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Text Analysis within Quantitative and Qualitative Psychotherapy Process Research: Introduction to Special Issue

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Abstract. The present paper introduces the special issue on Text Analysis in Quantitative and Qualitative Psychotherapy Process Research. The motivation for this special issue grew out of recognition of the following: (1) both quantitative and qualitative psychotherapy process research (PPR) make extensive use of text analysis (TA); (2) TA presents different characteristics that serve different aims in quantitative and qualitative PPR; and (3) researchers are not always fully aware of these differences in explicit and systematic ways. The present paper, together with the special issue it introduces, aims at stimulating a more explicit and systematic methodological reflection on the different ways in which TA may be used in quantitative and qualitative PPR. We first outline the general differences between TA in quantitative and qualitative PPR; then, we describe the extent to which the papers in this special issue illustrate these differences. Finally, we conclude by stressing that PPR may significantly benefit from researchers becoming more fully aware of the differences.

Keywords: psychotherapy process research, text analysis, quantitative methods, qualitative methods

Psychotherapy Process Research (PPR) consists of the scientific investigation of in-therapy processes and can be performed by means of both quantitative and qualitative research approaches (Elliott, 2010; Hill & Lambert, 2004; Lutz & Hill, 2009; Manzo, 2010; Orlinsky, Rønnestad, & Willutzki, 2004; Rice & Greenberg, 1984; see also Gelo, Auletta, & Braakmann, 2010; Gennaro, Venuleo, Auletta, & Salvatore, 2012; for mixed-methods research combining quantitative and qualitative methods, see Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005; see also Gelo, Braakmann, & Benetka, 2008, 2009). This type of research heavily relies on textual material (Greenberg & Pinsof, 1986; Lepper & Riding, 2005), which is defined here as any material having a linguistic and, eventually, a paralinguistic structure. Such material is, in fact, considered to (potentially) carry a substantial amount of meaningful information about the psychotherapeutic process and is usually derived from either therapeutic sessions or ad-hoc interviews, which are usually audio or video recorded and, in most cases, transcribed.

Text analysis (TA) is used to analyze this textual material. TA may be very generally defined as *any set of procedures of inquiry of a text used to draw meaningful information from it with regard to its explicit and/or implicit content, organization, and/or structure*.[1] Within PPR, TA may be approached in several ways and serve different aims, especially in quantitative versus qualitative PPR. Although researchers may (intuitively) acknowledge these differences, they are not always fully aware of them in a systematic and explicit way.

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[1] The term "content analysis" may be used to refer to both the manifest and latent content of a text (Mayring, 2000) or, alternatively, only to the manifest content (Berelson, 1952). Moreover, note that there is a tendency to associate the term with a (post)positivistic approach to TA (see Silverman, 2011).

In a time of "methodological flexibility and systematic pluralism" (Elliott, 1999, p. 252; see also Slife & Gantt, 1999), this lack of awareness may prevent PPR from developing. This paper, together with the special issue it introduces, is a contribution intended to stimulate a methodological reflection on the differences in TA in quantitative and qualitative PPR. We begin by outlining the general differences in TA in quantitative and qualitative PPR, with reference to some specific features; then, we describe the extent to which the papers in this special issue illustrate these differences.

Quantitative vs. qualitative PPR and TA

Quantitative and qualitative PPR are the two main approaches to the empirical investigation of the psychotherapeutic process (Hill & Lambert, 2004; Lutz & Hill, 2009; see also Timulak, 2008). Both require procedures for systematically collecting and analyzing empirical data (i.e., information) on in-therapy processes. However, they differ with regard to several issues. At a pragmatic and procedural level (i.e., the research methods), the main difference between them involves the *nature* (i.e., the symbolic format) of the data that they rely upon to answer the research questions. Quantitative PPR primarily makes use of *numerical* data, which are analyzed by means of statistical analysis, while qualitative PPR makes use of non-numerical *languaged* (Polkinghorne, 2005, p. 317) data, which are analyzed using meaning-based forms of data analysis (Elliott, 1999; Hill & Lambert, 2004; Lutz & Hill, 2009).[2] It is due to these differences that TA presents different characteristics and serves different aims in quantitative and qualitative PPR. These differences are summarized in Table 1.

Within quantitative PPR, TA is used to *collect data* in a numerical format. This is the case when quantitative *observational* data collection instruments are applied by raters to audio/video recordings or transcripts of therapy sessions (see Mergenthaler & Stinson, 1992); in some minor cases, ad-hoc interviews are also used as sources of material (for an overview, see Barker, Pistrang, & Elliott, 2002; Greenberg & Pinsof, 1986; Lepper & Riding, 2005).[3]

Examples of quantitative observational instruments are category systems (e.g. the Core Conflictual Relationship Theme [Luborsky et al., 1994], the Verbal Response Modes [Elliott et al., 1987], the Collaborative Interactions Scale [Colli & Lingiardi, 2007, 2009]), rating scales (e.g. the Defense Mechanism Rating Scale [Perry, 1990], the Comparative Psychotherapy Process Scale [Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005], the Assimilation of Problematic Experiences Scale [Stiles et al., 1990]), Q-sort techniques (e.g. the Psychotherapy Process Q-Sort [Ablon, Levy, & Smith-Hansen, 2011; Jones, 2000; Lingiardi, Bonalume, Colli, Gentile, & Tanzilli, 2011]), and other types of coding systems (e.g. the Adult Attachment Interview [Main, Hesse, & Goldwyn, 2008]).[4] These and some other examples of observational instruments used in quantitative PPR are reported in Table 1.

These instruments allow for the assessment of the investigated text with regard to a limited set of previously defined theoretical constructs (i.e., relational patterns, response modes, defenses, metacognitive functions, etc.), thus adopting a *theory-driven* approach to TA. Thus, each of these instruments specifies both the construct (i.e., category) assessed in the text (e.g., different relational patterns, defenses, etc.) and the textual characteristic that may indicate the presence of the construct. The TA involved in the application of these instruments is mainly focused on the speech *content*, although some other aspects of *textual organization* (e.g., speech coherence) may be considered (e.g., in the case of the AAI). The categories are explicitly defined, usually in a manual, and text passages prototypical of those categories are provided as examples to "guide" the rater in the application of the instrument. Then, the eventual presence of a construct in the text is coded by the rater on a dichotomous, nominal, or Likert scale.

Finally, specific procedures of inter-rater reliability are applied, in which codings by different raters are compared by numerically calculating the degree of agreement among them (Hill & Lambert, 2004). This type of TA represents a standardized version of what has been described as *deductive content analysis* (Elo & Kyngäs, 2008; Mayring, 2000; see also Berelson, 1952). The ratings provided by the raters will constitute the numerical data that will be then used in the statistical analysis to answer the research questions of the study (see Pokorny, Gelo, & Moertl, in prep.; see the special issue of Lutz & Lambert, 2009, for some examples of the most recent

[2] Actually, the difference between quantitative and qualitative approaches in psychotherapy research goes beyond the *research methods*; it also involves the *methodological principles* underlining these methods and the *worldviews* grounding them. We direct the reader to Ponterotto (2005) for a more general discussion of these issues in the field of psychotherapy research (see also Gelo, 2012 and Polkhingorne, 1983, for a similar discussion regarding the general social sciences).

[3] Another main way to collect numerical data in quantitative PPR is through the use of quantitative self-reports, in which subjects directly provide their responses by rating items on a scale (e.g., the Working Alliance Inventory [Horvath & Greenberg, 1989], Session Reports [Orlinsky & Howard, 1986]).

[4] Strictly speaking, attachment as assessed by the Adult Attachment Interview (AAI) is more of an input or output variable than a process variable (see Orlinsky et al., 2004). However, considering the relevance that attachment may have for the therapeutic process (e.g., Steele, Steele, & Murphy, 2009), we decided to consider the AAI as an instrument ascribable to (quantitative) PPR.

Table 1. Some common features distinguishing between TA in quantitative and qualitative PPR

Feature	TA in quantitative PPR	TA in qualitative PPR
Scope	Data collection	Data analysis
Focus and examples of methods	*Speech content* Core Conflictual Relationship Themes (Luborsky et al., 1994)[a] Verbal Response Modes (Elliott et al., 1987)[a] Structural Analysis of Social behavior (Benjamin et al., 2006)[a] Generic Change Indicators (Krause et al., 2007)[a] Innovative Moments Coding System (Gonçalves et al., 2009)[a] Dynamic Mapping of the Structures of Content (Salvatore et al., 2012)[a] Therapeutic Activity Coding System (Valdés et al., 2010)[a] Narrative Process Coding system (Angus et al., 1999)[a] Grid of the Models of Interpretation (Auletta et al., 2012)[a] Assessment of Interpersonal Motivation in Transcripts (Fassone et al., 2012)[a] Defense Mechanisms Rating Scale (Perry, 1990)[b] Metacognition Assessment Scale (Semerari et al., 2003)[b] Comparative Psychotherapy Process Scale (Hilsenroth et al., 2005)[b] Comprehensive Psychotherapy Intervention Rating Scale (Trijsburg et al., 2002)[b] Motivational Areas Rating Scale (Sarracino & Dazzi, 2007) Collaborative Interactions Scale (Colli & Lingiardi, 2009)[b] Referential Activity (Bucci et al., 1992)[b] Assimilation of Problematic Experiences Scale (Stiles et al., 1990)[b] Psychotherapy Process Q-Sort (2000)[c] Adult Attachment Interview (Main et al., 2008)[d] *Speech organization* Assessment of Interpersonal Motivation in Transcripts (Fassone et al., 2012)[a] Adult Attachment Interview (Main et al., 2008)[d]	*Participants' subjective experiences* Grounded Theory Analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998) Phenomenological Analysis (Giorgi, 2009; Smith, 1996) Narrative Analysis (Avdi & Georgaca, 2007a) Biographical Analysis (Riemann & Schuetze, 1991) Consensual Qualitative Research (Hill et al., 1997) Thematic Analysis (Braun & Clarke, 2006) Inductive Content Analysis (Mayring, 2000) *Pragmatics, functions or structure of language-in-use* Conversation Analysis (Madill, 2001) Discourse Analysis (Avdi & Georgaca, 2007b) *Clinical processes* Task Analysis (discovery phase) (Greenberg, 2007) Comprehensive Process Analysis (Elliott, 1989) Assimilation Analysis (Stiles et al., 1992) Metaphor Analysis (Buchholz, 1993)
Strategy of analysis	Theory-driven, top-down	Data-driven/theory-informed, cyclical
Logical operations involved	Deduction	Eduction, abduction, induction, deduction
Type and amount of categories worked with	Preset, limited	Emergent, variable
Quality criteria	Inter-rater reliability (Cohen's *K*, ICC)[d]	Demonstrative rhetoric (use of examples) Consensus (group discussion, peer review, audit, debriefing)
Prototypical reference	Deductive content analysis	Methodical hermeneutics

Note. TA = text analysis. PPR = psychotherapy process research. ICC = intra-class correlation.
[a] Category system. [b] Rating scale. [c] Q-sort technique. [d] Coding system.

advancements).[5]

On the other hand, in qualitative PPR, TA represents the core of the *data analysis* process that is necessary for answering the research questions of the study. In fact, in this type of PPR, data are already collected in a languaged format by recording therapy sessions (see Mergenthaler & Stinson, 1992; Sack, Schegloff, & Jefferson, 1974) and/or through ad-hoc interviews (see Knox & Burkard, 2009). In some cases, audio/video assisted recall procedures are used in combination with interviews, as in Interpersonal Process Recall (IPR; Elliott, 1986; for an overview, see Barker et al., 2002; Blasi, 2010; Elliott, Slatick, & Urman, 2001). Three main types of TA may be used within qualitative PPR (see Rennie, 2012; for an overview, see Frommer & Rennie, 2001; Madill & Gough, 2008; Mcleod, 2011; Moertl, Gelo, & Pokorny, in prep.): *experiential* TA, which focuses on the subjective experiences of the participants; *discursive* TA, focusing on the pragmatics, functions or structure of the language-in-use; and *experiential/discursive* TA, entailing focus on either the experience or the discourse with the aim of a clinically meaningful analysis of one or more cases. Examples of experiential TA are Grounded Theory Analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998), Descriptive and Interpretative Phenomenological Analysis (Giorgi, 2009; Smith, 1996), Narrative Analysis (Avdi & Georgaca, 2007a; McLeod & Balmoutsou, 2006), Biographical Analysis (Riemann & Schuetze, 1991),[6] Consensual Qualitative Research methods (Hill, Thompson, & Williams, 1997) and, to some extent, Inductive Content Analysis (Elo & Kyngäs, 2008; Mayring, 2000) and Thematic Analysis (Braun & Clarke, 2006).[7] Examples of discursive TA are Conversation Analysis (Lepper, 2000; Madill, 2001; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008) and Discourse Analysis (Avdi & Georgaca, 2007b). Examples of experiential/discursive TA are the discovery phase of Task Analysis (Greenberg, 2007), Comprehensive Process Analysis (Elliott, 1989), Assimilation Analysis (Stiles, Meshot, Anderson, & Sloan, 1992)[8] and Systematic Metaphor Analysis (Buchholz, 1993; Schmitt, 2005; for a slightly different approach, see Gelo & Mergenthaler, 2012).

The interpretation required to conduct this type of TA goes far beyond what is required to deductively apply a standardized set of categories to a text, as in the case in quantitative PPR. In fact, TA used in qualitative PPR involve a much deeper and more thorough *cyclical interaction* between the analyzer and the text (see hermeneutic circle; Dilthey, 1996). Within this process, eduction (Rennie, 2012) and abduction (Haig, 2005, 2008; Salvatore & Valsiner, 2010) cyclically interact with induction and deduction, and a variable number of *emergent* patterns of experience, language use, or clinically significant processes may be identified within the text under analysis. Finally, the trustworthiness or credibility of the analysis (see Elliott, Fischer, & Rennie, 1999; Nutt, Williams, & Morrow, 2009) is, in many cases, demonstrated rhetorically (Rennie, 2012). That is, the researcher conducting the TA grounds his or her arguments for the identification of specific textual patterns (of experience, language use, or clinical process) on the discussion of typical examples that are persuasive. In some other cases, a greater emphasis may be placed upon intersubjective interpretative agreement, which is achieved by means of group discussions and, eventually, external audits, peer reviews, and debriefing. The features of TA found in qualitative PPR are consistent with what Rennie (2012) calls *methodical hermeneutics*.

TA in quantitative PPR: Narrative processes, innovative moments, communicative intentions, and attachment

The first four contributions of this special issue illustrate quantitative approaches to PPR making use of TA; the commonalities and the differences between them are summarized in Table 2. Each of these papers is characterized by a specific topic. Angus et al. (2012) review the application of the Narrative Process Coding System (NPCS) to emotion-focused therapy for depression and show how this allowed investigating the relationship between different narrative modalities, in-session process variables, and treatment outcomes. Cunha, Spínola, and Gonçalves (2012) make use of the Innovative Moments Coding System (IMCS) to assess, in both good and poor outcome cases of narrative therapy for depression, different types of Innovative Moments (IMs), as well as different modalities of their emergence. Associations between these variables and differences in the two cases are analyzed. Dagnino, Krause, Pérez, Valdés, and Tomicic (2012) apply the Therapeutic Activity Coding System (TACS) to assess different types of clients' and therapists' communicative intentions during change

[5] Computer-assisted TA procedures may also be used to collect numerical data within quantitative PPR (e.g., the Therapeutic Cycle Model [Mergenthaler, 1996, 2008], the Referential Activity [Bucci & Maskit, 2006; Mergenthaler & Bucci, 1999], and the Automated Co-occurrence Analysis for Semantic Mapping [Salvatore, Gennaro, Auletta, Tonti, & Nitti, 2011]). Although these procedures may share some of the features of TA described so far, they present high degrees of specificity. For this reason, we decided to exclude them from consideration in this special issue.

[6] The biography of a subject is not necessarily related to treatment in-session processes. However, considering the potential mutual interconnections that can occur between a life trajectory and in-session processes, we decided to consider Biographical Analysis a method ascribable to (qualitative) PPR.

[7] Unlike Rennie (2012), we consider Thematic Analysis an experiential type of TA. However, we acknowledge that the subjective experience that can be depicted and reconstructed through Thematic Analysis is rather superficial compared to other experiential methods.

[8] Assimilation Analysis is usually used to identify the client's *voices* as a preliminary step to the application of the APES (Osatuke & Stiles, 2011).

Table 2. Summary of features of special issue articles

Article	Topic	Data collection	Data analysis	Method of TA	Focus of TA	Strategy of TA	Logical operations involved	Type and amount of categories	Quality criteria of TA
Angus et al. (2012)[a]	Overview of NPCS	Sessions (video recording)+TA	Statistics (regression analyses)	NPCS	Narrative processes	Theory-driven, top-down	Deduction	Preset; 3[b]	Cohen's *K*
Cuhna et al. (2012)[a]	Application of IMCS	Sessions (trans-cription)+TA	Statistics (Chi-squared)	IMCS	Emergence of IMs	Theory-driven, top-down	Deduction	Preset; 5+3[c]	Cohen's *K*
Dagnino et al. (2012)[a]	Application of TACS	Sessions (trans-cription)+TA	Statistics (logistic regression analysis)	TACS	Communicative intentions during change processes	Theory-driven, top-down	Deduction	Preset; 3[d]	Cohen's *K*
Kriss et al. (2012)[a]	Overview of FFI	FFI Interview (transcription)	Not used	FFI scoring system		Theory-driven, top-down	Deduction	Preset; 3+4[e]	Cohen's *K*, ICC
Dourdouma & Mörtl (2012)[f]	Overview of Grounded Theory Analysis	Change Interview (transcription)	TA	Grounded Theory Analysis	Experience of therapeutic change	Data-driven/theory-informed, cyclical	Eduction, abduction, deduction, induction	Emergent; 1[g, h]	Discussion with supervisor
Heine et al. (2012)[f]	Application of Biographical Analysis	Autobiographical Narrative Interview (transcription)	TA	Biographical analysis	Trajectory of suffering	Data-driven/theory-informed, cyclical	Eduction, abduction, deduction, induction	Emergent; 6[g, i]	Peer review
Muntigl et al. (2012)[f]	Overview of Conversation Analysis	Sessions (transcription)	TA	Conversation analysis	Linguistic and paralinguistic realizations of attitudinal stance and affiliation	Data-driven/theory-informed, cyclical	Eduction, abduction, deduction, induction	Emergent; 3[g, l]	Demonstrative rhetoric

Note. TA = textual analysis. NPCS = Narrative Process Coding System. IMCS = Innovative Moments Coding System. IM = Innovative moment. TACS = Therapeutic Activity Coding System. FFI = Friends and Family Interview.

[a] Quantitative approach to psychotherapy process research. [b] 1) "External narrative processes", 2) "Internal narrative processes", and 3) "Reflexive narrative processes". [c] 1) "Action IMs", 2) "Reflection IMs", 3) "Protest IMs", 4) "Reconceptualization IMs", and 5) "Performing change IMs"; 1) "IMs produced by the therapist", 2) "IMs prompted by the therapist", and 3) "IMs produced by the client". [d] 1) "Exploring", 2) "Attuning", and 3) "Resignifying". [e] 1) "Internal working models", 2) "Reflective functioning", and 3) "Coherence"; 1) "Secure attachment", 2) "Dismissive attachment", 3) "Preoccupied attachment", and 4) "Disorganized attachment". [f] Qualitative approach to psychotherapy process research. [g] In this kind of TA, the amount of categories involved in the analysis varies across the different steps involved in the analysis. Here we indicate the amount of categories representing the final step (results) of the analysis. [h] "The experience of therapeutic change, under the secure frame of therapy, is a process of deconstructing and reconstructing the house you live in: Yourself". [i] 1) "Personal meaningful nourishments", 2) "Challenging experience with significant others", 3) "Courage to persevere", 4) "Family support", 5) "Dramatic family events", and 6) "Dreams". [l] 1) "Scripting experience", 2) "Stories of agency and positive affect", and 3) "Client disaffiliation: achieving re-affiliation with a contrasting stance".

episodes in psychotherapies with different orientations. Differences between clients' and therapists' communicative intentions, as well as their temporal courses, are analyzed. Finally, Kriss, Steele, and Steele (2012) introduce the Family and Friends Interview (FFI), which represents both a semi-structured interview protocol to collect attachment-relevant information and a rating system assessing attachment in middle and late childhood. The authors describe the theoretical background of the FFI and the methodology of rating.

Notwithstanding these differences, these four papers share many commonalities. They all use TA in their quantitative *data collection*, which is performed either by means of a category system (NPCS, IMCS, or TACS) applied to the audio recordings (Angus et al., 2012) or transcripts (Cunha et al., 2012; Dagnino et al., 2012) of sessions or by means of a rating scale (FFI) applied to transcripts of ad-hoc interviews (Kriss at al., 2012). The data collected in this way are then analyzed, using either parametric or non-parametric statistics, to answer the research questions addressed in each paper. The only exception is the paper by Kriss et al. (2012), which focused on the theoretical background and rating procedure of the FFI without reference to the statistics that might be used with the scores obtained from the application of the instrument (for the application of statistics to relate attachment-relevant variables to in-process variables, see, for example, Saypol & Farber, 2010).

Moreover, all of the instruments presented or applied in these four contributions follow a *theory-driven*, top-down approach to TA, which consists, in the *deductive* application of a previously defined and limited number of categories to be rated on nominal (Angus et al., 2012; Cuhna et al., 2012; Dagnino et al., 2012) and/or Likert (Kriss et al., 2012) scale(s). Finally, the reliability of the TA is assessed using numerical coefficients. In the case of nominal ratings (such as on the NPCS, IMCS, TACS, and part of the FFI), Cohen's (1960) kappa is used (Angus et al., 2012; Cuhna et al., 2012; Dagnino et al., 2012; Kriss et al., 2012), while the intra-class correlation coefficient (Shrout & Fleiss, 1979) is used for Likert scale ratings (as on part of the FFI; Kriss et al., 2012).

TA in qualitative PPR: Experience of therapeutic change, trajectories of suffering, and attitudinal stance and affiliation

The last three contributions of this special issue illustrate TA employed in qualitative PPR. Table 2 summarizes the commonalities and the differences among them. Each of these papers is characterized by a specific topic. Dourdouma and Mörtl (2012) provide a methodological overview of Grounded Theory Analysis, along with a set of guidelines for its application; concrete examples are given, with reference to the investigation of the experience of change in clients who have undergone systemic family therapy. Heine, Schütze, Köhler, and Frommer (2012) make use of Biographical Analysis to investigate the trajectory of suffering among leukemia survivors and identify different modalities of coping with it. Finally, Muntigl, Knight, Horvath, and Watkins (2012) provide an overview of one specific approach to Conversation Analysis for the investigation of client attitudinal stance and therapist-client affiliation. Excerpts from couples therapy and from one individual therapy case with a depressed client are analyzed to provide examples of the application of this method.

Notwithstanding these differences, these three papers share many commonalities that clearly distinguish them from those presented in the previous section. First of all, TA here represents the procedure of *data analysis*, which is necessary to answer the research questions of each study; the languaged data are collected by transcribing ad-hoc interviews (Dourdouma & Mörtl, 2012; Heine et al., 2012) or therapy sessions (Muntigl et al., 2012).

Moreover, all of the different methodologies presented or applied in these three contributions follow a *data-driven/theory-informed* approach to TA, in which eduction, abduction, deduction, and induction interact differently with each other. This allows the researcher(s) to identify variable numbers of emergent patterns regarding clients' experiences of therapeutic change (Dourdouma & Mörtl, 2012), autobiographical trajectories of suffering and the related coping strategies (Heine et al., 2012), and/or linguistic and paralinguistic realizations of attitudinal stance and affiliation (Muntigl, 2012). Finally, the credibility of the analyses is supported, whether by means of regular discussions with a supervisor (Dourdouma & Mörtl, 2012) or research team (Heine et al., 2012) or by means of demonstrative rhetoric (Muntigl et al., 2012).

Conclusion

To investigate in-session psychotherapeutic processes, both quantitative and qualitative PPR make extensive use of TA. Taken together, the papers reviewed in this special issue display the extent to which TA may be differently used in each of these two empirical approaches to PPR. We believe that being explicitly and systematically aware of these differences can significantly contribute to the further development of methodological flexibility and pluralism and that PPR will benefit from such awareness. In agreement with Lutz and Hill (2009, p. 372), we hope that this special issue will stimulate not only better PPR by means of TA but also more research on TA itself.

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Narrative Processes Coding System: A Dialectical Constructivist Approach to Assessing Client Change Processes in Emotion-Focused Therapy of Depression

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Abstract. Drawing on a Dialectical Constructivist model of therapeutic change, this paper addresses the fundamental contributions of client narrative disclosure, emotional differentiation and reflexive meaning-making processes in emotion-focused treatments of depression. An overview of the multi-methodological steps undertaken to empirically investigate the contributions of client storytelling, emotional differentiation, and meaning-making processes, using the Narrative Processes Coding System (NPCS; Angus et al., 1999) are provided, followed by a summary of key research findings that informed the development of a narrative-informed approach to emotion-focused therapy of depression (Angus & Greenberg, 2011). Finally, therapy practice implications for the adoption of a research-informed approach to working with narrative and emotion processes in emotion-focused therapy are described and future research directions discussed.

Keywords: narrative processes, process-outcome research, emotion-focused therapy

As Strupp and Binder (1984) suggest, client storytelling is a central focus of psychological activity, structure, and organization in psychotherapy. Drawing on a Dialectical Constructivist model of therapeutic change, Angus and Greenberg (2011) further note that the reflexive construction of new personal meanings also involves the narrative organization and articulation of client emotional experiences in productive emotion-focused therapy (EFT) sessions. In this paper, we first provide a brief overview of Angus and Greenberg's (2011) Dialectical Constructivist model of therapeutic change that highlights the contributions of narrative and emotion processes for productive meaning-making construction, and efficacious treatment outcomes, in EFT of depression. Next, through the development and application of the Narrative Processes Coding System (NPCS; Angus, 2012), we describe the methodological steps undertaken to investigate the contributions of client storytelling, emotional differentiation and meaning-making processes in EFT of depression (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004). A summary of key research findings emerging from this Narrative Process Coding System research program are discussed in terms of (a) providing empirical support for a Dialectical Constructivist model of client change and (b) informing the development of a narrative-informed approach to EFT of Depression (Angus & Greenberg, 2011). Finally, we identify directions for future psychotherapy research that include the recent development of a Narrative-Emotion Process Coding System (NEPCS; Boritz, Bryntwick, Angus, Carpenter, & Greenberg, 2012), for application to psychotherapy session videotapes.

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A Dialectical Constructivist model of narrative, emotion and meaning-making processes in EFT of depression

In the context of their Dialectical Constructivist approach to facilitating client change processes in EFT of depression, Angus and Greenberg (2011)

argue that client narrative expression is foundational for the elaboration of emotional meaning-making and the emergence of new self-understanding in EFT of depression. As noted by Bruner (2004), when we become narrators of our own stories, we produce a selfhood that can be shared with others that permits us to look back selectively to our past and shape possibilities for an imagined future. Importantly, it is in the act of articulating a situated point of view, in relation to actions and events, that storytelling gives expression to human agency and self-identity.

Consistent with Damasio's (1999) contention that the first impetus to story a lived experience is the awareness of an inner bodily felt feeling, Angus and Greenberg (2011) argue that it is often the expression of an emotional feeling that is a key indicator of the personal significance of a story. Furthermore, they note that it is the narrative scaffolding of emotional experiences that provides a framework for the organization and integration of felt emotions with unfolding action sequences. For Angus and Greenberg (2011), core emotional experiences such as pain, hurt, sadness or loving compassion need to be situated and symbolized in the context of personal stories so that important information about a client's needs and goals, and the personal meaning of what happened, can be further articulated and understood. As such, emotion-focused therapists are encouraged to help clients vividly experience bodily felt emotions, in the present moment of a session, through the disclosure of emotionally salient personal stories and/or participation in EFT role play interventions.

Within the context of their Dialectical Constructivist model of emotion, narrative and meaning-making process in EFT of depression (Angus & Greenberg, 2011), the meaning of an emotion is understood when it can be organized within a narrative framework that identifies what is felt, about whom, in relation to a specific need or issue. As such, the reflexive processing and symbolization of clients' emotional experiences, in the context of salient personal stories, is viewed as a key intervention strategy that enables clients to meaningfully integrate their narrative and emotional lives, as a vehicle for therapeutic change.

The contributions of narrative and emotion processes for the development of heightened client reflection in psychotherapy has been increasingly addressed (Bucci, 1995; Mergenthaler, 2008; Salvatore, Gennaro, Auletta, Tonti, & Nitti, 2012; Santos, Goncalves, Matos, & Salvatore, 2009) in the psychotherapy research literature. More specifically, Angus, Hardtke and Levitt co-developed the Narrative Processes Coding System (Angus, Levitt, & Hardtke, 1999) in order to empirically assess the specific contributions of personal storytelling, meaning-making and emotion processes for treatment outcomes in EFT of depression (Greenberg & Angus, 2004; Angus & Greenberg, 2011).

Narrative Processes Coding System (NPCS): Assessing narrative, emotion and meaning-making modes in EFT of depression

The Narrative Processes Coding System (NPCS; Angus, Hardtke, & Levitt, 1996) entails a two-step procedure that enables researchers to: (1) reliably subdivide and characterize therapy session transcripts into Topic Segments according to content shifts in verbal dialogue; and then (2) further subdivide and characterize identified Topic Segments in terms of one of three Dialectical Constructivist process modes: (a) *External* sequences that include the disclosure of personal stories (past, present, and/or future; actual or imagined); (b) *Internal* sequences that includes descriptions of bodily felt feelings and emotions; and (c) *Reflexive* sequences that entail recursive questioning and meaning-making processes in relation to reflection on core beliefs, actions, emotions and personal stories.

Step 1: Identification of Topic Segments

The first stage of the NPCS procedures enables trained raters to reliably subdivide therapy session transcripts into Topic Segments according to content shifts in the verbal exchange between client and therapist. For research purposes, the initiator of each Topic Segment is identified and each segment is required to be at least ten transcript lines in length. The transcript line length criteria was established to ensure that additional coding measures could be applied to Topic Segments to evaluate the depth and quality of narrative, emotion or meaning-making processes within and across topic segments (Levitt & Angus, 2000).

Once identified, each Topic Segment is characterized in terms of a key issue and relationship focus. When identifying key issue, raters try to provide a gist of the therapy session discourse that uses the client's and/or therapist's own words. Relationship focus reflects the primary relationship that is addressed in the topic segment as demonstrated in the example below.

> Topic Segment Relational Focus—self in relation to mother. Topic Segment Key issue: "so helpless and scary"—emotional impact of childhood memory.
>
> C: I remember once, coming home from school and finding her sitting in a chair in the living room, staring out the window and just refusing to talk, to my dad, to my sister, to anyone [...] she didn't talk for 3 days and it was so hard being around her [...] not knowing what was on her mind or what she was planning to do [...] I just didn't know what to say or do.
>
> T: and that was distressing for you? Just not knowing "what can I do?" What was that like for you [...] living with that feeling? Can you tell me a bit more about the feeling you are experiencing now?
>
> C: it was like stepping on eggshells [...] always feeling afraid that she was going to do something to hurt herself [...] so helpless and scary like there is nothing I could ever do to make a difference (Angus, 2012, p. 4).

Step 2: Identification of External, Internal and Reflexive sequence subtypes

Next, raters code each identified Topic Segment for the presence or absence of three narrative process sequence subtypes—External, Internal and Reflexive—that correspond to storytelling, emotion and meaning-making process modes identified by Angus and Greenberg (2011) in their Dialectical Constructivist model of client change in EFT.

External narrative sequences. It is crucial that clients remember emotionally-salient events in order to fill in the gaps in the narrative that may have been forgotten or never fully acknowledged and therefore not understood (Angus et al., 1999). This therapeutic process is represented by External narrative sequences that address the question of "what happened?" (Angus & Hardtke, 1994). An External narrative sequence may entail a description of either a specific event, a general description of many repeated similar events or a composite of many specific events (Angus et al., 1996). Angus and Kagan (2007) point out that the more a client can describe emotionally-salient, personal stories in a detailed and descriptive manner, the more opportunity a therapist has to develop an imagistic rendering of that experience and to empathically adopt the internal frame of the client. Additionally, a growing number of psychotherapy researchers and practitioners (Angus & Greenberg, 2011; Bucci, 1995; Salovey & Singer, 1993; Borkovec & Roemer, 1995) have pointed out that the articulation of a detailed description of a specific personal memory often provides the client with an opportunity to more fully access emotions and thoughts experienced in the context of a past event.

A growing number of developmental (Stern, 1985) and personality researchers (Epstein, 1984; Janoff-Bulman, 1992; Salovey & Singer, 1993) also suggest that key episodic memories may function as core emotion schemes (Angus & Greenberg, 2011) that shape the development of a client's self-identity narrative. Accordingly, in the context of their dialectical constructivist model, Angus and Greenberg (2011) suggest that accessing and reflecting on clients' core emotion schemes is an important therapeutic task for heightened emotion and narrative integration and meaning-making in effective EFT sessions. For instance, they suggest that emotion-focused therapists can intentionally shift clients into an External narrative sequence by asking the client to provide a detailed concrete description of an important life event in order to facilitate a re-experiencing, rather than a retelling, of personal stories in therapy sessions.

In terms of the Narrative Process Coding System method, External narrative sequences address the question of "what happened to me?" and may entail information sharing or, as is more often the case, disclosures of personal stories that become the focus for heightened self-reflection and further emotional elaboration in therapy sessions. Drawing on the Topic Segment presented earlier, the following text would be identified as an External sequence:

> C: I remember once, coming home from school and finding her sitting in a chair in the living room, staring out the window and just refusing to talk, to my dad, to my sister, to anyone [...] she didn't talk for three days.

Internal narrative process sequences. Clients also need to be fully engaged in the lived experience of an event in order to bring to awareness, and fully articulate, tacit feelings and emotions. This is achieved by both the therapist and client engaging in the detailed unfolding and exploration of associated sensations and emotions, which can emerge in the re-telling of an autobiographical memory. An Internal narrative process mode addresses the question of what was felt by a client in the context of disclosing a personal story to his or her therapist. The function of client Internal narrative sequences is to share with the therapist his/her re-experienced feelings and emotions that are associated with the retelling of a particular event (External narrative sequence) or, to articulate newly emerging feelings and emotions occurring during the therapy hour (Angus et al., 1999).

In the context of dealing with physical and psychological trauma, there are compelling research findings which demonstrate that emotional disclosure in the context of trauma narratives is predictive of positive immunological and psychological effects for survivors (Pennebaker, 1995). And, while a growing consensus of psychotherapy researchers (Greenberg, Rice, & Elliot, 1993; Greenberg & Safran, 1987; Mahoney, 1991) are recognizing the importance of emotional disclosure as a basis for the generation of new personal meanings and self-narrative change, psychotherapy approaches differ to the extent to which they prioritize the description of what was experienced in the past versus focussing on the processing of emotion schemes emerging in the session.

For instance, Angus and Greenberg (2011) argue that the more evocative and descriptive a client can be regarding his or her experiencing during a session, the greater the opportunity an EFT therapist has to empathically resonate with and attune to the client's feeling state. Additionally, in the context of Internal narrative sequences, metaphors have been found to help deepen client experiencing during EFT sessions (Levitt, Korman, Angus, & Hardtke, 1997; Levitt, Korman, & Angus, 2000) and contribute to the development of a shared context of understanding, between client and therapist (Angus & Rennie, 1988, 1989).

In summary, Internal narrative sequences address the question of "what am I feeling?" and entail the symbolization of affective responses that often signal the personal significance of the story for the client. The following transcript example selected from the Topic Segment presented earlier in this paper

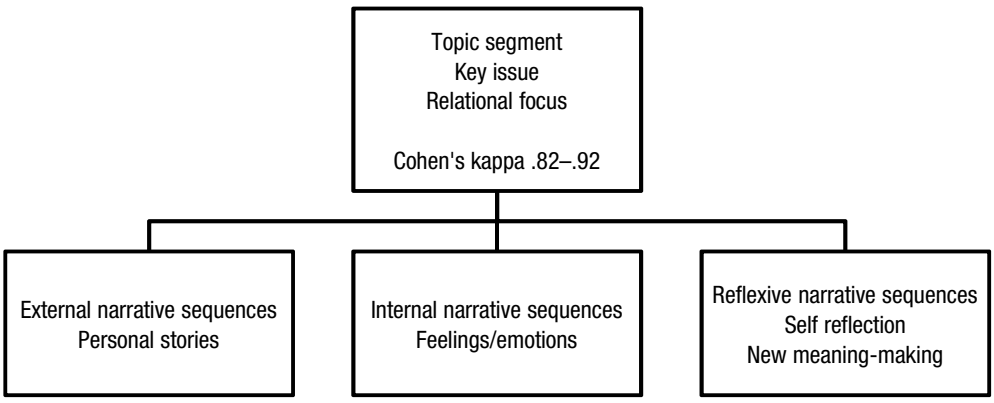

Figure 1. Narrative process coding system (NPCS; Angus, Levitt, & Hardtke, 1999).

would be identified as an Internal narrative sequence:

> C: it was like stepping on eggshells [...] always feeling afraid that she was going to do something to hurt herself [...] so helpless and scary like that there was nothing I could ever do to make a difference.

Reflexive narrative process sequences. Angus and Greenberg (2011) suggest that it is clients' reflexive analyses of salient personal stories and the emotional experiences they evoke, that often leads to the construction of new meanings and perspectives on situations and self-identity reconstruction in EFT of depression. As such, it is in the context of the Reflexive narrative mode that clients' are likely to explore personal expectations, needs, motivations, anticipations, and beliefs in order to make meaning of their personal stories. Citing findings from Pennebaker's (1995) work with trauma survivors, Greenberg and Angus (2004) argue that reflexive elaboration and meaning creation is an important therapeutic consequence of client emotional expression emerging from the disclosure of painful personal stories and the description of traumatic events.

Reflexive narrative sequences address the question of "what does this mean to me now?," and entail heightened reflection on intentions, beliefs, goals, feelings and actions that further facilitates client engagement in productive meaning-making, emotional transformation and story reconstruction—narrative change—in EFT sessions. The following transcript, identified in the Topic Segment present earlier, provides an example of a Reflexive narrative sequence:

> C: and it was so hard being around her [...] not knowing what was on her mind or what she was planning to do [...] I just didn't know what to say or do.
> T: and that was distressing for you? Just not knowing "what can I do?" Can you tell me a bit more about the feeling you are experiencing now?

In summary, the Narrative Process Coding System (Angus et al., 1996; Angus et al., 1999) is designed to code interactional transcript segments which can include both client and therapist discourse. In terms of Kiesler's (1973) classification of psychotherapy process measures, the NPCS can be described as a nominal method for the categorization of psycholinguistic dimensions of the therapeutic interaction. Given that the entire therapy session transcript (summary unit) is used for the identification of topic segments (contextual units) and narrative sequences (scoring units), the NPCS can also be characterized as a comprehensive categorization method. As such, the NPCS provides a comprehensive method for the identification of the three key processing modes—client storytelling, emotional expression and meaning-making—identified by Angus and Greenberg (2011) in their Dialectical Constructivist approach to working with depression in EFT.

The starting point for the empirical investigation of client storytelling, emotional differentiation and reflexive meaning-making process in EFT of depression began with the intensive analyses of Narrative Process Coding System patterns evidenced in EFT sessions drawn from three recovered and three unchanged clients selected from the York I Depression study (Greenberg & Watson, 1998). Once transcribed, all 96 therapy sessions were coded using the Narrative Process Coding System (Angus et al., 1996) wherein good levels of inter rater agreement (Angus et al., 1999; Angus et al., 2004) were established for both the identification of topic segments and narrative process mode subtypes: External, Internal and Reflexive (see figure 1).

External narrative sequence analyses: Contributions of personal story disclosure in EFT of depression

In terms of descriptive research findings, Angus et al. (2004) report that 74% of all External narrative sequences identified in EFT therapy sessions entailed the disclosure of an autobiographical memory narra-

tive or personal story (Angus et al., 2004). Stated another way, on average, clients disclosed four to six personal stories to their emotion-focused therapists during therapy sessions. Angus et al. (2004) also found that, irrespective of treatment outcome, at least 50% of all narrative process sequence shifts identified in EFT sessions involved movement from story disclosure (External narrative sequence) to personal meaning-making (Reflexive narrative sequence). This story-focused meaning-making pattern typically started with a client's disclosure of a personal story (External narrative sequence).

> C: I remember once, coming home from school and finding her sitting in a chair in the living room, staring out the window and just refusing to talk, to my dad, to my sister, to anyone [...] she didn't talk for three days [followed by a shift to a meaning-making mode (Reflexive narrative sequence)] and it was so hard being around her [...] I just didn't know what to say or do.

To further understand the unique contributions of External narrative sequences to differential treatment outcomes in the York I Depression Study, the relationship between External narrative sequence subtypes and overall treatment outcomes (Boritz, Angus, Monette, & Hollis-Walker, 2008), was investigated in the full York I Depression sample. While previous research studies had established a link between over-general memory recall and symptoms of depression (Williams et al., 2007), no study to date had examined the degree of client autobiographical memory specificity expressed during therapy sessions and level of depression at therapy termination. The transcript sample for this study consisted of External narrative sequences selected from two early, two middle and two late phase sessions that had been rated using the Narrative Processes Coding System (Angus et al., 1996). All External narrative sequences that met criteria as a personal autobiographical memory were further assessed for degree of narrative specificity—single event, generic or eventless (Singer & Moffit, 1992). Good levels of inter rater reliability were established for both the identification of External narrative sequences and narrative specificity subtypes (Boritz et al., 2008).

In order to investigate the relationship between narrative specificity and pre-post change in level of depression at treatment outcome, a multi-level regression analysis was performed using the proportions of narrative specificity subtypes (single-event, generic, extended) identified in External narrative sequences as the dependent variable and stage of therapy (early, middle, late) as the independent variable, with random intercepts for sessions within dyads. Level of depression was assessed using the Beck Depression Inventory (Beck, Steer, & Garbin, 1988). As reported by Boritz et al. (2008), a significant increase in the degree of narrative specificity was evidenced from middle to late, and from early to late stages of therapy for the sample as a whole, while no significant differences were established for non-depressed vs. depressed clients at treatment termination.

Based on evidence in the research literature proposing a strong link between over-general narrative disclosure and emotional avoidance in clinical samples (Williams et al., 2007), Boritz, Angus, Monette, Hollis-Walker and Warwar (2011) decided to investigate the relationship between expressed emotional arousal (Warwar & Greenberg, 1999), and degree of narrative specificity (Boritz et al., 2008) identified in the context of External narrative sequences. Multilevel mixed, regression analyses showed a significant positive relationship between higher levels of expressed emotional arousal and narrative specificity for EFT clients who were no longer depressed at therapy termination. In contrast, a non-significant, negative relationship between expressed arousal and narrative specificity was established for EFT clients who remained clinically depressed at therapy termination (Boritz et al., 2011).

Taken as a whole, the study results suggest that EFT clients who recovered from Depression by therapy termination were significantly more likely to emotionally express their feelings in the context of specific autobiographical memory narratives (External sequences), than EFT clients who remained depressed at treatment termination. As such, these empirical research findings appear to provide preliminary empirical support for the importance of narrative and emotion integration as discussed in Angus & Greenberg's Dialectical Constructivist model (2011). Having explored the contributions of External narrative sequences to EFT treatment outcomes, the role and function of Internal and Reflexive sequences, to treatment outcomes, was investigated next.

Internal and Reflexive narrative sequence analyses: Investigating the contributions of emotion-focused meaning-making in EFT of depression

Using hierarchical log linear regression analyses, Lewin, Angus, and Blagov (2003) established that EFT clients who recover from depression evidence a significantly higher proportion of sequential Reflexive to Internal and/or Internal to Reflexive narrative sequence shifts—what they term emotion-focused meaning-making shifts—when compared to EFT dyads who remained depressed at therapy termination. Drawing on the previous clinical example, the following therapy session segment demonstrates how emotion-focused meaning making shifts typically follow from the disclosure of a personal story:

> C: I remember once, coming home from school and finding her sitting in a chair in the living room, staring out the window and just refusing to talk, to my dad, to my sister, to anyone [...] she didn't talk for three days (External narrative sequence) and it was so hard being around her [...] I just didn't

know what to say or do (Reflexive narrative sequence).

T: and that was distressing for you? Just not knowing "what can I do?" What was that like for you...living with that feeling? (Therapist invites client shift to Internal narrative sequence).

C: it was like stepping on eggshells [...] always feeling afraid that she was going to do something to hurt herself so helpless and scary that there was nothing I could do to make a difference (Internal narrative sequence) (Angus, 2012, p. 5)

In order to further understand the connection between productive EFT outcomes and the occurrence of emotion-focused meaning-making shifts, Lewin and Angus (2008) decided to directly investigate the relationship between the occurrence of Internal to Reflexive and Reflexive to Internal narrative sequence shifts and client productive engagement, measured by the Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986). The Experiencing Scale is an ordinal measurement system that evaluates the degree to which clients are actively engaged in productive experiential meaning-making during therapy sessions. Good levels of inter rater agreement for the Experiencing Scale had been established by Pos, Greenberg and Warwar (2009) who reported that higher level Experiencing scores significantly predicted positive treatment outcomes for clients undergoing EFT of depression.

Based on Angus and Greenberg's Dialectical Constructivist tenets of productive client change (Angus & Greenberg, 2011), Lewin and Angus hypothesized that higher proportions of co-occurring Internal-Reflexive and Reflexive-Internal narrative sequences (emotionally-focused meaning-making shifts) would be significantly correlated with higher Experiencing Scale scores for EFT clients who were no longer depressed at therapy termination. A Hierarchical Linear Modelling analysis was conducted wherein Experiencing Scale scores were identified as the dependent variable and proportion of co-occurring Internal-Reflexive and Reflexive-Internal narrative sequence shifts (emotionally-focused meaning-making shifts) were identified as independent variable. As predicted, Lewin and Angus (2008) found that from early to late stages of therapy, EFT clients who recover from depression evidenced a significantly greater increase in Experiencing Scale scores when compared to EFT clients who remained depressed at therapy termination.

Supporting Angus & Greenberg's (2011) Dialectical Constructivist model of client change processes, returns from our extended Narrative Process Coding System analyses of EFT of depression sessions suggests that the disclosure of emotionally alive, specific personal narratives may be an important means by which depressed clients begin to learn how to tolerate and story their most vulnerable emotions of pain, hurt, anger and rage in service of further reflection, increased emotion regulation and new meaning-making in productive EFT therapy sessions (Boritz et al., 2008, 2011). As such, results from our Narrative Process Coding System research program suggest that depressed clients' reflection on emotional experiences evoked in the context of specific personal story disclosures may provide a unique opportunity to (a) identify specific factors, events or actions that evoked an emotional response and (b) understand more fully the meaning of those emotions, in the context of their own personal stories (Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Toukmanian, 1992) that in turn increases emotional self-regulation and self- understanding.

Working with External, Internal and Reflexive narrative processes in EFT of depression: Clinical implications and future research directions

Angus and Greenberg's (2011) Dialectical Constructivist model suggests that the narrative organization of emotional experiences temporally sequences events and co-ordinates actions, objects and people in our lives for enhanced self-reflection and new meaning-making. As such, this Dialectical Constructivist interplay of narrative and meaning-making processes appears to help EFT clients organize and symbolize emotional experiences, as an integrated, coherent story that makes sense of their experiences in the world.

To further develop a Dialectical Constructivist approach to working with narrative and emotion processes in EFT, Angus and Greenberg (2011) have recently identified a set of specific client utterances and behaviors that are indicators of underlying narrative, emotion, and new meaning-making markers that afford opportunities for particular types of effective therapeutic interventions. Although they share a common empathic base, the identified markers differ in (a) the degree to which specific personal stories are evoked (External narrative mode); (b) the degree of context elaboration needed; (c) the degree of symbolization of bodily felt experience and emotion (Internal narrative mode); (d) the degree of promoting story coherence; and (e) the degree of noticing and heightening client self- reflection (Reflexive narrative mode). As such, each specific narrative-emotion marker not only indicates to a therapist the type of intervention use but also the clients' current *readiness* to work on these problems (Angus, 2012).

Narrative and emotion Problem Markers (Angus, 2012) include: the *same old story* are repetitive unproductive experience based on core maladaptive emotion schemes; *unstoried emotions* are states of undifferentiated affect and unregulated emotional states; *empty stories* are clients' autobiographical memory disclosures that are stripped of lived emotional experience; and *competing plotline stories* represent client experiences of self-narrative and emotion incoherence.

In contrast, narrative and emotion process Change

Markers highlight opportunities for therapists to recognize and enhance client experiences of positive change events (Angus, 2012). Examples of Change Markers include: *Untold stories* are identified when a client discloses an emotionally salient personal experience that has not yet been externalized as a told story; *unexpected outcome stories* (White, 2007) are identified when clients' express surprise, excitement, contentment or inner peace when comparing current adaptive experiences to past maladaptive events and story outcomes and *healing stories* are those moments when clients convey an unexpected recollection of a vivid personal memory that captures when an important relational need was met by a significant other (Sandler, 2011).

Conclusion

Over the past twenty years we have undertaken a systematic investigation of story telling, emotion and meaning-making processes in emotion-focused treatments of depression, using the Narrative Processes Coding System (Angus, 2012). Taken as a whole, returns from our narrative processes research program have provided growing empirical support for Angus and Greenberg's (2011) contention that client disclosures of specific, emotionally-charged personal narratives are an important foundation for the symbolization, reflection and transformation of maladaptive emotional experiences in EFT of depression (Boritz et al., 2011).

In terms of future research, specific client indicators that provide detailed criteria for the identification of narrative and emotion problem and change markers in therapy session video tapes have been recently identified for the development of a Narrative and Emotion Processes Coding System (NEPCS; Boritz, et al., 2012) and manual. Ongoing studies in our Narrative Processes research lab at York University are investigating the prevalence and pattern of NEPCS patterns in recovered versus unchanged client treatment subgroups drawn from EFT, Client centered therapy and Cognitive therapy treatments of depressions (Boritz, 2012; Boritz, Angus & Constantino, 2012) as well as for use in the treatment of trauma (Paivio & Pascual-Leone, 2010). As noted by Angus (2012), it will be important for future studies to investigate the specific steps and therapeutic strategies that help depressed clients shift from unproductive engagement in Same Old Stories to accessing and symbolizing primary emotions for adaptive action tendencies and unexpected story outcomes in differing treatment approaches and clinical samples.

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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, sociocultural 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, Gennaro, 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, reflection, 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
Action IMs. Refer to events or episodes when the person acted in a way that is contrary to the problematic self-narrative.	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.
Reflection IMs. Refer to new understandings or thoughts that undermine the dominance of the problematic self-narrative. They can involve a cognitive challenge to the problem or cultural norms and practices that sustain it or new insights and understandings about the problem or problem supporters. These IMs frequently can also assume the form of new perspectives or insights upon the self while relating to the problem, which contradict the problematic self-narrative.	C: [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.
Protest IMs. Involve moments of critique, confrontation or antagonism towards the problem and its specifications and implications or people that support it. They can be directed at others or at the self. Oppositions of this sort can either take the form of actions (achieved or planned), thoughts or emotions, but necessarily imply an active form of resistance, repositioning the client in a more proactive confrontation to the problem (which does not happen in the previous action and reflection IMs). Thus, this type of IMs entails two positions in the self: one that supports the problematic self-narrative and another that challenges it. These IMs are coded when the second position acquires more power than the first.	C: [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.
Reconceptualization IMs. Always involve two dimensions: (a) a description of the shift between two positions (past and present) and (b) the transformation process that underlies this shift. In this type of IMs there is the recognition of a contrast between the past and the present in terms of change, and also the ability to describe the processes that lead to that transformation. In other words, not only is the client capable of noticing something new, but also capable of recognizing oneself as different when compared to the past due to a transformation process that happened in between.	C: [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 naïve [...]. 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" [...]
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.	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.

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 communalities 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-

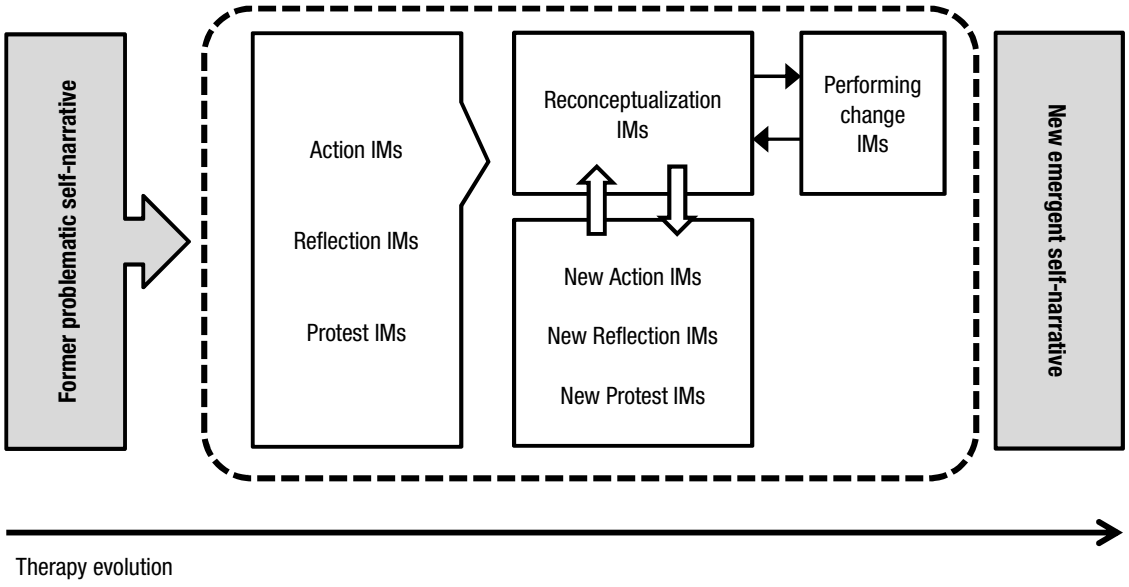

Figure 1. A heuristic model of narrative change on the perspective of innovative moments.

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)
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.	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] 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]
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.	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] 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]
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.	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] 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]

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	Initial phase: 2,3,4
	Middle phase: 9, 10, 11	Middle phase: 9, 10, 11
	Final phase: 17, 18, 19	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

	IMs produced by the therapist	IMs prompted by the therapist	IMs produced by the client	Total IMs
Forms of emergence	*n* (%)	*n* (%)	*n* (%)	*n* (%)
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)
Reconceptualization IMs	0 (0)	6 (4)	3 (2)	9 (3)
Performing change IMs	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)
Reconceptualization IMs	0 (0)	0 (0)	0 (0)	0 (0)
Performing change IMs	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 given 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).

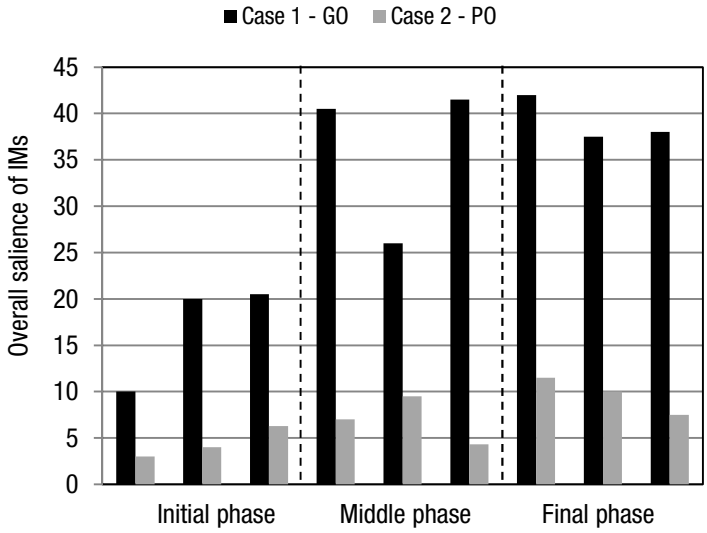

Figure 2. Overall salience of IMs in the good outcome (GO) and poor outcome (PO) case.

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 ($n = 6$).

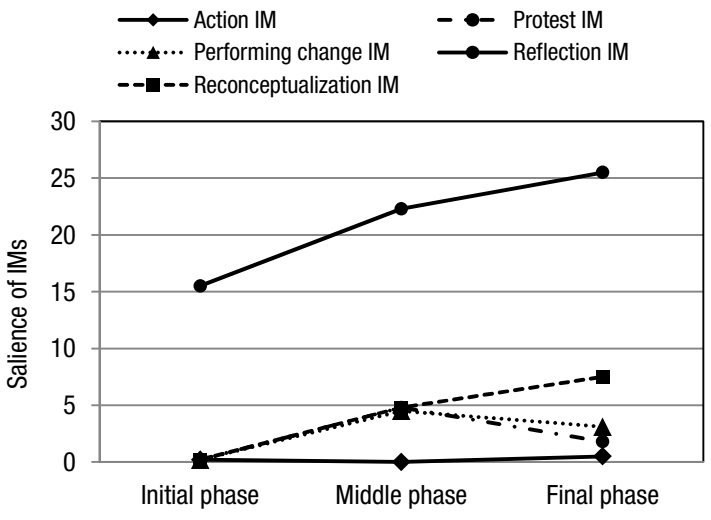

Figure 3. Salience of IMs per therapy phase in the GO case.

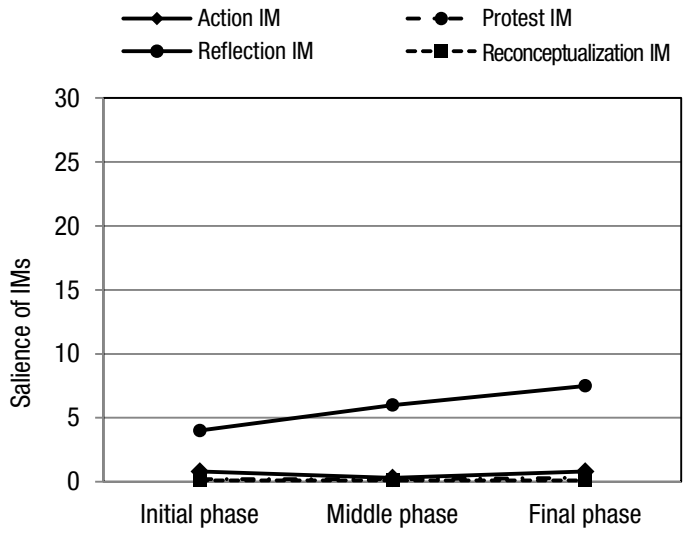

Figure 4. Salience of IMs per therapy phase in the PO case.

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, χ^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, respectively. 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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The Evolution of Communicative Intentions During Change Episodes and Throughout the Therapeutic Process

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Abstract. The present study examines the heterogeneity of the therapeutic process through the analysis of the conversation between therapists and clients in psychotherapy. The Communicative Intentions dimension of the Therapeutic Activity Coding System (TACS) was applied to 69 change episodes taken from 100 sessions that belong to five brief psychotherapies. Depending on what the participants are trying to achieve with their communication, the TACS distinguishes three types of Communicative Intentions: Exploring, Attuning, and Resignifying. Client and therapist verbalizations corresponding to these categories were analysed searching for differences between (a) both speakers, (b) initial, middle and final change episode stages, and (c) initial, middle and final phases of the whole therapeutic process. Results indicate that, in general, therapists resignify and attune more frequently, while clients explore more often. The analysis of Communicative Intentions within change episodes and during the whole therapeutic process reveals that there is an evolution in both: Even small therapy segments, as change episodes are, show that the process is not homogeneous, since in initial stages, the use of Exploring is more frequent than the use of Resignifying, especially for clients, while during the end of the episode clients and therapists increase their use of Resignifying. The analysis of the whole process confirms that Resignifying surpasses the use of Exploring in the final phases of therapy.

Keywords: therapeutic verbal communication, communicative actions, change episodes, therapeutic process

Progress in psychotherapy has been shown to be seldom smooth. There are ups and downs, moments of intensity, of reduced pace, and even interruptions (Detert, Llewelyn, Hardy, Barkham, & Stiles, 2006), resembling a saw tooth pattern (Gabalda, 2006). The focus of this paper is on describing this irregularity in terms of what clients and therapists are doing throughout the therapeutic process, specifically in the specific components of their conversation. Psychotherapeutic interaction processes should be reflected in language and in the verbalizations of the speakers involved. This paper will follow a performative conception of language, according to which "to say something is to do something" (Reyes et al., 2008). Here, language is the vehicle for change, hence the importance of studying it.

Of the dimensions that can be studied in verbal communication, communicative purpose is the most interesting for understanding the interactive construction process of psychic change, regarded as that which takes place in subjective patterns of interpretation and explanations that lead to the development of new subjective theories (Krause, 2005, 2011).

The present article analyses how a specific type of these communicative actions, the communicative purpose of the speaker's utterances—their Communicative Intentions—evolve through the therapeutic process. The aim of the study performed was to as-

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sess the evolution of this specific type of communicative actions on a microanalytic level, during change episodes as well as during the whole therapeutic process. In addition to the existing knowledge in psychotherapy, this research intends to provide evidence regarding how therapeutic communication relates to change. By using this evidence clinicians may monitor both their their own and their clients' language and be alert to whether or not their communicative actions favour the change process.

Research on therapeutic conversation

The growing interest in understanding therapeutic conversation between therapist and client is highlighted by the recent emergence of several systems for classifying their verbal communication during therapeutic interactions. Some of these classification systems were constructed for a specific therapeutic approach, i.e. to measure therapist adherence to manuals, or to address specific therapeutic problems (Elkin, Parloff, Hadley, & Autrey, 1985; Evans, Piasecki, Kriss, & Hollon, 1984; Trijsburg et al., 2002). Other measures are of a more generic nature, but focus mainly on therapists' activity, for example on their communication or techniques (Elliott, 1984; Goldberg et al., 1984; Hill, 1978; Mahrer, Nadler, Stalikas, Schachter, & Sterner, 1988; Watzke, Koch, & Schulz, 2006). Generic classification systems are suitable for different therapeutic approaches and client problems and for classifying verbal communication by both therapist and client. One of them is Stiles' Verbal Response Taxonomy (VRM; Stiles, 1992) which measures eight basic response modes: Interpretation, Question, Reflection, Acknowledgment, Advisement, Disclosure, Confirmation and Edification. Another generic classification system, the Therapeutic Activity Coding System (TACS; Valdés, Tomicic, Pérez, & Krause, 2010), includes five dimensions for classifying verbal communication—Basic Form, Communicative Intention, Technique, Domain and Reference—which can be used in combination or alone, depending on the research questions addressed.

In the TACS, client and/or therapist verbalizations are called *communicative actions* since they "fulfil a double purpose of bearing information (communication) and exercising an influence over the other participant and the realities created by both (action)" (Krause, Valdés, & Tomicic, 2010, p. 2). Of the different dimensions of communicative actions distinguished in the TACS, the Communicative Intention is the facet of speech that specifically expresses the speaker's communicative purpose, and is thus closer to the action aspect of communication. In the case of the present study, which targets the evolution of the purposes involved in communication during the therapeutic process, the Communicative Intention dimension is the best match for this aim.

The TACS distinguishes three Communicative Intention types: Exploring, Attuning, and Resignifying, which reflect the different purposes of verbal interaction during the therapeutic conversation. Exploring includes asking for or providing new information or clarifying contents. Attuning is aimed at achieving mutual comprehension, with an important emotional component. Resignifying is focused on transforming meanings (Krause et al., 2010).

In addition, communication is expected to be determined by the role of the participant (client or therapist). For instance Stiles (1992), using the VRM, observed a different distribution for each of the participants in a therapeutic session, showing that each role has a distinctive and characteristic verbalization profile. Other studies have also shown these different role profiles (e.g., Mergenthaler, 1985, using the Therapeutic Cycles Model, and Valdés, Krause, & Álamo, 2011, using the TACS). Different role profiles can furthermore be related to the effectiveness of the therapeutic process. The results of Hölzer, Erhard, Pokorny, Kächele, and Luborsky (1996) point in this direction, showing that in therapies with a poor outcome, therapists speak more than their clients in later phases of the treatment compared to the beginning of the therapy. Finally, comparisons of change and stuck episodes also show that it is important to address roles when studying episodes that are more or less related to change (Fernández et al., 2012).

Change episodes

To understand therapeutic conversation, it is necessary to segment the therapy into minor units because only through this fine-grained analysis can the essential nature of the mechanisms leading to clients' change be understood (Rice & Greenberg, 1984). For this reason we analyzed the Communicative Intentions of clients and therapists specifically during change episodes, in order to characterize the kinds of Communicative Intentions that are involved in change. These episodes refer to meaningful events, moments or segments that, from the point of view of the participants or the observers of the process, seem to be associated with therapeutic change (Bastine, Fiedler, & Kommer, 1989). These segments or moments have received various labels, such as critical events (Fitzpatrick & Chamodraka, 2007), significant events (Elliott, 1984; Elliott & Shapiro, 1992), task events (Rice & Greenberg, 1984), helpful events (Elliott, 1985), and change episodes (Fiedler & Rogge, 1989; Krause et al., 2007). The latter designation is used in this study to refer to those significant segments that stand out in the psychotherapeutic process due to the presence of a change moment (Rice & Greenberg, 1984), a moment during which a change of meaning in the client's view of him or herself takes place. Change episodes are fragments of sessions in which there is an intensification of the process of change, culminating in a change moment (Krause et al., 2007; Reyes et al., 2008). In this view, change is regarded as the development of subjective

Table 1. Sample characteristics

Therapy	Sex	Age	Outcome	Focus of therapy	Total sessions	Change episodes	Speaking turns with communicative intentions
Psychodynamic	F	29	Successful	Decreasing anxiety stemming from separation; strengthening autonomy; expression of needs	23	10	356
Psychodynamic	F	41	Successful	Development of mourning for separation and recent losses	18	14	321
Social constructionist	F	38	Functional	Resolution of conflict between mother and son and between the parents	20	12	604
Drug abuse group therapy	M	34	Successful	Recognition of addiction; strengthening the ability to set limits; identification of situations of risk	18	9	404
	M	29	Successful				
	M	19	Successful				
	M	23	Unsuccessful				
	M	35	Successful				
	M	49	Successful				
Psychodynamic	F	42	Successful	Expression of needs; strengthening autonomy; increasing quality of relationships	21	24	375
Total					100	69	2060

Note. Clients' age when the therapeutic process started. Outcome was measured through the Chilean version of Lambert's OQ-45.2 (de la Parra & von Bergen, 2001; de la Parra, von Bergen, & del Rio, 2002).

patterns of interpretation and explanation that lead to new subjective theories.

Some researchers claim that therapeutic outcome does not depend so much on isolated episodes as on their connection and evolution during the therapeutic process (Fiedler & Rogge, 1989). Change in therapy can be gradual and linear, but also discontinuous and non-linear, although it generally shows a heterogeneous progress (Hill, 2005; Krause et al., 2007; Mergenthaler, 1998). As Hill (2005) reports, psychotherapy manifests itself in a succession of stages (exploration, insight, and action) during which therapists and clients progress from an initial impression, to the identification of therapeutic goals, and eventually to the termination of the process. Therefore, in this study, Communicative Intentions in change episodes belonging to different phases in therapy will be analysed and compared.

Considering the fact that the therapeutic process does not evolve homogeneously (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Hill, 2005; Krause et al., 2007; Mergenthaler, 1998), and that this can also be observed during the therapeutic session (Bucci, 1993), one of our hypotheses states that the evolution of communication towards change may be observed not only during the process, but also during the change episode. For example, the participants' verbal communication may show differences between the change moment, the point at which the change in meanings takes place, and the initial or intermediate moments of the episode.

In brief, the aim of this study is to analyse therapists and clients' Communicative Intentions during change episodes and in different phases of therapy, in order to answer the following research questions: (1) Are there any differences between the predominant Communicative Intentions of therapists and clients? (2) Are there any differences in the Communicative Intentions predominant in the different change episode stages, and (3) in different phases of the therapeutic process?

Considering that previous studies have revealed differences in the communicative role profiles of the therapist-client dyad (Mergenthaler, 1985; Stiles, 1992; Valdés et al., 2011) and that the existing evidence regarding the TACS system illustrates its usefulness in obtaining knowledge about the evolution of communication and verbal actions related to change (Valdés et al., 2010, 2011) we hypothesize that (a) clients and therapists will use the three types of Communicative Intentions in different proportions. Following the idea that there is an evolution of therapeutic communication within sessions (Bucci, 1993) we expect to find that (b) Communicative Intentions will evolve throughout the change episode. Furthermore, we hypothesize that—since change moments are characterized by the construction of new meanings (Krause et al., 2007)—communication within change episodes will evolve in the direction of a more frequent use of Resignifying and a less frequent use of

Exploring. Evidence regarding the heterogeneous evolution of the whole therapeutic process (Hayes et al., 2007; Hill, 2005; Krause et al., 2007) leads us to predict that (c) Communicative Intentions will evolve during the therapeutic process, showing an increase in Resignifying and a decrease in Exploring. This third hypothesis rests on theoretical and empirical literature that considers the evolution of therapeutic change as a process of *successive* meaning-making (Krause, 2005; Salvatore, Gelo, Gennaro, Manzo, & Al-Radaideh, 2010). Combining hypotheses (b) and (c), we expect that (d) the pattern of the evolution of Communicative Intentions in different change episode stages and different phases of the whole therapeutic process will be a similar. By testing these hypotheses we intend to generate empirical evidence that may, as Lepper (2009, p. 1090) puts it, "enhance our clinical skills in listening for, and addressing in the here-and-now," the procedures therapists as well as clients implement during their clinical interaction.

Method

Therapies and participants

The study included 10 clients (4 women, 6 men; age range = 19-49 years, M = 34.4 years, SD = 9.13) and five therapists (1 woman, 4 men) with 10 to 30 years of professional experience, who participated in five therapies delivered in outpatient university clinics. As the table shows, the common focuses of all therapies were interpersonal issues (Table 1). Clients participated in five brief psychotherapeutic processes of different approaches (three psychodynamic therapies, one social-constructionist, and one behavioral-oriented group therapy). The rationale of including psychotherapies of different modalities rests on the assumption that the communicative actions addressed in this research are generic, in the sense that they are present in different types of therapies.

Data set

A total of 69 separate change episodes were identified in 100 sessions belonging to five psychotherapeutic processes (see the procedure section: *delimiting change episodes*). The average number of change episodes per session was 0.69 (*SD* = 0.81, range 0–4). The set of change episodes contained a total of 2833 speaking turns, 2060 of which met the requirements for coding a Communicative Intention (see the procedure section: *coding speaking turns*). The length of the episodes ranged from 3 to 139 speaking turns, with an average of 41.06 (SD = 31.74).

Procedure

Written consents were signed by all clients and therapists, who agreed to be videotaped and observed through a one-way mirror by members of the research team. The research project was conducted in compliance with the review board of the Chilean National Fund for Scientific and Technological Development.

Delimiting change episodes. All psychotherapy sessions were video and audio-taped as well as observed by expert observers *in situ* through a one-way mirror. The observers were eight psychotherapists, all of them part of the research group, experienced in different theoretical approaches and trained in the use of a protocol developed in order to guide and facilitate the observation and recording of change moments. The raters observed the therapy processes and—independently—identified the change moments, paying attention to the client's verbalizations and non-verbal manifestations and following the indications for the identification of Change and Stuck Episodes (Fernández et al., 2012).

Raters coded a change moment when the following criteria were met: (a) theoretical correspondence: the therapeutic interaction topic agrees with the contents of one of the Generic Change Indicators, (b) verifiability: The interaction is observed in the session, (c) novelty: The specific topic of that change moment is present for the first time in the course of the therapeutic process, and (d) consistency: The change is consistent with nonverbal cues and is not denied later on in the session or in the therapy (Krause et al., 2007). These change moments were agreed on intersubjectively. When no consensus was achieved, the change moment was eliminated, and therefore not included in further analyses. This procedure prioritized consensus between raters.

Once the change moment was identified, the whole change episode was delimited, identifying its beginning according to a thematic approach. Based on transcribed sessions, raters went backwards and looked for the verbal interaction where the client and the therapist started to talk about the subject that led to the client's change. The segment of interaction between client and therapist that precedes the change moment constitutes the change episode (which ends when the change moment emerges).

Coding of speaking turns in change episodes. All delimited change episodes were broken down into speaking turns, which constituted the unit of analysis. A speaking turn is defined as "an uninterrupted utterance by one speaker, surrounded by utterances of another speaker" (Elliott, 1991, p. 99). The speaking turn included all the words uttered by the psychotherapist and the client in their turn during the psychotherapeutic dialogue (e.g., roughly a sentence of dialogue).

Speaking turns were coded using the Therapeutic Activity Coding System (TACS; Valdés et al., 2010; see Measures section). A speaking turn meets the requirements for coding a Communicative Intention if it has a subject (even if it is implicit) and a predicate. Pairs of raters coded in two consecutive stages. In the

first one, each researcher individually coded the specific Communicative Intentions (Exploring, Attuning, and Resignifying) that appeared in the speaking turns (according to the TACS system; see below for more details). The inter-rater agreement of these individual codes is adequate ($\kappa \geq .71$, 95% IC [.63, .87]). In the second stage, the pairs of researchers discussed their differences in coding in order to obtain a fully agreed final coding (100% agreement). These agreed categories were included in logistic regression models.

Measures

Communicative Intentions. As stated previously, a Communicative Intention refers to the purpose expressed by the speaker's words, as considered by the TACS (Krause et al., 2010). In other words, it refers to "what the participant is trying to achieve with his/her communication" (Valdés et al., 2010, p. 122), and not whether this effect is actually achieved. For example, the therapist could verbalize with the Communicative Intention of Resignifying, and it would be coded as such regardless of whether or not the client accepts the new meaning.[1]

According to the TACS, there are three types of Communicative Intentions: Exploring, Attuning, and Resignifying. *Exploring* is coded when client or therapist asks for or provides information that is unknown, or clarifies contents (e.g., the therapist asks "how would you describe your husband so that I can get an idea of him?"). *Attuning* is coded when the purpose is to understand or to be understood by the other; to harmonize with the other; and/or to provide feedback (e.g., the therapist says "let me see if I understand, what you are trying to say is that..." or the client expresses "I need you to understand what I am trying to explain"). *Resignifying* is coded when there is the purpose of generating or consolidating new meanings (e.g., the therapist says "You are telling me that you want to do something, but that you really don't dare. So I think that happens in other parts of your life and I think that it is happening here, it is happening to you right now at this very moment" (Krause et al., 2010, p. 19).

Data analysis

Logistic regression analyses were conducted to test the study's hypothesis. To perform the statistical analysis, each one of the Communicative Intentions was transformed into a dichotomous dependent variable. For example, Exploring was coded one "1" when it was used and coded zero "0" when Attuning or Resignifying appeared. This dichotomization process makes it possible to compare the probability of occurrence of a category (coded 1) with respect to that of other categories (coded 0).

Three simple logistic regression equations were estimated to test the first hypothesis about the differences between therapists' and clients' Communicative Intentions. Each of the dichotomized Communicative Intentions was regressed on the *Actor* variable (Clients = 1 and Therapist = 0 as reference category).

A similar procedure was used to test the second hypothesis, comparing the probability of occurrence for Communicative Intention types through the change episode stages. Change episodes were divided into five stages (henceforth, the variable will be referred to as *change episode stage*). The final change episode stage was composed of the last six speaking turns, in order to include the "change moment" in this stage. When the remaining speaking turns were more than 15, the initial change episode stage was formed by the first six speaking turns, so as to homogenize the number of speaking turns belonging to the initial and final change episode stages; however, if the remaining speaking turns were between 10 and 15, the initial change episode stage was formed by five or fewer Communicative Intentions, depending on the length of each episode. After defining the initial and the final change episode stages, the remaining speaking turns were divided into three equal parts, coding only the middle section as the "middle change episode stage." The other two parts of the middle stage were considered transitional stages and were not included in the analysis. Each of the dichotomized Communicative Intentions was regressed on change episode stage. Change episode stage was included as a categorical variable comparing the initial and the middle stages vs. the final stage (final stage as reference category).

Simple logistic regression equations were estimated to test the third hypothesis, comparing the probability of occurrence of Communicative Intention types through the *phase of the therapy*. The therapy phase variable was constructed by dividing the total number of sessions into three equal parts, so that the beginning, middle and final phases would have a similar number of sessions. For example, in a therapeutic process of 18 sessions, each phase will have 6 sessions (the number of sessions per therapeutic process is shown in Table 1). Therapy phase was included as a categorical variable comparing the first and second phases vs. the third phase (third phase as reference category).

To test the last hypothesis two multiple logistic regression analyses were carried out. These analyses show the variations of Communicative Intentions in the different change episode stages and the phases of the therapeutic process, and reveal any differences between the Communicative Intentions of clients and therapists in both types of evolution. To perform these statistical analysis two independent logistic regression equations were estimated:

[1] TACS was originally developed with data from five different psychotherapeutic approaches (psychodynamic, social-constructionist, CBT, gestalt and humanistic).

(a) Logit $(y) = a_{Constant} + b1_{Actor} + b2_{Stage\ (I/F)} + b3_{Stage\ (I/F)} + [b4_{Actor^*\ Stage\ (I/F)}] + [b5_{Actor^*\ Stage\ (I/F)}]$

(b) Logit $(y) = a_{Constant} + b1_{Actor} + b2_{Phase\ (1/3)} + b3_{Phase\ (1/3)} + [b4_{Actor^*\ Phase\ (1/3)}] + [b5_{Actor^*\ Phase\ (2/3)}]$

The main effects of each of the predictors: Actors, change episode stages or phases of the therapeutic process were included first in the logistic regression equation. Afterwards, interaction terms were added to the model.

Logistic regression results are presented following the recommendations by Peng, Lee, and Ingersoll (2002). Tables displaying main effects parameters are presented for all the variables analysed. The interaction term is incorporated only when it is statistically significant. Odds ratios were estimated to show interaction terms with the simplest model of predictors. No relevant differences exist between the simple and the complete models.

Results

Considering both clients' and therapists' speech conjointly ($N = 2060$), the most frequent Communicative Intention is Exploring (45.2%). Resignifying comes second with 39.4%, while Attuning reaches 15.4%.

Clients and therapists Communicative Intentions

As was hypothesized, clients and therapists differ regarding their use of the three Communicative Intentions (see Figure 1). Statistically significant differences can be observed in the probability of occurrence of the Communicative Intentions in client and therapist speech. Therapists attune (β = -.96, OR = .39, $p < .001$, 95% CI [.30, .50]) and resignify (β = -.38, OR = .68, $p < .001$, 95% CI [.57, .82]) more often than clients; in contrast, the latter tend to explore more frequently (β = .84, OR = 2.31, $p < .001$, 95% CI [1.93, 2.76]).

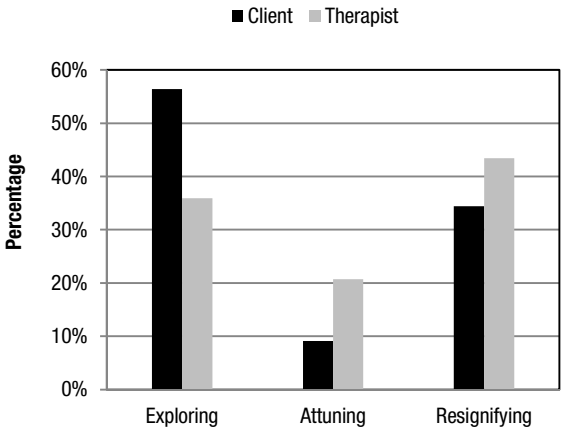

Figure 1. Client and therapist use of the different communicative intentions.

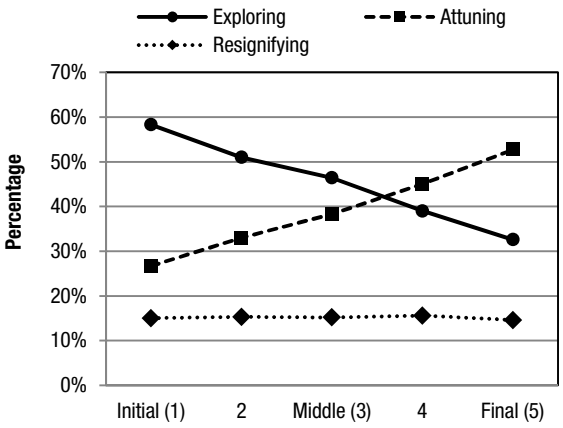

Figure 2. Communicative intentions at different change episode stages.

Communicative Intentions through the change episode (change episode stages)

Figure 2 shows the use of the Communicative Intentions by both participants of the therapeutic dialog throughout the different change episode stages. The results indicate that the probability of Exploring is higher in the initial (β = 1.06, OR = 2.88, $p < .001$, 95% CI [2.18, 3.82]) and middle stages (β = .58, OR = 1.79, $p < .001$, 95% CI [1.36, 2.35]) compared to the final stage of the change episode. The opposite pattern was observed in the case of Resignifying: The probability of Resignifying is lower in the initial (β = -1.12, OR = .33, $p < .001$, 95% CI [.26, .44]) and middle stages (β = -.58, OR = .56, $p < .001$, 95% CI [.42, .73]) compared to the final change episode stage. The use of Attuning remains constant in the three change episode stages (Model χ^2 (2, $N = 1266$) = .07, $p = .97$, & *-2LL* = 1067.11). These results are consistent with the second hypothesis: Since change moments are characterized by the construction of new meanings, communication within change episodes will evolve in the direction of a more frequent use of Resignifying and a less frequent use of Exploring.

Communicative Intentions throughout the therapeutic process (phases of therapy)

Communicative intentions were used differentially according to the phase of the therapeutic process by the participants in the therapeutic dialog (see Figure 3). Statistically significant differences were observed in the probability of occurrence of Exploring and Attuning, but not in the probability of Resignifying (Model χ^2 (2, $N = 2060$) = 2.25, $p = .32$, & -2LL = 2759.67).

Compared with the final phase (third phase of therapy), the probability of Exploring is higher both in the initial (β = .36, OR = 1.43, $p < .001$, 95% CI [1.15, 1.79]) and middle phases of therapy (β = .32, OR = 1.37, $p < .05$, 95% CI [1.09, 1.72]). Additionally, in the

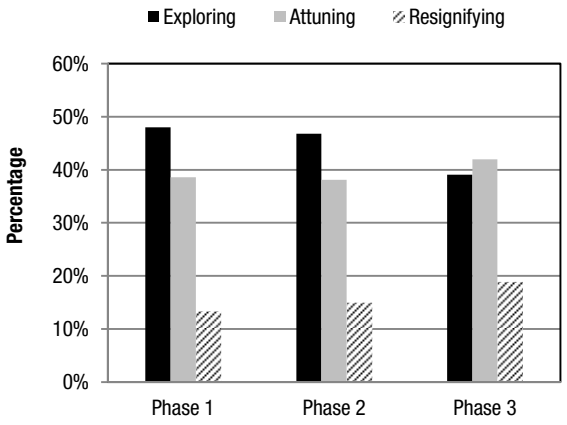

Figure 3. Use of communicative intentions at different stages of therapy.

third therapy phase there was a more extensive use of Attuning than in the first phase (β = -.41, OR = .67, p < .01, 95% CI [.50, .90]), but no differences were observed when comparing the second and third phases (β = -.27, OR = .76, p =. 71, 95% CI [.57, 1.02]).

These results partially support the third hypothesis. Although a decrease in Exploring was observed, there was no evidence of an increase in Resignifying as the therapy process progressed.

Evolution of client and therapist Communicative Intentions in change episode stages and therapy phases

The final hypothesis stipulates that the pattern of the evolution of Communicative Intentions in different change episode stages and therapeutic phases will be similar. Given the results showing the differences between clients and therapists, this hypothesis must be tested considering the speakers of the therapeutic discourse and the micro (change episode stages) and macro (therapy process phases) moments of the therapeutic process jointly.

Change episode stages. In order to analyse the effect of the change episode stages on the probability of using Communicative Intentions (Exploring, Attuning and Resignifying), each of dichotomized dependent variables was regressed on the variables *actors*, *change episode stages* and *their interaction.*

As Table 2 shows, the relation between the change episode stage and the probability of Exploring and Resignifying depends on who the speaker is (significant interaction terms). There were no significant interactions between actor and change episode stages when predicting Attuning.[2]

Odds ratios were estimated to account for the interaction terms (Actor X Change episode stage). When the odds ratio is equal to 1, both categories have the same odds. When the odds ratio is greater than 1, the odds for one of the categories of variables (i.e., the clients) are greater than the odds for the reference category (i.e., the therapist). When the odds ratio is less than 1, the reverse is true (Hosmer & Lemeshow, 2000).

The results indicate that clients were 3.7 times more likely to use Exploring than therapists in the initial change episode stage (OR = 3.72, 95% IC [2.40, 5.75]). This pattern was less clear at the end of the change episode (final stage), where clients Explored only one and a half times more than therapists (OR = 1.69, 95% IC [1.13, 2.54]).

With respect to Resignifying, the odds ratios indicate that clients were less likely to resignify than therapists in the initial (OR = .43, 95% IC [.26, .68]), and middle change episode stages (OR = .67, 95% IC [.45, .99]), although this difference was less clear in the final stage, when clients and therapists had the same probability of Resignifying (OR = 1.17, 95% IC [.81, 1.71]).

In brief, the relation between the change episode stage and the probability of Exploring depends on who the speaker is. In the initial change episode stage the clients explore much more frequently than therapists (3 times more frequently); in contrast, this Communicative Intentions asymmetry decreases in the final change episode stage. Additionally, something similar occurs with Resignifying. Communication asymmetry, present in the initial and middle change episode stages and characterized by a higher Resignifying rate by the therapist compared with the client, disappears in the final change episode stage.

Phases of the therapeutic process. In order to analyse the effect of the phases of the therapeutic process on the probability of using each of the Communicative Intentions, each of the dichotomized dependent variables was regressed on the variables *actors*, *therapy phase*, and *their interaction.*

As Table 3 shows, the relation between phases of therapy and the probability of Exploring, Attuning and Resignifying depends on who the speaker is (significant interaction terms).

Odds ratios indicate that clients are more likely to explore than therapists in the first (OR = 2.99, 95% IC [2.22, 4.02]) and second phases (OR = 2.69, 95% IC [1.99, 3.64]) compared to the third therapy phase. At the end of the therapy (third phase), this pattern is less clear; as the use of Exploring by clients and therapists becomes more similar (OR = 1.46, 95% IC [1.03, 2.05]).

With respect to Attuning, odds ratios indicate that clients were less likely to use Attuning than therapists in the first therapy phase (OR = .22, 95% IC [.12, .38]) compared to the third therapy phase. In the last therapy phase, clients increased their tendency to Attune, thus establishing a less asymmetric pattern in

[2] Direct effects are not interpreted when interactions are present.

Table 2. Logistic regression models predicting therapist-client communicative intentions during change episodes

Model	β	*SE* β	OR	95% CI Low	95% CI High
Exploring					
Actor[a]	.68***	.14	1.98	1.49	2.63
Initial change episode stage[b]	.93***	.19	2.56	1.78	3.67
Middle change episode stage[b]	.65***	.14	1.91	1.44	2.53
Actor x Stage (Initial *vs* Final)[c]	.63*	.26	1.88	1.15	3.16
Actor x Stage (Middle *vs* Final)[c]	–	–			
Constant	−1.10***	.13			
Attuning					
Actor[a]	−1.19***	.18	.31	.21	.44
Initial change episode stage[b]	−.09	.20	.92	.62	1.35
Middle change episode stage[b]	−.03	.20	.98	.66	1.43
Actor x Stage (Initial *vs* Final)[c]	–	–			
Actor x Stage (Middle *vs* Final)[c]	–	–			
Constant	−1.28***	.15			
Resignifying					
Actor[a]	.16	.19	1.17	.81	1.71
Initial change episode stage[b]	−.73***	.19	.48	.33	.71
Middle change episode stage[b]	−.33	.19	.72	.49	1.05
Actor x Stage (Initial *vs* Final)[c]	−1.02***	.31	.36	.20	.67
Actor x Stage (Middle *vs* Final)[c]	-.56*	.28	.57	.33	.99
Constant	.03	.14			

Note. Model based on *N*= 1266 speaking turns. 95% CI: 95% Confidence Interval. Overall model evaluation for Exploring: χ^2 (4 *df*)=117.80, $p < .001$ & *-2LL*= 1626.96; Overall model evaluation for Attuning: χ^2 (3)= 47.92, $p < .001$ & *-2LL*= 1019.25; Overall model evaluation for Resignifying χ^2 (5)= 78.56, $p < .001$ & *-2LL* 1621.03.
[a] Reference category 0 = Therapist. [b] Reference category 0 = Final Change episode stage.
* $p < .05$; ** $p < .01$; *** $p < .001$.

the use of this Communicative Intention (OR = 0.60, 95% IC [.39, .94]).

Regarding Resignifying, the results indicate that clients were less likely to use this Communicative Intention in the first phase of the therapy, compared to the third phase (OR = .58, 95% IC [.43, .78]). In the final phase of therapy, the differences in the use of Resignifying by clients and therapists disappear (OR = .94, 95% IC [.67, 1.32]).

In summary, the relation between the therapy phase and the probability of Exploring depends on who the speaker is. In the first therapeutic phases, clients explore much more often than therapists (nearly 3 times more often), but this asymmetry decreases in the final therapy phase. There is also less asymmetry between clients and therapists in their use of Attuning in the final phase of therapy. Finally, client-therapist asymmetry in the first therapeutic phase, characterized by the more frequent use of Resignifying by therapists, disappears in the third therapy phase.

These results support the hypothesis of a parallelism between the micro (change episode stages) and macro (whole therapy) process. Similar patterns were observed at both levels (micro vs. macro) regarding the participants' use of Exploring and Resignifying.

Discussion

We have described the heterogeneity of the therapeutic process through the implementation and results of a micro-analytical research focused on the analysis of the Communicative Intentions performed during change episodes. With an emphasis on the real actions of clients and therapists, our study intended to bring research and practice closer, an objective shared by many scholars in the history of psychotherapy research (Goldfried, Raue, & Castonguay, 1998; Marmar, 1990; Stiles, Shapiro, & Fith-Cozens, 1990).

Our results show that, in general, some Communicative Intentions are performed more often than others; the most frequent one is Exploring, followed by Resignifying and Attuning.

When looking at client and therapist verbalizations, different communicative profiles where found, as had been hypothesized. Specifically, therapists tend to attune and resignify more than clients, while the latter

Table 3. Logistic regression models predicting therapist-client communicative intentions during therapy phases.

Model	β	*SE* β	OR	95% CI Low	95% CI High
Exploring					
Actor[a]	.38*	.17	1.46	1.04	2.05
First phase[b]	.11	.15	1.11	.83	1.51
Second phase[b]	–.02	.16	.98	.71	1.35
Actor x Phase (1 *vs* 2)	.72**	.23	2.05	1.30	3.22
Actor x Phase (2 *vs* 3)	.61**	.23	1.85	1.17	2.91
Constant	-.62***	.12			
Attuning					
Actor[a]	–.78***	.16	.46	.34	.62
First phase[b]	–.31	.17	.74	.53	1.02
Second phase[b]	–.24	.15	.78	.58	1.06
Actor x Phase (1 *vs* 2)	–.74*	.33	.48	.25	.91
Actor x Phase (2 *vs* 3)	–	–			
Constant	-1.15***	.12			
Resignifying					
Actor[a]	–.06	.17	.94	.67	1.32
First phase[b]	.04	.15	1.04	.77	1.39
Second phase[b]	.05	.16	1.05	.77	1.44
Actor x Phase (1 *vs* 2)	–.48*	.23	.62	.39	.97
Actor x Phase (2 *vs* 3)	–.43	.23	.65	.42	1.03
Constant	–.30	.12			

Note. Model based on N= 2060 speaking turns. 95% CI: 95% Confidence Interval. Overall model evaluation for Exploring: $\chi^2(5)$=112.76, $p < .001$ & *-2LL*= 2723.94; Overall model evaluation for Attuning: $\chi^2(4)$= 69.58, $p < .001$ & *-2LL*= 1702.90; Overall model evaluation for Resignifying $\chi^2(3)$= 19.83, $p < .001$ & *-2LL* 2742.09.
[a] Reference category 0 = Therapist. [b] Reference category 0 = Third therapy phase.
* $p < .05$. ** $p < .01$. *** $p < .001$.

explore more. The fact that both actors have different profiles in their use of Communicative Intentions can be understood as an indicator of the complementary nature of verbal interaction during therapeutic dialogue (Heatherington, 1988). These results enrich those observed in other studies showing the difference in clients' and therapists' communication profiles (e.g., Hölzer et al., 1996; Stiles, 1992; Valdés et al., 2011).

With regard to the hypothesis that Communicative Intentions will evolve during the change episode, the results show that Exploring is more frequent during the initial change episode stage while Resignifying is more frequent in the final episode stage, and that this evolution depends mostly on the client. This result is concordant with the clinical impression that every process requires an initial stage of inquiry or information exchange: In order to understand or be understood, clarification is sought and attention is directed to certain key points, especially by the client (as the TACS system states [Krause et al., 2010] the Intention Exploring includes communicative actions aimed at clarifying). The result supports the idea that the construction of new meanings is an interactive activity where both participants work together delivering or asking for material and then working on a new meaning (Anderson, 1997). This implies that client and therapist, by means of their differential use of Communicative Intentions, configure a context in which the client can be the main agent of his/her subjective changes (Reyes et al., 2008).

The low but constant presence of Attuning throughout the entire episode can be interpreted as evidence of the need for a shared meaning context between client and therapist. The verbalizations involving Attuning refer to a core "ingredient" of the psychotherapy process, the therapeutic alliance, specifically to the positive bond that is one of the main dimensions of the construct (Krause, Altimir, & Horvath, 2011). This important aspect of the therapeutic process directly contributes to overall client

change across a range of theoretically diverse treatments (Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), and can be defined as the dynamic interpersonal process where verbalizations allude to therapist empathy, degree of client involvement in treatment, being understood, etc. (Horvath & Greenberg, 1994; Krause et al., 2011). All of these elements can be found under the concept of Attuning, which refers to communicative and emotional adjustment (understanding or being understood by the other, achieving a harmonious relationship, and dealing with feedback issues). Therefore, having a constant presence of Attuning is regarded as a fundamental requisite for change, allowing the construction of new meanings and thus of subjective change (Krause, 1992).

On the other hand, as was hypothesized, the results of the analysis of Communicative Intentions throughout the therapeutic process show that verbal communication can distinguish between phases, thus providing evidence for the notion that therapy evolves (Hill, 2005; Krause et al., 2007), with clients and therapists going through different types of communication.

When considering discourse of clients and therapists jointly, the initial and middle phases of the process have a similar pattern, in which Exploring predominates over Attuning and Resignifying. This pattern changes in the final phase of therapy, where Exploring is less frequent and Attuning increases compared to the first.

In contrast, when their discourse is separated by speaker, the clients' increased use of Resignifying at the end of the process becomes apparent. This result can be understood from a clinical point of view, as clients tend to need less of the therapist's interpretations when they acquire a certain degree of autonomy in the construction of their own subjective theories (Krause, 2005, 2011). On the other hand, the more frequent use of Attuning can be related to the fact that when termination comes, especially in brief psychotherapies (like the ones studied), there is a need to evaluate the process, provide feedback, check the work done, assess progress, etc.

The results of this study show that the therapeutic process—at least when the focus is on verbal client-therapist communication—is not homogeneous (e.g., Mergenthaler, 1998), either in terms of its global evolution or its microprocess. Even small therapy segments display such heterogeneity. These results go beyond the existing literature, allowing the development of a model that facilitates understanding of the complexities of the therapeutic process by simultaneously including a macro level (session to session) and a micro level (within session) approach.

In general terms, a parallelism is observed between the evolution of change episodes and the global evolution of therapeutic phases. Considering these results, this model has a hologramatic characteristic, in the sense that the features observed at the macro level (e.g., the evolution of Communicative Intentions throughout the psychotherapy) are also observed at the micro level (e.g., the evolution of Communicative Intentions within change episodes). This characteristic has implications not only for ongoing and future research, but also for clinical practice.

With respect to clinical practice, these results might encourage therapists to attend to their own and the client's verbalizations, since they show that therapists should allow and even encourage clients to explore initially, not forgetting to resignify what is said during the conversation, while constantly attuning with the client. This general strategy does not have to be used only within sessions (micro level): Therapists could also consider the phases of the therapeutic process (macro level), allowing the client to increasingly resignify during the whole process so he/she can gain autonomy in the construction of his/her subjective change.

With respect to future directions of research, the results of this study suggest linking Communicative Intentions to the evolution of change—through the use of Generic Change Indicators (Krause et al., 2007), in order to evaluate how the verbalizations of the actors lead to different types of change—and different outcomes, comparing successful and unsuccessful therapies. Furthermore, it would be important to deepen the analysis of the relation between Communicative Intentions and the construction of the therapeutic alliance. An example of this would be to study the use of Attuning as part of the construction of a positive bond by relating its use to measurements of therapeutic alliance like the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986).

A limitation of this study is the fact that the cases included in the study, since they come from natural settings, do not have formal DSM-IV diagnosis. Therefore, a challenging research topic for the future would be to relate the evolution of Communicative Intentions to different client profiles; for example, looking at a specific disorder, such as depression, or even more ambitiously, at personality disorders.

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Measuring Attachment and Reflective Functioning in Early Adolescence: An Introduction to the Friends and Family Interview

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Abstract. Internal working models (IWMs; Bowlby, 1969/1982) develop before language and are, initially at least, pre-symbolic, nonverbal notions. With reflective functioning (RF; Fonagy, Steele, Steele, Moran, & Higgitt, 1991) we have the possibility to refashion IWMs based on language, but linguistic skills only develop between 18-24 months, and then steadily over time. Reliable instruments are available to assess these constructs in infancy and adulthood: The Strange Situation observational measure (Ainsworth, Blehar, Waters, & Wall, 1978) reveals the infant's IWMs of his caregivers, while the Adult Attachment Interview (AAI; Main, Hesse, & Goldwyn, 2008; George, Kaplan, & Main, 1985) exposes the adult speaker's capacity for RF. This paper addresses the middle ground of early adolescent children who are not yet mature enough to respond to a full AAI, but are too old to expect that an observational attachment measure would reveal much about their inner thoughts, feelings, and beliefs about attachment. We outline an interview protocol designed for 9 to 16-year old children, asking about self, friends, teachers, and family, with the aim of elucidating both IWMs, regarding earlier experience, and the extent of RF concerning past and present experiences. The protocol is the Friends and Family Interview (FFI; Steele & Steele, 2005), which has a multidimensional scoring system to be elaborated with verbatim examples of response from both low-risk community samples, and higher-risk samples of youth.

Keywords: attachment measures, reflective functioning, early adolescence

When measuring attachment across the lifespan, different methods are required to match the increasingly sophisticated cognitive and affective systems that emerge and mature over the course of development. In the early years of life, primacy is placed on assessing the largely pre-symbolic, pre-verbal internal working models (IWMs; Bowlby, 1969/1982) through behavioral observation. As linguistic skills come online and the child can begin to think about thinking, reflective functioning (RF; Fonagy, Steele, Steele, Moran, & Higgitt, 1991) becomes an important concept that can help to moderate or refashion the child's early-established IWMs. At present, researchers and clinicians interested in attachment phenomena have reliable and popular measures at their disposal for working with infants and adults: The Strange Situation observational measure (Ainsworth, Blehar, Waters, & Wall, 1978) reveals the infant's IWMs of his or her caregivers, while the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) exposes the adult speaker's capacity for RF.

This paper addresses the middle ground of assessing early adolescent children who are not yet mature enough to respond to a full AAI, but are too old to expect that an observational measure would reveal much about their inner thoughts, feelings, and beliefs about attachment. First, we review the theoretical and empirical literature around IWMs and RF, constructs central to understanding any attachment instrument. We then provide a comprehensive overview of our measure, the Friends and Family Interview (FFI; Steele & Steele, 2005), which has a multi-dimensional scoring system to be elaborated with verbatim examples of response from both low-risk community samples, and higher-risk samples of youth.

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Internal Working Models

Beginning in infancy, observation can be used in controlled conditions—as in the Strange Situation—to assess behaviors such as the child's exploration of the environment, proximity-seeking of caregiver, and ability to be soothed. These concrete variables are considered to be derivatives of the infant's IWMs, the subjective representations that form in the infant according to how caregivers respond to his or her needs. The IWM serves as a template for future relationships; it determines in large part what the child expects from ambiguous interpersonal experiences. IWMs are considered to stabilize as early as 12 months of age (Main, Kaplan, & Cassidy, 1985), and though they are not wholly fixed, they are also not easily changed (Bowlby, 1973; Bretherton, 1985). Previous studies have shown that even when initially deprived children go on to develop healthier IWMs based on new relational experiences—such as in adoption cases—these representations do not eradicate the older, problematic IWMs (Hodges, Steele, Hillman, Henderson, & Neil, 2000; Steele, Hodges, Kaniuk, Hillman, & Henderson, 2003; Steele et al., 2008). Rather, the old and new coexist in the child's mind and continue to influence his or her expectations and behavior to greater or lesser degrees (Main, 1991).

Infants and children who have "secure" IWMs are able to conceptualize caregivers as both a *secure base* and a *safe haven*: their models stem from early objective experiences of being able to confidently explore the environment in the presence of caregivers, and also from finding the caregivers to be available and sensitive when a threat is perceived (i.e., when the attachment system is activated). Secure IWMs are a significant protective factor during the challenges of normal development (De Wolff & van IJzendoorn, 1997), while infants who develop "insecure" IWMs are less protected from developmental challenges, and can experience adjustment problems (Easterbrooks & Abeles, 2000).

Children whose early lives are marked by especially unpredictable and frightening caregiver behavior develop IWMs that are fragmented, chaotic, and disorganized. These children are often the victims of maltreatment, and they are at risk for long-term pathological outcomes, including affect dysregulation, dissociation, and violence in intimate adult relationships (Carlson, 1998; Hesse & Main, 2000; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999; West & George, 1999).

However, solely considering IWMs as a predictor of normal or pathological development paints an incomplete picture, particularly as the child grows older. Though disorganized IWMs are a strong indicator of poor psychosocial outcome, Fonagy and colleagues point out that insecure IWMs are commonly found in community and clinical populations alike (Fonagy et al., 2003). This is why as the child develops, increasing emphasis is placed on RF in addition to IWMs when assessing attachment.

Reflective Functioning

RF is a collective term for the psychological processes that allow children to "mind-read"—that is, appreciate the existence and nature of other people's mental states, as well as their own (Fonagy & Target, 1997). This appreciation makes behavior "*meaningful* and predictable," (p. 679, original emphasis) and facilitates the development of more complex internal representations of self and other than are possible in infancy and early childhood. The abilities to hold ambiguous or mixed feelings about important interpersonal relationships, speculate on the motivations of self and others, and consider intrapsychic and interpersonal changes over time are all examples of the advanced modes of thinking inherent in the development of RF.

Unlike IWMs, RF does not develop and solidify early, but emerges over time according to normative developmental milestones and the particular characteristics and circumstances of the child (Fonagy & Target, 1996). Around age 3, a normal child can readily distinguish internal experience from the outside world, which facilitates an ability to shift knowingly between modes of fantasy and reality, such as in games of pretend. By age 4, a "theory of mind" typically becomes evident, wherein the child demonstrates a cognitive appreciation that his or her perspective is distinct from the perspectives of others. Behaviors of self and others begin to "make sense" as the child sees that they are dictated by mental states. At this stage, however, the child still views these states as concrete and absolute. It is not until the fifth year that the normal child comes to understand mental states as *representations,* including the important appreciation that they "may be fallible and change, because they are based on but one of a range of possible perspectives" (Fonagy & Target, 1996, p. 221). This marks the beginning of a more nuanced, flexible, and abstracted stance on the behavior and thoughts of self and others that continues to grow and inform over the course of normal development.

A dearth of RF in childhood—in which limited distinction is established between the objective and subjective, and the behaviors of self and others remain unpredictable—has been theorized to relate to poor social-emotional outcomes, including borderline pathology (Fonagy, 1995; Fonagy et al., 2003). Alternatively, RF has been proposed as a protective factor against developmental problems and psychopathology in children from abusive or deprived backgrounds, who would be expected to have developed insecure or disorganized IWMs in the first year of life (Fonagy et al., 1994, 1995; Fonagy & Target, 1998; Main, 1991). For this reason in particular it is important to have methods of measuring both IWMs and RF within the developing child.

The Friends and Family Interview

The FFI was first developed and tested by Miriam and Howard Steele in the context of the 11-year follow-up of the London Parent-Child Project (Steele &

Steele, 2005). That work showed that reliable ratings of coherence (a construct detailed below) in 11-year-olds' narratives about themselves, their siblings, parents, best friend, and favorite teacher were linked backward in time to their attachment status as infants with mother and father, and to parents' AAI responses. These links held even after taking into account verbal IQ of children and their parents.

The FFI is deemed appropriate for children aged 9-16 years, a historically difficult age range in which to reliably measure attachment (Ainsworth, 1985). Though the AAI—typically considered the "gold standard" narrative attachment interview for adults—has been validated with adolescent samples in the past (e.g., Allen, McElhaney, Kuperminc, & Jodl, 2004), it has also produced inconsistent results (Kiang & Furman, 2007). Given the AAI's emphasis on "looking back" at the respondent's first 12 years of life, it leaves something to be desired when assessing attachment in early adolescence. The FFI is theoretically guided by the AAI, but scaled to the developmental abilities of its intended age group. The FFI also features explicit questions on sibling, peer, and teacher relationships, which are incredibly salient to the young adolescent, but understandably absent from the AAI protocol.

Overview

The FFI begins with the interviewer stating that our strongest feelings and wishes tend to arise in the context of our closest relationships. For example, there are things about our relationships (to parents or siblings, best friends, and perhaps teachers) that we want to stay the same, and things we would like to see change. Following this introduction, the FFI proceeds with some basic information gathering. The child is asked to describe with whom he lives, and whether there are other family or friends that live elsewhere with whom he is especially close. The interviewer then inquires over the child's favorite hobbies, and attempts to elicit specific examples concerning these activities. This phase is intended to help establish a rapport between the interviewer and the child, as well as acculturate the child to the format of the interview, which frequently demands general statements to be elaborated with relevant examples. As such, the first few minutes of the interview contribute relatively little to the coding process.

The substantive portion of the FFI begins when the child is asked to reflect on himself, first by considering what he likes best and least about himself (accompanied by specific examples), and then by answering the important question, "What do you do when you are upset?" This question is borrowed directly from the AAI, and the child's response is highly revealing as to whether or not he feels there is a safe haven and secure base in his life. The FFI then proceeds to inquire about the child's important relationships in turn. Most and least favorite qualities in his relationship with teachers, friends, parents, and siblings are elicited, and discussion of each relationship concludes with the question, "What do you think *X* thinks about you?". In this way, respondents are prompted to show the extent to which they can reflect on relationships ongoing among family and friends.

The child is next asked to think back to his earliest memory of separation from caregivers, first in terms of his own behavior, thoughts, and feelings, and then in terms of how he imagines his caregivers might have felt at the time. Inquiry then shifts toward the child's impressions of how his caregivers relate to one another, including questions about whether they argue, what about, and how the child perceives and reacts to such moments of conflict.

Lastly, the child is asked to think into the past and future in considering himself and his relationship with his caregivers. He is asked how things have changed in the last five years, and how he believes things might change in the following five years. The FFI concludes with a few debriefing questions, intended to clarify how the child experienced the interview itself, as well as to offer some "cool down" time in the event of a challenging or stressful interview.

Collected interviews are recorded, transcribed, and then independently rated according to a standardized coding manual (Steele, Steele, & Kriss, 2009). Like in the AAI, FFI raters assign broad attachment classifications to an entire interview—namely, *secure* or *insecure* (with subtypes *dismissive, preoccupied,* or *other*), with an additional specifier if a child appears *disorganized/disoriented* in his or her narrative. The coding process also yields dimensional scores across numerous domains. In the present paper, we focus on three important constructs, describing in detail how coherence of narrative, IWMs, and RF are coded in the FFI.

Coherence in the FFI

A central concept in narrative assessments of attachment, particularly the FFI and AAI, is *coherence*. Primacy is placed on the process of language; as Oppenheim and Waters (1995) point out, *what* is said is usually less informative than *how* the content is communicated when seeking to reveal largely unconscious attachment representations. This is particularly salient when considering the variability in how activation of the attachment system manifests depending on the level at which IWMs are abstracted (Main et al., 1985). As individuals move from behavioral to representational levels of abstraction, there is a complex shift in their strategies for coping with the pressures of internal and external realities. Developmentally, early adolescents are between infant and adult levels of abstraction, and may offer mixed presentations of behavioral and somatic versus cognitive and affective expressions of how they have internalized their IWMs. For instance, a child being administered the FFI describes how she frequently fights with her sister, but these supposedly heated bouts are referred to with a cool detachment. How do we understand

such an incongruity? Should we prize the description of aggression and inability to be consoled (behavior associated with an insecure-preoccupied stance in infants), or the palpable sense of distance between the speaker and her experience (indicative of an insecure-dismissive position in adults)?

In making inferences regarding the child's internal representations, *content of speech is interpreted in the context of the here-and-now process of the interview.* Coherence of speech (as well as nonverbal behaviors) informs our understanding of what the child describes. Therefore, in the above example, we would be inclined to consider the child's fighting as a context-specific manifestation of her overall dismissive orientation, rather than evidence of preoccupation.

Coherence in the FFI is rated according to Grice's (1975) maxims: *truth*, the degree to which convincing evidence is provided to support the appraisal of self and others; *economy*, the degree to which the "right amount" of information is given, neither too much nor too little; *relation*, the degree to which given examples are relevant; and *manner*, the degree to which an age-appropriate level of attention, politeness, and interest is maintained. Interruptions in the flow speech, unelaborated examples, unmonitored rants, excessive use of filler words, guardedness, dissociation, and so on, are all considered in assigning Likert-type numerical scores to these dimensions.

Coherence is a global construct and may be considered to reflect the individual's overall organization across levels of representation. In other words, an especially coherent or incoherent narrative does not stand in for "secure" or "insecure" IWMs, or high or low RF, but rather suggests a certain constellation of these and other factors. The more specific scales elaborated below, when taken in consideration with the global coherence ratings, provide a detailed picture of the child's psychic reality.

Internal Working Models in the FFI

IWMs are coded according to the child's narrative portrayal of caregivers as a *safe haven* and *secure base*, as well as the child's elaboration of his or her *adaptive response* to distress.

Safe haven/secure base. A core attachment assumption is that the child's mental health continues to depend, as it did during infancy, on the sense that a secure base (from which autonomy can be explored) and a safe haven (to return to in times of distress) are available from mother, father, or others. Raters pay special attention to the questions that probe what the young person does when he or she is upset, as well as those asking for most and least favorite aspects of each parent. Does the child express the importance of the attachment relationship, the need to rely on others, and does he or she acknowledge past and/or present dependence on parents?

At the lowest end of the spectrum, no evidence is given to suggest that the respondent seeks out or expects instrumental or emotional support from the caregiver, who may be minimally referred to in the narrative. For instance, one child from a community sample, when asked about his relationship with his father, responded "I don't see him much" and did not want to elaborate further. Another respondent from a higher-risk group of inner-city youth, when asked about his mother with whom he was recently estranged, simply said, "Pass."

Above this level but still on the lower end, the caregiver is portrayed as an occasional or unreliable source of support. Support given is largely instrumental, and examples of emotional support may seem idealized, untruthful, or seem to otherwise leave the respondent dissatisfied.

> Interviewer: Do you remember a time when you felt like you could ask your mother about anything?
> Respondent: It's just when I'm upset, really, and uh [...] she just tries the best she can and then, who knows, we see what happens.

Alternatively, an explicit longing or desire for a closer relationship may be expressed. Such a response may be couched in angry, preoccupied feelings of being unloved or uncared for, or in dismissive, guarded feelings of not needing parental care, as emphasized below.

> Respondent: Sometimes when I want to talk to my mom about things I can't, *but it doesn't bother me* [...] it's just that I wonder if it would be different if I could do that with my mother.

On the higher end of this dimension, the caregiver is portrayed as a positive resource, one who readily bestows affection and is available to provide instrumental and emotional support. Examples given should support the respondent's appraisal with little to no sense of idealization or untruthfulness. In the later years of adolescence, convincing *knowledge* of such availability, without necessarily utilizing it, is sufficient.

> Respondent: These days I don't really have much in common with my mom, she's not a big football fan (*laughs*). But if something was really wrong at school or even between me and my friends or something, I know I could talk to her. She'd hear me out and be on my side.

Adaptive response. When working with adolescents—who are beginning to grapple with the important developmental challenges of independence and autonomy—it is incorrect to equate IWMs with the degree to which the child overtly expresses "needing" his or her caregivers. How the respondent reacts to distress in general is an important factor to consider alongside how he or she specifically talks about caregivers when attempting to assess internal representations. Certain strategies that do not in-

volve interpersonal dependence—such as engaging in a favorite activity for relieving unhappiness—may be age-appropriate and highly adaptive, and therefore indicative of how the child's IWMs have, over the course of development, helped to shape his or her ability to regulate painful and upset feelings. On this scale, raters looks most carefully at responses to the question asking what the respondent does when distressed.

Lowest scores are given when there is a marked lack of strategy, such as "fight or flight" approaches. These are exemplified respectively in the following two responses to the question, "What do you do when you're upset?"

> Respondent: If I had gotten in a fight with someone I would fight them and just keep fighting until someone loses or someone goes home.
> Respondent: I would push my head against a pillow and not react in any way at all.

Responses can be either highly aggressive *or* highly avoidant to be given lowest scores; the central feature is the respondent's inability to effectively adapt to and recover from feeling upset. Low marks may also result when respondents refuse to provide a strategy, either because they claim they don't know what they do or because they claim that they never feel upset. In the latter case, the child's response would also indicate poor truthfulness.

High scores are given when the respondent displays a clear adaptive strategy, which appears consistent (i.e., high in truth) and is accompanied by a relevant example (i.e., high in relation).

> Interviewer: When you're upset, what do you do usually?
> Respondent: Oh, I don't really know. If I can, I go out for a walk and if I'm at school, I will just go and sit somewhere quiet, and just be satisfied listening to music, if I'm mad or upset, up or down.
> Interviewer: And can you tell me about a time when you were upset?
> Respondent: I had a whole day when my brother was going back to England, and I wanted to go back, as well. There really wasn't enough time, but I wanted to go back with him and thought it was really unfair.
> Interviewer: And what did you do then? What happened?
> Respondent: I just went inside my bedroom and threw a few pillows or something. I stayed in there awhile till I calmed down. I realized it wasn't so bad, I would go back soon enough.

In the above example, the pseudo-aggressive component of her example ("threw a few pillows") is still considered adaptive, as she presents it in a context that demonstrates her secure IWMs. By telling the interviewer that she "realized it wasn't so bad", she is showing her internal representation of the world as coherent and self-righting, and that she (unconsciously) uses that representation to calm down and organize her experience. Also important to note is that the child's initial ambiguity ("Oh, I don't know") is not counted against her in rating adaptive response. Here and throughout the interview our interest is to give respondents the benefit of the doubt and have the final coding reflect their best capacity in all domains.

Reflective functioning in the FFI

In the FFI, RF is operationalized across three subdomains associated with high RF capacity: developmental perspective, theory of mind, and diversity of feeling. *Developmental perspective* represents the child's ability to contrast current thoughts and feelings concerning important relationships or his or her self-view with past attitudes. *Theory of mind* is the ability to assume the mental or emotional perspective of another person. *Diversity of feeling* is defined as the child's ability to show an understanding of diverse (negative and positive) feelings being present in significant relationships. As appropriate, these dimensions are scored for each relationship investigated during the interview, including caregivers, siblings, peers, teachers, and self.

Developmental perspective. To demonstrate developmental perspective, the respondent contrasts his or her current thoughts and feelings on a matter of substance (i.e., something other than tastes in food or sporting activities) with past attitudes or styles of response. This pertains particularly to a pair of questions in the interview, "How has your relationship with your parents changed since you were little?" and "What do you think the relationship with your parents will be like five years from now?". Evidence for developmental perspective may come from other portions of the interview, as well, such as when one child from a community sample oriented his experience by reflecting on a sibling:

> Respondent: I've seen that in the last year or so, my parents give my brother a lot more freedom, you know, they let him do his thing. So I expect, I don't know, it feels like they're very over-protective of me now, but I expect that once I'm his age, they'll ease back, as well.

Especially impressive are responses that acknowledge that the relationship has both changed and stayed the same in different ways over time, and will continue to do so in the future.

> Interviewer: Can you think back and tell me if you think that your relationship with your parents has changed since you were little?
> Respondent: Um, yes and no. The fact that they can sort of trust me now and they know that I will be able to look after myself, um, but not really, no, because we still get along really well like we did when I was younger.
> Interviewer: Thinking ahead to the future, say, in five years, can you think how your relationship with

your parents might be different?
Respondent: Um, we might not see each other as much because I'll be off at sort of university or whatever, but probably still the same—get on really well and be able to tell them whatever.

RF is akin to an "as-if" mode of thinking in which multiple perspectives can be considered without being taken as concrete and objective truths. As such, when children are able to tolerate ambiguous "yes and no" states without becoming confused, distressed, or contradictory, it is usually indicative of high RF. When rating theory of mind, described below, appreciation of the opaqueness of the mental states of others is a similar indicator of the child's ability to hold several possibilities in mind at once.

Theory of mind. In coding theory of mind, raters look for evidence of the respondent's ability to assume the mental and emotional perspective of another person, paying special attention to responses to the questions, "What do you think your [mother/father/sibling/best friend/teacher] thinks of you?", which appear periodically throughout the interview. Responses need not be lengthy or overly detailed—one clear and compelling statement about what the other person thinks and feels merits the highest score. As mentioned previously, the most sophisticated responses often show appreciation for the opacity of another's mental state. This may involve the respondent expressing what he or she "hopes" or "imagines" the other person to think and feel, or acknowledging the difficulty of the question but then going on to answer it as clearly as possible.

Respondent (re best friend): I hope she thinks I'm a good and trustworthy friend. I guess you never know, but I mean we tell each other everything, so I imagine she thinks of me that way.

When looking at a fully scored protocol, it can be clinically informative to consider consistency of theory of mind across relationships. A child with all low scores may, for one reason or another, be developmentally incapable of assuming a mentalizing stance. This is quite different from a child who gives clear responses in reference to sibling and best friend, but then cannot provide or gives an incoherent response in regard to mother. This pattern would indicate that there is not a global deficit in RF, but rather that the relationship with mother in particular inhibits reflection.

Diversity of feeling. This dimension covers evidence of the respondent's ability to show an understanding of diverse (negative and positive) feelings being present in significant relationships. The guiding question for raters is how easily the child can think of both negative and positive aspects of relationships involving self and other people. Higher scores require that the respondent not only show that he or she holds diverse feelings, but also demonstrate an understanding of those diverse feelings.

Unsurprisingly, total refusal to acknowledge either favorite or least favorite qualities, in response to specific prompts as well as anywhere else in the narrative, yields lowest scores.

Interviewer: What's the best part of your relationship with your mom?
Respondent: The best part? I'm going to skip that one.

Low scores also result when favorite and least favorite responses display marked contradiction with one another, so that no diversity of feeling is actually present. This may also influence overall truthfulness of the narrative. For instance:

Interviewer: What's the best part of your relationship with your mom?
Respondent: She—, that *she listens to me*. I go on for ages about something and she just sits and listens to me.

The child goes onto contradict herself later in the same interview, suggesting that both her responses are anxiety-laden and driven by an idealizing defensiveness rather than genuine reflection:

Interviewer: And what's the one thing you like least about your relationship with your mom?
Respondent: I—, well she doesn't—, I don't know. She, she gets back quite late from work and she's not there in the morning, she's at work as well, so-, it's just *I don't really talk to her a lot* and when she gets home she has to do dinner and work and everything so *I don't talk with her a lot*.

Still on the low end are instances when diversity of feelings is shown but the respondent does not have a clear understanding of it. One or both statements regarding most and least favorite aspects are *instrumental* in nature, focusing on behavior over emotion. Accompanying examples are absent, or contain some contradiction or incoherence, damaging the credibility of the diversity of feeling offered.

Interviewer: What's the best part of your relationship with your dad?
Respondent: Well, usually when we're going to watch a film on Friday he gets take-out, he might get a Chinese take-away or something.
Interviewer: And what's the one thing you like least about your relationship with your dad?
Respondent: He is a very, very deep sleeper [...] It just can be irritating if you want, if there's something you've done for him and he just can't be bothered.

When positive and negative qualities are described in a thoughtful way that demonstrates not only their presence, but the respondent's understanding of his or her own complex feelings regarding self or others, highest scores are granted. Accompanying examples are concise and relevant illustrations of the diverse feelings, with no evidence of anxiety, contradiction, or incoherence.

Method of analysis

Analysis of an FFI transcript demands consideration of multiple constructs that involve both the content and process of narrative speech. Even those dimensions that are strongly influenced by what is said (e.g., does the respondent provide a "favorite" and "least favorite" quality about himself) must also be evaluated in terms of how the information is presented (e.g., presence of idealization, anxiety, or disorganization). As such, we advocate a "double read" method for analyzing FFI texts.

On first read, raters can make provisional notes pertaining to content-related scores, but should focus predominantly on the process of speech and obtaining a general "feel" of the interview, which will contribute to the global coherence ratings. Is the respondent concise and on point throughout, or does he or she regularly "lose the thread," give flat monosyllabic responses, or fall into overwhelming, preoccupied tirades? The *quality* of digressions into incoherence should be noted in terms of Grice's (1975) maxims, but so should the *temporal flow* and *range* of those digressions. In other words, what is the maximum coherence achieved by the respondent, and what is the minimum? Are the oscillations mild or severe, frequent or rare? In this first read we are hoping to derive some sense of the "tug of war" going on between the respondent's early-established IWMs, which are deep-seeded and automatic, and the respondent's RF, which developed later and is challenged by some of the FFI's more cognitively and emotionally demanding questions. The ebb and flow of coherence is our global proxy of this IWM-RF dynamic, and once we have a sense of it, we return to the beginning for a closer read.

The second time through, we engage in a slower, more content-specific analysis and start to assign numbers to the FFI's various scales. Having already familiarized ourselves with the interview on the first read, we are less likely to make coding errors that would typically result in under-representing the respondent's capacity. For instance, a brazen or impatient rater may see on first read-through that, when asked "What do you think your mother thinks of you?" the respondent replied, "I don't know," and the rater will immediately give Theory of Mind for mother the lowest score of "1." With this already committed to paper, the rater may gloss over a later statement made spontaneously by the respondent, in which he says, "Sometimes I think my mother wants to me to care about school more than I really do," which clearly indicates an ability to consider his mother's mental state. By only attending to the question that explicitly demanded theory of mind, the rater is no longer measuring the respondent's RF capacity, but simply his capacity to provide a specific answer at a specific point in the interview.

Final classification. Assigning an attachment classification to an interview is the last step of the FFI coding process, and represents an integration of the constructs discussed above. Before a final classification is made, transcripts are rated for the presence of security, dismissiveness, preoccupation, and disorganization on Likert-type scales. This approach reflects our contention that attachment patterns are dimensional, and that a child may exhibit diverse strategies when the attachment system is activated, some healthier or more adaptive than others.

A child's rating in security is directly tied to the coherence of his transcript—an interview cannot be considered high in attachment security if it is low in overall coherence. Adaptive response and developmental perspective codes are also regarded as particularly indicative of the balanced, open, and reflective style typical of secure adolescents. The insecure and disorganized ratings, conversely, demand correspondingly low overall coherence scores. A high dismissive rating is considered when the child is low in relation and economy (on the side of providing too little information), as well as when diversity of feeling is restricted, either because the child is inclined toward idealization or derogation in his view of the self or others. The preoccupied rating is highest when relation and economy (on the side of providing too much information) are low, and the child's capacities to reflect on self and others are restricted by excessive anger, blaming, and indecisiveness. Disorganized transcripts are marked by poorly monitored speech and incompatible strategies, in which the narrative feels disoriented and the child appears manifestly frightened or dissociative during the interview. As a result, significant impairment is typically observed across all coherence, RF, and IWM codes when assigning the highest disorganization score to an FFI.

Each dimensional classification code is made independently before a categorical determination is considered. The final attachment classification represents the *dominant strategy* observed in the transcript. In cases where multiple strategies are present, a subtype of "other" may be assigned to the overall classification of secure or insecure. For instance, a child's transcript may be scored as exhibiting high security, mild dismissiveness, no preoccupation, and no disorganization—the final classification is secure-autonomous, as this represents the dominant strategy of the interview. Another child's transcript may be rated with mild security, moderate dismissiveness, high preoccupation, and no disorganization. In this instance, coders must decide if the interview predominantly features a preoccupied strategy—resulting in a classification of insecure-preoccupied—or a significant combination of preoccupied and dismissive strategies—resulting in a classification of insecure-other. Finally, a third transcript may be given codes of no security, mild dismissiveness, mild preoccupation, and high disorganization. In this case, coders would likely determine that the transcript is marked by a *lack* of strategy, thus earning the classification of disorganized/disoriented.

Conclusion

IWMs and RF develop and solidify at different periods over the course of development, and they dynamically interact within and between generations to inform an individual's overall attachment. While the field has well-established methods of measuring IWMs in infancy and RF in adulthood, there are few ways of exploring how these two vital constructs coexist in the developing child. In this paper we provided an introduction to the Friends and Family Interview, which attempts to fill that gap by catering its design and scoring approach to the developmental capacities of early adolescents. We elaborated in detail three constructs central to using and understanding the FFI—coherence, IWMs, and RF—while placing special emphasis on carefully considering both content and process of speech when analyzing transcripts.

To date, the FFI has appeared in few published research articles, and more data is needed to establish its psychometric properties and cement it is as a standard for measuring attachment and RF in early adolescent populations. However, our work thus far has demonstrated robust inter-rater reliability and construct validity in both community (Kriss, Steele, & Steele, 2011; Steele & Steele, 2005) and at-risk (Kriss, Steele, & Steele, 2012) samples, and we hope the current and future work of other researchers utilizing the FFI will uphold and expand these early findings across a diverse range of populations. The FFI holds significant research and clinical value in its unique approach to eliciting and systematically rating autobiographical narratives from an age group that has been notoriously difficult to assess from an attachment perspective.

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The Creative Journey of Grounded Theory Analysis: A Guide to its Principles and Applications

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Abstract. Grounded theory analysis is a method widely used by qualitative researchers. This method interprets empirical materials to formulate a theory about a particular social phenomenon. In this article, we describe the steps of grounded theory method, which comprises open coding of the material followed by the grouping of open codes into categories that are increasingly abstracted to capture the essential meaning of the phenomenon. This depiction is offered as a set of explicit guidelines for researchers interested in the method.

Keywords: grounded theory, methodology, guidelines, qualitative research

Grounded theory analysis is described as a flexible approach to studying language and meaning-making in the social world (McLeod, 2011). It is attractive to researchers who prefer to immerse themselves in the data before formulating a theory and who enjoy working with natural language (Rennie, 1998a, 1998b). Grounded theory method can be used not only with qualitative data, such as interview transcripts, discourse and observational notes, but also with arrays of quantitative data (Glaser & Strauss, 1967). Any source of information that helps to explore and understand a specific phenomenon of interest can produce data for a grounded theory analysis.

Grounded theory analysis was first introduced in the 1960s by two sociologists, Glaser and Strauss, as a method for using preexisting data to conceptualize theories. At the time, this method was an important innovation that contrasted with the conventional, deductive theorizing typically used in sociology. Grounded theory method has been applied to a wide range of topics by qualitative researchers and has been adopted by other health and social science disciplines, including counseling and psychotherapy.

The Discovery of Grounded Theory was published by Glaser and Strauss in 1967. This work emphasizes the approach's three main principles: First, that the researcher should discover new meanings in the social world; second, that the aim is to generate a theory for better understanding the phenomenon being investigated; and third, that this theory should be grounded in the data (McLeod, 2011). Glaser and Strauss had diverse backgrounds, and this diversity was reflected in their individual versions of the method. Glaser (1978; 1992) was a student of Lazarsfeld and Zetterberg at Columbia University and had a comparatively more quantitative orientation. Strauss (1987; Strauss & Corbin, 1990, 1998) hailed from the Chicago School of Sociology, which emphasized ethnography and pragmatism. While there, he conducted field studies of psychiatric institutions. Although these approaches were complementary in the beginning (Strauss in an interview from 1994; Legewie, 2004), the differences later led to a schism between Glaser and Strauss (see the exchange between Rennie, 1998a, 1998b, and Corbin, 1998). Some contemporary authors argue that Glaserian and Straussian grounded theory are two profoundly different procedures (Strübing, 2007). Although a comprehensive overview of the coding procedures will be given later on, it is important to address this issue, albeit briefly. To provide an overview of terminology specific to grounded theory, it is necessary to understand the method in its historical context and to describe its development over time.

Reviewing the literature on this topic, Mey and Mruck (2007) compare Glaser's (1978) basic coding procedures with those of Strauss (1987) and Strauss

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and Corbin (1990).[1] To preface this comparison, it should be noted that in the original 1967 work, Glaser and Strauss used the term "coding" to refer to the activity that produces both codes and categories; the latter were more abstract than the former. Recently, the software Atlas.ti (see Gibbs, 2007; Muhr, 1994) has simplified its author's interpretation of Glaser's method by using the term "code" to refer to both codes and categories. In the case study presented below, we used the Atlas.ti software. Therefore, to make this overview consistent with our presentation of the case study, we shall use the term "coding."[2] Although we use this wording throughout the text, we do not subscribe exclusively to Glaser's approach to grounded theory. This fact will become apparent when we implement a coding procedure (axial coding) that was introduced and labeled by Strauss and Corbin.

Glaser enumerates the steps of analysis as follows: First, open coding, or low-abstraction codes that use the constant comparison procedure, including what Glaser and Strauss (1967) referred to as *in vivo* codes, or codes that use pithy representations of experience provided by the participants themselves. Second, selective coding, which entails system modifications that focus on an emerging preliminary coding idea. The aim of this step is to reach code saturation, at which point new data will require no further coding. The third step is theoretical coding, or the emergence of a core idea expressed as a core code that is then used in theory development.

Alternatively, in Strauss and Corbin's work (1998; see also Strauss, 1987); Corbin & Strauss, 2008), the procedural steps are open coding (as in Glaser's [1978, 1992] model); axial coding (analyzing a given code in terms of a coding paradigm and conditional matrix [see below] and relating the given code to other codes); and selective coding (integrating and refining code families to form a concept that results in the theoretical model).

The function and meaning of "selective coding" in Glaser's work places more emphasis on exploring the specific phenomenon/material under investigation and is not yet directed towards building the theory. It serves a perspective-giving function during the process of open coding, leading the researcher in a specific direction. In Strauss and Corbin's (1990, 1998) work, "selective coding" is the final step of the analysis. After the open codes are put into perspective and connected among each other (axial coding), the final selective coding step is focused on the emerging core code. According to the procedural sequence (from open coding to the core code and emerging grounded theory), the selective coding step in Strauss and Corbin's work can be compared to the theoretical coding step in Glaser's procedure, though it is not exactly the same. Additionally, Strauss and Corbin adopted and modified Glaser's notion of the "Basic Social Process" (which Glaser saw as a prominent member of his "coding families") when formulating what they called the "Coding Paradigm," which became a prominent part of their grounded theory procedure. Specifically, during axial coding, the researcher analyzes the given code in terms of (a) the coding paradigm, which comprises the conditions, context, actions and consequences of the behavior that is codified, and (b) what they term the "conditional matrix," or network of potentially relevant conditions that need to be taken into account when analyzing a given incident.

More recent versions of grounded theory analysis have been introduced by several researchers (Glaser, 1978; Rennie et al., 1988; Charmaz, 2000; Strauss & Corbin, 1990, 1998; see McLeod, 2003), who have modified the original grounded theory procedures in several respects. This has led some observers to use the term "grounded theory methodology" instead of referring to one grounded theory method (Mey & Mruck, 2007).

Allen (2010) argues that whereas Glaser and Strauss (1967) employ a more formal and classic form of grounded theory in which the emergence of a theory is considered to be as important as verification of the theory, Strauss and Corbin (1998) provide a set of procedures embedded in the coding paradigm that they claim validates the codes and categories. Meanwhile, Charmaz (2006, in Allen, 2010, p. 7) articulates a more constructivist view and suggests that "the researchers are not separate from the theories but construct them through their interactions with people, places and research perspectives." In addition, Rennie (2000) emphasizes the interpretive aspect of the grounded theory method, asserting that it is methodologically hermeneutical (see also Locke, 2001). Clarke (2005) suggests a more postmodern view of grounded theory, introducing an innovative method that uses situational maps to analyze the data. For a general overview, see Bryant and Charmaz (2007) and Morse et al. (2009).

Despite these differences, in all of the versions, the researcher intends to generate theory through the exploratory, interested and open-minded examina-

[1] Mey and Mruck (2007) compare the two procedures in an elaborate literature review that begins on page 25 of their popular "Grounded Theory Reader," which consists of articles by leading grounded theory experts in the German and English language, including original interview material from Barney Glaser and Anselm Strauss.

[2] Specifically, some grounded theory researchers describe the results of open coding as "codes" (as can be seen in the grounded theory-based software Atlas.ti, which was highly influenced by Glaserian grounded theory) and identify higher level, or second-level codes, which include more interpretation and are therefore called "categories." Other grounded theory researchers argue that a low-abstraction "code" is already a low-abstraction category because it already involves interpretation. We use the following sequential labeling: codes, second-level codes, code families (which are groups of first- and/or second-level codes) and core categories. We agree that "codes" already involve interpretation. We chose this terminology based on our computer-assisted work with Atlas.ti, which uses the Glaserian terminology.

tion of material rather than using that material to verify an existing theory (McLeod, 2001; Rennie, 1994; Rennie et al., 1988). In addition, all of the versions entail a family of procedures. Specifically, all involve the constant comparison method. This means that new codes evolve and are compared to codes already conceptualized during the research project. Throughout this coding activity, the researcher reflects on his or her own background and the ideas he or she contributes to the research and formulates preliminary thoughts about the meanings of the texts under analysis, considering possible connections between codes, etc. The text as a whole is used to inform the meaning of its parts and vice versa, creating a hermeneutic circle that eventuates in the creation of concepts, which are represented as codes. This is accomplished through the procedures described as selective, axial and theoretical coding, in which the researchers try to create connections among the codes and connect the codes with existing theories. This process yields a set of core codes or an emerging grounded theory that explains the phenomenon of interest as a whole and in its particulars.

These explicit steps for applying grounded theory method can also be described in more theoretical terms as eductive,[3] abductive, deductive and inductive processes. Although the method is commonly described as involving induction, or bottom-up analysis, it has been argued that it entails more than induction. During the inductive collection of data, researchers may discover new meaning that is drawn out, or educed, from the data. The educed meaning is represented as a concept, which is turned into a hypothesis or abduction—an initial prediction of how the phenomenon might be described (see Salvatore & Valsiner, 2010). We proceed to deduce that the additional text may provide evidence in support of the hypothesis, which constitutes an inductive analysis of the text. During this induction, new meaning may be educed, necessitating a new round of the logical operations. This cycle continues until no new meanings are educed from the corpus of texts, at which point the analyst may consider the categorization of meanings educed to be saturated (Rennie, 2012; see also Rennie & Fergus, 2006, on embodied categorizing).[4]

The skill of the researcher

An important aspect of the grounded theory approach is the attitude of the researcher. The approach requires a curious and passionate researcher who is primarily interested in understanding a particular phenomenon and is also able to apply specific research procedures. The goal of the researcher is to examine the data thoroughly, and it is therefore important to be able to be sensitive to the different meanings the data may suggest. As Rennie et al. (1988, p. 141) stress, "the grounded approach forces investigators to stay close to their data, so that somewhat different theories arising from the same data are the result of the different analysts emphasizing different aspects of them." Additionally, for the researcher to be both immersed in the data and able to act with theoretical sensitivity, it is important for him or her to be able to reflect on his or her own biases and assumptions (McLeod, 2011).

Another important characteristic of the grounded theory approach, which some authors stress more strictly than others, is that the researcher should not review the literature before collecting the data (McLeod, 2011). Proponents of this practice believe that the research process should begin with the acceptance of uncertainty and move gradually towards the development of a differentiated theory (Elliott, Slatick & Urman, 2001). It is important to approach the phenomenon with no prior specific knowledge and to explore its nature during the process of analysis without being influenced by previous theories and assumptions and without presuming the outcome of the study. Strauss and Corbin (1990), for instance, assert that a literature review is unnecessary because the analysis of an effective researcher will reveal previously unthought of categories. In addition, the absence of a specific research question is important; the researcher should only have an abstract idea of the phenomenon he is investigating and remain open to exploration (Glaser, 1992).

The application of grounded theory is inspired by the everyday language of the participants of the study, is influenced by the theoretical and professional community to which the researcher belongs and depends on the analyst's interpretation of the participants' responses (McLeod, 2011). The researcher's representation of the meanings of the text in terms of a set of codes is a complex, creative process. Users of the method have mentioned that they have become so immersed in the phenomenon under investigation that it has become their life. Therefore, good interpretation involves "living inside and outside of the experience and monitoring of the degree of fit between the two aspects" (Rennie, 2000, p. 487).

Method

Data collection and theoretical sampling

Having presented a broad overview of grounded theory method and the role of the researcher, we now proceed to describe a set of guidelines and specific steps for applying the method. In what follows, we will describe the key concepts of the method, namely, theoretical sampling, constant comparative data analysis,

[3] Eduction is defined as "The action of drawing forth, eliciting, or developing from a state of latent, rudimentary, or potential existence; the action of educing (principles, results of calculation) from the data" (Oxford English Dictionary in Rennie, 2012, p. 388).

[4] For a more detailed discussion, see Rennie's paper (2012) on Methodical Hermeneutics.

diagramming, memo writing, and conceptualization of a core code, to explain how users of the method collect data and code them to the point of saturation.

Once the researcher identifies a research question that is broad and open-ended, data are collected that may contribute to the exploration of the phenomenon. Levitt (in prep.) states that differences among participants are seen as strength in grounded theory analysis because these differences enrich and broaden the theory. A diverse sample is able to represent existing variation in people's perceptiveness (Higginbottom, 2004). However, that which is sampled must not exceed the boundary of the specific research question.

First, participants are chosen who promise to maximize the chances that aspects of the phenomenon will emerge clearly in the initial stages (Rennie et al., 1988). Thus, data collection begins with selective sampling, or identification of the population and its characteristics prior to data collection (Schatzman & Strauss, 1973, in Draucker, Martsolf, Ross, & Rusk, 2007). In this case, one knows how sampling needs to begin but not what the final results will be (Coyne, 1997). As the study progresses, the researcher should shift to theoretical sampling when concepts and descriptive categories begin to emerge (Draucker et al., 2007).

Theoretical sampling is a central feature of grounded theory method and can be defined as an approach "in which new observations are selected to pursue analytically relevant distinctions rather to establish the frequency of phenomena" (Emerson, 1981, in Higginbottom, 2004, p. 9). Theoretical sampling is considered crucial to the development of a dense theory (Fassinger, 2005). Procedurally, the researcher compares and contrasts the available data to decide what data would be useful to collect next. Schwandt (2001, p. 111) mentions that "theoretical sampling means that the sampling of additional incidents, events, activities, population, and so on is directed by the evolving theoretical constructs." When conducting theoretical sampling, the researcher collects and analyzes his or her data *simultaneously* and then decides what data to collect next.

Theoretical sampling involves testing, elaborating and refining a code and then sampling in a way that promises to develop the categories and their relationships and interrelationships (Coyne, 1997). A researcher using the theoretical sampling method can enhance the process by being flexible enough to change interview styles between participants and add diversity to the sample. It is also possible to ask key participants to provide more information for essential categories (Glaser, 1978). Some studies also mention that authors who use theoretical sampling tend to modify their interview questions as the study progresses (Draucker et al., 2007).

Clearly, theoretical sampling is a complex process that is dependent on the skills of the qualitative researcher. Therefore, according to Mason (2002), the researcher needs to be skilled in putting people at their ease, listening and reflecting and monitoring and structuring the flow of the interview.[5]

Furthermore, sample sizes are usually small by conventional research standards. Small samples are more conducive to thoroughly reviewing and capturing the richness of the data (Miles & Huberman, 1994). Typically, grounded theory research is carried out on samples of between 8 and 20 participants (McLeod, 2011). In theoretical sampling, data collection continues until the investigator judges that there are no more new emergent themes or concepts to be discovered. At this point, the categories are considered saturated because the constant comparative procedure has led to the conclusion that no new information is forthcoming (Tuckett, 2004). A more detailed explanation of the process of constant comparison will be given below in the description of the analysis.

Data analysis

The data analysis method resembles theoretical sampling because, as was indicated above, data gathering and coding occur simultaneously. The researcher, after collecting the initial sample, begins the process of conceptualizing descriptive categories. Glaser (1978) suggests that the material should be analyzed line by line, whereas Rennie et al. (1988; see also Rennie, 2012) argue that the method is expedited when the text is divided into meaning units. They define meaning units as passages of text that typically, but not always, "contain" a single idea. The meaning units may be short (e.g., a phrase), as in the line-by-line coding used by Charmaz (2006), or as long as a paragraph, a page, or more (see Rennie, 2006).

The style in which researchers conduct analysis in practice currently varies greatly. Some keep analytic notes; others prefer to condense the content of meaning units on cards; and still others use Microsoft Word to document their categories or even use a computer software that was designed to assist the qualitative research process, for example, Nvivo (Gibbs, 2002) or Atlas.ti (Gibbs, 2007; see also Muhr, 1994). The latter is designed to accommodate the grounded theory method and can be used for various types of text, audio and video analyses. Once the data are broken into meaning units, the researcher educes their meanings and represents each meaning as a descriptive code. For the initial stages of the study, it is recommended that the codes remain close to the language of the informants to promote grounding in the data. This process is thus open to the adoption *in vivo* codes or pithy terms and phrases used by the par-

[5] Occasionally, theoretical sampling is not possible. This is the case when the researcher is presented with a "found" sample intact, acquires a sample through a "snowball" approach or has access to a data bank. It is generally agreed that use of such sampling, while not ideal, is acceptable if the researcher recognizes its limitations.

ticipants (see above; see also Strauss and Corbin, 1998). Each code is filed with the given meaning unit assigned to it, accompanied, perhaps, by a condensation of the meaning unit if such condensations provide convenient overviews of the meaning units assigned to the codes. This process of categorization is called open coding (Elliott et al., 2001). Open coding is considered the heart of the method, and its aim is to generate as many codes as is deemed appropriate for each meaning unit in the text. Strauss and Corbin (1990, p. 61, in McLeod, 2011) define open coding as the process of "breaking down, examining, comparing, conceptualizing and categorizing data." The same authors suggest that the codes should refer to activities or processes and not to static entities, but this admonition is not set in stone.

In the following example, we present a text segment derived from a transcript of an interview study titled *Exploring the process of therapeutic change in systemic family therapy* (Dourdouma, in prep.). The segment originated in an interview (conducted by the first author of this paper) with a female client in her forties. She is describing her experience of internal change after having completed her therapy:

> Interviewer (repeats and summarizes what the client has just said in her own words): So the changes had to do with you, with your internal life?
>
> Client: Personally, to me, yes [...] the changes had to do with my internal life...also very much with the expression of my feelings, because that is really, really important [...] emmm, the fact that it (the emotion) can come to the surface too, that it can be externalized [...] because once I was a very introversive person, so I think that if something changed, it is through self-awareness [...] mmm I think I changed towards me, not me towards others that much.
>
> Interviewer: Yes, I have understood that, I think that is very clear to you.
>
> Client: Yes, that is clear
>
> Interviewer: But what exactly has changed, what has changed towards yourself? [...] You already mentioned some things, for example that you are more open.
>
> Client: Yes, I am more open, I certainly have more self-esteem, which I didn't have in the past, I appreciate myself differently, I am more assertive, whereas in the past I was not [...] I am less tolerant [...] There are people that are in therapy in order to become more tolerant because they are not, but I became less [...] I mean that I became less tolerant with things that I don't like, with things that are not in my interests [...] I distanced myself. You know, I don't want to waste my time anymore, I want my time to be qualitative and substantial.
>
> Interviewer: So we talk about internal and substantial changes, which may, as you say, not influence your behavior that much, but they have certainly influenced your life, your relationships with other people.
>
> Client: My relationship with other people is on a second level. The changes influenced the relationship with myself and then with others. That's why I am telling you that I didn't change my behavior. I think that my behavior didn't change. This is the way I feel, I think I am the same person. I think that because of the fact that the relationship with myself changed, the place where I have placed myself changed [...] I think that this has consequences [...] certainly it has consequences.

To model open coding, we present the following codes, which we conceptualized for the above meaning unit. The coding process of the study presented above was discussed and reviewed by a supervisor (the second author of this paper) in order to reach consensus (Guba & Lincoln, 1989) and ensure the trustworthiness of the results. To represent our results, we will use the following sequential labeling: Codes (the result of the open coding phase, low in abstraction, close to the actual words of the interviewee), second-level codes (higher order codes created by subsuming codes), even higher order codes representing groups of first- and/or second-level codes and core codes (the primary conceptual results, most prominent and general aspects of the investigated phenomenon). For more detailed information about why we chose this terminology, please refer to footnote 3. The following codes depict the concept-themes derived from the client's experience of internal change:

- Code 1: *Through self-awareness, the emotion came to the surface. towards myself, not to others.*
- Code 2: *I changed towards myself, not to others.*
- Code 3: *I became more assertive (less tolerant, which was good and in my interest).*
- Code 4: *Becoming more focused on what I want, not wasting myself anymore.*
- Code 5: *Behavior does not change, but the way I understand/relate to myself does.*

It is important to carry out the analytic process of open coding with what Strauss and Corbin (1990) call theoretical sensitivity (see also Glaser, 1978). This means that the researcher must challenge his own preconceptions and assumptions and delve into the experience of the participant. Wertz (1983, in Elliott et al., 2001) agrees and refers to this process as psychological reflection, or immersing oneself in the informant's experience. The researcher accomplishes this through the empathic process of "entering and dwelling," separating his or her assumptions from the meanings that emerge from the data. As mentioned in the introduction, Rennie and Fergus (2006) describe this process as *embodied categorizing*. During this process, the researcher, who has just begun to interpret and understand the text, feels its meaning intuitively. This understanding is arrived at through one's intellectual capacities and through the memories, images and associations that are stored and actualized in one's body.

In the process of analyzing, the researcher employs another intuitive technique: the constant comparative method. This method consists of a constant comparison of the categories until the meanings of

Table 1. Axial coding that represents main categories (I, II), second level codes (A, B, C) and low abstract codes (1,2,3,4) from a grounded theory study of clients' experience of change

I. Getting in touch with my Inner Self
A. Focusing on my needs
1. I stopped living the life of others and I saw my own deep needs of partnership
2. I stopped wasting myself and my time on things I was not interested in
3. Becoming more focused on what I want
4. I realized I should do things for me and not neglect myself
B. Putting my own boundaries
1. I learned to put my own rules for myself
2. I learned to say "NO" and that is relieving
3. I realized I need to put boundaries
C. Allow differentiation of myself
1. I was afraid to change my life and I let things the way they were
2. It was important to be different from the mass
3. Allowing myself to change
II. Relating to the others
A. Improving existing relationships
1. I reformed the relationship with my parents
2. I stopped being afraid and this improved my communication with others
B. Being more attuned to others
1. Understanding that people have different timings
2. Giving value on my partners' needs
3. Changing my behavior towards other people

all of the categories have been compared and contrasted with each other (McLeod, 2011). This approach encourages the analyst to constantly observe the similarities and differences among the categories, and it allows the diversity and the complexity of the data to be explored (Elliott et al., 2001). The researcher compares his previous understanding with the new discoveries, becoming increasingly immersed in the data. According to Rennie (2006; Rennie et al., 1988), during the process of constant comparison, the researcher begins to categorize data with the intention of creating a theory. Thus, the development of a new theory, which is the central aim of grounded theory method, occurs through the constant comparison of the data collected via theoretical sampling (Coyne, 1997).

In the following example, we present the comparison of the codes and the formulation of the more abstract, second-level code. The following three (low abstract) codes were compared and contrasted and then combined into one second-level code as follows:

- Code 1: *Change happened through pain and personal work.*
- Code 2: *Change through therapy comes with time and hard work on the client's part.*
- Code 3: *There is no magic recipe for bringing about change; it requires time and hard work*

After comparing the three codes, one second-level code emerges that includes the meanings of all three codes:

- Second-level code: *Pain, time and hard work bring about change.*

As the analysis progresses, the analyst begins to develop a focus, which is expressed through theoretical sampling and selective coding.[6] During this process, the previously identified categories are used for more deductive coding. Nevertheless, the researcher remains open to discovering new emerging categories. Muckel (2007) highlights that this openness to new categories expresses the researcher's openness to a change of direction. Even when one believes that he or she has reached the end of an analysis, new, unexpected information may appear that suggests a new path. Flexibility is a key characteristic of Grounded Theory and distinguishes it from other qualitative analysis procedures (such as Mayring's [2003] *qualitative content analysis*).

The next step in grounded theory analysis is axial coding, in which connections are created among the codes. To complete this task, the researcher identifies and observes the connections between the categories and organizes the data into a general formal framework according to a previous or emerging general understanding of the phenomenon (Elliott et al., 2001).[7] Elliott, Slatick and Urman (2001), note that axial coding plays an important role because it reduces the complexity of the analysis and produces a

[6] However, consider the differences among grounded theory methods that have emerged over time, described in the introduction of this paper.

[7] In Strauss and Corbin's work (1990), axial coding is a fundamental part of their coding paradigm. In Glaser's work (1978), this step includes the utilization of coding families for sensitizing concepts and overlaps with the next step, theoretical coding.

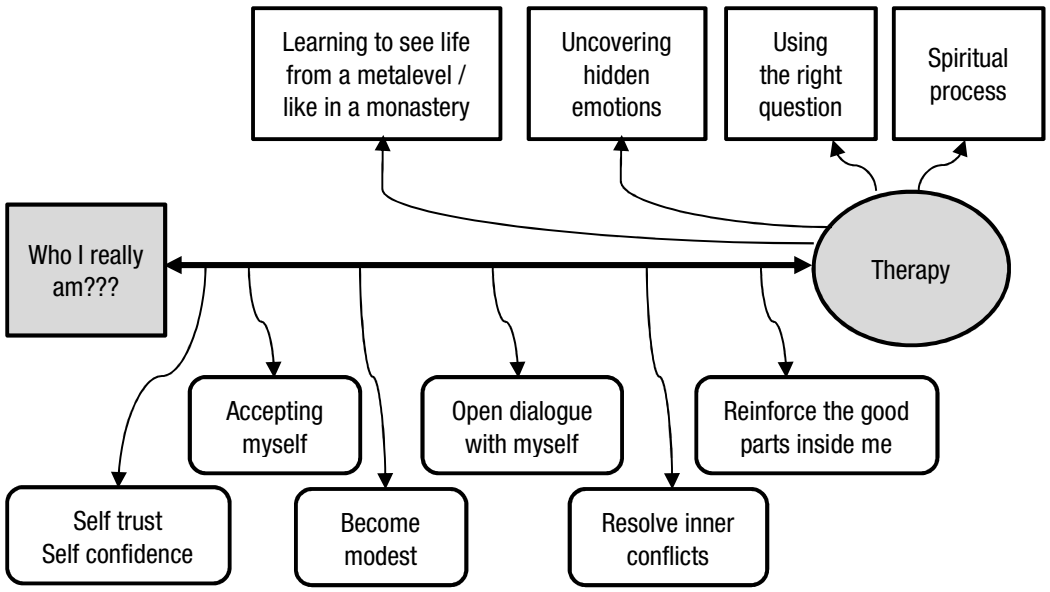

Figure 1. Graphic mirroring a male client's experience of systemic family therapy.

general narrative structure.

Table 1 provides an example of axial coding that was performed for a grounded theory analysis of data from our study of clients who had completed systemic family therapy. Clients' description of their experiences of change after completing therapy created the following second-level codes: (I) Getting in touch with my Inner Self; (II) Relating to others.

Table 1 shows that the second-level categories subsume lower-level codes.[8] In particular, clients referred to the process of "Getting in touch with my Inner Self," which is closely related to "Focusing on my needs." Furthermore, the latter process includes the processes of "Ceasing to live other people's lives and seeing my own deep needs for partnership," "Not wasting myself and my life in uninteresting things" and "Realizing that I should do things for me and not neglect myself." In addition, two other aspects of "Getting in touch with my Inner Self" included "Establishing my own boundaries" and "Allowing myself to differentiate." These processes also included subcategories, such as "Learning to establish my own rules." "Learning to say 'No'," "Allowing myself to change," etc.

The next second-level code described by clients was the process of "Relating to others," which included the following two processes: "Improving existing relationships" and "Being more attuned to others." Clients improved their "Relating to others" process by "Reforming relationships," "Eliminating fear to improve communication with others," "Understanding the differences in other people's timing," "Recognizing the value of other people's needs" and "Changing my behavior towards others."

The above example demonstrates that axial coding is a helpful process for the researcher because it emphasizes specific aspects and meanings and enhances the narrative structure of the analysis. As the data analysis progresses, fewer new descriptive categories emerge, and the analysis eventually reaches a point at which the codes (or categories; see footnote 3 for further information about these terms) are saturated (Rennie & Brewer, 1987). Saturation of the data means that no new meaning can be educed from new data that has not already been accounted for by the codes/categories previously conceptualized. Therefore, no new data need to be sought. The researcher then observes and identifies interrelationships between the codes and combines the codes into common themes. In other words, the initial codes are grouped, based on commonalities, into second-level codes.

Helpful tools for the data analysis process. From the beginning of the analysis process, the researcher is forming different hypotheses, observations, connections and associations regarding the codes that influence how the codes are formed and labeled. To make this (abductive-inductive) process transparent, the researcher should record these ideas and thoughts. The researcher's memos can be written accounts but can also include graphics. The type of graphic used depends on the researcher's preference; they may be pencil drawings on notepaper, PowerPoint slides saved on the computer or simply mental images inspired by metaphors. However the researcher documents his or her growing understanding, this

[3] Researchers use different words for this depending on the grounded theory tradition to which they ascribe. For some, higher-order categories subsume lower-order categories. For others, it is the properties of the higher-order categories that are subsumed.

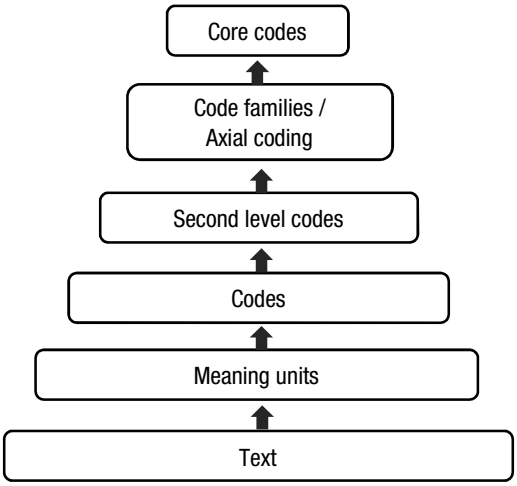

Figure 2. Main steps of grounded theory analysis.

documentation is considered the first step of conceptualization, and graphics typically accompany the qualitative analysis. Good (comprehensive and expressive) graphics mirror the researcher's understanding and his or her grounding in the categorizations, which in turn mirror the experience of the client.

For example, for the purposes of the study mentioned above (see Dourdouma, 2012b), the first author conducted an interview with a 38-year-old man who was asked about his experiences with systemic family therapy in Greece. The interview was focused on the process of change and was based on the *Change interview* (Elliott, 1996). We analyzed the interview, applied open coding and developed specific ideas about how these codes were connected. Figure 1 displays our understanding of this client's experience and presents the impressions created and the understanding reached in the process of the interview.

A good graphic (especially one that appears at the end of the analysis) that represents the main findings of a study should be as self-explanatory as possible. However, psychotherapeutic processes are complex phenomena, and the graphics representing them may therefore require a brief explanation. The graphic above depicts the therapeutic process of change of a client whose basic concern was to discover "Who he really is" (exact quotation from the client). Through his therapeutic journey, he seems to have gained self-trust and self-confidence, accepted himself as he is, resolved his inner conflicts, become modest and begun to hold an open dialogue with himself (these processes are all grounded in the data and represent codes). The client described therapy as a spiritual process that helped him to see life from a meta-level (the relevant code is "To see my life from a distance, like when living in a monastery"). He added that the therapist helped him to uncover hidden emotions by asking the right questions. In addition to listing the codes, the graphic (with its lines and arrangement of graphical items) condenses the individual codes *into a concept*. A graphic can include a sequence (first, next and last), causal links (if-then, because of) or suggest which codes are more closely related than others. The graphic above shows the client's reflections on therapy as a process. Beginning with "Therapy," the graphic explains how the client defines psychotherapy (uncovering hidden emotions, etc.). Therapy is here opposed to the "Who I really am" item. This reflects the client's struggle to discover who he is, what therapy is and how he can make use of this well-defined concept of therapy. The intermediate codes that connect the left and right side organize the client's experience of psychotherapy sequentially: By reinforcing his positive traits, he came to experience self-trust and developed more confidence in who he really was.

As this discussion demonstrates, memos and diagrams/graphics can help the researcher construct an interpretation of the material (McLeod, 2003). They may also help researchers "bracket-off" their ideas or assumptions to prevent them from interfering in the analysis process (Strauss & Corbin, 1990).

Reaching the end of a grounded theory analysis: Aiming at a core code. At the end of the analysis, the researcher conceptualizes the most central code. The core code is related to the other codes (and the second-level codes); it colligates or expresses in a single code the fundamental principle of the phenomenon under exploration. The core code should encompass the whole structure of the codes, including the relationships among them and among the codes and the data (Rennie & Brewer, 1987). Strauss and Corbin (1998) argue that the core code must be related to all of the other codes, appear frequently in the data and that its name should be abstract enough to generate a preliminary theory. In addition, the main code or codes should be theoretically related to the findings and theories of other studies (McLeod, 2011). The main code or codes that emerge conceptualize the data and capture their essential meanings. However, although arriving at a core code can be a difficult process, it is a meaningful process that contributes to the coherence and analytic depth of the study (McLeod, 2003).[9]

Figure 2 conveys our understanding of grounded theory analysis and presents the basic steps that researchers follow to arrive at the core code. The figure is constructed linearly to facilitate easy recognition of the steps. However, all of the sequenced steps are actually connected with each other recursively in a manner reminiscent of the hermeneutic circle; the core codes, relations among codes and among groups of

[9] For example, in the study (Dourdouma, 2012b) we refer to in the previous pages, the following preliminary core category has been identified: "The experience of therapeutic change, within the secure frame of therapy, is a process of deconstructing and reconstructing the house you live in: Yourself".

codes, etc. always refer to and build upon each other.

In the final sentences, we intentionally refer to the main code *or* "codes," which highlights another important modification in contemporary grounded theory analyses. Although the core code (or *the* code that organizes the resulting grounded theory) is the desired result in classic grounded theory designs, often researchers represent the results in a group of main codes. This may be because grounded theory techniques are sometimes embedded in research designs whose scope extends beyond generating one hypothesis/theory generating. In this case, some phenomena may require the interplay of three or four codes, rather than one overarching conceptualization (or one core code), to capture their complexity. In whatever way the results are made to best represent a phenomenon, the researcher must engage in a complex process at the end of the analysis. It is the researcher's primary task to first collect codes that are as differentiated as possible and then to sort them, become immersed in the data, rediscover the central themes and then, finally, to condense the work of one or two years into a simple, comprehensible concept. Whether the concept is expressed in the form of one grounded theoretical sentence, one core code or a set of interconnected main codes is therefore a secondary consideration.

Before concluding, it is necessary to mention that, according to Glaser (1998), a substantial grounded theory should be judged according to four components: fit, relevance, workability and modifiability. Glaser considers fit to be an aspect of validity that shows how successfully the concepts match the incidents they represent. Relevance describes whether the concepts are related to the actual phenomenon and whether the study addresses the real concerns of the participants. Workability refers to whether a theory really works. A theory is said to work when it explains how a main concern is resolved through variation. Lastly, modifiability means that the theory can be modified when new data are compared to the existing data. Importantly, a grounded theory is never right or wrong. Instead, it has more or less fit, relevance, workability and modifiability (Glaser, 1998).

Conclusions and reflections on grounded theory analysis

The process of grounded theory analysis can be described as an activity in which the data are broken up through the process of categorization and are reassembled through the process of theory construction (McLeod, 2003). The former process has been criticized by some authors. For instance, Thomas and Games (2006) claim that this method, which includes dividing the text (through axial coding, codes, second-level codes, etc.), seeks to impose a specific type of thinking that reduces the role of the original voice, the narratives and even clear accounts by researchers themselves because it over-emphasizes methodology and techniques. The same authors argue that using the method entails a denial of acquired knowledge and a rejection of simple understanding.

We see grounded theory method as a way to make sense of the complex phenomena and processes constituting an individual's experiences, which are often private in nature. Grounded theory analysis is a qualitative method that facilitates researchers' explorations of a variety of phenomena. Because its aim is to generate new theory, it is used in fields where little is known or in fields in which knowledge about a social phenomenon already exists but could be further enhanced. It involves the researcher in the creative activity of theory building (Silverman & Marvasti, 2008).

Whether or not the method enables the conceptualization of what Glaser and Strauss (1967) called formal theory, as opposed to substantive theory that is localized in particular contexts, is a moot point. In recent years, researchers have addressed this methodological issue. Mörtl, Gelo, and Pokorny (in press), argue that the original intent of grounded theory could be interpreted as a post-positivist method for approaching an objective truth (represented by one formal theory). Grounded theory methodology has undergone constructive and hermeneutical revisions (see also Charmaz, 2006; Rennie, 2012) and no longer claims to reach one explanatory theory.

Breaking the text into smaller units and labeling them is a process that requires the researcher to be truly immersed in the data. The method's respect for the data and the possibility it creates for exploring the material with openness, untrammeled by previous knowledge, is what makes it a way to facilitate new discoveries. Therefore, McLeod (2003, p. 143) characterizes it as an a-theoretical and a-historical method "which produces pragmatic frameworks for understanding categories and procedural models that are effective in specific contexts." We complement these remarks by underlining one more key aspect of grounded theory: the researcher. Grounded theory is more than a method or a methodology. It is a research attitude (Denzin & Lincoln, 2000) localized in a person and affected by all of his or her personal potential and limitations. However, we also want to critically reflect upon this point: While we agree with Denzin & Lincoln's statement, it should be noted that in the last 20 years, grounded theory has been used as a label not only for the application of the method itself but for a wide variety of qualitative procedures. Suddaby (cited in the introduction to the grounded theory reader by Mey & Mruck, 2007, p. 14) says pointedly: "I note, with some concern, that 'grounded theory' is often used as rhetorical sleight of hand by authors who are unfamiliar with qualitative research and who wish to avoid close description or illumination of their methods."

In conclusion, the manner in which a grounded theory study is carried out depends on the unique contributions of the researcher. Thus, we suggest that interested readers experiment with this exciting

method; if it suits their basic attitudes and understanding of science, they will find a way to fit the method's procedures to their needs and the needs of the given phenomenon that they seek to explore.

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From Life-Threatening Experiences to Ideas of Rescue: Coping with "Trajectories of Suffering" in Adult Acute Leukaemia Survivors

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Abstract. We investigated the illness records and life stories of 17 leukaemia survivors using narrative autobiographical interviews. Audio tapes were transcribed and analysed according to qualitative methodology. Using the sociological concept of "trajectory of suffering" (TOS) as a means of analysis we focused on the survivors' mechanisms of psychosocial adaptation including integration of disease-related experiences as part of their autobiographical narration. Verbal data show how the diagnosis pulls affected people out of their everyday life from healthy, strong and with plans for the future to seriously ill, weak and facing death, and thus suspends their self-confidence and social action competence. Analysing the interview transcripts we found six categories of coping with TOS: (1) personal meaningful nourishments, (2) challenging experience with significant others, (3), courage to persevere, (4) family support, (5) dramatic family events, and (6) dreams. The results of our study demonstrate that the cancer is still a dark shadow over the lives of all survivors. They are discussed in the context of coping theory postulating creativity as an up to now underestimated resource of coping behaviour. As a consequence it seems to be vital that medical staff should recognize and discuss these individual needs and feelings of their patients in daily clinical practice.

Keywords: psycho-oncology, cancer survivors, leukaemia, qualitative research, biography, coping

Acute leukaemia is a rapidly proceeding malignant disease of the haemopoietic system. Hence, the diagnosis of acute leukaemia presents a sudden vital threat for the patient, an attack to his or her very existence. According to the nature of this disease, treatment starts immediately (Estey & Kantarjian, 2005). During the treatment, chemotherapies and repeated hospitalisations are necessary for months. Despite intensive therapy, most of the adult patients die: merely 30-40 percent of the patients younger than 60 with acute leukaemia survive (Buechner et al., 2009). Moreover, a high illness and therapy-related morbidity for all patients as well as a vital threat exists.

The history of research on subjective conceptualizations of the causes of illness and treatment expectations in cancer patients is closely linked with the history of interview-based qualitative research itself. Data of open interviews plays an important role in psycho-oncological research and has done so ever since Glaser and Strauss's inaugural study in San Francisco in the 1960's on dying in hospitals (Glaser & Strauss, 1965). Apart from this, the coping concept has its origin in stress theory, research on coping in the context of life events, and psychoanalytical theory of defence mechanisms (Koehler, Koenigsmann, & Frommer, 2009; Livneh & Martz, 2007; Snyder & Dinhoff, 1999). The most influential theory of coping and stress management today has been developed by Lazarus and Folkman (1984). This model emphasises that coping processes are situa-

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tional and conceptual. It states a distinction between *problem-focused* and *emotion-focused* efforts. Problem-focused efforts of coping should help to solve or adapt to the problem by collecting information, acting and non-acting. Emotion-focused efforts of coping intend to reduce or to regulate the emotional stress inherent in the situation (e.g., acceptance, cognitive or behavioural avoidance).

The interest in subjective narrative representations of suffering from disease and of personally dealing with and working on it (Strauss, Fagerhaugh, Suscek, & Wiener, 1985) as well as in qualitative research on patients' perspectives in general has grown in the last years in the fields of oncology (Loprinzi, 2003), psychology (Rennie, Watson, & Monteiro, 2002), psychotherapy research (Frommer & Rennie, 2006) as well as in medicine in general (Greenhalg & Hurwitz, 1998). Different methodological concepts were developed for exploring subjective illness narratives and coping processes. Quantitative questionnaire-based methods focus on generalizability of results whereas interview-based methods are particularly suited to gaining more information in non-quantifiable intrapersonal and interpersonal processes of feeling, thinking and meaningful interaction. They are not only explorative and useful for generating hypotheses, but also unique regarding their access to specific psychic and social phenomena. It is known that the degree of concordance of results generated with these two assessment approaches on the same research subject is different (Fischer-Kern et al., 2004), and thus, one of these types of study designs cannot be replaced by the other without significant loss of relevant empirical information.

However, hitherto only a few studies have been published in the field of research on adult leukaemia patients. As in other forms of cancer, results are complex, for example with regard to quality of life. Summing up, it can be concluded that having leukaemia leads to an existential insecurity which expresses itself at times in seemingly irrational forms of coping that are of high subjective evidence for the patients themselves, and which are influenced by the patients' life stories rather than by medical explanations (Friis, Elverdam, & Schmidt, 2003, 2005; Koenigsmann, Koehler, Franke, & Frommer, 2006a; Koenigsmann, Koehler, Regner, Franke, & Frommer, 2006b).

While some studies address psychosocial variables in relation to the disease's progress (Tschuschke et al., 2001), the focus of our study lies on the survivors' psychosocial adaptation including integration of disease-related experiences as part of their autobiographical narration. The clinical significance of this biographical grounding comes into view through the determining function of subjective illness concepts in psychotherapy with cancer patients. One type of survivors' subjective adaptation is the so-called *trajectory of suffering* (TOS) from the disease. TOS is a microsociological concept that can be used for empirical research on how cancer patients adapt to the mental shock situation after diagnosis. Process structures in general are mental ordering principles of life history. Schütze differentiates four elementary process structures: (1) *institutional expectation pattern* of the life course, (2) biographical *action schemes*, (3) *creative metamorphoses* of biographical identity, and (4) TOS (Riemann & Schütze, 1991; Schütze, 1981, 2007a, 2007b). According to Schütze TOS is one of the process structures of human biography and is defined as sequences of events and activities that arise and which cannot be grasped in terms of intentional actions or controlled by them. TOS is characterised by being no longer able to organise one's own life in an active way (Betts, Griffiths, Schütze, & Straus, 2007). TOS allows the systematic description of the processes involved in a stepwise loss of social normality towards a situation of *anomie*, which means "normlessness" in terms of the breakdown of social bonds between an individual and his community, including fragmentation of social and personal identity, and rejection of self-regulatory values.

The aim of our study is to examine the concept of TOS, exemplified with the life-threatening experience of suffering from acute leukaemia in terms of biographical grounded coping processes. Under this perspective our interest is situated in the recognition of the coping strategies of the study participants, in particular what types of thoughts, feelings and fantasies have occurred, and which of these ideas were felt to be helpful to escape the fatal "from-bad-to-worse" dynamics of the leukaemia TOS, and to regain control and self-confidence. Using a qualitative approach, based on autobiographical narrations of leukaemia survivors, we will challenge whether the dichotomic distinction between the problem-oriented and emotion-driven strategies currently used in coping research are sufficient to grasp all relevant processes dealing with the integration of the disease into the life story of cancer survivors.

Material

Participants

The current study investigates the life stories of 17 acute leukaemia survivors (8 male, 9 female). The age range was from 24 to 73. According to Kornblith (1998), survivors of acute leukaemia have neither been sick nor undergone treatment for at least one year. Following this definition, people who had had no treatment for a minimum of one year were included in the study. All participants underwent written and informed consent as approved by the Internal Review Board. They were recruited by the Department of Haematology and Oncology at the University Hospital of Magdeburg. The first author of this paper conducted all interviews.

Table 1. Age, socio-demographic data and length of interview

Nr.	ID	Age	Sex	Education (highest degree)	Current profession	Interview length (in min.)
1	001-UE	58	Female	Technical School	Early retiree	80
2	002-UE	25	Female	Secondary Modern Diploma	Unemployed	144
3	003-UE	64	Female	8th Grade	Pensioner	57
4	004-UE	63	Female	8th Grade	Pensioner	70
5	005-UE	25	Female	Secondary Modern Diploma	Telephone operator	118
6	006-UE	54	Female	Technical School	Company group-manager	140
7	007-UE	41	Female	10th Grade	Office worker - Police	160
8	008-UE	71	Male	8th Grade	Pensioner	119
9	009-UE	61	Male	8th Grade	Taxi driver	53
10	010-UE	43	Male	9th Grade	Building worker	63
11	011-UE	25	Female	Advanced Technical Certificate	Unemployed	99
12	012-UE	24	Male	Secondary Modern Diploma	Apprentice	102
13	013-UE	73	Female	8th Grade	Pensioner	127
14	014-UE	51	Male	10th Grade	Early retiree	145
15	015-UE	39	Male	10th Grade	Unemployed	116
16	016-UE	64	Male	8th Grade	Retiree	176
17	017-UE	50	Male	8th Grade	Long-distance truck driver	157

Depiction and analysis of autobiographical narrative interviews

We conducted *autobiographical narrative interviews* (ANI), which were recorded on tape with the participants' informed consent and transcribed according to guidelines developed by Mergenthaler and Stinson (1992). In contrast with quantitative research or fully structured interviews, the narrative interview approach allows the participants to openly describe and explain their thoughts and emotions and permits our multidisciplinary working group the best possible search for variability and different phenomena of the above research subject.

All names and locations were anonymised through pseudonyms. Speech dialects are depicted, to make the background of the lived-in world clear.

Each ANI begins with an open invitation to the participant to tell her or his life history (e.g., "Please tell me your life story. You can take all the time that you need. I will listen to you and make some notes for myself"). This invitation is oriented to the participant's autobiographical memory and designed to generate an autobiographical narrative. The participant's extempore narration constitutes an unplanned spontaneous narrative, which is not influenced by previous preparation; it dismisses "the standardised version" of a repeatedly told story.

The very low level of structuring of ANI facilitates the reproduction of the inner form of the participant's sedimentation of experience with respect to occurrences in the life course. The participant indicates the end of the narrative by a so-called "narrative coda" (e.g., "That's all"). This signals to the researcher that he can start with the narrative questioning part. The interviewer prods the participant to repeat vague or even unclear aspects of the concatenation of events and to dwell on topics just alluded to but not further developed. The researcher can also formulate questions of research interest not touched in the main story line of the participant (e.g. "Seen from today's perspective: How did you experience yourself as a patient in the hospital?" or "Were there moments during the illness in which you were highly uncertain and no longer knew what to do next?"). And then further questioning follows.

The data analysis was carried out along the proposed rules by Schütze (1981, 2007a, b). Relevant aspects of quality criteria were published elsewhere (Steinke, 2004).

The ANI analysis differentiates between single case analysis and cross-case analysis. Through the single case analysis (steps are description of content, analysis of text type, and so-called analytical abstraction), provisional categories are developed (e. g., dealing with feelings, own theories of aetiology, previous experience of illness). With the evaluation of additional interviews in the cross-case analysis, the established categories can be verified, complemented and new connections deduced in the empirical data involved. Finally, the common patterns of social and biographical processes identified are integrated into a theoretical model. During the research process interviews and findings were presented and critically discussed iteratively at periodic meetings of the research team.

Results

The presentation of the results is structured according to two main exploratory aspects: First, how acute leukaemia triggers TOS and how those TOS can be

characterised; and secondly, how individuals handle the shock and trauma of being threatened by death and manage to return to normal daily life. This encloses the question of which feelings, experiences, ideas and fantasies the patients subjectively found to be helpful to cope with the TOS.

Entering the trajectory of suffering: First symptoms and diagnosis

We first address the unfolding of the life-threatening leukaemia TOS: All participants suffered from unspecific symptoms and/or suspicious blood tests before the diagnosis of acute leukaemia was executed; e. g. Mr *Hasel described that he felt "weak," as though coming down with a cold. Following this interpretation of the symptoms, he took a bath. He "passed out," and regained consciousness in hospital. The family doctor, notified of Mr *Hasel's collapse, referred him to hospital, where "they found it out."

The quote from the interview with Ms *Birke shows how the announcement of the diagnosis can lead to an abrupt fragmentation, loss of control and psychic traumatisation through the disease:

> Said to me, "yep: you have leukaemia" I think man, another one, another slap in the face, yeah, that's leukaemia! Great! I think "no, that's enough", then I stood up, "Ms *Birke, I'm not finished yet", I said "leave me alone, just leave me alone", [...] I started to cry, but I didn't care, okay? "What's the matter?" I said "Leave me alone! Don't touch me!" She said "you don't have to be so aggressive", I said "I'm not aggressive, I'm calmness itself just don't touch me".

For Ms *Birke, the diagnosis appears abstract, unreal and cannot at first be completely taken in. At the same time, the instability of the actual illness situation makes quick medical action imperative; the prognosis worsens with every day without treatment. Between the diagnosis and the start of therapy, participants are given almost no time to realise what is happening or to converse and reflect about it with their families. They often enter the hospital with the apparently harmless symptoms of a common cold. Once there, they suddenly become seriously ill individuals in a completely foreign environment. During the first cycle of therapy, they start to begin to understand gradually by step their life-threatening situation:

> I just turned off and thought, who knows what's going to come, maybe it's all over, the thought comes automatically [...]. After seven days, after I got Chemo, after seven days my hair fell out, all my hair, and I really noticed how weak I was [...]. After the first Chemo I had a [...] phase, I was allowed to go home for eight days. I felt so bad I thought, "when the second time is as bad as that I'm gonna slit my wrists!". I couldn't take it anymore, I was just worn out [...]. I just kep' thinking, "are you gonna make it? Or not?" (Mr *Fichte).

This text passage also clearly shows the burden of therapy side effects on the participant. It shows that the interviewee feels that he would rather die than go through such a torture again. The examples of Ms *Birke and Mr *Fichte show how the leukaemia TOS becomes the dominating process structure of their autobiographical narration. The diagnosis pulls them out of their everyday life (from healthy, strong and with plans for the future to seriously ill, weak and facing death) and thus suspends their action competences. The severe side effects of the therapy intensify the leukaemia TOS development. Their own body becomes estranged and is perceived as a threat (Hefferon, Grealy, & Mutrie, 2010). Subsequently, Ms *Birke and Mr *Fichte behave in a reactive manner and feel directed by external circumstances. Influencing the further development by one's own efforts is not imaginable for them, their orientation in life becomes increasingly despondent (Betts et al., 2007; Riemann & Schütze, 1991). These all-overshadowing events lead to the situation where the study participants lose trust in themselves and the helpful relationship with their partners. Some of them develop fantasies about choosing suicide over painful therapy, view themselves as incapable of everyday actions, and feel as if they are non-reliable from their partners' perspective. In addition, they feel incapable of engaging in social relationships or taking care of themselves. They mistrust their own abilities, oscillating between denial of their factual situation and feelings of hopelessness.

Coping with trajectory of suffering

The inability to act in everyday affairs and in the framework of longer lasting biographical provisions, and the feeling of being a stranger to oneself as well as to one's social and spiritual environment force the participants to radically redefine their life situation. Among all participants of our study, there is a discrete moment identifiable in the interviews where the situation changes again after the climax of the TOS development. From this point onwards, they begin to attempt to defend themselves against death's grasp and exert control over their trajectory. Impulses to cope with the leukaemia TOS can be favourably influenced by felicitous events or experiences or by compassionate and helpful individuals and their actions. This special kind of survivor's coping by a reflective entering one's own illness story helps the participants to adjust to their illness and develop new perspectives.

According to our research interest, we focussed on those parts of the interviews, in which the survivors felt in the phase of suffering most and tell what helped them find their way back into normal life. The quotations presented from the interviews are examples. For each category one quote was selected which suited best to the respective category.

Personal meaningful nourishments (Mr *Fichte, Mr *Tanne, Mrs *Esche, Ms *Eiche). One of the categories we identified is the participant's focus on specific nourishments. Although dietary advice is given by physicians in order not to jeopardise the successes in treatment (Denmark-Wahnefried, Aziz, Rowland, & Pinto, 2005), for example not to eat unwashed and unpeeled fruit, we could observe that certain food was of particular importance for the study participants. One reason might be that the participants could exercise control over this aspect of their situation, while doctors and nurses determined and controlled most other daily life processes. Nourishment thus represents a comforting experience of regaining action capacity and everyday normality. Moreover, feeding seems to be an opportunity to strengthen the weakened and diseased body. By this, the participants felt like active protagonists in the healing process. Thirdly, feeding the participant was a way for the relatives to express their care, sympathy and concern. Fourthly, the interviewees experienced homemade food as something from outside the hospital world, and thus saw it as an almost magic source of providing healing power. The following quotation shows this topic exemplified by a conflict between Mr *Fichte and his doctor regarding autonomy, represented by an egg from the henhouse of the interviewee's home:

> I had no appetite, so I said "ya know what, when you come, then you bring a whisked egg, with sugar, whisked" and I drank that [...]. And one time the doctor, he came to me and said "what's that you're drinking?" I said "Doctor, raw egg," "My, my, you're not allowed to do that," "why not?," "there could be salmonella in it, I said 'there ain't any," said "my chickens at home are all healthy, we don't have salmonella," "you don't know that, uh, you didn't know about your own illness either," I said "our animals are vaccinated [...] there's nothin' in there, don't worry" and I kept doing that and it was good for me, wasn't it? Cause it's healthy, isn't it?

This illustrates the participant's fundamental conviction that his own ecological niche at home contains the way to cope with his illness. For the doctor, a raw egg is dangerous and detrimental as it can cause salmonella. However, Mr *Fichte is firmly convinced that an egg from his own chicken can help him to regain health. From his point of view, a body weakened by chemotherapy regains strength through healthy, domestic products. This conviction allows him to regain a certain feeling of mental and emotional control over the illness's progression and his own body. In terms of the types provided by Lazarus and Folkman (1984), this category is mainly about problem-focused coping, in particular representing a suitable strategy for physical strengthening. However, the assignment to this type of coping is not completely satisfactory, because personal meaningful nourishments are indeed subjectively problem-oriented, but not from the objective perspective of the medical staff. Thus, emotional and irrational aspects are essential, too.

Challenging experiences with significant others (Mrs *Erle, Mr *Lärche, Mr *Ulme, Mrs *Linde). Another category derived inductively from the narrations captures the tendency of significant others to shape interpersonal conflicts and thus to provoke experiences that act as revelations. Those struggles can exert a formative influence on the leukaemia sufferers. The study participants evaluated those experiences in the interview, as the following example depicts.

Mrs *Erle, like many others, was not allowed to eat all kinds of food. For fear of making a mistake, she asked one of the nurses if she could eat a tangerine. Mrs *Erle had what she called a "really stupid experience" with the nurse. The occurrence made her so indignant that she felt compelled to fight against her illness.

> [...] so I asked the nurse if I could maybe eat a [...] tangerine and she said to me "I'd eat it if I were you, you never know how long you'll be able to," I thought, "what's her problem? She must be crazy" and I said, "I'm gonna get well here!," and so I thought, "just for that I'm not [...] gonna eat it at all! [....] I'm gonna eat it later, cause there's gonna be a later," I knew I'd make it, deep inside! Not always in my head, but inside, I like protested inside, how could she say something like that to someone with cancer, "you don't know how long you'll be able to do that."

Mrs* Erle reacts angrily. She is bewildered about the non-empathic utterances of the nurse. What follows are her remarks on the development of resistance and fighting spirit (Grulke & Bailer, 2007) against the disease. In our interpretation, her anger seems to be not only an additional burden, but also a challenge, helping her to conceptualise ideas to recover from her leukaemia in order to show the nurse, that she will be able to enjoy tangerines in the future, too. The example shows that interpersonal struggles and conflicts can help the patient to resist leukaemia and thus help to solve the problem of health threat. In addition to these problem-focussed aspects in terms of Lazarus and Folkman emotional aspects play an important role, too, because having arguments often is triggered by emotions like anger, anxiety, or desperation.

Courage to persevere (Ms *Linde, Mrs *Ahorn, Mr *Pappel, Mr *Kastanie). The third category we have found is already described in the coping literature on fighting spirit (Grulke & Bailer, 2007). Despite the fact that Ms *Linde is aware that medical treatment plays a major role in the success of healing, she is convinced that if she believes in herself and has the courage to face the challenges of the disease, her chance of healing will increase essentially. Complementarily she supposes that if she gives up, she will lose the fight against the disease:

> But I said to myself, that's the only way you can maybe make it, if you don't think about it all the time and, uh, when you keep your guts, and I heard, it doesn't just depend on doctors, uh, whether you get better, they've got a lot to do with it of course, maybe the most important part, but it depends on yourself, too. That you get up the courage to fight, and that's what I tried to do.

Similar to the two categories above, this category represents problem-focused aspects as well as emotion-focussed ones. On the one hand, the interviewees told that it helped them to conceptualise leukaemia as a problem that could be solved by their own will and efforts. On the other hand, it is overt from an objective perspective that these feelings occurred in situations characterised by a maximum of helplessness, powerlessness, and surrender.

Family Support (Mr *Hasel, Ms *Kiefer, Mr *Weide, Mrs *Esche). As known from studies on family support and social support, interpersonal relationships play a significant role in coping behavior (Given, Given, & Kozachik, 2001). Family support does not only provide important assistance for the participant throughout the entire course of therapy, it also acts as a link to the outside world and thus presents a kind of communicative normality between the secluded participant and the "healthy" world of normal everyday affairs outside. However, not only does the *family* care about and show concern for the participant, she or he is in turn concerned about the family's welfare, how it manages on a daily basis and suffers from her or his absence. This is especially true when the family's existence depends on the patient's health. Mr *Hasel owns a taxi business into which he pours great energy to develop and therefore does not want to abandon. His efforts to keep his business going strengthened him:

> We're not gonna let ourselves down! that's what distracts you a little and when you achieve something you get stronger [...]. If you fight for something a long time then you don't give it up so easily [...] that's what I thought, see, the will, "it's gotta go on" and I wanted to be independent, that was probably what kept me going, and I was ambitious, see?!—up 'til, you could say up 'til now.

As the small taxi company was a family business, Mr *Hasel was able to rely on his wife during his illness. She managed the company during his absence ("was busy, had to run the business, you know"). This example not only reveals the importance of his family's economic existence to Mr *Hasel, but also the enormous challenges which had to be met by the family. Both aspects confirm the mental and emotional importance of a stable family environment for coping with leukaemia TOS. Hence, according to our view and to the proposed definition by Lazarus and Folkman, this category can rather be assigned to emotion-focused coping, because feelings of being part of a healthy and positively developing whole are the core of the text passages assigned to it.

Dramatic family events (Mrs *Buche, Mrs *Eibe). An additional category found to be crucial in the narratives has to do with incisive family events during the illness that influence the participant to redefine their current life situation. Such an event is exemplified by the tragic death of Mrs *Buche's grandchild, an event she described as one of many "strokes of fate:"

> anyway, I sat down on my bed, all of the sudden the door opened and black—six figures dressed in black came in [...] and my grandchild, he flung himself around my neck and said "grandma, my brother is dead" [...] now that was a shock! I lay down on my bed and put my head under the covers I—I couldn't believe it [...]. Everything was just terrible and then I wasn't allowed to go to the funeral, they didn't let me [...] that time when that was going on with my grandchild, this and that, "why *M? why not me?" It was really bitter.

Through the loss of her beloved grandchild, the seriousness of Mrs *Buche's own illness receded into the background, and the ill fate and loss of a young family member took precedence over everything else. The situation was aggravated by the fact that Mrs *Buche was too ill to take her leave of her grandchild at the graveside. In addition, her severe suffering is intensified by her mental and emotional comparison of the disproportion in her and her grandchild's life expectancy. Her utterances gain transcendental overtones of theodicy: Why can there be the obvious injustice to let the child die and the grandmother live? From Mrs *Buche's lengthy description of her relationship to the deceased (weekly cemetery visits, conversations with the deceased at the grave, refusal to wear mourning), and visiting the grave, can be interpreted as symbolizing these questions. She feels she has a legacy and responsibility to live, handed down to her by her beloved family member who had to die so very early.

The case with Mrs *Eibe was something different. She told of a happy event in their family: the birth of her grandchild. Because the grandchild is not allowed to visit Mrs *Eibe in hospital, for her it became crucial to be healthy so that she can embrace her grandchild. Although both the examples presented of dramatic family events are completely opposing, they showed that good fortune as well as great tragedy could have the effect of changing the focus from being suffering from an sinister, unswayable and dangerous disease to other significant and touching life events. In our view this category could be rather assigned to emotion-focused coping in the sense of Lazarus and Folkman.

Dreams (Ms *Birke, Mr *Kastanie, Ms *Kiefer, Mrs *Erle). Since Freud's *Interpretation of Dreams* (Freud, 1900), dreams are often regarded as symbolically meaningful occurrences: as revealing definitions of a deeper sense of the current life situation or as prophecies. Accordingly, they can have effects on the

dreamer and can influence her or his actions. The most dramatic dreams reported in our study were those described by Ms *Birke. Her dream could be identified as a trigger of a specific coping strategy and was characterised by a high degree of details. She dreamed in a situation of suffering from severe side effects and losing the will to survive at the beginning of therapy because of a fungal infection:

> [...] so I thought, I just don't want to anymore! I thought, I don't want to wake up in the morning, I thought to myself, that went through my head, I couldn't say anything because of the fungus everywhere, I don't want! to get up! anymore! don't wake up anymore.

During this period, Ms *Birke dreamt of entering the basement of a house situated in a dark forest. There she met black-clad schoolchildren with smooth black hair and nothing but black eyes in their faces. A woman who looked similar to the children screamed, "Catch her." In panic, the dreamer ran away into the forest, followed by these eerie creatures. Yet:

> They got me anyway! They got me! Those hussies! All of them on top of me! And then I, I pushed them all away! And got up, and in that second I woke up [...] I was really loud, in the room [...] that dream! It was horrible, I was sweating non-stop!

In this situation Ms *Birke reported her dream to a nurse who interpreted it as both the cancer's attack on Ms *Birke and her defence against this attack. The interviewee told that she could identify with this interpretation of the nurse and remembered her mother's "prophetic" words:

> [...] "you've got to fight, fight, fight" [....] "how am I supposed to do that?" Well? "Well! I can't tell you how! You'll learn it" and then I had that dream, right? Then I knew what fighting was!

Unlike, for example, the case of a broken leg, most leukaemia patients cannot pinpoint the origin and circumscriptive locus of their disease. Because of the complex haematological pathophysiology and the quasi-invisibility of the disease their assumptions are vague, unclear, and without concreteness. The capacity to dream allows concretizing both threats and healing fantasies emanating from this situation. Her dream helped Ms *Birke to regain belief in her own healing powers. Her ability to thrust back cancer within the finite province of the dream meant for her that she would also be able to take up the battle in reality, and that she would be able to take control over her life and not allow cancer to determine it. In order not to deviate from the new course of action, she sought diversion through contact with her peers:

> [...] and then I sort of blocked everything out, took care of the others and then I felt better [...] I always had someone to talk to [...] and I was never really fully conscious of my sickness, I didn't give a damn, I didn't care about it, you gotta make it, [...] and go home, call it a day.

In some interviews, dreams were reported as occurring during the first weeks of therapy or following a traumatic experience, such as the sudden death of a fellow patient as Mr *Kastanie says, for example, or a painful medical procedure (injection, Ms *Kiefer) respectively an unpleasant remark from one of the hospital employees (Mrs *Erle). Such experiences, indirectly or in a veiled manner, seemed to remind the study participants of their own proximity to death.

The categories identified show aspects of both problem-focused and emotion-focused coping strategies. The category *Dreams* illustrates best the difficulties to assign these categories exhaustively to one of these types *or* the other. On the one hand dreaming encloses the handling and solving of conflicts and problems in a virtual space; on the other hand, dreams are an effective possibility to express feelings and concerns—even those which are suppressed when people are awake.

Discussion

The aim of our study was to conceptualise leukaemia survivors' coping processes using the micro-sociological concept of TOS. The results show firstly, that coping processes are determined by biographical predefined subjective illness concepts about cancer. These concepts are related to biographical experiences in everyday life before cancer diagnosis especially those dealing with critical episodes. Secondly, cancer survivors undergo their own, subjective cancer experience, high impact and everlasting "like an old handbag. It is sometimes visible or not, sometimes you seem to forget where it is, but this fear, your handbag, you will never lose it. It stays with you for a lifetime."[1] As a consequence of our study we assume that not only in cases with negative prognosis, but also in cases with complete remission, the experiences related to leukaemia remain a dominant and persistent threat that overshadows the whole future life of the affected persons.

The participants in our study showed different coping strategies as a reaction against the vicious circle of losing their psychic balance triggered by leukaemia: *Personal meaningful nourishments* represent an area where participants could feel themselves to be agents. Although their fate lies in the doctor's hands, and they must be able to rely on the doctor's competence, consumption of special nourishment not only offers a feeling of well-being but also of actively contributing to one's own healing. *Dreams* and *challenging experiences with significant others* confront the survivor with the possibility of her or his

[1] Quotation from a leukaemia patient not included in this study.

own death. Realising the high probability of a fatal outcome galvanises them and triggers a combative stance against the disease. *Family support*, *dramatic family events* and the participant's *courage to persevere* help them to relinquish day-to-day worries and concentrate on the healing process.

Although all participants survived their disease, leukaemia still took up a predominant position in their autobiographical narratives. This is most evident in the fact that they mentioned the period before falling ill with acute leukaemia only briefly, whereas they presented occurrences from the time of the diagnosis in detail and partly with verbatim doctor-patient conversation quotations. Moreover, hardly any study participant was able to recount her or his biography in chronological order. In most cases, events related with leukaemia were predominantly told. All this leads to the assumption that none of the participants was fully able to integrate the disease into their biography up to the time of the interview. Acute leukaemia is therefore still a dark shadow over the lives of all study participants, regardless of how long the treatment has been over, or whether the survivors were male or female. One of the reasons may be that the risk of relapse was not entirely excluded at the time of the interview.

Even after the end of treatment, leukaemia is an important biographical topic in our interviews. This becomes evident from reports showing that after-care consultations lead to re-traumatising experiences (Schmitt, Singer, & Schwarz, 2003). Thus, cancer is not psychic trauma of limited duration. The cancer sufferers interviewed in our study, even though they were cured from a medical point of view, did not completely reach the posttraumatic stage (Cordova, 2008). Enduring posttraumatic stress was caused by the "serious current threat" (Ehlers & Clark, 2000) the study participants had to cope with. However, indications of posttraumatic growth, as described by Hefferon et al. (2010) can be detected especially among the female participants by applying the body as a kind of tool or barometer in terms of being experienced and competent to indicate positive versus negative states of the whole self.

We identified emotion-focused and problem-focused coping strategies in both women and men. The results, however, tentatively indicate that women could be more prone to emotional coping, while men could be more prone to problem-orientation. Differences between the sexes, such as conscious and healthier lifestyles for women and recovery of physical strength for men, were found. Woman and men share a strong desire for normalisation, and integration into everyday life, and the desire for distance from the hospital atmosphere. The regular after-care for women and men involves both stressors as well as calming measures to check their health.

Studies conducted by other authors confirm our results regarding the mediating role of biography-related factors and patients' self-concept for coping with illness (Xuereb & Dunlop, 2003). Recurring appraisals of personal meaning of life, attitudes toward death, re-evaluation of life goals, and integration of stressful events into a coherent autobiography become significant concerns during the course of a life-threatening illness (Vehling et al., 2011). In discussing these results many authors (e.g., Snyder & Dinhoff, 1999) follow the model of Lazarus and Folkman (1984). According to their definition, coping is a constantly changing cognitive and behavioral effort in order to manage specific demands. These efforts can demand or exceed the capabilities of the particular person to a certain extent. In this context Lazarus and Folkman regard coping as functional behaviour. Thereby they differentiate between problem-focused and emotion-oriented coping. Problem-focused coping involves the active solution of the particular problem or the encumbering situation, whereas emotional coping aims at modulation or avoidance of particular emotions. The point in doing so is to change the condition perceived as burdensome and to alleviate stress emotions (e.g., fear or depression). In addition to Lazarus and Folkman's comprehension of coping as functional behaviour, Koehler et al. (2009) focus on the essential coherence between *patients' subjective concepts of illness* and coping with illness. The particular concepts of illness lead to specific defence strategies and coping behaviour styles. All these coping efforts should be understood as biographical grounded conscious and unconscious *regulation* efforts (Koehler, Dogan, Koehler, Heine, & Frommer, 2011a; Koehler et al., 2011b).

According to Lazarus and Folkman's classification of problem-focused and emotion-focused coping strategies, the six categories that were found can be assigned as follows: "meaningful personal nourishments," "challenging experiences with significant others" and "courage to persevere" might be assigned to problem-focused coping because they provide the means of active influencing the physiological treatment as well as mental recovery. They counteract to the weakening of the body by chemotherapy and the resulting threat of self-abandonment. The categories "family support" and "dramatic family events" are closer to emotion-focused coping strategies. They provide a part in everyday life and a substitute for the concern about oneself. No category found can be unambiguously assigned to problem-focused or the emotional group of coping styles, because both rational and emotional aspects are relevant throughout.

The category "dreams" has been identified as an important resource for our participants. Problem-focused and emotional aspects might have a certain meaning in producing dreams, but they are subordinate. Thus, this category shows best that coping is not only triggered by rational and/or emotional motifs, but also by other forces. We propose to name this kind of coping behaviour the *creative* one. Dreams can be the basis for a problem-focused as well as an emotional coping, like every other subjec-

tive representation, too. Moreover, dreams demonstrate that creative acts can be a coping resource themselves. In our definition: Creative phenomena (e.g., dreams) refer to a mental activity in which the person is not directly dealing with the problem and not trying to change emotions. Rather, a person uses it to obtain a vital subjective regulation (e.g., positive feelings or impulses for action regulation). Dreams and other creative activities (e.g., singing, dancing) can be a starting basis or stimulus for following sensations or events. Moreover, through the dreamer's interpretation of his dreams, dreams gain a functional character.

Participants were recruited through psycho-oncology services and knew the focus of the study to be leukaemia, so one of the limitations of the study is a presumption through the recruiting process. Although participants were asked to give an unselective account of their entire biography, a deliberate selection of leukaemia-connected themes cannot be excluded. Another limitation could be the small sample compared to the age ranging from 24 to 73. Furthermore, no distinction has been made between acute myeloid leukaemia (AML) and acute lymphoblastic leukaemia (ALL). Instead, both were subsumed under the term acute leukaemia. AML as well as the ALL were assessed as potentially fatal diseases with similar coping efforts. Lastly, the wide span of one to ten years after treatment could be regarded as a limitation. Nevertheless, similarities emerged between the narrations of participants whose end of treatment had been only a few years ago and of those lying ten years in the past.

In summary, our main concern was to point attention to cancer survivors' mental regulation, taking account of their biographically grounded coping processes by use of the autobiographical narrative method. Due to the possibility that ANI allows for freely telling the life stories of our research participants, we gained an innovative and deep insight into the biography and the life-threatening experience of suffering from acute leukaemia. This and the systematic comparison of survivors' coping efforts allow a detailed understanding of the biographical grounding of their strategies.

Finally, we would like to summarize for daily clinical practice. Our results imply for clinical practice that successful coping strategies not only develop based on objectives, but also on subjective evaluation mechanisms (Koehler et al., 2009). Nourishment for example is not known for an objective support of oncological healing processes (Gardner et al., 2008). Nonetheless, from patients' perspectives it can be a plausible coping strategy to influence the treatment course and quality of life. It must be taken into account by oncologists that the patients' preferences for treatment, the patients' compliance and their coping strategies are affected by their subjective concepts of illness (Koehler et al., 2009). Because survivors' respect and fear of cancer is stable over time in view of their remission status, it is vital that the medical staff should recognize and discuss the individual needs, ideas and feelings of the persons affected. Early identification of survivors' subjective perceptions of the cancer experience might improve quality of life (Smith et al., 2011). The findings may also be integrated in medical and psycho-oncological training. Especially the aspect of creativity should be involved in psychotherapeutical interventions.

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Client Attitudinal Stance and Therapist-Client Affiliation: A View from Grammar and Social Interaction

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Abstract. Although it is widely acknowledged in psychotherapy research that the development and maintenance of positive relational bonds are central to the therapeutic process, the ways that therapists and clients become affiliated through discourse and interaction has not received very much attention. Taking up this concern from a conversation analytic perspective, this paper explores how therapists and clients negotiate affiliation around clients' affective and evaluative talk or attitudinal stance. In order to illustrate the application of our method, we have chosen to analyze audio- and video-recordings of two clinically relevant interactional contexts in which client stance constructions frequently occur: (1) client narratives; (2) client disagreements with therapists. We show that therapist responses to client attitudinal stances play an important role not only in securing affiliation and positive relational bonds with clients, but also in moving the interaction in a therapeutically relevant direction.

Keywords: affiliation, attitudinal stance, conversation analysis, therapeutic collaboration

In psychotherapeutic settings, much of client talk has an affectual or evaluative component: Clients express their emotions concerning certain personal events and they make judgements about own and others' behaviour. These personal life episodes thus become permeated with evaluative meaning, which in linguistic terms is called a *stance* (Biber & Finegan, 1989). In conversation, a stance may be realized in various parts of the grammar (e.g., adjective, adverb, verb), but it may be realized non-verbally as well through gestures and facial expressions. Communicating one's stance through evaluative or affectual displays can have therapeutic significance. In fact, many psychotherapy researchers have already been exploring client emotional expressions or themes from a variety of theoretical perspectives (e.g., Greenberg & Paivio, 1997; Lepper & Mergenthaler, 2007). The expression of specific emotions, at certain points during therapy and in certain discursive contexts, may be indicative that a positive change process is underway (Greenberg & Angus, 2004). But a client's stance display may have additional relevance. Social interactional research has shown that stance displays create potential points of affiliation with others (Stivers, 2008). For example, when clients convey sadness in relation to a personal event, this creates an opportunity for the therapist to affiliate with the client's affectual stance (i.e., sadness) and, thus, to create or intensify the relational bond between them. Although the quality of affiliation may vary for different contexts, many therapy approaches advocate therapist responses that convey understanding and acceptance or *empathy* (Rogers, 1951, 1957).

The general perspective we adopt on stance and therapist-client affiliation for this paper is *social interactional*. Special focus is placed on *language use* and how language and other semiotic resources construct and negotiate social realities (Atkinson & Heritage, 1984; Garfinkel, 1967; Goffman, 1967; Halliday, 1978; Sacks, 1992). As Schegloff (2006) has recently argued, interaction is a primordial site of sociality: The ordered ways in which speakers take turns and organize their social actions into sequences do not just reflect a structured method in achieving a common ground for understanding. Above and beyond that, ordered practices of interacting construct

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Table 1. Typical stance markers for style expressing personal affect

Stance marker category	Examples of grammatical markers	Example from data
Explicit affect markers (positive/negative)	Adjectives: *pleased, disturbed* Verbs: *adore, regret* Adverbs: *gladly, unfortunately*	"After the last session I was re:ally like **frustrated**"
Emphatics	*So, very, definitely*	"It's **really** horrifying."
Certainty verbs	*Concur, contends*	"But I **know** where this all dose s(h)ings come from."
Doubt verbs	*Seems, appears*	"I **think** it's okay to be lo:ud or quiet,"
Hedges	*Maybe, kind of*	"An this h's always **sort've** bothered me too."
Possibility modals	*Might, could, may*	"Certain situations **might** make me: angry?"

social relationships, identity and culture from "the ground up," through our deployment of linguistic and other communicative resources.

Seen from a linguistic vantage point, language is used, albeit not exclusively, in the service of negotiating and securing interpersonal relations (Enfield, 2006; Halliday, 1978, 1994). Our use of lexis and grammar or *lexico-grammar*, for instance, plays a decisive role in conveying our attitudes. It is through specific lexico-grammatical selections that we make affectual displays of sadness, happiness, surprise and so on, or pronounce judgements that sanction our own or others' behaviour (Martin, 2000). Attitudinal displays, whether they are affectual, judgemental or evaluative, are deeply interpersonal not only because they often implicate others, but because they make a response from others relevant.

For this paper, we use the methods of conversation analysis (CA; Schegloff, 2007; Stivers, 2008) to examine how clients display an attitudinal stance and to explore how therapists and clients achieve affiliation around a given stance. This paper, therefore, serves as an illustration of how CA may be applied to shed further understanding on how therapeutically relevant interactional sequences are managed by clients and therapists. To begin, we provide an overview of *stance* and *affiliation* and show how these constructs may be identified in conversation. In this section, we discuss how stance can be realized through a range of interactional resources, including prosody, lexico-grammar and "larger" discursive units. Further, in order to make more fine-grained, lexico-grammatical distinctions between different attitudinal stance types, we draw from the work of corpus linguistics (Biber & Finegan, 1989) and systemic functional linguistics (Martin, 2000). Second, using a diverse set of data involving different psychotherapy treatments (i.e., couples therapy, client-centred therapy and process experiential therapy) we show two applications of our method to psychotherapy research: (1) client stance displays during storytelling; (2) managing disaffiliation around a client's stance. Finally, we conclude by discussing future directions and limitations of stance research in psychotherapy.

Attitudinal stance

The conceptualization of stance, as it is used in this paper, draws its origins from lexico-grammatical and semantic-focussed work in linguistics. Very influential in this regard were Biber and Finegan (1989), who defined stance as "the lexical and grammatical expression of attitudes, feelings, judgments, or commitment concerning the propositional content of a message" (p. 93). Taking grammar as a point of departure, their studies aimed to provide a comprehensive, quantitative account of how stance is expressed through grammatical markers of attitude in English. Drawing on four relevant categories (verbs, adjectives, adverbs and modals), Biber and Finegan further described clusters of typical markers for particular stance styles, identifying *Emphatic Expressions of Affect* as a cluster of markers encompassing the direct expression of personal affect and evidentiality.[1] Table 1 illustrates the different stance markers of this style mentioned in Biber and Finegan (1989), along with specific examples of their use taken from client talk during psychotherapy.

These markers illustrate the various ways in which we can build an attitudinal stance word by word through lexical and grammatical means. According to Biber, Johansson, Leech, Conrad and Finegan (1999), "attitude adverbials tell of the writer's or speaker's attitude toward the proposition typically conveying an evaluation, value judgment, or assessment of experience" (p. 856). In the excerpts given of client talk from our data, it is clear that these markers usefully indicate rather overt stances created by

[1] While "stance" for Biber and Finegan (1989) also includes the lexical and grammatical expression of evidentiality (p. 94), attitudes towards knowledge (later given the term "epistemic stance" by Biber et al. [1999] and "engagement" by Martin and White [2005]) are not focused upon in this paper, but rather the expression of personal attitude is treated exclusively as our concern in psychotherapeutic interactions. Similarly, Biber et al.'s (1999) third domain of "style stance" will also not be covered in this paper.

clients as they relay their experiences to therapists. Thus, this method provides a lexico-grammatical profile of clients' and therapists' attitudinal stance towards people and events.

Since Biber and Finegan's (1989) classic work, other linguists have been developing the notion of stance by considering how various lexico-grammatical expressions specifically relate to semantics. For example, although the expressions "I feel really sad" and "she's really selfish" both convey attitudes, the semantics of each is different. Whereas the first expression conveys affect the second conveys a judgement about someone's character. It was to account for these kinds of differences that led researchers from a systemic functional linguistic (SFL) tradition to consider the different semantic types that stance adverbials tend to express. The result was a division of stance across three semantic domains: *affect* (expressing emotion), *judgement* (evaluating a person's behaviour or character), and *appreciation*[2] (evaluating things and abstract phenomena [Martin, 2000]). Other features deemed important for stance construction were also considered such as a stance's *valence* (positive vs. negative),[3] the nature and target of the evaluation (e.g. *who* is being judged, *what* is being assessed) as well as the up/downgrading of intensity of these categories. These different semantic stance types may undergo further refinement: *Affect* may be considered in terms of un/happiness, in/security and dis/satisfaction; *Judgements* may orient to such general oppositions as praise/condemnation or admiration/criticism; and *appreciation* may concern our emotive reactions to ("wow") or assessments of ("that was an elegant and detailed story"; "what you said was very significant") things and events. Martin and White (2005) explain that when we make different choices between these categories, we can interpret the ways that "writers/speakers approve and disapprove, enthuse and abhor, applaud and criticise, and with how they position their readers/listeners to do likewise" (p. 1). The linguistic approaches indicated above provide an impressively detailed method for identifying stances through the grammar or semantics, but our interest in stance is broader; that is, we want to explore attitudinal stance that not only takes the grammatical-semantic level into account, but also (1) other interactional resources such as prosody and non-verbal expressions; (2) interactional units other than the clause; and (3) the context through which action sequences are realized.[4] An approach that takes appropriate stock of these dimensions is CA (Sacks, 1992; Schegloff, 2007; Stivers, 2008). By using the methods of CA, we will not only be able to examine attitudinal stance with regard to a wide range of interactional resources (including its grammatical design), but also with regard to how a client's stance may develop throughout sequences of talk, and how client stances are taken up by therapists and further negotiated. Stivers' (2008) study on storytelling in everyday situations provides the most current view of attitudinal stance within CA. She characterizes stance in terms of the interactional means through which events are given an affective treatment. For Stivers, lexico-grammatical resources hold a central place in how speakers construct stances. However, special focus is also given to the role of prosody (e.g., stress and intonation) and also "larger" interactional units such as story prefaces (e.g. "I have a friend who became depressed a long time ago").

In order to illustrate how our method may be used to identify client stances realized within therapy, we consider a short interaction involving the client Bonnie and her therapist.[5] The example we show has been transcribed according to CA conventions and involves some detailed prosodic information (e.g., stress placed on word or word segments, rising or following intonation, etc.; see Appendix A for explanations of the symbols and their meanings); although our examples have been simplified to make them more accessible for readers not accustomed to these transcriptions.[6]

The example in Table 2 shows how Bonnie draws from a variety of attitudinal markers that target herself and her Aunt Fern. Just prior to this example, Bonnie recounted to the therapist that her Aunt had accused her of stealing from her. Bonnie's stance markers are highlighted in bold.

For the first part of our analysis, we consider Bonnie's use of lexico-grammatical stance markers that target. Her attitudes are expressed through various kinds of negative affect and judgement, as seen from the following lists.

Expressions of affect:

I **rese:nted** it
I felt **guilty**
I think I ∩**REAlly** felt **guilty**
I **didn't like** her.
but I **really didn't like** her

[2] As stated in the introduction, in the psychotherapy context, clients often express emotions about events in their lives and judge their own and others' behaviours, but appreciation of things does not seem to take on such a strong role. However, it will be shown in the following section that appreciation (or "assessment" in CA terms) comes into play more in the therapists' response to a client display of stance.

[3] Biber and Finegan's (1989) model also makes this distinction.

[4] We would add that it is not our aim to compare different linguistic or discourse analytic approaches with regard to how they handle attitudinal stance. That would far exceed the scope of this paper. Readers wishing to learn more about some of the similarities and differences between CA and SFL should consult Muntigl (2004a, 2010) and Muntigl and Ventola (2010).

[5] This example is taken from the York I Depression Study (Greenberg & Watson, 1998). Clients from all the examples used in this paper have been given pseudonyms. All identifying information has been removed from transcripts to preserve anonymity. The therapist's approach in this example was client-centred.

[6] Transcription conventions modified from CA notation in Jefferson (2004). See Appendix A for outline.

Table 2. Lexico-grammatical stance markers in Bonnie session

01	Bonnie:	and of course I was getting this from Aunt Fern.
02		and (0.4) I think in a way I **rese:nted** it mainly becau-
03		well first of all I wasn't doing it [(h) hehhehhehhehheh hehheh]
04	Ther:	[↑right! I mean it sounds like y-you]
05		had a right to resent it [if it was]
06	Bonnie:	[.hhh] right. .hh but- an I think I w's (.) I felt
07		**guilty**. (0.4) because I felt I **should be more understanding**
08		because she was an old lady, [she was] confused(h) ya(h) know.
09	Ther:	[I see]
10	Bonnie:	but at the same time I thought .hh I'm ↑doing **my (level) best** for you.
11		you have ↑**never bothered** with me. you have ↑**never wanted anything to do**
12		with me ↑or my children,
13	Ther:	h:m.
14	Bonnie:	and (0.2) I'm trying to do it because you're an old lady, an ↑then.
15		(0.4)
16	Bonnie:	I think I ↑**REAlly** felt **guilty** (0.4) because quite frankly, I **didn't like** her.
17		(0.5)
18	Ther:	°mm hm.°
19		(0.4)
20	Bonnie:	naw- I mean that sounds **awful**.
21	Ther:	mm hm.
22	Bonnie:	but I **really didn't like** her [she was] a **very very selfish** woman.
23	Ther:	[mm hm]
24	Ther:	mm hm.

Expressions of judgement:

I felt I **should be more understanding**
you have ↑**never bothered with me.**
you have ↑**never wanted anything to do with me ↑or my children,**
that sounds **awful.**
she was a **very very selfish** woman

With regard to affect, Bonnie feels resentment, guilt and dislike. Her judgements involve criticisms of herself and her Aunt Fern. For instance, whereas Bonnie "should be more understanding," Aunt Fern never showed interest in Bonnie or her children and is very selfish.

In addition to identifying all the single expressions of attitude, we also want to get a better handle on how these attitudes cohere with one another, how they are built up throughout Bonnie's turn and what kinds of discursive work they are enacting in the process. To perform this kind of analysis, we also need to take slightly larger textual units of Bonnie's utterances into account. The following textual units show some interesting ways in which affect and judgement interrelate:

I think I w's I felt **guilty**. because I felt I should be **more understanding**
I think I ↑**REAlly** felt **guilty** because quite frankly, I **didn't like** her

To begin, Bonnie feels guilt (*affect*) because she should have been more understanding (*judgement*). Thus, her guilt is constructed as deriving from not having shown more compassion to Aunt Fern. Her guilt is then further intensified due to various attributes of her aunt such as being "old" and "confused," while simultaneously evoking the negative judgement or criticism that her Aunt is less capable and is not in possession of all her faculties. Then, as Bonnie develops her utterance we note a shift in stance. She begins to justify her resentment towards her aunt and, at the same time, shifts the focus of her guilty feelings towards her great dislike of her aunt, rather than her own lack of compassion. Bonnie accomplishes this by contrasting positive judgements of self ("I'm ↑doing my (level) best for you") with negative judgements towards her aunt ("you have ↑never bothered with me. You have ↑never wanted anething to do with me ↑or my children"). After having begun on a trajectory in which Bonnie begins to highlight her aunt's negative attributes, she continues by altering the object of her guilt: "Because quite frankly, I didn't like her." She then continues by justifying her dislike of her aunt by stating that "she was a very very selfish woman," using emphatic and prosodic markers to upgrade the force of her attitude, and lending even more to her justification.

Thus, by considering these different forms of attitudinal stance displays and how these displays cohere and interact within an utterance, we are able to show how speakers justify their stance and how stance develops over time. In this example, Bonnie began by justifying her own guilt with a negative judgement of self. But, as

Table 3. Inclusion of non-verbal information in Bonnie example

01	Bonnie:	and of course I was getting this from Aunt Fern.	
02		and (0.4) I <u>thi</u>nk in a way I **rese:nted** it <u>mai</u>nly becau-	
03		well first of all I wasn't <u>do</u>ing it	[(h) hehhehhehhehheh hehheh]
04	Ther:		[↑right! I mean it sounds like y-you]
			B: fast multiple nods----------->
			T: fast double nod, smiles at B
05		had a <u>ri</u>ght to resent it	[if it was]
06	Bonnie:		[.hhh] right. .hh but- an I think I w's (.) I <u>fe</u>lt
			B: fast nod
			T: shallow double nod. T: shallow double nod

she continued with her turn, she gradually revealed her dislike for her aunt and, as a result, changed the object of her guilt and her portrayal of her aunt: from "old" and "confused" to "uncaring" and "selfish."

We have also only considered Bonnie's displays of attitudinal stance and not the therapist's. However, in order to determine how the client's stance is being taken up by the therapist and negotiated, the therapist's interactive contributions need to enter into our analysis. We address the issue of stance and its interactive management in the next section.

Affiliation around stance

In her work on storytelling, Stivers (2008) argues that a teller's stance provides the recipient of the telling with insight into the teller's specific attitude about a given event. Returning to the Bonnie example, we have shown how Bonnie built up a complex interplay of affect and judgement concerning how she felt about her Aunt's apparent indifference towards Bonnie and her family as opposed to Bonnie's guilt because she feels dislike for her aunt. According to Stivers, these stance displays serve as potential points of *affiliation* for the recipient to respond by supporting or endorsing the teller's perspective or stance. By incorporating Stiver's view of affiliation into our stance analysis, stance work may be considered within a context of unfolding talk between speakers and, more specifically, as the interplay between a teller's display of stance and a recipient's response in terms of endorsing, modifying or even rejecting teller's stance.

Affiliation may be conveyed in a variety of ways, verbally and non-verbally. For example, an agreement may be expressed through the word "yes," but also through a nod. In fact, non-verbal expressions such as nodding and smiling have been found to be very important for securing affiliation. Research in CA has shown that simultaneous or sequentially produced nods can reinforce affectual bonds between speakers in everyday (Kita & Ide, 2007; Stivers, 2008) and psychotherapy contexts (Muntigl, Knight, & Watkins, 2012).

In order to illustrate how stance negotiation and affiliation during therapy may be accomplished verbally and non-verbally, let us revisit the first six turns of our previous example with Bonnie, as shown in Table 3. Non-verbal information is added within the lines of the transcript here (in italics below the concurrent verbal text) to illustrate how these resources play an important role in affiliating with Bonnie's expressed attitudes.

As can be recalled, Bonnie begins her turn by communicating her resentment towards her aunt for having accused her of stealing and then justifies her resentment by denying any wrongdoing, thus implicating that she has been wrongly accused ("well first of all I wasn't <u>do</u>ing it"). The therapist's response is strongly affiliative: First, she expresses agreement ("↑right!"); second, she echoes Bonnie's innocence by underscoring Bonnie's right to feel her emotion; and third, her agreement occurs immediately and in partial overlap with Bonnie's turn. The contiguous production of a next turn has been argued to express strong affinity with the prior turn (Pomerantz, 1984).

The non-verbal level, however, also plays a very important role in securing affiliation between the speakers. Notice that Bonnie and the therapist nod simultaneously and the therapist also smiles (line 04), presumably in response to Bonnie's laughter. Further affiliation is realized when Bonnie confirms the therapist's move by uttering "right" and when the two speakers again nod in unison. It may then be that, as a result of the strong mutual affiliative displays between the speakers, Bonnie was then offered a 'secure' context through which to keep developing her stance concerning her relationship with her aunt.

Thus, by considering the therapist's responding utterance, we can see how the client's stance is affiliated with both verbally and non-verbally. Martin (2000) contends that "all appraisal involves the negotiation of solidarity-you can hardly say how you feel without inviting empathy" (p. 170), and here the therapist provides an empathic response that demonstrates her understanding of, and agreement with, Bonnie's feeling as a point of bonding and solidarity between them; that is, the response confirms Bonnie's "right" to have a feeling of resentment and reiterates Bonnie's explicit affectual verb "resent" to open up this stance as an interpersonal negotiation of their solidarity together. As shown in the example with Bonnie, stance

Table 4. Story involving negative stance by Wendy

01	Wendy:	well I think that uh (2.0) Fred just gives up now hh heh .hh
02		I think that secretly he still wants to win the argument
03		he wants to prolo::ng
04		Fred is a: uh
05		he likes to lecture? (1.2) on any: any subject
06		that he feels even mildly uh uh y'know animated abou::t
07		he likes to lecture
08		and and go on and on and on and on about it
09		and I- there wuz one this morning or yesterday or something
10		that .hh that I thought well its deci:ded
11		but Fred still had to:: really make sure
12		that I knew what wuz going on uh
13		that that uh he had he had pressed his point
14		[he has] done that all uh all my my years with him
15	Ther:	[what I'm]
16	Ther:	.hh what I'm starting tuh see here is a pattern uh um
17		as a couples therapist um I'm always looking for patterns?
18		that people get into that they get stuck in .hh
19		and I'm I need your agreement
20		as tuh whether or not what we're seeing here is this particular pattern
21		umm which is leading tuh the kinda communication
22		that (both) you're talking about

is not a matter of the speaker conveying a fixed attitude, but instead is composed of a host of attitudinal meanings that develop and shift over time. For example, Bonnie was shown to often account for her feelings and judgements. By providing more discursive detail to her attitudes, Bonnie places her hearer, the therapist, in a better position to share or empathize with her strong stances. Thus, when the client talks through her experiences in this way, it is part of a process of negotiation, a 'back and forth' interaction that involves the therapist's responses as key elements in the expansion of talk. Furthermore, these responses do not necessarily add to the attitudinal content of the talk—they may be minimal or even non-verbal in nature and thus work primarily as affiliative devices; non-verbal displays have also been shown to be especially significant in the psychotherapy context (Bänninger-Huber, 1992, 1996; Muntigl, et al., 2012), particularly with respect to achieving strong affectual bonds between therapist and client.

Applications to psychotherapy

Thus far, we have shown the importance of examining stance work interactively within a sequence of turns and how non-verbal resources are important for accomplishing mutual affiliation between a therapist and client around a client's attitudinal stance. In this next section, we provide some examples of how the CA method for analyzing stance and affiliation may be applied in different psychotherapy contexts. It should be emphasized that our approach is not limited to certain kinds of therapy (e.g., client-centred, cognitive-behavioural, experiential, etc.). Clients in all types of therapy formulate stances and therapists will respond to these stance displays in some manner, whether they affiliate with the stance or not. What we are interested in is *how* this is accomplished and the kinds of consequences stance management has for the ensuing therapeutic conversation.

In order to showcase our CA method for examining stance, we will examine therapeutic interactions taken from diverse forms of therapy; the first from couples therapy and the second from one-on-one therapy with a depressed client. We have chosen these examples in order to demonstrate how stance management is important in different clinically relevant contexts involving (1) client narratives and (2) client disaffiliation with therapist interventions. Our aim is to show that, by analyzing a range of therapy contexts, CA can show how therapy-relevant constructs such as "relational bonds" and "therapist-client collaboration" are realized at the level of talk, through the moment-by-moment interactional processes between clients and therapists.

Client narratives: Attitudinal stance and affiliation

There has been an interest in client narrative production among therapy researchers for some time now (see Angus & McLeod, 2004). It has been argued, for instance, that narratives are important discursive resources for identity construction and for forming and negotiating interpersonal connections (Angus & McLeod, 2004; Bruner, 1986; Labov, 1972; Labov, & Fanshel, 1977; Labov & Waletzky, 1967; McLeod,

1997; Muntigl, 2004a, 2004b; Muntigl & Horvath, 2005). There is also growing interest in the actual 'content' of the narrative, to what degree of detail or specificity clients tell their stories. Angus, Lewin, Bouffard and Rotondi-Trevisan (2004) have suggested that, for process experiential therapy, "clients' disclosure of personal stories, and the subsequent elaboration of the dual landscapes of narrative action and consciousness, are fundamental to the facilitation of significant client shifts and personal change" (p. 99). The details (or lack thereof) of how a client stories personal experience is also therapeutically relevant for the following reasons: The degree of detail may show how clients construct elaborated attitudinal stances to underscore the significance of the narrative (Labov & Waletzky, 1967), and also how they interweave emotional expressions or "themes" to give prize to their anger, grief, happiness and so on (Greenberg & Angus, 2004). But specificity of degree of elaboration is not the only relevant issue pertaining to client narratives. It is important to also consider the kinds of discursive work the client's stances are doing (e.g., complaining about others, conveying new emotions in specific life contexts, etc.) and how the client's stance may provide a certain relevant next response from the therapist (e.g., empathy).

In this section, we show how attitudinal stances are conveyed in client stories and how changes in stance can be detected by using our CA method. Story examples are taken from previously published work involving couples therapy and particular focus is given to the client Wendy (Muntigl, 2004a, 2004b).

We provide two examples: one from the beginning of therapy in which Wendy tends to produce stories that over-generalize or *script formulate* (Edwards, 1995) personal experience and criticize her husband's lecturing; the second is from the end of therapy in which Wendy stories a unique episode of experience in which she is able to overcome feelings of depression and confusion.[7] We not only show how Wendy constructs stories to realize different attitudinal stances, but also how these stance displays implicate different kinds of uptake from the therapist.[8]

Early therapy: Scripting experience. In the early stages of therapy, the couple Wendy and Fred were found to script their experience through stories that mainly involved overt negative judgements, especially criticisms, of self or spouse. In the example in Table 4, Wendy produces an extended turn at talk in which she elaborates on Fred's excessive lecturing.

During her turn, Wendy conveys an attitudinal stance in which she criticizes her husband Fred. Her stance is mainly realized as a series of extreme judgements that cast Fred as an incessant lecturer. Wendy uses various linguistic resources to upgrade the magnitude, duration and scope of his lecturing such as lexical repetition (*any: any* subject; and *go on and on and on and on*), adverbs (*even mildly*, *really* make sure), verbs (*pressed* his point), and plural deictic-terms (*all* my my years). Wendy's judgemental stance is further developed through a short story in lines 9-14 that serves as an example of Fred's lecturing. Through this story, Wendy portrays Fred's lecturing as extremely harsh and as intentionally so. By lecturing, even though Wendy considered the discussion finished ("well its deci:ded") and by going above and beyond what would be considered necessary (*really* make sure; *pressed* his point), Fred is depicted as merciless and unrelenting, as someone who enjoys subjecting others to his lecturing and who has always done so ("he has done that *all uh all my my years with him*").

Wendy's stance displays that characterize Fred's lecturing as extreme and repetitive, within the context of a story or narrative, have the function of generalizing her experience of her husband's actions. Modes of talk that generalize people's behaviours in extreme ways have been described by CA researchers as script formulations (Edwards, 1995) and by psychologists and psychotherapy researchers as overgeneral autobiographical narratives or memories (Boritz, Angus, Monette, & Hollis-Walker, 2008; Singer & Moffitt, 1992). Wendy's stance thus works to construct a 'life script' pertaining to Fred: He has a tendency to behave in a certain way (i.e., lecture) and this behaviour is judged as strongly negative.

It is important to point out that no relation is being drawn here between Wendy's tendency to script formulate her experiences in the early stages of couples therapy and depression (see Boritz et al., 2008); that is, no implication should be drawn that these narrative types will signal that the client is depressed. In fact, because we have observed these scripts to commonly occur in many other cases involving different couples, we would argue instead that these scripts are a general feature of the beginning of couples therapy in which spouses position themselves vis-à-vis each other, often to criticize or complain about other's behaviour.

Turning now to the therapist's response, we note that the therapist does not affiliate with Wendy's criticisms of Fred. For instance, he does not respond with confirmation (e.g., "yes, he does") or with a move that summarizes or reworks Wendy's stance (e.g., "so how does his lecturing make you feel?"). Instead, the therapist's response to Wendy's stance displays is strongly interpretive (Peräkylä, 2005; Stiles, 1992), involving the therapist's rather than the client's perspective. This is shown from expressions that highlight the therapist's point of view ("what *I*'m starting tuh see;" "*I*'m always looking for patterns"). This move from the therapist performs a variety of actions. First, by not displaying affiliation with Wendy's stance, talk that negatively judges Fred is brought

[7] Examples were taken from a corpus of couples therapy data collected by Adam O. Horvath (see Muntigl & Horvath, 2005).

[8] White and Epston's (1990) *narrative therapy* was used as the treatment modality.

Table 5. Wendy display of positive stance in storytelling

01	Ther:	so wuz that an example of you being assertive against the
02		[problem.] is that
03	Wendy:	[ye:s]
04	Ther:	how ya did it. you you became assertive again.
05	Wendy:	I I vuh verbally (1.0) d uh u::m:: god (1.0)
06		I spoke it. [out ward. stop it.]
07	Ther:	[uh huh. uh huh.]
08	Wendy:	[jus] sto::p it.
09	Ther:	[uh huh]
10	Ther:	mhm.
11	Wendy:	a::n I sto::pped (.) feeling (.) depressed. (.)
12		an I stopped feeling (1.0) uh confused. (0.8)
13		an I got I ma- did something work in the kitchen
14		or I:: did something
15		went outside for a little while
16		an .hh and uh felt good about that.
17		I felt good enough about it .hh
18		tuh tell Fred about it a couple've times.
19		thet thet I had done that.
20	Ther:	okay uh I like tuh stop people
21		when they say things that are stand out as
22		signifi [cant].
23	Wendy:	[y(h)eah]
24	Ther:	so you said I:: stopped (.) feeling (.)
25		d'you hear what you're saying.
26	Ther:	I stopped feeling depressed.=
27	Wendy:	=yeah.
28	Ther:	I simply said STOP IT.
29	Wendy:	yeah.
30		(1.0)
31	Ther:	you really became assertive against the problem.=
32	Wendy:	=mm hm=
33	Ther:	=an you stopped feeling de[pressed.]
34	Wendy:	[yeah]
35		(1.5)
36	Wendy:	I did.

to a halt. Using CA terms, the *progressivity* of this line of stance construction is disrupted (see Stivers & Robinson, 2006). Second, by not directly affiliating with Wendy's activity of criticizing Fred, he is able to shift the direction of talk by focussing on his own therapeutic agenda of identifying communicative patterns and relationship problems (for a more detailed discussion of this process see Muntigl, 2004a). In sum, the therapist was able to recast the client's stance involving negative judgements into talk that was more relevant to the aims of narrative therapy: identifying problems and (not shown in the example above), later on, exploring the effects of the problem on the clients' lives.

Later sessions: Stories of agency and positive affect. In the final sessions of therapy, Wendy began to produce stories that focused on single, positive change events. Wendy's construction of attitudinal stance in these stories is vastly different from her scripts; that is, she would display positive affect and agency in relation to specific events. Also, the therapist's response to these stories tended to be strongly affiliative and would attempt to maintain progressivity of talk regarding the client's positively expressed attitudes (see Table 5).

Towards the beginning of this example, the therapist prompts Wendy into explaining how she became assertive against *the problem* (i.e., feeling badly or feeling that she is letting Fred down when she feels she is not meeting his expectations). As a response, Wendy produced a narrative explaining how she was able to overcome her feelings of confusion and depression. Her stance construction is interwoven with specific actions and events in which she takes on an agentive role. To begin, she verbalizes commands ("jus sto::p it"), ordering an end to her depressed feelings. The manner in which she does so also suggests a state of heightened affect: vowel lengthening, repeated stress on whole lexical items, emphatic terms ("god"). Subsequent to that, she describes a certain action trajectory in which she works to overcome negative affect and, as a result, to begin to feel good about it.

There is another important aspect to the way in which Wendy constructs her attitudinal stance: She contrasts the absence of negative affect with the onset of positive affect (i.e., feeling good):

Absence of negative affect

a::n I sto::pped feeling depressed.
an I stopped feeling uh confused.

Onset of positive affect

I felt good enough about it .hh tuh tell Fred about it a couple've times.

By emphasizing that she "stopped" having certain emotions, Wendy presents these "facts" as highly newsworthy and significant. The newsworthiness of not being depressed or confused is further strengthened when she announces that she relayed this information to her husband not just once, but "a couple've times".

The therapist's response to Wendy's story is vastly different from his response in Table 4. Rather than interpret Wendy's narrative, he displays strong affiliation with what Wendy had said in a number of ways: First, he positively assesses Wendy's talk as "significant;" second, through his assessment he reinforces Wendy's prior claim that stopping to feel depression and confusion is newsworthy; third, he mirrors back Wendy's utterances by repeating not only her lexical and grammatical choices, but also her intonation. Thus, by preserving the linguistic construction of her utterances, the therapist makes a strong empathic connection with Wendy's positive affect displays and, in doing so, marks their significance as actions in their own right and as actions that signal that a change process may be occurring.

The therapist's displays of affiliation were important practices for maintaining progressivity on the topic of Wendy's newly felt emotions. In fact, subsequent talk became devoted to further exploring Wendy's agency and affect in other contexts of her life (see Muntigl, 2004a for a detailed discussion of these activities). The therapist's affiliative response, therefore, was important in setting the stage for future relevant therapist work. What we want to stress in these examples, however, is that stance takings and responses to stance are interactive achievements. Thus, what is important is not just whether the client has produced a detailed story about her personal experiences or whether the therapist has affiliated, but how these two actions unfold together and the possibilities they make available for taking further action. The client initiated the sequence by sharing a story with the therapist about her ability to stop having certain negative emotions and her ability to feel good about that. The therapist, in turn, affiliated with and thus continued to share and develop Wendy's positive affect. It is this kind of interactive process of negotiating affect that our method allows us to describe in a detailed way.

Client disaffiliation: Achieving re-affiliation with a contrasting stance

Constructing and managing stance expressions in psychotherapy can be a delicate and risky task for therapists. For example, when therapists seek to affiliate with a client's stance by reflecting back or interpreting various affectual meanings of a client's utterance, clients may choose to disaffiliate with these attempts. This is because clients may find the therapist's response to be an inaccurate representation of their felt experience; thus, in order to re-affiliate, therapists must then work to restore their standpoint of empathy and re-connect around the client's perspective or stance.

We have found that, for person-centred therapists, when clients rejected the therapist's construction of their stance, therapists would retreat from their prior position so that affiliation—and the therapeutic track—would not be placed further at risk (Muntigl, et al., 2012; Muntigl, Knight, Watkins, Horvath, & Angus, 2012). Therapists often worked instead to re-affiliate with the client's stance—and 'let go' of their own prior position—through a range of verbal and particularly non-verbal practices. For instance, therapists sometimes named the client's newly expressed feelings in order to display empathy and to affiliate together with those feelings instead.

They also would respond minimally to the client's talk so as to not impede upon their stance construction, often displaying affiliation only non-verbally such as through nodding. In fact, therapists were found to use nodding at key moments in the client's stance construction (such as after the expression of an attitudinal stance marker) to direct their affiliative display towards this content without interrupting the client's process of telling. Affiliating with a teller's explicit stance displays through nods has also been observed by Stivers (2008) for everyday storytelling contexts. Thus, nodding is usefully employed by therapists in our psychotherapy contexts to display token understanding of the client's divergent stance in response to disaffiliation.

Consider example in the Table 6, which shows a short sequence of process experiential therapy with the client Paula (non-verbal information is once again represented in italics below lines of speech).[9] Here, the therapist's attempted recasting of Paula's stance is rejected, resulting in disaffiliation. The transcript illustrates how the therapist secures re-affiliation with Paula by producing nods in direct response to Paula's stance displays and, later, by reflecting back Paula's divergent position.

Paula begins by providing an affectual stance that highlights her dissatisfaction with her current boy-

[9] This example was also taken from the York I Depression Study (Greenberg & Watson, 1998), but involving a different client.

Table 6. Nodding in response to Paula's stance display

01	Paula:	and it's just **really hard**, (0.8) to say oka:y (1.3) this person,
		T: slow double nod-------->
02		(2.0) doesn't make me feel **good**, (3.4) a:n- (.) like jus- (.) just
		T: slow shallow double nod
03		to ↻leave it like just to sa::y, like f::- (.)↶f:orget it. like just drop it an- and
		T: shallow nod
04		move o:n. like it **doesn't work**.
05		(2.5)
06	Ther:	and is there (.) a feeling of somehow, (0.9) I **fa:iled** if tha- I do that or I-
07		(1.1)
08	Paula:	.hhh::: hhh:::
09		(8.8)
10	Paula:	I- euh no:. like- (.) w- what ↶I'm wondering about like wis this- (0.8)
11		particular man. like why: (.) am I **so: hung up** (0.3) on him. like why do
		T: shallow multiple nods. *T: slow double nod→*
12		I have to **try**:, (1.2) ↶**so hard**, (0.5) and at the same time like it's almost
		T: nod---------> *T: shallow nod*
13		like he **doesn't ca:re**. (1.5) and why do, (0.4) why do I keep, (3.9) ↶running.
		T: deep nod. T: slow nod. *T: slow nod*
14		[(1.6)]
		[*T: multiple nods→*]
15	Paula:	uh(hh) (.) and why does he say certain things, (0.3) which kind of make me
		T: nods --->
16		↶thi:nk (.) that he **cares**, but then (0.8) in his behaviour he doesn't really- (.)
		P: double nod
17		**live up to it**. uh(hh)
		P: smiles
		T: nod
18	Ther:	so you feel **very confused** by his behaviour
19		(1.0)
20	Paula:	oh ↶yeah. (h)he he he!
		P: rolls eyes to side
		T: shallow nod

friend and the relationship. This stance is realized with the help of adverbials that are framed by negative particles (i.e., "not"), as shown in the following clauses:

> this person, **doesn't** make me feel **good**
> like it **doesn't work**.

Furthermore, the client also conveys a sense of hopelessness and frustration about the relationship. This stance is not conveyed by explicit lexical expressions of "hopelessness" or "frustration" terms or their synonyms, but rather through activity-type terms that directly express a *reaction* to end the relationship:

> to ↻leave it like
> just to sa::y, like f::- ↶f:orget it.
> like just drop it
> an- and move o:n

It should be noted, however, that the client's stance of dissatisfaction, hopelessness and frustration is framed by her initial upgraded assessment of "it's just really hard to say [...]". Her stance is also consistently upgraded through various prosodic features (i.e., word stress, rise/falling intonation, syllable lengthening). In sum, Paula's message to the therapist is that the major inadequacies concerning her relationship get compounded through her expressed difficulty in taking concrete action on these relationship issues.

The therapist's response, in turn, *formulates* an upshot of the client's prior talk (see Antaki, 2008 on therapist formulations). She thus picks up on and engages with her client's affectual stance further, to drive the conversation forward on these terms. What the therapist does is draw attention to a possible reason that could explain the client's difficulty in taking action: "is there (.) a feeling of somehow, (0.9) I **fa:iled** if tha- I do that." By turning the focus on the client's potential feelings of failure, the therapist also subtly shifts the focus of stance talk towards an implicit judgement. Thus, talk moves from expressions of negative affect towards the boyfriend and relationship to a hypothetical context in which the client might blame herself if the relationship failed.

That the stance proposed by the therapist is a crucial point to their affiliation is made clear by the client's response: She disaffiliates with the therapist's position and instead expands with more attitudinal

talk to clarify her stance viewpoint. Her disaffiliation is realized through a deep in- and out-breath (".hhh::: hhh:::"), followed by a long pause and ending with an explicit disagreement ("no:."). After this, Paula continues by constructing a stance in which criticisms of self (i.e., her excessive feelings for the boyfriend and her effort in keeping the relationship going) are contrasted with a criticism of the boyfriend's lack of interest:

Negative judgements/criticisms of self

I **so: hung up** on him
I have to **try**:, ↶**so hard**
I keep, ↶running

Negative judgements/criticisms of boyfriend

he **doesn't ca:re**

Paula's stance is further strengthened through her repeated use of "why" prefacing her self-criticisms (e.g., "why: (.) am I **so: hung up** (0.3) on him"). The implied response for each of these constructions is that there is no convincing reason for her to do this; there is no payoff because the boyfriend does not return her feelings in kind. Contrast is expressed further at the end of her turn when she asserts that although the boyfriend tells her things to make her think that he cares, his words do not live up to his actions ("but then (0.8) in his behaviour he doesn't really- **live up to it**."). Through her turn, Paula avoids making any links to the therapist's previous allusions to "failure" or self-blame, and instead proceeds to focus more explicitly on the contrasting attitudes between her positive feelings and resolve and her boyfriend's lack of interest.

During this time in which Paula rejects the therapist's suggestions that failure might motivate her lack of action, the therapist does not remain inert, but instead displays affiliation non-verbally through nodding. These nods also occur at specific places in Paula's turn; at the end of a clause that contains an explicit stance. Note the direct sequential alignment of these nods with Paula's stance expressions highlightened in the segment shown in Table 7.

The therapist's nods seem to be strategically placed within Paula's turn, with each nod following the completion of a stance expression that indicates her direct support of what Paula is expressing. The therapist's nods thus affiliate directly with the content of Paula's new, divergent stance and foster the expansion of this stance until she reaches the point where she can offer another verbal response to secure their re-affiliation. Instead of reiterating the feeling of "failure," as in the therapist's initial proposition, she encourages the expansion of this new stance and offers a stance for Paula once again to confirm. This time the therapist provides a formulation that forms a closer tie to Paula's expressed stance: "so you feel **very confused** by his behaviour." She subtly transforms Paula's contrasting assessments of herself and her boyfriend into a stance that is realized by the affect term "confused." On the positive side, the therapist is able to effect successful re-affiliation with her client, as evidenced by Paula's response of confirmation. On the negative side, however, the therapist was not able to get Paula to consider some of the implications (i.e., feelings of failure) evoked through her stance displays. Thus, this interaction may be interpreted as a mixed success: Although mutual affiliation between therapist and client was achieved, the therapist's goal of developing the client's stance in a more therapeutically relevant direction was not.[10]

Contexts of disaffiliation between therapist and client are particularly telling of how important stances are to the psychotherapeutic interaction; that is, we can see that when the therapist puts affiliation at risk by delivering a version of the client's own attitude towards an event, and the client deems the formulation inaccurate, both therapist and client work to rectify their shared understanding of the client's stance meanings expressed.[11] Thus, by paying close attention to overt and more implicit expressions of stance, the rather intricate interactional work that therapists do may be revealed; that is, therapists are shown to utilize a range of verbal and non-verbal resources at their disposal to achieve re-affiliation when affiliation is at risk of breaking down, and thereby avoid rupturing the track of therapeutic progressivity with clients. The progression of turns between client and therapist when disagreements occur exhibits how a stance can go from being a resource through which affiliation may be secured and a positive therapeutic relationship may be developed to a potential point of contention between them, requiring a delicate and immediate recourse by therapists to recapture positive affiliative bonds.

Future directions

Our goal in this paper was to illustrate the utility of analyzing clients' attitudinal stances and the dynamics of therapist-client affiliation from a conversation analytic perspective. Examining therapy dialogue using the tools of CA offers a detailed view of the "micro" interactional processes through which clients link important affective qualities to their personal experiences, and provides a novel window to explore how therapists' verbal and non-verbal responses to these stances affect the quality of the therapists' relational bond with the client at the discursive, turn-by-turn, level (see Peräkylä,

[10] Examples that show how, following client disaffiliation, therapists and clients are able to negotiate the client's stance in ways that orient to both the client's and therapist's perspectives may be found in Muntigl et al. (2012).

[11] Readers interested in seeing a broader array of examples that focus on the different practices through which therapists secure re-affiliation with clients or, more generally, how disaffiliation around a client's stance gets negotiated over longer sequences should consult Muntigl et al. (2012).

Table 7. Nodding sequentially aligned with Paula's stance displays

01	Paula:	like why: (.) am I **so: hung up** (0.3) on him. *T: slow multiple nods*
02		like why do I have to **try**:, (1.2) ↶**so hard**, (0.5) *T: slow double nod------>* *T: shallow nod*
03		and at the same time like it's almost like he **doesn't ca:re**. (1.5) and why do, (0.4) *T: deep nod. T: slow nod*
04		why do I keep, (3.9) ↶running. *T: slow nod*

Antaki, Vehviläinen & Leudar, 2008 for an overview of CA applications to psychotherapy).

We argue that CA offers a practical, systematic method to explore the fine-grained realizations of attitudinal stances and the ways in which affiliations with stance between the therapist and client are an ongoing achievement. The specific benefits for psychotherapy research are that we can get a more detailed understanding of (1) how the interactional resources used to manage attitudinal stance play a part in constructing the Bond components of the therapeutic alliance (Bordin, 1979, 1994; Horvath & Bedi, 2002); and (2) how certain activities occurring in therapy (i.e., storytelling, disaffiliation sequences) provide the relevant sequential contexts through which relational bonds—via the interactional resources mentioned in (1)—are accomplished. Further, our focus extends prior CA work on how collaborative rapport in therapy may be achieved through talk (Lepper & Mergenthaler, 2007); that is, our work provides another angle on therapist-client *collaboration* by focussing on how therapists and clients affiliate around a client's attitudinal stance (Table 7).

We now turn to some of the limitations of this sort of interactional-based work: To begin, the CA perspective and methods are not meant to replace or obviate other forms of detailed analyses of the therapy process commonly used in psychotherapy research; CA should be seen instead as a complementary perspective that provides a detailed account of how therapeutic interactions are talked into being. There are also certain limitations to stance analysis. First, attitudinal stances are not always overtly expressed through the lexico-grammar (Martin, 2000; Stivers, 2008). These implicit stance displays are not always easy to identify and so some important client stance displays may be missed. As well, attitudinal stances and practices for affiliating with stance may be realized on many semiotic levels: prosody, lexico-grammar, larger discourse units and non-verbal (nods, facial expressions, body position, gesture). Identifying stances and affiliation can therefore be a very time consuming process, especially if larger stretches of talk or multiple sessions are analyzed. This, however, is a practical limitation and not a limitation of the analytic framework per se. Finally, we have only chosen and presented excerpts that illustrate the process and utility of our approach. This paper, therefore, should be viewed as a first step in exploring the range of practices therapists have at their disposal for managing affiliation around stance. Much more work needs to be done.

The work we have presented here is part of a programmatic investigation of therapy process at the micro-interactive level. As part of this program, we are presently collaborating with Lynne Angus by examining narratives of depressed clients using York Depression Study data. Here, we will be exploring constructions of client attitudinal stance and how client stances may develop and change over the course of therapy. We are also just beginning to examine in more detail how disaffiliation is realized during therapy, how clients perform resistive acts, how resistance persists or becomes resolved and how attitudinal stance may play a role in this process. Some work is already being prepared for publication (Muntigl et al., 2012; Muntigl & Horvath, 2012). Finally, although we have already considered many of the linguistic and non-verbal resources (e.g., nodding) that play a deciding role in stance construction and securing affiliation around stance, we plan to devote our attention to other resources such as facial expressions and vocalizations such as laughter (see Bänninger-Huber, 1992; Ruusuvuori & Peräkylä, 2009). Our general aims for this work are to further our understanding about important aspects of the therapist-client relationship and, on a more practical note, to help therapists to reflect on their practices in terms of how certain actions (verbal and non-verbal)—in certain contexts at specific *locations* within the interaction—may be more successful at achieving affiliation with their clients.

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Appendix A: Transcription notation

[	Starting point of overlapping speech
]	Endpoint of overlapping speech
(1.5)	Silence measured in seconds
(.)	Silences less than 0.2 s
wo:rd	Prolongation of sound
(word)	Transcriber's guess
wo-	Speech cut off in the middle of the word
WORD	Spoken loudly
°word°	Spoken quietly
word	Emphasis
.hhh	Audible inhalation
hhh	Audible exhalation
wo(h)rd	Laugh particle (or outbreath) inserted within a word
heh	Laugh particle
.	Falling intonation at end of utterance
?	Rising intonation at end of utterance
,	Continuing intonation at end of utterance
↺word	Fall-rising intonation
↻word	Rise-falling intonation
italics	Non-verbal behavior (actor indicated by initial)
bold	Highlighted markers of stance

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