or, as we prefer to call them, IMs); (3) therapeutic questioning around these *unique outcomes*, in order to create a new and alternative narrative to the problematic one; (4) consolidation of the changes through social validation (i.e., exploring how changes are influenced by the relationship with others).

Coding procedures

Innovative Moments Coding System (IMCS).

Two trained judges (one male, one female), with a master's degree in clinical psychology and with previous clinical experience, unaware of the outcome status, applied the IMCS to 10 cases of narrative therapy (Gonçalves, 2007). Their training involved the familiarization with the relevant theoretical notions and coding procedures, through training exercises. After training, the two judges engaged independently in an initial visualization of the sessions in order to be familiarized with the problems under analysis and their development. Next, the judges met in order to discuss and agree in terms of what the problematic self-narrative was for each case and the different dimensions that it involved. A list of problems was, then, consensually elaborated in close approximation to the client's self-narrative (in terms of words, expressions, metaphors). The following independent identification of IMs departed from this first step, as IMs are always identified in their relation to the previously identified problematic self-narrative and take into consideration the specificity of the client's problems.

Table 4. Frequencies and percentages of the three forms of IMs emergence in the GO and PO case

Forms of emergence	IMs produced by the therapist	IMs prompted by the therapist	IMs produced by the client	Total IMs
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Case 1 (Good Outcome)				
Action IMs	0 (0)	4 (3)	9 (6)	13 (4)
Reflection IMs	14 (100)	123 (82)	116 (82)	253 (83)
Protest IMs	0 (0)	9 (6)	10 (7)	19 (6)
<i>Reconceptualization IMs</i>	0 (0)	6 (4)	3 (2)	9 (3)
<i>Performing change IMs</i>	0 (0)	8 (5)	4 (3)	12 (4)
Total emergence	14 (100)	150 (100)	142 (100)	306 (100)
Case 2 (Poor Outcome)				
Action IMs	1 (3)	10 (10)	31 (21)	42 (15)
Reflection IMs	29 (97)	89 (89)	113 (75)	231 (83)
Protest IMs	0 (0)	1 (1)	6 (4)	7 (2)
<i>Reconceptualization IMs</i>	0 (0)	0 (0)	0 (0)	0 (0)
<i>Performing change IMs</i>	30 (0)	0 (0)	0 (0)	0 (0)
Total emergence	0 (100)	100 (100)	150 (100)	280 (100)

Note. Later types of IMs (*Reconceptualization* and *Performing change*) appear in italics to contrast with the earlier types of IMs (*Action*, *Reflection* and *Protest*). GO = good outcome. PO = poor outcome.

Each session was then analyzed independently by each judge, first, for the identification of IMs (defining their onset and offset in the session) and, second, for the categorization of each IM in terms of the five types (action, reflection, protest, reconceptualization and performing change). Third, overall salience measures were computed (as the proportion of session, measured in words, occupied by all IMs in a gi-

ven session divided by the total words of the session). To assess reliability regarding the application of the IMCS, researchers used (a) the inter-judge percentage of agreement of overall salience of IMs and (b) Cohen's Kappa for IMs' codings (for further details, see Gonçalves et al., 2011a). Divergences in coding were resolved through consensual discussion (Hill, Thompson, & Williams, 1997).

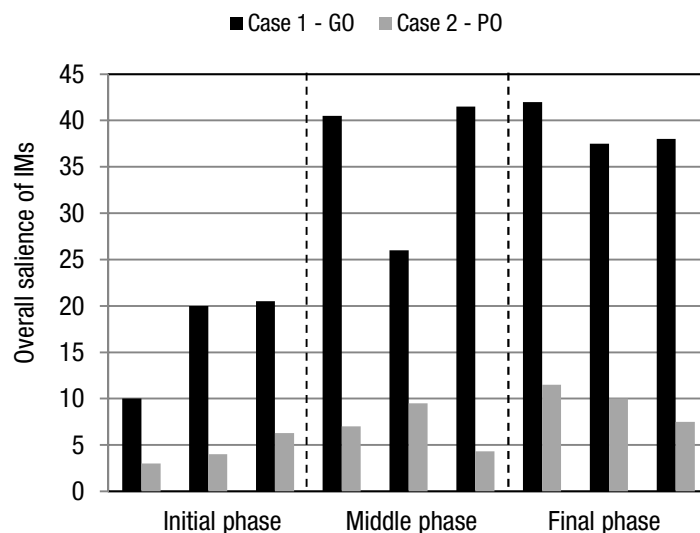


Figure 2. Overall salience of IMs in the good outcome (GO) and poor outcome (PO) case.

Coding of the emergence of IMs. Two other (female) judges, unaware of the outcome status, coded the emergence of IMs in a sample of 6 cases of narrative therapy previously coded with the IMCS ($N = 10$). Nine sessions were selected from each case, to represent different therapy phases: three initial sessions, three middle sessions and three final sessions (see Table 3). One of the judges (judge A: second author) was a master student in clinical psychology and the other (judge B: first author) had recently completed a PhD in clinical psychology and had 10 years of clinical experience and research experience in the use of qualitative methods.

First, the judges trained with a sample of training exercises and discussed the coding of emergence, departing from three forms of emergence (see Table 2): (1) IMs produced by the therapist (i.e., an IM is produced by the therapist and accepted by the client); (2) IMs prompted by the therapist (i.e., an IM is facilitated or encouraged by the therapist—e.g. through the use of an open question or a similar intervention—and is then developed by the client); or (3) IMs produced by the client (i.e., an IM is spontaneously produced by the client, with minimal therapist directivity—e.g. the therapist inquires about the problem). Second, in order to get familiarized with each case of narrative therapy, the judges independently read the transcripts of all the sessions and the respective list of problems. Third, they independently analyzed the selected sample of sessions, looking specifically at each IM appearing in the flow of the therapeutic conversation and indicated the more suited form of emergence (one of the three possibilities above). Judge A coded the complete sample ($n = 6$ cases; 54 sessions) and judge B coded 50% of the sample ($n = 3$ cases; 27

sessions). This decision was carried out after strong agreement was achieved in the independent coding according to the reliability checks, see more below. Divergences in coding were resolved through consensual discussion (Hill et al., 1997).

After coding the emergence, we computed salience measures for the sample of 54 sessions analyzed: (a) the overall salience of IMs (as the total percentage of words occupied by all IMs, for each session and for all the case) and the salience for each type of IM (as the total percentage of words occupied by a given type of IM, for each session and for all the case).

Reliability issues

The application of the IMCS has evidenced good reliability across therapeutic models and diagnosis (or client problems), with studies showing an average percentage of agreement ranging from 84% to 94% and Cohen's Kappa ranging from 0.80 to 0.97 (see Matos et al., 2009; Mendes et al., 2010), which evidences a strong inter-judge agreement (Hill & Lambert, 2004) in the application of the IMCS. For the present study, the two independent judges involved in the application of the IMCS exhibited a Cohen's Kappa of 0.92 regarding IMs' types and 89% as the percentage of agreement for IMs' salience, indicative of strong agreement (Hill & Lambert, 2004).

As for the independent coding of the emergence of IMs, the two judges (A and B) exhibited a percentage of agreement of 94% and a Cohen's Kappa of 0.90, showing also a strong inter-judge agreement (Hill & Lambert, 2004) for the sample of narrative therapy cases analyzed ($n = 6$).

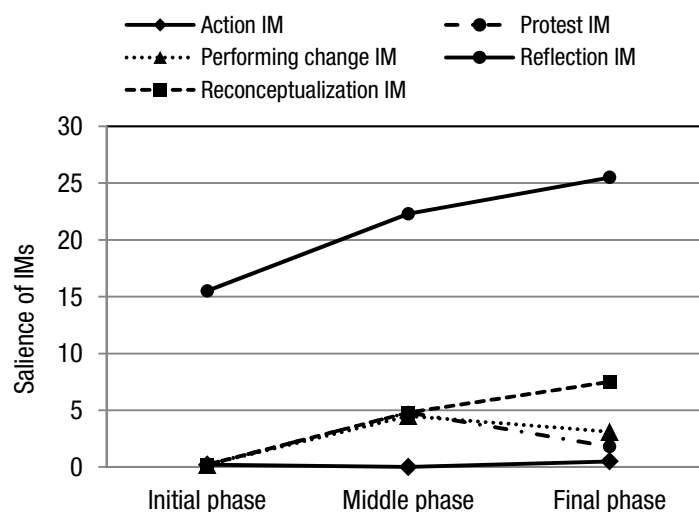


Figure 3. Salience of IMs per therapy phase in the GO case.

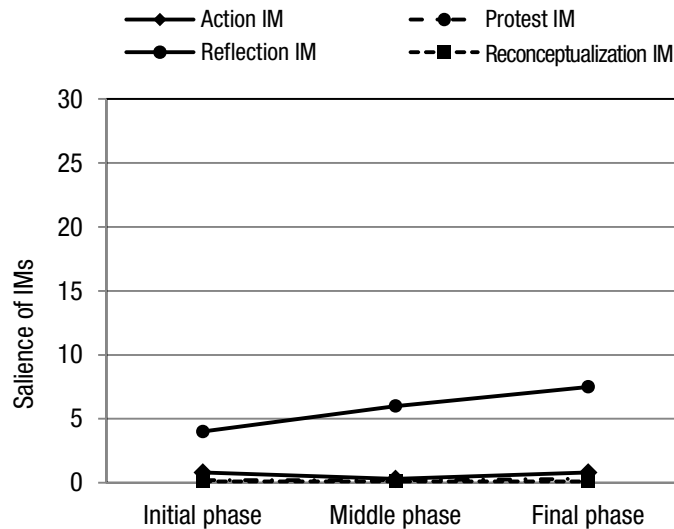


Figure 4. Salience of IMs per therapy phase in the PO case.

Results

This section is structured according to the research goals (identified above in the Introduction). In order to provide an overview of the two cases in terms of IMs' evolution, we will first characterize which IMs appear and how they evolve throughout therapy phases and later analyze the specific forms of emergence, addressing the main aims of the present study.

IMs evolution in the two cases of narrative therapy for depression

Figure 2 shows the results on the overall salience of IMs across the sample of sessions from the initial, middle and final therapy phases in the GO and the PO case. As displayed in this figure, the overall salience was higher in the initial, middle and final phases of the GO case ($M = 16.92; 36.11; 39.25$, respectively) when compared to the PO case ($M = 4.85; 6.80; 9.95$, respectively). In the GO case (case 1), the overall salience of IMs increased steadily in sessions 2, 3 and 4, reaching 20.6 in the last session of the initial phase. During the middle phase, the overall salience of IMs increased to 40.6 and 41.6 in sessions 9 and 11, even though session 10 exhibited a decrease (to 26.3) when compared with the other sessions from this phase. The overall salience of IMs in the final phase of therapy in the GO case remained similar across sessions 17 to 19, ranging from 37.8 to 41.2. Contrastingly, in the PO case (case 2), the overall salience of IMs departed from a lower level (in comparison to the GO case) and showed small increases throughout the three sessions from the initial phase (ranging from 3.6 to 6.8). In the middle phase, even though there was a small increase from session 9 to 10 (7.1 to 9.3), the

overall salience of IMs dropped to 4.0 in session 11 of the PO case. In the final phase of this case, there was a steady decrease from sessions 15 to 17 (from 11.9 to 7.8).

Figures 3 and 4 show the mean salience of IMs' types across the three therapy phases in the GO and in the PO case. When we compare figures 3 and 4, the salience of reflection IMs was the highest across all therapy phases in both cases; however, the salience of this type of IMs (reflection) was highest across all phases of the GO case when compared to the PO case. Moreover, the PO case showed a residual salience of reconceptualization IMs and an absence of performing change IMs.

Emergence of IMs

We proceed now to the analysis on the specific forms of emergence. Table 4 shows the frequencies and percentages of the three forms of emergence of IMs and for each type. An analysis of this table shows that in the GO case, the emergence form that is most prevalent is *IMs prompted by the therapist*, being closely followed by another form of emergence: *IMs produced by the client*. In the PO case, the most prevalent form of emergence is *IMs produced by the client*.

We also wanted to test if specific forms of emergence were related to outcome in the contrast of these two cases. Thus, to test for the association between the three forms of emergence and the two cases (according to therapy outcome), we conducted chi-square tests (Field, 2000). The data for this test comes from the lines titled Emergence total, on Table 4, using a 3x2 table between the 3 forms of emergence and the 2 cases. Results showed a significant association between the case and the form of emergence, $\chi^2(2, N = 586) = 14.91, p \leq .001$. The analysis of adjusted

standardized residuals (referred hereafter as *s.r.*) informed that the PO case exhibited a higher frequency than expected in one form of emergence: IMs produced by the therapist (*s.r.* = 2.8); contrastingly, the GO case exhibited a higher frequency than expected in another form of emergence: IMs prompted by the therapist (*s.r.* = 3.3). The frequencies of the remaining form of emergence—IMs produced by the client—did not show a significant association with the type of case (*s.r.* = 1.7).

Finally, we studied the association between the three forms of emergence and types of IMs. For this analysis, we grouped action, reflection and protest IMs (into a new category, called ARP-IMs) on the one hand and grouped reconceptualization and performing change IMs (into a new category, called RCPC-IMs) on the other hand, to fulfill the requirements of chi-square tests (Field, 2000) and to test if different forms of emergence were related to earlier (i.e., ARP-IMs) and later (i.e., RCPC-IMs) types of IMs (we did not separate the cases in terms of outcome type, for this analysis, since here we were not interested in the outcome type but instead on the types of IMs). This grouping of IMs (into earlier versus later types) is related to the narrative change model, according to the IMs' perspective (see Introduction section above). However, the results from this analysis (between the three forms of emergence and ARP-IMs and RCPC-IMs) showed no significant association, $\chi^2(2, N = 586) = 5.77, p = .06$.

Discussion

This exploratory study analyzing two contrasting cases of narrative therapy for depression shows a developmental profile of IMs that is overall consistent with the previous studies using the IMCS (Alves et al., 2012; Gonçalves et al., 2010, 2011a, 2012; Matos et al., 2009; Mendes et al., 2010, 2011; Ribeiro et al., 2009; Santos et al., 2009). More specifically, the GO case here presented has (a) a higher salience of narrative novelties—or IMs—and also (b) a higher salience of reconceptualization and performing change IMs, both features that have typically differentiated good outcome therapy across different samples and therapeutic models. Therefore, this GO case follows the evolution path presented by the heuristic model of change previously elaborated by Gonçalves and colleagues (see Gonçalves et al., 2009) and the differences between the GO and the PO case are congruent with the previous studies in this domain.

As for the profile of IMs presented by each case, these two cases suggest that reflection IMs may occupy a significant role in these narrative therapy processes, independently of the outcome. This feature contrasts with the profile of IMs found previously in another sample of narrative therapy with women victims of partner violence (Matos et al., 2009) where reconceptualization, protest and performing change IMs were the most salient IMs in GO cases, respec-

tively. Instead, in these two cases, if we look at the salience of the five types, reflection IMs seem to be key to the process. Yet, these differences need to be further explored in future studies, as several explanations may be viable (such as the particular style of this narrative therapist, common to both cases, or the specificities of the clinical diagnosis of depression, among other plausible explanations).

On the topic of IMs' emergence, this study found that each case was related to a specific form of emergence: IMs produced by the therapist appear more associated to the PO case, while IMs prompted by the client appear more related to the GO case. This suggests that the GO case may be characterized by a stronger collaboration between therapist and client, since the therapist may point to novelties, introduce IMs or even ask general questions and the client produces an IM and further elaborates them. In contrast, the PO case is much more associated with IMs produced by the therapist and merely accepted by the client, without further elaboration. This points to the idea that therapeutic collaboration is an important ingredient of a favorable outcome, as suggested by other authors (e.g., Ribeiro, Ribeiro, Gonçalves, Horvath, & Stiles, 2012).

In conclusion, this is the first study in which the categorization of these forms of IM's emergence were applied, but the results suggest that this might be a promising line of further enquiry (through the study of a broader sample of cases), and particularly important to understand how narrative change is co-constructed.

Limitations

First of all, the use of only two cases—one to represent good outcome and another to represent poor outcome—limits the generalizability of the findings. Every time we compare these cases, we are unsure if the findings suggest good versus poor outcome contrasts or are indicate only specificities of the contrast between the single therapy of client 1 and the single therapy of client 2. Thus, future studies should investigate a larger sample of narrative therapy cases, in both outcome groups, to ascertain if the contrasts are maintained in a study of samples with different therapy outcomes. It would be interesting to explore the evolution of particular IMs in other cases of narrative therapy for depression (e.g., looking at the role that reflection IMs might play in this form of therapy) and also to further explore the particular forms of IMs' emergence, which appear related to different therapy outcomes.

Finally, the use of only these categories to differentiate between specific forms of IMs' emergence may be too limited. That is, these three categories may be too narrow to capture different degrees of client and therapist participation in the co-construction of IMs in therapy and also unable to track the subtleties of IMs' emergence in cases of good and poor outcomes. Further studies might help to clarify these matters.

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